CIHI directions ICIS

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Interview with CIHI Board Chair Michael Decter

In the past few years, there has been much attention paid to health care reform and the future of Medicare in Canada. Inevitably, when one engages in a dialogue aimed at shaping the future of health care in Canada, accountability and the need to base decisions on good data, information and evidence become part of the discussion. Recently, *Directions'* Managing Editor and CIHI's Director of Client Relations and Communications, Serge Taillon, spoke with Board Chair Michael Decter to share his thoughts.

Serge Taillon: What does "accountability" in health care mean to the average Canadian?

Michael Decter: First, it is not about accountability from one level of government to another; in fact, people have little appetite for that sort of wrangling. Rather, at the core, accountability means having enough information to make judgments both at the broad system level and at the user level. In other words, the average Canadian wants to know that those who fund the system are putting in sufficient financial resources and providing good stewardship. They want to know that managers are delivering value for money, just as shareholders demand in the private sector.

While we do a reasonably good job of managing our system, a good deal of inefficiency exists. So Canadians want answers to questions like: Are we buying the right things? Are we training enough health care professionals and are we making optimal use of their skills? Is the system modern enough? Are we underspending or overspending on new technologies? These are all issues on which CIHI is currently working. For example, I am proud to say that CIHI is working on a major report on imaging technology, to be released in September.

At the same time, Canadians also want to be reassured that they are getting reasonable access to the services they need. Again CIHI, in collaboration with others, is doing important work on this front, developing new data sets and indicators to measure access and performance in key areas.

ST: As we move forward in reshaping our health care system, what will this mean in terms of further development and use of data, information and reports?

MD: Initially, physician and hospital services were at the core of Medicare, so we have quite good data on doctors and inpatient care provided in hospitals.

However, the practice of medicine has changed considerably over the last few years. For example, we know that advances in technologies, pharmaceutical products and treatments mean that people who previously required long hospital stays are now being treated via day surgery or short inpatient stays. As well, future efforts to ensure that we have a sustainable, accessible and quality system will necessitate further adjustments in how services are delivered. Our reporting systems will have to mirror these changes in health care in order to ensure effective governance and the good use of resources.

Therefore, the challenge in terms of data, information and reports will be two-fold. First, we will need to know more about these other sectors and new interventions—that is why CIHI is already working on new reporting systems for community and home care as well as prescription drug utilization information, which I mentioned a moment ago.

A second challenge will be to look at care effectiveness and outcomes, with the goal of improving performance. To do this, we will need to look at the interface between Statistics Canada's data on the self-reported health of individuals and our health care data. (*continued on page 2*)

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That way, we will be able to shed light on key questions both at the health region and individual levels (while respecting individual privacy). For example, in a region like Algoma-Cochrane-Manitoulin or Sudbury where there is a high rate of patients dying in hospital within 30 days of initial hospitalization for a heart attack, what is the best strategy to reduce the number of premature deaths? Where should further investments be directed…to prevention or diagnostic and medical intervention? Similarly, we will be looking at outcomes for specific technical interventions. In the future, we should know what types of total hip replacement implants last longer and provide better quality of life.

Finally, we will also want to do better on the health human resources front. We will augment existing databases and develop new ones so that we may better equip provinces and territories as they address the challenge of training, recruiting and retaining health care providers, not only for urban centres but also in rural and remote communities.

ST: Recently the creation of a new Health Council of Canada and Patient Safety Institute were announced. What will their roles be? What will be their working relationships with CIHI and Statistics Canada?

MD: While it is difficult to give a definitive answer to these questions since neither has yet been formed, our Board has a strong view that we should do whatever we can to assist these new agencies. Since they will likely have a complementary role to ours, we will seek to establish a strong working relationship. Specifically, at a minimum, this will likely involve the provision of data and analytical services. So, if I had to summarize the working relationship in one word, it would be *partnership*.

Of course, the Council will provide policy advice, which we don't do. However, they will need our assistance. For example, each year we report on the number of Canadians waiting for an organ transplant. By publishing comparable data, we can foster a constructive kind of competition within the public system. In the future, the Council could comment and seek to build consensus on solutions to reduce wait times and wait lists. It stands to reason that those who run the system (the provinces and territories) should share in the formulation of ideas and meet a minimum standard. Home care services and catastrophic drug coverage lend themselves well to this approach. So, it will be up to the Council to cajole and encourage the provinces, while bringing forth the views of the general public. In that sense Romanow was a huge success; it successfully undertook a dialogue with Canadians (and the media) on the future of our health care system. It would be a shame if it was a one-time effort only. The Council, I think, offers us that hope.

