

Better health, better care, better value *for all:*

Refocusing health care reform in Canada



Health Council of Canada
Conseil canadien de la santé

About the Health Council of Canada

Created by the 2003 *First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on innovative practices across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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A decade of reform under the health accords led to only modest improvements in health and health care. The transformation we hoped for did not occur.

It's time to refocus.

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FOREWORD

Ten years ago, the federal, provincial, and territorial governments set out to fix an ailing health care system. The result was the 2003 and 2004 health accords. With an eye to public accountability, the First Ministers also established the Health Council of Canada to monitor progress and outcomes against the commitments made in the health accords and to track the impact on health care reform across the country.

The Health Council has carried out that mandate through the last decade, producing more than 50 reports while engaging the public, patients, and other system stakeholders in how to improve our health system.

With the health accords ending in 2014, the federal government made the decision to wind up funding for the Health Council.

In this, one of our last reports, we draw on our accumulated knowledge and insights into Canada's health system to look back on the investments and impact of the health accords as a driver for health reform across Canada. Our conclusion: The outcomes have been modest and Canada's overall performance is lagging behind that of many other high-income countries. The status quo is not working. We need to do the business of health reform differently.

However, we *can* learn from the approach used in the design and implementation of the health accords. This report outlines some key lessons on what worked well and what didn't. Building on these observations and the recommendations of others who have examined successful strategies for health system improvement, we set out an approach for achieving a higher-performing health system.

All of us have a stake in the future of our health system.

Most of us, our families, and our friends, have had first-hand experience with health care in Canada—both good and bad. We need to make health care in Canada better. We need to see greater progress in reforming health care than we've seen over the last 10 years. We need a high-performing health system that will benefit all Canadians—today and for generations to come. In achieving that vision, all governments, health care organizations, health care providers, and the public have a role to play.

The health accords and the Health Council may be coming to a close, but the work has just begun.

Dr. Jack Kitts
Chair, Health Council of Canada

EXECUTIVE SUMMARY

Ten years ago, the federal, provincial, and territorial governments created an agenda for health care reform in the 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care*.^{1,2}

This report looks back on the last decade of health care reform, identifies what worked and what didn't, and outlines a better path to achieve a high-performing health system for Canada into the future. Attaining this vision will require a shared and clearly articulated approach, strong and sustained leadership, and a commitment by all stakeholders to support the ongoing change that is necessary—all of which have been found wanting in Canada over the last decade.

The themes of quality, accessibility, and sustainability shaped the two health accords, and governments committed to specific actions in a number of areas to address them. The funding associated with the health accords, together with increases in provincial, territorial, and private spending, contributed to an overall rise in total health expenditures (public and private) from \$124 billion in 2003 to an estimated \$207 billion in 2012.¹⁻³

A DECADE OF REFORM: DISAPPOINTING RESULTS

Although the resources to improve our health system and the health of Canadians were made available, the success of the health accords in stimulating health system reform was limited. Overall, the decade saw few notable improvements on measures of patient care and health outcomes, and Canada's performance compared to other high-income countries is disappointing. Some pressing issues have been addressed including wait times, primary health care reform, drug coverage, and physicians' use of electronic health records. But none of these changes have transformed Canada's health system into a high-performing one, and health disparities and inequities continue to persist across the country.

Furthermore, the health system has not kept pace with the evolving needs of Canadians. Expenditures on hospital care, drugs, and physicians continue to dominate Canada's health care spending despite the growing need for better prevention and management of chronic disease, improved primary care, and expanded home care services to meet the needs of our aging society.

LESSONS LEARNED AND AN APPROACH FOR THE FUTURE

Ten years of investments and reforms have resulted in only modest improvements in health and health care in this country and an unfulfilled promise of transformative change. However, the experience of the last decade also provided some valuable insights into how best to work toward a higher-performing health system—lessons we need to act upon.

It is clear that tackling individual components of the health system is not sufficient. A broader and balanced transformation of the system is required—one guided by a shared vision for a high-performing health system, explicit system goals, and a sustained focus on supporting key enablers.

In recent years, a number of Canadian jurisdictions and organizations have adapted the US-based Institute for Healthcare Improvement's *Triple Aim* framework^{4,5} and broadened its focus from the organizational level to the system level.⁶⁻¹⁴ The Health Council of Canada supports the use of the *Triple Aim* framework as a starting point for pursuing a higher-performing health system in Canada, with a balanced focus on achieving the complementary goals of *better health*, *better care*, and *better value*. However, we believe that any approach to transformation must acknowledge the importance of equity to Canadians. To address this, the Health Council includes equity as a complementary, overarching aim. The result: better health, better care, and better value for *all*.

Drawing on our work and recent assessments of health system reform efforts in Canada and elsewhere, we have identified five key enablers we believe must be actively supported and sustained to realize these goals:

- leadership;
- policies and legislation;
- capacity building;
- innovation and spread; and
- measurement and reporting.

All are interconnected and fundamental to achieving meaningful changes in our health system. From the experience of the last decade, it is clear that these key enablers were not always present or actively supported.

We believe the approach to health system transformation we outline will provide useful guidance to all governments, health care organizations, and health care providers responsible for planning, managing, and delivering care.

A CALL FOR ACTION

Investing significantly more money in Canada's health system is unrealistic given the current financial climate. The experience of the last decade also suggests that spending more money is unlikely to achieve the desired results. We need to refocus health care reform and make the necessary choices to achieve a higher-performing health system. We must, and we can, do better.

Canadians expect their health system to provide high-quality care regardless of the province or territory in which they live or their ability to pay.¹⁵ In order to deliver on that expectation, the federal, provincial, and territorial governments, along with Canadian health care organizations and providers, must pursue the same balanced goals and encourage and support pan-Canadian collaboration. For its part, the federal government should play a central role in providing funding to ensure a level of equity across Canada and continue to represent the fundamental “Canadian” perspective through active participation in health system planning and policy development. At the same time, the provinces and territories must look beyond their jurisdictional responsibilities and recognize that they are co-owners of a national system. They have a shared responsibility to ensure that each jurisdiction delivers comparable results.

The results of the last 10 years make it clear that we need to do things differently. If we want to achieve better outcomes in the future, we cannot continue our disparate, tentative approaches to health care reform across the country.

A high-performing health system *is* possible in this country. However, it will require a renewed commitment to pan-Canadian collaboration, the articulation and pursuit of balanced goals, and the active and sustained support of key enablers.

It is a vision worth pursuing—for the health of all Canadians.

INTRODUCTION

Canadians have a long-standing confidence in their health care system. In fact, a recent national survey suggests that Canadians have more confidence in the health care system now than at any other time in the last decade.¹⁶

But is that confidence warranted?

Canada is one of the top spenders internationally when it comes to health care, yet our results are mixed. For example, among high-income countries we fall in the middle when comparing life expectancy and the prevalence of multiple, chronic conditions, while we rank near the bottom in areas such as access to after-hours care and wait times for elective surgeries.^{3, 17-20}

Ten years ago, the federal, provincial, and territorial governments set out an agenda for health care reform in the 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care*. A decade of reform initiatives and many billions of dollars later, we need to ask what was accomplished.

Many national and regional organizations and agencies have provided their appraisals of progress under the health accords (see *Views on health system reform in Canada* on page 7). In this report, we draw on their work and our

own assessments, including our past progress reports, to consider the impact of a decade of health reform. How much did we spend and on what? Is our health and health care any better as a result? And how do we compare with other countries?

We also consider what we can learn from the health accords as our health system leaders chart a new way forward. Were the health accords an effective mechanism for making improvements to our health system? What worked, what didn't, and why?

Drawing on the lessons learned over the last 10 years, we set out an approach for achieving a high-performing health system in Canada. It is time for comprehensive, goal-directed action if we hope to make sustainable improvements to our health system for the future.

VIEWS ON HEALTH SYSTEM REFORM IN CANADA

In recent years, numerous organizations have examined the state and future prospects of Canada's health system. In 2012, the Senate Committee on Social Affairs, Science and Technology completed a comprehensive review of the 2004 health accord and made no fewer than 46 recommendations for the future of health care in Canada.²¹ The federal government subsequently released a response addressing the recommendations in that report.²² Other reports and papers examining the health accords have been released by Canada 2020, the Canadian Foundation for Healthcare Improvement, the Canadian Nurses Association, the Canadian Medical Association, The Conference Board of Canada, The Council of the Federation, and the Health Action Lobby, among others. The C.D. Howe Institute, the Canadian Institute for Health Information, and TD Economics have also weighed in with financial analyses of health care spending.^{8, 9, 23-33}

A review of these reports reveals some common themes:

Limitations of “buying change” and the business case for quality

Many of the reports note that the past 10 to 15 years have seen a significant investment in health care that has resulted in more personnel, technology, and other resources. In the case of wait times, the health accords provided increased funding for specific priority procedures, namely hip and knee replacements, hip fracture repairs, coronary bypass surgery, cataract surgery, and cancer radiation therapy. Funding was tied to specific target volumes—increasing the number of surgeries in order to reduce wait times, for example.^{2, 23, 27, 34, 35}

However, a report by TD Economics argues that health care investments over the last decade did not result in real reform and that there was a lack of “appetite to implement bold change.” Others suggest that the current level of health care spending in Canada is not sustainable given rising demand and increasing costs. Most significantly, it is not clear whether the money invested over the past decade has actually improved the health of Canadians.^{25, 31-34}

The focus of recent discussions about health system reform has shifted to quality, safety, and cost-effectiveness—an explicit recognition that more services do not necessarily result in better care. Instead, quality can be improved through the better use of existing resources and a fundamental change in how health care services are organized, managed, and delivered. There is a business case for quality.^{23, 27, 30, 32, 34, 36-38}

A call for pan-Canadian leadership

The reports consistently call for strong leadership as an absolute necessity if meaningful transformation of our health system is to occur. Several reports call for federal leadership in health system transformation, including the 2012 Senate Committee report on the 2004 health accord.^{8, 9, 21, 23-25, 30}



CHAPTER ONE

A decade of health care reform: Investment and impact

A decade ago, health care was at the top of the agenda for the Canadian public. A period of fiscal restraint in the 1990s had resulted in closed hospital beds, long wait times for health care services, and a growing public dissatisfaction with the Canadian health care system.

