

Progress Report 2011:

HEALTH CARE RENEWAL IN CANADA

May 2011





ABOUT THE HEALTH COUNCIL OF CANADA

Created by the 2003 *First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal in Canada.

The Council provides a system-wide perspective on health care reform and disseminates information on best practices and innovation across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

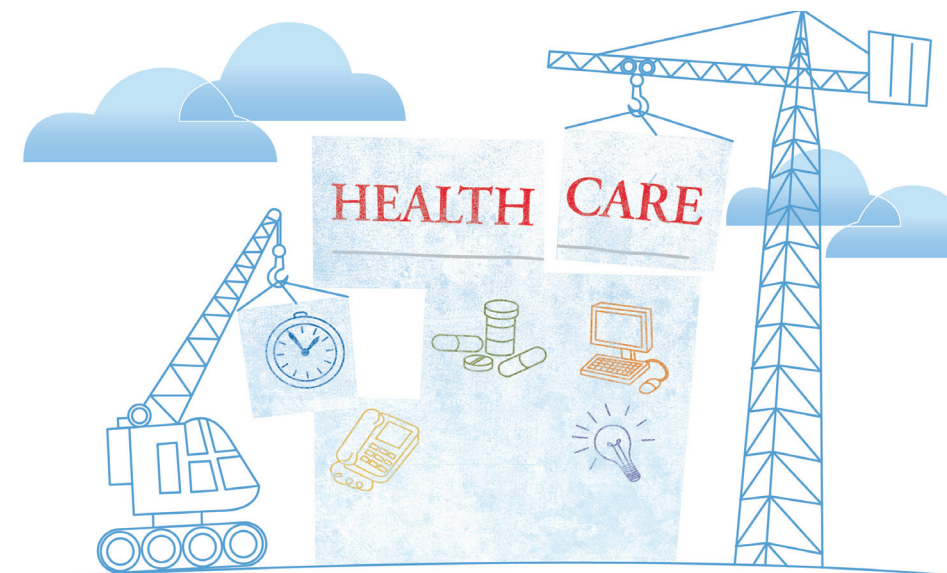
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Foreword

A recent report on the sustainability of health care in Ontario begins with a sobering reminder about the importance of work being done by all governments to renew and sustain Canada's health care system. These words echo beyond Ontario, and apply to every jurisdiction charged with setting policies and delivering health care programs that are accessible, of high quality and sustainable:

Health care is integral to our well-being. Our quality of life and standard of living are inextricably linked to our health and well-being. One cannot overestimate the integral role [Ontario's health care system] plays in serving both patients and the province.

With our first breath, we become direct beneficiaries of the system. As we age, its role only increases with importance. A healthier society tends to be a wealthier society, enabling a highly educated and productive workforce. Our health care system is not perfect, but it is envied around the world. We have a vested interest to preserve, sustain and enhance it.¹

With the broad commitments of the 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care*, First Ministers recognized both the complexities and challenges that governments faced to improve Canada's health care system. The accords left room for interpretation, while providing directional guidance. They also respected the need for individual jurisdictions to map out unique solutions for their specific populations.

In *Rekindling Reform* (2008), the Health Council of Canada described the progress the jurisdictions had made toward turning the 2003 and 2004 health accords into reality. Three years later, *Progress Report 2011* examines changes in the Canadian health care landscape, and progress made at the federal, provincial, and territorial levels in five specific program areas.

To demonstrate improved access to care, we have chosen to look at work on wait times and telephone health-advice services across the provinces and territories. To look at sustaining and improving quality of care, we have investigated two areas: advances in managing and accelerating the use of electronic health records, and provincial and territorial efforts to address the increasing cost and use of pharmaceuticals. Finally, we focus on health innovation—finding new ways to tackle persistent challenges—which we believe will contribute to the sustainability of Canada's publicly-funded health care system. In the development of this report, we have been supported by federal, provincial, and territorial ministries of health.

The Health Council of Canada recently presented our overall take on the implementation of the *10-Year Plan to Strengthen Health Care* to the Senate Committee on Social Affairs, Science and Technology. We told them that progress has been made, mainly by jurisdictions working on their own. This report delves into the details and gives Canadians the information to reach their own conclusions.

Dr. Jack Kitts
Chair, Health Council of Canada

Introduction

In 2008, the Health Council of Canada released *Rekindling Reform: Health Care Renewal in Canada, 2003–2008*, a report on the progress made since First Ministers' groundbreaking attempts to renew the health care system: the 2003 *First Ministers' Accord on Health Care Renewal*, and the 2004 *10-Year Plan to Strengthen Health Care* (commonly referred to as the health accords).

The Council found that well into the accords, there was “much to celebrate and yet much that falls short of what could—and should—have been achieved by this time,” and called on governments to “rekindle” their commitments to health care renewal across Canada.

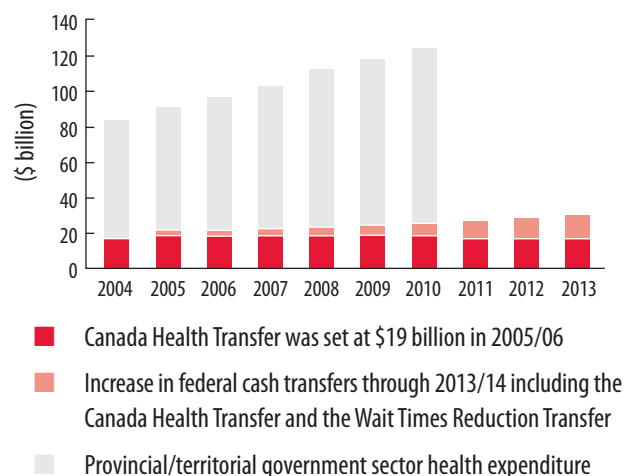
The accords contained a series of commitments by First Ministers to improve Canada's health care system in several areas including wait times, health human resources, home care, primary health care, pharmaceuticals management, prevention, public health, and health innovation.

To accelerate change in these areas, the federal government agreed to transfer additional funds to provincial and territorial governments. This was largely done through the Canada Health Transfer, an unconditional block transfer where funds flow into provincial and territorial general revenues and contribute to the overall cost of providing health services and undertaking health system reform.

So, while the accords themselves promised a number of changes, most of the funding that accompanied the accords was not tied to them. There was, however, some federal funding earmarked for specific purposes, such as reducing wait times, buying medical equipment, and improving the health of Aboriginal Peoples.

Since the accords, the provincial and territorial governments have increased their annual health care spending by about \$40 billion, from \$85 billion in 2004 to a projected \$125 billion in 2010.² That's an average annual increase of 6.7%, although it varies by province and territory. Over the same period, federal transfer payments for health care have also increased. In 2005, the federal government allocated \$19 billion to the Canada Health Transfer for annual cash payments to health care. This transfer has increased by 6% per year, an annual increase the federal government has legislated through 2013/14.³ (See Figure 1)

FIGURE 1: TRACKING OF FEDERAL CASH TRANSFERS AND PROVINCIAL/TERRITORIAL SPENDING ON HEALTH

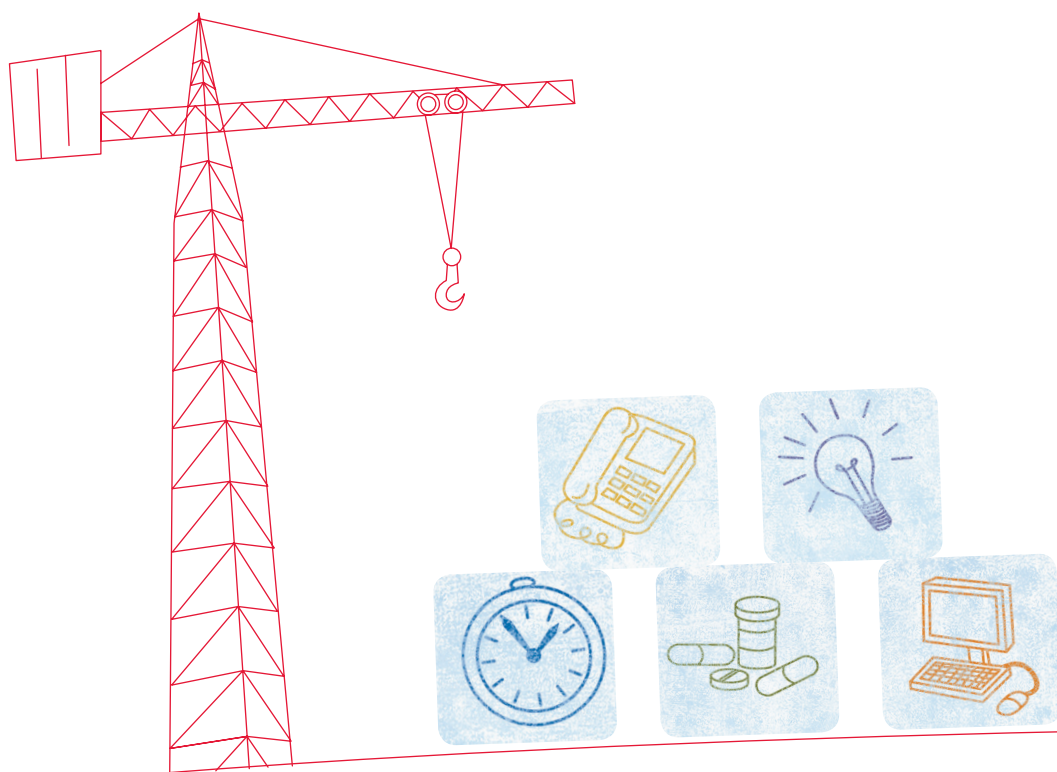


Provincial/territorial spending for 2009 and 2010 are forecasted amounts.