Similarly, I expect that we will be involved with the Patient Safety Institute (PSI) from the get-go. For example, our joint effort with CIHR on adverse event rates in Canada will be useful to them. As well, our DAD will be a leading source of data. Furthermore, we will be able to provide advice on what other data exists, and the limitations and caveats around its use, as well as analytical support.

So the Council, the PSI and others such as the Health Human Resources Initiative and the newly created P/T Quality Councils will all benefit from our infrastructure and expertise as they strive to make our health system even better!

Health Care in Canada 2003 Focuses on Primary Health Care

Health Care in Canada, CIHI's fourth annual report, was released May 28 in Toronto. The flagship report gives the most comprehensive view available of the health of Canadians and their health system, bringing together information from CIHI's own data holdings and other sources.

This year's report takes an in-depth look at primary health care services and providers, highlighting successes and shortfalls in key aspects of primary care targeted in recent reports and the First Ministers Accord.

The report also tracks the $34-billion increase in health spending over the past five years. "We found that more than one-third (36%) of the total increase was eaten up by population growth and inflation," says CIHI President and CEO Dick Alvarez. "That's a big chunk of the money but it did still leave room for some real growth in per-capita spending. That growth produced increases relative to population in rates of key procedures like joint replacements, dialysis and diagnostic tests; yet we know the public and providers continue to identify waiting lists as a major concern. We need to do more of this kind of analysis, to show the public where their money goes."

"When I look past the details, this year's report is about two things," says Alvarez. "It's about opportunity and accountability. First of all, the report shows that we have an unprecedented opportunity to move forward on the agenda for change laid out by the First Ministers. The public is ready for change, and the system is ready to deliver it." The report points out that half of Canadians would be willing to see a nurse for routine care instead of a physician and three-quarters would prefer that their physician work in a team setting with other providers.

CIHI President and CEO Richard C. Alvarez at the launch of Health Care in Canada 2003 on May 28, 2003

Federal Minister of Health Anne McLellan and Minister of Health and Long-term Care for Ontario Tony Clement

That openness to change is confirmed by this year's Pollara "Health Care in Canada" poll, which found two-thirds of Canadians support an Electronic Health Record, even though it would mean wider access to personal information, and three-quarters support requiring that patients register with a single family physician. As CIHI's report points out, these kinds of innovations are already in place in Canada, along with many others, like electronic prescribing. But they're being used so far only on a very limited scale: fewer than 7% of family physicians, for example, routinely work with a nurse practitioner.

"Canadians are way ahead of the system as it stands today, in terms of their openness to change," says Alvarez. "So there's opportunity, and there's optimism too. Some recent polls have found Canadians are feeling more hopeful about the system's prospects than they did last year. I think that optimism is real, but it could fade if the system doesn't show progress. And that brings up the other theme of our Health Report: accountability. In this day and age, just opening more beds and hiring more nurses won't be enough to win back the public's confidence for the long haul. To do that, we have to show Canadians what the system does with their money and what kind of value it delivers. We're doing that more and more each year through the Health Report, and we're working on another big step forward with comparable case-costing for hospitals across the country."

Accountability is important not just to public confidence, but also to the quality of the product itself. For example, a recent Commonwealth Fund study found US health care plans that publicly report their performance give better care than those that don't. In fact, the study found the disparity so large that the authors advocate mandatory reporting. "Here in Canada, we're making progress on a voluntary basis, but we have to keep pushing forward," says Alvarez. "Accountability is critical to building a better health system, and to maintaining the confidence of Canadians. And ultimately, that's what the Health Report and CIHI are all about."

You can view *Health Care in Canada 2003* at **www.cihi.ca**.

HL7: A Commitment to Data Quality

The quality of any form of data is governed in large part by the system that produces it. For hospitals, clinics and other health service organizations, this includes not only the organization-specific policies and procedures involved with data generation and transmission, but in particular the growing number of technical and clinical standards which support the construction, configuration and operation of health information technology. It is really these standards which allow health data to exist and, to a large extent, determine its quality. CIHI has an extensive and historic commitment to a host of health informatics standards, which have already made major contribution to the quality of health data in Canada. One of CIHI's key commitments involves Health Level Seven (HL7).