Discussions among politicians and policy-makers mirrored this public concern, and in 2000, a meeting of the prime minister and premiers resulted in new plans and funding for health system reform.^{35, 39}

The momentum continued to grow with a series of provincial and national commissions, reviews, and reports calling for health care reform. The demand for action culminated in two influential 2002 reports: the Senate's *The Health of Canadians—The Federal Role* (the Kirby report) and the report from the Royal Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (the Romanow report).^{15, 40-44} The Romanow report called for a restoration of federal funding for health care and envisioned a transformation of the Canadian health system. It demanded a “more comprehensive, responsive and accountable” system, one that supports the Canadian values of “equity, fairness and solidarity.”¹⁵

PROMISES, PROMISES: CANADA'S HEALTH ACCORDS

In response to this call, in early 2003, the prime minister and premiers signed the *First Ministers' Accord on Health Care Renewal* and followed it one year later with *A 10-Year Plan to Strengthen Health Care*. The themes of quality, accessibility, and sustainability shaped the two agreements, and the federal, provincial, and territorial governments committed to specific actions in the following areas:^{1, 2}

- Aboriginal health;
- access and wait times;
- access to care in the North;
- electronic health records;
- health human resources;
- health innovation;
- health prevention, health promotion, and public health;
- home care;
- pharmaceuticals management;
- primary care;
- telehealth/teletriage;
- accountability and reporting; and
- dispute avoidance and resolution.

The two health accords were supported by billions of dollars in new federal funding to address the issues plaguing Canada's health system. In the 2003 health accord, the First Ministers restructured the Canada Health and Social Transfer (CHST) to create two separate funding blocks, with 62% of CHST funds directed to health through a new Canada Health Transfer (CHT) and the remainder allocated to a Canada Social Transfer to support post-secondary education and a variety of social programs. The 2003 federal budget supplemented the CHT with a new Health Reform Fund of \$16 billion over five years to support the implementation of reforms in primary health care, home care, and catastrophic drug coverage.^{45, 46}

Federal funding for health care further expanded under the 2004 10-year plan, when an additional \$41.3 billion were allocated to the provinces and territories. Some of this investment was tied to the priority areas identified in the plan—\$5.5 billion for reducing wait times, for example—but the majority of the new funding was simply allocated to the CHT, reflecting a commitment by the federal government to increase the transfer payment by 6% annually beginning in 2006. Although the wait times funding had some conditions—provinces and territories were required to establish evidence-based benchmarks and comparable indicators and to report on their progress to the public—CHT funds could be spent largely at the discretion of the provinces and territories provided the conditions in the *Canada Health Act* were fulfilled. Thus, the common understanding that the health accord funding had “strings attached” is largely overstated.^{2, 45}

Building on one of the Romanow report recommendations, the First Ministers also used the 2003 health accord to establish the Health Council of Canada, the first time that an independent reporting body was created by both levels of government to monitor and report on the performance of Canada's health system against a series of policy, program, and funding commitments. The Health Council was to consult with the federal, provincial, and territorial governments and draw on the data and work of other organizations to report publicly on the progress of health reform.^{1, 15}

With all of these health accord promises—“a fix for a generation”⁴⁷—what was achieved? To address this question, we examine health care spending and the impact on patient care, health status, and equity.

INTERNATIONAL COMPARISONS

Throughout this report, we compare Canada's health care investments and performance to those of 10 other high-income countries—Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States.

Although all countries vary in the ways in which they organize, finance, manage, and deliver health services, these 10 countries were selected because they provide similar social, political, and economic contexts to allow useful comparisons on health system performance. This report draws primarily on international data (where available) from The Commonwealth Fund International Health Policy Surveys and the Organisation for Economic Co-operation and Development to assess how Canada compares with these 10 countries.

For more information on our approach and methods for analyzing the data, see *Notes on methods and data sources* on page 36.

A DECADE OF SPENDING: HOW DO WE COMPARE?

The funding associated with the health accords contributed to an overall rise in total health expenditures (public and private) between 2003 and 2012, from \$124 billion to an estimated \$207 billion.³

However, despite health accord commitments to address primary health care, Aboriginal health, home care, and drug coverage, Canada's allocation of health care dollars changed very little during the last decade. The proportion of total Canadian health expenditures directed to hospitals, drugs, and physicians—the three largest areas of health care spending—remained remarkably consistent over this period.¹⁻³

According to the most recent spending estimates from the Canadian Institute for Health Information (2012), hospital expenditures account for the largest proportion of total health expenditures in Canada (29%), unchanged since 2003. Salaries represent 60% of hospital costs, the majority of it nursing salaries. Drugsⁱ are the second largest health care expenditure at 16%, followed by physiciansⁱⁱ at 14%. The share of drug and physician spending changed only slightly from 2003. Compared to other high-income countriesⁱⁱⁱ, Canada's hospital spending^{iv} is low. Conversely, drug spending in Canada is relatively high, as are physician salaries, despite Canada having the lowest number of physicians per capita.^{3,17}

i / Drug expenditure does not include drugs dispensed in hospitals or in other institutions.

ii / Physician expenditure does not include physicians on salary in hospitals or in public sector health agencies.

iii / Due to differences in definitions, data collection, and analysis, international data may not always be directly comparable.

iv / The Canadian Institute for Health Information notes that Canadian hospital expenditures may be underestimated because the data do not capture physician services in hospital that are paid for by private insurance plans.³

Generally, most high-income countries spend a large proportion of their national income (as measured by Gross Domestic Product—GDP) on health care, and Canada is no exception.³ Furthermore, from 2003 to 2011, 10 of 11 high-income countries, including Canada, increased the proportion of their GDP allocated to health care. Only four other high-income countries shifted more of their GDP to health care than did Canada (Figure 1). Like Canada, most high-income countries made few changes to how these additional funds were allocated within their health systems. The Netherlands was a notable exception—during the same period, that country reduced the proportion of its expenditures on hospitals and drugs and dramatically increased its proportional investment in long-term care (Figure 2). It is noteworthy that the Netherlands emerged from the last decade as a top-performing health system.⁴⁸

New investments under the health accords provided an opportunity to transform our health system and improve the health of Canadians. Yet, for the most part, our spending patterns didn't change. Did Canada miss a significant opportunity? To provide insights, we look first at the care Canadians received. How did that care change over time? Which parts of our health system improved?

ASSESSING THE IMPACT: THE CARE CANADIANS RECEIVED

Hospital care provides a logical starting point to assess the impact of a decade of investments on the care Canadians receive. Hospital care figures prominently in the *Canada Health Act* and, as noted above, represents the largest single area of health care spending in this country.^{3,49}

Canada's hospitals generate tremendous amounts of data. Since 2009, they have provided data to the Canadian Institute for Health Information's (CIHI) Canadian Hospital Reporting Project, which publicly reports on performance in areas such as patient outcomes and patient safety. However, it remains difficult for CIHI to compare hospitals across different health systems in a timely manner due to issues such as privacy, data quality, and delays in receiving data.⁵⁰ As a result, Canadians cannot easily determine which hospitals provide safer or higher-quality services. To address this concern, a national network of teaching hospitals is collaborating with CIHI and other partners to develop a simple scorecard that uses up-to-date data to compare performance across hospitals in specific areas of patient care.^{51,52}

We do know that 76% of Canadians rate the quality of the medical care received from their primary care doctor as excellent or very good. However, the perceptions of individuals who use the health system frequently are far less favourable. Only 48% of individuals with multiple chronic conditions (typically regular users of the health system) described the care they received as excellent or very good.^{53, 54}

Reforms to primary health care over the last decade have led to more interdisciplinary teams and new models for chronic disease management and care coordination. But while most Canadians have a primary care provider, more than half still cannot get a same-day or next-day appointment, and their reliance on hospital emergency rooms is high compared to 10 other high-income countries.^{19, 53, 55, 56}

Investments in diagnostic equipment have significantly increased the number of computed tomography (CT) and magnetic resonance imaging (MRI) scanners in Canada; the number of scans nearly doubled between 2003/04 and 2009/10. However, limited evidence is available to guide

the appropriate use of scanning technology, and studies show great variation in use, often driven by factors such as patient demand.⁵⁷⁻⁵⁹

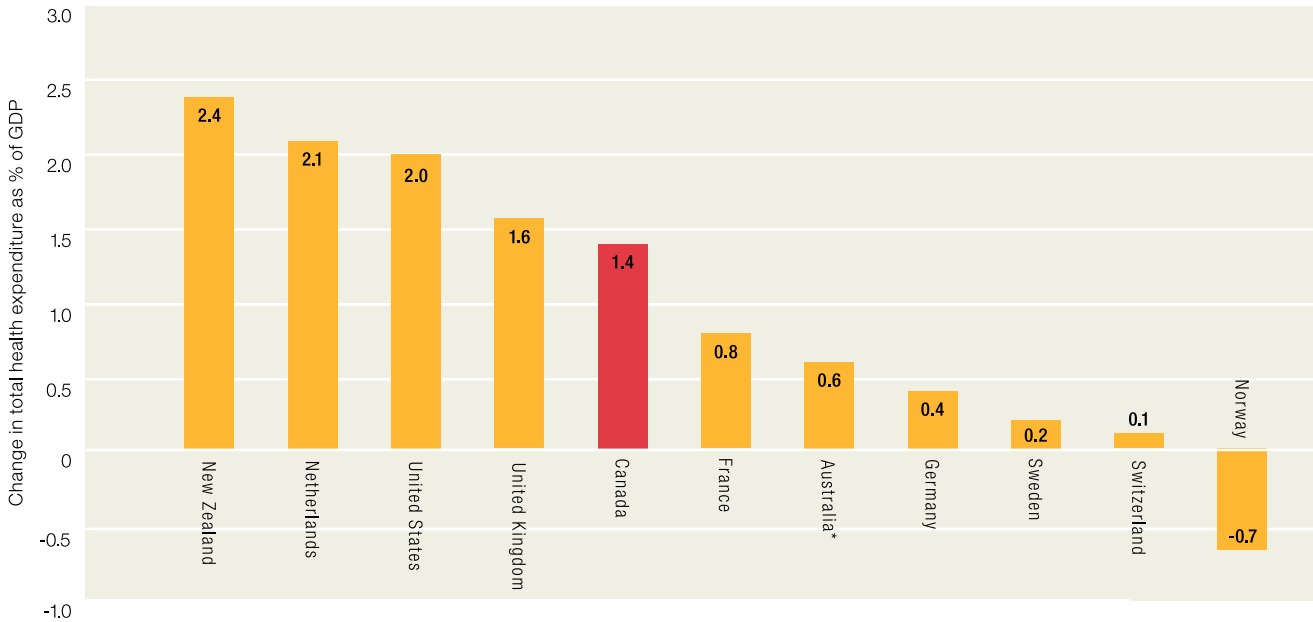
Wait times for procedures prioritized in the health accords, such as hip and knee replacements, improved over the last decade. Still, most gains were made during the early years of the health accords; since 2009, progress has stalled. In fact, the proportion of patients receiving care within some of the identified benchmarks is now decreasing in several provinces. This is due in part to rising demand for some procedures, which creates further access pressures.⁶⁰

