



HEALTH CARE RENEWAL IN CANADA:

MEASURING UP?

Health Council of Canada



Conseil canadien de la santé

ANNUAL REPORT TO CANADIANS 2006

February 2007

About the Health Council of Canada

Who we are

Canada's First Ministers established the Health Council of Canada in the 2003 Accord on Health Care Renewal and enhanced our role in the 2004 10-Year Plan to Strengthen Health Care. We report on the progress of health care renewal, on the health status of Canadians, and on the health outcomes of our system. We are 26 Canadians who care about the future of Canada's health care system and want to ensure its sustainability. Councillors include governmental and non-governmental representatives whose expertise and experience range from health care to education to finance.

Funded by Health Canada, the Council operates as an independent, non-profit agency, with members of the corporation being the ministers of health of the participating jurisdictions, namely the federal government and all territories and provinces except Alberta and Quebec.

What we do

The Health Council has a unique mandate from the First Ministers to report directly to Canadians on progress in implementing the 2003 and 2004 health care agreements, particularly their accountability and transparency provisions. The Council provides a national, system-wide perspective on health care reform and offers constructive advice on how to improve health care access, quality, effectiveness and population health.

Production of this report has been made possible through a financial contribution from Health Canada. This report is published by the Health Council of Canada acting within its sole authority and not under the control or supervision of Health Canada. The views expressed herein represent the views of the Health Council and do not necessarily represent the views of Health Canada or any provincial or territorial government.

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Health Care Renewal in Canada: Measuring Up?
February 2007
ISBN: 0-9780488-0-6

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Jurisdictional tables on health care renewal are available in a companion report.

Foreword: Looking for answers, achievements and accountability

The Health Council of Canada's first annual report to Canadians focused on access; in the second, we zeroed in on quality. This year, the Council believes it is time to examine our collective capacity to measure the performance of health care systems across the country and to suggest ways to strengthen transparency and accountability in health care.

Four years after the 2003 *First Ministers' Accord on Health Care Renewal* – and following the infusion of billions of dollars in federal health transfers as well as provincial and territorial investments – how far has health care renewal advanced?

It is difficult to make global statements about the extent to which health care renewal is taking root because the pace of progress varies by sector and jurisdiction. We do, however, have some good news to report. The country has been awash in announcements as initiatives from the health care agreements proceed. Work on wait times and primary health care reform, for instance, is beginning to bear fruit. Enrolments in medical and nursing schools are up everywhere, and health care providers are beginning to be educated in a way that encourages them to break down professional silos and focus on the patient. Jurisdictions are getting on board – across the board – with healthy living strategies.

However, to answer questions about the strength and sustainability of health care renewal, too often we have to rely more on anecdote than evidence. We are unable to specify where the provinces and territories are investing funds from the federal health care agreements because no financial breakdowns are provided. And in important areas, like catastrophic drug coverage, health inequalities, and the health status of Aboriginal peoples, we know we are missing the mark.

After three years of monitoring commitments from the 2003 and 2004 health care agreements, it is clear that the accuracy and precision of our reporting to Canadians depends on several factors:

- the capacity of hard-working governments to report in a transparent and meaningful way on health care spending and results;
- the clarity, comprehensiveness and utility of the questions being posed and the quality of the responses received; and
- the capacity of data collection systems across this country to provide the comparable and comprehensive data needed to draw conclusions from a national perspective.

It is troubling that First Ministers have not reported this year on comparable health indicators as agreed in the 2003 accord and disturbing that the federal/provincial/territorial (F/P/T) committee that oversees this work has been disbanded. Data were posted on the website of the Canadian Institute for Health Information in late December, and Health Canada has produced a federal level report, but provincial/territorial reports have not been created. This falls short of agreement commitments. To evaluate the promise of accountability that heralded the health care agreements, the public needs a more detailed and transparent account of how historic investments have helped strengthen the health of the system and the people it serves.

According to a companion document being released with this year's report, *Canadian Perceptions of the Health Care System*, the vast majority of Canadians "believe that five years or less is a reasonable time frame within which to expect to see real change in Canada's health care system." As the Health Council of Canada heads into the fourth year of our first five-year mandate, we call on governments, providers and policy makers to create mechanisms to facilitate the collection and reporting of high-quality, standardized data to strengthen accountability and guide decision-making to improve health and health outcomes.

Jeanne Besner, RN, PhD
Interim Chair, Health Council of Canada

About this report

In this, the Council's third annual report to Canadians, we remind Canadians of the goals of the 2003 and 2004 health care agreements, discuss what steps governments have taken during the year towards meeting those goals, identify areas of inaction, and provide advice on how to support and strengthen renewal.

To prepare the report, Council staff conducted face-to-face interviews with senior representatives of all member jurisdictions of the Health Council. Because Alberta and Quebec are not members, we did not request information directly from these governments. Full accounts of their health care renewal efforts are not included, but examples are sprinkled throughout the report.

Staff also collected materials, conducted literature searches, and obtained relevant information from major national health organizations. After assessing and compiling the data, we asked the jurisdictions to verify the information. The report presents the results of our data gathering on health care renewal over the year, presenting from a national perspective as accurate a picture of renewal as possible given the state of data collection and reporting in Canada. Tables with information from member jurisdictions are provided in a companion document and on our website.

As in previous years, the report groups health care renewal efforts into three broad categories – access, quality of care, and population health.

The section on access examines primary health care, home care services, pharmaceuticals, wait times for surgical and diagnostic procedures, and health human resources. Under the banner of quality, we report on efforts to improve patient safety, and we take a close look at indicators, funding, and public reporting. The third section, population health, deals with healthy living strategies and chronic disease prevention, as well as Aboriginal health.

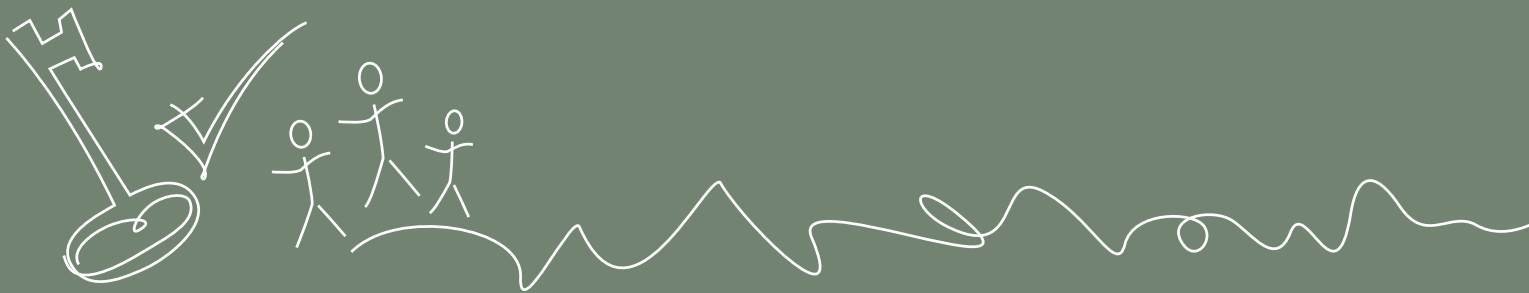
This report reflects the most current information at the time of publication. Health ministers were to report to the First Ministers by December 31, 2006, on home care services provided without out-of-pocket costs to Canadians. As of January 17, 2007, it was not known if, or how fully, health ministers reported on goals related to this deadline. When the information becomes available, the Health Council will issue an update.

Examples of noteworthy practices or developments in health care appear throughout this report, reminding us that renewal is happening and is possible when leadership, determination and resources combine to strengthen our system.



What governments promised | What Canadians perceive |
What we found | What we advise

OVERVIEW



What governments promised: a summary

2003 First Ministers' Accord on Health Care Renewal

In February 2003, the prime minister and premiers signed an accord on health care renewal, worth \$36 billion over five years. They pledged to increase access to health care providers, diagnostic procedures and treatments, home and community care services, and necessary drugs. They also agreed to establish the Health Council of Canada.

The 2004 10-Year Plan to Strengthen Health Care

In September 2004, the prime minister and premiers signed a second health care agreement which committed an additional \$41 billion in federal funds over the next 10 years. In it, they re-confirmed their commitment to the principles of the *Canada Health Act* and also promised to collaborate, share best practices, and be accountable to the public with respect to the progress of renewal. The Health Council was given additional responsibilities to report on the health status of Canadians and on health outcomes.

Aboriginal Health Transition Fund

In September 2004, a special meeting of First Ministers and national Aboriginal leaders announced a \$200 million Aboriginal health transition fund, to be created over five years. The fund was designed to improve the integration of federal and provincial health services, improve access to health services, make available health programs and services that are better suited to Aboriginal people, and increase the participation of Aboriginal people in the design, delivery and evaluation of health programs and services.

2005 Annual Conference of Ministers of Health

At this conference, the ministers of health made a number of important commitments regarding drug coverage and pharmaceuticals management, including accelerating work on options for catastrophic drug coverage, developing a common drug review, and working towards a national formulary. As well, they agreed on a set of goals for improving the health of Canadians.

2005 Kelowna Accord and Blueprint on Aboriginal Health

In November 2005, a two-day summit of First Ministers was held in Kelowna, British Columbia. At this meeting the federal government pledged \$5 billion over five years to improve the lives of Aboriginal people in the areas of health care, housing and education. The leaders from 19 jurisdictions, including the Government of Canada, every province and territory, and five national Aboriginal groups (the Assembly of First Nations, Inuit of Canada, Métis National Council, Congress of Aboriginal Peoples, and Native Women's Association of Canada) agreed to the tenets of this commitment, subject to further discussion on the funding and how it was to be spent.

The *Blueprint on Aboriginal Health*, a 10-year transformative plan to help close the gap in health outcomes between Aboriginal peoples and the general Canadian population, was tabled at this meeting. The federal government committed to use the blueprint in creating Aboriginal health programs; since then, no funding has been committed to the blueprint by the federal government. As a collective, the provinces and territories have not indicated their commitment to the blueprint as their framework for the development or implementation of such programs.

2006 First Ministers' Conference

In the 2004 *10-Year Plan to Strengthen Health Care*, governments committed to establish a ministerial task force to develop and implement a national pharmaceuticals strategy (NPS), including coverage for catastrophic drug costs, and to report on progress by June 30, 2006. At the conclusion of the Council of the Federation meeting in St. John's on July 28, 2006, the premiers accepted a task force report on the NPS and directed provincial and territorial health ministers to release a report by September 2006 on the status of NPS and to "continue to work on key elements ... with a special focus on the Catastrophic Drug Program."

On September 21, 2006, the provincial and territorial ministers of health released a progress report. The federal minister did not participate in the release. The report recommended, among other things, that the task force focus further on policy, design and costing analysis for options for catastrophic drug coverage.

What Canadians perceive

The Council felt that it was important to understand what Canadians think about the state and pace of health care renewal – their concerns, priorities, and hopes for the future.

After all, health care renewal is a national undertaking with but one ultimate objective: to improve the health and well-being of our system and our citizens. So it seemed appropriate for the Council to ask, after four years and an estimated \$25 billion increase in spending on health,¹ whether Canadians perceived that their health care system was improving.

The Council commissioned Professor Stuart Soroka of McGill University to review the last four years (2002 – 2006) of public opinion polling data on the Canadian health care system. Polls by Ipsos Canada, Decima Research, Environics Research Group, Innovative Research Group Inc., Ekos Research Associates Inc., Pollara Inc., and The Strategic Counsel, among others, were examined. *Canadian Perceptions of the Health Care System* is a synthesis of these data and is being released as a companion document to our 2006 annual report.

Soroka's synthesis shows the public's evolving opinions on health care issues since the Romanow Commission report in 2002. It examines Canadian attitudes and views on the progress of renewal, government spending, problems with the current system, and priorities for the future.

The key findings of the synthesis are:

- The vast majority of Canadians support universal public health care.
- While Canadians feel that their health care system has slightly improved over the past four years, 71 per cent of Canadians believe that the system is urgently in need of fundamental change. 54 per cent called for major repair, and 17 per cent for rebuilding.
- Canadians continue to rate their own experiences with the health care system as mostly positive while at the same time expressing concern over its sustainability.
- However, since 2002, fewer Canadians indicate that their confidence in the health care system is falling (from 58 per cent in 2002 to 50 per cent in 2005), and even fewer indicated that the quality of health

care has deteriorated in the past two years, from 63 per cent in 2003 to 39 per cent in March 2006.

- In 2005, 63 per cent of Canadians indicated they were confident that access to necessary health care services would be available if they or a family member became seriously ill. Timely access to services is still a major concern for Canadians, however, topping the list of health care concerns.
- Spending was not seen as the only solution even among the majority who support increased government funding for health care. In 2004, two-thirds of respondents believed that a combination of more money and fundamental change is required. In 2004, 74 per cent of the polled public expressed a strong sense that the federal government should transfer more money to the provinces. While Canadians supported provincial flexibility in the use of this funding, 67 per cent wanted “strings” to be attached and 70 per cent wanted national standards to apply.
- In 2003 and 2004, 85 per cent of polled Canadians expected to see substantive change within five years.



Further public opinion information is provided throughout this report (look for the megaphone icon to learn more about Canadian perceptions). The full Soroka synthesis is available at www.healthcouncilcanada.ca.

What we found

In this section, we summarize the Council's major findings about the progress in health care renewal over the past year – the achievements as well as the shortcomings. Additional detail is provided in the report as well as in Appendix Table 1 and a companion report. We have also identified common challenges in reporting on health care renewal in Canada that emerged from our monitoring efforts.

Primary health care

- Progress, while significant, is somewhat qualified.
- Every jurisdiction reports that they are in the process of implementing interprofessional teams or collaborative practices. Most report growth in the number and breadth of their teams.

- Primary health care teams are largely the result of pilot projects – with some notable exceptions such as those in Ontario.
- The array of health professionals in primary health care practice is limited, and collaborative practices tend to be disease-oriented.
- By far the majority of Canadians still receive their primary health care without the benefits of an interprofessional approach.
- Standard indicators for measuring the development and expansion of primary health care have been developed through a consensus process, led by the Canadian Institute for Health Information, that identified the indicators deemed most appropriate regardless of the availability of the data source. This process revealed that there is no data available for the majority of indicators the participants indicated were important. This finding highlights the need to improve the primary health care data collection infrastructure. In the absence of this data, it is difficult to report on progress systematically.
- The commitment to 24/7 access to appropriate health care providers has been defined in many cases as after-hours tele-health services and emergency departments, without a linkage back to the patient's primary health care provider. This is not the Council's understanding of the F/P/T commitment; the Council's interpretation includes a link back to the patient's primary health care provider.
- Canada Health Infoway has increased its share of funding for electronic health record implementation to 75 per cent of eligible costs, and there has been good collaboration on system standards. However, the pace of implementation in primary health care settings is still too slow.

Health human resources

- There has been good progress in implementing interprofessional education programs.
- Medical and nursing school enrolments have increased in all jurisdictions where these programs are available.
- Most jurisdictions have released their recruitment and retention plans. However, only four – New Brunswick, Nunavut, Manitoba, and Ontario – have established targets.
- A Pan-Canadian Health Human Resources Planning Framework has been developed.

Home care

- As of January 17, 2007, it was not known if, or how fully, health ministers reported to First Ministers on goals related to the December 31 deadline. When the information becomes available, the Health Council will analyze it and issue an update.
- The federal definition of family members eligible for the Compassionate Care Benefit has been broadened to support more Canadians taking care of their loved ones who are dying at home. The Council called for this in its last annual report to Canadians. Ontario introduced legislation in October 2006 amending the province's *Employment Standards Act* to provide job protection for the wider range of people eligible to use the federal Compassionate Care Benefit. The Ontario provision defines family member broadly and includes close friends as eligible caregivers, in line with revisions to federal legislation in June 2006.
- Alberta and the Northwest Territories have yet to provide complementary legislative protection for caregivers. Across the 11 jurisdictions that have written job protection for compassionate leave into their regulations, definitions of eligible caregivers continue to vary.

Pharmaceuticals management

- The progress report on the implementation of the national pharmaceuticals strategy (NPS) was released in September 2006. While the report contains options for coverage of catastrophic drug costs, there has been no action on implementation.
- There is no indication whether the federal government will help cover the cost of a pan-Canadian catastrophic drug program. Most jurisdictions already provide some coverage, but 600,000 Atlantic Canadians have no protection, and many other Canadians have limited coverage.
- The scope of the Common Drug Review, the national committee that recommends which drugs should be funded, has been expanded. Preliminary work on developing a common national formulary, or list of drugs covered by various public drug insurance plans, is underway.

- Beyond efforts by individual jurisdictions, the NPS has not yet addressed efforts to encourage or support appropriate prescribing. The Council will host a symposium in 2007 to focus on this issue.
- Drug Information Solutions will provide physicians and pharmacists with the ability to electronically capture, store and receive prescriptions and pharmacy dispensing information as well as clinical decision support. Canada Health Infoway has allocated \$185 million to the Drug Information Solutions investment program. Several jurisdictions have moved ahead on implementation projects, which, when completed, will contribute to patient safety (i.e. declines in adverse drug events) and provider productivity. Support from Canada Health Infoway has been instrumental to success. Electronic prescribing – the electronic forwarding of a prescription to a pharmacy – is not yet widespread.
- The commitment to a broader role for the Patented Medicine Prices Review Board has been met.
- A paper commissioned by the Council and released in early 2006, *Direct-to-Consumer Advertising of Prescription Drugs in Canada: What Are the Public Health Implications?*, found no evidence to show that drug advertising has improved health, provided better compliance in taking medications, led to more appropriate early diagnosis of under-treated conditions, or prevented hospitalization. The paper concluded that increased drug advertising will lead to increased prescribing and increased costs to the health care system.

Wait times

- Wait times are being reduced in most of the five targeted areas – cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration. There are questions raised, however, about whether this progress can be sustained beyond the funding commitment of the Wait Times Reduction Fund.
- More information is now being made available to the public on websites. Some of it is approaching “real time” but other information needs to be more current to be helpful.
- Lack of comparability of reporting methods makes comparison of wait times across jurisdictions difficult.
- In February 2006, Quebec became the first province to announce a wait-times guarantee, with a commitment that citizens will receive hip, knee or cataract surgery within six months of diagnosis. If the public system cannot accommodate someone within that time frame, the government will purchase services from the private sector.

Patient safety

- An increasing number of health care organizations and teams are participating in *Safer Healthcare Now!* and the Canadian Patient Safety Institute plans to expand the program.
- The Canadian Council on Health Services Accreditation continues to integrate patient safety requirements into accreditation standards.
- Accreditation of health care facilities is still not mandatory, and many of the health care facilities that go through the accreditation process do not publicly release the findings of their accreditation reports.
- There is some required reporting of adverse events (in hospital emergency rooms and for some types of drug reactions), but there is no coordinated, uniform system of what gets reported in each jurisdiction.

Public reporting on health indicators and funding

- Comparable health indicator reports were not published by the provinces and territories in 2006, but data have been posted on CIHI's website. Health Canada produced a federal level report.
- The Federal/Provincial/Territorial Advisory Committee on Governance and Accountability has been disbanded.
- Information about how provinces and territories spend targeted funds transferred from the federal government is not easily accessible or, in some cases, not available at all.

Healthy living

- The National Immunization Strategy has resulted in the implementation of standardized coverage across the country, including four new vaccines.
- The development of national public health goals is complete. In phase two, the provinces and territories are to set targets and indicators to measure progress. Only Nova Scotia has set targets thus far.
- Of the \$300 million announced by the federal government under the Integrated Strategy on Healthy Living and Chronic Disease, only \$26.4 million has been released.
- In October 2005, the federal government committed \$27.6 million over five years (\$7.15 million per year ongoing) to a Healthy Living Fund which will make strategic investments at the national/regional/community/local levels in support of sustainable national and community health promotion activities. No funding announcements have been made.

