

Progress Report 2013:

Health care renewal in Canada



Table of contents

2	Introduction
4	Access and wait times
12	Primary health care reform and electronic health records
18	Pharmaceuticals management
26	Disease prevention, health promotion, and public health
32	Aboriginal health
38	Conclusion
40	References

Illustrator: Laura Pérez

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

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Foreword



If you live in Ontario, there is a good chance you'll have a shorter wait for your hip replacement than someone in another part of the country. If you live in Alberta, it's more likely that your family physician will keep track of your health information using an electronic medical record. If you live in New Brunswick, yours is one of the few provinces where a pharmacist can administer a drug by injection. And if you are an Aboriginal person, you are more likely to have poor health than other Canadians.

What does this say about health care in Canada?

Ten years ago, the federal, provincial, and territorial governments signed the 2003 *First Ministers' Accord on Health Care Renewal* and, a year later, the 2004 *10-Year Plan to Strengthen Health Care*. In doing so, they committed to the goal that all Canadians should have access to the health care they need, regardless of where they live and what they can afford. Commitments were made, priorities identified, and funding put in place.

But as the examples above demonstrate, where you live *does* matter. Access to high-quality care still varies across the country. And disparities in health status remain.

The Health Council of Canada has examined and reported in detail on progress against each of the commitments made in the 2003 and 2004 health accords in *Progress Report 2011*, *Progress Report 2012*, and now *Progress Report 2013*.

Some clear patterns emerge. Reform is happening and progress is being made. But we have yet to find effective ways to share knowledge and best practices among jurisdictions so they can benefit from, and build on, one another's successes. As a result, we are not taking full advantage of the innovations in health care delivery that are occurring.

And we still aren't where we should be in terms of measuring performance. At the end of the day, we can't accurately assess and compare health care across Canada because targets are often unclear and each jurisdiction measures and reports progress in its own way.

Addressing these issues will require continuing leadership from governments and provider organizations, and stronger collaboration among jurisdictions. I called for such leadership and collaboration when I appeared before the Standing Senate Committee on Social Affairs, Science and Technology on behalf of the Health Council of Canada in 2011. This report provides further evidence to support this need.

High-quality health care for all Canadians—a decade after the first health accord, we are closer to realizing our goal, but we're not there yet.

Dr. Jack Kitts
Chair, Health Council of Canada



Introduction

At the heart of the 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care* is a commitment to accountability. The documents articulate the responsibility of federal, provincial, and territorial governments to regularly report to Canadians on how the health care system is performing and how health care dollars are spent. They also articulate a role for the Health Council of Canada in this ongoing activity.

However, the intent of the health accords was also to follow through on the stated goals for health care renewal and develop indicators that would allow progress to be measured. Although each jurisdiction has undertaken considerable work on the health accord themes, the shared vision expressed 10 years ago has not been fully realized. For the most part, each province and territory has developed its own approach for responding to its jurisdictional needs; the resulting variability makes it more difficult to assess pan-Canadian progress on the health accord commitments. But by reviewing and assessing information available from the federal, provincial, and territorial governments and other sources, a picture begins to emerge.

In *Progress Report 2011*, the Health Council reported on progress in meeting health accord commitments in the areas of wait times, pharmaceuticals management, electronic health records, teletriage, and health system innovation. *Progress Report 2012* looked at progress in home and community care, health human resources, telehealth, access to care in the North, and the development of comparable health indicators.



This 2013 report revisits wait times and pharmaceuticals management and reports on progress in primary health care (including electronic health records), Aboriginal health (including health human resources), and disease prevention, health promotion, and public health. All provinces and territories, with the exception of Quebec, are members of the Health Council of Canada, and this report provides an overview of progress across the country.

For detailed information on each jurisdiction, please see province and territory specific profiles online at healthcouncilcanada.ca/progress.

The Health Council of Canada analyzes information from a broad range of sources, including websites and reports of governments and organizations that report on health care or health system reform. An important source document for this report was *Time for Transformative Change: A Review of the 2004 Health Accord*, published in 2012 by the Standing Senate Committee on Social Affairs, Science and Technology following extensive hearings with experts and other witnesses. In addition, the Health Council used its formal process to gather information directly from federal, provincial, and territorial health ministries and departments.

Health care reform is occurring through initiatives across the country. This report highlights some of those efforts to encourage discussion on how they might be adapted in more jurisdictions. Through the Health Innovation Portal (healthcouncilcanada.ca/innovation), the Health Council of Canada has also created a resource of innovative practices to facilitate the dissemination, sharing, and uptake of these practices across the country.



Access and wait times

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

This health accord mentioned access and wait times in relation to developing performance indicators.¹ Progress on the development of performance indicators was reported on in *Progress Report 2012*.

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 services, hip and knee replacements, and sight restoration, recognizing the different starting points, priorities, and strategies across jurisdictions.

The Wait Times Reduction Fund will augment existing provincial and territorial investments and assist jurisdictions in their diverse initiatives to reduce wait times. This Fund will primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times.

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.
- ▶ Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established 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.
- ▶ 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.²





What the Health Council has said about access and wait times

- ▶ In its 2005 report *10 Steps to a Common Framework for Reporting on Wait Times*, the Health Council recommended ways governments could move forward in reducing wait times.³
- ▶ In its 2007 report *Wading through Wait Times*, the Health Council reported that although work was underway in each jurisdiction to reduce wait times, there was insufficient information to paint a cross-Canada picture.⁴
- ▶ In its 2008 report *Rekindling Reform*, the Health Council found that governments had established evidence-based benchmarks for most priority areas and some provinces had reported substantial wait time reductions. However, provinces were not adequately reporting information on their progress.⁵
- ▶ In 2011, the Health Council found that
 - the \$5.5 billion Wait Times Reduction Fund had enabled jurisdictions to address wait times using a range of approaches;
 - early efforts focused on reducing surgery wait times, but jurisdictions had expanded their focus beyond the five priority areas identified in the 2004 10-year plan;
 - the quality and quantity of public reporting on wait times far exceeded the annual report promised by First Ministers. In most provinces, residents could use provincial websites to compare wait times between regions or hospitals, and annual reporting on wait times by the Canadian Institute of Health Information (CIHI) provided comparisons against benchmarks and among provinces;
 - the 2007 federal budget allocated more than \$1 billion over three years to implement wait time guarantees. These were in place in nine provinces by April 2010, but it was unclear whether these guarantees had improved health outcomes; and
 - continued coordinated effort and greater use of effective management tools could make wait times management one of the success stories of the health accords.⁶

Progress to date

In 2004, Health Ministers committed to reducing wait times in the five priority areas of cancer, heart, diagnostic imaging, joint replacements, and cataract surgery.² The following wait time benchmarks were agreed to by provincial and territorial governments in December 2005⁷:

- ▶ hip/knee replacement within 26 weeks;
- ▶ hip fracture repair within 48 hours;
- ▶ cataract surgery within 16 weeks for those at high risk;
- ▶ radiation therapy for cancer within four weeks of patients being ready for treatment; and
- ▶ coronary artery bypass surgery within two weeks for level 1 urgency, six weeks for level 2 urgency, and 26 weeks for level 3 urgency.

Achieving benchmarks in five priority areas

CIHI reports that in most provinces there has been little improvement in the proportion of patients receiving care within the benchmarks since 2010. However, CIHI also notes that the number of priority surgical procedures performed continues to grow. More than 538,000 Canadians received these procedures in 2012, an increase of approximately 21,000 over the previous year.⁸

In reporting on jurisdictional performance, CIHI notes that not all delays are directly related to access issues. As a result, CIHI defines 90% as a reasonable performance target against the benchmarks. In 2012, all provinces met the radiation therapy benchmark for at least 90% of patients (except Nova Scotia at 89%). However, none of the provinces reached the 90% target for the other priority procedures.⁸ (See Figure 1 for the proportion of patients receiving care within the pan-Canadian benchmarks in 2012 and for trends since 2010).

In 2012, 15% more hip and knee replacement surgeries were performed in Canada than two years earlier. But the proportion of these surgeries performed within the pan-Canadian benchmark decreased by 4%. In British Columbia, Manitoba, Quebec, New Brunswick, and Prince Edward Island, the percentage of hip replacement surgeries performed within the benchmark declined substantially during that same time period. These same provinces, along with Saskatchewan and Ontario, also had substantial

declines in the percentage of knee replacement surgeries performed within the benchmark. CIHI suggests that rising demand for hip and knee replacements due to aging and growing rates of osteoarthritis and obesity is outpacing system capacity. Among all priority areas, patients seeking knee replacements have the longest waits. Knee replacements were also responsible for the most variation in wait times across provinces.⁸

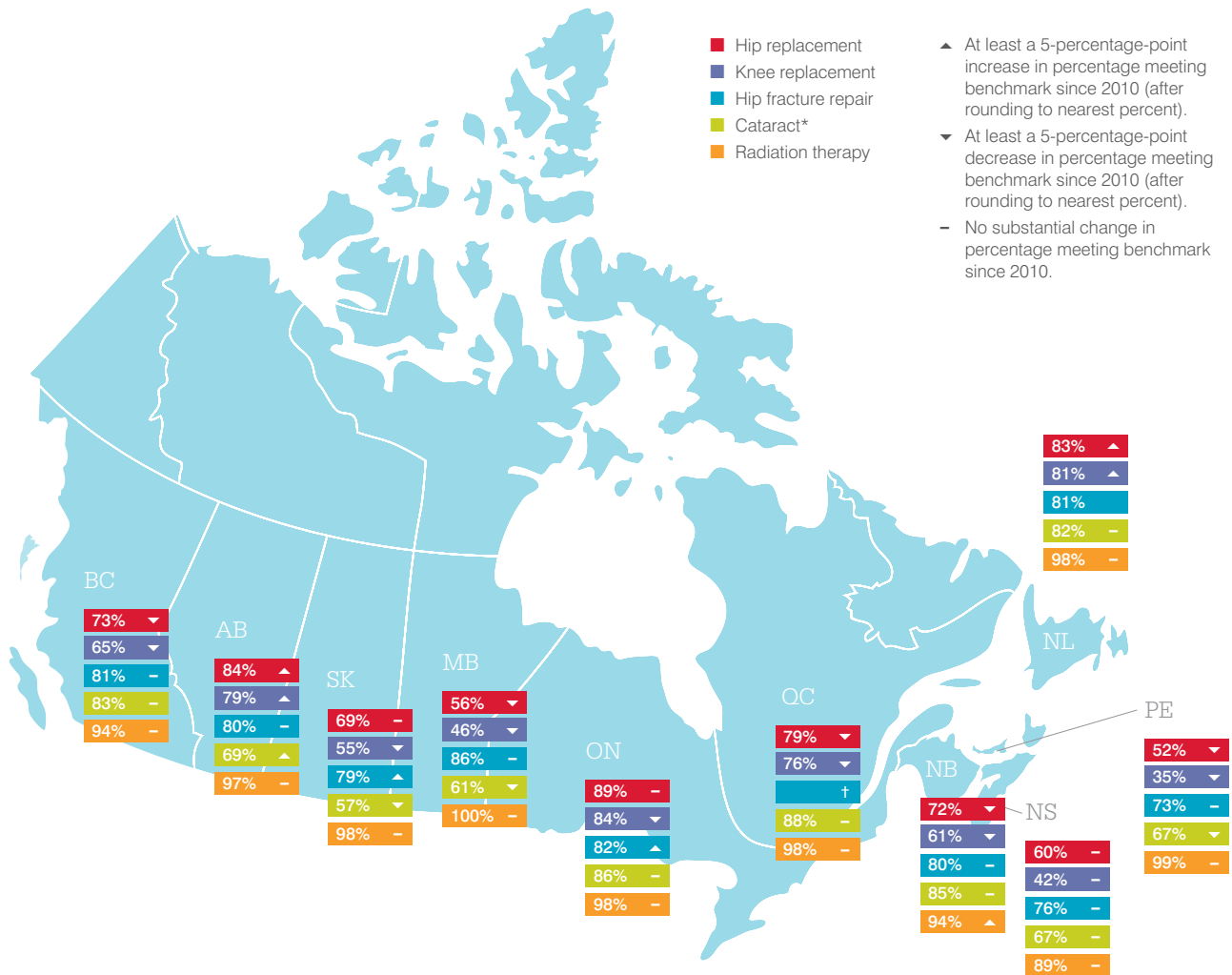
Newfoundland and Labrador and Alberta are the only two provinces that improved their performance against the benchmarks for hip and knee replacement surgeries between 2010 and 2012.⁸ Over the past eight years, Newfoundland and Labrador invested in wait time reduction, including \$5 million in 2012 to enhance access to health care services, which includes additional hip and knee replacement surgeries.⁹ In Alberta, more hip and knee replacement surgeries were performed as a result of an evidence-based initiative to reduce the length of post-surgery hospital stays. Preliminary results for 2011/12 suggest the initiative saved over 13,500 bed days, creating capacity for more than 3,375 additional surgeries.¹⁰

Wait times for hip fracture repair and cataract surgeries have remained fairly stable since 2010. Alberta is the only province in which the percentage of cataract surgeries performed within the benchmark increased between 2010 and 2012. During the same period, the percentage of cataract surgeries within the benchmark decreased in Saskatchewan, Manitoba, and Prince Edward Island. From 2010 to 2012, wait times for hip fracture repair improved in only two provinces—Saskatchewan and Ontario.⁸

Due to the lack of comparable wait time data for coronary artery bypass graft (CABG) surgery, CIHI no longer includes CABG wait times in its annual report.⁸ However, CIHI's website indicates that on average, 90% of Canadian patients receive CABG surgery within 46 days, although waits range from 19 days in Saskatchewan to 84 days in Alberta.¹¹

The Wait Time Alliance (WTA), a group composed of the Canadian Medical Association and 13 national medical specialty organizations, also reports on wait times using data from government websites. Where methods of reporting differ among jurisdictions, the WTA makes best estimates or uses specific criteria to assign grades based on performance.