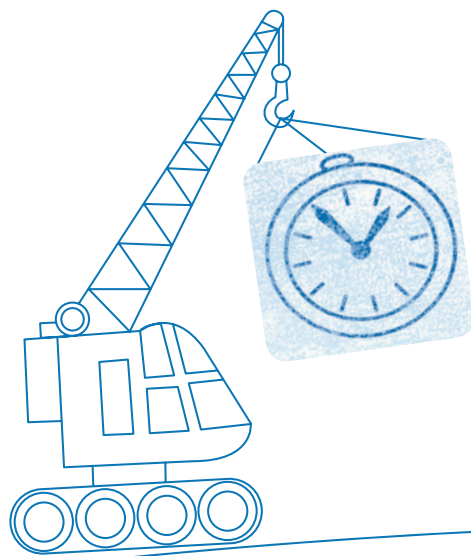
Sources: Canadian Institute for Health Information, National Health Expenditure Trends, 1975 to 2010, Table B.4.1. Department of Finance Canada, The Budget Plan 2007 (charts 16 and 18), 2007.

Three years after the release of *Rekindling Reform*, the Health Council of Canada offers this report which, along with subsequent annual reports, will assess progress made on selected accord commitments. This year, we are reporting on wait times, pharmaceuticals management, electronic health records, teletriage, and health innovation. Each section summarizes what the accords say, what we said in *Rekindling Reform*, and where things stand today (which we have gathered from public sources; through feedback from federal, provincial, and territorial health officials; and from interviews with key stakeholders in the Canadian health care system).

To properly assess progress, it is important to look at what governments have reported to their residents to see whether targets were set for reaching the goals expressed in the accords. Where jurisdictions have set targets for their commitments, we used them to assess progress. Some commitments, such as wait times, have well-developed measures to gauge progress, while others require a more narrative approach. Where we can, we describe provincial and territorial strategies for addressing challenges and bringing about renewal.



Wait Times



ACCORD COMMITMENTS

2004 10-Year Plan to Strengthen Health Care

- First Ministers commit to achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007.
- First Ministers agree to collect and provide meaningful information to Canadians on progress made in reducing wait times, as follows:
 - Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005.
 - Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.
 - Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.
 - Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.
- The Canadian Institute for Health Information will report on progress on wait times across jurisdictions.

WHAT WE SAID IN 2008

- In priority areas, more procedures were being performed and substantial reductions in wait times had been achieved in some provinces. However, we said that “long waits continue to frustrate health care providers and the public.”
- Governments had implemented new ways of managing wait times.
- Governments had established evidence-based benchmarks in four of the five priority areas: cancer, cardiac surgery, hip and knee replacement, and cataract surgery.
- Only a few provinces had set targets for achieving benchmarks by the December 2007 deadline.

PROGRESS TO DATE

With support from a \$5.5-billion Wait Times Reduction Fund, governments have tackled long waits in many ways, including:

- promoting the use of guidelines and other decision-support tools to reduce unnecessary procedures;
- applying queue-management techniques;
- paying hospitals to perform additional procedures;
- establishing specialty clinics to address backlogs for certain procedures; and
- receiving input from physicians.

Early efforts to cut wait times focused on surgery. However, in the last few years, important progress has been made in expanding wait times management beyond the five clinical areas mentioned in the *10-Year Plan to Strengthen Health Care* (cancer, heart, diagnostic imaging, joint replacements, and sight restoration). When the *10-Year Plan* was first announced, there was concern that singling out just five areas might skew priorities and result in longer waits for other services. Since then, some provinces and territories, such as British Columbia, Ontario, and New Brunswick, have expanded their wait times strategies to include other types of surgery and even emergency department visits⁴ (see sidebar, *Stories of health care renewal: emergency department wait times in Ontario*, pg. 8). In Saskatchewan, in response to their Patient First Review, the government has promised that by 2014 no patient will wait longer than three months for any surgery.⁵ The territories are also undertaking wait times strategies to address their own unique needs in the services they provide.

In December 2005, the provinces and territories announced a set of research-based benchmarks for procedures including hip and knee replacements, cataract surgery, some cancer services, and cardiac bypass surgery.⁶

In some provinces, such as British Columbia, Saskatchewan, Ontario, and New Brunswick, waiting lists, which used to reside with individual surgeons, are now tracked centrally on electronic registries. These registries allow for the capture of the urgency of each patient's condition, along with other details. All provinces now have websites giving

information on waits for priority types of care. Some also list waits by facility or by individual surgeon. Not all of these websites compare the existing wait times with the agreed-upon 2005 pan-Canadian benchmarks, although the Canadian Institute for Health Information (CIHI) provides this comparison in its annual report on wait times.⁷ How often the information is updated varies widely by jurisdiction, ranging from monthly to twice a year.⁸

The 2003 *First Ministers' Accord on Health Care Renewal* created a Diagnostic and Medical Equipment Fund of \$1.5 billion. However, reporting on imaging—namely CT and MRI scans—still lags behind other priority areas. Due to a lack of research evidence, there are no pan-Canadian benchmarks for diagnostic imaging, and only a few jurisdictions report targets for them on their websites (e.g. Saskatchewan, Ontario, and Prince Edward Island).

New investments in imaging equipment have increased the number of scanners available and scans being performed, but have not necessarily led to shorter wait times. Between 2008 and 2010, wait times for MRI scans decreased in Alberta and Prince Edward Island and increased in Ontario. Governments continue to face challenges in collecting data on wait times for diagnostic imaging, in part because many scans are done outside hospitals in free-standing clinics. Trending data is not currently available for the other seven provinces.⁷

CIHI facilitates the development of comparable data, defining and measuring wait times and tracking overall progress. Having agreed to a series of indicators in 2005, governments—with support from CIHI—have continued to work towards reporting on these comparable indicators.

The Wait Time Alliance, a group associated with the Canadian Medical Association, is another important pan-Canadian player in developing benchmarks and assessing progress on wait times. Over time, the Wait Time Alliance has broadened its focus beyond the initial five priority areas, and now reports on several areas of specialty care and the total wait facing patients. It has proposed benchmarks for a number of procedures based on the advice of clinical experts and on research evidence.

To complement the work being done by provinces and territories to reduce wait times, the 2007 federal budget included more than \$1 billion to be used over three years to help jurisdictions test and implement wait times guarantees. This included a \$612-million Patient Wait Times Guarantee Trust—a funding transfer to each province and territory to implement a wait times guarantee for its residents for at least one procedure by March 2010.⁹ (It also included \$400 million for Canada Health Infoway and \$30 million for pilot projects.) While not part of the health accords, guarantees are generally understood to be a maximum time a patient can wait; if exceeded, the government provides the patient with some form of recourse, such as having the procedure in another region. For example, Newfoundland and Labrador's wait times website explains that, as of March 31, 2010, residents are guaranteed cardiac bypass surgery within 182 days. In the event of a longer wait, they will be offered the procedure in another province.¹⁰

According to the Wait Time Alliance, nine out of 10 provinces had guarantees in place by April 2010.¹¹ Little information is publicly available about progress on wait times guarantees. It is unclear how often the guarantees have been invoked by patients, and whether they have resulted in improved health outcomes for Canadians. The Wait Time Alliance has noted that in some jurisdictions the guaranteed maximum wait times are twice as long as the benchmarks announced by governments in 2005.¹¹

THE BOTTOM LINE

Have governments actually achieved meaningful reductions in wait times since the accords? The answer is not straightforward. Wait times are complex due to local factors and the dynamic nature of supply and demand in health care. CIHI's reporting tells us that eight out of 10 Canadian patients are treated within the pan-Canadian benchmarks announced by governments in 2005 (for hip and knee replacement, hip fracture repair, cataract surgery, radiation, and bypass surgery), but the likelihood of receiving care within these timeframes varies by procedure and by hospital.⁷

LEGEND

- ↑ At least a 10 percentage point increase in the proportion of patients receiving care within the benchmark.
- ↓ At least a 10 percentage point decrease in the proportion of patients receiving care within the benchmark.
- ★ Achieved 90% or greater within the benchmark.
- No change in achievement within the benchmark.
- Three years of comparable data are not available.