Aboriginal health

- There is no clear direction with respect to the future of the *Blueprint on Aboriginal Health* and the Kelowna Accord.
- In late 2006 and early 2007, the federal government announced a series of pilot projects on patient wait-time guarantees. These projects will take place in a number of First Nations communities and will focus on prenatal and diabetes care.
- In November 2006, the federal government, British Columbia and First Nations' leaders signed an agreement on improving the health of Aboriginal people in the province over the next decade.

Common challenges

A common theme emerges from our monitoring efforts: our ability to report on the progress of health care renewal is impeded by the lack of comparable data and by inconsistent reporting across the country.

Lack of consistent, comparable data

Under various agreements over the years, governments committed to develop comparable information on many

indicators including the quality of health care services, timely access to health professionals, enhancements to diagnostic and medical equipment, and progress on Aboriginal health.

"First Ministers agree that Canadians are entitled to better and more fully comparable information," noted the 2003 *First Ministers' Accord on Health Care Renewal*. "Enhanced accountability to Canadians and improved performance reporting are essential to reassuring Canadians that reforms are occurring."

There has been little headway in identifying and reporting on comparable information. In some instances, critical data are simply not being collected. In other instances, the right data are not being collected, or the data are insufficient to report on most of the indicators. And in other cases, the commitment to continue to collect data and build infrastructure to support their use is missing. Furthermore, when data are being collected and shared, it is not evident that they are routinely informing policy development and decision-making. Data may be on a website, but there may be no reports.

As a result, governments are unable to share information in any meaningful way – either among themselves or with the public – because they have not agreed on the data to be collected, the indicators to be used, or the measurements to be applied.

Without adequate data, it will be difficult to determine if additional public investments are actually leading to better health – i.e. improved health outcomes for the population overall.

It is also difficult to ascertain how much money is spent by each province/territory on the provisions in the 2003 and 2004 health care agreements. The jurisdictions identify the amount they received, but not specifically where the money goes.

Little formal sharing of information

The Council does see examples of success in various renewal efforts, but often these are snapshots of particular programs in particular locations and settings. Generally, there is not much of a network for sharing this information – even within jurisdictions.

When a pilot project produces good results it may not be widely adopted, in part because there is no formal mechanism for the transfer of this knowledge. Too often health care planners and decision-makers

end up re-inventing the wheel as a result. This is an inefficient use of time and resources, and Canada needs to make the best use of both if it is to achieve health care renewal.

Successes may not be sustainable

Local successes may not be sustainable over the longer term if pilot programs are not implemented more broadly and embedded into public policy. They may become orphans in the system and vulnerable to future funding cuts.

Lack of transparency

The Council has an obligation to provide Canadians with as comprehensive and accurate an account as possible of the status of renewal efforts across the country, the funding being spent, and the success of various initiatives. Yet we are finding it increasingly difficult to provide Canadians with the information they need to properly assess whether health care renewal is being achieved in a systematic way.

What is the status of health care renewal in Canada today? The Council's search for a definitive answer would be easier if there were more transparency and comprehensiveness in health care reporting. Our health care system is complex; tracking funding and results even more so. But without better data, we'll fall short of our search for accountability.

As evidenced by the lack of reporting on comparable health indicators, the necessary priority is not being given to improving the collection and release of high-quality, standardized data in areas key to health care renewal. (For instance, we have data in areas such as hospital services, but not in primary health care.) Until it is, the public will not be kept fully informed about the progress of health care renewal, and governments will find it increasingly difficult to demonstrate that they are meeting their commitments.



What we advise

Council offers the following advice to achieve agreed-upon goals as laid out in the health care renewal agreements. Governments should:

- Commit to improved and standardized reporting – both on programs and spending of transfer funds from the 2003 and 2004 agreements. This should include: focusing on outcomes, quality and performance; developing targets and monitoring progress; reducing the number of indicators and making the data more current; creating one annual comparative report with national, provincial and territorial information presented in a consistent manner; and identifying key population health outcomes for regular reporting.
- Continue to support data collection and report publicly on agreed-upon standard indicators for measuring the outcomes of primary health care reform, the numbers of patients enrolled, and the development and expansion of primary health care teams.
- Accelerate implementation of the electronic health record (EHR) in the primary health care setting. The EHR supports efficiency and effectiveness and will be a highly valuable source of data for evaluating health care renewal efforts.
- Promote coordinated national/provincial/territorial strategies for health human resources, with specific targets based on the health care needs of their respective populations, and create a national coordinating mechanism.

- Develop appropriate measurement tools so that Canadians can evaluate whether investments in health human resources are resulting in improved patient access, better coordination of care, and improved health outcomes.
- Ensure that provincial/territorial legislation aligns with new federal government definitions of broadened eligibility for the Compassionate Care Benefits program.
- Proceed quickly on meeting their commitment to provide all Canadians with access to catastrophic drug coverage. Governments should inform Canadians of the funding that may be required to support options being considered for coverage of drugs with catastrophic costs.
- Continue to assess whether reducing wait times in the five targeted areas is affecting waiting times for other services.
- Ensure that the urgency of a patient's condition is factored into the patient's placement on the wait list, and put a mechanism in place to monitor that it is.
- Develop a centralized registry of wait times for all procedures to centralize the management of wait-time data collection and increase the likelihood that it is accurate and comparable.
- Move as quickly as possible to provide real-time, hospital-specific information on wait times through government websites, readily accessible to residents/patients.
- Include wait-time information at all facilities, even those not participating in the Wait Times Reduction Fund; over time, expand the reporting process to non-targeted procedures as well.
- Mandate that all health care facilities be accredited as a condition of funding, and that the findings from accreditation surveys be made public.
- At a minimum, establish a mechanism for the mandatory reporting of all defined adverse events in each jurisdiction.
- Ensure that national public health goals are more targeted and based on measurable outcomes, including reductions in health inequalities.
- Increase significantly investments in healthy living strategies and accelerate the development of primary health care teams, to better prevent and manage chronic diseases.
- Strengthen upstream investments in order to lessen the burden of the downstream costs of treatment.
- Provide clear direction at the federal level with respect to the *Blueprint on Aboriginal Health* and the Kelowna accord; outline overall plan and direction in support of Aboriginal health.
- Continue to address the gaps in health status and programs for Aboriginal populations in all provinces and territories.

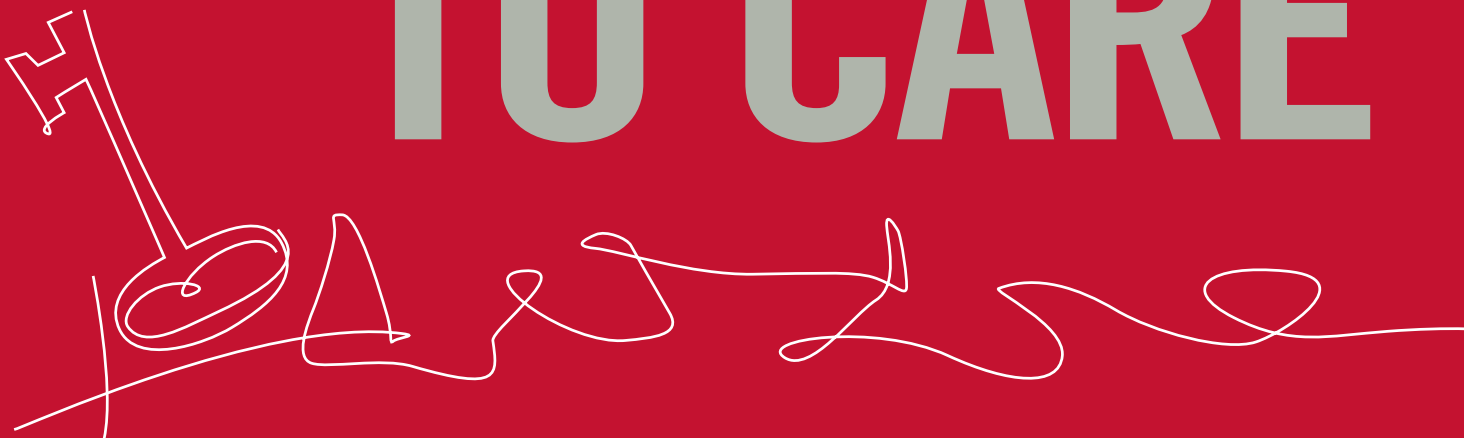
While not specifically referenced in the agreements, based on our research and consultations, the Council also advises that:

- federal legislation be strengthened to ban all forms of direct-to-consumer advertising of prescription drugs in Canada. Legislation should clearly prohibit help-seeking and reminder ads.
- the adoption of no-fault compensation for injured patients be examined to see if it would be effective in improving patient safety in Canada.



Interprofessional teams | 24/7 access | Electronic health care records | Primary Health Care Transition Fund | Best Practices Network | Chronic disease management | Primary health care reform | Interprofessional education | Recruitment and retention | Health human resources | Compassionate care benefits | Home care reporting | Catastrophic drug coverage | Common drug review | Common national formulary | Prescribing behaviours | Drug information systems | Direct-to-consumer advertising | Wait times

ACCESS TO CARE



Access to needed health care will continue to be an issue for Canadians as long as our services are not well integrated, coverage for services is not equitable across the country, and individuals experience long waits for necessary care. Pockets of the country have achieved real improvement, but change needs to be more widespread and more comprehensive.

Primary Health Care

What governments promised

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to accelerate primary health care renewal so that citizens routinely receive needed care from an appropriate health care provider. The First Ministers agreed to the goal that by 2011 “at least 50 per cent of their residents have access to an appropriate health care provider, 24 hours a day, seven days a week.”

In the 2004 *10-Year Plan to Strengthen Health Care*, this target was described differently – as “the objective of 50 per cent of Canadians having 24/7 access to multidisciplinary teams by 2011.” First Ministers agreed in 2003 to use comparable indicators on key health outcomes and to develop the necessary data infrastructure for reporting to Canadians. The 2004 plan committed governments to establish a best practices network and to continue work with Canada Health Infoway to realize the vision of an electronic health record.

What we know /what we don't know

The transformation of primary health care is fundamental to health care renewal and Canadians' confidence in the sustainability of our system. The health care agreements of 2003 and 2004

provided the focus and the funding for change. The consensus, expressed clearly in the Romanow commission report, was that fundamental changes are necessary to provide a more effective primary health care system to improve timely access, quality, continuity, and coordination of care.

Interprofessional teams: new models are providing only a small proportion of Canadians with truly interprofessional care

Primary health care renewal has focused on the redesign of the delivery model from a single first-provider contact model to interprofessional care teams. The intent of interprofessional teams is to provide more comprehensive and patient-centred care by achieving:

- a more integrated entry point for patients that will help improve the efficiency and effectiveness of the entire system;
- a broad range of health promotion and illness prevention services and medical treatments;
- more timely access and treatment, including enhanced 24/7 access;
- better coordination; and
- better quality care.

Over the past number of years, we have seen all provinces and territories begin to introduce variations on the interprofessional team. While team-based care is being implemented, most Canadians still do not receive their care or services in a team setting.

In 2006, the Commonwealth Fund surveyed some 6,000 physicians in seven industrialized countries – Germany, the United Kingdom, the Netherlands, Australia, the United States, New Zealand, and Canada – by mail and telephone.

Findings from a 2006 Commonwealth Fund comparative survey of primary care doctors in seven countries underscore Canada's weak performance on primary health care reform.

According to the survey, only 32 per cent of physicians in Canada report “routinely using multidisciplinary teams and involving nurses and other non-physicians” in the care of individual patients, while 81 per cent in the UK report doing so. And when asked “if their practice uses non-physician clinicians to help manage patients with multiple chronic diseases,” almost 50 per cent of Canadian physicians responded “no” versus 10 per cent in the UK and 17 per cent in Germany.² Of the seven nations surveyed on this measure, Canada was the least likely to use these health professionals.

In many cases, the way we pay many of our primary health care providers can serve as a barrier to implementing interprofessional teams. And, with the wrap-up of the Primary Health Care Transition Fund in 2006, it remains to be seen whether the implementation of team models will continue to grow.

Most provinces and territories do not yet have verifiable targets for the implementation of teams. Furthermore, most provinces and territories do not roster or register their patients with a specific team so it is difficult to determine how many patients have access to teams. Across the country, establishing primary health care teams continues to be largely a voluntary process driven in most instances by interested professionals. As a result, the prevalence and make-up of interprofessional teams is uneven. Supply issues in health human resources may also make expanding teams more difficult in many jurisdictions.

Here is a snapshot of primary health care reform across the country over the past year, as reported by the provinces and territories.

- There has been no increase in the number of interprofessional teams in New Brunswick or Prince Edward Island.
- In Saskatchewan, the number of teams put in place has risen from 34 to 41; a full complement would be about 110 teams.
- Nova Scotia reports over 20 teams across the province, but there is no information on team composition or last year's numbers.
- Manitoba is piloting four Physician Integrated Networks, but there are no non-physicians on these teams.
- Ontario has increased the number of interprofessional Family Health Teams operating in the province from 25 a year ago to 66, with a commitment to get 150 teams up and running by 2008. The province also reports it has enrolled 6,500 physicians – about 60 per cent of all family physicians practising in the province – in these and other primary health care models, which offer after-hours coverage and patient registration. While the number of other health professionals who also participate in these models is increasing – there are more than 290 – most care by existing models is not being provided through interprofessional teams. The most recent National Physician Survey numbers for Ontario show that 33 per cent of family physicians are still in solo practice; 58 per cent are in a group practice; and only four per cent are in a practice network.

24/7 access: more links needed to primary health care providers

The number one concern of Canadians about the health care system is timely access to health care. Jurisdictions across the country have made it a priority to provide access 24 hours a day and seven days a week. But access to after-hours care that links back to the patients' primary health care provider is still spotty. Five jurisdictions still report that they do not have a mechanism for such linking back at all. After-hours care is still provided largely by telephone or emergency department visit.

Only 27 per cent of Canadian physicians surveyed in the 2006 Commonwealth Fund study indicated that they offer extended hours before 8:30 a.m. and 48 per cent said that they had some extended hours after 6:00 p.m. Forty-seven per cent said that they have a mechanism for providing after-hours care other than through emergency departments.

As the Council has said in previous annual reports, the only way of ensuring effective access is if information from the after-hours encounter is communicated to the patient's own primary health care provider. (The absence of an interoperable electronic health record is often cited as a barrier to communicating information about the encounter back to the patient's primary health care provider.) However, efforts to find ways of meeting this objective other than through an electronic health record are not evident. This crucial link continues to be missing in many jurisdictions.

Most jurisdictions respond that they are meeting primary health care reform targets by providing care 24/7 through nurse advisory telephone triage systems and emergency room services. British Columbia has observed that the objective of primary health care reform can be achieved not only through interprofessional teams, but through other models that also incorporate continuity of care as a principle. The essential point is not that a patient went to the ER to receive primary health care, but whether the results of a patient's visit to the ER were linked back to the primary health care provider.

While we are seeing progress on the redesign of primary health care delivery models, the core question is: how many teams are truly interprofessional and provide collaborative care? In Manitoba, teams are made up strictly of physicians. In Ontario, Family Health Teams go beyond physicians and nurses, but Family Health Groups, the prevalent primary care model, is generally limited to doctors. Other jurisdictions consider doctors who work with one or more nurse practitioners a team.

Use of information technology lagging in Canada

Team-based care is key to transforming the health care system. To make it work, all health care providers need quick access to information to help them provide the best possible care. But Canada's health care system still manages information using old technologies and practices. Ninety-four per cent of physician visits in Canada still involve paper records and most prescriptions continue to be handwritten.³ Only one in five Canadian physicians uses computers for clinical care. In comparison to 10 other countries, Canada comes last in the proportion of doctors who use computers for care.⁴

The 2006 Commonwealth Fund Study shows that, of the seven countries surveyed, Canadian primary care physicians are the least likely of physicians to have information systems that provide decision support. For example:

- only 10 per cent of Canadian doctors compared to between 23 and 93 per cent of doctors from other surveyed countries receive computerized alerts about potential prescribing problems;
- six per cent compared to between 15 and 53 per cent have reminder systems to notify patients about preventive or follow-up care; and
- eight per cent compared to between 18 and 93 per cent receive prompts to provide patients with test results.

Electronic health records (EHR): greater uptake needed

To improve quality and efficiency, high-quality, user-friendly health information must be compiled and delivered electronically. An electronic information system gives health care teams ready access to necessary patient information and easy ways to share it. An interoperable EHR allows clinicians to view current information and update an integrated



patient-centric health record that includes demographic, diagnostic imaging, drug, laboratory, infectious disease, immunization and other relevant health information anywhere, any time.

The 2006 Commonwealth Fund study found that only 23 per cent of Canadian doctors said they used electronic medical records, well behind the Netherlands (at 98 per cent), New Zealand (92 per cent), the UK (89 per cent) and Australia (79 per cent).

The benefits of the EHR to patients and the system are significant. That is why the Health Council of Canada called for 100 per cent coverage by 2010, well ahead of Canada Health Infoway's mandate to provide a fully interoperable EHR for 50 per cent of Canadians by end of 2009. For patients, the EHR translates into improved safety, better coordination, and more appropriate care. For the system, it means savings and a high return on investment. The Booz Allen Hamilton study, commissioned by Canada Health Infoway, estimated savings of \$6 billion annually with a fully developed EHR, costing about \$1 billion a year for 10 years to implement, a solid return on investment.⁵

Canada Health Infoway did achieve its goal of having four per cent of the Canadian population with an interoperable EHR by March 31, 2006. Alberta, PEI and the Northwest Territories are on track to achieve the 2009 goal. British Columbia, Quebec, Saskatchewan and Newfoundland and Labrador are on track to achieve the goal by 2010. The remaining provinces and territories are, for funding and capacity reasons, lagging. Despite this progress, clinician adoption and change management are key success factors in these implementations. Funding for connectivity for physicians' offices remains a challenge, but one that Infoway will continue to work on with the jurisdictions.

The Primary Health Care Transition Fund, what next?

The Primary Health Care Transition Fund, which earmarked \$800 million in project funding over six years, was well received by jurisdictions across the

country. They reported it helped support the creation of primary health care teams. That fund has now ended, and an evaluation on it is expected to be released in the winter of 2007. It will be instructive to learn how many pilot projects succeeded in providing sustainable solutions. It is not clear whether the momentum to create more team practice across the country will continue without the fund.

Best Practices Network's potential untapped

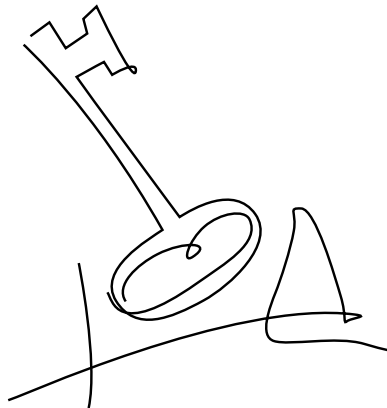
The 2004 health accord committed to developing a best practices network on primary health care. This network got underway in late 2005 and sponsored events across the country to share information. A November 2005 event in Winnipeg highlighted "provider participation

and collaboration." A February 2006 meeting in Newfoundland and Labrador looked at "interdisciplinary approaches to care" and a June 2006 event focused on "responding to community needs." The network has huge potential to help spread innovations across the country, but its existence is not well known. Some provinces and territories reported that they have been sharing best practices within their own jurisdictions, but clearly the network needs to build awareness

and generate excitement about its possibilities within and among provinces and territories.