Figure 1: Trending for the proportion of patients receiving care within benchmarks by province and priority area, 2010–2012



Notes:

Figure reproduced and adapted with permission.

* The pan-Canadian benchmark specifies cataract surgery within 16 weeks (112 days) for patients who are at high risk. There is not yet consensus on a definition of “high risk,” so the benchmark is applied across all priority levels.

† Quebec wait times for hip fracture repair are not included due to methodological differences in the data.

There are no pan-Canadian benchmarks for MRI and CT scans.

Percentage of patients receiving coronary artery bypass graft surgery within the benchmark will no longer be reported for 2012 and onwards.

Source: Canadian Institute for Health Information. (2012). *Wait times in Canada—A summary, 2012*.

The WTA's grades reflect the percentage of the population that is treated within the pan-Canadian benchmark:

A: 80–100%; B: 70–79%; C: 60–69%; D: 50–59%; and F: less than 50%.¹²

In its 2012 report, the WTA gave an A grade to all provinces providing radiation therapy and coronary artery bypass graft surgeries. British Columbia, Ontario, and Newfoundland and Labrador received an A grade for hip replacement surgery, Ontario received an A grade for knee replacement surgery, and Ontario and New Brunswick received an A grade for cataract surgery. An F grade was awarded to Nova Scotia and Prince Edward Island for knee replacement surgery wait times.¹³ The report notes that regional variations in wait times may be due to a variety of reasons, including inadequate technological and human resources, uneven demand, and lack of coordination.¹³

Reporting on diagnostic imaging wait times

Diagnostic imaging was identified as a priority in the health accords, but no national wait time benchmarks were set due to lack of evidence.¹⁴ Five provinces submitted data on wait times for magnetic resonance imaging (MRI) and computerized tomography (CT) to CIHI in 2012.⁸ For patients requiring MRI scans, 90% receive these scans within 261 days in Alberta, 99 days in Manitoba, 86 days in Ontario, 148 days in Nova Scotia, and 143 days in Prince Edward Island.¹⁵ For patients requiring CT scans, 90% receive them within 36 days in Alberta, 41 days in Manitoba, 32 days in Ontario, 68 days in Nova Scotia, and 34 days in Prince Edward Island.¹⁶

In the absence of evidence on patient outcomes and access related to waits for diagnostic imaging, the Canadian Association of Radiologists (CAR) used a pan-Canadian consultation process to set its own diagnostic imaging wait time benchmarks in 2005. These benchmarks were updated in 2013 and prioritize MRI and CT scans by urgency level. CAR recommends a maximum wait of 24 hours for an emergent issue, seven days for urgent needs, 30 days for semi-urgent needs, and 60 days for non-urgent needs.¹⁷ The appropriateness of these benchmarks for each provincial and territorial health system needs to be determined.

Addressing accountability and transparency

Jurisdictions have made progress in addressing accountability and transparency by regularly reporting wait time information on their respective websites. The WTA assesses provincial wait time websites using a number of criteria, such as ease of use, comprehensiveness, whether the information is current, and the quality and reliability of the data. The quality of these websites continues to improve, and in 2012 the WTA gave them a B grade overall.¹³ The most recent wait time information available on provincial websites when this report was being prepared is in each of the Health Council's online profiles at healthcouncilcanada.ca/progress.

CIHI is mandated to collect and analyze wait times data, and all provinces submit data to CIHI using a standardized format. Although provinces report on wait times differently to reflect their priorities and contexts, CIHI's annual wait time reports provide a national picture and allow cross-jurisdictional comparisons. CIHI's interactive website also provides a more in-depth view of wait times in each province.

The territories do not report publicly on wait times because residents often must travel out of the jurisdiction to access complex medical services. The Northwest Territories tracks wait times for knee and hip replacement surgery, but does not distinguish between the procedures. In the Yukon, wait times are monitored but not publicly reported.

Addressing wait times

Under the health accords, the federal government established the Wait Times Reduction Fund to help jurisdictions manage and reduce wait times. The fund supported initiatives in specific areas, including training and hiring health professionals and expanding capacity in ambulatory and community care.

Limited information is available on how jurisdictions are addressing wait times through such strategies. All jurisdictions are engaged in health human resources strategies, including enhancing scopes of practice, developing recruitment and retention policies, providing financial incentives for relocation to rural and remote areas, and providing financial assistance for training.

Information about improving access to ambulatory care is not available in most provinces and territories. Community care is expanding across the country, often with a focus on chronic disease management and prevention.

Wait times in other areas

Patients also experience waits in areas beyond the original wait time priorities of the health accords, including emergency departments, primary health care, and long-term care. These waits can affect wait times in the priority areas as well.

Jurisdictions have initiated work in many of these areas. For example, a number of provinces have established emergency department wait time benchmarks and targets,¹⁴ although only Ontario and Alberta report publicly on their performance. The WTA grades emergency department wait times against the benchmark of a four-hour wait for non-admitted patients and an eight-hour wait for admitted patients. In 2012, the WTA awarded Ontario an A grade for non-admitted emergency patients, but D and F grades for admitted patients. Alberta also received an A grade for non-admitted emergency patients, but a D for all admitted patients.¹³

In 2010/11, CIHI found that 90% of emergency department visits across Canada were completed in eight hours or less. However, most patients waited longer for an initial assessment by a physician than the guideline set by the Canadian Association of Emergency Physicians.¹⁸

CIHI also provides an international comparison of wait times in various areas using 2010 Commonwealth Fund survey data:

- ▶ Of 11 countries, Canada had the highest proportion (31%) of adults reporting a wait of more than four hours in the emergency department before receiving treatment, which is 19 percentage points higher than the average.
- ▶ In the area of primary health care, only 45% of Canadians reported seeing a doctor or nurse the same day or the next day when sick, the lowest percentage among comparator countries; 33% of Canadians reported waiting six or more days.
- ▶ Canadians also waited the longest to see a specialist, with 41% of Canadians reporting a wait of two or more months.¹⁸

Patients who no longer need acute care but are waiting in hospital for discharge to rehabilitation, home with home care support, or long-term care are designated as receiving an alternate level of care (ALC).¹⁸ In its 2011 report card, the WTA noted that ALC stays can affect emergency department wait times, waits to receive paramedic services, and waits for scheduled surgeries.¹⁹ Approximately 5% of in-patient hospitalizations are considered ALC in Canada, and this rate has remained relatively stable for several years. Those most likely to wait in ALC are those with dementia, those receiving palliative care, and those waiting for rehabilitation and convalescence. In 2011, approximately 16% of ALC patients waited a day or two for discharge, 21% waited more than a month, and 5% waited more than 100 days.¹⁸

Remaining challenges

In its review of the 2004 health accord, the Standing Senate Committee on Social Affairs, Science and Technology heard from witnesses that wait time commitments in priority areas had largely been met, but that the development of benchmarks was not sufficiently evidence-based or patient-centred. The Committee recommended that efforts be made to develop strategies to address wait times in specialty care, emergency departments, and long-term care; research and develop evidence-based and patient-centred pan-Canadian benchmarks; and collaborate to share best practices in reducing wait times.²⁰

The WTA also suggests wait time benchmarks should take the entire patient experience into account. Wait times are usually measured from the patient's visit to the specialist to the start of treatment. The WTA argues that several prior stages should be considered part of the wait time, including finding and seeing a family physician, waiting to see a specialist, and/or waiting for diagnostic testing.¹³

The bottom line

- ▶ In the first years of the health accords, gains were made in reducing wait times, reporting wait times publicly, and collecting standardized wait time data in priority areas to allow cross-country comparisons.
- ▶ In recent years, progress has stalled in some areas. With respect to knee replacement surgery, for example, the proportion of patients receiving care within benchmarks is decreasing. For diagnostic imaging, there is still a need to set evidence-based benchmarks. And for coronary artery bypass graft surgery, a lack of standardized data on wait times across jurisdictions prevents meaningful comparisons.
- ▶ Efforts to monitor wait times beyond the designated priority areas vary widely. In the absence of wait time benchmarks in these areas, other organizations have established their own.

Commentary

The federal and provincial governments recognize the need to address wait times and have dedicated significant resources to reducing them. Wait time guarantees were put in place and successful strategies and best practices were identified and implemented across the country.

But despite significant improvements in the early years of the health accords, wait time benchmarks are not yet fully met in most of the priority areas. Even more concerning, the proportion of patients receiving care within benchmarks has decreased over recent years in some provinces. At the same time, the demand for procedures such as knee and hip replacement surgery continues to rise,⁸ raising concerns about insufficient capacity and poorer health outcomes in the future.

CIHI has also identified a number of areas in which no clear progress has been shown, including wait times for routine care, the impact of wait times in one area on other services, the impact of surgical wait times on post-operative care and outcomes, and the problem of multi-step waits for different types of care.¹⁸

It is also unclear how individuals are added to or removed from wait lists. Some patients who are waiting may not be on a list; others on a list may not need to be. Increased transparency is needed in the management of wait lists, and information sharing among health care providers must improve.²¹

Achieving existing wait time benchmarks must remain a priority for all jurisdictions, and they must continue to identify, share, evaluate, and apply innovative practices to reach this goal. Not all approaches to reducing wait times are effective or sustainable. For example, a 2013 report by the Organisation for Economic Co-operation and Development (OECD) suggests that wait time guarantees are only effective when systematic measurement is in place and health providers are held accountable for achieving targets. The report also notes that targeted funding is rarely effective over the long term, because wait times often increase once funding ends.²² CIHI suggests broader implementation of successful wait time strategies such as those that focus on financial incentives, human resources policies, technology, and patient flow.¹⁸

We also need to broaden our definition of wait times to reflect the full patient experience, including the wait to see the family physician and specialist, and the wait for diagnostic testing.¹³

Looking to the future, we must move beyond the initial priority areas identified in the health accords and address wait times in emergency departments, primary and specialist care, home care, and long-term care. The issues are complex and call on us to address health system coordination, duplication of services, and unnecessary and inappropriate procedures and services.

In the past decade, provinces have recognized the value in publicly reporting on wait times, and they regularly provide updated information on their websites. CIHI also collects and reports standardized wait time data in priority areas. This practice must expand to include the other areas in which Canadians experience waits, such as those noted above. It is also important to note that wait times in the territories have not been monitored or publicly reported by national bodies because residents gain access to most complex procedures in other jurisdictions. To ensure accountability, it is time for the territories and the provinces that provide services to territorial residents to work with CIHI to collect, extract, analyze, and report these data. Expanding and enhancing comparable reporting on wait times among all jurisdictions will give governments a valuable tool to gauge their progress and help them take action, where necessary, to improve access to care—an ongoing concern of Canadians.^{23,24}

Innovative practices in access and wait times – Alberta

Beyond wait times: Improving referral management

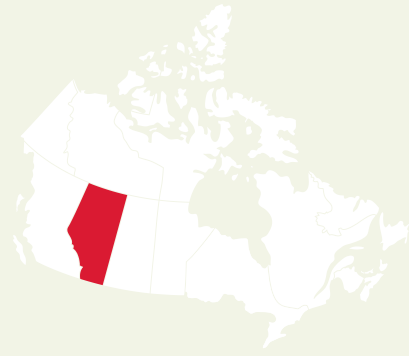
Referrals play a key role in accessing health services, whether it is an appointment with a specialist, a diagnostic test, or home care.