HL7 is the most successful health messaging standards development forum in the world. Founded in 1987, HL7's mandate is to develop and sustain an international set of open standards for data format and content that allows different health information systems to communicate with one another.

CIHI operates **HL7 Canada**, the domestic forum for Canadian HL7 stakeholders—health information system users, vendors and administrators. A recognized international affiliate and voting member of the HL7 International Committee, HL7 Canada facilitates Canadian input to the development and application of the HL7 standard internationally, while allowing Canadians to take account of their needs, and priorities in deciding how HL7 is adapted for use here at home.

Based on the need of the user (e.g. a doctor, a nurse or an administrator), HL7 offers the user the advantage and flexibility of defining, and then reusing over and over again, the collection of data needed to build a message about a particular health event or episode.

HL7 also provides the "architecture" which enables multiple clinical applications or programs (e.g. laboratory, pharmacy or nursing information systems) to be automatically coordinated and synchronized in clinically meaningful ways at the point of use.

HL7 message data quality will be further advanced when development of the next generation, HL7 Version 3, is completed later this year. In particular, Version 3 incorporates the Reference Information Model (RIM) as a means to clarify and improve the message development process: an object-based model created as part of the Version 3 methodology, the RIM is a pictorial representation of the clinical data (or domains) that identifies the life cycle of events that a data message or groups of related data messages will carry.

The completion of this generation, and the consequent development and implementation of HL7 Version 3-compliant applications will therefore be crucial to HL7 Canada's contribution to the efficient, effective organization and delivery of health services. By improving the precision, accuracy and reliability of messaging in health information systems, the standards work of HL7 Canada reflects CIHI's ongoing commitment and contribution of CIHI to advance the overall quality of health data in Canada.

HL7 CANADA

Health Indicators 2003 Provides Glimpse at Delivery of Care

The 2003 edition of the Health Indicators insert provides a glimpse at how health care is delivered in regions across Canada. In its June 9th issue, Maclean's magazine published its fifth annual health ranking, which has become a fixture in the health care industry. The ranking methodology developed by Maclean's draws on a range indicators from the *Health Indicators 2003* publication.

CIHI's *Health Indicators 2003* are available on the Web site at **www.cihi.ca**, under Research and Reports.

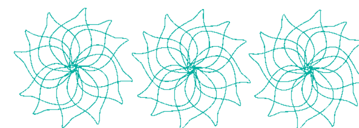
New Chair for Partnership

The Partnership Secretariat is pleased to announce the appointment of Mike Leavy as the new Chair for the Partnership for Health Information Standards. Mr. Leavy has a 25-year background in information management and information technology. Since 1991, he has held several progressive management positions in the British Columbia Ministry of Health, most recently as the Senior Manager, Standards and Architecture with HealthNet/B.C. where he focused on electronic health record architecture with other B.C., health system architects.

He has chaired and participated in a number of B.C., Western and pan-Canadian health information collaborative activities, and has presented to regional, provincial and national conferences on health information topics such as security management.

The Partnership is a CIHI initiative designed to bring together public and private sector experts in the health information standards field. It is the bridge to a vibrant health information standards community.

Understanding Women's Health



Scheduled for release in September, a new report from the Canadian Population Health Initiative promises to advance the field of women's health by providing a wide range of information on women's health issues in Canada.

"We're extremely pleased with the depth and scope of the study," says co-principal investigator Yang Mao of the University of Ottawa. Mao, along with Marie DesMeules and Donna Stewart of Health Canada, led the project. "The compilation of up-to-date, gender-specific health information and analysis can only help health policy decision makers to develop programs and interventions to improve the health of women in this country."

The research team started with data that questioned the conventional wisdom that there are biological reasons women live longer than men. When "preventable" deaths (caused by smoking, AIDS and injuries, for example) were removed, the so-called "sex gap" narrowed from five years to just six months.

"When you look at gender specific or gender prevalent health conditions—female cancers, cardiovascular diseases, menopause, or arthritis for example—it becomes readily apparent that Canadian women face a set of significantly unique health vulnerabilities which bear more intense investigation and action," notes Donna Stewart.