Chronic disease management: Canadian record comparatively poor

Emphasis on the management of chronic conditions is emerging worldwide. Chronic diseases such as diabetes, heart disease, cancer and chronic respiratory disease are responsible for 60 per cent of deaths worldwide,⁶ and are the leading causes of death, disability and poor quality of life. In 2005, just over 30 per cent of Canadians aged 12 and older reported having at least one of a selected group of chronic health conditions.⁷ Those with chronic health conditions and especially those with multiple co-existing conditions are heavy users of the health care system and the cost implications of their care are significant.



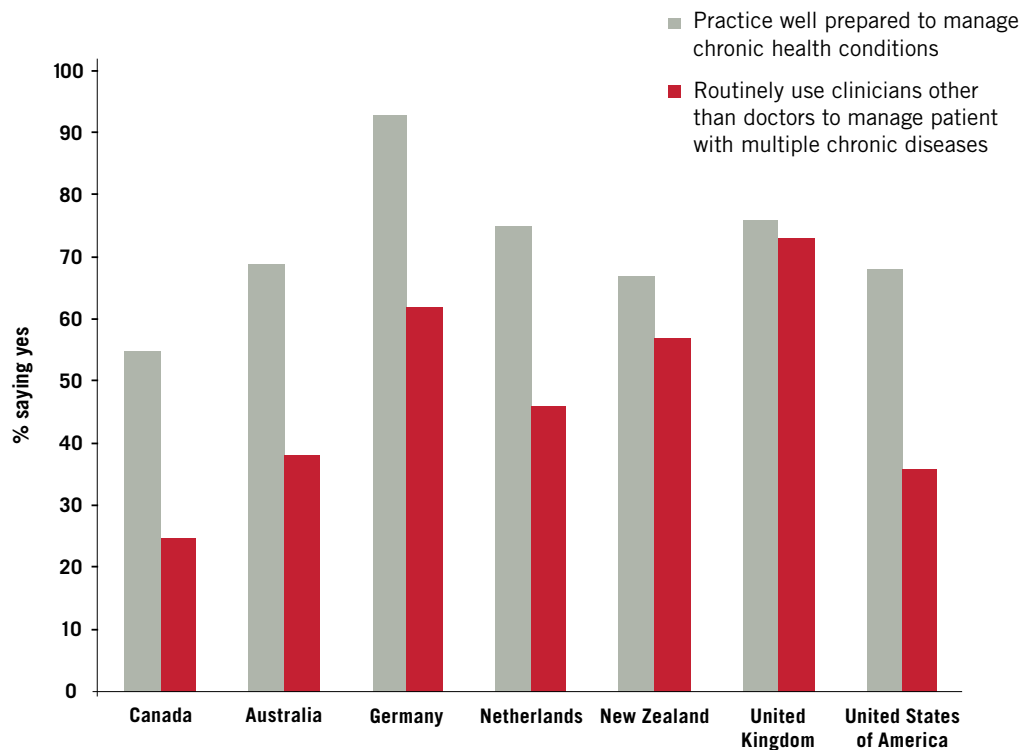
Our current approach to managing and controlling chronic health conditions is based on a single-disease management approach. It is piecemeal and out of date. This is particularly evident when patients with chronic conditions develop multiple chronic problems and they experience fragmented care, which by its very nature is of poor quality.

There is little evidence that our primary health care system is sufficiently prepared to manage the predicted

increases in chronic illness. Canadian primary care physicians lag behind their counterparts in other countries in how prepared they feel their practice is to provide optimal care for patients with multiple chronic diseases. According to the Commonwealth Fund study, only 55 per cent of Canadian primary care physicians indicated that they were well prepared to provide optimal care for patients with multiple chronic diseases compared to 93 per cent in Germany and 67 per cent in New Zealand.²

Figure 1. Do physicians feel prepared to manage chronic illness optimally?

The Commonwealth Fund recently asked physicians in 7 countries about the delivery of primary health care in their countries. Included were questions about managing patients with multiple chronic health conditions. Canadian physicians were the least likely to report feeling well prepared to optimally manage patients with multiple chronic health conditions compared to all other countries surveyed. The same was true for their use of non-physician clinicians to help with these patients.



Source: Schoen C, Osborn R, Trang Huynh P et al. (2006 Nov 2). On the front lines of care: Primary care doctors' office systems, experiences, and views in seven countries. *Health Affairs*; Web Exclusive: w555–w571.



Collaborating for change in primary health care

Changing health care requires a collaborative effort, and that fact is underscored by Canadian health care providers' growing participation in innovative entities called *collaboratives*.

A collaborative is a process that accelerates change in primary health care to make it more responsive to the needs of patients with chronic health conditions. Patients get the care they need more quickly because collaboratives encourage a shift to team-based care. And health improves because patients get more time, and more quality time, with health care providers who help them learn how to manage their chronic health conditions.

British Columbia was the first province in the country to adopt the collaborative way of improving quality of care, and several provinces have followed suit. Beginning in 2003, collaboratives in BC first tackled congestive heart failure; there are now 11 collaboratives, all engaged in diabetes care. Collaboratives have proven to be a positive experience for providers and patients alike.

In a collaborative, teams of health care providers receive external support from a regional or provincial health authority to improve the quality of care for their patients. Participating health care providers get access to learning opportunities to help them set goals to improve care (such as the percentage of patients with diabetes who have good control over their blood sugar and heart health). They also get access to a series of electronic tools that trigger the recommended steps in care and allow them to monitor their progress towards their goals. Financial incentives for health care providers and organizations may also be part of the process – particularly to stimulate greater involvement of nurses, pharmacists, dietitians, and other non-physician team members.

For example, at the Clearbrook Family Practice Group in Abbotsford, BC (in the Fraser Health Authority), patients with heart disease or diabetes are referred to a nurse practitioner on the team, Janet Baillies, when their check-ups show that their cholesterol level is high. The nurse practitioner provides support for self-care and prevention, part of the redesign of this family practice that followed from participation in the regional collaborative on chronic disease management. “The most rewarding thing about what I do with these patients is coach them to make lifestyle changes for the better,” Baillies says. “I really like seeing people taking control of themselves.”

In a March 2007 report on health outcomes, the Health Council will profile the work of chronic disease collaboratives in Saskatchewan, Newfoundland and Labrador, as well as British Columbia.

For more information on collaboratives in BC, see: www.heartbc.ca/pro/cdm.htm and www.healthservices.gov.bc.ca/cdm.



There is a clear need for better integration of information and services to support chronic disease management across primary health care teams, pharmacies, specialists and hospitals. Considerable evidence shows that the involvement of interprofessional teams in primary health care can produce better patient outcomes with better quality services to people suffering from chronic disease.⁸

The Health Council has gathered evidence on the role that health care system renewal can play in improving care for people with chronic conditions, and that evidence will inform the Council's first report on health outcomes, to be released in early March 2007.

Being more accountable to Canadians on primary health care reform

Tracking progress in achieving primary health care goals continues to be a challenge. Information is being reported, but it is unclear how the teams or the care they provide are being measured. There is conflicting information on the actual numbers of interprofessional teams being established, the number and type of professionals on the teams within each jurisdiction, as well as the number and types of patients enrolled or registered in these new models of care.

Jurisdictions report on their activities, but it is difficult to evaluate them without appropriate indicators, common definitions or parameters for measurement, and the data to support those indicators. Health Canada has made a significant investment through CIHI to develop primary health care indicators. There are 105 indicators, but pan-Canadian data are not available for the majority of these indicators. If Canadians are to see the results of all the investments and activities to achieve primary health care renewal in Canada, an improved data collection infrastructure is crucial.

Promoting interprofessional education to improve access and quality

In 2003, part of an \$85 million fund established for health human resources (HHR) was set aside for interprofessional education in collaborative patient-centred care.

Its goal is for a wide range of health care professionals to train together, learning to share in problem-solving and decision-making while developing a mutual understanding of and respect for the contributions of all disciplines on the team. Interprofessional education should take place before and after entry to practice, at the undergraduate, graduate and continuing education levels, and across the continuum of care.



The Health Council has devoted much time and attention to this issue. Following the proceedings of a national HHR summit that we organized in June 2005, we released a report which included a focus and recommendations on interprofessional education. And in our first annual report to Canadians, we highlighted a number of interprofessional education projects. We are pleased to report that an additional nine projects to promote interprofessional education and training were funded in 2006.

Select projects promoting interprofessional education:

- *An Innovative National Distance Education Initiative for Interprofessional Practice in Psychosocial Oncology:* Capital Health District Authority in Nova Scotia is using blended learning strategies for graduate students to develop a distance course in interprofessional psychosocial oncology and establish a Canadian network of psychosocial oncology educators and researchers.
- *Education Projet ECIP: Éducation à la collaboration interprofessionnelle centrée sur le patient:* Université de Montréal is creating model environments for training and practice in collaborative patient-centred care for patients affected by chronic diseases.
- *A University of Manitoba Initiative, IECPCP:* The University of Manitoba is establishing interprofessional groups of faculty and students who value, understand, practice and promote collaborative patient-centred practices, with a focus on involving practice sites in northern and remote communities, particularly those with Inuit and Aboriginal populations as well as under-served populations in Winnipeg.
- *Creating Interprofessional Collaborative Teams for Comprehensive Mental Health Services:* The University of Western Ontario is facilitating interprofessional collaborative mental health care in both education and practice settings, while augmenting the work toward provincial priorities such as mental health care reform, care of the homeless, and development of local health integration networks.

This is good news, but it is still too early to tell if the strategies and investments are sufficient to promote collaborative practice. Are those taking interprofessional training actually ending up practising differently as members of interprofessional teams? We need information systems to monitor and guide the success of these initiatives.



What we advise

- Governments should continue to support data collection and report publicly on agreed-upon standard indicators for measuring the outcomes of primary health care reform, the numbers of patients enrolled, and the development and expansion of primary health care teams.
- Implementation of the electronic patient record must be accelerated to cover 100 per cent of Canadians by 2010.

Health Human Resources

What governments promised

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to collaborative strategies to strengthen the evidence base for national planning, to promote interprofessional education, to improve recruitment and retention, and to ensure the supply of needed health providers.

The 2004 *First Ministers' 10-Year Plan to Strengthen Health Care* committed governments to increase the supply of health professionals based on an assessment of the gaps, including targets for the training, recruitment and retention of professionals by December 31, 2005. All governments committed to making their plans public and regularly report on progress. At that time, the federal government agreed:

- to expand the assessment of internationally trained graduates;
- to target efforts in Aboriginal communities;
- to reduce the financial burden on students; and
- to participate in health human resources planning with interested governments.

What we know/what we don't know

Since its inception, the Health Council of Canada has said that without appropriate health human resources, all other health care renewal efforts will fail. But it will take more than an increase in numbers of health care professionals; we also need to change the way we plan for, educate, train and deploy those professionals.

In his study of Canadian perceptions of the health care system, Professor Stuart Soroka points to an Ipsos Reid study that reflects the public's belief that over the last couple of years health care



providers and their efforts to adopt innovative and efficient practices have contributed the most, over and above all other factors, to the sustainability of the system.⁹

Council highlights the following activities in HHR over the past year:

Increased investment in training, recruitment and retention

Jurisdictions with the capacity to train nurses and physicians have increased enrolment. For example:

- New Brunswick last year welcomed its first 24 students to a decentralized “programme de formation médicale” at the Moncton campus of the Université de Sherbrooke;
- BC has doubled medical school enrolment in the last three years;
- Ontario increased medical school enrolment by 23 per cent and opened a northern medical school;
- Ontario expanded the number of nurse practitioner seats to 150; and
- New Brunswick announced 95 new nursing seats in September 2005.

All jurisdictions have also initiated new recruitment and retention strategies targeted primarily at physicians and nurses. For example:

- New Brunswick increased the number of billing numbers available to physicians and announced bursaries and income tax incentives.
- Saskatchewan increased investments directed to clinical placements, central recruitment and a repatriation program.



Increasing Aboriginal access to careers in health care

With one of the highest and fastest growing Aboriginal populations of any province (currently 13.5 per cent and estimated to rise to 33 per cent by 2045),^a Saskatchewan has established a goal of creating a more representative health care workforce.^b

But a number of common barriers confront Aboriginal young people considering post-secondary education. They often have gaps in their education stemming from inadequate preparation in primary grades and high school. They have few professional role models, and they may face the added strain of being away from home and off reserve for the first time.

That's where initiatives like the Northern Health Sciences Access Program (NHSAP) come in. Five years ago, the Saskatchewan-based First Nations University of Canada and the University of Saskatchewan collaborated to create this ground-breaking program that prepares Aboriginal students for post-secondary education in health sciences. In 10 months, students can be ready to apply to the Nursing Education Program of Saskatchewan or the National School of Dental Therapy at the Prince Albert Campus of First Nations University. The University of Saskatchewan grants the final degree.

In May 2006, Valerie McLeod became the first NHSAP graduate to earn a nursing degree from the University of Saskatchewan. "The NHSAP program gave me the grounding I needed in math and sciences after being out of school for four years," McLeod said of the support she received. In addition to studying biology, chemistry, math and English, students learn medical language, anatomy, physiology, first aid and CPR. "After my first year, only 20 of 40 nursing students were still there – some failed and others dropped out." Today, Valerie works as an RN on the surgical floor of Prince Albert's Victoria Hospital, and six other graduates of that first NHSAP class are on their way to completing their nursing degrees.

While other university programs across Canada offer special programs for Aboriginal students, First Nations University is unique in providing a completely culturally supportive environment that emphasizes, among other things, the role of elders and the spiritual power of knowledge. NHSAP employs a range of strategies to enrich learning and help students meet the challenges of higher education. A resident elder provides cultural teaching, spiritual guidance, and a link with traditions. Academic advisors and personal counselors work closely with each student to keep them on the path to success.

"We have noticed better academic performance and, for sure, greater self-confidence among those students who went through the NHSAP," says Jackie Nixon, one of five counselor/advisors at the Prince Albert campus. "I keep my door open as do my colleagues in the Student Success Services Department. It is important for students, especially those who live far north of Prince Albert, to know we are there. Often, all a student wants is someone to listen."

For more information about the Northern Health Sciences Access Program, see: www.firstnationsuniversity.ca.

^a Saskatchewan Department of First Nations and Métis Relations. (2004). *Saskatchewan First Nations and Métis Demographic Data*. [web page]. www.fnmr.gov.sk.ca/html/demographics/index.htm.

^b Saskatchewan Health. (2005 Dec). *Working Together: Saskatchewan's Health Workforce Action Plan*. www.health.gov.sk.ca/hplan_intro.html.



- Ontario introduced a late-career initiative offering incentives to retain nurses nearing retirement. Ontario also announced that in 2007, it will guarantee every nursing graduate in Ontario a full-time job as part of a new human resources strategy, HealthForceOntario.
- Yukon has announced that \$127 million of the \$21.6 million received through the Territorial Health Access Fund will go towards the development and implementation of an HHR strategy. Yukon is offering health education bursaries for students in nursing, medicine and other health professions. Recruitment initiatives are underway through family physician incentive and nurse mentorship programs, and professional legislation issues are being addressed, beginning with the regulation of nurse practitioners.

Better planning to meet future needs for health care professionals

There have been increased efforts recently to develop more and better data to inform policy and planning decisions in human resources. Much of the data are on physicians and nurses, with little on other health care professions integral to interprofessional teams.

To address this issue, the Canadian Institute of Health Information (CIHI) is developing five new health human resources databases on five health professions: occupational therapists, pharmacists, physiotherapists, medical laboratory technologists and medical radiation technologists. The data on pharmacists and occupational therapists will be available in December 2007; data collection for physiotherapists is expected to begin in the fall of 2007; work related to databases for medical laboratory technologists and medical radiation technologists was launched in the fall of 2006. Ontario has completed the first phase of an allied HHR database project. In addition, Statistics Canada is beginning work on a survey to identify institutional capacity in training schools.

Findings of the 2005 National Survey of the Work and Health of Nurses, a collaborative effort involving CIHI, Health Canada, and Statistics Canada, were released in December 2006. This survey provides a huge pool of data and a baseline from which to measure future workplace health issues for registered nurses.

Strengthening collaboration for better planning nationally

In 2004, all governments committed to increase the supply of health professionals based on their assessment of gaps. They committed to develop workforce planning action plans (including targets for the training, recruitment and retention of professionals) by December 31, 2005.

By mid-January of 2006, all but a handful of jurisdictions – British Columbia, Alberta, and the Yukon¹⁰ – had submitted separate reports. Many of the plans lack detail. Only four include population health needs; some don't have targets; and only four link their targets to the Pan-Canadian HHR Planning Framework.

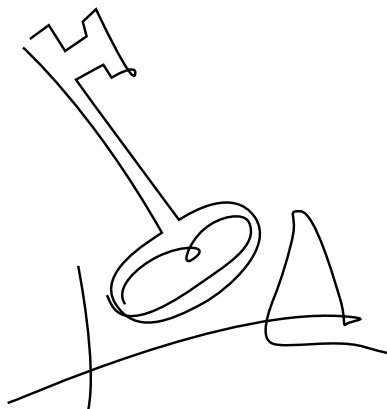
While we still have no national HHR strategy clearly linked to future delivery models, the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources has developed its Pan-Canadian Human Resources Planning Framework and conducted a follow-up consultation with provider groups.

The framework includes many items previously proposed by the Health Council. It sets out a common vision, goals and objectives, linking them to desired outcomes. Now that we

have a national HHR planning framework, we need a national coordinating mechanism that includes input from professional organizations, health care providers, regulatory bodies, unions, and employers, as well as governments.

There is, however, an increase in collaborative HHR planning at the regional level through the Atlantic Health Human Resource Association and the Western Health Human Resource Planning Forum. Some jurisdictions have also begun to work collaboratively with providers. For example, with funding from the federal government, Prince Edward Island has created a Health Sector Council which brings all health care stakeholders to the planning table. These are positive steps.

Up-to-date information on the national health human resource strategy is available from Health Canada at www.hc-sc.gc.ca/hcs-sss/hhr-rhs/strateg/index_e.html.



Moving past interprovincial competition for health human resources

Strong interprovincial competition for the existing supply of health human resources remains a reality, and sometimes a troubling reality, in Canada. Jurisdictions each do their own planning for recruitment and retention with no efforts to coordinate strategies. Headlines herald how some jurisdictions have an easier time attracting health care professionals than others. “Doctors heed the call of the West; Specialists lured by opportunities”¹¹ and statistics back up that headline. According to CIHI, in 2005, only BC and Alberta gained doctors through interprovincial migration. BC showed the highest gains with 117 doctors moving there. Saskatchewan, Newfoundland and Labrador, and Manitoba were hardest hit, with net losses of 37, 24 and 22 physicians respectively. This jurisdictional competition for talent only aggravates the supply and distribution issues facing all areas of the country.

Internationally educated health care professionals

In 2005, the federal government agreed to \$75 million in funding over five years to help internationally educated health care professionals qualify to work in Canada. Some provinces, like Ontario, have capitalized on this funding to improve their system for integrating these professionals by more than doubling the number of training and assessment positions for international medical graduates – from 90 to 200.



At the 2005 summit on health human resources, the Council called for a national approach to managing international graduates. Through the Medical Council of Canada, a permanent subcommittee called the National Assessment Consortium has been established to centralize and standardize the assessment process. The consortium has consulted program directors of international medical graduate programs in each jurisdiction and is now developing a set of competencies and assessment tools that will be in place by 2008.