Furthermore, data from the Commonwealth Fund survey suggests that one in 10 Canadians reports not filling a prescription or skipping doses because of cost. This is happening despite efforts across the country over the last decade to expand drug coverage and lower brand-name and generic drug prices.^{53, 61}

An examination of a number of patient care indicators in Canada over the last decade reveals few notable improvements, and Canada's performance frequently ranks near the bottom when compared to other high-income countries (Table 1).

Figure 1. Change in total health expenditure between 2003 and 2011 as a percentage of GDP: International comparisons

Since 2003, most high-income countries, including Canada, have spent a larger proportion of their GDP on health care.

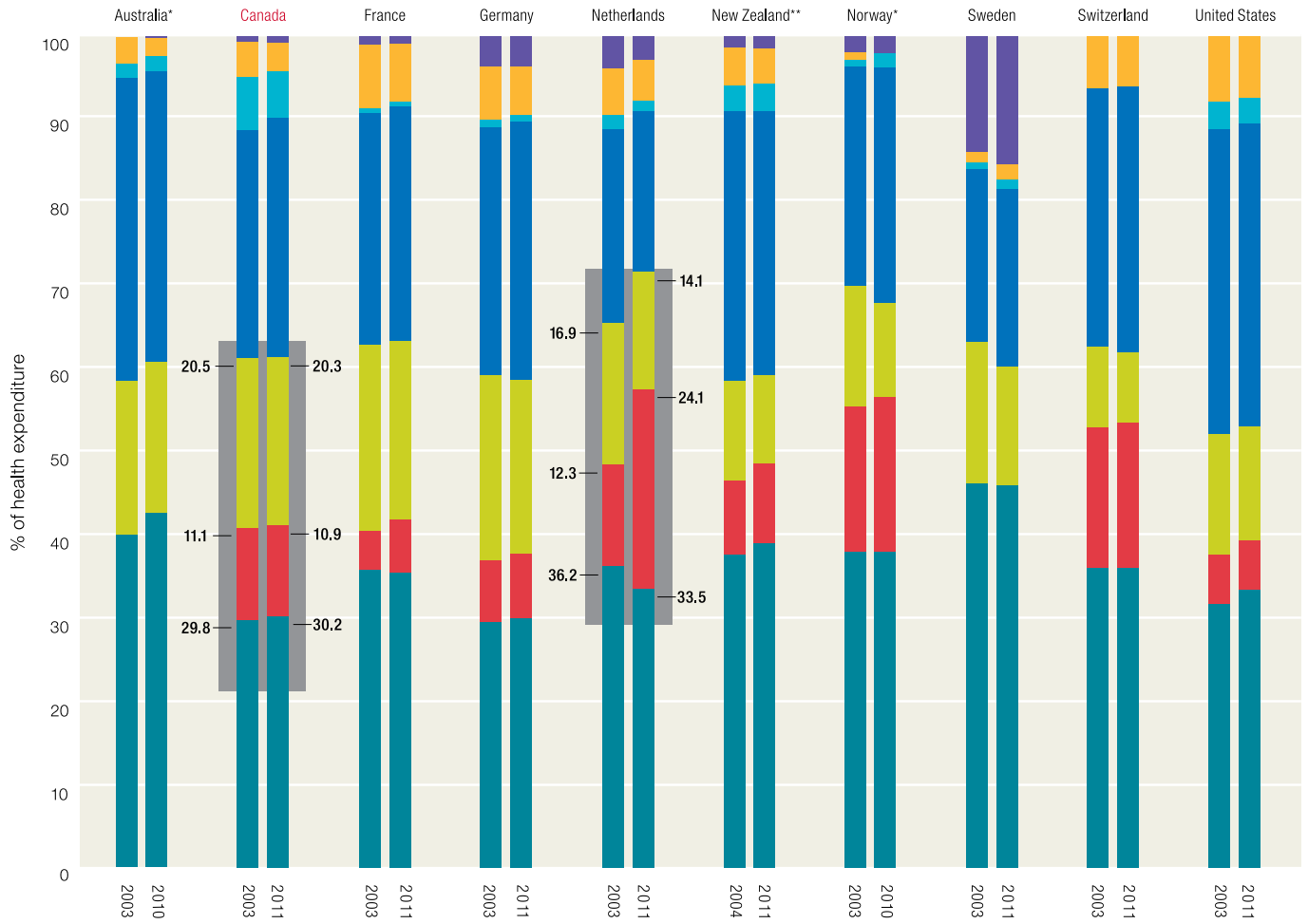


Source: OECD.StatExtracts (2013).¹⁷

Note: *Australia's data are from 2003 and 2010

Figure 2. Allocation of health care spending in 2003 and 2011: International comparisons

Like most other high-income countries, Canada's pattern of health care spending changed little during the last decade. The Netherlands was a notable exception, with more dramatic shifts in health care spending during the same period.



- Hospitals
- Long-term care facilities
- Pharmaceuticals/medical supplies/equipment
- Primary/ambulatory/other care providers
- Public health services
- Health administration
- Other

Source: OECD.StatExtracts (2013).¹⁷
 Notes: *Australia's and Norway's data are from 2003 and 2010;
 **New Zealand's data are from 2004 and 2011.

TABLE 1
Changes in care Canadians received over the last decade and Canada's international ranking^v

PATIENT CARE MEASURE	CHANGES IN CARE CANADIANS RECEIVED OVER THE LAST DECADE	CANADA'S RANKING AMONG HIGH-INCOME COUNTRIES
Perceptions of care	In 2004, 70% of Canadians rated the quality of medical care received from their primary doctor as excellent or very good. By 2010, that percentage had risen to 76%. ⁵³	At 76%, Canada ranks third out of 11 countries (tied with Australia) on the quality of medical care rated as excellent or very good. (Best: New Zealand, 84%; Worst: Germany, 50%) ⁵³
In-hospital care	In 2003, 5.6% of Canadian patients died in hospital within 30 days of admission due to a heart attack. That percentage improved to 3.9% in 2009. ¹⁷	At 3.9%, Canada ranks fourth out of 6 countries on 30-day, in-hospital mortality due to a heart attack. (Best: Norway, 2.5%; Worst: Germany, 6.8%) ¹⁷
Ability to get same-day/next-day appointments	Only 48% of Canadian primary care doctors in 2006, and 47% in 2012, reported that most of their patients could get a same-day or next-day appointment when it was requested. ¹⁹	At 47%, Canada ranks last out of 10 countries in primary care doctors providing same-day or next-day appointments. (Best: France, 95%; Worst: Canada, 47%) ¹⁹
After-hours care	Only 47% of Canadian primary care doctors in 2006, and 46% in 2012, reported they have after-hours arrangements so that patients can see a doctor or nurse without going to a hospital emergency department. ¹⁹	At 46%, Canada ranks ninth out of 10 countries in access to after-hours arrangements. (Best: United Kingdom and the Netherlands, 95%; Worst: United States, 35%) ¹⁹
Access to elective surgery	In 2005, 33% of Canadians reported that they waited four months or more for elective surgery, compared to 25% of Canadians in 2010. ²⁰	At 25%, Canada ranks last out of 11 countries in the percentage of patients reporting that they had waited over four months for elective surgeries. (Best: Germany, 0%; Worst: Canada, 25%) ²⁰
Access to drugs	The percentage of Canadians who reported that they did not fill a prescription or skipped doses because of cost was 9% in 2004 and 10% in 2010. ⁵³	At 10%, Canada ranks ninth out of 11 countries in the percentage of patients who did not fill a prescription or who skipped doses due to cost. (Best: United Kingdom, 2%; Worst: United States, 21%) ⁵³
Availability of records	In 2004, 14% of Canadian patients reported that their test results or medical records were not available at their medical appointment, compared to 12% of patients in 2010. ⁵³	At 12%, Canada ranks tenth out of 11 countries for unavailability of test results and medical records at medical appointments. (Best: Switzerland, France, and Germany, 8%; Worst: United States, 16%) ⁵³
Information sharing	In 2004, 58% of Canadian patients reported that doctors and staff at their usual place of care seemed informed and up-to-date about the care they had received in the emergency department. In 2010, that percentage had risen to 65%. ⁵³	At 65%, Canada ranks seventh out of 11 countries (tied with Germany) in information sharing between the emergency department and the family doctor. (Best: Switzerland and New Zealand, 76%; Worst: Sweden, 52%) ⁵³
Use of electronic medical records (EMRs)	The percentage of Canadian primary care doctors who reported using EMRs increased from 23% in 2006 to 57% in 2012. ¹⁹	At 57%, Canada ranks ninth out of 10 countries in physicians' use of EMRs. (Best: Norway, 100%; Worst: Switzerland, 41%) ¹⁹

^v/ Table 1 presents 2003 and 2012 data or the nearest years for which data are available.