One of several key issues addressed by the report is the identification of disparities in women's health status and pinpointing the more vulnerable groups of Canadian women.

The report also contains timely information about women's health behaviours and outcomes and their use of the health care system, as well as a portrait of how women experience various health conditions and their levels of access to health, community and family services.

The report begins with a presentation of the current health status of Canadian women. This overview of life expectancy, mortality rates, potential years of life lost and overall morbidity (including hospitalizations and living with chronic conditions) leads into a look at the health determinants among Canadian women. Socio-economic factors including the influences of income, education, ethnicity, housing, family and marital status are studied as are the effects of substance abuse, eating disorders, fitness, body weight and image, along with overall utilization rates of health services and social support mechanisms.

Health conditions unique or more frequent in women are then examined including reproductive and sexual health, pregnancy outcomes and female cancers in the former category, and depression, mental health, arthritis, cardiovascular disease, diabetes and the effects of violence in the latter.

The report makes several concrete recommendations for both future surveillance activities and new directions in women's health policies. The report's authors express the hope that this research initiative will continue on an annual or biannual basis to measure progress and suggest new directions and refinements to the treatment of women health issues.

"In many respects, we are just getting a start on understanding women's health issues," says Marie DesMeules. "The more we know, the more we will be able, as a health care system and as a country, to focus appropriate attention and resources on gender specific health and medical care."

Socio-Economic Impact on Childhood Obesity

On May 10, a new CPHI-funded research study was published in Obesity Research, a research journal of the North American Association for the Study of Obesity (NAASO). Led by authors Douglas Willms, Mark Tremblay and Peter Katzmarzyk, the study found that the risk of becoming overweight or obese was affected by such socio-economic factors as geographic location, parents' income and education level and number of siblings.

This research article is part of an overall study on childhood obesity, one of CPHI's research priorities. "The number of overweight Canadian children is reaching epidemic levels and we must understand factors affecting population health so that we can target strategies that will make the most difference," says CPHI Director, Carmen Connolly.

The study can be found on *Obesity Research*'s Web site at **www.naaso.org**

Zelmer Named VP, Research and Analysis

Mr. Richard C. Alvarez, President and CEO is pleased to announce the appointment of Jennifer Zelmer to Vice-President, Research and Analysis. Ms. Zelmer is currently Director of Research and Special Projects, and leads the team responsible for CIHI's annual "Health Care in Canada" report, among other projects.

Ms. Zelmer is an adjunct lecturer at the University of Toronto, a research associate at McMaster University, and a member of a number of health-related advisory committees and boards, including the Canadian Centre for the Analysis of Regionalization and Health. In 2002, she was one of two Canadians selected to receive a prestigious Harkness Associate award. Ms. Zelmer has a Bachelor's degree in Health Information Science and a Master's degree in Economics, and is currently pursuing a PhD in Economics.

Recently Published

Health Care in Canada
Released in May 2003

Drug Expenditures in Canada 1985-2002
Released in April 2003

Bringing the Future into Focus: Projecting RN Retirement in Canada
Released in July 2003

Hospital Mental Health Services in Canada 2000–2001
Released in August 2003

CIHI directions ICIS

CIHI directions ICIS is published by the Canadian Institute for Health Information (CIHI). Since 1994, this national, not-for-profit organization has been working to improve the health of Canadians and the health system by providing quality health information.

CIHI provides reliable and relevant information to support sound health policies, help manage the Canadian health system effectively, and promote informed public discussion of issues affecting health and health services.

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Upcoming Releases Fall 2003

- Canadian Organ Replacement Register (Renal Dialysis) 2002
- Workforce Trends of Registered Nurses 2002
- Medical Imaging in Canada
- Supply, Distribution and Migration of Canadian Physicians 2002
- CPHI: Women's Health Surveillance
- Hospital Morbidity Database 2001/2002
- Workforce Trends of Licensed Practical Nurses in Canada 2002
- Workforce Trends of Registered Psychiatric Nurses in Canada 2002
- National Trauma Registry: Major Injury in Canada (2001/2002 data)
- Preliminary Provincial and Territorial Government Health Expenditure Estimates 1974/1975 to 2003/2004