But an evaluation of referral initiatives in Alberta found that the current paper-based referral process lacked standardization and transparency, and was frequently inefficient. For example, patients may wait longer for a diagnosis if a referral is missing information, if it is illegible, or if the clinical question is unclear. Poor communication among providers and with patients leaves everyone in the dark: Has the referral been accepted? Has an appointment been booked? What was the outcome?^{S1}

Path to Care: Referral and Wait Time Measurement and Management is a multi-year plan launched by Alberta Health Services to improve access and reduce health service and referral wait times. The plan includes a major initiative to improve referral management and implement electronic referrals across the province that builds on work that has been done internationally in the United States, Denmark, Australia, and New Zealand.^{S2}

The referral management initiative has three key components:

- ▶ **Service redesign through partnership and engagement:** The initiative brings together primary and specialty care to address referral and access issues and processes.
- ▶ **Standardized referral guidelines and pathways:** The initiative will standardize the referral process to improve communication, care transitions, and patient care. Provincial guidelines will be developed for each clinical population that specify when a referral should be made, what information is required, a defined urgency scale (urgent, routine), the appropriate timeline for a patient to be seen, what tests should be done prior to making a referral, and other components necessary for a complete referral.



- ▶ **Automated referral process:** The majority of referrals in Alberta are still faxed. This requires data re-entry and results in data errors, lost referrals, and inefficiencies. The province plans to automate the process in the short-term with the long-term goal of integrating referrals into existing electronic medical records and clinical scheduling systems across the province.^{S1}

A provincial rollout of e-referrals is scheduled to begin in November 2013 for hip surgery, knee surgery, breast cancer, and lung cancer. This rollout will test the e-referral platform prior to broader implementation. These areas were chosen because provincial guidelines already exist, processes have been streamlined, and clinical champions are in place.

Work is underway to establish clinical design teams who will liaise with the service areas shifting to e-referrals. The teams will work with stakeholders to determine what processes need to change and what support they need to help them transition successfully. E-referral capability will be developed within the province's existing Alberta Netcare Portal.^{S3}



For more detailed information on this innovative practice, visit the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.



Primary health care reform and electronic health records

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

Primary health care reform

- ▶ 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, seven days a week, as soon as possible and that this target be fully met within eight years.
- ▶ First Ministers agree that each jurisdiction will publicly set out its own multi-year targets for verifiable progress towards achieving this objective.¹

Electronic health records

- ▶ 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.* The Government of Canada will provide additional support for Canada Health Infoway to achieve this objective.
- ▶ First Ministers are also committed to the appropriate protection of personal information in building a national system of electronic health records.¹

2004 10-Year Plan to Strengthen Health Care

Primary health care reform

- ▶ First Ministers agree to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform such as scope of practice. First Ministers agree to regularly report on progress.²

Electronic health records

- ▶ Recognizing the significant investment that has been made and achievements to date, First Ministers agree to accelerate the development and implementation of the electronic health record, including e-prescribing. To this end, First Ministers commit to work with Canada Health Infoway to realize the investment. First Ministers have also asked for acceleration of efforts on telehealth to improve access for remote and rural communities.²



* The Health Council reported on telehealth in *Progress Report 2012: Health care renewal in Canada*.

What the Health Council has said about primary health care

- ▶ In 2008, the Health Council reported the following progress in primary health care:
 - an \$800 million Primary Health Care Transition Fund was established to fund the transitional costs of implementing large-scale primary health care reform in provinces and territories from 2000 to 2006, but funds were largely used for small initiatives;
 - a Best Practices Network created to share information and advice across providers was dissolved due to lack of funding; and
 - governments and health care organizations collaborated on a National Primary Health Care Awareness Strategy and invested \$9.5 million in a seven-month advertising campaign in 2005/06.⁵
- ▶ In our 2009 *Teams in Action* report the Health Council found that 32% of Canadians had access to more than one primary health care provider and that those with a chronic health condition were 41% more likely to have access to multiple care providers.²⁵
- ▶ Since 2009, the Health Council has released seven bulletins that profile data primarily from the Commonwealth Fund International Survey. The bulletins have addressed a range of issues related to primary health care, including access to primary health care, chronic disease management, coordination of care, and patient engagement in care.²⁶⁻³²
- ▶ In its 2010 commentary, *At the Tipping Point*, the Health Council noted that Canada's primary health care system lags behind those in similar countries, and that primary health care reform is not happening as broadly and rapidly as it should be.³³

- ▶ In its 2012 *Self-management support for Canadians with chronic health conditions* report, the Health Council highlighted success factors, barriers, opportunities, and resources to move the delivery of self-management support forward through integration with primary health care and community-based services and continued research in key areas.³⁴

What the Health Council has said about electronic health records

- ▶ In its 2010 *Decisions, Decisions* report, the Health Council highlighted electronic health and medical records as essential tools to facilitate decision-making by physicians.³⁵
- ▶ In 2011, the Health Council reported that
 - across Canada, 37% of Canadian physicians were using an electronic medical record (EMR) in 2009; and
 - in collaboration with the provinces and territories, Canada Health Infoway had nearly achieved the goal of having the core elements of an electronic health record (EHR) in place for 50% of Canadians.⁶
- ▶ In 2013, the Health Council reported that
 - the use of EMRs has more than doubled since 2006, with 57% of Canada's primary care physicians now using electronic medical records; and
 - in 2012, 43% of Canadian primary care physicians routinely use e-prescribing technology, up from only 11% in 2006.³²



Progress to date

In the 2003 health accord, First Ministers focused on interprofessional teams and 24/7 access to primary health care providers. In the 2004 10-year plan, emphasis was placed on sharing best practices, accelerating the implementation of electronic health records, and accountability for progress on primary health care reform.

Improving access to interprofessional teams

Interprofessional teams enhance the quality and comprehensiveness of primary health care, giving patients access to a variety of health professionals and leading to improvements in health and quality of life—particularly for those with chronic health conditions, seniors, and those living in rural and remote locations.³⁶⁻⁴⁴ These teams now exist in almost all jurisdictions, although team composition and collaborative approaches differ across the country.²⁵

However, after-hours primary health care remains unavailable to most Canadians. The Health Council's analysis of Canadian data from the 2012 Commonwealth

Fund International Survey of Primary Care Doctors showed that the percentage of practices providing after-hours care remained below 50% for all provinces except Ontario³¹ (see Figure 2). Similarly, in its review of the 2004 health accord, the Senate Committee heard from witnesses that there was insufficient progress towards the goal of ensuring that 50% of Canadians had 24/7 access to interprofessional teams.²⁰

Reporting on primary health care

A number of provinces report publicly on primary health care reform in their jurisdiction but do not have specific targets against which to measure their progress. Where targets exist, indicators and reporting varies among jurisdictions. Most jurisdictions do not report on the proportion of their residents with 24/7 access to interprofessional teams.

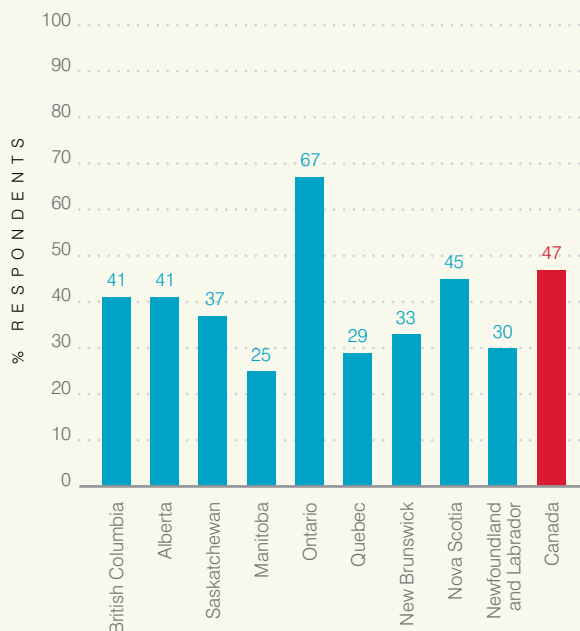
Advancing primary health care reform

A 2012 report on primary health care policy from the Canadian Foundation for Healthcare Improvement found that progress has been made in expanding initiatives such as collaborative practice, interdisciplinary teams, prevention and promotion, and chronic disease management. However, there is a lack of consistency in definitions, policy, and service delivery, and progress on primary health care reform is often not sufficiently documented or shared.⁴⁵

The report notes that although interprofessional teams are proliferating, roles remain unclear and teams are often still too “physician-centric” rather than patient-focused. In addition, physicians in many areas remain in traditional roles and allied professionals are typically not included in teams or in dialogues about primary health care reform. The report concludes that Canada's primary health care system is lagging behind other countries and that a lack of data, research, and interoperable information systems present further barriers to advancing primary health care reform.⁴⁵

A report on primary health care reform in Canada from the Agence de la santé et des services sociaux de Montréal noted that progress has not been made in integrating and coordinating primary health care practices with other services. In some situations, funding was insufficient to implement the necessary reforms; in others, too much funding led to a level of support that could not be sustained.⁴⁶

Figure 2: Provincial comparison of the proportion of physicians who say their patients can see a physician or nurse when the practice is closed without using emergency departments.



Note: Results for Prince Edward Island and the territories are not presented due to small sample sizes.

Source: Health Council of Canada. (2013). *How do Canadian primary care physicians rate the health system? Results from the 2012 Commonwealth Fund International Health Policy Survey of Primary Care Doctors*. *Canadian Health Care Matters, Bulletin 7*. Toronto: Health Council of Canada.

Witnesses to the Senate Committee said that challenges to primary health care reform include current remuneration models, the lack of governance mechanisms to manage and bring about reforms, and the need for targeted conditional funding arrangements.²⁰

However, funding from the Primary Health Care Transition Fund did lead to some innovative practices across the country. The Senate Committee heard from witnesses that these models need to be evaluated and success factors brought forward and implemented broadly.²⁰

The Collaborative Emergency Centre model is one example of a new approach to primary health care that was developed recently and shared between jurisdictions. The model was developed by Nova Scotia to help increase access to interprofessional primary health care teams in smaller communities. It has now been adopted by Saskatchewan, which will implement it over the coming year, and Prince Edward Island, which will open its first centre this year.¹⁴

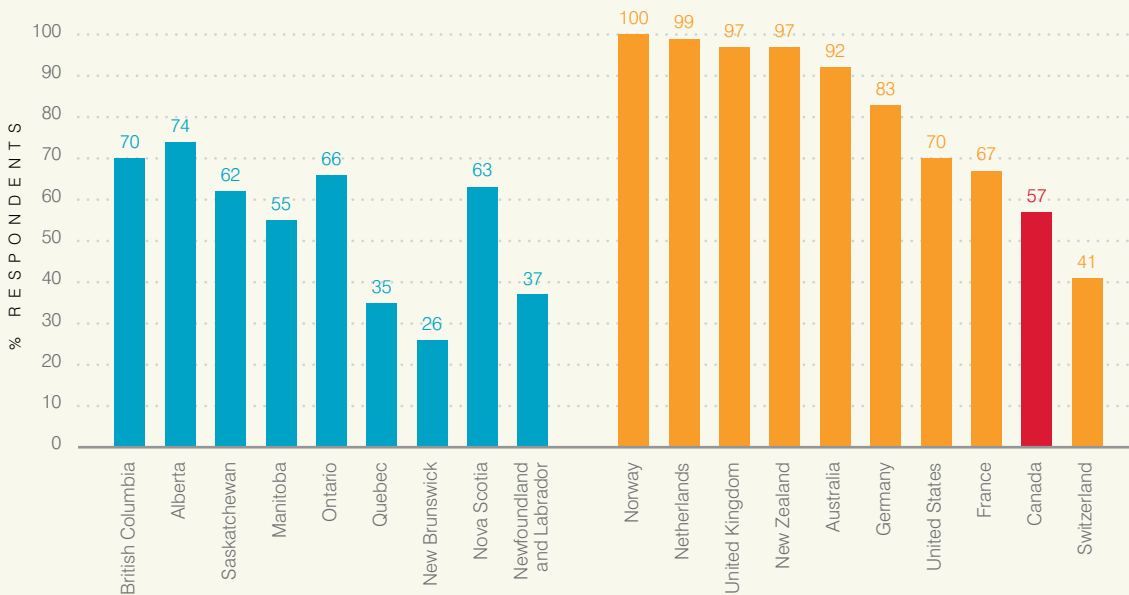
Implementing electronic health and medical records