TABLE 2
Changes in Canadians' health over the last decade and
Canada's international ranking^{vi}

HEALTH OUTCOME/ STATUS MEASURE	CHANGES IN CANADIANS' HEALTH OVER THE LAST DECADE	CANADA'S RANKING AMONG HIGH-INCOME COUNTRIES
Life expectancy	Life expectancy for the average Canadian rose, from 79.7 years in 2003 to 81.0 years in 2009. ¹⁷	At 81.0 years, Canada ranks fifth out of 11 countries in life expectancy (tied with Norway). (Best: Switzerland, 82.3 years; Worst: United States, 78.5 years) ¹⁷
Prevalence of multiple chronic conditions^{vii}	In 2007, 26% of Canadians reported having two or more chronic conditions. By 2010, that percentage had risen to 31%. ^{18, 63}	At 31%, Canada ranks seventh out of 11 countries in the percentage of people with multiple chronic conditions. (Best: United Kingdom, 21%; Worst: United States, 41%) ¹⁸
Cancer mortality	In 2003, 239 of every 100,000 Canadians died from cancer. By 2009, the number had fallen to 218 per 100,000. ¹⁷	At 218 deaths per 100,000, Canada ranks seventh out of 11 countries in cancer mortality. (Best: Switzerland, 188 per 100,000; Worst: the Netherlands, 246 per 100,000) ¹⁷
Cardiovascular disease mortality	In 2003, 275 of every 100,000 Canadians died from cardiovascular disease. By 2009, the number had fallen to 207 per 100,000. ¹⁷	At 207 deaths per 100,000, Canada ranks second out of 11 countries in cardiovascular disease mortality. (Best: France, 185 per 100,000; Worst: Germany, 342 per 100,000). ¹⁷
Obesity^{viii}	The percentage of obese adults in Canada rose from 15% in 2003 to 18% in 2010. ¹⁷	With an obesity rate of 18%, Canada ranks fourth out of 5 countries. (Best: Sweden and the Netherlands, 11%; Worst: United States, 28%) ¹⁷
Physical inactivity^{ix}	According to Statistics Canada's definition of physical activity, 48% of Canadians were considered to be physically inactive during their leisure time in 2003, compared to 46% in 2012. ⁶⁴	According to the World Health Organization definition of physical activity, 34% of Canadians were considered insufficiently active in 2008. Canada ranked fourth out of 10 countries. (Best: The Netherlands, 18%; Worst: United Kingdom, 63%) ⁶⁵
Smoking^{ix}	The percentage of Canadians aged 15 and over who reported that they smoked dropped from 19% in 2003 to 16% in 2010. ¹⁷	With a 16% smoking rate, Canada ranks fourth out of 8 countries. (Best: Sweden, 14%; Worst: France, 23%) ¹⁷

vi / Table 2 presents 2003 and 2012 data or the nearest years for which data are available.

vii / Survey respondents were asked which, if any, of the following chronic conditions they had: arthritis, asthma, cancer, depression, anxiety or other mental health problems, diabetes, heart disease, hypertension, and high cholesterol.

viii / Obesity rate is based on self-reported height and weight data.

ix / Physical inactivity and smoking rates are based on self-reported data.

ASSESSING THE IMPACT: THE HEALTH OF CANADIANS

The health accords focused on improving the health care Canadians received. However, to fully assess the impact of the health accords and the investments that were made, we must move beyond health “care” to consider whether the “health” of Canadians has improved.

There is long-standing consensus that good health is tied to a wide range of factors, many of which fall outside of the health system. Generally referred to as the social determinants of health, these include household income, level of education, networks of family and friends, the safety and quality of housing and communities, gender, race, and cultural group.⁶⁶ The relationship between investments in health care and health outcomes is therefore difficult to isolate and assess.³¹ We can, however, examine whether the health of Canadians has improved over the last decade. And on that front, the data show we didn’t achieve the results we should have.

Life expectancy has risen marginally. Chronic conditions such as diabetes are on the rise, and the percentage of Canadians who report that they have two or more chronic conditions has increased—from 26% in 2007 to 31% in 2010 (Table 2).

Lifestyle factors such as obesity, physical inactivity, and smoking play a critical role in health status and the prevention and management of chronic disease. Yet despite commitments made toward improving healthy living initiatives, primary health care, and chronic disease programs over the last decade,² progress has been minimal. While the rates of physical inactivity and smoking have declined slightly, the percentage of obese adult Canadians has increased (Table 2).

The lack of notable improvements over the last decade is also reflected in Canada’s ranking internationally. Canada most often ranks in the middle when compared to other high-income countries on a number of measures of health outcomes and status (Table 2).

ASSESSING THE IMPACT: INEQUITIES IN CARE AND HEALTH

The principle of equity is central to Canadians’ perception of their health care system. It is embedded in the *Canada Health Act* and was an overarching theme of the Romanow report. Equity was also a key focus of the health accords. In particular, the health accords emphasized the need to improve Canadians’ access to the care they need, when they need it, regardless of where they live or what they can pay.^{1, 2, 15, 49}

However, despite significant investments, disparities remain. For example, access to primary health care, drugs, and home care services varies among the provinces and territories. Rates of chronic disease also differ across the country.^{19, 67-69} The examples of inequities below underscore the growing reality that where you live *does* matter:

- In 2009, 93% of Nova Scotia residents had access to a regular medical doctor, compared to 74% of Quebec residents.⁷⁰
- In 2009, 8.1% of Newfoundland and Labrador residents had diabetes, almost double the rate (4.2%) of Yukon residents.⁷⁰
- In 2010,^x Ontario seniors who received home care were more likely to receive care from a personal support worker (69%) than seniors in the Yukon (55%) and the Northern Health Authority in British Columbia (50%).⁶⁷

x / 2010 data on home care services were available only for Ontario, Yukon, and one regional health authority in British Columbia.

The principle of equity is central to Canadians’ perception of their health care system.

- In 2011, 8.3% of teens aged 15 to 19 years in Alberta smoked, compared to 19.8% in Saskatchewan.⁷¹
- In 2012, 84% of Ontario residents waiting for knee replacement surgery received treatment within the pan-Canadian benchmark of 26 weeks, compared to just 35% of Prince Edward Island residents.⁶⁰
- In 2012, 62% of primary care doctors in British Columbia reported that most of their patients could get same-day or next-day appointments. In Quebec, that percentage was 22%.¹⁹
- In 2012, 36% of Quebec residents believed they had easier access to drugs compared to five years earlier. In the Atlantic provinces, only 22% of residents believed this was the case.⁷²

Factors other than geography also contribute to health inequities in this country. Despite much investment and efforts to improve Aboriginal health, glaring disparities in health status still exist between Aboriginal Canadians and the broader Canadian population. For example, a Statistics Canada study of the health of Métis, Inuit, and First Nations people living off-reserve found higher rates of chronic disease, smoking, obesity, and food insecurity compared to non-Aboriginal Canadians.⁷³⁻⁷⁶

Socioeconomic factors, such as income and education level, also contribute to health inequities. Canadians with higher incomes and levels of education have longer lifespans, are less likely to suffer from chronic conditions such as diabetes, and report better overall health status than those with lower incomes and levels of education.^{70, 77}

Although improving health equity was a focus of the health accords, many health inequities persist after a decade of health reform.

TURNING THE PAGE ON A DECADE OF HEALTH REFORM

How best to sum up a decade that was intended to bring about health care reform? The *First Ministers' Accord on Health Care Renewal* and the *10-Year Plan to Strengthen Health Care* proposed a straightforward solution to the problems affecting Canada's health system in 2003 and 2004: Invest more money to buy more health care.

The resulting increase in capacity and services did address some pressing issues. For example, wait times for a number of types of surgeries decreased, various primary care reforms were implemented, and physicians' use of electronic medical records increased.^{19, 55, 60}

However, none of the changes that occurred during the last 10 years have transformed Canada's health system into a high-performing one. Although Canada is one of the top spenders on health care internationally,³ we often rank poorly compared to other high-income countries when it comes to how individuals experience their care. More importantly, the health of Canadians improved only marginally over the last decade — a disappointing lack of progress given our health care investments. Compared to other high-income countries, our performance with respect to health status and outcomes is unimpressive. Furthermore, disparities and inequities persist across the country.

At the same time, changes to the health system have not kept pace with the evolving needs of our population. Hospital care continues to dominate Canada's health care spending despite the growing need for better prevention and management of chronic disease, improved primary health care, and expanded home care services to meet the needs of our aging society. Spending on drugs remains high despite collaborative action on drug pricing by the provinces. And spending on health human resources continues to claim a large portion of our health care dollars.^{3, 26, 29, 55, 78}

Finally, the issue of long-term sustainability remains. It has been noted that our health system is good at sustaining bad ideas.⁷⁹ In that regard, we need to think carefully and collectively about what kind of health system we want to sustain. Should Canadians be satisfied with the reforms and the focus of health care investments of the last decade? The short answer is no. How, then, can we achieve better results over the next decade? What do we need to do differently?



CHAPTER TWO

**Lessons learned from
the health accord “approach”**

In 2003 and 2004, Canada’s prime minister and premiers came together with a shared agenda: health care reform. Together, they discussed and documented common priorities, established commitments, and reached agreements on funding and public reporting.^{1,2}

The resulting 2003 *First Ministers’ Accord on Health Care Renewal* and 2004 *10-Year Plan to Strengthen Health Care* provided governments, health care organizations, and providers with new opportunities to improve health care in agreed-upon priority areas. The health accords also emphasized the need for better measurement of health system performance across the country.^{1,2} However, 10 years of investments and reforms have resulted in only modest improvements in health and health care and an unfulfilled promise of transformative change.

At the same time, the experience of the last decade also provided some valuable insights into how best to work toward a higher-performing health system. To move forward, we need to consider what worked well and what could and should have been done differently. What would an ideal approach to health system transformation look like? How can the different levels of government work together more effectively to achieve higher performance?

