

Progress report 2012: Health care renewal in Canada



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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 leading practices and innovation across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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Foreword

What we call the Canadian health care system is, in reality, 14 different health care systems, each governed individually to meet the needs of its citizens. The 2003 *First Ministers' Accord on Health Care Renewal* and the 2004 *10-Year Plan to Strengthen Health Care* were attempts to identify common priority areas shared by federal, provincial, and territorial governments, and to set out steps that needed to be taken to help improve the Canadian health care system as a whole.

Part of the Health Council of Canada's mandate is to report on the progress made by the federal, provincial, and territorial governments since these accords. In this year's report, we examine progress for five specific priority areas: home and community care, health human resources, telehealth, access to care in the North, and comparable health indicators. Another important part of our mandate is sharing innovative practices, so that governments, organizations, and the public can better understand what approaches are working, and why. In this report we have shone a spotlight on a number of innovative practices that reflect the spirit of innovation across the country. In addition, we are pleased to include Alberta, which recently joined the Health Council of Canada, in our progress reporting for the first time.

Progress Report 2012 uses the Health Council's 2008 comprehensive report of progress on the health accords as a starting point. That report, *Rekindling Reform*, found that there was "much to celebrate and yet much that falls short of what could—and should—have been achieved by this time." I believe this message still holds true today.

As this report shows, there is a lot of activity taking place across the country to improve our health care services. However, the jurisdictions, for the most part, act in isolation from each other. Perhaps, as the Premiers work together to improve health care, progress in health care renewal in Canada will be accelerated by the adoption of innovative practices across the country.

Dr. Jack Kitts
Chair, Health Council of Canada

Introduction

As the 2004 10-Year Plan to Strengthen Health Care is set to expire, the future of the Canadian health care system is under the microscope. In order to understand where Canada's health care system should be headed, there must be an understanding of where it is today.

Monitoring progress on the accords—the 2003 *First Ministers' Accord on Health Care Renewal*¹ and the 2004 *10-Year Plan to Strengthen Health Care*²—is a key element of the Health Council of Canada's mandate. But the challenge is to determine how the commitments made in the accords have resulted in demonstrable change at the provincial and territorial levels. The accords did not, by and large, set out clear parameters for change, or the type of reporting that would be useful to the jurisdictions to measure such change. First Ministers did establish a series of comparable indicators for the provinces and territories to report on in 2004. However, their reporting only lasted a few years. Since then, the provinces and territories have developed their own indicators to address their respective planning needs. As a result, they do not consistently report on progress in the same manner, particularly in a comparable way that is useful to other governments and the public.

In this report, the Health Council of Canada provides an assessment of what has been accomplished to date in five priority areas. The Health Council searched government websites and health care stakeholder websites—such as Canada Health Infoway, the Canadian Institute for Health Information (CIHI), and Statistics Canada—as well as the websites of national organizations that report on specific aspects of health care or health care reform. To fill in many information gaps, the Health Council of Canada used a formal process for gathering information directly from provincial, territorial, and federal health ministries and departments, and consulted with experts in relevant fields. The Health Council's approach provides an overall picture of how the accord commitments are being met. Specific information on each jurisdiction is provided in the *Jurisdictional profiles on health care renewal*.

In 2008's *Rekindling Reform*, the Health Council of Canada reviewed and reported on progress resulting from the 2003 *First Ministers' Accord on Health Care Renewal*.³ Last year, the Health Council of Canada released *Progress Report 2011*, a review of progress on both the health accords in the areas of wait times, pharmaceuticals management, electronic health records, teletriage, and health innovation.^{4,5} This 2012 report documents progress on home and community care, health human resources, telehealth, access to care in the North, and comparable health indicators. The report also showcases innovative practices to inform Canadians about promising efforts to improve their health care systems, and to facilitate consideration of how these efforts might be expanded or adapted in other provinces and territories.

Home and community care

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

First Ministers agree that additional investments in primary health care, home care, and catastrophic drug coverage are needed for a long-term sustainable public health care system in Canada. The federal government will create a five-year Health Reform Fund which will transfer resources to the provinces and territories to address these three priorities.

First Ministers direct health ministers to determine by September 30, 2003, the minimum services to be provided.

The Government of Canada will complement these efforts with a compassionate care benefit through the Employment Insurance Program and job protection through the *Canada Labour Code*, for those who need to temporarily leave their job to care for a gravely ill or dying child, parent, or spouse.

2004 10-Year Plan to Strengthen Health Care

First Ministers agree to provide first-dollar coverage by 2006 for certain home care services, based on assessed need, specifically to include:

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

Each jurisdiction will develop a plan for the staged implementation of these services, and report annually to its citizens on progress in implementing home care services. First Ministers task their health ministers to explore next steps to fulfill the home care commitment and report to First Ministers by December 31, 2006.

What the Health Council said in 2008

- Even as the need for home care services increases, governments are not inclined to commit to a broad, inclusive, publicly funded home care program, leading to increasing amounts of unmet need.
- The federal compassionate care benefit program created in 2004 was expanded to include a wider range of eligible caregivers, yet many Canadians were still not accessing this program.
- In January 2007, health ministers reported that all provinces and territories had taken steps towards fulfilling their commitments for home and community care services. However, specifics were not provided.
- In February 2007, the Yukon was the first province or territory to submit its home care data fully to the Canadian Institute for Health Information using the Home Care Reporting System.
- Current publicly funded home care coverage was not adequate to meet needs.
- Overall, home care had not been integrated into the health care system to ensure that services were well coordinated, accessible, and contributed to a high quality of life.