The 2004 10-year plan identified EHRs as a priority for primary health care reform. EHRs capture a patient’s health information from across the health system (e.g., primary

health care, diagnostic imaging, laboratory tests, and medication information), making information available to authorized health care professionals across health settings. EMRs, such as those created and maintained in a primary health care practice, are one component of an EHR.⁴⁷ Canada Health Infoway has been working with federal, provincial, and territorial governments and investing in innovative projects designed to implement EHR systems across the country. Infoway is also working collaboratively with privacy commissioners, health ministries, and other stakeholders to ensure that privacy and security of information are upheld.⁴⁸

All jurisdictions have made progress on EHRs. As of March 2012, EHRs with the six core components (registries, diagnostic imaging, drug information systems, lab test results, clinical reports, and immunizations) were available for 52% of the Canadian population.⁴⁹ Drug information systems are also expanding across Canada, and 90% of most common radiology exams are now digital. However, the lack of interoperability between different information systems poses a challenge to further implementation of EHR components. Witnesses to the Senate Committee estimated that a \$10 billion investment would be required in order to fully realize a national interoperable EHR system.²⁰

Figure 3: Provincial and international comparison of electronic medical record use by primary care physicians



Note: Results for Prince Edward Island and the territories are not presented due to small sample sizes.

Source: Health Council of Canada. (2013). *How do Canadian primary care physicians rate the health system? Results from the 2012 Commonwealth Fund International Health Policy Survey of Primary Care Doctors*. Canadian Health Care Matters, Bulletin 7. Toronto: Health Council of Canada.

The Health Council's analysis of Canadian data from the 2012 Commonwealth Fund International Survey of Primary Care Doctors showed that physician-reported use of EMRs increased 34% from 2006 to 2012. In the 2012 survey, 57% of Canadian physicians reported using EMRs, but use varied across the country. For example, more than 70% of physicians in British Columbia and Alberta reported using EMRs, but only 26% of physicians in New Brunswick reported doing so. Provinces where at least 50% of doctors reported using EMRs are also those that are providing implementation support to their physicians, as indicated in our jurisdictional profiles. It should be noted that in international comparisons, Canada is well behind in implementing EMRs³¹ (see Figure 3).

The bottom line

- ▶ Canadians have not received the promised 24/7 access to primary health care services. Many jurisdictions are tackling primary health care reform through investments, innovation, and policy change, but the absence of specific targets and performance measures makes it hard to measure progress against this goal.
- ▶ Provinces have implemented—and increasingly shared—innovative primary health care models to improve patient access to primary health care.
- ▶ Electronic health and medical records can lead to better-quality care and efficiencies within the health care system, and the number of health care providers using them continues to grow. However, voluntary implementation and ongoing interoperability issues among information systems remain a challenge, slowing Canada's progress in this area.

Commentary

The Primary Health Care Transition Fund was established in 2000 to support provinces and territories in reforming primary health care in their regions and to support pan-Canadian initiatives to address common barriers and advance primary health care reform at a national level.⁵⁰ Since that time, reform has continued across the jurisdictions through a variety of programs, but the need for sustainable, system-level change remains.

Jurisdictions can facilitate implementation of primary health care innovations across the country by learning from one another. For example, the Council of the Federation identified more than 60 leading team-based

models of care across the country that are delivering patient-centred care to individuals in rural and remote areas, seniors, and those living with chronic diseases.⁵¹ Sharing innovative practices is even more important given that provinces and territories face common challenges in their health care systems. Organizations have started to identify, evaluate, and disseminate innovative practices, including Accreditation Canada, the Canadian Working Group for Primary Healthcare Improvement, the Public Health Agency of Canada, the Ivey International Centre for Health Innovation, the BC Ministry of Health, and the Health Council of Canada (healthcouncilcanada.ca/innovation). In the absence of a national best practices network, provinces and territories need to work with these organizations and one another to share information, increase collaboration, and adopt or adapt innovations that have improved primary health care delivery.

Electronic medical records are critical to improving primary health care. But despite progress, Canada's performance remains poor compared to that of other countries, including the United States, Australia, and the United Kingdom.³¹ The federal government, through Canada Health Infoway, must continue to work with provincial and territorial governments and primary health care teams to understand what barriers still exist and what incentives are needed to accelerate change. Many physicians have already adopted EMRs. Those who have not must be challenged to adopt EMRs as standard practice and governments must seriously consider mandating their use.

We need to consider expanding access to EMRs to patients to meet their needs and expectations with regard to accessing their own personal health information. This is already underway in some provinces. For example, Alberta is developing a personal health record that will allow individuals to maintain and access their own records through the Internet.⁵²

At the same time, the implementation of EHRs must also be accelerated. While EMRs are most useful to doctors, they become more effective when they are integrated within a full EHR. On a technical level, interoperability must continue to be addressed. And as technology advances, we must continue to invest in and enhance our existing infrastructure or face the risk of falling even further behind.

Innovative practices in primary health care – Manitoba

Reducing wait times in primary health care

When we are ill, most of us want and need to see our family doctor without a long wait. But according to 2012 survey data reported in the Health Council of Canada's recent bulletin on primary health care, only 47% of Canadian primary care physicians are able to provide patients with a same-day or next-day appointment.^{S4}

Manitoba is implementing a model known as *advanced access* as one strategy to reduce primary health care wait times and to help the province meet its goal of providing every Manitoban with access to a family physician by 2015.^{S5} Advanced access originated in the United States and has spread to a number of Canadian jurisdictions, including British Columbia, Alberta, Saskatchewan, and Ontario, and some areas of New Brunswick and Nova Scotia.^{S6-S9} Manitoba launched its program in 2007, working in close collaboration with Alberta's Access Improvement Measures (AIM) program. (In Alberta, 55% of family practice units that implemented the model improved patient access.) Alberta provided Manitoba with tools and consultations on strategy and lessons learned.^{S6,S10,S11}

Advanced access uses a team approach to plan, implement, and evaluate changes that reduce wait times and facilitate same-day access. In Manitoba, primary health care clinics enrolled in the 12-month program create a three- to eight-member improvement team (including an administrator, physician, nurse, receptionist, etc.) that receives eight days of training over the course of the program. Each clinic identifies its own goals and strategies, measuring and tracking progress along the way.^{S5}

Using the advanced access model, Manitoba clinics have made significant progress in reducing wait times for appointments through strategies such as:

- ▶ reducing the types of appointments (e.g., pre-natal, pap smears, routine physical) to two—one long, one short—to allow more flexible scheduling;
- ▶ reducing “no shows” through reminder telephone calls;
- ▶ stocking all exam rooms with the same equipment to reduce delays caused by clinicians tracking down what they need;
- ▶ clarifying roles to allow all team members to work to the full scope of their practice; and
- ▶ addressing clinic policy/practice issues (e.g., ensuring no more than 50% of physicians are scheduled to be away at any one time).^{S11}



As is common with any health system change, challenges have emerged over time. For example, the training commitment for members of the improvement team is a barrier to enrollment for some clinics due to workload or financial implications. Among participating clinics, some improvement teams found it difficult to gain the staff and physician support necessary to implement change. In other instances, clinics lost momentum due to staff turnover. The province is working on strategies to address these issues.^{S11}

To date, Manitoba has implemented the advanced access model in 50 primary health care clinics and plans to spread the model to 75% of all primary health care clinics across the province by 2015.^{S6,S11}

Results from the year-long training and implementation process have been promising, although long-term data are not yet available.^{S10} For example, one clinic achieved same-day or next-day appointments with most of its clinicians. Patient complaints regarding wait times dropped to zero and the clinic was able to reassign a staff member who previously managed complaints and requests for urgent appointments.^{S12} Another clinic decreased its no-show rates by 20%.^{S13} The province plans an external evaluation of the first four phases of the program (2007–2013) in 2013/14.^{S11}



For more detailed information on this innovative practice, visit the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.



Pharmaceuticals management

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

First Ministers agree that no Canadian should suffer undue financial hardship for needed drug therapy. Accordingly, as an integral component of these reforms, First Ministers will take measures 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.¹

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. 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.²





What the Health Council has said about pharmaceuticals management

- ▶ In its 2008 report *Rekindling Reform*, the Health Council reported that progress on catastrophic drug coverage had stalled and there had not been adequate progress on ensuring that medicines prescribed are safe and appropriate.⁵
- ▶ In its 2009 report *The National Pharmaceutical Strategy: A Prescription Unfilled*, the Health Council noted that governments can and have moved ahead with pharmaceutical reforms individually, but a National Pharmaceuticals Strategy is essential to ensure that through collective action, all Canadians can benefit from equitable access.⁵³
- ▶ In its 2010 report *Generic Drug Pricing and Access in Canada*, the Health Council discussed the impact of high generic drug prices in Canada and presented options for decreasing these prices while minimizing negative consequences to stakeholders.⁵⁴
- ▶ In its 2010 report *Keeping an Eye on Prescription Drugs, Keeping Canadians Safe*, the Health Council made recommendations to ensure drugs are monitored appropriately for safety and effectiveness after they have reached the market.⁵⁵
- ▶ In 2011, the Health Council reported that
 - although each jurisdiction offers some form of publicly funded drug coverage, not all offer universal plans with catastrophic drug coverage;
 - the role of pharmacists is expanding to include medication assessments and prescription renewal;
 - all premiers committed in 2010 to joint purchasing of pharmaceuticals to achieve savings; and
 - nearly one third of community pharmacists and about half of emergency departments and hospital pharmacies have access to a drug information system, although implementation across Canada is varied.⁶

Progress to date

The intent of the National Pharmaceuticals Strategy was that all Canadians, wherever they live, should have access to the medications they need without suffering undue financial hardship. The strategy included nine specific commitments focused on cost, appropriateness, and safety.

Addressing catastrophic drug coverage

All provinces except New Brunswick and Prince Edward Island provide catastrophic drug coverage— coverage for individuals and families whose drug costs cause undue financial hardship. New Brunswick is currently developing a new drug plan that will address the needs of those without drug coverage and those who face financial challenges in paying for medications.⁵⁶ PEI announced in May 2013 that a catastrophic drug plan will come into effect on October 1, 2013.⁵⁷ Among the other provinces, catastrophic drug coverage varies—some cover all drug costs beyond a certain income-tested level, while others cover only a portion of the costs. Among the territories, Nunavut and the Northwest Territories offer partial catastrophic drug coverage; the government of the Yukon does not provide coverage.