FIGURE 2: TRENDING FOR THE PROPORTION OF PATIENTS RECEIVING JOINT REPLACEMENTS, CATARACT SURGERY AND RADIATION THERAPY WITHIN BENCHMARKS, 2008 TO 2010

	HIP REPLACEMENTS	KNEE REPLACEMENTS	CATARACT SURGERY	RADIATION THERAPY
British Columbia	—	—	—	★ —
Alberta	—	—	↓	■
Saskatchewan	↑	↑	↑	★ ↑
Manitoba	↓	↓	—	★ —
Ontario	★ —	—	—	★ —
Quebec	★ —	—	—	■
New Brunswick	↑	↑	↑	—
Nova Scotia	↑	—	—	■
Prince Edward Island	★ ↑	—	↑	★ —
Newfoundland and Labrador	■	■	■	★ —

A trend is at least a 10 percentage point increase or decrease in the proportion of patients receiving care within the benchmark from the first year (2008). The proportion was considered unchanged with any difference of less than 10 percentage points.

For additional information, see Table 1 (p.11) in *Wait Times in Canada – A Comparison by Province, 2011*, available at www.cihi.ca

Source: Canadian Institute for Health Information, *Wait Times in Canada – A Comparison by Province, 2011*

However, there has been progress across Canada on wait times reporting. All provinces now give access to detailed information on wait times—a great help to patients, and to the providers advocating on their behalf, all of whom now have more information to help them make decisions for the best, most timely care possible.

COMMENTARY

We commend the jurisdictions for continuing to develop the comprehensive queue-management strategies they put in place in the early years of the accords. Although some governments, such as British Columbia, Saskatchewan, and Ontario, have adopted activity-based funding to encourage hospitals to perform more surgeries, they also recognize that paying for more procedures is only one part of a successful wait times strategy. Some have made an effort to bring in the viewpoints of providers and patients as they develop their strategies. Importantly, governments have moved beyond the five clinical areas mentioned in the accords.

The quality and quantity of public reporting on wait times has far exceeded the annual report promised by First Ministers. Most provincial websites are easy to navigate and informative. In most provinces, residents can use the websites to compare wait times between regions or hospitals. CIHI's annual reporting on wait times provides comparisons between provinces.

Despite the fact that the 2003 accord created a separate Diagnostic and Medical Equipment Fund of \$1.5 billion to shorten wait times, long waits for diagnostic imaging (particularly MRI scans) persist in many jurisdictions, and there is reason to believe that some people waiting in the queues don't medically need to be there.¹² This lack of progress shows that it takes more than money to reduce wait times. A comprehensive strategy, which would include the use of computerized order-entry systems linked to best practice guidelines, should also help physicians order the appropriate tests.

We believe that continued coordinated effort and greater use of effective management tools could make wait times management one of the success stories of the health accords.

Stories of health care renewal: emergency department wait times in Ontario

Ontario's 160 hospital emergency departments get more than five million visits each year, and many of these patients face long waits.¹³ To combat this, Ontario launched an Emergency Room Wait Times Strategy in 2008. Because many patients wind up in emergency with problems that could better be treated in primary care, the strategy is linked to another of Ontario's top health priorities—increasing access to primary care.¹⁴ The province used a combination of tactics to bring down waits. It spent more to increase capacity and improve efficiency; it introduced improvements in care through standardized best practices; and it set targets for collecting and reporting data that could help improve care.

Ontario set two targets for emergency department waits:

- for *minor or uncomplicated conditions*, 90% of patients will be treated and discharged within four hours;
- for *complex conditions* requiring admission to hospital or needing more time for diagnosis and treatment in emergency, 90% of patients will be admitted or discharged within eight hours.¹⁵

By February 2011, wait times for uncomplicated cases had declined by 5%, and by 14% for complex cases. The four- and eight-hour targets were met for more than 80% of patients. Wait times tended to be longer for those who had to be admitted (about one in 10 emergency patients). On average, they spent more than 30 hours in emergency; only 40% were admitted within eight hours¹⁶—a problem highlighted in the provincial auditor general's 2010 report.

Data on emergency waits are available at www.ontariowaittimes.ca. They are updated monthly. People can also use this website to search for nearby emergency departments and see their recent typical wait times, and to find a list of alternative sources of care (such as family medical practices and walk-in clinics).

Individual hospitals across the province have taken innovative steps to reduce waits in emergency. Trillium Health Centre in Mississauga knew that a major cause of long waits in its emergency department was that other patients were staying in hospital longer than necessary because supports weren't in place to let them return home, or to another type of care. In just over 12 months, Trillium reduced the number of patients waiting for alternate types of care by 67%, by improving how they planned and organized discharge, and by working more closely with other health care organizations in their region to move patients home or to long-term care.¹⁷

Other hospitals benefited from the Emergency Department Process Improvement Program, which helps staff diagnose what causes long waits, and design and test solutions. More than 60 hospitals have completed the program so far.¹⁸

Other ideas for shortening waits in emergency can be found at www.patientflowtoolkit.ca. They include "see and treat zones," where people with minor conditions are seen quickly by a doctor or nurse practitioner.

Pharmaceuticals Management



ACCORD COMMITMENTS

2003 First Ministers' Accord on Health Care Renewal

- First Ministers agree that no Canadian should suffer undue financial hardships for needed drug therapy. Accordingly, as an integral component of these reforms, 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.
- As a priority, First Ministers agree to further collaborate to promote optimal drug use, best practices in drug prescription and better manage the costs of all drugs including generic drugs, to ensure that drugs are safe, effective and accessible in a timely and cost-effective fashion.

2004 10-Year Plan to Strengthen Health Care

- First Ministers direct Health Ministers to establish a Ministerial Task Force to develop and implement the national pharmaceuticals strategy and report on progress by June 30, 2006. The strategy will include the following actions:
 - develop, assess, and cost options for catastrophic pharmaceutical coverage;
- establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness;
- accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process;
- strengthen evaluation of real-world drug safety and effectiveness;
- pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines;
- enhance action to influence the prescribing behaviour of health care professionals so that drugs are used only when needed and the right drug is used for the right problem;
- broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record;
- accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and
- enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

WHAT WE SAID IN 2008

- Although some provinces had enhanced coverage for those unable to afford medications due to low incomes or high drug costs, the creation of a national, coordinated plan had stalled. This left a patchwork of public drug plans and inequitable access.
- There was still not enough progress on monitoring the safety and effectiveness of drugs, often leading to inappropriate prescribing and use of medication.

PROGRESS TO DATE

For the purposes of this report, we have selected four areas of pharmaceuticals management. However, jurisdictional work on this topic extends beyond these four areas.

a) Catastrophic drug coverage

Catastrophic drug coverage provides protection to individuals who face “catastrophic” or undue financial hardship because of the cost of their medications.

