

# The College of Family Physicians of Canada

February 2005

## Summary Note from the Report of The Health Council of Canada

### *Health Care Renewal in Canada: Accelerating Change*

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#### **Introduction**

In the 2003 Health Accord, Canada's First Ministers (Premiers, Territorial Leaders and the Prime Minister) committed to the establishment of the Health Council of Canada. The Council is funded by the federal government and mandated to monitor and report to the Canadian public on the 2003 Accord. The Council issued its first annual report on January 27<sup>th</sup>, 2005 at an invitational meeting in Ottawa that was attended by the President, Dr. Alain Pavilanis, and Chief Executive Officer, Dr. Calvin Gutkin, of The College of Family Physicians of Canada (CFPC).

In their national health reports, Kirby (2002) and Romanow (2002) highlighted the value of an independent council informing Canadians on health care issues while promoting accountability and transparency. The CFPC supports the need for increased attention to these principles and the establishment of an independent body to monitor progress and improvement in our health system.

Although the Council's report covers a number of health care issues, there is a significant emphasis on Health Human Resources (HHR). A comprehensive, workable HHR plan is the linchpin to a sustainable health care system. In fact, the Council acknowledges that many of its recommendations cannot be implemented without addressing shortages in HHR. The CFPC commends the Council for highlighting this issue and looks forward to being a part of the Council's ongoing efforts to encourage the recruitment and retention of family doctors in Canada.

The following document prepared for CFPC leaders and members is only a summary of the Health Council report released January 27<sup>th</sup>, ending with a brief commentary that highlights some of the issues.

*For the complete report, please see:*

[http://hcccs.com/report/Annual\\_Report/report\\_index.html](http://hcccs.com/report/Annual_Report/report_index.html).

## Highlights from the Council Report

The report is divided into sections dealing with:

- A) The Health of Canadians
  - I. Health disparities
  - II. Aboriginal health
  - III. Patient Safety
- B) Access to Health Care Services
  - I. Primary health care
  - II. Home care
  - III. Pharmaceuticals
  - IV. Wait times
- C) Infrastructure to Support Health Care Renewal
  - I. Health human resources
  - II. Information technologies
  - III. Funding
  - IV. Comparable Indicators

### **A) The Health of Canadians**

#### **i. Health disparities**

##### *Statement*

Health disparities are the number one health problem in the country and health care alone is powerless to overcome them.

##### *Council Advice*

Broaden the Healthy Living Strategy to move beyond lifestyle issues to focus on health disparities and engage sectors beyond health.

#### **ii. Aboriginal health**

##### *Statement*

The health of First Nations, Inuit and Métis people is worse than that of the general Canadian population on virtually every measure of health and every health condition.

##### *Council Advice*

- Develop an Aboriginal health work force to improve service delivery.
- Develop primary health care models to address the broader social determinants of health, relevant to Aboriginal communities.
- Accelerate the use of information technology.

#### **iii.**

## **Patient Safety**

### ***Statements***

There is a clear link between patient safety and information technology. Reducing medication error has been achieved through online prescribing programs.

### ***Council Advice***

The Council recommends that governments consider mandating electronic prescribing over a reasonable time period with the appropriate financial and educational supports for providers.

## **B) Access to Health Care Services**

### **i. Primary health care**

#### ***Statements***

The Council applauds governments for recognizing the need to reform primary health care delivery. They clearly recognize the magnitude of the challenge: their target of 50% of the population having access to an appropriate health care provider by 2011 is modest. This target may not be achieved. Reforming primary health care is far from done.

#### ***Council Advice***

- Use common definitions
- Accelerate new delivery models
- Remove regulatory barriers
- Change education and training models
- Accelerate the introduction of information technology

### **ii. Home care**

#### ***Statement***

Home care services in Canada are not covered under the Canada Health Act and jurisdictions have designed their own programs based on policy choices and funding capacity.

#### ***Council Advice***

- Treat community mental health home care as part of primary health care programs: not within this basket of services.
- Discuss extending the two-week time frame.
- Pay attention to chronic home care needs: short-term acute home care does not fully take advantage of the potential to prevent admissions to institutions.
- Link planning efforts to a health human resource strategy.
- Take advantage of information technology.

### **iii.**

## **Pharmaceuticals**

### ***Statement***

Some drugs provide only minimal added value because they are similar to existing drugs; costs are increasing faster than the rate of inflation and population growth; and the recent revelations of serious negative side effects of high volume drugs has highlighted the potential risks of drug therapy.

### ***Council Advice***

- Define a minimum standard for drug coverage that applies across the country.
- Establish a process to review and compare the catalogue covered by programs.
- Identify drugs that cost more than \$5,000 / person / year and assess coverage.
- Invest in developing unbiased, evidence-based drug information for physicians, pharmacists and patients.

#### **iv. Wait times**

### ***Statements***

Some waits are necessary and are not harmful to patients. It is not waiting lists that should be of concern but waiting that nobody wants — waits that are uncertain, waits that are unfair, and waits that create greater risk for the patient. Wait times need to better reflect the complete patient experience. They start when a patient first identifies symptoms and end when the patient recovers fully or begins the cycle again.