HEALTH CARE IN CANADA:**A CHALLENGING CONTEXT**

There are no easy answers. Canada is a complex federation, particularly when we consider health care and any plans to reform it. We don’t have a single health system. The responsibility for health care falls to 14 different governments—federal, provincial, and territorial—and the role of Aboriginal governance models continues to grow. Furthermore, these health systems are set within different geographic, demographic, economic, social, and political contexts, as the following examples illustrate:

- Ontario has a population more than 90 times larger than that of Prince Edward Island.⁸⁰
- Nova Scotia and Saskatchewan have similar-sized populations, but the population density in Saskatchewan is approximately one-tenth of that in Nova Scotia.⁸⁰
- Just over 3% of Nunavut’s population are seniors (65+) compared to almost 17% in Nova Scotia.⁸¹
- Alberta’s GDP per capita is almost double that of Prince Edward Island.⁸²
- Due to its responsibility for Aboriginal Canadians, military personnel, and certain other groups, the federal government administers health care for a population similar in size to that of Manitoba.⁸³

While some significant principles and factors tie the various governments together on health care, including the *Canada Health Act* and federal funding transfers, much of what we call the “Canadian” health system is actually a loose association of separate, independent health systems. As a result, Canadians cannot assume that the health care they receive in one part of the country will be the same as the health care they could receive in another part. Our governments recognize this too—they have expressed the desire to share and learn from one another—but effective mechanisms to support pan-Canadian collaboration on health care represent a long-standing challenge. The Council of the Federation’s Health Care Innovation Working Group is one example of recent attempts to foster this kind of collaboration.²⁹

Since 2003, a number of organizations have emerged or evolved to build pan-Canadian support and capacity for the pursuit of shared goals within the Canadian health care landscape. Through different funding mechanisms and approaches, agencies like the Canadian Agency for Drugs and Technologies in Health, Canadian Blood Services, the Canadian Institute for Health Information, the Canadian Partnership Against Cancer, the Canadian Patient Safety Institute, and the Mental Health Commission of Canada are making varying degrees of progress in providing pan-Canadian leadership in their areas of expertise.⁸⁴⁻⁹⁴

Economically, much has changed in the 10 years since the health accords were established. The early 2000s marked a period of economic strength and budgetary surplus which allowed new investments in health care following years of fiscal restraint. In 2013, as Canada slowly emerges from a global economic recession, it is widely recognized that achieving greater value with limited resources is essential. There is also a greater urgency to address issues of preventive care, home care, and chronic disease management, and to integrate services better within and across sectors based on a patient-centred model of care.^{35, 37}

To a large degree, these challenges fall to the provinces and territories. The federal government’s role in shaping health care is far less evident than it was 10 years ago. This reality is reflected in the funding formula that will succeed the health accords—the latitude and limited accountability that the provinces and territories currently have in how they spend their health care dollars will remain.^{35, 95}

How, then, should we proceed?

Canada needs a shared vision for a high-performing health care system and an approach that can effectively help us achieve it. It must be specific enough to provide useful guidance to the various levels of government, health care organizations, and providers responsible for planning, managing, and delivering care, but flexible enough to accommodate the structural and contextual realities of the “Canadian” health system.

The federal government’s role in shaping health care is far less evident than it was 10 years ago.

ESTABLISHING CLEAR AND BALANCED GOALS

If the efforts of the last decade have taught us anything, it is this: Tackling individual components of the health system is not sufficient. A broader and balanced transformation of the system is required—one guided by a shared vision for a high-performing health system and explicit system goals. Although the health accords outlined key priority areas and changes to health care processes to improve quality, access, and sustainability, a clear vision and a set of balanced goals was missing.

System goals describe the outcomes we want to see happen, rather than the processes that will get us there. They help us to remain focused on the big picture and not get bogged down in the details of change. They remind us why we are undergoing transformation and why it is worthwhile.

Balanced system goals ensure a comprehensive approach to address all components of the health system. One of the major limitations of the health accords was the focus on a short list of specific priorities within the broader health system. This focus did not explicitly state what the desired impact of these changes would be on the overall health of Canadians, nor did it consider whether these specific priorities would have unintended consequences in other areas.

In the years since the health accords were established, more attention has been paid globally to the need to develop clear and balanced goals for health care organizations and systems. For example, the US-based Institute for Healthcare Improvement promotes the *Triple Aim* framework as a guide for quality improvement initiatives. The framework provides three clear and interdependent goals to improve the performance of a health care organization: (1) improve the health of populations, (2) improve the individual experience of care, and (3) reduce the per capita cost of care.^{4, 5, 96}

In recent years, a number of Canadian jurisdictions and organizations have broadened the focus of the *Triple Aim* framework from the organizational level to the system level.⁸⁻¹⁰ For example, in 2011, the Canadian Medical Association and the Canadian Nurses Association set out principles for health system transformation based on this framework.¹⁴ This framework has also been adapted to suit the needs of individual provinces.^{7, 11-13, 97, 98} For example, a 2012 report commissioned by Alberta's Minister of Health to guide the province's implementation of primary care interventions recommended a focus on better health, better care, and better value.⁹⁸ For its 2013/2014 Strategic Plan, Saskatchewan's Ministry of Health added a fourth aim of "better teams." And Health Quality Ontario's 2012 Strategic Plan summarized the *Triple Aim*'s focus as "best health, best care and best value."⁷

The *Triple Aim* clearly resonates with Canadian health policy-makers, and the Health Council supports its use as a starting point to guide the pursuit of a higher-performing health system in Canada. The Health Council defines the three goals as follows:

- **Better health**—Addresses the overall health of Canadians, including how long we are living, our lifestyle activities (e.g., smoking, exercise), if we are living with chronic conditions (e.g., diabetes, high blood pressure, mental illness), and how well we are living (e.g., quality of life);
- **Better care**—Addresses patient and provider experiences of care (e.g., access, satisfaction, engagement, continuity) and the quality of care (e.g., effective, safe, accessible, integrated); and
- **Better value**—Addresses value for the resources invested in health care (e.g., getting more out of the health care dollars spent without compromising care). This includes focusing on efficiency (e.g., reducing waste/duplication, improving management processes) and appropriateness (e.g., receiving the right care in the right setting at the right time, reducing the overuse of services, and following clinical practice guidelines).^{6, 7, 9}

These goals are implicit in many initiatives designed to improve health care, and they underlie the priorities set out in the health accords. However, stating them explicitly clarifies the purpose of all health system activities and aligns actions toward a common vision.

It is important to emphasize that these goals are interdependent and need to be pursued simultaneously—one goal should not be achieved at the expense of another.⁵ By comparison, the health accords focused primarily on achieving “better care” at the expense of efforts to improve health and value. This created an imbalance. For example, the 10 years of activity focused on decreasing wait times has improved access to care. But we don’t know if our investments improved Canadians’ overall health and their experience of care, or whether those funds could have had greater impact elsewhere in the system. Put simply, if we could turn back the clock, would our focus include greater emphasis on health and value?

A balanced approach to achieving a high-performing health system will ultimately result in better health, better care, and better value for *all* Canadians.

ENHANCING THE TRIPLE AIM: ENSURING EQUITY

While a key focus of the *Triple Aim* framework is the simultaneous pursuit of the three aims, equity is not a central focus.

Equity has been defined as “...the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage ...”⁹⁹

The *Triple Aim* framework evolved within the American health system—a very different context than Canada’s health system where equity is a central principle. In fact, the Canadian political context requires that our government and health system leaders find the means to ensure equity within and among all provinces and territories.

Therefore, the Health Council believes that the *Triple Aim* framework, as it was originally intended, does not adequately reflect the importance of equity to Canadians or the equity focus of many health ministries and health quality councils.¹⁰⁰⁻¹⁰² The Health Council views equity as a complementary, overarching aim. We believe a balanced approach to achieving a high-performing health system will ultimately result in better health, better care, and better value for *all* Canadians.

SUPPORTING AND SUSTAINING KEY ENABLERS

While the Health Council believes that the goals of better health, better care, and better value for *all* Canadians provide an appropriate focus for transforming the health system across the country, balanced goals are not enough. Creating “an enabling environment” has also been identified as critical to transformation.²⁷

Drawing on interviews conducted with senior health system leaders for our 2013 report *Which Way to Quality?*¹⁰³ and on recent assessments of health system reform efforts in Canada and elsewhere, we have identified a consistent set of key enablers that contribute to health system performance.^{8, 9, 14, 21, 23-25, 27-30, 33, 104-111}

These key enablers are:

- leadership;
- policies and legislation;
- capacity building;
- innovation and spread; and
- measurement and reporting.

These five enablers (explained in *Defining and understanding the key enablers* on page 24) represent complex and interrelated concepts. Based on our analysis of the lessons learned from the health accords, we believe these enablers must be actively supported and sustained if we are to achieve the balanced goals.

Defining and understanding the key enablers

The enablers described in this report are complex, interrelated concepts that can have many definitions and interpretations. Based on the policy literature and other materials reviewed for this report, we define these concepts as follows:

LEADERSHIP

In health care, leadership is demonstrated at all levels, from governments to health care providers; it has been identified as a critical component of high-performing health systems. Leadership can be described in several ways. However, in our analysis of progress made during the years of the health accords, two distinct types of leadership were evident: system-level leadership involving governance and oversight that directs development of health policy and legislation, and leadership at the delivery level that optimizes the organization and management of available resources and drives research and innovation on improved approaches to health care delivery.^{104, 112, 113}

We view leadership as the foundation for the other key enablers because it supports and provides momentum to move actions towards attaining health system goals. Leaders recognize and manage change, define roles, encourage collaboration, build consensus, provide vision, align goals and activities, and measure performance. Leadership needs to be continual, dynamic, and responsive to changing needs.¹¹⁴⁻¹¹⁷

POLICIES AND LEGISLATION

Policies and legislation articulate a government's priorities and intentions. A policy is a statement that a government or organization makes about its intended actions. Legislation is a more formal type of policy; it is a law made by parliament that can help governments align the components of the health system to implement change. Legislation can unify commitments to change and align the visions and goals of the different stakeholders (such as regional health authorities and hospitals). In some cases, legislation provides a mechanism for accountability. Most major health system transformation over the last 50 years has been linked to major policies or legislation.^{35, 118, 119}

CAPACITY BUILDING

Capacity building refers to a wide range of activities aimed at producing sustained change. Capacity building activities may include increasing overall resources and the effectiveness and efficiency of existing resources. High-performing health systems train health care professionals and develop their practice skills and technical expertise. They also focus on developing the leadership and management abilities of health care professionals and administrators and provide opportunities for interdisciplinary collaboration and networks. Capacity building also includes fostering patient and community participation in their own health and health care, with the aim of transforming individuals from passive recipients of care to active participants in their health.^{36, 104, 120}

INNOVATION AND SPREAD

In health care, innovation is the term often used to describe a breakthrough process, product, strategy, or management approach. It implies a new way of doing things that results in additional benefits. Innovation is derived from formal or practical research (that is, the creation of new knowledge), collaboration, and the spread of ideas. Leadership plays an important role in supporting innovation and spread, whereby opportunities for knowledge creation are recognized and the development and delivery of new approaches are supported, implemented, evaluated, and shared. For example, recent discussions about transforming health care in Canada looked to high-performing health systems elsewhere for innovative approaches to health care delivery.^{27, 104, 116, 121, 122}

The Health Council's Health Innovation Portal is one of a number of emerging tools to support the spread of innovation (healthcouncilcanada.ca/innovation).