Each provincial and territorial government offers some form of public drug insurance, although each of these insurance plans is unique. Most have programs that specifically address high drug costs. Coverage for their residents depends largely on personal or family income, and whether they are privately insured, and varies between federal, provincial, and territorial plans. Which drugs are covered and how much residents must pay in deductibles also varies.^{19, 20} A 2009 report from the Canadian Cancer Society noted the disparities in coverage for newer cancer drugs, which patients increasingly take at home rather than in hospital (often meaning that the drugs aren’t covered by provincial plans).²¹

British Columbia, Saskatchewan, Manitoba, Ontario, Quebec, Nova Scotia, Newfoundland and Labrador, and Nunavut offer universal plans that provide catastrophic drug coverage either by capping drug costs at a fixed amount or at a certain percentage of income. These plans

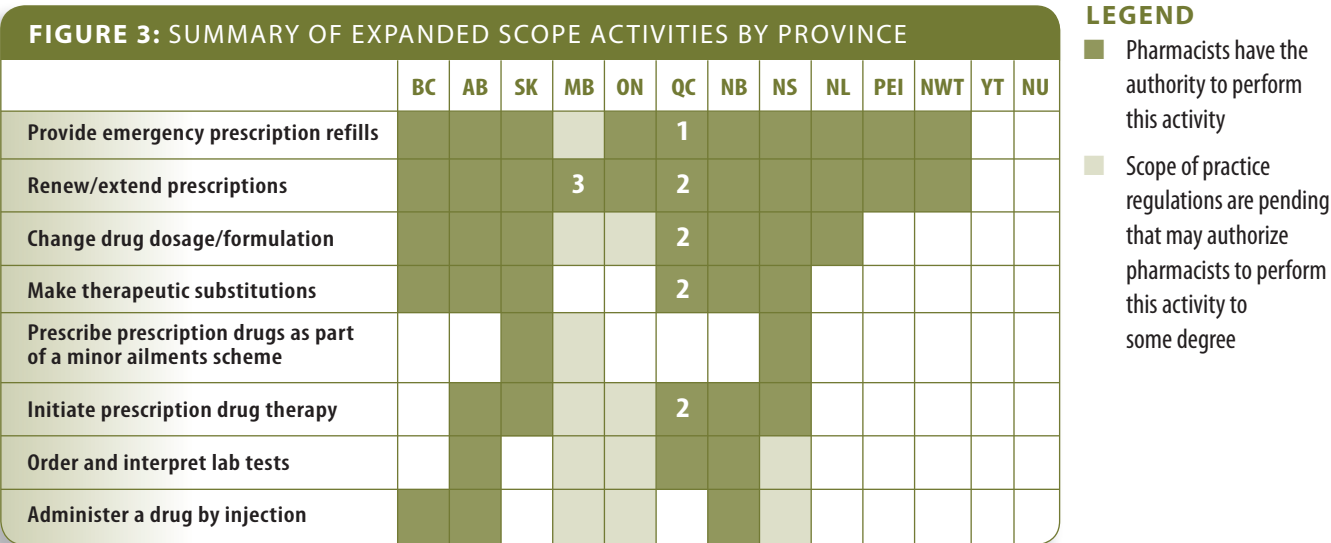
are augmented in some cases by specific provisions to cover people on social assistance, seniors receiving the guaranteed income supplement, or families with low incomes.²⁰

Alberta also has a universal plan, but limits the maximum payout. Prince Edward Island, New Brunswick, Northwest Territories, and Yukon do not have universal plans, but offer coverage to specific groups, including seniors and residents on social assistance or with particular diseases. Federal plans which cover specific groups offer protection from catastrophic drug costs. A 2009 Library of Parliament report, *Catastrophic Drug Coverage in Canada*, lists all the public drug plans and their terms.²⁰

b) Pharmacists’ scope of practice

In many jurisdictions, the role of pharmacists has grown to include initiating and adapting prescriptions, and, at times, delivering hands-on care such as inoculation and emergency prescribing. Pharmacists’ scope of practice—that is, what care they are allowed to provide—varies among jurisdictions. (See Figure 3)

All licensed health professionals, including pharmacists, have scopes of practice, usually overseen by a provincial regulatory college. Changing pharmacists’ scope of practice is complex, since it would affect the work of other providers such as nurses and physicians, and might require renegotiating pharmacists’ fees.



1 Limited to oral contraception only
 2 When delegated by a physician by means of a prescription
 3 As per Continued Care Prescriptions policy

Source: Reproduced with permission from the Canadian Pharmacists Association
 Note: as of May 2011

One major change in what pharmacists do is the addition of provincially funded medication assessment reviews, where the pharmacist looks for possible drug interactions or redundant prescriptions. At least six jurisdictions (British Columbia, Saskatchewan, Ontario, Quebec, New Brunswick, and Nova Scotia) have put versions of such programs into place.²² Most jurisdictions permit pharmacists to renew existing prescriptions.

c) Joint purchasing initiatives

Programs to pool procurement can be found in most jurisdictions for a range of medical devices and pharmaceuticals. Historically, these arrangements have focused on hospital supplies, though some jurisdictions currently tender for certain drugs dispensed in community pharmacies.

Recently, there has been discussion among governments about expanding joint purchasing across provincial and territorial borders. In June 2010, a memorandum of understanding on pharmaceutical pricing and purchasing strategies was signed by British Columbia, Alberta, Saskatchewan, Manitoba, and Yukon, with the Northwest Territories signing on more recently.^{23, 24} The governments of British Columbia, Alberta, and Saskatchewan have also signed the New West Partnership Trade Agreement, which includes an approach on the joint procurement of some health supplies, including drugs provided in hospitals.²⁵ Similar strategies are being discussed by some eastern provinces.^{26, 27}

At a Council of the Federation meeting on August 6, 2010, premiers of the provinces and territories took steps towards a collaborative effort on joint purchasing. They unveiled an agreement to establish a pan-Canadian purchasing alliance to realize economies of scale on the purchase of drugs, and medical supplies and equipment.²⁸ Subsequently, provincial and territorial health ministers committed to work together to develop recommendations on joint procurement.

Stories of health care renewal: consolidation of health authority procurement in British Columbia

In February 2009, British Columbia formally established Health Shared Services BC (HSSBC), an agency mandated to consolidate and deliver shared non-clinical services for British Columbia's six health authorities. The goals for HSSBC's province-wide shared services include: enhanced value for the health care system through increased process efficiency, standardization, capital avoidance, and leveraged buying power; enhanced service quality through the delivery of customer-focused services; and improved alignment and integration across health authorities.

The services for which HSSBC has assumed responsibility include supply chain management and procurement functions. Through aggregation of purchasing volumes and product standardization, HSSBC has generated significant value for the British Columbia health care system. Aggregate savings from HSSBC's procurement activities to date exceed \$150 million.

d) Drug information systems

Canada Health Infoway reports that across Canada, nearly a third of community pharmacists and roughly half of emergency departments and hospital pharmacies have access to a drug information system.²⁹ Progress across the country is varied. As of April 2011, British Columbia, Alberta, Saskatchewan, Manitoba, and Prince Edward Island have drug information systems in place; other provinces and territories are in various stages of planning and implementation. (See Figure 4)

Despite uneven uptake across Canada, the benefits of drug information systems are already being seen. Canada Health Infoway projected that drug information systems would generate \$436 million in cost savings and efficiencies in 2010 by streamlining the work of pharmacists, improving medication compliance, reducing adverse drug interactions and medication abuse, and improving management of drug costs.²⁹ Canada Health Infoway notes that these benefits will grow with greater use of drug information systems, which includes e-prescribing.

e) e-prescribing

In a 2009 report, the National e-Pharmacy Task Force proposed the following definition: “e-Prescribing is the secure electronic transmission from an authorized prescriber of a prescription to a patient’s pharmacy of choice integrated with pharmacy software.”³⁰ This goes beyond the printing of a prescription, which already happens about 40% of the time.²⁹

Despite its mention in the accords, and while both the pharmacist and physician communities seem eager to embrace it, e-prescribing is generally at the early stages of implementation. In 2009, the Canadian Pharmacists Association and the Canadian Association of Chain Drug Stores published recommendations for implementing e-prescribing, outlining principles for rapid adoption of new technology and systems, and privacy guarantees for patients.³⁰ The Canadian Medical Association’s *Health Care Transformation in Canada* called on governments to “accelerate the introduction of e-prescribing in Canada to make it the main method of prescribing by 2012.”³¹

The federal government, through Canada Health Infoway, is funding a clinician-led project to define a national e-prescribing specification. The funding will also go towards supporting e-prescribing by upgrading electronic medical records, and supporting their interoperability with provincial drug information systems.

THE BOTTOM LINE

Advances in pharmaceutical policies are integral to overall health care renewal, since drugs are the second highest spending area in the Canadian health care system. In 2004, First Ministers announced their intention to develop a National Pharmaceuticals Strategy. In our 2009 publication, *A Status Report on the National Pharmaceuticals Strategy: A Prescription Unfilled*, we reported that the strategy had stalled. Two years later, it has not gained momentum.