### ***Council Advice***

- Ensure comprehensiveness
- Make information publicly available
- Evaluate outcomes
- Engage key players in simplifying the patient journey
- Align incentives — eliminate disincentives
- Enhance capacity where needed

## **C) Infrastructure to Support Health Care Renewal**

### **i. Health human resources**

### ***Statements***

Canada does not have a national health human resource strategy. Most jurisdictions have not linked interprofessional education to HHR planning. The health care renewal goals established by the First Ministers cannot be achieved without collaborative HHR planning amongst the jurisdictions.

### ***Council Advice***

- Focus on teams.
- Remove barriers, e.g. regulatory and issues of scopes of practice.

- Transform health professions education programs: need to be integrated.
- Develop non-financial recruitment and retention incentives.
- Plan collaboratively

## **ii. Information technologies**

### ***Statements***

The majority of physicians and other caregivers have not implemented electronic health records or stored key patient data electronically. Incentives to change have largely been financial. Education and training for new users have not been addressed. Providers are concerned with the confidentiality of patient information.

### ***Council Advice***

The Council recommends that providers, governments and the public jointly commit to the rapid adoption of these tools.

## **iii. Funding**

### ***Statements***

Health care spending in Canada is expected to reach \$130B in 2004 or \$4,078 per person. 70% is public funded (\$91B) and 30% is private funding (\$39B). The money is spent on hospitals (30%), drugs (16%), physicians (13%), other health professionals (12%), and other institutions (9%).

### ***Council Advice***

Canadians want to know whether the increased investments in health care are supporting the kind of change governments have agreed to implement. Canada needs a public debate on whether additional investments in health care versus other social programs would be most beneficial.

## **iv. Comparable health indicators**

### ***Statements***

The 2003 Accord directed Health Ministers to develop indicators for reporting on progress. The Canadian Institute for Health Information identified 70 indicators. 18 were selected for reporting by each jurisdiction and are found at [www.cihi.ca](http://www.cihi.ca). These focus on access to primary health care, drug coverage, diagnostic and medical equipment, health human resources, and the health of the population. Are these the right indicators?

### ***Council Advice***

The Council recommends that Health Ministers take another look at their approach to generating these indicator reports and that the information be compiled into one report so that the public can understand differences and similarities across the country. The Council recommends the inclusion of socio-economic factors in the health indicator framework.

## Conclusion

The Council plans a number of activities for 2005. Some of these include:

- **Releasing background papers** on primary health care, home care, pharmaceuticals, wait times, health human resources and Aboriginal health; **identifying and promoting innovative practices** in each of these areas;
- **Commissioning research** on industry practices **in the pharmaceutical sector**;
- Participating in efforts to **develop indicators to measure health care renewal**;
- **Sponsoring a National Health Human Resources Summit** focused on impediments to multidisciplinary care, including the impact of education and training; and
- Generating a **template for reporting on funding**.

## Comments

This is the first Health Council report, covering a wide range of health care issues of importance to all Canadians. The report serves as a good summary of the many challenges presently facing our health system in Canada. But it is also noteworthy for its lack of attention to increasing accountability and transparency by measuring and monitoring the performance of the system to assure Canadians that inequities in the system are being addressed and that committed dollars are being used appropriately.

The Council's mandate, as described in the 2003 First Ministers' Accord on Health Care Renewal, is *to monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions*. While this first report is helpful, further work is needed to develop appropriate benchmarks and indicators that will measure and track changes in our health system. The CFPC welcomes an increasing focus on these issues in future reports as the Health Council seeks to meet its goals and objectives.

The Council is to be commended for giving health human resources a high profile and for recognizing this as key to any further health system planning and implementation in Canada. The CFPC supports the development of a national HHR plan, one that includes support for an independent infrastructure responsible for collecting HHR data as well as monitoring, conducting research and reporting to the Canadian public. While there is also support for the development of interdisciplinary teams in health delivery, there is a need for cautious optimism. The loss of definition of the professional responsibilities of family doctors is not acceptable and does not serve the system well. Indeed, this has contributed to uncertainty for some medical students choosing family practice as a career. Primary care should not be a melting pot for professionals but should recognize the special skills, knowledge and training that each brings to the team. The distinct roles and responsibilities of family doctors must be supported to promote and maintain their value and importance.

As our health system evolves, governments should support changes in health delivery that align with changes in population demographics (paying particular attention to health disparities in underserved populations), changes in the workforce (considering new data such as that just released from the National Physician Survey), new and more complex diseases and disease processes, an increasing focus on public health (promotion, prevention and chronic disease management) and newer technologies (for community-based care, not just traditional models of hospital-based care). This support should be evaluated with the kinds of performance measures that the Health Council is mandated to develop, implement and track.

On the issue of wait times, the Council report builds on key messages from the CFPC, messages that define when wait times start for our patients – when the patient first experiences a problem and seeks help. Patient safety will continue to be important to Canadians who access the health system. Not only should Canadians be aware that they can access care within a measurable and safe timeframe, they should also be assured that the health system is being monitored to minimize adverse events by focusing on activities that prevent system errors in delivery.

The Council report also recognizes that jurisdictional cooperation is imperative. As some provinces have chosen not to participate in the tracking mechanisms being established by the Council, benchmarking and comparing data at a national level will continue to be a challenge.

The CFPC calls on governments to take action and to ensure that issues identified in this first Council report are appropriately addressed. The Health Council should continue to fulfill its mandate to independently monitor our health system performance and to provide meaningful reports to all Canadians. The CFPC welcomes opportunities to work with the Health Council and with all governments as they develop and implement plans to address the important issues identified in these reports.