New roles, new scopes introduced

To address shortages in areas of high need, Ontario has developed four new professional roles: physician assistant, nurse endoscopist, surgical first assist, and clinical specialist radiation therapist (see p. 28). The Council will monitor the province's recruitment efforts to see if they meet intended outcomes.

Alberta has introduced new regulations that give Alberta pharmacists the broadest scope of practice in Canada. Effective in 2007, Alberta pharmacists will be able to prescribe many specified drugs, administer some injections, and assess patients and prescribe without necessarily obtaining physician authorization.

Provinces have not only agreed to a standardized and centralized process for reviewing changes to entry-to-practice credentials, they have begun to use it. In 2006, the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources established the Pan-Canadian Coordinating Committee, a subcommittee that will centralize the process for reviewing requests for changes to entry-to-practice credentials. Professions proposing a change are now required to prepare a detailed submission for the committee providing a strong rationale for changes.

New health professions in Ontario

Physician assistant: Assists supervising physicians to deliver medical services, such as conducting patient interviews, histories, and physical examinations; performing selected diagnostic and therapeutic interventions; ordering and interpreting patient laboratory and radiological results; and counselling patients on preventive health care.

Nurse endoscopist: A registered nurse with extended specialized education (in anatomy, physiology and pathophysiology) who works with a physician to perform flexible sigmoidoscopies (diagnostic procedure used to screen for abnormalities in the lower third of the colon).

Surgical first assist: Works with the surgeon and the rest of the operating room team to ensure the safe outcome for a surgical patient before, during and after surgery. A registered nurse can perform this role with an additional certification in surgical assistance.

Clinical specialist radiation therapist: Medical radiation technologists (radiation therapists) with additional training to provide more specialized care. They will work with the radiation oncologists, nurses and medical physicists to ensure safe and optimal patient outcomes.

Source: HealthForceOntario, www.healthforceontario.ca



What we advise

- Promote coordinated national/provincial/territorial strategies on health human resources, with specific targets based on the health care needs of their populations, and create a national coordinating mechanism.
- Develop appropriate measurement tools so that Canadians can evaluate whether investments in health human resources are resulting in improved patient access, better coordination of care, and improved outcomes.

Home Care

What governments promised

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to determine, by September 30, 2003, the minimum “basket of services” to be provided in homes and communities. First Ministers agreed to provide first-dollar coverage for short-term acute home care, including community mental health and end-of-life care. First Ministers also agreed that access to these services be based on an assessment of need and that they be available by 2006. First-dollar coverage means that once the threshold of assessed need has been met, the recipient pays nothing out of pocket for the two-week basket of services.

The Government of Canada agreed to establish compassionate care benefits and job protection for Canadians who need to leave their jobs temporarily to care for a gravely ill or dying child, parent or spouse.

The 2004 10-year plan added the following specifics on the types of services to be covered, based on assessed need:

- short-term acute home care for two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care;



- short-term acute community mental health home care for two-week provision of case management and crisis response services; and
- end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life.

Health ministers agreed to explore the next steps to fulfilling the home care commitment – including plans for staged implementation and annual reporting to their citizens – and to report to First Ministers by December 31, 2006.

What we know/what we don't know

Jurisdictions to report December 31, 2006 on home care services

As January 17, 2007, it was not known if, or how fully, health ministers reported to First Ministers on goals related to the December 31 deadline. When the information becomes available, the Health Council will analyze it and issue an update.

All jurisdictions, with the exception of Prince Edward Island, have reported that they have met the commitment to provide first dollar coverage for short-term (two weeks) acute home care services, community mental health services and end-of-life care.

To read the Health Council's previous analyses on home care, read the 2006 annual report to Canadians or the 2005 background paper at www.healthcouncilcanada.ca.

Eligibility for compassionate care benefits broadened

In 2004, the Government of Canada created the Compassionate Care Benefits program through its Employment Insurance program and complementary job protection through the *Canada Labour Code*. The program alleviates the loss of income and employment insecurity for family members – recently expanded to include close friends – who provide home care to loved ones in the last stages of life.



Bringing care home in New Brunswick

Most organizations take great pride in recalling the day their doors officially opened. While the New Brunswick Extra-Mural Program (EMP) – the hospital without walls – has no doors to speak of, it can celebrate a 25-year commitment to providing home care services across the province.

Anticipating the pressures that an aging population would place on hospital services, the New Brunswick Department of Health established the Extra-Mural Program to provide an alternative to hospital admissions and facilitate early discharge from hospital. The program accepted its first patient in 1981 and by 1993, the EMP covered every area in New Brunswick under the administration of regional health authorities.

Today, the EMP is a province-wide strategy providing a wide range of in-home services: acute care, care for chronic health conditions and, most recently, palliative care. At the core of this program is a comprehensive interprofessional team including physicians, nurses, dietitians, respiratory therapists, occupational therapists, physiotherapists, speech-language pathologists and social workers.

Each health authority delivers services according to local needs, while the province funds the program and sets provincial policies and standards for care. The program accounts for just three per cent of New Brunswick's total health care budget and serves tens of thousands of clients across the life span each year. (19,000 clients – 42 per cent of them younger than 65 years old – were discharged from EMP services in 2005/2006.)^a

Highlights of EMP's growth reflect changes in health care delivery over the last quarter century:

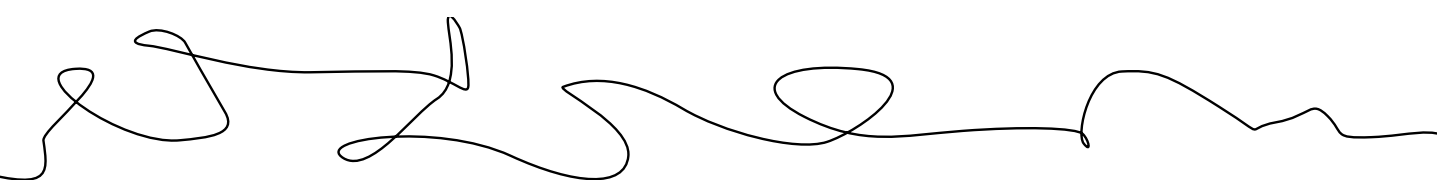
- 1991: EMP partners with Family and Community Services to provide a single point of entry to individuals over 65; later expands to include adults with disabilities;
- 1997: EMP expands to include community rehabilitation services; and
- 2005: EMP implements telehealth to provide remote monitoring to patients with chronic diseases; enhances acute and palliative home care services with 28 new nurses, three social workers and a respiratory therapist.

What underlies EMP's success? A recent internal report on the program^a pointed to these factors among others, as multi-faceted as the services EMP provides: designing a comprehensive home care system to meet future needs; recognizing that community care can fill gaps in health care services; ensuring that all stakeholders are committed to caring for people at home; adopting new technology to help people monitor their health at home; and responding to consumer demand for services such as in-home palliative care.

EMP has matured to become an established component of New Brunswick's health care system, but remains flexible enough to embrace change in anticipation of future health care needs.

For more information on the New Brunswick Extra-Mural Program, see: www.gnb.ca/0051/0384/index-e.asp

^aHansen C. (2006 Jul). *Healthcare Without Walls: The New Brunswick Extra-Mural Program*. New Brunswick Health Department



Alberta and the Northwest Territories remain the only jurisdictions that have not yet amended local regulations to provide job protection for workers using the Compassionate Care Benefit. Across the 11 jurisdictions that have written job protection for compassionate leave into their regulations, definitions of eligible caregivers continue to vary.

In December 2005, the Council released a background paper, *Compassionate Care Benefit: Analysis and Evaluation*, which examined why so few Canadians had taken advantage of the program during its first two years. We recommended that the federal government broaden the definition of family member for purposes of the program. In June 2006 the federal government enacted legislation to expand the eligibility to include a wider range of family members and close friends.

In October 2006, Ontario introduced legislation to amend the province's *Employment Standards Act* to provide job protection for the wider range of people eligible to use the federal Compassionate Care Benefit. The

Ontario provision defines family member broadly and includes close friends as eligible caregivers, in line with revisions made to federal legislation in June 2006.

New home care reporting system developed

The capacity to measure the status of home care services is improving. CIHI has worked with several jurisdictions to establish a Home Care Reporting System to collect information about people receiving home care in Canada. CIHI is creating a database to which five regions in BC will submit home care data as of early 2007. These data will provide demographic (e.g. age and gender) and service information (e.g. the type and length of services accessed) on all home care clients. For long-term clients, it will capture such things as people's capacity to maintain activities of daily living or adverse events (e.g. falls). Alberta and Yukon will come on board later in 2007. Saskatchewan, Manitoba, Ontario and Nova Scotia are in discussions with CIHI regarding participation.



What we advise

- Ensure that provincial/territorial legislation aligns with new federal government definitions of broadened eligibility for the Compassionate Care Benefits program.

Pharmaceuticals Management

What governments promised

The 2003 *First Ministers' Accord on Health Care Renewal* committed governments to ensure that Canadians, wherever they live, have reasonable access to coverage for catastrophic drug costs by the end of 2005/06. The First Ministers agreed that one of their priorities would be to collaborate to promote optimal drug use and best practices in drug prescribing. They also pledged to better manage the costs of all drugs, including generic drugs, and to ensure that drugs are safe, effective and accessible in a timely and cost-effective fashion.

The 2004 *10-Year Plan to Strengthen Health Care* directed health ministers to establish a task force to develop and implement a national pharmaceuticals strategy and report on progress by June 30, 2006. The strategy was to include: cost options for catastrophic drug coverage, a national formulary for participating jurisdictions, faster access for breakthrough drugs, better monitoring for safety and effectiveness, purchasing strategies, action to influence prescribing behaviour, action to support electronic prescribing, and an analysis of cost drivers and cost-effectiveness in drug plan policies.

In October 2005, health ministers met and reaffirmed their commitment to a national pharmaceuticals strategy. At that time, they asked their officials to:

- accelerate the work on catastrophic drug coverage and undertake research on expensive drugs for two rare diseases – Fabry's disease and MPS1-Hurler Schie syndrome;
- expand the scope of the Common Drug Review (the national committee that recommends whether drugs should be funded) to consider all drugs, not just the new ones considered after the CDR began its work;

- work towards a common national formulary (a listing of drugs that are approved as benefits under the various public drug insurance plans);
- give the Patented Medicine Prices Review Board responsibility to monitor and report on non-patented drug prices; and
- collect, integrate and disseminate information on the real-world risks and benefits of drugs.

What we know /what we don't know

Pharmaceuticals are the second-largest cost centre in health care. Second only to hospital costs, retail sales of prescription and non-prescription drugs are the largest and fastest growing sectors in the system, growing at six per cent a year.¹ Except for drugs prescribed in hospitals, publicly funded coverage for medication is not mandated by the *Canada Health Act*. This has resulted in a patchwork of public drug plans across the country, leaving millions of Canadians with little or no protection against catastrophic drug costs. Some 3.5 million Canadians remain today without any or adequate coverage for catastrophic costs for drugs, 600,000 of them in Atlantic Canada.¹² This reality does not match the expectations of Canadians.



In a 2005 Pollara study, 84 per cent of respondents agreed that "governments should ensure that there is a maximum limit to how much individuals should have to pay personally for drug costs."¹³

In addition, there has been little collaborative effort to promote improvements in appropriate prescribing or to move substantively towards the goal of a common national formulary.

Work on catastrophic drug coverage disappointing

Over the past five years, federal, provincial and territorial ministers have made a number of commitments to collaborate on policies that will ensure Canadians have access to affordable and required drug therapies. Their work to date on a national pharmaceuticals strategy includes the commitment that all Canadians have access to protection against catastrophic drug costs. Catastrophic drug coverage aims to ensure that all Canadians have access to necessary drug therapies and that no individual Canadian suffers undue financial hardship from catastrophic costs associated with those therapies.

However, progress on implementing a plan to provide coverage for catastrophic drug costs for all Canadians has been disappointing. There is little of substantive progress to report. Yet in 2004, 40 per cent of Canadians



polled indicated that catastrophic drug coverage would make a significant difference in efforts to improve the quality of health care.¹⁴ The Council continues to support the principles underpinning catastrophic drug coverage and expresses great disappointment with the lack of progress in providing Canadians, wherever they live, with protection against unbearable costs.

While we were encouraged to see costing options in the release of the First Ministers' progress report in September 2006, there has been no action on implementation. We encourage all governments – federal, provincial and territorial – to work out the funding details so that implementing adequate support can proceed. An implementation plan should be an immediate priority and a timeline should be communicated to Canadians as soon as possible.

Ad hoc approach to improve access to expensive drugs for rare diseases

Jurisdictions across Canada are under increasing pressure to provide exceedingly expensive, and sometimes unproven or inadequately tested, drug therapies to the few who present with rare diseases. This poses difficult questions for the public system about quality, ethics and funding.

Work on a national framework to help individual provinces and territories deal with these issues has been slow. The challenge is to avoid institutionalizing a patchwork of drug delivery across the country, which would only hinder efforts at pharmaceutical reform.

In 2005, the First Ministers agreed to fund drugs for two rare diseases – Fabry's disease and MPS1-Hurler Schie syndrome. Meanwhile, governments and two pharmaceutical companies have begun a three-year study to investigate the challenges of assessing the effectiveness of drugs for rare diseases, using treatment for Fabry's disease as an example.

Common Drug Review well received

The Common Drug Review, introduced in 2003, represents a major step forward in interjurisdictional cooperation. The evidence-based drug review process provides consistent information to all the jurisdictions while enabling individual drug benefit programs to make independent decisions about which drugs they will cover.

One of the benefits of the centralized approach of the Common Drug Review is that jurisdictions have been able to save money through administrative efficiencies and increase interjurisdictional alignment of drug benefits. The Common Drug Review has been



well-received by the provinces and territories who have all agreed to its staged expansion, starting with new uses for existing drugs. A business plan for a common review of cancer drugs is to be prepared by March 2007.

Progress on a common national formulary tentative

Progress toward a common formulary remains tentative. With each province and territory managing its own drug plan, there are considerable inconsistencies and inequities in drug coverage across the country. For example, an analysis undertaken by the National Prescription Drug Utilization Information System showed that 90 per cent of all drug plan reimbursement occurs within a set of core drugs, but only 55 to 60 per cent of the drugs are common across jurisdictions. This has implications for anyone with a chronic disease drug regimen who wishes to move within Canada and be eligible for the same drug plan coverage in the new jurisdiction.

NPS focus on prescribing behaviours deferred

The 2004 10-year plan committed governments to develop and implement a national pharmaceuticals strategy. The strategy was to contain nine elements including one to “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.”

Subsequently, governments agreed to focus on five areas of the original nine; influencing prescribing behaviours was not one of the top priorities. Given this, the Council will sponsor a pharmaceuticals management symposium, scheduled for June 2007, focusing on initiatives to modify and improve prescribing behaviours and providing further evidence-based information and policy options for discussion.

Drug information systems underway

Most jurisdictions have moved ahead with implementing drug information systems, a critical building block for the patient electronic medical record. A drug information system, such as BC's PharmaNet, is a secure computer

network that links all pharmacies in an area to a central set of data systems that provide quick access to the most up-to-date information on drug safety and interactions as well as patients' medication histories.

Drug information systems provide a platform for e-prescribing, allowing prescriptions to be sent, viewed and confirmed electronically by the pharmacist. In 2006, there was a rapid increase in planning and implementation projects with most of the provinces jumping on board (Figure 2). \$185 million is being spent to build provincial systems. Canada Health Infoway's support of these projects has been instrumental to success.

Ban on direct-to-consumer advertising challenged

Last year, the Council commissioned a paper, *Direct-to-Consumer Advertising of Prescription Drugs in Canada. What Are the Public Health Implications?*, that concluded there was no evidence of public interest or health benefit to support relaxing the *Food and Drug Act* restrictions on drug advertising. The paper found no evidence to show drug advertising improves health, provides better compliance in taking medications, leads to more appropriate early diagnosis of under-treated conditions, or prevents hospitalization. What it did find was that increased drug advertising can lead to increased prescribing and increased costs to the health care system which is already under pressure from soaring drug costs.

Since then, CanWest Mediaworks has mounted a Charter challenge to the statutory prohibition on direct-to-consumer advertising of prescription drugs, which is expected to be heard in court in 2007. All reporting jurisdictions indicate that they support a ban on direct-to-consumer drug advertising.

Figure 2. E-prescribing Development Projects

Jurisdiction	Project Name*
National (Canada Health Infoway)	Deployment Plan for Multiple Jurisdictions
	Drug Information Program Investment Strategy Development
	Drug Information Solution Toolkit
	Drug Information System Business Case
	Pan Canadian Drug Messaging Standards
	Pan Canadian ePrescribing Transmission Requirements Standard
British Columbia	Drug Expansion Strategy
Alberta	Pharmacy Information Network Implementation
Saskatchewan	Pharmacy Information Program
Ontario	Drug Profile Viewer
Quebec	Drug Information System
Newfoundland and Labrador	Drug Information System
Prince Edward Island	Drug Information System
Yukon	Drug Information System

**As of the end of March 2006*

What we advise

- We encourage governments to proceed quickly on meeting their commitment to provide all Canadians with access to catastrophic drug coverage. A timeline for implementation should be established and communicated, and work should begin immediately on an implementation plan.
- Canadians should be informed of the potential cost of pan-Canadian catastrophic drug coverage, and all governments, including the federal government, should indicate how they will contribute to ensuring that all Canadians, regardless of where they live, have access to similar levels of protection from catastrophic drug costs.
- The federal government should strengthen legislation to ban all forms of direct-to-consumer advertising of prescription drugs in Canada. Legislation should clearly prohibit help-seeking and reminder ads.

Wait Times

What governments promised

In response to strong public concern about wait times, the First Ministers made five specific commitments to Canadians in their *10-Year Plan to Strengthen Health Care*:

- First Ministers committed to providing, by the end of December 2005, evidence-based benchmarks for wait times in five priority areas – cancer care, cardiac surgery, diagnostic imaging, joint replacement and cataract surgery.
- They also agreed to develop comparable indicators of access to health care professionals and diagnostic and treatment procedures by the end of 2005.
- The provinces and territories made a commitment to set targets, by the end of 2007, to achieve the wait-time benchmarks.
- They agreed to report annually on their progress in meeting these targets.
- To assist the provinces and territories in their efforts in reducing wait times, the federal government established a \$5.5 billion Wait Times Reduction Fund allocated on a per capita basis.

What we know/what we don't know

The Wait Times Reduction Fund (Appendix Table 4) has helped jurisdictions to move forward quickly on wait times. As a result, and as noted in the *Final Report of the Federal Advisor on Wait Times*, there has been considerable activity across the country to build capacity and address wait-list backlogs.¹⁵ Investments have been made in equipment, human resources, training/education of professionals, technology and information systems.

The provinces and territories have reported progress on wait times. As committed to in the 2004 10-year plan, the provinces and territories announced in December 2005 the first set of evidence-based benchmarks for wait times on radiation therapy, hip and knee replacement, cardiac bypass surgery, cataract removal surgery, cervical cancer screening, and hip fracture surgery. (See Appendix Table 2)

Benchmarks for diagnostic imaging could not be established because there was not enough evidence upon which to build a definitive benchmark for CT scans or MRIs; more research is required. Ontario set its own. Comparable indicators of access to health care professionals and diagnostic and treatment procedures, also agreed to in the 2004 10-year plan, had not been reported by the December 2005 delivery date. These reports are still outstanding.