Some governments are bringing in a package of policy changes to take an integrated approach to enhancing the quality of pharmaceutical care, while controlling costs. This package includes support for pharmacists to provide

FIGURE 4: DRUG INFORMATION SYSTEM ACCESS IN CANADA
(at various points of care)

PROVINCE/ TERRITORY	PHARMACISTS (Community)	HOSPITAL PHARMACISTS	HOSPITAL (ER only)	HOSPITALS (All)
British Columbia	100%	100%	88%	62%
Alberta	97%	90%	90%	90%
Saskatchewan	100%	100%	100%	50%
Manitoba	100%	100%	100%	50%
Ontario	◆	40%	100%	20%
Quebec	◆	◆	◆	◆
New Brunswick	◆	◆	◆	◆
Nova Scotia	◆	◆	◆	◆
Prince Edward Island	100%	100%	◆	◆
Newfoundland and Labrador	◆	◆	◆	◆
Nunavut	◆	◆	◆	◆
Northwest Territories	◆	◆	◆	◆
Yukon Territory	◆	◆	◆	◆
National	32%	46%	51%	29%

◆ Indicates that Central, Northern and Eastern Jurisdictions are mostly in early stages of planning or implementation

Source: Canada Health Infoway, *National Impacts of Generation 2 Drug Information Systems*, 2010.

a greater range of services by expanding their scope of practice, and reimbursement for them to provide medication reviews and other services. Governments are also taking steps to bring down generic drug prices. In some cases, provincial and territorial governments are working collaboratively, such as on the National Drug Evaluation Process for Rare Diseases, the pan-Canadian Oncology Drug Review, and a pan-Canadian purchasing alliance. In addition, the Drug Safety and Effectiveness Network has been established with federal support to fund studies in post-market pharmaceutical research that will inform decision-making in all jurisdictions.

Catastrophic drug coverage

The 2003 *First Ministers' Accord on Health Care Renewal* included catastrophic drug coverage in its five-year \$16-billion Health Reform Fund. When provincial and territorial ministers of health met in September 2008, they sought to establish a national standard of coverage, which would ensure that prescription drug costs would not exceed 5% of the net income base of their respective populations. However, they warned there would be significant fiscal challenges to moving forward on catastrophic drug coverage (and other key elements of the national pharmaceuticals strategy) unless the federal government was willing to take leadership and share costs.^{32, 33}

Drug information systems

Progress on drug information systems (and other components of the electronic health record) is improving the quality and safety of our health care system, while helping to tame the cost curve.²⁹ These benefits are expected to grow as more jurisdictions implement drug information systems in 2011 and beyond.

E-prescribing

Despite being singled out in the 2004 *10-Year Plan to Strengthen Health Care*, the practice of e-prescribing is yet not widespread. In those provinces and territories where it is being implemented, e-prescribing ranges from pilot projects (such as at the Group Health Centre in Sault Ste. Marie and the Georgian Bay Family Health Team in Collingwood, both in Ontario) to being available to all prescribers (such as in Saskatchewan).³⁴

COMMENTARY

In 2003 and 2004, when the health accords were negotiated, pharmaceutical costs were the fastest-growing segment of health care budgets. It is not surprising, then, that pharmaceuticals management was such a major focus of the agreements.

It is important to note that Canada's patchwork of public drug plans can limit patients' ability to move around the country, and their access to medications. A few governments have moved to expand coverage. However, as we reported in our 2010 bulletin, *How Do Canadians Rate the Health Care System?*, one in 10 Canadians say they have failed to fill a prescription, or have skipped a dose, because of cost.

Although there has been little concerted national action on pharmaceuticals in recent years, provincial and territorial governments are undertaking a range of policies to cover the growing costs of publicly-funded drug programs, including steps to control the cost of generic drug prices and to expand pharmacists' scopes of practice, which vary across Canada.

Pharmacists work in many communities and are available without an appointment. (It is important to note that pharmacists are few and far between in many remote regions and communities.) Expanding their scope of practice or expanding their role within their scope of practice will help increase access to primary health care and encourage team-based care.

Drug information systems are being used by pharmacists in about half the provinces. They appear to bring significant benefits, including fewer inappropriate prescriptions and adverse drug events. These are real gains in quality and safety for patients, and they also save money.²⁹ These benefits are expected to grow when drug information systems become part of a fully integrated electronic health record.

Given the increasing use of medications and their rising costs, joint purchasing and joint pricing strategies have the potential to reduce provincial and territorial drug costs, and make it easier to expand drug coverage. It should be noted that Canada's premiers have called for a national alliance to consolidate public-sector procurement of common drugs, and of medical supplies and equipment.²⁸ This is a major development for Canada.

Stories of health care renewal: expansion of public drug coverage in Newfoundland and Labrador

Newfoundland and Labrador's Poverty Reduction Strategy identified a significant barrier to getting unemployed people back to work—a barrier that was the direct result of government policy. The province provided drug coverage for people on income support, but the benefits were lost when a person found work. Because the cost of prescription drugs can be high, losing coverage was definitely a disincentive to some people taking a job. At the same time, people with low-wage jobs often struggle financially because of the cost of drugs. This sometimes leads people not to keep up their prescriptions—which can lead to serious health problems.

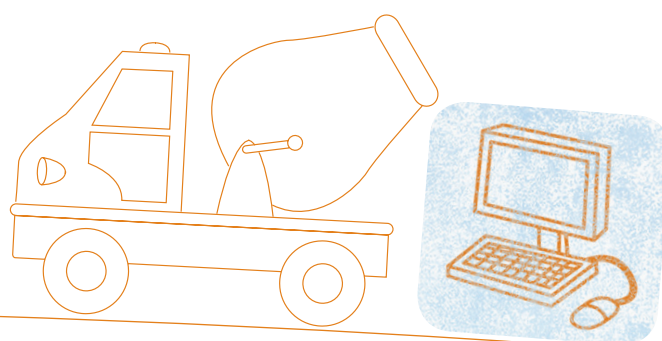
As a result, Newfoundland and Labrador expanded its public drug coverage to provide individuals and families with low incomes access to eligible prescription medications. The amount of coverage individuals receive is determined by net income level and family status. The Access Plan (formerly called the Low Income Drug Program) was launched in January 2007.³⁵ In 2010/11, an investment of \$2.5 million was made to increase the income thresholds of the Access Plan under the Newfoundland and Labrador Prescription Drug Program (NLPDP).

Concern over another issue followed soon after the launch of the Access Plan. Because the Access Plan was based only on income, many individuals with high drug costs were not eligible. In October 2007, the government responded with its Assurance Plan to “significantly reduce the financial hardship faced by individuals and families with high drug costs.” The plan offers people whose drug costs are high, relative to their income, protection against the cost of expensive drugs or multiple drugs being used by a patient.³⁶

Specifically, families with net incomes below \$40,000 pay a maximum of 5% out-of-pocket for eligible drugs; those with net incomes between \$40,000 and \$74,999 pay a maximum of 7.5%; those earning between \$75,000 and \$149,999 pay a maximum of 10%.³⁶

However, concerned about a lower uptake than anticipated, the province launched a marketing campaign in November 2010 to increase awareness of the plans and encourage more eligible people to apply.³⁷

Electronic Health Records



ACCORD COMMITMENTS

2004 10-Year Plan to Strengthen Health Care

- First Ministers agree to accelerate the development and implementation of electronic health records, including e-prescribing. To this end, First Ministers commit to work with Canada Health Infoway to realize the vision of the electronic health record through an ambitious plan and associated investment.

WHAT WE SAID IN 2008

- Electronic health records held great promise but had “yet to convert the paper-laden world of health care in Canada.”
- Change was too slow.
- Canada Health Infoway had invested in nearly 250 projects. Provinces and territories had also invested significantly.
- As of March 2008, electronic health records were available for 7% of Canadians—not on track to meet the goal of 50% of Canadians by 2010.
- 64% of all diagnostic images taken in hospitals and clinics were digital, 30% of published lab test results were available electronically, and 24% of Canadians benefited from drug information systems.

PROGRESS TO DATE

By the end of 2010, an electronic health record was available for nearly half of all Canadians.³⁸ As of April 2011, the core databases that make up electronic health records were available for use by health care providers for all residents of British Columbia, Alberta, and Prince Edward Island, and some residents of Saskatchewan, Manitoba, Ontario, Quebec, New Brunswick, and Newfoundland and Labrador. Nine jurisdictions had at least four of the six core databases (client registry, provider registry, diagnostic images, laboratory test results, drug information systems, clinical reports/immunization) in place.³⁹ (See Figure 5)

In 2009, the federal government allocated \$500 million to Canada Health Infoway for electronic health initiatives. In total, the federal government has contributed \$2.1 billion to the initiative. When matching funds from the provinces and territories are included, the total grows to nearly \$4 billion.³⁸

By December 2010, Canada Health Infoway had approved funding for over 300 electronic health records projects, with nearly 200 of them completed. To be funded, projects must be consistent with Canada Health Infoway's *Electronic Health Record Solution (EHRS) Blueprint*, which lays out a framework for interoperability, and

privacy and security standards.⁴⁰ The EHRS Blueprint was developed in collaboration with the provinces and territories and provides a common vision to guide the development of health information systems in Canada. Within this blueprint, individual governments are responsible for building their systems according to their own health care priorities.