MEASUREMENT AND REPORTING

Health system performance refers to the extent to which the health system and the delivery of health care services achieve specific targets (standards or benchmarks). Measuring performance requires that goals be set using indicators for which data exist or could be captured; targets must align with the goals. Continuous measurement against the targets provides feedback on performance for both internal and public audiences.^{119, 123} The availability of timely, comparable, and high-quality data allows accurate performance measurement and relevant reporting to decision-makers, health care providers, and the public.

To illustrate how the presence or absence of these enablers has affected Canada's efforts in health care reform over the last decade, we assess their role in several priority areas drawn from the two health accords.

ENABLERS AND WAIT TIMES REDUCTION

Reducing wait times to increase access in the areas of hip and knee replacements, hip fracture repair, coronary bypass surgery, cataract surgery, and cancer radiation therapy was a high-profile commitment of the health accords, one in which progress was made over the last 10 years.^{1, 2, 60, 61} A review of the initiative demonstrates the sustained presence of the five enablers:

Leadership: With strong leadership from the federal, provincial, and territorial governments along with key pan-Canadian agencies and professional organizations, multiple system stakeholders engaged in a collaborative process to build consensus on addressing wait times. Governments demonstrated a commitment to improving performance and accountability by agreeing to establish pan-Canadian benchmarks, wait-time guarantees for the maximum time a patient would wait, and mechanisms for public reporting.^{2, 124, 125}

Policies and legislation: Under the 10-year plan, the provinces agreed to establish common wait-times benchmarks and jurisdiction-specific, multi-year targets to achieve them; in 2005, evidence-based benchmarks were set for five priority areas. The development and implementation of this key policy was supported by an initial \$5.5 billion Wait Times Reduction Fund created by the federal government in 2004, followed by the three-year National Wait Times Initiative in 2005 to support research, knowledge development, and dissemination. The federal government subsequently provided additional funding of over \$1 billion to assist the provinces and territories in establishing wait-times guarantees. This included a Patient Wait Times Guarantee Trust to support implementation plans, a Patient Wait Times Guarantee Pilot Fund to support innovative pilot projects, and funding to Canada

Health Infoway to enhance health information systems in order to support the delivery of wait-time guarantees. In 2007, all provinces and territories agreed to establish a wait-time guarantee by 2010 in at least one of the priority areas.^{124, 126}

Capacity building: The provinces and territories engaged in a variety of capacity-building activities to address wait times, including creating regional centres of excellence, acquiring facilities and equipment, and hiring and training staff. Recognizing the shortages in health human resources in some parts of the country, provinces used federal funds to increase the supply, mix, and scope of practice of health professionals through a variety of initiatives including training and recruiting/retention strategies, particularly in rural and remote communities. Funds were also committed to expand capacity in ambulatory and community care to accommodate patients who no longer required hospital care, resulting in better use of surgical beds.^{2, 21, 127, 128}

Innovation and spread: The National Wait Times Initiative supported new approaches by the provinces and territories in areas such as queue management, centralized patient registries, clinical pathways, and patient navigator programs. Innovation in implementing wait-times guarantees was encouraged and supported through the Patient Wait Times Guarantee Pilot Fund.^{124, 129}

Measurement and reporting: Governments committed to measure and publicly report on their progress in reducing wait times. CIHI, in collaboration with the provinces, developed a standardized method of collecting wait times data and reporting on wait times across the country. In addition, provinces report on wait times on their own websites, and the Health Council of Canada reports on progress in achieving wait times in each province and territory, thereby providing another mechanism for accountability.^{2, 60, 61, 130}

The presence of the key enablers clearly contributed to progress in reducing wait times for the priority areas. However, balanced system goals for the initiative were not articulated, (i.e., to improve the care and health of Canadians while ensuring reasonable costs and appropriate allocation of resources). Had the enablers been aligned to support the system goals of better health, better care, and better value for all, a number of other critical areas might have received more attention, including:

- stemming the growing need for hip and knee replacement surgery through health promotion and community care;
- addressing the patient experience of wait times;
- tackling wait times in emergency departments; and
- reducing wait times for primary health care and long-term care.

ENABLERS AND THE NATIONAL PHARMACEUTICALS STRATEGY

The National Pharmaceuticals Strategy (NPS), proposed in 2004, was intended to address concerns about drug access, affordability, and safety across the country, and to level the playing field so that all Canadians could have access to safe and appropriate drugs.¹³¹ A review of the efforts to establish the NPS suggests the presence of the five enablers was not sustained over time.

Leadership: Leadership from the federal, provincial, and territorial governments was evident in the early days of attempting to develop the NPS. A joint task force developed a strategy with nine action items including commitments to lower drug costs, improve drug safety, and change prescribing behaviours. However, progress on the NPS stalled when collective action supported by federal leadership declined. Leadership subsequently shifted to the provinces and territories, which moved forward in the areas of catastrophic drug coverage and generic drug pricing. This has resulted in some progress, but with variable approaches across the country.^{131, 132}

Policies and legislation: At the federal level, the Patented Medicines Prices Review Board (PMPRB) regulates prices for patented drugs to ensure that prices of brand-name drugs sold in Canada are not excessive. Its role in establishing pricing policy helps to maintain brand-name drug prices at the median price of selected comparator countries. The federal government recently expanded its efforts to enhance regulatory frameworks for the safety and effectiveness of health products and food by publishing the Regulatory Roadmap for Health Products and Food. For their part, the provinces and territories have used policies and legislation as a primary tool to extend catastrophic drug coverage, reduce the prices of generic drugs, increase the use of generics over more expensive brand-name equivalents, and expand the scope of practice for pharmacists.^{61, 128, 133, 134}

Capacity building: Between 2004 and 2006, the joint task force worked collaboratively to identify the elements necessary to move the NPS forward by defining concepts, identifying capacity and resource issues, and conducting research and comparative analyses. For example, during this period the task force defined catastrophic drug coverage, agreed to a set of principles to guide the development of catastrophic drug coverage options, and provided several costing estimates for coverage options. The Canadian Institutes of Health Research provided funding for the establishment of the Drug Safety Effectiveness Network (DSEN) and the Canadian Network for Observational Drug Effect Studies (CNODES) to build research capacity in drug safety and effectiveness.^{131, 135-137}

Innovation and spread: In addition to building capacity, DSEN and CNODES facilitate collaborative research and innovation in the areas of drug safety and post-market monitoring. Some provinces and territories expanded the scopes of practice for pharmacists, and are implementing innovative approaches to dispensing drugs.^{61, 135-137}

Measurement and reporting: The PMPRB monitors, measures, and reports on international prescription drug prices, enabling progress on lowering the cost of drugs. CIHI collects and analyzes drug cost and utilization data through the National Prescription Drug Utilization Information System database. CIHI's National Health Expenditure database is also a source of drug spending data. The Health Council of Canada has reported on progress on the implementation of NPS initiatives; however, there is no consistent reporting by the provinces and territories on their initiatives in the area of pharmaceuticals management.^{3, 61, 130, 131, 133, 138}

Despite early consensus on priorities, collaboration on the NPS among the federal, provincial, and territorial governments quickly dissolved as governments changed. Although the key enablers were present to varying degrees, the lack of sustained leadership contributed to the failure to implement a comprehensive national pharmaceuticals strategy as envisioned in the 10-year plan.

ENABLERS AND IMPLEMENTING ELECTRONIC HEALTH AND MEDICAL RECORDS^{xi, xii}

The 10-year plan highlighted the importance of electronic health records (EHRs) to health system renewal, and called for efforts to accelerate their development and implementation. There has been considerable progress since. For example, the use of electronic medical records (EMRs) in primary health care has more than doubled since 2006. Key medication, laboratory, diagnostic imaging, and other information is now available to authorized health care providers for more than half of the population.^{19, 139} Although Canada's performance still lags behind many other high-income countries, the seeds of this consistent progress can be seen in the key enablers:

xi/ This example was developed based on feedback provided by Canada Health Infoway.

xii/EHRs capture a patient's health information from across the health system (e.g., primary health care, diagnostic imaging, laboratory tests, and medication information), making information available to authorized health care professionals across health settings. EMRs such as those created and maintained in a primary health care practice, are one component of an EHR.