Public views on wait times

The highest priorities for Canadians are wait times and timely access to care, encompassing a wide range of health care services, from access to family doctors and primary health care, to emergency services, and surgical procedures.¹⁶

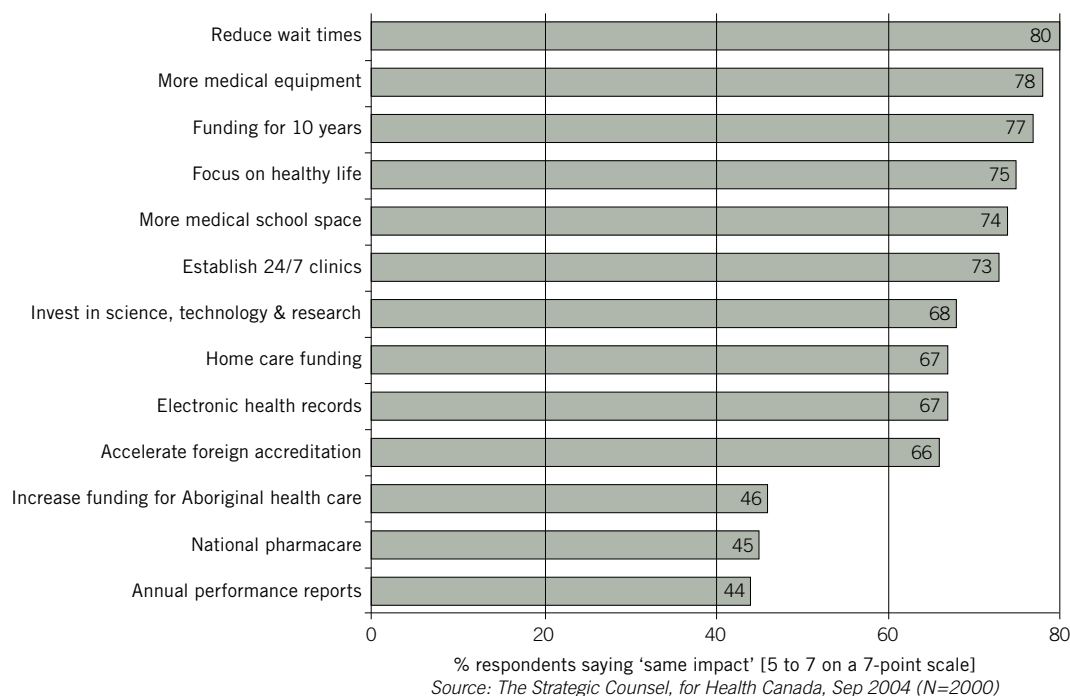


Governments' investments and visible actions on wait times have been broadly welcomed by Canadians who see wait times as a good measure of how well the health care system is performing, and whether it is, in fact, improving.¹⁷

In 2004, 80 per cent of Canadians who were polled rated wait-time reduction as having a significant impact on improving care in Canada (see Figure 3).¹⁸ Since 2003, there has been some improvement in perceptions of the health care system but little evidence of improvement in perceptions of wait times and the likelihood of improved wait times in the future.¹⁹ This is the case despite targeted investments to reduce waits, particularly with respect to the five targeted areas.

Figure 3. Policy Priorities, 2004 10-Year Plan to Strengthen Health Care

For each of the following elements included in the 10-Year Plan to Strengthen Health Care, please tell me to what extent you believe it will make a difference in improving the quality of health care



Have there been meaningful reductions in wait times in the five targeted areas?

While the health care agreements don't require reporting on achievements in wait time reductions until March 31, 2007, there are already signs of progress.

There has been a flurry of activity as jurisdictions tap into the \$5.5 billion Wait Times Reduction Fund. Innovative strategies are being fielded across the country. Some have focused on backlogs; some have adopted specialization strategies; others have proceeded with system redesigns that improve patient flows and better overall management.

CIHI released a report last March, *Waiting for Health Care in Canada: What We Know and What We Don't Know*, which provides a unique time-specific picture of waits for assessment and diagnosis, surgery and post-acute care. The report notes that while a lot more is known about wait times now than a year ago, we do not yet have a comprehensive, cross-Canada picture. The data do suggest, however, that nationally, wait times tend to be longest for knee replacements, followed by hip replacements and cataract surgery while typical waits for cardiac procedures tend to be shorter.

Figure 4. Reported Trends in Wait Times for Joint Replacement

The following table is a snapshot of wait times for hip/knee replacements across Canada as of December 2006. For a complete overview of wait times in the five targeted areas see Appendix Table 2.

Jurisdiction	Reported trend in wait times		Website
	Hip replacement surgery	Knee replacement surgery	
British Columbia	From 2001 to 2006 ~ median wait time decreased from 19.6 to 16.3 weeks.	From 2001 to 2006 ~ median wait time decreased from 25.3 to 19.9 weeks.	www.health.gov.bc.ca/cpa/mediasite/waitlist/median.html
Alberta	From Sept 2005 to Sept 2006 ~ 3-week decrease in median waits for hip replacement reported.	From Sept 2005 to Sept 2006 ~ 5-week decrease in median waits for knee replacement reported.	www.ahw.gov.ab.ca/waitlist/WaitListPublicHome.jsp
Saskatchewan	No trends reported. Website reports only current median times for orthopedic surgery. Median wait time was 6.3 weeks between Jan-June 2006. No reported reduction in wait time found for hip and knee replacement on website.		www.sasksurgery.ca/wait-list-info.htm
Manitoba	No trends reported. Median waits reported for current year only (2006); median ranges from 16-20 weeks depending on region. No reported reduction in wait time found for hip replacement on website.	No trends reported. Median waits reported for current year (2006) only; median ranges from 25-47 weeks depending on region. No reported reduction in wait time found for knee replacement on website.	www.gov.mb.ca/health/waitlist/surgical/index.html
*Ontario	90th percentile reported. Between 2005 and 2006 decrease in waits from 351 to 281 days.	90th percentile reported. Between 2005 and 2006 decrease in waits from 440 days to 353 days.	www.health.gov.on.ca/transformation/wait_times/wt_data/data_ontario.html#
Quebec	Website reports percent of those who received procedure within 6 months of waiting in 2004/2005. Percent varies by region/facility. For the Montreal region percents ranged from 0-30%. No reported reduction in wait time found for hip replacement on website.	Website reports percent of those who received procedure within 6 months of waiting in 2004/2005. Percent varies by region/facility. For the Montreal region percents ranged from 0-81%. No reported reduction in wait time found for knee replacement on website.	www.msss.gouv.qc.ca/en/
New Brunswick	Only 2004/05 data available - ~ 90% cases done within 6-9 months wait. No reported reduction in wait time found for hip replacement on website.	Only 2004/05 data available - ~ 90% cases done within 9-12 months wait. No reported reduction in wait time found for hip replacement on website.	www.gnb.ca/0217/NBSCN-RSCNB/wait-e.asp
Nova Scotia	Data from April to June 2006 reports 92% of cases done within 540 days. No reported reduction in wait time found for hip replacement on website.	Data from April to June 2006 reports 93% of cases done within 720 days. No reported reduction in wait time found for knee replacement on website.	www.gov.ns.ca/heal/waittimes/wt_treatment_service/default.htm
Prince Edward Island	None reported	None reported	No website
Newfoundland and Labrador	Website reports percent of cases completed within 182 days by quarter year. For the third quarter, the provincial range is from 87.5% in Eastern Health region to 94% in Central Health region of all cases completed in 182 days. This compares to provincial ranges of 92% in Western Health region to 100% in Central Health region of all cases completed in 182 days in the second quarter.	Website reports percent of cases completed within 182 days by quarter year. For the third quarter, provincial range is from 88.2% in Eastern Health region to 100% in Central Health region of all cases completed in 182 days, as compared to a range of 70% in Eastern Health region to 100% in Central Health region of all cases completed in 182 days in the second quarter.	www.releases.gov.nl.ca/releases/2006/health/0418n02.htm
Nunavut	None reported	None reported	No website
Northwest Territories	From July 2005 to September 2006 decrease in number of people waiting for hip/knee replacement from ~ 250 to ~100		www.srhb.org/cont_public/surgical_wait/index.html
Yukon	None reported	None reported	No website

*Only reports priority 4 or least urgent.

In some instances, we have seen real progress. Manitoba, for example, has turned around long wait times for radiation treatment for cancer patients. Five years ago, cancer patients waited six weeks for radiation therapy and the province was sending patients to the United States for treatment. Today, the wait time is one week. Manitoba did this by making system-wide changes, paying competitive wages to attract and retain employees, expanding training for radiation therapists, and purchasing new radiotherapy equipment (see www.gov.mb.ca/health/waitlist/report2006.pdf).

In November 2005, the Council released a paper, *10 Steps to a Common Framework for Reporting on Wait Times*. In it, we called for wait times to be measured from the patient's first presentation to his or her doctor with the problem. We called for the urgency of the patient's condition to be factored into the patient's placement on the wait list; and we called for in-patient and out-patient wait times to be separately measured and recorded. Given that the wait-time priority areas have focused on acute care, we assume that level of urgency is a factor, but it is unclear whether it is a consistent measure since not all publicly available information from the jurisdictions' websites reports wait times by urgency scores. Benchmark reporting might address this to some extent particularly in cardiac care where level of urgency has been explicitly defined.

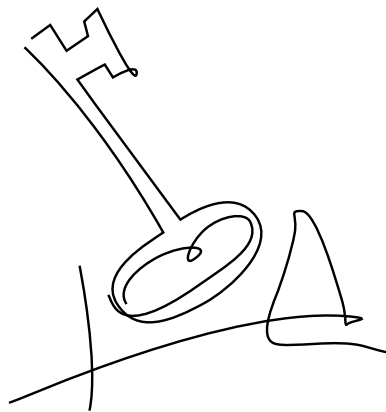
The Council will provide an update and analysis on the jurisdictions' reductions on wait times, following their March 31, 2007 reporting deadline.

Are we providing Canadians better access to wait-time information?

Since wait times are one of the most visible signs of how well the health care system is performing, communicating successes in reducing wait times is an important way to help rebuild public confidence in the system. The introduction of pan-Canadian wait-time benchmarks provides patients and their families with a guideline for how long they should have to wait for care in certain areas.

Many jurisdictions have created websites where patients can view wait times for a variety of procedures. Others, like Prince Edward Island and Newfoundland and Labrador, have not. In some cases, Saskatchewan and Nova Scotia being examples, wait-time data are publicly available for all surgical services. This strengthens accountability to the public and can also provide patients with valuable information on their own likely wait time for surgery or other priority procedures.

These websites are a good first step to providing patients access to more information on wait times and rebuilding confidence in the system. No doubt, jurisdictions will strive to improve the quality of the data on their sites and move closer to real-time reporting.



We encourage all jurisdictions to work to provide wait times specific to the hospital or facility where the procedure or surgery will occur. Eight jurisdictions currently provide regional level data and of those eight, three – British Columbia, Alberta and Quebec – also report waits at the facility or surgeon level. The Health Council also encourages provinces to include wait-time information at all facilities, even those not participating in the Wait Times Reduction Fund,

and over time to expand the reporting process to non-targeted procedures as well.

Here is a snapshot of efforts to provide patients with ample and accessible information on wait times:

- Ontario comes closest to real-time reporting.
- British Columbia, Alberta, Manitoba, Ontario and Nova Scotia report on all five targeted procedures.
- Nova Scotia's wait times website provides patients with a user-friendly, easy-to-navigate resource for relevant and meaningful wait time information (see www.gov.ns.ca/health/waittimes/default.htm).

Overall, the provinces and territories have devoted significant activity and deliberate effort to increase measurement and to report it publicly. This indicates a real commitment to sharing information. But the websites still report data in different ways, making it difficult to compare and evaluate progress on wait-times reductions from a national perspective (see Figure 4).



Getting a grip on waiting lists, patient by patient

A key problem with health care waiting lists in many parts of Canada is the lack of centralized processes to verify and manage the lists. In some cases, people on a list are no longer waiting for care (for example, if they have gone elsewhere for the procedure). In other instances, people on the wait list may be willing to see another physician but have no way of knowing who else is available.

In July 2004, Hospitals of St. John's (part of Eastern Health, the Regional Integrated Health Authority for the Newfoundland and Labrador capital region) launched a coordinated strategy to manage their wait lists for elective surgery.

They started by hiring a wait-list manager who would work with a newly established committee to spearhead an intensive review of adult patients waiting for elective surgery across the region.

The goals of the review were to verify the actual number of patients waiting for elective surgery and to classify patients with an appropriate urgency code. Meeting these goals would allow Eastern Health to identify patients who were waiting longer than is considered acceptable and give patients the benefit of being re-assessed and placed on the updated wait list according to each person's need.

The review centred on contacting every patient who had been on the elective surgery waiting list prior to April 2005, when a new patient urgency classification process was implemented. This process required the active participation of many people including patients, health care providers, physicians, private office staff, and the Waitlist and Information Management Teams.

A systematic roll-out of 2,353 questionnaires began in September 2005. Close to half of the patients (48 per cent) responded to the written survey, and follow-up efforts brought the total response rate to 66 per cent.

As a result of this effort, Eastern Health was able to:

- remove 32 per cent of patients from the waiting list;
- confirm that 45 per cent of patients who remained on the waiting list were willing to see another surgeon;
- determine that, of the 741 patients who responded to the specific question, 38 per cent felt their condition had worsened while they waited. (This number is about 10 per cent lower than the Canadian Medical Association found in a survey of patients reporting unreasonable waits in 2004.)

"Patients have appreciated being part of the wait-list review. It not only allowed them to be part of the initiative, but gave them the opportunity to express their opinions about wait times and surgery delays," says Kathy Fowler, manager of Waitlist Management Services for Hospitals of St. John's.

If there is a single lesson to be learned from this quality improvement initiative, Fowler continues, "it would be to have a process in place for the regular, systematic review of existing wait-list information that engages all stakeholders, including patients." Under a three-year plan, the hospitals are using the same strategy to tackle wait lists for diagnostic imaging and ambulatory care services.



Comparable and meaningful data are essential for ongoing analysis and evaluation. The Ontario Auditor General's report in December 2006 questioned the validity of combining in-patient and out-patient statistics in one measure – a common practice across the country, which the Council also questioned in our 10 Steps paper. The Ontario government appointed former senator Michael Kirby to provide recommendations for future public reporting.

Has the focus on the five targeted areas increased wait times for other procedures?

Concerns have been raised that efforts to shorten wait times for the priority areas of cancer, heart disease, diagnostic imaging, joint replacement and sight restoration have had the unintended consequence of lengthening wait times for other procedures. This issue, which the Council has raised since 2005, speaks to the need for a comprehensive, pan-Canadian approach to measuring, monitoring and managing wait times for all procedures. We look forward to CIHI's work this year providing a preliminary analysis of five-year trends in surgical volumes to provide additional information to inform the discussion.

Is the progress on wait times sustainable?

We continue to caution jurisdictions against addressing long queues through the addition of resources alone. This will provide short-term relief, but it will not build a sustainable foundation on which to deal with wait times in the future when federal funding runs out. Instead, we propose that jurisdictions look at system redesign and re-engineering. These solutions offer more effective management of resources and better patient flow management.

We have seen a number of innovative approaches to system redesign across the country including the creation of dedicated facilities, specialized care teams, and channeling resources in large facilities to meet specific targets, to highlight a few.



What we advise

- Governments must continue to assess whether reducing wait times in the five targeted areas is crowding out wait times for other services.
- Governments must ensure that the urgency of the patient's condition is being factored into the patient's placement on the waiting list, and that there is some mechanism to monitor that it is.
- Jurisdictions should develop their own centralized registry of wait times for **all** procedures. Centralizing the management of wait-time data collection increases the likelihood that it is accurate and comparable.
- Jurisdictions should move as quickly as possible to provide real-time, hospital-specific information on wait times through government websites readily accessible to residents/patients.
- Jurisdictions should include wait-time information at **all** facilities, even those not participating in the Wait Times Reduction Fund, and over time, expand the reporting process to non-targeted procedures as well.



Patient safety interventions | Accreditation and disclosure | Electronic
information management | No-fault patient compensation | Reporting
of adverse events | Legislating patient safety | Indicators and public
reporting | Federal transfers to provinces and territories | The Canada
Health Transfer | Wait Times Reduction Fund | Diagnostic and Medical
Equipment Fund | Health Reform Fund

QUALITY OF CARE



Our health care system delivers safe and appropriate care to Canadians every day. However, a large body of evidence from international and Canadian research shows that health care services can and do result in so-called adverse events – unintended injuries or complications caused by the delivery of health care that result in prolonged hospital stay, disability, or death. Some adverse events are unavoidable, such as an unanticipated allergic reaction to an antibiotic.

The landmark study by Dr. Baker and Dr. Norton found that about 7.5 per cent (185,000) of hospital admissions in this country were associated with an adverse event in the year 2000, and that close to 70,000 of these mishaps were potentially preventable.²⁰

Even more startling, the study determined that adverse events could be responsible for up to 23,750 deaths among hospital patients and more than a million additional in-hospital days each year.

How we respond to adverse events is key to improving the quality of care in Canada. We must acknowledge and learn from these events to change the processes that led to them.

Patient Safety

What governments promised

In 2003, First Ministers agreed to establish the Canadian Patient Safety Institute to provide advice on effective strategies to improve patient safety, coordinate information across sectors and systems, promote best practices, and raise awareness with stakeholders, patients and the general public about patient safety.

What we know /what we don't know

Patient safety is a crucial component of a quality health care system. In 2006, the Health Council was very active on this issue. We undertook a research project to better document accreditation practices and information disclosure across the country. In June, we partnered with Canada Health Infoway to host a conference on the implementation of the electronic health record (summary report available at www.healthcouncilcanada.ca).

The EHR holds great promise for improving the quality, efficiency, and safety of health care. In September, the Council also organized a roundtable on patient safety and no-fault compensation. These and other initiatives, and their potential impact on patient safety, are explored further in this section.

Are we making strides in improving patient safety? Some of the initiatives outlined below appear to be having a positive impact, and others offer significant opportunity. But because information about adverse events is not collected and evaluated in a coordinated fashion, it is difficult to determine whether real progress is being made.

Patient safety interventions increase

The Canadian Patient Safety Institute (CPSI) launched its Safer Healthcare Now! campaign in April 2005. This voluntary program encourages Canadian health care organizations to implement targeted interventions that evidence has shown improve patient safety. To date, 171 hospitals and health regions and 404 teams are enrolled in the grassroots campaign aimed at reducing the number of injuries and deaths related to adverse events, such as infections and medication incidents.

In the longer term, CPSI plans to develop other interventions to be applied in a greater variety of health care settings.

Accreditation and disclosure needed

The Council has recommended that all health care facilities should be accredited as a condition of public funding. We have also called for the findings of accreditation reports to be made public.

Accreditation is a powerful lever that can move care organizations towards improved quality and safety. By publishing the results of their accreditation reviews and plans for improvement, these facilities become more accountable to the public they serve.

The need for mandatory accreditation and disclosure became all the more apparent to Council after we conducted a study in eight jurisdictions and found no uniformity

in accreditation practices across the country. Some sectors have 100 per cent participation while others do not, and even this varies by province. Some organizations release the results of their reports, including information about where they need to improve, but most do not.

In recent years, the Canadian Council on Health Services Accreditation (CCHSA) has emphasized patient safety. It developed patient/client safety goals and required organizational practices, which became an integral part of the program in 2006 and, over the next few years, will be integrated into accreditation standards.