The federal government provides catastrophic drug coverage, subject to a deductible, to eligible registered First Nations people and recognized Inuit under the Non-Insured Health Benefits Program.⁵⁸ Federal public service employees, members of the Canadian Forces and the Royal Canadian Mounted Police, members of Parliament, federal judges, and Canadian veterans receive catastrophic drug coverage under the Public Service Health Care Plan.¹⁴

Establishing a national drug formulary

Although the commitment to establish a national drug formulary was not met, all provinces and the Yukon have a drug formulary and drug review process that includes input from the national Common Drug Review (CDR) of the Canadian Agency for Drugs and Technologies in Health (CADTH). In CADTH's submission to the Senate Committee, it said that although jurisdictions are not required to comply with the CDR's recommendations, the recommendations are followed 90% of the time. Other witnesses indicated that through its recommendations, the CDR helped to contain costs and achieve harmonized drug formularies. However, some witnesses suggested there was still a need for a national formulary.²⁰

The Canadian Diabetes Association has also identified several challenges with the current drug review process, including continued duplication of review processes and unequal access to medications due to inconsistencies between CDR recommendations and drug plan decisions by the provinces and territories.⁵⁹ The Canadian Diabetes Association recommends clarifying all aspects of the drug review process to ensure that the process considers the patient experience and to strengthen transparency and accountability.⁶⁰

Addressing drug prices through joint pricing strategies

A study of 2009 generic drug prices from the UBC Centre for Health Services and Policy Research found that Canadian prices for generic drugs are high compared to international prices. The study compared prices of the most commonly prescribed generic drugs in Ontario to those in public drug programs in the United States and New Zealand. It found that if Ontario had paid the lowest comparator price, the province could have paid for all generic drugs and saved \$87 million within one year.⁶¹

In the case of brand-name drugs, the Patented Medicine Prices Review Board (PMPRB) reviews and regulates the manufacturer's price for patented drugs in Canada to ensure that prices are not excessive; however, the PMPRB has no authority to regulate prices charged by wholesalers or pharmacies. In its 2011 report, the PMPRB compared Canadian prices for patented drugs against those in seven other countries (France, Germany, Italy, Sweden, Switzerland, the United Kingdom, and the United States) and found that Canadian prices were typically within range.⁶²

However, a 2010 report notes that PMPRB sets Canadian prices at the median price of these selected countries, most of which have a strong pharmaceutical industry and typically higher prices. The report argues that if additional countries with pharmaceutical industries similar to Canada were included—such as Austria, Australia, Finland, the Netherlands, New Zealand, and Spain—average brand-name drug prices in 2008 would have been 11% lower, resulting in savings of \$1.43 billion.⁶³

There has been much debate and discussion on the best approach to reducing both brand-name and generic drug costs in Canada,⁶³⁻⁶⁶ and in its report on generic drug pricing, the Health Council outlined various options for policy-makers.⁵⁴

In 2010, the premiers established a Pan-Canadian Pricing Alliance through the Council of the Federation to consolidate procurement of common brand-name drugs and medical supplies and equipment, where appropriate. The initiative was expanded in 2012 and has already yielded savings.^{14,67,68} The Alliance capitalizes on jurisdictions' combined purchasing power to achieve lower drug costs, increase drug treatment options, and support more consistent drug listing decisions across the country.¹⁴

In 2012, the Council of the Federation Working Group on Health Care Innovation launched another collaborative initiative—this time to reduce the price of generic drugs across Canada.⁶⁸ The Competitive Value Price Initiative will determine a national pricing process for generic drugs to achieve more internationally comparable prices.¹⁴

In the meantime, all jurisdictions except Manitoba and the territories have developed generic drug policies to decrease the cost of generic drugs. Most provinces are gradually reducing generic drug prices to 35% of the brand-name cost; Ontario and British Columbia are reducing prices to 25% of the brand-name cost. Many of these price changes have already been made; more will be implemented in the coming months.

The Council of the Federation has also announced that the provinces and territories are collaborating to set prices for six widely used generic drugs at 18% of the price of the brand-name equivalent. This initiative is expected to save up to \$100 million for provincial and territorial drug plans. The new prices came into effect April 1, 2013.⁶⁹

Analyzing cost drivers

CIHI collects and analyzes drug cost and utilization data through the National Prescription Drug Utilization Information System database. The National Health Expenditure database is also a source of drug utilization and spending data.⁷⁰ In a recent report, CIHI noted that since 2005, drug spending has not increased as quickly as hospital, physician, or overall health care spending. The largest cost drivers between 1998 and 2007 were an increase in the volume of drugs used and changes in the mix of treatments, mainly the result of modifications to treatment guidelines, increases in disease prevalence, and the uptake of new drugs.⁷¹

Cost analysis of drug spending in Canada is also contained in the 2008 *Rx Atlas*, which breaks down drug spending by jurisdictions and reports on the factors driving drug costs in each province over time. Findings showed that there is wide variation in drug spending across Canada. The Atlas also analyzed drug spending by age, reporting that drug spending has been growing rapidly for those over age 45.⁷² A new edition of the Atlas will be released in 2013.⁷³

Strengthening real-world drug safety and effectiveness

Effective reporting and monitoring throughout a product's pre- and post-market phases are necessary to ensure drug safety. However, the 2011 Auditor General's report on regulating pharmaceutical drugs found that Health Canada had not adequately fulfilled most of the key pre-market responsibilities related to clinical trials and submission reviews, and had fallen short in the area of post-market monitoring.⁷⁴ In response, Health Canada took a number of steps, including improving public access to information on clinical trials, drug submissions, and drug approval decisions.⁷⁵

The Drug Safety and Effectiveness Network (DSEN), which was established by the Canadian Institute for Health Research (CIHR), funds independent post-market research on drug safety and effectiveness through Canadian and international research collaborations.⁷⁶ In Canada, the DSEN currently funds seven research teams comprised of more than 150 researchers across the country.⁷⁷ In October 2011, the federal government announced \$17.5 million in funding over five years through the DSEN to support the Canadian Network for Observational Drug Effect Studies (CNODES). CNODES is a new network of collaborating research centres that conduct independent research on the safety and effectiveness of drugs approved for the Canadian market. The network will facilitate research collaboration, build capacity in drug safety and effectiveness research, and foster dissemination of knowledge to end-users, including policy-makers.

CNODES has access to the health and prescription drug records of over 40 million Canadians, providing a robust database for drug safety research. CNODES develops protocols to enable consistent analyses in each province, and data are kept confidential and reported in summary form to ensure anonymity.⁷⁸⁻⁸⁰

Post-market drug surveillance is a responsibility of the federal government and a crucial aspect of drug safety in this country. However, a 2010 Health Council-commissioned report assessing drug safety in Canada noted that Health Canada does not have the authority to require drug companies to conduct post-market studies or to make labelling changes in response to safety issues. In addition, Health Canada is not authorized to monitor drug company patient registries or impose penalties.⁵⁵

To help address these limitations, Health Canada recently published the *Regulatory Roadmap for Health Products and Food*. This document outlines a phased approach to improve existing regulatory frameworks to ensure greater transparency and efficiency and to reflect the full life cycle of products. However, the frameworks are designed for pre-market regulation and provide limited authority and few requirements for drugs in the post-market stage.⁸¹

In an effort to increase public involvement in post-market surveillance, the MedEffect™ Canada Initiative was launched by Health Canada in 2005. The MedEffect™ Canada website provides consumers, patients, and health professionals with access to new safety information about health products and allows individuals to report adverse reactions. The initiative also participates in post-market surveillance activities and consultations to develop and implement effective policies to regulate marketed health products.⁸²

In September 2012, Health Canada also released a Health Product Vigilance Framework to facilitate information gathering and processing, monitoring and evaluation, and risk management throughout the life cycle of a drug product.⁸³

The issue of post-approval monitoring of pharmaceuticals was also addressed in a March 2013 report by the Standing Senate Committee on Social Affairs, Science and Technology. The report, which drew on expert testimony from the Health Council of Canada and other stakeholder groups, acknowledged the work of Health Canada and DSEN towards a more active surveillance approach. However, the Committee expressed concern with Canada's ability to monitor drugs on the market effectively, especially when compared with advances occurring internationally in post-marketing regulations. The Committee's recommendations include advancing legislative and regulatory reform, ensuring DSEN's independence, improving DSEN's effectiveness and ability to collect data, and ensuring adequate reporting of adverse drug reactions.⁸⁴

Expanding e-prescribing and pharmacists' scope of practice

Drug information system projects are completed or being planned in all provinces and territories except the Northwest Territories. The percentage of physicians who report prescribing medications electronically ranges from 10% in Newfoundland and Labrador to 58% in Alberta.³¹ A study commissioned by Canada Health Infoway found that by 2010, the use of drug information systems and e-prescribing across the country had resulted in benefits of \$436 million through improved safety and quality, fewer adverse drug events, increased medication compliance, greater pharmacist efficiencies, and improved drug cost management.⁸⁵

Expanding the scope of practice for pharmacists is an important step in ensuring that drugs are used safely and effectively and is a way to increase efficiencies within the system. Currently the scope of practice for pharmacists varies across the country. The Canadian Pharmacists Association identifies eight activities within pharmacists'

scope of practice: providing emergency prescription refills, renewing/extending prescriptions, changing drug dosages/formulations, making therapeutic substitutions, prescribing for minor ailments, initiating prescription drug therapy, ordering and interpreting lab tests, and administering a drug by injection. Alberta and New Brunswick have expanded pharmacists' scope of practice the furthest to include seven of the eight activities; Saskatchewan and Nova Scotia have implemented six. Nunavut and the Yukon are the only jurisdictions that have made no changes to pharmacists' scope of practice.⁸⁶

The bottom line

- ▶ Collaborative efforts among provinces and territories to negotiate lower brand-name and generic drug prices have started to yield positive results. Many provinces have also introduced policies to reduce generic drug prices.
- ▶ CADTH's Common Drug Review can be seen as a cooperative approach given that a majority of its recommendations are adopted by provincial governments. However, the CDR continues to exist alongside similar provincial review bodies, which creates some duplication and approval delays. Canada still does not have a common drug formulary.
- ▶ Health Canada continues to have limited authority over post-market drug monitoring and removal. Canadians could benefit from additional regulatory changes to protect them from the risk of adverse drug events.
- ▶ Many provinces have expanded the scope of practice for pharmacists, providing patients with better access to the care and medications they need on a continuing basis. Drug information systems and e-prescribing facilitate this process. However, variations in scope of practice across the country continue to contribute to unnecessary pressures on family physicians for services that could be provided by pharmacists.

Commentary

Under the 10-year plan, First Ministers agreed to establish a National Pharmaceuticals Strategy as a mechanism to address common challenges associated with pharmaceuticals management. The strategy was also intended to create a level playing field for all Canadians to ensure access to safe, appropriate, and affordable drugs.

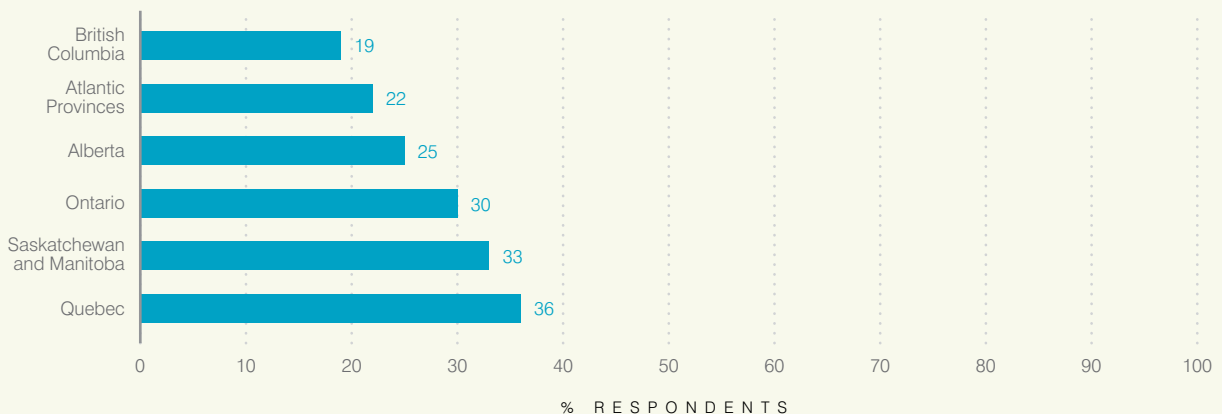
Provincial governments have introduced some of the changes envisioned in the national strategy. Yet, the percentage of Canadians that believe that they have better access to drugs today than they did five years ago remains quite low²³ (see Figure 4).

Most jurisdictions have implemented catastrophic drug coverage. However, variability among legislation, drug plans, and provincial resources has resulted in inequitable access across Canada. Likewise, not all jurisdictions have implemented comparable policies to reduce the cost of generic drugs, although recent collaborative efforts through the Council of the Federation are contributing to lower prices in all jurisdictions. Pharmacists' scope of practice also continues to vary widely across the country, and progress on the implementation of e-prescribing remains slow in many jurisdictions.

In the absence of a continued commitment to the National Pharmaceuticals Strategy, there has been uneven progress on the priorities identified in the 10-year plan. The willingness of provincial/territorial governments to collaborate on joint pricing initiatives and follow each other's lead on generic drug pricing policy suggests it may also be time to collectively re-examine the priorities identified in the National Pharmaceuticals Strategy. Collaboration on these priorities has the potential to help governments develop and implement pharmaceuticals management solutions that meet pressing jurisdictional needs, control drug costs, and ensure that all Canadians have access to the medications they need, regardless of where they live.