Leadership: Over the last 10 years, the federal, provincial, and territorial governments have all demonstrated a sustained commitment to invest in information and communication technologies. Together with Canada Health Infoway, they worked to find consensus on priorities and directions and to deliver on them in ways appropriate to the needs and contexts of individual jurisdictions. Health sector leaders have also been clear about the importance of the effective use of digital health solutions to achieve this country's health goals.^{140, 141}

Policies and legislation: Progress on ensuring appropriate legislative and policy frameworks has occurred across the country. For instance, a number of jurisdictions either introduced health information protection legislation or amended existing legislation to reflect evolving needs. In addition, the pan-Canadian Health Information Privacy Group, composed of representatives of the Ministries of Health, agreed to a set of 53 common understandings to support appropriate disclosures of EHR information.¹⁴²

Capacity building: A range of efforts over the last decade identified capacity and addressed gaps. Examples include expanded educational opportunities and agreed-upon core competencies, work by the faculties of medicine, nursing, and pharmacy to ensure that clinicians-in-training are ready to practice in a technology-enabled environment when they graduate, clinical peer-support networks, efforts to establish common standards, investments in research, and various activities to strengthen Canada's health information technology industry. A pan-Canadian network and resources were developed to support effective change management.¹⁴³⁻¹⁵⁰

Innovation and spread: Digital health represents both an example of innovation applied in the health sector and a platform that enables innovation in health and health care. For example, a recent Canada Health Infoway study showed that primary health care clinics using EMRs were able to generate a list of patients who might benefit from screening for diabetes or cancer 30 times faster than could clinics with paper records.¹⁵¹

Measurement and reporting: Canada Health Infoway developed a benefits evaluation framework and strategy in 2006, as well as indicators that can be used for tracking and evaluating digital health progress. These have since been applied to a wide range of projects across Canada. The Auditor General of Canada, several provincial Auditors General, and the Health Council of Canada also reported on progress, thereby providing additional mechanisms for accountability.^{61, 152-155}

The five key enablers contributed to progress toward the implementation of EMRs. However, full implementation of a national, comprehensive EHR system has not been achieved to date. Reports from Canada Health Infoway focused on achieving better value for money and provided some data on improvements in care, but health outcomes were typically not measured.¹⁵⁶ Equitable access to EHRs has not been an explicit goal, as evidenced by the variable funding and implementation of EHR components across the country.¹⁹ Alignment with the balanced system goals of better health, better care, and better value, with equity as an overarching aim, could have moved progress forward at a quicker pace and will be essential to optimizing results in the future.

ACHIEVING A HIGH-PERFORMING HEALTH SYSTEM IN CANADA

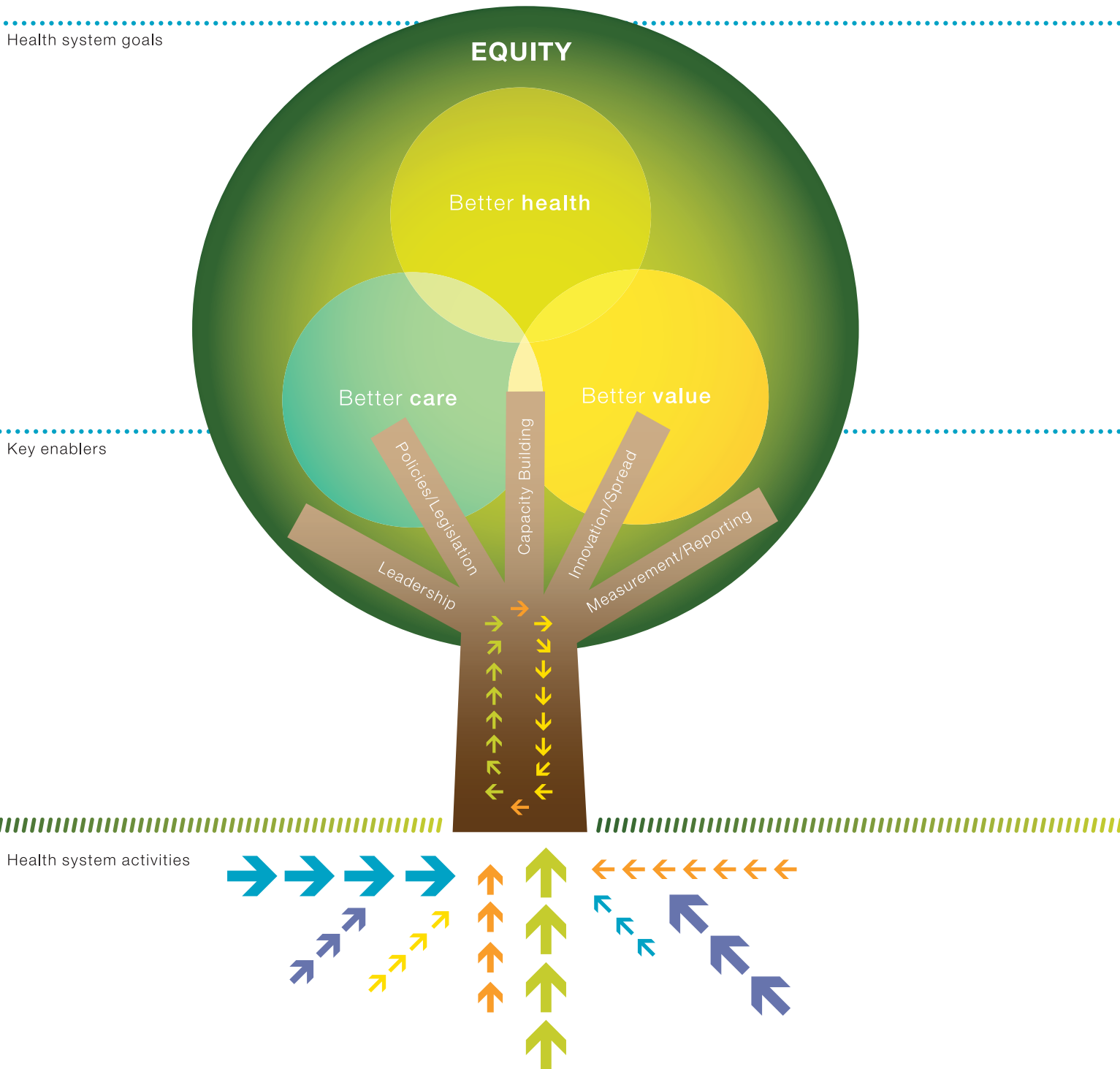
Drawing on these lessons, the Health Council outlines an approach to achieve a high-performing health system in Canada. This approach (see Figure 3) directs more attention toward the alignment of all health system activities in order to achieve the goals of better health, better care, and better value for all Canadians. These health system activities include, for example:

- patient engagement (e.g., active participation in their care);
- individual contributions of health care providers (e.g., nursing care);
- management processes at the organizational level (e.g., operationalizing a hospital surgical checklist); and
- strategic planning and policy decisions at the regional health authority level (e.g., implementing integrated service plans) and health ministry levels (e.g., implementing a provincial disease strategy).

Enablers are critical to support this alignment and to guide all health system activities toward achieving the goals. The key enablers—leadership, policies and legislation, capacity building, innovation and spread, and measurement and reporting—are interconnected and interdependent. Dedicated efforts to address each on an ongoing basis are needed. Continuous monitoring and assessment of health system activity provide feedback to health system stakeholders that facilitates engagement and allows ongoing improvements.

The key enablers—leadership, policies and legislation, capacity building, innovation and spread, and measurement and reporting—are interconnected and interdependent.

Figure 3. An approach to achieving a high-performing health system in Canada



Our approach draws on international health system reform frameworks and activities and aligns with health system transformation thinking and activity taking place in Canada.^{7-9, 11, 14, 23-25, 27-29, 97, 104, 106, 157-163}

Organizations such as the Canadian Institute for Health Information, the Commonwealth Fund, the Institute for Healthcare Improvement, the Organisation for Economic Co-operation and Development, and the World Health Organization have developed measurement frameworks to *measure the extent of change* toward identified goals.¹⁵⁷⁻¹⁶³ Our approach outlines *how to achieve* the goals, and can be used by all health system stakeholders to guide health care reform efforts at the provider, organizational, regional health authority, provincial, territorial, and federal government levels.

MOVING THE APPROACH FORWARD: HOME CARE AND PRIMARY HEALTH CARE

To illustrate the Health Council's approach, we consider home care and primary health care. Limited system-level reform occurred in these areas during the last decade, and there will be significant demand for action in the next decade.

The health accords focused on providing short-term (two-week) home care services for people discharged from hospital and those with mental health issues, and on providing end-of-life care at home.

However, there was no commitment to address the longer-term needs of people with chronic conditions, particularly seniors, or the needs of family caregivers.² Access to home care services continues to vary across the country, and demand is growing.^{67, 78}

Under the health accords, innovative primary health care models were developed and implemented. However, many were not evaluated or shared widely and Canada's performance in primary health care does not compare well to that of many other high-income countries. Effective primary health care is consistently recognized as being critical to the transformation of our health system.^{55, 61}

In Table 3, we provide examples of balanced goals and specific actions within each enabler in home care and primary health care that would contribute to better health, better care, and better value for all Canadians.

TABLE 3
Applying the approach: Two examples

	HOME CARE ⁶⁷	PRIMARY HEALTH CARE ^{19, 55, 164}
BALANCED GOALS		
Better health	<p>More seniors and others in need of home care are able to remain at home.</p> <p>Individuals remaining at home are able to maintain a better quality of life.</p> <p>Fewer family caregivers show signs of distress.</p>	<p>More individuals live healthy lives (e.g., are physically active, maintain a healthy weight, do not smoke).</p> <p>Fewer individuals develop chronic conditions, and those that do are able to manage them effectively and have a better quality of life.</p>
Better care	<p>Home care clients have greater access to the services they need when they need them.</p> <p>Safe care is provided at home.</p> <p>Family caregivers receive the support they need.</p> <p>Home care clients and family caregivers are engaged in care planning.</p>	<p>Primary health care planning engages providers and patients.</p> <p>More individuals have timely access to a primary health care provider or team when they need care.</p> <p>Care is provided by interdisciplinary teams supported by electronic medical/health records.</p> <p>Primary health care providers are sensitive and responsive to patient needs, engage patients in their care, and support self-management of care.</p>
Better value	<p>Individuals receive care at home when it is the most appropriate and cost-effective place to receive care.</p> <p>The financial impact on family caregivers is reduced.</p>	<p>Fewer patients are seen in emergency departments and hospital admissions are reduced.</p> <p>Appropriate care is provided by appropriate providers, according to need.</p>
Equity	<p>Individuals receive home care based on their need and potential to achieve the same health outcomes, regardless of who they are, how much they can pay, or where they live in Canada.</p>	<p>All individuals are able to access a primary health care provider or team when they require care, regardless of who they are or where they live in Canada.</p> <p>Disparities in health status are reduced.</p>