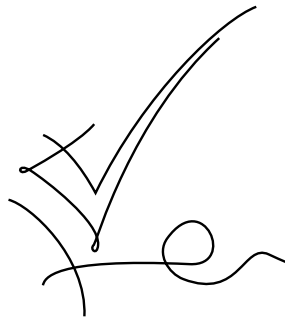
Electronic information management needs boost

Electronic information management systems, such as the electronic health record and e-prescribing systems, offer tremendous opportunity to reduce error and improve patient safety. The timely transmittal of accurate information can dramatically decrease medical errors and save lives.

As previously stated, we need to adopt a much more aggressive timetable for the development and implementation of electronic information management systems. The Council is calling for 100 per cent of Canadians to have access to an EHR within the next four years. To spur renewal and strengthen patient safety, Infoway's 2009 timeline to have an EHR for 50 per cent of Canadians should be accelerated.

No-fault patient compensation warrants further research

In Canada, the only option for compensation available to injured patients is to sue their health care provider. This tort-based system – largely premised on a finding of fault – creates an adversarial relationship between provider and patient. This inhibits disclosure of errors, and limits the ability of the health care system to learn from its mistakes.



Under a no-fault model, injured patients may receive compensation without suing, and health care professionals may disclose mistakes without fear of legal action. The potential benefits may include better reporting of adverse events, better understanding of their underlying causes, and better-directed interventions to reduce the chance of future harm.

Council continues to call for jurisdictions to take a fresh look at how injured patients are compensated in Canada and whether current insurance schemes inhibit the development of a culture of safety.

In September, Council held a meeting of international experts and stakeholders to discuss the pros and cons of no-fault patient compensation and reforming professional liability insurance. Experts from New Zealand (where a form of no-fault compensation has been in place for more than 30 years) and Canadian health care leaders shared their different perspectives. For additional information on the various perspectives around this issue, visit the Health Council of Canada's website, www.healthcouncilcanada.ca.

In a May 2006 report looking at patient safety, medical error and tort law in several countries, including Canada, Osgoode Hall Law School professor Joan Gilmour recommends that research be sponsored "to evaluate

alternative compensation mechanisms, including no-fault compensation systems, with a view to determining their desirability in the Canadian environment." The Council agrees that the relationship between patient safety and no-fault patient compensation is worthy of further research.

Reporting of adverse events spotty

Each province and territory currently has its own set of guidelines and protocols for reporting adverse events, and even within these jurisdictions, the requirements vary by sector.

There is wide divergence, for example, in reporting of adverse events in community and home care settings. In British Columbia, licensed community care facilities must report certain incidents to their respective licensing officers; assisted living residences must report serious incidents to the assisted living registrar; and standards are in place to assist health authorities, service organizations, and care providers in evaluating care. In New Brunswick, adverse events are reported at the regional health authority level. Ontario's Community Care Access Centres (CCAC) have established their own internal policies for quality and risk management. And protocols are being developed under a health incident reporting system in Prince Edward Island.



While there has been growing interest in patient safety over the last few years, much of it has been focused on institutions. Patient safety in community and home care settings is a relatively wide-open field of study that will become increasingly important as the number of seniors in Canada is expected to hit 10 million by 2041 – double the 1996 number.

Without standard, systematic reporting of adverse events across all sectors, jurisdictions are unable to collect and monitor the information, understand the extent and cause of the errors, and share learning and knowledge.

Legislating patient safety on the rise

Some jurisdictions are legislating their way to improved patient safety. For example, Saskatchewan passed legislation in 2004 requiring health care facilities and regional health authorities to report, investigate and share learning arising from critical incidents. Manitoba recently followed suit and announced similar legislation during Patient Safety Week in October 2006.



What we advise

- All health care facilities should have to be accredited as a condition of funding, and the findings of these reports should be made public.
- At a minimum, each jurisdiction should establish a mechanism for the mandatory reporting of all defined adverse events.
- Governments should examine whether the adoption of no-fault compensation for injured patients would be effective in improving patient safety in Canada.

Public Reporting on Health Indicators and Funding

What governments promised

Indicators and public reporting

Over the past seven years, four separate agreements between the federal, provincial and territorial governments have contained commitments to report publicly on the performance of social programs.

The *Social Union Framework Agreement* of 1999 committed governments to monitoring and reporting on the outcomes of social programs delivered to Canadians. However, this agreement applied only to new programs, effectively excluding public reporting on existing health care programs.

The 2000 First Ministers' Meeting resulted in requirements for specific health care reporting on existing programs. Governments agreed to produce a comparable public report on the health of Canadians and the health care system in every jurisdiction. Each government agreed to publish a first report in 2002, with subsequent reports to follow every two years. The First Ministers reaffirmed their commitment to produce public comparable health care reports in the 2003 *First Ministers' Accord on Health Care Renewal* and in the 2004 *10-Year Plan to Strengthen Health Care*.

Federal transfers to provinces and territories

In the 2003 and 2004 agreements, the federal government made major new funding commitments, and the provinces and territories agreed to report on how they spend this funding.

In the 2003 accord, First Ministers agreed:

- to prepare an annual public report to their citizens on primary health care, home care, and catastrophic drug coverage, commencing in 2004 as part of the objectives funded through the Health Reform Fund.
- to use comparable indicators and to develop the necessary data infrastructure for their annual public reports. This reporting would inform Canadians on progress achieved and key outcomes; service levels; and current programs and expenditures, providing a baseline against which new investments can be tracked.
- to report to their citizens on an annual basis, commencing in 2004, on enhancements to diagnostic and medical equipment and services as part of the Diagnostic and Medical Equipment Fund.
- that Canadians are entitled to better and more fully comparable information on the timeliness and quality of health care services. To this end, First Ministers agreed that each jurisdiction would report to its constituents on its use of all health care dollars spent on an annual basis.

The 2004 10-year plan contains the following references to financial reporting:

- All governments agree to report to their residents on health system performance including the elements set out in the 10-year plan.
- All funding arrangements require that jurisdictions comply with the reporting provisions of the 10-year plan.

What we know/what we don't know

Comparable indicators: reporting falls short

In September 2002, the federal government and all provinces and territories released their first set of reports, which contained 67 indicators on Canadians' health and health care. These included different rates of disease, lifestyle choices such as smoking or exercise, wait times for health care services and other information, such as mortality rates for different types of cancer.

In 2004, 70 potential indicators were identified for public reporting. Deputy ministers selected 18 for reporting by each jurisdiction. These included access to primary health care, drug coverage, diagnostic and medical equipment, health human resources, and the general health of the population.

It now appears, at the time of this writing, that there will be no such reporting of comparable indicators by jurisdictions in 2006. The data have been posted on CIHI's website (www.cihi.ca) and Health Canada produced a federal-level report in late December,²¹ but the provinces and territories have not created comparable reports to their citizens, as promised.

This is troubling. If governments are unable to fully meet their reporting commitments, how will Canadians be able to gauge the relative success of various renewal efforts, and assess whether their tax dollars are being invested in ways that produce maximum health benefits? Instead, they will be left with a hodgepodge of statements, inconsistent data and no way to verify progress in any standardized way. Currently, much of the published data are hard to find, difficult to compare, out of date, and not linked to stated goals.

It is equally troubling that the federal/provincial/territorial advisory committee on governance and accountability, under whose auspices this work was to be done, has been disbanded. It is not clear if any other mechanism to carry out this work is being contemplated.

The Council recognizes the enormous effort behind developing the framework on comparable health indicators and producing ongoing data for public release. Still, it is only by working through the challenges of securing comparative information that Canada will enhance its capacity to measure and to report on the performance of its health care system.

Public reporting on funding: all over the map

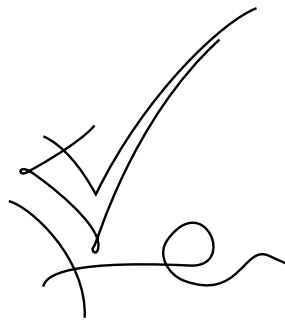
With respect to financial reporting, the province and territories are creating reports – but not always in ways that truly inform Canadians. Jurisdictions report on the federal financial contribution to their renewal efforts in a variety of ways.

Some have produced a separate report outlining how the Health Reform Fund (British Columbia, Saskatchewan) and the Diagnostic and Medical Equipment Fund (British

Columbia, Saskatchewan, Ontario and Nova Scotia) have been spent, although not for all fiscal years. Quebec has produced a report on the progress made on its bilateral agreement entered into during the First Ministers meeting in September 2004 but without financial information. All jurisdictions make a general statement recognizing the Government of Canada's contribution in health department documents and budgets.

The federal government provides its allocation estimates for each jurisdiction on the Department of Finance website (www.fin.gc.ca). It does not provide separate reports for the populations for which it has direct responsibility.

Federal transfers tied to specific policy initiatives are, in some instances, identified. But most jurisdictions are not living up to their commitment to provide annual public reports (see Figure 6). Generally, we are unable to determine how provinces and territories spend federal allocations. For such a large and important national undertaking as health care renewal, with billions of dollars being invested, Canadians expect – and deserve – greater transparency.



With respect to primary health care indicators, funding from the Primary Health Care Transition Fund was dedicated to creating a set of standardized measurements. Through an extensive process, 105 indicators were identified to address different needs. Of the 105, 18 were available with current data, but half of them can only be partially reported. At present, these indicators are not being developed or used by jurisdictions to report on progress.

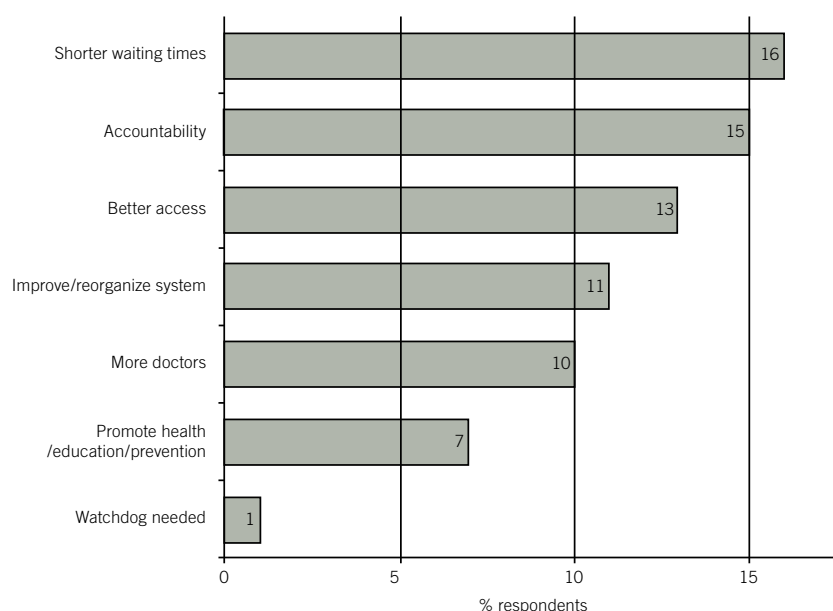
In the absence of meaningful reporting, the provinces and territories will find that the data will be interpreted for them – by non-governmental organizations whose methodology may be wanting.



According to the polling synthesis provided by Professor Soroka, Canadians attach a high priority to accountability. They want to know what their governments are doing to improve health care, how the money is being spent, and what outcomes are being derived from specific initiatives. In an open-ended polling question to Canadians about what the Health Council's priorities should be, "accountability" was cited the second most, just one percentage point below the top priority of "shorter waiting times" (see Figure 5).²² "These results are testament to the importance that Canadians assign to accountability and monitoring in health care policy," the author noted.

Figure 5. Council Priorities

In 2004, the Health Council of Canada was formed to report to Canadians on the progress of health reforms in Canada. Their first report will be in January 2005. What do you think the priorities of the Council should be?



Source: Pollara, HCIC 2004 (N=1000)

Federal funding for the 2003 accord and the 2004 10-year plan

In the 2003 accord, the federal government committed new funding totaling \$36 billion over five years. In 2004, a further \$41 billion to be spent over 10 years was added to the funding pool. The money would flow through four types of federal health transfers:

The Canada Health Transfer (CHT)

This is an annual transfer for general health spending. As well as giving direct cash, the federal government also provides “tax room” which allows the provinces and territories to tax their citizens directly to raise revenue in lieu of federal taxation.

The Canada Health Transfer flows directly into the general revenues of the provinces and territories, to be allocated according to their own priorities. **There are no formal reporting requirements for provinces and territories to describe how they spent their CHT allocation.**

An estimated \$20.1 billion will be transferred to the provinces and territories in 2006/07 (see Appendix Table 3).

Wait Times Reduction Fund

This transfer was created in the 2004 agreement to provide \$5.5 billion over 10 years to support provincial and territorial initiatives to reduce wait times. It was created as a third-party trust through which provinces and territories can draw down funding until 2008/09; it then becomes an annual transfer, ending in 2013/14. **This fund has no specific reporting requirements.** However, Parliament is required by law to review, by March 31, 2008, the country's overall progress in implementing the 2004 10-year plan, and to review it again three years later.

An estimated \$1.2 billion will be transferred through this fund to the provinces and territories in 2006/07 (see Appendix Table 4).

The Diagnostic and Medical Equipment Fund

This fund was first established in 2000 as a two-year \$1 billion fund to support specialized staff training and equipment purchase. The 2003 accord provided an additional \$1.5 billion over three years. Governments were required to report to their residents annually on the enhancements to diagnostic and medical equipment. **Only four jurisdictions fulfilled this reporting requirement (see Figure 6).**

This fund was completed in 2004/05.

The Health Reform Fund

This \$16 billion transfer was created in the 2003 accord to provide funds over a five-year period for renewal in primary health care, catastrophic drug coverage and home care. The funding was intended to reach specific objectives outlined in the 2003 accord, such as increasing 24/7 access to primary health care providers. Governments were to have flexibility in determining the best ways to achieve these objectives and were to prepare annual public reports on these priorities commencing in 2004, using comparable indicators to inform Canadians on progress achieved and key outcomes. **Only two jurisdictions have ever prepared these specific reports (see Figure 6).**

The Health Reform Fund was rolled into the Canada Health Transfer in 2005/06.

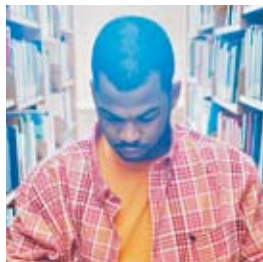
Figure 6. Financial Reporting on Federal Health Transfers

Jurisdiction	Separate reports on funds from the 2003 Accord and the 2004 10-Year Plan
Canada	<ul style="list-style-type: none"> • Department of Finance reports on annual allocations to provinces and territories
British Columbia	<ul style="list-style-type: none"> • Health Reform Fund, 2003/04 • Diagnostic and Medical Equipment Fund, 2003/04 • Primary Health Care 2003/04
Alberta	<ul style="list-style-type: none"> • No separate report
Saskatchewan	<ul style="list-style-type: none"> • Health Reform Fund, 2003/04 • Health Reform Fund, 2004/05 • Diagnostic and Medical Equipment Fund, 2003/04 • Diagnostic and Medical Equipment Fund, 2004/05 • A Report on the 10-Year Plan to Strengthen Health Care and Medical and Diagnostic Equipment Funding, March 2006
Manitoba	<ul style="list-style-type: none"> • No separate report
Ontario	<ul style="list-style-type: none"> • Diagnostic and Medical Equipment Fund, 2003/04 • Diagnostic and Medical Equipment Fund, 2004/05 • Diagnostic and Medical Equipment Fund, 2005/06 • Health Results Team Second Annual Report 2005/06 (no federal financial information)
Quebec	<ul style="list-style-type: none"> • Separate report on policy reforms for all aspects of the 2004 agreement • No federal financial information
New Brunswick	<ul style="list-style-type: none"> • Health Care Report Card 2003 • Health Care Report Card 2004 • Health Care Report Card 2005 • No federal financial information
Nova Scotia	<ul style="list-style-type: none"> • Diagnostic and Medical Equipment Fund, 2004/05 • Annual Accountability Report 2003/04 • Annual Accountability Report 2004/05 • No federal financial information
Prince Edward Island	<ul style="list-style-type: none"> • No separate report
Newfoundland and Labrador	<ul style="list-style-type: none"> • Reporting to the People of Newfoundland and Labrador: First Ministers Accord 2004 Implementation Report, December 2005 • Some federal financial information
Nunavut	<ul style="list-style-type: none"> • No separate report
Northwest Territories	<ul style="list-style-type: none"> • No separate report
Yukon	<ul style="list-style-type: none"> • No separate report



What we advise

- In addition to meeting existing reporting commitments, all governments need to improve and standardize reporting on programs and spending of transfers. This should include: focusing on outcomes, quality and performance; developing targets and monitoring progress; reducing the number of indicators and making the data more current; creating one annual comparative report with national, provincial and territorial information presented in a consistent manner; and identifying key population health outcomes for regular reporting.





Integrated Strategy on Healthy Living and Chronic Disease |
The Pan-Canadian Healthy Living Strategy | Health Goals for Canada
| National Immunization Strategy | Aboriginal health

POPULATION HEALTH



By international standards, Canadians are a relatively healthy lot. We have one of the highest life expectancies in the world: 77 years for men and 82 years for women. Our infant mortality rates have fallen over the last 20 years from eight per 1,000 births to five per 1,000. And 60 per cent of the general population rates their health as excellent or very good.

But we have a high burden of chronic disease and a growing level of health inequality between different groups in Canadian society. Key factors in health inequalities in Canada are income, gender and disability. We need to address these issues outside of the health care system to improve population health. Aboriginal Canadians, in particular, have markedly poorer health status than the rest of the Canadian population.

Healthy Living Strategies

What governments promised

One of the ways to prevent and manage chronic diseases is through public policies that support healthy living. To this end, at their annual meeting in September 2002, federal, provincial and territorial ministers of health agreed to develop a long-term comprehensive strategy to increase Canadians' engagement in healthy living practices that would reduce the burden of disease. The initial emphasis was on healthy eating and physical activity, and their relationship to healthy weights.

In September 2003, the ministers of health agreed to:

- create an inter-sectoral healthy living network;
- explore options for an inter-sectoral fund;
- look at a communications or health information strategy; and
- undertake further discussion with Aboriginal communities.

In 2004, First Ministers agreed to accelerate work on a pan-Canadian public health strategy, set goals and targets for improving the health status of Canadians, and support a national immunization strategy.

What we know /what we don't know

Integrated Strategy on Healthy Living and Chronic Disease

The 2005 federal budget announced \$300 million over five years for an Integrated Strategy on Healthy Living and Chronic Disease.

Some 16 million Canadians live with long-term illnesses, and chronic disease accounts for an estimated \$80 billion annually in health care and disability costs.²³ A population-wide approach to reducing chronic disease offers great potential to significantly improve the health of many lives and reduce cost pressures on the system. This approach focuses on addressing the causes rather than the consequences of chronic diseases – promoting lifelong health and reducing the demand for treatment services. It also looks at addressing the underlying determinants of health.

But a population-based approach to reducing risk of chronic disease requires adequate investment in health education and health promotion, as well as using these resources wisely through integrated efforts aimed at addressing common risk factors (e.g. tobacco use, unhealthy diet and physical inactivity) and collaborating across jurisdictions and sectors.

Of the \$300 million promised for a national healthy living strategy, \$18 million in funding has been released for diabetes initiatives. In the area of cardiovascular disease, the federal government has announced \$3.2 million in 2006/07 and \$5.2 million annually in future years to support the development of a heart health strategy and initial work in hypertension and disease surveillance. And in November 2006, the federal government established the Canadian Partnership Against Cancer to implement the Canadian Strategy for Cancer Control as part of the \$260 million commitment to this strategy in Budget 2006.

It is unclear whether the federal government plans to fund the integrated strategy in its entirety.