The accords contained no specific targets or milestones for electronic health records. Some jurisdictions have set up agencies to manage their information technology or e-health programs, while others manage these efforts from within their ministries.

Recognizing the importance of electronic health records to renewing the health system and aware of the large investments involved, the federal and six provincial auditors general undertook audits of their respective electronic health record programs. The reports, released in late 2009 and early 2010, noted room for improvement in how governments measure and report the performance of their electronic health record investments. They also noted continuing challenges faced by all jurisdictions, such as the need to increase the number of physicians' offices (especially in primary health care) using electronic medical records, which can connect clinicians to the patient information contained in the electronic health record.⁴¹

FIGURE 5: PROGRESS IN BUILDING THE CORE DATABASES OF THE ELECTRONIC HEALTH RECORD



Source: Reproduced with permission from Canada Health Infoway

The 2009 Commonwealth Fund International Health Policy Survey (as reported by the Health Council of Canada) placed Canada in last place among the 11 participating countries, with only 37% of physicians using an electronic medical record in primary care.⁴² Most of the \$500 million the federal government provided to Canada Health Infoway in 2010 is earmarked to speed up the implementation of electronic medical records and advance the integration of points of service.³⁸

The need to increase the number of physicians using electronic medical records has also been expressed by the Canadian Medical Association, which put forth a five-year strategy for health information technologies in September 2010. The strategy also noted the need to demonstrate the value that investment in information technology brings to patients.⁴³ As of April 2011, British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Nova Scotia have programs in place to encourage physicians to use electronic medical records. Several jurisdictions such as British Columbia, Ontario, and Nova Scotia have publicized annual targets for the uptake of electronic medical records and report their progress toward these targets.

THE BOTTOM LINE

Governments have made advances in electronic health record infrastructure. Nationally, 32% of community pharmacists and 51% of hospital emergency departments have access to a drug information system which allows access to patients' medication profiles.²⁹ More than 80% of radiology scans done in Canadian hospitals are now stored digitally.³⁸

Having nearly achieved the objective of having the core elements of electronic health records in place for half of Canadians by 2010, Canada Health Infoway and the provinces and territories are broadening their strategies to support the use of electronic health record infrastructure by providers and patients.³⁸

COMMENTARY

Given the complexity of health care delivery today, electronic health records are more important than ever. They help ensure that critical patient information isn't lost or delayed, and that all health care providers are, literally, on the same page.

We can't assume care will necessarily improve when an electronic health record is used.^{44,45} However, there are tools and frameworks available for measuring whether quality, access, and productivity are improving.⁴⁶ It is important that health information technology be evaluated routinely and the results shared across Canada.

In a number of reports, we have called for increased use of electronic health records, and noted the low uptake of electronic medical records. The fact that most Canadian physicians still rely on paper records means patients aren't experiencing the great potential of electronic records to improve care. Although there is electronic health record infrastructure for half of Canadians, many physicians are not using it in their clinical decision-making and patients can't benefit fully from the technology until they do.

For governments, an interoperable electronic health record is essential to realizing general health system goals, such as integration, measuring effectiveness, and patient safety. As one jurisdiction described life before electronic health records: "The lack of a common technology platform and information base in our system doesn't just slow things down, it seriously compromises patient care."⁴⁷

Governments should take every opportunity to clarify how investments in electronic health records will help them improve patient care in such areas as improving coordination of care, reducing errors, and improving efficiency—and then to report their performance accordingly.

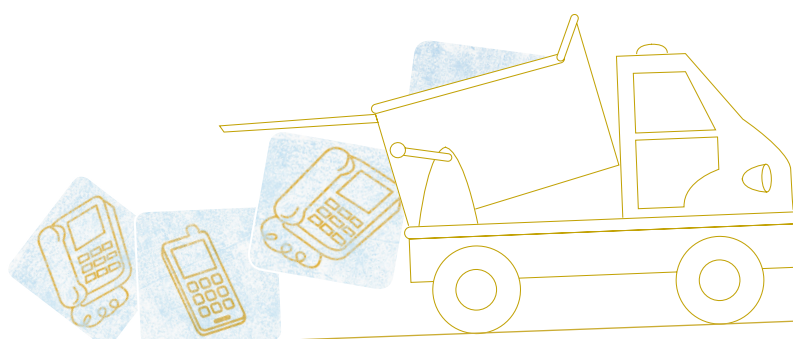
Stories of health care renewal: electronic health records in Saskatchewan

In the spring of 2011, the Saskatchewan Health Information Network became eHealth Saskatchewan. This newly formed Treasury Board Crown corporation is tasked with overseeing the development and implementation of the province's electronic health care system. The goal is to have an electronic health record for each patient, to help ensure continuity of care across health care providers, improve patient safety, allow for e-prescribing, and improve chronic disease management. The initiative will add to existing components of the provincial electronic health record, such as the Pharmaceutical Information System and the Diagnostic Imaging and Picture Archiving System.⁴⁸

The eHealth Saskatchewan initiative was born from the Patient First Review, a series of consultations with patients, health care providers, and system leaders about their experiences with the Saskatchewan health care system. Patients and health care providers felt a key barrier to coordinated health care and system integration was the current health care system's inability to electronically share patient health information securely and efficiently among health care providers. In the Patient First Review Commissioner's report, *For Patients' Sake*, the Commissioner urged the Ministry of Health, in consultation with the health regions, the Saskatchewan Cancer Agency, and clinical leaders to invest in and accelerate development of provincial information technology capabilities.⁴⁹

The Government of Saskatchewan has been working in partnership with Canada Health Infoway and the Saskatchewan Medical Association to accelerate the adoption of electronic medical records in physicians' offices across the province. The first phase of implementation will also see physicians being able to access the Saskatchewan Lab Results Repository from their own office computer systems, giving them timely and accurate laboratory test results on their patients. The next phase involves establishing specifications for e-prescribing, so that physicians can safely prescribe drugs directly from within a patient's electronic medical record. Saskatchewan currently has a provincial repository that is a secure web application where physicians can electronically prescribe drugs (and have them checked against the patient's current drug profile to reduce avoidable drug interactions), but their preference is to be able to do this within the patient's electronic medical record itself. A timeline for developing these specifications and implementing e-prescribing will be established through consultations with physicians, pharmacists, electronic medical record systems providers, Canada Health Infoway, and other provinces.⁵⁰

Teletriage



ACCORD COMMITMENTS

2003 First Ministers' Accord on Health Care Renewal

- First Ministers agree that the ultimate goal of primary health care reform is to provide all Canadians, wherever they live, with access to an appropriate health care provider, 24 hours a day, seven days a week.

WHAT WE SAID IN 2008

- Most jurisdictions achieved their goal of providing 24/7 access to a health care provider for at least 50% of their citizens by 2006, using a combination of after-hours service in physicians' offices, emergency departments, and 24/7 telephone lines where health care professionals (mainly nurses) offer health information and advice.
- The Health Council of Canada called for better coordination and communication between teletriage and the patient's primary care physician.

PROGRESS TO DATE

In most provinces and territories, teletriage has been set up to assess the urgency of patients' symptoms over the phone. A patient can call a toll-free number at any time of day to discuss health symptoms with a qualified health care provider, who may direct the patient to the appropriate service or provide advice on how to manage the concern at home. The idea is that giving patients convenient access to health-symptom information can help them look after themselves and encourage the use of appropriate health care services.^{51,52}

Today, three jurisdictions—Prince Edward Island, Nunavut, and Northwest Territories—do not offer teletriage services to their residents. However, residents of these jurisdictions have 24/7 access to information and advice through community health services or hospitals. Increasingly, governments are using websites to offer health information on a range of topics. Roughly half of jurisdictions manage their own teletriage systems; the rest contract them out to private companies.

Some jurisdictions link their teletriage systems to other types of care, such as on-call mental health assistance, pharmacists, advice on diet and wellness, and help with self-management of chronic disease. Some also directly link teletriage to 911 and poison control. As well, some jurisdictions provide a teletriage encounter record to emergency departments when the caller is advised to seek care at an emergency department. In many jurisdictions, teletriage played an important public health role during the H1N1 pandemic.