Improving drug access must be balanced with ensuring drug safety. Health Canada's regulatory roadmap outlines plans to improve transparency on drug safety. But a road map is not enough. Implementation of more effective post-market drug surveillance measures should be accelerated to ensure Canadians can remain confident about the safety of their medications.

Figure 4: Regional comparison of % of population that perceives it is easier to access drugs today compared to five years ago



Data source: Ipsos Reid. (2013). *Checking in with Canadians on their healthcare system: 2013 score cards on ease of access, patient experience.*

Innovative practices in pharmaceuticals management – Ontario

Improving patient safety through electronic medication reconciliation

Studies have shown that a high proportion of the adverse events that patients experience in hospital and following discharge are drug related.^{S14}

Part of the solution to reducing the number of adverse events lies in improved medication reconciliation—the systematic review of all medications when a patient is admitted to hospital, transitioned to another service or provider, or discharged home. Effective medication reconciliation ensures that medications being added, changed, or discontinued are properly assessed and documented, and that comprehensive medication information is communicated among care providers and with patients.^{S14}

Accreditation Canada has identified medication reconciliation as a patient safety priority,^{S14} and organizations across the country are responding. To improve its performance in this area, The Ottawa Hospital is piloting an electronic solution—an approach that earned the hospital first place in the medication reconciliation category of Canada Health Infoway's 2012 ImagineNation Outcomes Challenge Trailblazer Awards.^{S15}

The hospital's medication reconciliation application is fully integrated with the hospital's mobile electronic medical record and can be used on a desktop computer or a tablet at the bedside. It provides drop-down menus, flags, prompts, and a variety of tools to assist clinicians. It also allows the entire process to be audited electronically to determine and manage compliance.

In November 2011, the hospital launched a pilot with 80 patients, focusing on patient flow from the emergency department to three medical services. Early results showed promise:

- ▶ The completion rate for documenting a patient's medication history rose to 100%.



- ▶ More than 70% of physicians completed medication reconciliation within 24 hours of a patient's admission.
- ▶ The number of unexplained medication discrepancies at discharge dropped from an average of three per discharge prescription to 0.7.^{S16}

However, the pilot was halted in February 2012 to address a number of issues. For example, the medication reconciliation application's drug database was not adequately aligned with the hospital's in-patient drug database, which slowed the reconciliation process. The effort to standardize the medication reconciliation process also raised a larger issue: completing a thorough medication history and medication reconciliation for every patient required additional time from pharmacy staff and physicians. Physicians, in particular, expressed concern.

The hospital has been working to address these issues. An additional database was purchased and integrated to improve the drug matching process, and the project team has been working closely with physicians to address their concerns and gain their support for the initiative. The pilot was relaunched in January 2013, and a second pilot in vascular surgery was planned for March. A large-scale rollout across the hospital will follow in mid-2013.^{S16}



For more detailed information on this innovative practice, visit the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.



Disease prevention, health promotion, and public health

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

- ▶ First Ministers direct Health Ministers to continue their work on healthy living strategies and other initiatives to reduce disparities in health status.
- ▶ First Ministers further recognize that immunization is a key intervention for disease prevention. They direct Health Ministers to pursue a National Immunization Strategy.¹

2004 10-Year Plan to Strengthen Health Care

- ▶ First Ministers recognize the progress that has been made by all jurisdictions to strengthen Canada's public health system, including the creation of the new Public Health Agency of Canada. All governments commit to further collaboration and cooperation in developing coordinated responses to infectious disease outbreaks and other public health emergencies through the new Public Health Network.
- ▶ The federal government also commits to building on recent investments in immunization through ongoing investments for needed vaccines, which are recognized as the single most cost-effective investment in public health, through the National Immunization Strategy. This Strategy will provide new immunization coverage for Canadian children.
- ▶ In addition, governments commit to accelerate work on a pan-Canadian Public Health Strategy. For the first time, governments will set goals and targets for improving the health status of Canadians through a collaborative process with experts. The Strategy will include efforts to address common risk factors, such as physical inactivity, and integrated disease strategies. First Ministers commit to working across sectors through initiatives such as Healthy Schools.²





What the Health Council has said about disease prevention, health promotion, and public health

- ▶ In 2008, the Health Council reported the following progress on disease prevention, health promotion, and public health:
 - six National Collaborating Centres for Public Health in Canada were created in 2005;
 - the National Immunization Strategy, launched in 2003, resulted in more consistent immunization programs across Canada;
 - in 2005, Health Ministers set a goal to achieve a 20% increase in the proportion of Canadians who are physically active, eat healthy food, and maintain healthy weights, but federal funding was not forthcoming;
 - a \$300 million investment for an Integrated Strategy on Healthy Living and Chronic Disease was announced in 2005 and targeted for disease-specific activities; and
 - the Health Goals for Canada, which emphasize the social determinants of health, were adopted by federal, provincial, and territorial governments in 2005.⁵
- ▶ The Health Council's 2010 *Stepping It Up* report explored how the social determinants of health affect health outcomes and said that achieving a healthier population will require collective and concerted action by multiple government departments and other sectors of society to reduce health inequities.⁸⁷

Progress to date

Although the area of disease prevention, health promotion, and public health is quite broad, 10 years ago First Ministers focused on preventing and responding to infectious disease outbreaks, developing a National Immunization Strategy, and implementing a pan-Canadian Public Health Strategy to address risk factors for chronic disease.

Strengthening Canada's public health system

The Pan-Canadian Public Health Network (PHN) was established by the federal, provincial, and territorial Health Ministers in 2005 to strengthen Canada's public health capacity, enable collaboration among governments with regard to public health, and prepare and respond to public health events and threats. In 2010/11, the PHN engaged in a variety of initiatives, including renewing pandemic and annual influenza vaccine contracts and developing options to engage Aboriginal public health expertise within the PHN.⁸⁸

Developing coordinated responses to outbreaks and emergencies

All jurisdictions have programs and measures in place to address infectious disease outbreaks and pandemic responses. In its review of the 2004 health accord, the Senate Committee heard from witnesses that the health accord facilitated collaborative efforts to develop coordinated responses to infectious disease outbreaks. The committee also heard that the establishment of the PHN enabled the development of a more robust national surveillance and response system that demonstrated its effectiveness during the H1N1 outbreak. Witnesses noted that the PHN facilitated negotiations and the signing of memoranda of understanding between provinces and territories on sharing information and providing mutual aid during health emergencies.²⁰ In their 2010 review of the H1N1 pandemic response, the Public Health Agency of Canada and Health Canada recommended further efforts to strengthen federal, provincial, and territorial pandemic response capacity, clarify roles, ensure sustainability of response capacities, and improve knowledge translation and dissemination.⁸⁹

Building on investments in immunization

All jurisdictions have immunization programs, and immunization schedules are available on government websites.

The Senate Committee heard from witnesses that investments in the National Immunization Strategy facilitated the introduction of new childhood and adolescent vaccine

programs. However, witnesses also suggested that there is insufficient progress in the development of a national immunization registry, a national research plan, training programs for health professionals, educational programs for the public, and a nationally harmonized pediatric immunization schedule.

Focusing on healthy living and chronic disease

The Public Health Agency of Canada, together with the provinces and territories, released an Integrated Pan-Canadian Healthy Living Strategy in 2005 with the goal of improving overall health outcomes and reducing disparities. The strategy set a goal of achieving a 20% increase in the proportion of Canadians who engage in healthy eating, participate in physical activity, and have healthy weights by 2015.⁹⁰

The federal government followed this with an Integrated Strategy on Healthy Living and Chronic Disease, which is focused on healthy eating and physical activity.⁹¹ The strategy had six components: surveillance; knowledge development, exchange, and dissemination; community-based programming and capacity building; public information; leadership, coordination, and strategic policy development; and monitoring and evaluation.⁹² A 2009 evaluation of the strategy found some progress and early successes, but noted a variety of issues, including challenges and gaps in design and delivery approaches and in addressing targeted populations. Progress was also inconsistent across the various initiatives.⁹³

In 2010, the Integrated Pan-Canadian Healthy Living Strategy was strengthened through a greater focus on prevention of obesity, promotion of mental health, and prevention of injury.⁹⁴ The enhanced strategy uses a population health approach that focuses on the determinants of health, addresses health disparities, and encourages intersectoral action.⁹⁵

To further support the strategy, the Ministers of Health endorsed a Declaration on Prevention and Promotion as well as a new framework, *Curbing Childhood Obesity: A Federal, Provincial and Territorial Framework for Action to Promote Healthy Weights*. This framework consists of three strategies: making childhood obesity a priority for health ministries; coordinating efforts on supportive environments, early action, and nutritious foods; and measuring and reporting on collective progress.⁹⁶ It also reflects a collaborative approach by the jurisdictions to addressing issues that are critical to the health of Canadians. Recent data on obesity confirm the need for action: the prevalence of obesity increased in most regions across Canada between 2003 and 2011⁹⁷ (see Figure 5).

However, despite this activity, some witnesses to the Senate Committee suggested that the original goal of a pan-Canadian public health strategy had not been met, that determinants of health were not being considered, and that health disparities continue to grow.²⁰

With respect to chronic diseases, most jurisdictions have frameworks, programs, or strategies in place and are dedicating resources to prevention and improved chronic disease management. Some jurisdictions are focusing on particular chronic diseases, while others have a broader approach.

Most jurisdictions also have strategies that focus on healthy eating, increased physical activity, or a combination of the two. A number of the jurisdictions are involving multiple departments in these areas in recognition that successful health promotion and disease prevention require a cross-governmental approach. For example, Alberta's Ever Active Schools program is funded by the ministries of education, health, and tourism, parks and recreation. In the Yukon, the departments of health, education, and community services, and the recreation and parks association, are collaborating to advance school health.⁹⁸

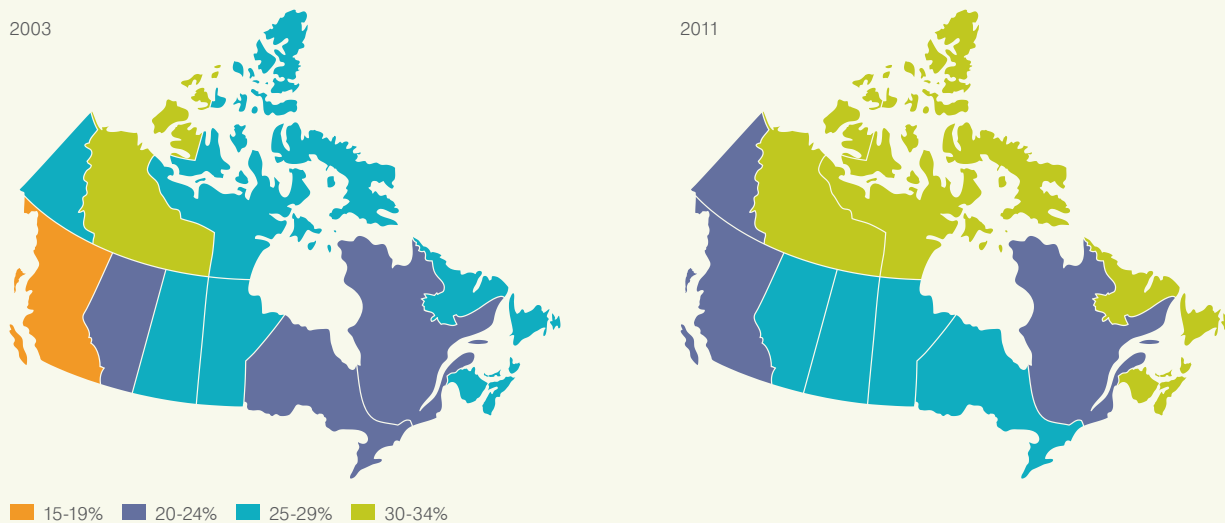
Creating healthy schools

Healthy students learn better and better-educated people are healthier.⁹⁸

With this in mind, the pan-Canadian Joint Consortium for School Health was established in 2005 by the federal, provincial, and territorial governments to facilitate collaboration among the health and education sectors. The consortium is funded by the Public Health Agency of Canada and other provinces and territories. It brings together departments and ministries responsible for health and education in all jurisdictions except Quebec. To reach shared goals, members share information and best practices, leverage resources, minimize duplication, support new research, and foster collaboration for comprehensive school health.⁹⁸

The consortium uses the internationally recognized comprehensive school health framework to focus on the social and physical environment, teaching and learning, healthy school policy, and partnerships and services. When actions in all four areas are harmonized, students can reach their full potential as healthy, productive learners.⁹⁸

Figure 5: Estimated prevalence of obesity in Canadian adults by province: 2003 and 2011



Notes: Figure reproduced and adapted with permission. Adults with BMI ≥ 30 kg/m² in each province as calculated from the self-reported height and weight surveys conducted by Statistics Canada's Canadian Community Health Survey and corrected to account for misreporting of height and weight.