(Table 3 cont'd)

	HOME CARE	PRIMARY HEALTH CARE
SUSTAINED ENABLERS		
Leadership	<p>Increase collaboration among the federal, provincial, and territorial governments to support consistent reform and a pan-Canadian approach aligned to system goals.</p> <p>Encourage continued leadership by the Canadian Home Care Association and other stakeholders to define shared principles for a national home care program.</p>	<p>Provincial and territorial governments provide sustained leadership to support reforms aligned toward shared and balanced system goals and to achieve more consistent primary care across Canada.</p> <p>Enhance effective governance at the regional level to support improved services, system integration, and adoption of best practices.</p>
Policies and legislation	<p>Build on work done by Ontario and other provinces to develop policies and legislation on home care and seniors' care.</p> <p>Ensure that policies align with shared principles and system goals, to develop consistency in access to, and quality of, home care services across Canada.</p>	<p>Align policies and legislation—in areas such as fee structures and patient enrolment—with the balanced goals in order to ensure timely access to primary health care providers and to coordinate and integrate primary health care with other aspects of health care.</p>
Capacity building	<p>Address the following: recruitment and retention challenges including disparities in compensation compared to other sectors; lack of standardized training; working conditions; and an aging workforce.</p> <p>Engage patients and family caregivers in planning efforts to ensure that caregivers receive adequate support and training.</p>	<p>Expand scopes of practice, interdisciplinary training, and quality improvement training among health professionals to support effective, functioning teams.</p> <p>Accelerate implementation of EHRs to improve patient care, evaluation, planning, and resource allocation.</p> <p>Build partnerships across sectors and with patient groups.</p>
Innovation and spread	<p>Support innovative approaches to better integrate home care within the care continuum.</p> <p>Conduct research in areas such as cost-effectiveness and home care safety to support future policy work.</p>	<p>Develop innovative evaluation methods to measure primary health care outcomes.</p> <p>Extend the connectivity of EHRs to enable information sharing across providers and sectors and to enable patient access.</p> <p>Invest in primary health care research and knowledge translation to inform primary health care policy and practice.</p>
Measurement and reporting	<p>Expand use of a standardized tool such as the Resident Assessment Instrument—Home Care (RAI—HC) (used to assess the need for home care services). The data collected would also allow measurement of the access to, and quality of, home care services.</p> <p>Expand public reporting on home care performance measures beyond that done by CIHI and some provinces, such as Ontario.</p>	<p>Measure primary health care outcomes in a standardized way to support evaluation of existing primary health care models and programs.</p> <p>Develop and implement continuous quality improvement measures.</p> <p>Publicly report on primary health care outcomes to facilitate evidence-informed decision-making by patients, providers, and policy-makers.</p>

CONCLUSION

Better health. Better care. Better value. *For all.*

Canadians expect, and deserve, no less.

Yet, after 10 years of efforts and investments to improve our health system, these goals remain a challenge. The success of the 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care* in stimulating health system reform has been limited. Overall, the decade saw few notable improvements on measures of patient care and health outcomes, and our performance compared to other high-income countries is disappointing.

Over the period of the health accords, Canada increased its spending on health care to more than \$200 billion a year, yet the concerns about quality, access, and sustainability reflected in the health accords persist. It has become clear that investing significantly more money in our health system is unrealistic given the current financial climate. Furthermore, the experience of the last decade suggests spending more money is unlikely to achieve the desired results. We need to refocus health care reform. Choices need to be made. We must, and we can, do better.

TOWARD A HIGH-PERFORMING HEALTH SYSTEM

As a means to stimulate health reform, the health accords exhibited a number of weaknesses. However, they did provide valuable insights into what works and what does not when it comes to achieving transformative change. Drawing on these experiences, this report provides a vision and an approach for achieving a high-performing health system.

All governments, health care organizations, and health care providers must pursue the same balanced goals: better health, better care, and better value, with an overarching aim of achieving equity. This is not simply a statement of the obvious. The 2003 and 2004 health accords did not articulate a shared vision with a balanced set of goals in the clear manner we advocate here, resulting in a lack of progress. Just as important, a sustained and simultaneous focus on supporting the key enablers—leadership, policies and legislation, capacity building, innovation and spread, and measurement and reporting—is fundamental to ensure that all health system stakeholders across the country are working toward the same vision and are positioned to achieve the shared goals.

THE NEED FOR STRONGER LEADERSHIP AND PAN-CANADIAN COLLABORATION

Canadians are free to live in the province or territory of their choosing. And most people assume that their own provincial or territorial health system provides care and yields outcomes similar to those in other parts of the country. In fact, this has not been the case for some time. Provincial and territorial leaders can expect Canadians to object as increasingly divergent systems lead to more explicit differences in access to, and the quality of, health services across the country.

The federal government's funding formula provides the provinces and territories with significant latitude in how they use the health care dollars provided through the Canada Health Transfer (CHT). However, the federal government has traditionally played a central role in ensuring a level of equity across Canada—using the CHT as a means to uphold the principles embedded in the *Canada Health Act*. This responsibility for equity provides the most compelling reason for the federal government

to actively engage in shaping our health system. Whether a Canadian lives in British Columbia, Nova Scotia, the Northwest Territories, or elsewhere, they expect high quality care. The federal government's active participation in health system planning and policy development, and its provision of appropriate funding support, brings a critical "Canadian" perspective to all discussions and decisions about health care.

At the same time, the provinces and territories must not use their jurisdictional responsibility for health care as a dialogue-ending argument, either with each other or with the federal government. They need to consciously recognize that they are co-owners of a national system and, as a result, have a shared responsibility to ensure that each jurisdiction delivers comparable results. Provincial and territorial leaders should encourage and support pan-Canadian collaboration. We hope that the Council of the Federation and its Health Care Innovation Working Group continue to seek effective ways to collaborate on these issues for the benefit of all jurisdictions and their residents. Their efforts must include inviting a willing federal government to the table to dialogue in good faith. Effective collaboration is critical if real transformation is to take place within and across all of Canada's health systems.

Beyond governments, all health care organizations and health care providers must move outside their organizational and professional silos to ensure that the available resources are used when and where they are needed to achieve better value for Canadians. Governments alone cannot transform the system; they need the active support and participation of other health system stakeholders.

A CALL FOR ACTION

The results of the last 10 years make it clear that we need to do things differently. If we want to achieve better outcomes in the future, we cannot continue our disparate, tentative approaches to health care reform across the country.

A high-performing health system *is* possible in this country. However, it will require a renewed commitment to pan-Canadian collaboration, the articulation and pursuit of balanced goals, and the active and sustained support of key enablers.

It is a vision worth pursuing—for the health of all Canadians.

We cannot continue to pursue disparate, tentative approaches to health care reform across the country.

NOTES ON METHODS AND DATA SOURCES

NOTES ON METHODS

Throughout the report we aim to compare data over the full period of the health accords. We examined data between 2003 and 2013 to draw comparisons over the decade, using data for the closest years available. We used, wherever possible, the same data sources to present Canadian and international data for each indicator presented in this report. Due to a lack of international data over time for the physical inactivity indicator, Statistics Canada data were used to present the change over the last decade within Canada. The international comparison was made using the most recent international data available from the World Health Organization.

Although in most cases we report data rounded to the nearest whole number, all analyses and rankings were carried out on the specific data values reported in the sources used.

DATA SOURCES

THE COMMONWEALTH FUND INTERNATIONAL HEALTH POLICY SURVEY

The Commonwealth Fund, a US-based organization, conducts an international survey each year to assess health system performance and experiences. Canada and 10 other countries participate in the survey each year. The Health Council of Canada has co-sponsored this survey annually since 2007 in order to increase the response size for Canada, and it receives raw data on all countries surveyed. Depending on the focus of the survey, Canadians and/or primary care physicians who practice in Canada are contacted by phone or mail to provide survey responses. For this report, we used data from the 2006 and 2012 surveys of primary care physicians, as well as data from the 2004, 2007, and 2010 surveys of adults from the general population. Commonwealth Fund survey data presented in this report are based on our own analyses, some of which have been published in previous Health Council reports. In our analyses of the raw data, we exclude non-respondents. Slight differences between our results and those reported by the Commonwealth Fund may reflect differences in analytic methods used. For more information, visit the Commonwealth Fund's website at <http://www.commonwealthfund.org/Surveys/View-All.aspx?topic=International+Health+Policy>.

ORGANISATION FOR ECONOMIC CO-OPERATION AND DEVELOPMENT (OECD) HEALTH DATA

Many of the international comparative data presented in this report are drawn from OECD's online health database *OECD.StatExtracts*. This database features data from the 34 member countries on health status, the determinants of health, health care expenditure and financing, utilization, and quality of care. Some of the countries may not collect relevant data for a given indicator, or may not collect them every year, resulting in missing data for some of our analyses. In addition, the countries may differ in the way they measure, define, or collect the data that they provide to the OECD. The OECD provides information on the limitations in data comparability for each indicator. This was included in our figures wherever applicable. For more information, visit the OECD website at <http://stats.oecd.org/Index.aspx>.

STATISTICS CANADA

The Canadian Community Health Survey is a cross-sectional survey conducted by Statistics Canada to gather information from Canadians across the country on health status, the use of health services, and the determinants of health. We used the CANSIM and the 2011 Census databases from Statistics Canada to extract the statistics presented in this report. For more information, visit Statistics Canada's CANSIM website at <http://www5.statcan.gc.ca/cansim/a01?lang=eng> and its 2011 Census website at <http://www12.statcan.ca/census-recensement/index-eng.cfm>.

WORLD HEALTH ORGANIZATION

The Global Health Observatory Data Repository from the World Health Organization (WHO) provides online access to health-related data for its 194 member states. In this report, we have presented international data obtained from this repository. These data include the WHO's best estimates using methodologies for specific indicators to allow comparable analyses across countries and time. Because estimates are updated as more recent or revised data become available or when changes to the methodology are implemented, they are not always the same as the official national estimates. For more information, visit WHO's Global Health Observatory Data Repository at <http://apps.who.int/gho/data/view.main>.

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