There are few evaluations of teletriage services available to the public. Northwest Territories conducted an evaluation of Tele-Care NWT which showed that most users had access to, and experience using, the Internet and, as a result, the service did not meet the goal of increasing access to health information and advice to residents in small communities. The teletriage service was discontinued in October 2010.⁵³ British Columbia and Yukon are planning to begin evaluations in the next year.

THE BOTTOM LINE

The implementation of teletriage has been widespread. Teletriage is one service jurisdictions have put in place to meet the accord commitment of ensuring that all Canadians have access to a health care provider 24 hours a day, seven days a week.

COMMENTARY

Generally, teletriage services are widely used. What isn't clear, however, is whether teletriage has reduced

inappropriate use of emergency departments. We also don't know whether teletriage calls are reported to the callers' physicians, which is important for continuity of care and integrating services. We expect any evaluations to help address this gap in the evidence on teletriage.

Most jurisdictions, especially the territories, use a broad array of telecommunications technology to reach their rural and remote populations. A future Health Council of Canada report will delve deeper into this topic, and describe standards in place for designing and maintaining high-quality telehealth services.

Stories of health care renewal: teletriage in Manitoba

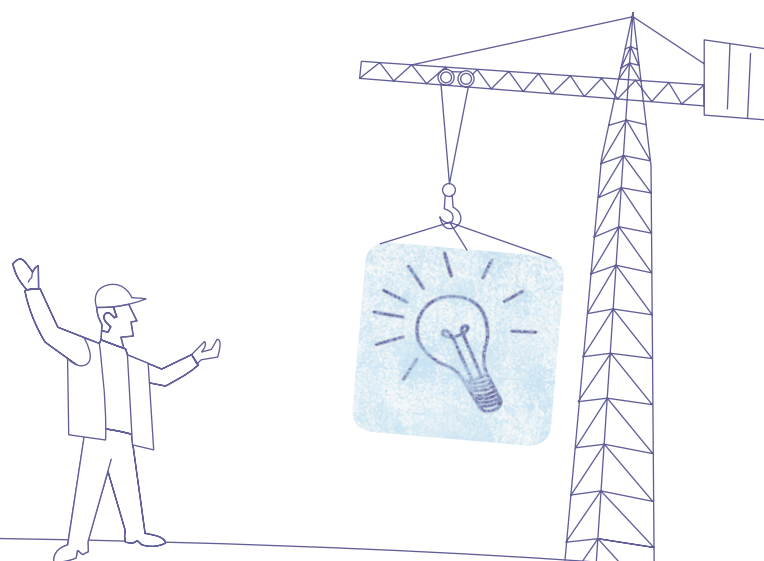
One-third of Manitoba's population of 1.2 million is spread across rural and remote areas, and access to health care services can be a challenge for these people. As a result, Manitoba has sought out innovative ways to use telecommunications to increase access and improve the quality of care people throughout the province receive.

Since 2003, the Manitoba teletriage program, Health Links-Info Santé, has been available to all Manitobans 24 hours a day, seven days a week; the system can handle up to 300,000 calls per year. All the toll-free calls are answered by registered nurses who are trained to assess health issues over the phone; they also have the authority to call a primary care physician for an after-hours consult, if necessary.

Health Links-Info Santé fulfills the health accord commitment to provide all residents with 24/7 access to a health care provider and is particularly valuable for people who cannot easily meet a health care provider face to face. But the service benefits anyone in the province who needs advice on how to live a healthier lifestyle, how to prevent disease and injuries, and how to manage chronic illness. Health Links-Info Santé services are offered in English and French, with translation support available for people who speak Swampy Cree, Ojibway, or any of 110 other languages.

Teletriage in Manitoba expanded again in 2008, when the CareLink pilot program was launched, funded by the Manitoba government and Canada Health Infoway. There are three components to CareLink projects, all with the goal of increasing access to primary health care. The first, TeleCARE, is for people living with diabetes or chronic heart disease—particularly those who live in northern, rural, or remote regions. The second aims to reduce unnecessary visits to emergency departments by allowing physicians' offices to offer 24-hour telephone service. The third extends the MBTelehealth Network, an extensive telemedicine program, to additional care settings, providing video-conferencing technology to support delivery of chronic disease management programs and other clinical services to patients from rural and remote communities. This is one of several areas of growth for MBTelehealth with the program recently announcing its 100th site and surpassing the 10,000 events per year landmark.^{54,55}

Health Innovation



ACCORD COMMITMENTS

2004 10-Year Plan to Strengthen Health Care

- A strong, modern health care system is a cornerstone of a healthy economy. Investments in health system innovation through science, technology and research help to strengthen health care as well as our competitiveness and productivity. Investments in science, technology and research are necessary to develop new, more cost-effective approaches and to facilitate and accelerate the adoption and evaluation of new models of health protection and chronic disease management.
- Recognizing the progress that has been made, the federal government commits to continued investments to sustain activities in support of health innovation.

WHAT WE SAID IN 2008

- Canadian governments invest billions of dollars each year in health research, fuelling world-class discoveries with the potential to improve health and health care. In Canada, we had considerable knowledge about how to renew health care, but we lacked focus on putting that knowledge into action, particularly at the system level.
- The Canadian Institutes of Health Research, established in 2000 as the major federal granting agency, funded research through its 13 institutes and assisted scientists and decision-makers to translate knowledge from research into changes in policy and practice in health care.

PROGRESS TO DATE

The focus of the federal government as a whole has not only been on supporting improvements in quality and access to care in the accord's priority areas, but also on ensuring that Canada's science and technology sectors are contributing to health innovation, and generating important economic and industrial benefits for Canadians. Provinces and territories have also played a valuable role in making strategic investments in health system innovation and pressing for continued federal funding. Provincial and territorial funding for research in health-related areas supports many organizations and activities, including provincial health research institutes, health quality councils, drug innovation initiatives, and disease-or condition-specific investments. A full description of these provincial and territorial investments is out of the scope of this report, as the accord commitment focused on federal investments in health system innovation.

In 2007, the federal government launched *Mobilizing Science and Technology to Canada's Advantage*, a federal science and technology strategy with the aim of promoting research that addresses challenges in health and other areas. The idea is a collaborative approach within the scientific community to build a critical mass of expertise in certain priority areas. Health and life sciences is one of the four priorities identified. The strategy involves supporting existing federal science and technology initiatives and organizations that fund independent research at academic institutions across Canada. Initiatives related to health and life sciences research include Networks of Centres of Excellence, the Canada Foundation for Innovation, Canada Research Chairs, and the Canadian Institutes of Health Research. The strategy emphasizes partnership with business, academic, and public sectors to drive innovation in science and technology research and development. Partnerships and collaborations are a key part of how these federal agencies and initiatives work.⁵⁶ For example, the Canadian Institutes of Health Research developed the Strategy on Patient-Oriented Research in collaboration with the industrial sector, provincial and territorial governments, charities, universities, and academic health care organizations. The strategy fosters innovation in clinical research and integrates research and scientific evidence into health care practice.

As part of the strategy, the federal government established the Science, Technology and Innovation Council to provide advice on science and technology issues. The Council includes a representative from Health Canada and Industry Canada, and is involved in measuring Canada's activities in science and technology against international standards. In its first report, *State of the Nation 2008*, the Council found that Canada was a middle-of-the-road performer in various science and technology indicators, and that, "while we have been good, we now need to be great."⁵⁷

A report on the strategy was released in 2009, two years after its launch, and the federal government reported several successes from this strategy.⁵⁸ There has been sustained investment in the strategy in recent federal budgets.

In addition to investing in the federal agencies that provide funding for health research, the federal government has invested in independent agencies. It continues to support Canada Health Infoway, contributing \$2.1 billion between 2001 and 2010.³⁸ The federal government also supports the Canadian Institute for Health Information, the Canadian Agency for Drugs and Technologies in Health, the Canadian Patient Safety Institute, the Canadian Health Services Research Foundation, Genome Canada, and the Canadian Institute for Advanced Research, all of which conduct or support leading-edge research in health-related areas.

There has also been substantial innovation within the federal government's own departments and agencies, namely Health Canada, Statistics Canada, and the Public Health Agency of Canada. In 2009, through a partnership between the Public Health Agency of Canada and the Canadian Institutes of Health Research (CIHR), the federal government committed \$10.8 million over three years to support a pan-Canadian influenza research network to strengthen Canada's capacity to prepare for an influenza pandemic.⁵⁹ In February 2011, the Government of Canada, in partnership with Genome Canada and CIHR, announced a \$4.5-million investment in two pan-Canadian research projects aimed at identifying genes that cause pediatric cancers and rare genetic diseases.⁶⁰

The Public Health Agency of Canada has funded the development of the Canadian Strategy for Cancer Control. Also, Health Canada offers support to the Mental Health Commission of Canada, the Health Care Policy Contribution Program, and the Canadian Partnership Against Cancer. In March 2011, the Government of Canada announced its plan to renew support for the Canadian Partnership Against Cancer by providing \$250 million over five years, beginning in April 2012.