Integrated Pan-Canadian Healthy Living Strategy

The Integrated Pan-Canadian Healthy Living Strategy was released in October 2005. It proposes specific targets to improve the health of Canadians. By 2015, the strategy targets a 20 per cent increase in the proportion of Canadians who make healthy food choices, participate in regular physical activity, and are at healthy body weight.

In 2005, the federal government committed \$27.6 million over five years (\$7.15 million per year ongoing) to a Healthy Living Fund. The fund was to make strategic investments at the national, regional and community/local levels in support of sustainable national and community health promotion actions. It would support the development and exchange

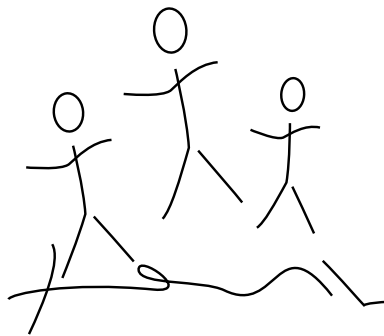
of knowledge, and help strengthen community-level capacity to promote integrated approaches to healthy living and preventing chronic disease.

On June 21, 2006, ministers responsible for sport, physical activity and recreation agreed on parameters for an infrastructure program that was shared with federal ministers of health and sport. Federal, provincial and territorial ministers re-affirmed their commitment to ensuring that Canadians across the country become more active. Officials were directed to develop

a framework and principles for bilateral agreements on physical activity within the context of healthy living that would be reviewed by ministers at their 2007 conference. Ministers recognized that jurisdictions would establish targets specific to their respective circumstances and implement action plans.

To date, there has been no release of funds for the Pan-Canadian Healthy Living Strategy. Recent federal funding cuts to adult literacy and First Nations' smoking cessation programs are not encouraging.

The new Children's Fitness Tax Credit, effective January 1, 2007, will apply to fees paid for eligible programs of physical activity for children under 16 years of age.





Taking action on healthy living across Canada

Since the announcement of the Integrated Pan-Canadian Healthy Living Strategy in 2005, every province and territory has stepped up efforts to promote the benefits of not smoking, following a good diet, and getting regular exercise. These programs generally fund community-based initiatives and coordinate public policy and services to support healthy living, including some efforts to improve food security and to help low-income families overcome cost barriers to participating in sports and recreation.

A few highlights of the past year's government-led activities to meet the goals of the healthy living strategy include:

- ActNow BC, a program that works across all government departments and partners with community organizations and the private sector (www.actnowbc.gov.bc.ca);
- Ontario's Active2010, a strategy to increase participation in sport and physical activity throughout the province (www.active2010.ca);
- A Wellness Strategy for New Brunswick, an approach that includes, among other initiatives, healthy food grants for schools and physical activity funding for communities (www.gnb.ca/0131/wellness_strategy/index-e.asp); and
- The PEI Healthy Eating Alliance, a collaboration of government agencies, educators and community groups (www.gov.pe.ca/peihea).

See www.healthcouncilcanada.ca for more information on government-led healthy living initiatives across Canada.

The emergence of youth-led initiatives to promote healthier eating provides hopeful news. In Ontario, the government is exploring a proposal by high school students for legislation to require more nutritious fare in school cafeterias. In British Columbia, a dynamic partnership between Revelstoke Secondary School principal Mike Hooker and a student healthy-eating committee is successfully changing the food culture at school. First, they banned pop from the school's vending machines and replaced it with juice and water. Next, they hired a new caterer to supply nutritious, lower-calorie lunches. Principal Hooker has been quoted as saying, "I think part of it is the kids feel they are in control because they started this."^a

At the community level, the national non-profit organization Go for Green promotes a simple way to keep kids fit. Go for Green receives funding from the federal government, 11 provinces and territories, and more than 20 municipal governments, as well as from the private sector and foundations. Among its other programs, Go for Green encourages walking and cycling through its Active and Safe Routes to School initiative, which now has representative groups in every jurisdiction. (For more information on Go for Green, see: www.goforgreen.ca.)

For more information on the Integrated Pan-Canadian Healthy Living Strategy, see: www.phac-aspc.gc.ca/hl-vs-strat/index.html.

^a Mason G. *Why one school's food fight should be emulated.* *Globe and Mail.* Oct 19, 2006.

In spite of the lack of federal funding, there has been a fair amount of activity at the provincial level in developing and implementing healthy living programs – especially in nutrition, physical activity, and early childhood development (see www.healthcouncilcanada.ca for examples of provincial and territorial healthy living initiatives). As an indication of the growing focus on healthy living, five provinces – Nova Scotia, New Brunswick, Ontario, Manitoba and Saskatchewan – have created separate ministries for healthy living. British Columbia has a minister responsible for ActNow BC.

These initiatives are providing resources for health promotion and illness prevention, many with an emphasis on children's health. In June 2006, the Council published a report, *Their Future Is Now: Healthy Choices for Canada's Children & Youth*, that called for ongoing research as a foundation for understanding why programs fail or succeed.

Health Goals for Canada

The Health Goals for Canada were approved by federal, provincial and territorial ministers of health at their annual conference in October 2005. The goals are a set of broad statements about basic physical and social needs, belonging and engagement, healthy living, and the health system. Ministers agreed that the goals would inform each provincial and territorial government, but that the setting of specific targets would be left to each jurisdiction based on its own priorities.

The development of national public health goals is complete. In phase two, the provinces and territories are to set targets and indicators to measure progress. Only Nova Scotia has set targets thus far.

The creation of common public health goals is an important first step. However, the next step is critical to success – namely, developing a set of measurable targets to help Canadians see how these goals have been translated into commitments by governments to achieve better public health and measure progress toward it.

Unfortunately, there has been no further progress in this respect. The provinces and territories have developed many health goals over the years, but these generally are not tied to specific targets.

National Immunization Strategy

The National Immunization Strategy (NIS) is a collaborative federal/provincial/ territorial approach to strengthen immunization in Canada. The Conference of Deputy Ministers of Health endorsed it in 2003, and the Government of Canada committed \$45 million over five years to implement it.

In 2004, the federal government also provided \$300 million directly to the provinces and territories over three years to support the introduction of new and recommended childhood and adolescent vaccines: the conjugate pneumococcal vaccine, conjugate meningococcal vaccine, varicella (chickenpox) vaccine, and acellular pertussis vaccine (a new whooping cough vaccine for adolescents).

Since that time, the provinces and territories have made good progress in making these four new vaccines available through publicly funded immunization programs (see Figure 7).



Figure 7. Availability of Four New Publicly Funded Vaccines

Province/Territory	Pneumococcal conjugate vaccine (≤18 months)	Meningococcal C conjugate vaccine (≤12 months)	Varicella vaccine (≤15 months)	Acellular pertussis vaccine (13-16 years)
British Columbia	✓	✓	✓	✓
Alberta	✓	✓	✓	✓
Saskatchewan	✓	✓	✓	✓
Manitoba	✓	*	✓	✓
Ontario	✓	✓	✓	✓
Quebec	✓	✓	*	✓
New Brunswick	✓	✓	✓	✓
Nova Scotia	✓	✓	✓	✓
Prince Edward Island	2007	✓	✓	✓
Newfoundland and Labrador	✓	✓	✓	✓
Nunavut	✓	•	✓	✓
Northwest Territories	✓	✓	✓	✓
Yukon	✓	✓	January 2007	✓

✓ = program available
 * = no program available

Information as of December 2006

Source: Public Health Agency of Canada with updates from jurisdictions provided to the Health Council of Canada

Notes:

- Nunavut: Meningococcal C immunization program is currently planned and budgeted but requires approval and availability of vaccine.



What we advise

- National public health goals need to be more targeted and based on measurable outcomes including reductions in health inequalities.
- Jurisdictions should significantly increase their investments in healthy living strategies as a way to better manage chronic diseases, along with accelerated development of primary health care teams.
- More upstream investment is needed to lessen the burden of the downstream costs of treatment.

Aboriginal Health

What governments promised

The 2003 accord and the 2004 *10-Year Plan to Strengthen Health Care* identified Aboriginal health as an issue for continuing discussion and action.

In September 2004, First Ministers and national Aboriginal leaders agreed to the creation, over five years, of a \$200-million Aboriginal Health Transition Fund to improve the availability, responsiveness, integrations and quality of health programs and services to Aboriginal people.

All jurisdictions endorsed the tenets of a communiqué in Kelowna, BC, in November 2005 with a pledge of \$5 billion over five years to improve the lives of Aboriginal people.

But while the agreement set targets to improve education, housing, economic development, and health and water services, details were left to be negotiated regarding how some of the money would be spent and who would provide the services.

In January 2006, a new federal government issued a statement supporting the objectives, targets and principles of the Kelowna communiqué but committed no further on the future of the \$5 billion announcement.

What we know/what we don't know

Aboriginal people have a health status that is well below the national average.

According to the 2004 Canadian Population Health Initiative report, *Improving the Health of Canadians*, some of the more striking disparities include:

- The life expectancy of Aboriginal people is, on average, 10 years less than for non-Aboriginal people.
- Aboriginal infant mortality is three times the rate of non-Aboriginal people.
- Suicide rate is six times higher.
- Diabetes rate is three times higher.
- Unemployment and poverty rates are three times higher.

The Blueprint on Aboriginal Health: A 10-Year Transformative Plan was developed to serve as a framework for collaborative action. Its goals were to guide the Aboriginal peoples' attainment of the same level of health and the same quality in health care services as that experienced by other Canadians and to significantly increase the number of Aboriginal physicians and nurses. The blueprint was presented in Kelowna, BC, in November 2005, where the federal government committed to use it as a framework to assist in the development of programs to support Aboriginal peoples.

The Council noted in last year's report that this framework has "tremendous potential to advance Aboriginal health in the next decade." At this time, the blueprint's future is unclear. We do not know whether the Aboriginal Health Reporting Framework will be implemented. This framework was hailed by Council as a critically important step in being able to monitor the health status of Aboriginal peoples and report on progress towards key health outcomes. We do not know whether the necessary investment will be made in building capacity and increasing the number of Aboriginal health professionals.

The federal government's intent with respect to its overall plan and direction for funding Aboriginal health programs is unclear. In the absence of further discussion and clarification regarding the funding arrangements suggested in Kelowna, the provinces and territories cannot move forward with the blueprint.

All jurisdictions have ongoing relationships with the Aboriginal peoples living in their jurisdiction. They acknowledge the gaps in health status and particular health needs of these residents and are working to address them.

Many of the jurisdictions have established programs designed to address specific health disparities faced by Aboriginal peoples. Some examples follow.

Nova Scotia

In 2004, Nova Scotia launched the Tui'kn Initiative designed to help people pass through barriers in the health care system. The initiative builds upon the most successful elements of a pilot program, the Eskasoni Primary Care Project, which ran from 1998 to 2000.

Health care teams established through Tui'kn generally consist of a doctor, a dietitian, a pharmacist, a nurse and a health educator. Team members are paid a salary rather than a per-procedure fee. These teams provide culturally appropriate care.²⁴

Newfoundland

In April 2006, the budget of the Air Foodlift Subsidy Program was increased by 33 per cent to \$400,000. This subsidy, paid to retail stores in Labrador's coastal communities to offset the high cost of flying in perishable foods, helps ensure that nutritious, fresh foods are available to residents, thereby supporting people in their efforts to maintain a healthy lifestyle.²⁵

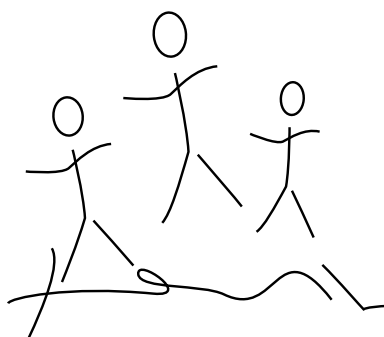
New Brunswick

Elsipogtog (or Big Cove) is a Mi'kmaq community of 2,700 people and the largest First Nation in New Brunswick. The community identified a need for improved access to culturally appropriate community-based services. Limited access to physician services in New Brunswick as a whole was also an identified concern.

Integrated Primary Health Care for Elsipogtog First Nation is a Health Integration Initiative project (under the Primary Health Care Transition Fund). This project focuses on combining community-based services, particularly mental health services, with

those provided by the Beauséjour Regional Health Authority. Under this approach, physicians and nurse practitioners will work with the community-based health programs to improve primary health care at the community and regional levels.

The project will design, put into practice, and test a holistic, patient-centred model of health service planning and delivery. It hopes to increase the First Nation community's access to primary health care services.²⁶



Ontario

Funded since 2001, the Aboriginal Tobacco Strategy (ATS) provides support to Aboriginal organizations in developing "tobacco wise" communities which promote the distinction between commercial tobacco use and traditional tobacco use. This year's focus for ATS is youth.

The government announced the establishment of a provincial Aboriginal Health Council in 2007 to advise the Minister of Health and Long-Term Care on priorities and strategies for improving Aboriginal health in Ontario.

The Ontario government plans to establish local Aboriginal health planning entities in 2007 to engage with local health integration networks and develop local reports on Aboriginal health care needs and priorities.

The government continues to collaborate with Aboriginal partners on implementation of the Aboriginal Healing and Wellness Strategy, a network of over 250 community-based Aboriginal family violence prevention and health programs.

Manitoba

Manitoba's Aboriginal Health Branch (AHB) is leading the implementation of the Aboriginal strategy on HIV/AIDS, *As Long as the Waters Flow*, for people infected and affected by this virus. The strategy was developed in partnership with the Public Health Branch, and numerous Aboriginal organizations and people affected by the virus, and is a major component of the provincial AIDS strategy.²⁷

Manitoba is also launching an Aboriginal Midwifery Education Program (AMEP) – a project of the Government of Manitoba in partnership with Nunavut and jointly administered by Manitoba Health and Manitoba Advanced Education and Training. Funding for the development phase of the AMEP is provided by Health Canada under the Aboriginal envelope of the Primary Health Care Transition Fund.

The overall goal of AMEP is to develop an educational program that will employ innovative learning models and strategies designed for adult learners. Aboriginal teachings and culture are to be AMEP's cornerstone. A four-year degree program, AMEP is designed specifically for Aboriginal students, particularly those living in northern Manitoba. The first nine students began their midwifery education in September 2006.²⁸

British Columbia

Improving the health status of Aboriginal peoples is one of the BC Ministry of Health's priority areas. There will be a focus on two key benchmarks – improved infant mortality rates and life expectancy rates for status Indians. These measures are reported on annually in the MOH Annual Service Plan Report.²⁹

In November 2006, the federal government, British Columbia and First Nations' leaders signed a new agreement aimed at improving the health of Aboriginal people in the province over the next decade. The goal is to reduce the gap in health outcomes between First Nations and other British Columbians, specifically targeting such areas as mental health, substance abuse, youth suicide, maternal health, and chronic conditions such as diabetes and hepatitis.

Government of Canada

While commitments have been cited for the \$200 million committed to the Aboriginal Health Transition Fund, we have not been able to determine that monies have actually been released.

As indicated above, the federal government was a co-signatory to the November 2006 agreement.

In November 2006, the federal government announced two patient wait-time guarantee pilot projects – for prenatal and diabetes care – in a number of First Nations communities.

Pregnant women in up to 10 First Nations reserves will have guaranteed wait times for prenatal care under a new pilot project. Women on participating reserves will be guaranteed an appointment with a health professional within two weeks of a positive pregnancy test. After that, they will be guaranteed prenatal checkups once every four weeks, or consultation



with a specialist within two weeks if the pregnancy is designated as at-risk. If needed to back up the guarantee, health care providers will be brought in to the reserve, or the expectant women will be able to see a health care provider off-reserve but nearby.

A two-year pilot project on wait times for diabetes care will be implemented in up to 10 First Nations communities identified by Health Canada and First Nations. The projects will provide the following:

- adults who test positive for diabetes will have an appointment within two months for an assessment and diabetes education with a primary health care provider on reserve;
- adults who test positive for pre-diabetes (early diabetes), will be given the opportunity to participate

in a diabetes prevention, education and support program within three months; and

- adults who have a normal test result will be retested within one year.

Once complete, the pilot projects will be evaluated and adapted for possible use in other First Nations communities across Canada.

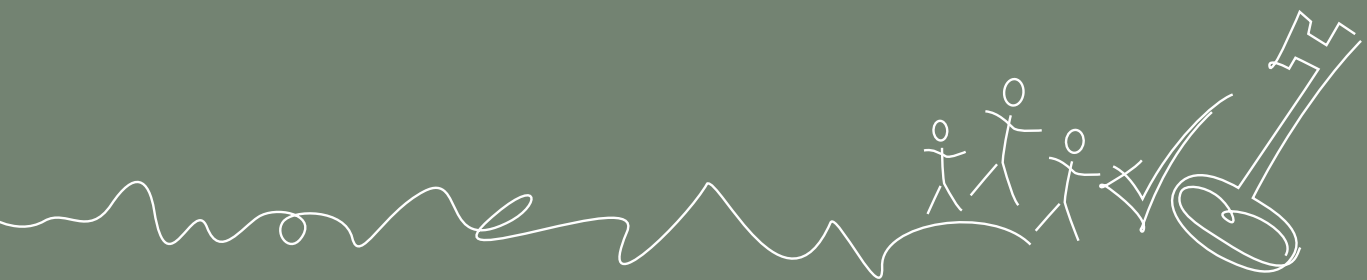
In early 2007, Health Canada announced it is developing a pilot project in partnership with Saint Elizabeth Health Care and the Assembly of Manitoba Chiefs to establish wait times guarantees for First Nations people living on reserve in Manitoba who face debilitating infections and possible amputations arising from diabetes.



What we advise

- The federal government should provide clear direction with respect to the *Blueprint on Aboriginal Health* and the Kelowna accord and outline its overall plan and direction in support of Aboriginal health.
- The jurisdictions should continue to address the gaps in health status and programs for their Aboriginal populations.

WHAT'S AHEAD



Throughout this report, the Council has highlighted the need for greater depth and transparency in health care reporting. We will look for that in all our efforts and initiatives in 2007, working closely with governments, stakeholders, and the policy and research communities to provide a clearer picture of the state of health care renewal in selected areas. For example:

- In the next annual report, we will examine what progress has been made over the five years since the first health care accord was signed. By looking back over this longer period, we hope to better discern the trends and provide Canadians with a meaningful accounting of progress. As noted in our Foreword, Canadians also believe that five years is a reasonable time frame within which to expect real change in the health care system. As part of this five-year review, we will also be assessing the level and quality of accountability in greater detail.
- In March 2007, we will be releasing the first of a series of reports on health outcomes related to chronic diseases. This inaugural study will examine diabetes and how changes to the health care system can improve the individual and collective health of those living with this chronic condition. We have already noted how interprofessional primary health care teams offer significant potential in this area, and this will be highlighted in the report.
- As identified earlier, the national pharmaceuticals strategy has not focused on pan-Canadian approaches to improving appropriate prescribing despite its being a priority under the health care accords. To stimulate discussion of prescribing behaviours and policy options, Council will be sponsoring a pharmaceuticals management symposium slated for June 2007.
- The Council will be developing a framework in 2007 for identifying the relative value of different investments in health care renewal.
- Council meetings will be held in Charlottetown (March), Yellowknife (May), Thunder Bay (September), and Calgary (November). Each of these meetings will include discussions with local stakeholders.
- The Council will be examining new ways to inform and be informed by Canadians directly.
- We will release separate reports on home care and wait times.
- Another important exercise will be a survey on Canadians' health care experiences. Our intent is to monitor and report on experiences with health care services in areas that patients consider most important, rather than their general satisfaction levels with the care received.