Source: Gotay, C.C., Katzmarzyk, P.T., Janssen, I., Dawson, M.Y., Aminoltejari, K., & Bartley, N.L. (2013). Updating the Canadian obesity maps: An epidemic in progress. *Canadian Journal of Public Health, 104*(1).

The consortium reports annually on the progress of the Healthy Schools initiative across all member jurisdictions. School programs that engage youth in healthy eating and physical activity are available in all jurisdictions, facilitated by collaboration across departments and often through government policies. School curricula and after-school programs have also been modified to ensure that children and youth have opportunities to participate in healthy living initiatives in school and in the community.⁹⁸

This consortium coordinated Canada's participation in the 2009–2010 Health Behaviour in School-aged Children surveys, an international research study supported by the World Health Organization that aims to increase understanding of the health of and the social determinants of health in young people.⁹⁹ The Public Health Agency of Canada released a report on the findings of this survey in 2011, focusing on the mental health of youth. The survey suggested that adolescents who have positive interpersonal relationships have better mental health. It also found that positive relationships with parents and family and support from teachers and peers are important predictors of good mental health.¹⁰⁰ In 2012, the consortium and the Public Health Agency of Canada developed a series of fact sheets on the findings of the study.⁹⁸

The consortium works with jurisdictions to build capacity to design and deliver comprehensive school health initiatives. In 2012, the consortium launched the Positive Mental Health Toolkit, which offers resources for developing positive mental health.⁹⁸

The bottom line

- ▶ Collaboration among the federal, provincial, and territorial governments in disease surveillance has resulted in coordinated responses to recent infectious disease outbreaks.
- ▶ The Integrated Pan-Canadian Healthy Living Strategy and subsequent strategies are intended to promote healthy living, improve health outcomes, and address health disparities. The provinces and territories have also taken action on healthy living and chronic disease management. However, specific targets have generally not been set and the effectiveness and impact of these strategies and initiatives is unclear.

- ▶ The pan-Canadian Joint Consortium for School Health has implemented a number of healthy schools initiatives across Canada, and there is an increased recognition of the interdependency of health and education. However, the impact of these programs is often not measured and much work remains to ensure Canadian children and youth, especially those at highest risk, can maintain healthy lifestyles.

Commentary

Federal, provincial, and territorial governments have undertaken many individual and joint initiatives to improve the health status of Canadians. The pan-Canadian Joint Consortium for School Health is one example that shows considerable promise as a model of various ministries and departments across multiple governments working together towards common goals.

However, since many jurisdictions have not established clear targets or developed indicators by which to measure outcomes, any progress is difficult to determine. Appropriate indicators, robust data, and program evaluation are required to measure return on investment for health promotion and disease prevention initiatives. Armed with the results of this analysis, governments may be prepared to invest more strategically in this underfunded area of health care.

This is a complex area and we acknowledge the efforts made by governments to improve the health of Canadians through health promotion and disease prevention strategies. A number of jurisdictions have embraced cross-departmental/ministry approaches and this must continue if governments are to achieve healthier populations.⁸⁷ However, the range of departments involved must expand beyond traditional partners to include areas such as finance, transportation, community services, the environment, agriculture, and land-use planning. Long-term success in improving health outcomes and reducing disparities will require a concerted multi-government, multi-sector effort that addresses the determinants of health. As the prevalence of obesity illustrates, governments will not achieve substantive progress in this area without such joint action.

Innovative practices in health promotion – Nova Scotia

Improving health through healthy public policy

In Nova Scotia, government policy in areas such as finance, transportation, community services, and land-use planning will soon be assessed for their impact on health and healthy living. The province plans to integrate health impact assessments into the policy development process in all departments to create better-informed government decisions that can contribute to the goal of a healthy population.^{S17}

The strategy is one component of Thrive! A Plan for a Healthier Nova Scotia. Launched in 2012, the multi-year plan focuses on creating supportive environments and policies to increase healthy eating and promote physical activity among residents of the province.^{S18}

By taking concerted action, Nova Scotia hopes to address some bleak statistics: one in three children and youth in the province is overweight or obese, and rates of unhealthy eating and inactivity are high. Nova Scotia is also grappling with one of the highest rates of chronic disease in the country.^{S18}

The Thrive! plan sets out four strategic directions: support a healthy start for children and families, equip people with skills and knowledge for lifelong health, create more opportunities to eat well and be active, and plan and build healthier communities.^{S18}

Thrive! uses a cross-governmental approach to address the broader determinants of health. Ten government departments are working together: Transportation and Infrastructure Renewal, Agriculture, Education, Justice, Environment, Community Services, Natural Resources, Service Nova Scotia & Municipal Relations, Energy, and Health and Wellness.^{S17} This emphasis on collaboration extends beyond government departments and is reflected in specific strategies in the plan, which include:

- ▶ **Expand healthy food policies in publicly funded institutions.** Building on work in schools and child care centres, Nova Scotia is providing grants for healthy eating policy work in health care, post-secondary education, sport and recreation, and municipal governments.
- ▶ **Develop policy options on food access and affordability.** A new cross-government committee will develop policies to improve food security and the production, distribution, and procurement of local, healthy food.



- ▶ **Develop a provincial active transportation policy and plan.** Nine government departments will come together to develop policy to help the province and municipalities design, plan, and fund active transportation infrastructure at the municipal level.

Thrive! also includes an engagement strategy and commitment for regular progress reporting to the public. Work is now underway on a comprehensive evaluation framework, indicators, and tools to measure:

- ▶ **short-term outcomes** (1–3 years) focused on planning, policy, and investment;
- ▶ **intermediate outcomes** (3–5 years) focused on changes in environments that support healthy behaviours;
- ▶ **long-term outcomes** (5–10 years) focused on improved health behaviours (e.g., sustainable upward and downward trends in rates of healthy eating, physical activity, unhealthy eating, and sedentary behaviour); and
- ▶ **ultimate outcomes** (10+ years) focused on a healthier population (e.g., reduction in preventable chronic disease).^{S18}



For more detailed information on this innovative practice, visit the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.



Aboriginal health



Accord commitments

2003 First Ministers' Accord on Health Care Renewal

- ▶ First Ministers recognize that addressing the serious challenges that face the health of Aboriginal Canadians will require dedicated effort. To this end, the federal government is committed to enhancing its funding and working collaboratively with other governments and Aboriginal peoples to meet the objectives set out in this Accord including the priorities established in the Health Reform Fund. Governments will work together to address the gap in health status between Aboriginal and non-Aboriginal Canadians through better integration of health services.
- ▶ First Ministers direct Health Ministers to consult with Aboriginal peoples on the development of a comparable Aboriginal Health Reporting Framework. They further agree to consult with Aboriginal peoples in this effort, to use comparable indicators, and to develop the necessary data infrastructure. This reporting will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as on service levels and outcomes.¹



2004 10-Year Plan to Strengthen Health Care

- ▶ All governments have agreed to work together on the important matter of Aboriginal health, as set out in a separate communiqué.
- ▶ Under the Strategic Health Human Resource Action Plans, Federal, Provincial and Territorial governments agree to increase the supply of health professionals, based on their assessment of the gaps and to make their action plans public, including targets for the training, recruitment and retention of professionals and to regularly report on progress. With regard to Aboriginal communities, the federal government commits to targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities.²

What the Health Council has said about Aboriginal health

- ▶ In 2008, the Health Council reported the following progress on Aboriginal health:
 - *Blueprint on Aboriginal Health: A 10-Year Transformative Plan* was released by First Ministers and national Aboriginal leaders in 2005. However, with the change in federal government in 2006, funding was reduced and agreements were not fulfilled;
 - the Aboriginal Health Transition Fund was supporting over 100 projects to integrate and improve access to services for Aboriginal Peoples, and to increase local participation in the design, delivery, and evaluation of programs;
 - the Tripartite First Nations Health Plan in British Columbia, signed in 2007, has become a model for similar agreements in other provinces;
 - Health Canada created the Office of Inuit Health in 2007 in collaboration with the Inuit Tapiriit Kanatami to better address Inuit health issues; and
 - the Aboriginal Health Human Resources Initiative tripled the number of bursaries and scholarships to attract and assist First Nations, Inuit, and Métis people to pursue health care careers.⁵
- ▶ In its 2011 report *Understanding and Improving Aboriginal Maternal and Child Health in Canada*, the Health Council identified promising practices that are improving Aboriginal maternal and child health and called on governments to expand these programs.¹⁰¹
- ▶ In its 2012 report *Empathy, dignity, and respect: Creating cultural safety for Aboriginal people in urban health care*, the Health Council explored the mistrust many Aboriginal people have of the health care system due to stereotyping and racism and called on governments and health care organizations to provide appropriate programs to increase the cultural competency of health care providers.¹⁰²

Progress to date

Disparities in health status between Aboriginal Peoples and the larger Canadian population were the impetus for a focus on improving Aboriginal health in the health accords. First Ministers committed to working collaboratively with Aboriginal Peoples to improve access to health care services and to improve health outcomes.

Reducing disparities through collaboration

In order to advance the goal of reducing health disparities, each jurisdiction is working collaboratively with Aboriginal communities to plan, implement, and evaluate culturally sensitive Aboriginal health care programs.

In 2007, British Columbia became the first jurisdiction to finalize a tripartite agreement between the province, Health Canada, and First Nations. The First Nations Health Authority (FNHA) followed in 2012. The FNHA is responsible for a new health governance structure in which First Nations will control health programs and services in British Columbia that are currently the responsibility of Health Canada, First Nations and Inuit Health Branch.^{14,103} In 2008, Saskatchewan signed a memorandum of understanding to establish a tripartite partnership to improve the health of First Nations communities in Saskatchewan and to develop a 10-year First Nations Health and Wellness Plan.¹⁰⁴ And in 2011, Ontario established the Trilateral First Nations Health Senior Officials Committee in partnership with the federal government and the Chiefs of Ontario. The Trilateral Committee is responsible for activities in four priority areas identified by the Chiefs of Ontario: mental health and addictions (with a focus on prescription drug abuse), public health, diabetes, and data management.¹⁴

The federal government has also collaborated with other jurisdictions on Aboriginal health initiatives through tripartite or trilateral partnerships in Nova Scotia and Prince Edward Island and a memorandum of agreement in New Brunswick. These agreements are described in detail in the individual jurisdictional profiles. See healthcouncilcanada.ca/progress.