Statistics Canada is also an innovator in health research. In addition to conducting health-related statistical analyses, the department contributes to health data collection through surveys such as the Canadian Community Health Survey and the Canadian Health Measures Survey.

Health research is also funded indirectly through the Canadian tax system, and by public donations to health charities, such as the Heart and Stroke Foundation of Canada, the Canadian Cancer Society, the Arthritis Society, and the Canadian Diabetes Association.

THE BOTTOM LINE

The federal government continues to invest in life sciences and health research innovation, and has met its commitment to health innovation, especially in health and life sciences research. However, Canada's progress as a world leader in innovation remains to be determined.

COMMENTARY

The federal government is a major supporter of health research and innovation in Canada. The greatest federal investment in health innovation has been in the Canadian Institutes of Health Research. Over the life of the accords, the Government of Canada has increased investment in the Canadian Institutes of Health Research from \$668.2 million in 2003/2004 to almost \$1 billion today (which funds over 14,000 researchers). However, experts have noted the need for more action across and beyond government to boost Canada's performance in bringing health innovation to patient care. Canada needs to continue investing to maintain its competitive edge in innovation, and to improve the health of Canadians.

Conclusion

The recent recession, the need for governments to better manage their spending, and concerns about sustainability have focused attention on the urgency of taming the health care cost curve, while protecting and improving access to the health care system. We can see the effect—in the seven years since the accords, almost all jurisdictions had made significant changes to the way they deliver health care.

First, many provincial health departments and ministries have moved to an oversight, or “stewardship” role. Almost all ministries have held on to the broad budget, health planning and policy, and health system accountability, but have transferred direct patient services to agencies and arms-length institutions. In some provinces, such as British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and New Brunswick, health quality councils are working to improve delivery and accountability by reporting on what is needed to improve the quality of health care services.

Second, many jurisdictions are integrating services regionally or even province-wide, and they continue to evolve, linking new community services and even primary care operations to acute care and long-term care facilities. The service delivery models vary from jurisdiction to jurisdiction, but they have one thing in common: a goal to integrate services across an ever-expanding continuum of care to better serve patients (including those in rural and remote regions) and drive efficiencies.


Our country is divided into provinces and territories with different challenges, different economies, and different ideas about what can and should be done in the health care system. To track progress on the health accords is to watch major change evolve in the delivery of a highly valued, publicly-delivered service across 14 separate health care systems. Even where provinces and territories are pursuing similar goals, they are generally doing so independently of each other. Progress has been made by all the jurisdictions in particular areas, depending on their own priorities.

In health care renewal, money is the fuel, management gets the traction

The accords reflect the health care challenges faced by governments in 2003 and 2004. They promise some broad solutions, but contain few concrete targets, leaving it to individual governments to identify priorities and set targets to meet the needs of their residents. Where provinces and territories had set and publicized targets, it was easier for us to track progress. Where we could not find targets, assessing progress was more difficult. In some cases, reports from national organizations filled the void.

In 2003, First Ministers said, “public health care in Canada requires more money, but that money alone will not fix the system.” Does our examination of progress in these areas suggest what, besides money, is required to make progress in health care renewal?

Jurisdictions with comprehensive management strategies—complete with meaningful targets and measurable goals—appear to have made better progress (such as in wait times). A good management strategy brings patients and providers to the table to ensure that everyone’s needs are met.



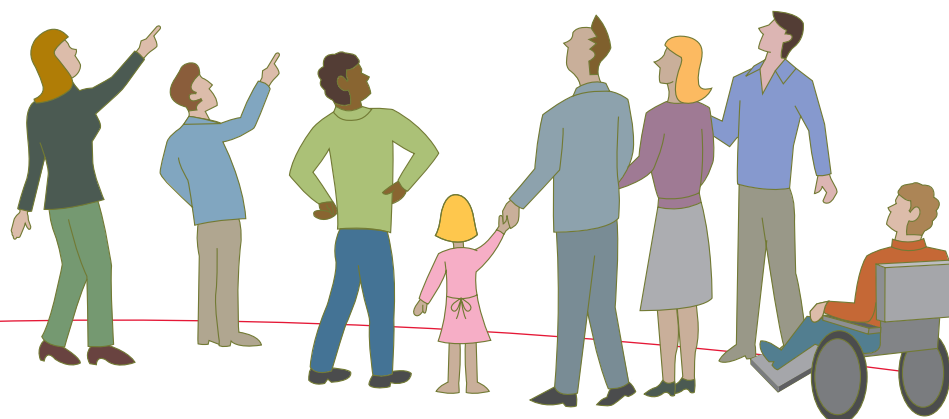
Meaningful targets and measurable goals are also essential to public accountability. We are encouraged that governments and other important players in the system, such as Canada Health Infoway and the Canadian Institute for Health Information, are informing Canadians of the benefits of the vast sums being spent on modernizing the health care system.

The Health Council of Canada is optimistic in its assessment of progress. As we told the Senate Committee on Social Affairs, Science and Technology in March 2011, we base our optimism on work in wait times, primary health care, electronic health records, catastrophic drug coverage, reduced generic drug costs, and improvements in our capacity to collect, interpret, and use health information to improve service delivery and increase patient safety. We noted that work is underway to address the issues of providing appropriate care, engaging patients, and improving quality.

LOOKING AHEAD

Progress never stops, nor is it linear. Therefore, the Health Council of Canada urges governments over the remaining years of the accords to focus on (i) health human resource planning and the development of concrete action plans; (ii) the state of home care and its integration with primary health, acute, and long-term care; (iii) improved public reporting; and (iv) achieving quality across the system, with no exceptions.

Leadership and stewardship in health care come from governments. While much of the progress since the accords has been generated by individual jurisdictions acting in the interests of their own citizens, the next push lies in having all governments work together—across the full spectrum of health care—in the interests of all Canadians, which was the real promise of the accords.



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ACKNOWLEDGEMENTS

The Health Council of Canada gratefully acknowledges the significant efforts by numerous people in the federal, provincial, and territorial ministries of health, and in various agencies, who participated in interviews and responded to our requests for information and feedback for this report.

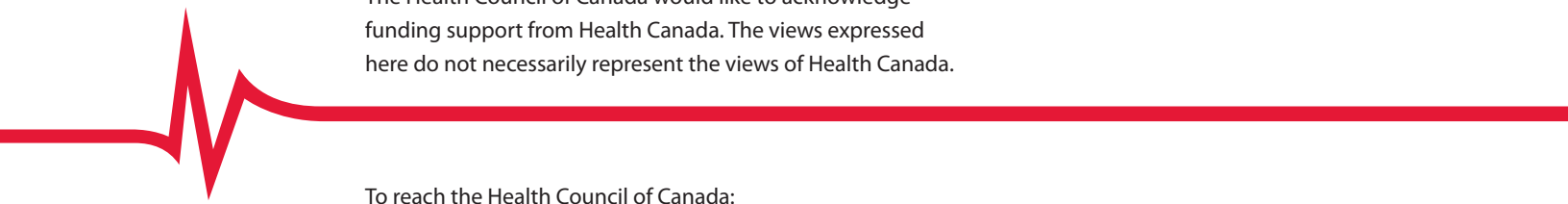
Development of this report was guided by the Council's Health System Reporting Committee, which includes Councillors Dr. Bruce Beaton, Dr. Catherine Cook, Cheryl Doiron, Dr. Dennis Kendel, Lyn McLeod, Dr. Michael Moffatt and Dr. Charles J. Wright.

The Council also thanks Ed Arundell, who conducted initial scans of publicly available jurisdictional information, and the Secretariat staff for their work in supporting the research, analysis and production of this report.

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The Health Council of Canada would like to acknowledge funding support from Health Canada. The views expressed here do not necessarily represent the views of Health Canada.

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Progress Report 2011: Health Care Renewal In Canada

May 2011

ISBN 978-1-926961-05-7 PDF

ISBN 978-1-926961-04-0 Print

How to cite this publication:

Health Council of Canada. (2011). *Progress Report 2011: Health Care Renewal In Canada*. Toronto: Health Council of Canada.
www.healthcouncilcanada.ca.

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