We look forward to continuing our contributions, be they in the form of information, analysis, advice or consultations, as together we work to strengthen our health care system.

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Acknowledgements

The Health Council of Canada gratefully acknowledges the significant efforts made by the federal, provincial and territorial ministries of health and ministries of health promotion / healthy living in participating in interviews and responding to our requests for information for this public report. Our government liaisons facilitated access to data charting the implementation of the 2003 and 2004 health care accords. The Canadian Institute for Health Information and Canada Health Infoway generously responded to our information requests. We also acknowledge the cooperation of a number of other national organizations: the Canadian Agency for Drugs and Technology in Health, Canadian Council for Health Services Accreditation, Canadian Patient Safety Institute, Public Health Agency of Canada, and Statistics Canada.

The creation of this year's annual report to Canadians was led by the Health Council's Monitoring Committee: Co-Chairs Alex Gillis and Lyn McLeod, Jeanne Besner, Jean-Guy Finn, Simone Comeau Geddry, and Les Vertesi. The Council also thanks Professor Stuart Soroka of McGill University for his synthesis of recent public opinion on health care in Canada, Robert Stephens and Sally Potter of PR Post for their writing talents, and the able staff at the Council secretariat for their work on this report.

The Council's vision

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

The Council's mission

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

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Appendices

- Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care
- Table 2 Actual Wait Times for Selected Treatments, Selected Jurisdictions – Public Website Information as of Nov 2006
- Table 3 Canada Health Transfer Fund
- Table 4 Wait Times Reduction Fund

Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care

	What governments promised	Summary of progress	What we know/don't know
Primary health care	50% of residents to have 24/7 access to an appropriate health care provider by 2011. (2003 Accord)	In many cases, this access has been defined as after-hours telehealth services and emergency departments.	There is variable linkage back to patient's primary health care provider when care is received elsewhere.
	50% of Canadians to have 24/7 access to interprofessional multidisciplinary teams by 2011. (2004 Plan)	Development of teams underway in all jurisdictions.	Teams mostly physicians and nurses. Initial vision of teams has been diluted. Innovation is occurring largely through pilot projects, and it is not clear how it will be sustained in the long term. Number of interprofessional teams needs to be expanded and pace of implementation accelerated.
	Each jurisdiction to set out its own multi-year targets for verifiable progress. (2003 Accord)	Indicators have been developed.	No data are available for most of the key indicators. Data collection infrastructure needs to be improved to enable meaningful reporting on progress.
	Place priority on the implementation of electronic health records and further development of telehealth applications. (2003 Accord) Accelerate electronic health record, including e-prescribing and telehealth. (2004 Plan)	Canada Health Infoway established goal of 50% of Canadians to have electronic health record by 2009. Achieved interim goal of 4% of Canadians having EHR by March 31, 2006. Three jurisdictions are on track to achieve the 2009 goal, and another 4 on track to achieve by 2010. Canada Health Infoway has increased its share of funding for electronic health record implementation to 75% of total costs.	Implementation of the electronic health record is too slow. Fruitful collaboration on system standards and purchasing is encouraging. Electronic drug information systems and e-prescribing not widespread.
Health human resources	Collaborate on strategies to ensure the supply of needed health providers: <ul style="list-style-type: none"> strengthen the evidence base for national planning; promote interdisciplinary provider education; improve the recruitment and retention of health professionals. (2003 Accord) 	Projects are underway in interprofessional education, assessment of international graduates and development of planning models. Initial work has begun to redesign education and training programs, which involves almost all medical schools but only a limited number of other professional schools.	Good progress on interprofessional education programs. Evaluation is needed to determine their effectiveness. Medical and nursing school enrolments have increased in all jurisdictions where these programs are available.
	Jurisdictions agree to increase the supply of health professionals, based on their assessment of gaps and to make their action plans public by December 2005, including targets for the training, recruitment and retention of professionals. (2004 Plan)	Most jurisdictions have released their plans to retain and recruit, (Alberta, Yukon, and BC still have not), but only four of these plans provide targets.	Action plans should be more comprehensive, include specific future-oriented targets, and be based on sound evidence of the health needs of the population. Jurisdictions continue to compete with each other for HHR.

Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care (continued)

	What governments promised	Summary of progress	What we know/don't know
Health human resources (continued)	<p>Federal government commits to:</p> <ul style="list-style-type: none"> • Accelerating and expanding the assessment of internationally trained health care graduates for participating jurisdictions; • targeting efforts to increase the supply of health care professionals in Aboriginal and official languages minority communities; • reducing the financial burden on students; • participating in health human resources planning with interested jurisdictions. (2004 Plan) 	<p>\$70 million earmarked to assist jurisdictions to increase their capacity to assess international graduates.</p> <p>Pan-Canadian planning framework document released in fall 2005.</p>	<p>Assessment processes for international graduates is being standardized.</p> <p>There are a number of projects underway in the priority areas identified but there is no pan-Canadian HHR strategy in place linked to future delivery models.</p>
	<p>The Government of Canada commits to doubling the number of Aboriginal physicians and nurses within 10 years. (2005 Blueprint)</p>	<p>Status of commitment is unclear.</p>	<p>Status is unclear.</p>
Home care	<p>First-dollar coverage for a basket of services for short-term acute home care, including acute community mental health, and end-of-life care. (2003 Accord)</p>	<p>Health ministers are working on the basket of services.</p>	<p>Current focus ignores Canadians with chronic disease.</p>
	<p>First-dollar coverage by 2006 for 2 weeks of acute home care; 2 weeks of acute community mental health home care; end-of-life care. (2004 Plan)</p> <p>Progress report expected December 2006. (2004 Plan)</p>	<p>Progress is unknown on a number of items. It is not known if, or how fully, health ministers reported to First Ministers on goals related to their December 31, 2006, reporting deadline.</p>	<p>Some jurisdictions already provide a broad range of services. All jurisdictions except PEI report meeting commitment to provide first-dollar coverage for short-term care.</p>
	<p>Federal government to create compassionate care benefit. (2003 Accord)</p>	<p>Compassionate care benefit is in place. Federal government has expanded program eligibility to include a broader definition of family member, and two provinces have followed suit.</p>	<p>Ontario has aligned its job protection legislation with the new federal definition. Others have not. Alberta and Northwest Territories have no legislation.</p>
Pharmaceuticals management	<p>Take measures, by the end of 2005/06, to ensure that Canadians have reasonable access to catastrophic drug coverage. (2003 Accord)</p>		<p>Reduced commitment to implementing catastrophic drug coverage between the 2003 and 2004 agreements.</p>
	<p>Develop and implement the national pharmaceuticals strategy and report on progress by June 2006. (2004 Plan)</p>	<p>Health Ministers' progress report on the national pharmaceuticals strategy was released in September 2006.</p>	<p>Progress report indicates where further work is to be undertaken. No decisions yet on program design or timeline for completion.</p>
	<p>Health ministers agreed in October 2005 to work on:</p> <ul style="list-style-type: none"> • catastrophic drug coverage; • expanded scope for Common Drug Review; 		<p>No decision yet on catastrophic drug coverage. Options for coverage proposed, but not costed.</p> <p>Scope of Common Drug Review has been expanded; but no progress on a common national formulary.</p>

Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care (continued)

	What governments promised	Summary of progress	What we know/don't know
Pharmaceuticals management (continued)	<ul style="list-style-type: none"> • a common national formulary; • broader role for the Patented Medicine Prices Review Board; • research on the rare diseases; • data on drug risks and benefits. 		<p>Electronic drug information systems are being put in place across the country, but e-prescribing not widespread.</p> <p>Broader role for the Patented Medicine Prices Review Board has been implemented.</p>
Wait times	<p>Meaningful reductions in wait times in cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration by March 2007. (2004 Plan)</p> <p>Each jurisdiction agrees to create:</p> <ul style="list-style-type: none"> • comparable indicators of access to health professionals and diagnostic and treatment procedures, with a report by December 2005; • evidence-based benchmarks for medically acceptable wait times in five areas by December 2005; • multi-year targets to achieve priority benchmarks by December 2007. (2004 Plan) 	<p>Strategies are being developed by individual provinces and territories.</p> <p>Wait Times Reduction Fund established.</p> <p>Federal Advisor on Wait Times released his report in June 2006.</p> <p>Benchmarks were announced in December 2005 for cancer, hip fracture, hip and knee replacements, and cataract and cardiac bypass surgery. Benchmarks were not announced for diagnostic imaging.</p> <p>Comparable indicators were not announced by December 31, 2005, and are still outstanding.</p>	<p>More information is now being made available to the public on websites; need for real-time information on waits for surgery.</p> <p>Wait times are being reduced in most of the five targeted areas (cancer treatment, heart procedures, diagnostic imaging, joint replacement and sight restoration).</p> <p>Evidence required to determine whether the focus on reducing wait times in the priority areas is resulting in longer waits for non-targeted procedures.</p> <p>Concern that the definition of wait time begins with the specialist consult and not with first contact.</p> <p>Lack of comparability of reporting methods makes comparison of wait times difficult.</p> <p>The sustainability of progress on wait time reductions beyond the funding commitment of the Wait Times Reduction Fund remains an issue.</p>
Patient safety	<p>First Ministers agreed to establish the Canadian Patient Safety Institute (2003 Accord).</p>	<p>Increasing number of health care organizations and teams are participating in Safer Healthcare Now!, and the Canadian Patient Safety Institute plans to expand the program.</p> <p>Canadian Council on Health Services Accreditation continues to integrate patient safety requirements into accreditation standards.</p>	<p>There is some required reporting of adverse events (in hospital emergency rooms and for some types of drug reactions), but there is no coordinated, uniform system of what gets reported in each jurisdiction.</p> <p>Many health care facilities do not release the findings of their accreditation reports, including the areas identified for improvement.</p>

Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care (continued)

	What governments promised	Summary of progress	What we know/don't know
Public reporting on health indicators and funding	Annual public reports on primary health care, home care, pharmaceuticals, diagnostic imaging and medical equipment using comparable indicators starting 2004. (2003 Accord)	All jurisdictions have participated in the comparable health indicators reports in 2002 and 2004. Indicators were made available on Statistics Canada and CIHI web sites in December 2006.	Comparable health indicator reports not published in 2006. Health Canada published national level report.
	Governments are to report to their residents on health system performance, including the elements set out in the plan. (2004 Plan)	British Columbia and Saskatchewan have reported specifically on the Health Reform Fund spending on primary health care, home care and pharmaceuticals. British Columbia, Saskatchewan, Ontario and Nova Scotia have reported specifically on the Diagnostic and Medical Equipment Fund. Quebec has published a report on all of the 2004 commitments. Federal Departments of Finance reports on annual allocations.	Information about how federal transfers are spent by provinces and territories is not easily accessible or, in some cases, not available at all.
	Health Council of Canada to report on elements in the agreements. (2003 Accord and 2004 Plan)	Health Council of Canada annual reports released in January 2005, February 2006, February 2007.	
	CIHI to report on progress on wait times. (2004 Plan)	CIHI reported on wait times in February 2006.	
Healthy living and public health	Work on healthy living strategies and other initiatives to reduce disparities in health status. (2003 Accord)	Healthy Living Strategy has been developed and 3 targets have been released for 2015: healthy eating, physical activity and healthy weights.	Targets do not address inequalities in health. Of the \$300 million promised under the Integrated Strategy on Healthy Living and Chronic Disease, only \$26.4 million has been released.
	Pursue a National Immunization Strategy. (2003 Accord)	Funding given to provinces and territories for vaccine purchase.	National Immunization Strategy has resulted in the implementation of standardized immunization coverage across the country, including four vaccines recently introduced.
	Accelerate work on a public health strategy with goals and targets to improve health status. (2004 Plan)	Development of national public health goals is complete, and goals have been released.	Health goal statements are broad and do not include measurable outcomes. Only Nova Scotia has developed further targets.

Table 1 Summary of Progress on Key Elements of the First Ministers' Agreements on Health Care (continued)

	What governments promised	Summary of progress	What we know/don't know
Aboriginal health	Develop Aboriginal health reporting framework. (2003 Accord)	Federal government established \$200 million Aboriginal Health Transition Fund.	Unclear if funds have been released.
	Aboriginal health reporting framework will be completed by 2007, with reporting to begin in 2010-2011. (2005 Blueprint)	Status of commitment is unclear.	Status is unclear.
	Aboriginal health blueprint released in November 2005 with an additional \$1.3 billion for health initiatives.	Status of commitment is unclear.	Status is unclear.
	Targets to reduce infant mortality, youth suicide, childhood obesity and diabetes by 20% in 5 years and by 50% in 10 years. (2005 Blueprint)	Status is unclear.	Status is unclear. Many jurisdictions have programs to address health disparities faced by Aboriginal peoples, but these programs are not coordinated through a national strategy.

Table 2 Actual Wait Times for Selected Treatments, Selected Provinces – Public Website Information as of Nov 2006*

	Cardiac surgery	Radiation therapy	Cataract surgery	Hip replacement	Knee replacement
Pan-Canadian benchmark (time within which care should be provided)	(Bypass only, by level of urgency) Level I: 2 weeks Level II: 6 weeks Level III: 26 weeks	4 weeks from being ready to treat	16 weeks for patients who are at high risk	26 weeks	26 weeks
British Columbia	<i>September 2006</i> All cardiac surgery Median wait: 10.7 wks	<i>August 2006</i> Median wait: 0.7 wks	<i>September 2006</i> Median wait: 8.0 wks	<i>September 2006</i> Median wait: 16.3 wks	<i>September 2006</i> Median wait: 19.9 wks
Alberta	<i>September 2006</i> Bypass only Median wait: 5.9 wks (% of cases done) 39 % in 0 – 3 wks 15 % in 3 – 6 wks 31 % in 7 wks – 3 mos 12 % in 4 – 6 mos 2 % in 7 – 12 mos 1 % in 13 + mos	2006 data not available	<i>September 2006</i> Median wait: 14.6 wks (% of cases done) 5.8 % in 0 – 3 wks 15.0 % in 3 – 6 wks 39.7 % in 7 wks – 3 mos 24.2 % in 4 – 6 mos 10.6 % in 7 – 12 mos 4.7 % in 13+ mos	<i>September 2006</i> Median wait: 14.3 wks (% of cases done) 6.4 % in 0 – 3 wks 13.5 % in 3 – 6 wks 37.9 % in 7 wks – 3 mos 21.1 % in 4 – 6 mos 16.1 % in 7 – 12 mos 5.1 % in 13 + mos	<i>September 2006</i> Median wait: 19.4 wks (% of cases done) 2.9 % in 0 – 3 wks 8.2 % in 3 – 6 wks 34.4 % in 7 wks – 3 mos 22.3 % in 4 – 6 mos 24.1 % in 7 – 12 mos 8.0 % in 13+ mos
Saskatchewan Does not break out pan-Canadian areas	<i>June 2006</i> All cardiovascular Median wait: 1.0 wks 83 % in 0 – 3 wks 8 % in 4 – 6 wks 5 % in 7 wks – 3 mos 4 % in 4 – 12 mos 1 % in 13 + mos	2006 data not available	<i>June 2006</i> All ophthalmology Median wait: 11.0 wks 26 % in 0 – 3 wks 10 % in 4 – 6 wks 19 % in 7 wks – 3 mos 40 % in 4 – 12 mos 5 % in 13 + mos	<i>June 2006</i> All orthopedics Median wait: 6.3 wks 43 % in 0 – 3 wks 7 % in 4 – 6 wks 11 % in 7 wks – 3 mos 26 % in 4 – 12 mos 13 % in 13 + mos	<i>June 2006</i> All orthopedics Median wait: 6.3 wks 43 % in 0 – 3 wks 7 % in 4 – 6 wks 11 % in 7 wks – 3 mos 26 % in 4 – 12 mos 13 % in 13 + mos
Manitoba	<i>September 2006</i> Bypass only Median wait: 13 days	<i>September 2006</i> All sites Median wait: 1.0 wks	<i>September 2006</i> Winnipeg facilities Median wait: 16 wks	<i>September 2006</i> Winnipeg facilities Median wait: 20 wks	<i>September 2006</i> Winnipeg facilities Median wait: 47 wks
Ontario	<i>July 2006</i> (Bypass only) 100 % completed within 6 mos target	2006 data not available	<i>July 2006</i> 82 % completed within 6 mos target	<i>July 2006</i> 77 % completed within 6 mos target	<i>July 2006</i> 65 % completed within 6 mos target
Quebec	<i>August 2006</i> Province level data not available	<i>August 2006</i> Province level data not available	<i>August 2006</i> 4 % wait longer than 6 mos	<i>August 2006</i> 9 % wait longer than 6 mos	<i>August 2006</i> 18 % wait longer than 6 mos
New Brunswick	2006 data not yet available	2006 data not yet available	2006 data not yet available	2006 data not yet available	2006 data not yet available
Nova Scotia P1 – P4 = priority levels	<i>September 2006</i> Cardiovascular surgery Average waits: P1 – 3 days P2 – 35 days P3 – 77 days P4 – 140 days	<i>September 2006</i> Capital Health Authority Average waits: P1 – 3 days P2 – 35 days P3 – 77 days P4 – 140 days	<i>September 2006</i> 29 % within 30 days 49 % within 60 days 63 % within 90 days 86 % within 180 days 94 % within 270 days 97 % within 360 days	<i>September 2006</i> 10 % within 30 days 18 % within 60 days 28 % within 90 days 57 % within 180 days 73 % within 270 days 84 % within 360 days 92 % within 540 days 95 % within 720 days	<i>September 2006</i> 1 % within 30 days 3 % within 60 days 10 % within 90 days 43 % within 180 days 58 % within 270 days 72 % within 360 days 86 % within 540 days 93 % within 720 days
Newfoundland and Labrador	2006 data not yet available	2006 data not yet available	2006 data not yet available	2006 data not yet available	2006 data not yet available

*In all cases, data describe wait times for patients who have had surgery and are not a prediction of future wait times.

Table 3 Canada Health Transfer Fund (\$ millions)

	2004/05	2005/06	2006/07
British Columbia	2,132	2,801	2,784
Alberta	1,272	1,797	1,822
Saskatchewan	506	691	718
Manitoba	594	774	761
Ontario	5,693	7,636	7,534
Quebec	3,828	5,001	4,945
New Brunswick	382	495	485
Nova Scotia	476	617	605
Prince Edward Island	70	91	89
Newfoundland and Labrador	263	339	330
Nunavut	18	22	23
Northwest Territories	20	25	23
Yukon	17	22	21
Total	15,271	20,311	20,140

Does not include other transfers such as the tax point and equalization payments.

Source: Department of Finance, Government of Canada. Federal Transfers to Provinces and Territories. www.fin.gc.ca/FEDPROV/mtpe.html. Numbers for 2006/07 are forecast as of Oct 2006.

Table 4 Wait Times Reduction Fund (\$ millions)

	2004/05	2005/06	2006/07
British Columbia	82	82	158
Alberta	63	63	121
Saskatchewan	19	19	37
Manitoba	23	23	44
Ontario	242	243	467
Quebec	148	147	282
New Brunswick	15	15	28
Nova Scotia	18	18	35
Prince Edward Island	2.7	2.7	5.1
Newfoundland and Labrador	10	10	19
Nunavut	0.6	0.6	1.1
Northwest Territories	0.8	0.8	1.6
Yukon	0.6	0.6	1.2
Total	625	625	1,200

Source: Department of Finance, Government of Canada. Federal Transfers to Provinces and Territories. www.fin.gc.ca/FEDPROV/mtpe.html. Numbers for 2006/07 are forecast as of Oct 2006.

Notes