Developing comparable indicators

Although British Columbia's tripartite partners are establishing a health indicators framework,¹⁰⁵ most jurisdictions have not developed indicators and measurement frameworks for measuring Aboriginal health outcomes. A number of issues must be addressed first, including data availability, data ownership, and the lack of data sharing agreements between governments and the relevant Aboriginal organizations.¹⁰⁶

In 2011, Nova Scotia entered into a data sharing agreement with five Unama'ki First Nations. The Unama'ki client registry links data from Aboriginal Affairs and Northern Development Canada and Nova Scotia's health care number registry. The data will enable a better understanding of health status, disease patterns, and use of health services, and will be used to plan health promotion, disease prevention, and treatment programs for the Unama'ki people. Funding was provided by Health Canada through the Aboriginal Health Transition Fund (AHTF) and the Public Health Agency of Canada. The province expects to expand the registry to all First Nations people in Nova Scotia.¹⁴

Improving access—the Aboriginal Health Transition Fund

The Aboriginal Health Transition Fund was established in 2004/05 to support the jurisdictions in adapting existing health services to better meet the needs of Aboriginal Peoples and to increase their participation in the design, delivery, and evaluation of health care programs.¹⁰⁷

The AHTF funded 311 projects across the jurisdictions in areas such as e-health, substance abuse, child and youth care, mental health, chronic disease, public health, home care, and governance.¹⁰⁸ The fund also supported the establishment of the Aboriginal liaison or navigator role to provide individuals and families with culturally sensitive support and advocacy, and to help them navigate the health care system. The Health Council has noted the benefits of this role, and navigators are currently available in British Columbia, Alberta, Saskatchewan, Ontario, New Brunswick, and Newfoundland and Labrador.^{102,109,110}

In 2010, Health Canada announced five-year funding for the new Health Services Integration Fund, a successor to the AHTF that focuses on service integration and collaboration. As of January 2013, more than 70 projects have been approved.^{111,112}

The federal government has implemented a number of health promotion and disease prevention programs, including the Aboriginal Diabetes Initiative, the National Aboriginal Youth Suicide Prevention Strategy, and the Maternal Child Health Program. In 2011, the Public Health Agency of Canada announced funding for a partnership initiative with the government of Nunavut to address tuberculosis.¹¹² The federal government also proposed investments in its 2013 budget to enhance health services for First Nations Peoples and Inuit, including mental health services.¹¹³

A Senate Committee review of the 2004 health accord heard from witnesses that 75% of AHTF projects were directed by First Nations, Inuit, or Métis organizations or communities. However, witnesses also indicated that not all Aboriginal groups benefited equitably from federal initiatives, because the majority of funds were directed to on-reserve communities. The lack of multi-year funding agreements also made program planning difficult.²⁰ The Health Council heard similar concerns during its regional consultations on Aboriginal maternal and child health. Participants in the consultations noted that a lack of multi-year agreements with adequate and stable funding makes it difficult for Aboriginal communities to plan and provide health care services comparable to those available to other Canadians.¹⁰¹

Witnesses also told the Senate Committee that the gap between health outcomes for Aboriginal Peoples and the larger Canadian population remains despite the investments made by the federal government. Significant disparities exist in areas such as life expectancy, infant mortality, and tuberculosis rates.²⁰

Building health human resources capacity—the Aboriginal Health Human Resources Initiative

The Aboriginal Health Human Resources Initiative (AHHRI) provided federal funds to jurisdictions and provincial, territorial, and Aboriginal organizations to increase capacity in health human resources in Aboriginal communities. Witnesses to the Senate Committee reported that the AHHRI provided support through bursaries and scholarships to over 2,200 Aboriginal students pursuing health care careers. A follow-up survey of these award recipients noted that 91% said the funding helped them pursue post-secondary education. The AHHRI also funded over 240 projects in post-secondary institutions to support greater access, curriculum adaptation, student supports, and the development of cultural competency frameworks.²⁰ A program review of the AHHRI from 2005 to 2008 found the initiative facilitated increased participation of Aboriginal people in health professions and increased the number of culturally competent health professionals. However, the review indicated a need to enhance strategic communications, establish sustainable networks, share best practices, improve efficiencies, streamline administration, and enhance the governance mechanism.¹¹⁴

The AHHRI was renewed for five years in 2010, focusing on training First Nations and Inuit community-based health care workers to ensure comparable skills and certification.^{20,115}

The Senate Committee heard that the percentage of Aboriginal people in the health care workforce has doubled since 2004, and that the AHHRI was generally considered successful. However, some challenges were noted, including short-term funding and the use of a pan-Aboriginal approach rather than considering the unique needs and circumstances of different Aboriginal groups.²⁰

The bottom line

- ▶ Despite significant investments to address inequities in the health status and health outcomes of Aboriginal Peoples, the impact of these initiatives is unclear. There is limited understanding of whether and how the health of Aboriginal Peoples has improved due to a lack of indicators and measurement frameworks. Furthermore, little progress has been made in addressing data ownership issues and developing appropriate data sharing agreements. These are critical to support effective measurement and evaluation.
- ▶ There has been increased collaboration among the federal government, provincial and territorial governments, health authorities and local health integration networks, and Aboriginal leadership and communities to bring about improved health care and health outcomes. It is critical that successful models and practices resulting from these collaborations be shared widely.
- ▶ First Nations, Inuit, and Métis organizations and communities directed a majority of AHTF-supported programs and initiatives. However, there are concerns that not all Aboriginal groups were able to benefit equitably from federal initiatives and that the lack of multi-year funding agreements affects the ability to bring about lasting change. It is important that future contributions be equitable, regular, and sustainable in order to enable long-term planning and programming.
- ▶ The AHHRI facilitated an increase in the Aboriginal health care workforce. This initiative has been renewed for an additional five years.

Commentary

The 2003 health accord lacked specific direction or explicit targets with regard to addressing the gaps in health status between Aboriginal and non-Aboriginal Canadians.¹ In the *10-Year Plan to Strengthen Health Care*, First Ministers agreed to outline commitments to Aboriginal health in a separate communiqué,² which subsequently identified federal funding for specific areas of action.¹¹⁶ The 2005 *Blueprint on Aboriginal Health* also provided direction for national and regional action on health care themes as they related to First Nations, Inuit, and Métis populations.¹¹⁷ However, as the Health Council noted previously, these commitments were largely unrealized following the change in federal government in 2006.⁵

There are many examples across the country where respectful collaborations and partnerships are occurring between government and First Nations, Inuit, and Métis leadership and communities.²⁰ Notably, the British Columbia, Saskatchewan, and Ontario governments are collaborating with their respective Aboriginal communities in planning, implementing, and evaluating new approaches to health care governance and health care delivery.

Across Canada, regional and provincial governments and organizations are also engaged in innovative practices that are improving access to care—and the quality and experience of that care. For example, Alberta's Aboriginal Health program is improving access to health services by building on the success of the Elbow River Healing Lodge, an urban health centre in Calgary. In addition, Saskatchewan's All Nations Healing Hospital is an internationally recognized model for its integration of services across different levels of government and funders.¹⁰² It is important to create opportunities to share and spread these practices. The Health Council commends those leading these innovations and urges others to join them.

Despite these signs of positive change, progress across Aboriginal communities is uneven. Furthermore, the underlying barriers to improved health care for the Aboriginal population remain largely unaddressed. Engaging Aboriginal Peoples in partnerships to plan and manage health services for Aboriginal populations is crucial to improving health outcomes. At the same time, leadership at all levels must confront the systemic racism that can prevent Aboriginal people from seeking health services. Ensuring cultural competency among health care providers and organizations through appropriate training, policies, and structures will be an important step forward.

Removing the barriers faced by Aboriginal people in obtaining health services will not, on its own, improve health outcomes. Governments must provide predictable, sustainable funding for health initiatives and work with Aboriginal communities to ensure targets and accountabilities are defined and progress on health outcomes is measured. At the same time, the determinants of health—such as education and housing—must be addressed. The 2004 communiqué, the 2005 *Blueprint on Aboriginal Health*, and various jurisdictional agreements pointed the way forward. These frameworks and agreements must be revisited and shared across jurisdictions to craft actionable, target-driven plans to reduce disparities and improve the health and well-being of Aboriginal Peoples across Canada. Furthermore, this work must proceed with the recognition that successful models and approaches will require modification in order to accommodate the variability in resources, needs, and cultures across different Aboriginal communities and in different regions of the country.

Innovative practices in Aboriginal health – British Columbia

Breaking new ground: BC First Nations Health Authority

Health care for British Columbia's First Nations is undergoing fundamental transformation with the establishment of Canada's first province-wide First Nations Health Authority (FNHA) in 2012.

As a result of this historic change, decision-making on health and health care is now in First Nations' hands. Through the new health authority, BC First Nations will plan, design, manage, fund, and deliver all health services and programs for the province's First Nations people that are currently provided by Health Canada's First Nations and Inuit Health Pacific Branch.^{S19}

The shift is the result of several agreements, including the 2006 *Transformative Change Accord: First Nations Health Plan*, the 2007 *Tripartite First Nations Health Plan*, and the *British Columbia Tripartite Framework Agreement on First Nation Health Governance*. These agreements were signed between BC First Nations and the Canadian and British Columbian governments in an effort to close the gap in health status between First Nations people and other residents of British Columbia.^{S20,S21}

By October 2013, all health programs and services delivered by Health Canada through its First Nations and Inuit Health Pacific Branch will be transferred to the FNHA.^{S22} The FNHA will also work with the BC Ministry of Health and BC's health authorities to coordinate and integrate services with the provincial health care system.^{S19}

Consistent with First Nations beliefs and values, community consultation and input is the hallmark of the new health authority. For example, the FNHA's role and governance structure was informed by 120 well-attended regional meetings held with First Nations leaders, citizens, and health professionals over a three-year period. The FNHA plans to continue this community-driven approach through an annual engagement process to ensure its policy directions reflect the First Nations community.^{S23}



Over time, the FNHA also intends to draw on community input and evaluation results to modify and redesign current federal health programs to better meet the needs of First Nations.^{S23} This approach reflects the FNHA's mandate to incorporate First Nations knowledge, beliefs, values, practices, medicines, and models of health and healing into the programs and services it provides.^{S19} As part of its evaluation efforts, the health authority will also gather, track, and report data on health indicators in areas such as life expectancy, mortality rates, youth suicide, diabetes, and childhood obesity.^{S23}

The FNHA is breaking new ground in Canada and anticipates that its learnings and evaluation outcomes will prove valuable to other provinces and territories that wish to explore similar service delivery models. For its part, the new health authority is drawing on the experience of a similar authority in Alaska, which also faced the challenges of providing services to remote communities and many language groups.^{S23}



For more detailed information on this innovative practice, visit the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.



Conclusion

As a Canadian, what should you expect from your health care system? Should where you live matter?

The health accords grew out of public concern about the underfunding of health care. Canadians were frustrated with growing wait times for health care services and worried about the quality of their care. Among providers and politicians, discussions centred on the need for reform to address the broader issues of access, quality, and sustainability.

Canadians want the same things now as they did then. Whether you live in Kelowna, British Columbia, Rocky Harbour, Newfoundland and Labrador, or Iqaluit, Nunavut, you should have access to a primary health care provider when you need care. Your health care provider should have access to an electronic health record to better coordinate your care. You should have timely access to knee replacement or cataract surgery. And the cost of medications you need should not cause you undue financial hardship. These are just a few of the commitments set out in the health accords.

Ten years later, we are closer to meeting these expectations. But health care continues to evolve and our efforts to reform the health care system are not keeping pace. Access to care continues to vary between and within jurisdictions. And the gap in health outcomes between Aboriginal Peoples and the larger Canadian population and between higher- and lower-income neighbourhoods remains wide. How then to proceed?

Given the current fiscal climate, investing more money in health care is not realistic, and not a cure-all. The solution lies elsewhere.

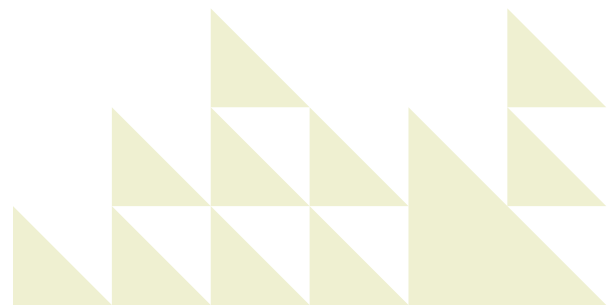


One answer is to implement the practices we know make a difference. For example, electronic health and medical records improve the quality of primary health care and medication safety, and create new efficiencies in the system. Yet, as noted in this report, our progress in this area needs to be accelerated. The provinces and territories share many common challenges as they struggle to deliver quality care within their financial resources. We need to prioritize the sharing and adaptation of successful innovations across the country and find new and better ways to facilitate this.

Furthermore, if we really want to address inequities in our health care system, we need to take a collaborative approach. Efforts by individual providers, hospitals, regions, and jurisdictions—while laudable—are not enough. Premiers have shown a willingness and ability to work together on common health agendas. Their promising collaborative efforts in drug pricing and other areas prove it can be done. The provinces and territories must expand these efforts, continue to identify shared priorities, establish long-term goals for health and health care in this country, and work together to achieve them. As suggested in the Senate Committee's recommendations, the federal government must also remain at the table, given its responsibility for public health, funding, and upholding and enforcing the *Canada Health Act*.

For their part, Canadians need information to allow them to constantly monitor the performance of governments and hold them accountable. Reports like this one can help.

The challenges are significant and the solutions far from simple. Canadians expect continuing action on health care reform to ensure they have access to high-quality health care and achieve better health—regardless of where they live in Canada.



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