Progress to date

The five-year Health Reform Fund that was referenced as part of the 2003 accord was created in 2004. It was meant to help jurisdictions reach the two-week commitments specified in the 2004 *10-Year Plan to Strengthen Health Care*. The fund was also intended to support investments in primary health care, home care, and catastrophic drug coverage, along with some aspects of mental health services. Since provinces and territories were at different stages of development in these three areas, the fund allowed jurisdictions that already had these services to increase the amount of service they provided.⁶

Post-acute home care

The accords stated that all provinces and territories were to provide short-term post-acute home care for a two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing, and personal care by 2006.² While this commitment was not met by all jurisdictions by that time, it has been met by all provinces and territories since then. British Columbia, Manitoba, Newfoundland and Labrador, Nova Scotia, and Ontario have gone beyond the initial commitment by developing broader strategies for home care, aging, or end-of-life services.

Mental health services

Many provinces have met this commitment. In most jurisdictions, community mental health care is not provided under home and community care programs. Instead, the funds for mental health home care flowed to mental health programs that were not home care specific. Commitments for two weeks of case-management and crisis response services for community mental health were often met through broader mental health strategies and programs.

Some provinces have gone beyond this initial commitment. For example, in 2005, Ontario developed a Mental Health Accountability Framework that addresses crisis response services and intensive case management standards.^{7,8} British Columbia has a mental health and substance abuse plan—*Healthy Minds, Healthy People*—that highlights community resources.⁹ New Brunswick is implementing an individualized patient-centred approach to mental health that is delivered within the community.¹⁰

End-of-life care

Alberta, British Columbia, New Brunswick, Nova Scotia, Ontario, Prince Edward Island, and Saskatchewan met the commitment. In 2005, Ontario invested about \$115 million in their end-of-life strategy, in large part to shift health care for persons in the last stages of their life from hospital to more appropriate settings.¹¹ British Columbia also exceeded this accord commitment with their 2006 end-of-life strategy.¹² In the remaining provinces and territories, there is not enough information available to measure progress on end-of-life home care.

All provinces and territories also agreed to amend their labour laws to allow residents to take advantage of the federally supported compassionate care benefit through employment insurance programs. The compassionate care benefit is provided to employed caregivers of people who are seriously ill with a significant risk of death within 26 weeks, although it's not clear how well used the benefit is across the country.¹³

According to a 2011 evaluation, most participants view the compassionate care benefit as an important support for family caregivers, although it is not being widely used and could be improved.¹⁴ Almost all jurisdictions met this commitment within a few years of the accords, with the exception of Alberta and the Northwest Territories. Some jurisdictions offered more than the standard eight weeks. Saskatchewan, for example, provides caregiver leave for up to 16 weeks.¹⁵

Home care data

Eight jurisdictions are at some stage of implementing the Resident Assessment Instrument-Home Care (RAI-HC),¹⁶ a standardized clinical assessment designed to assess the needs of clients requiring long-term home care. The RAI-HC is used by home care professionals to assess the strengths, preferences, and needs of home care clients in order to develop a person-centred care plan and allocate services. These assessments have been tested in several countries, including Canada, and were found to have strong reliability and validity.¹⁷

Prince Edward Island is working with CIHI to make their home care data comparable with the RAI-HC.¹⁸ New Brunswick, the Northwest Territories, and Nunavut have no plans to implement the RAI-HC,¹⁶ but are using other tools to assess needs and measure outcomes.¹⁸ Various other instruments are used in each jurisdiction to supplement information derived from the RAI-HC.¹⁹

For a more detailed account of home and community care progress provincially, territorially, and federally, read the *Jurisdictional profiles on health care renewal* (healthcouncilcanada.ca/pub/progress2012).

The bottom line

- Commitments to short-term care have been largely met. Jurisdictions are moving forward on mental health strategies, but these are not being developed under the home care umbrella.
- Progress on end-of-life care is variable in terms of what services are covered in each jurisdiction. The compassionate care benefit program appears to be underutilized.
- Eight jurisdictions have implemented, or are implementing, the RAI-HC assessment, increasing the available comparable performance data among them.

Commentary

Many jurisdictions had already met the post-acute and mental health short-term home care commitments at the time of the accords. However, rather than pushing jurisdictions to improve home care services, the commitments instead created an even playing field by establishing a level of service all provinces and territories could achieve. Since some jurisdictions had already achieved this level of service, further progress in subsequent years has increased the variability of home care services among jurisdictions.

CIHI's Home Care Reporting System (HCRS) uses RAI-HC data to provide quarterly reports to participating organizations, which provide access to data from their own and other organizations, as well as jurisdiction-level reports. Jurisdiction-level information on home care is also available on CIHI's website, allowing for comparisons of home care populations and services. This allows provinces and territories to see how others are doing and learn from one another, with the potential to provide a pan-Canadian perspective. CIHI also uses this information in their analytical reports.²⁰ While many jurisdictions use the RAI-HC assessments and provide that information to CIHI, not all jurisdictions use that system. Provinces and territories that are using other forms of assessment and data collection may want to consider ways to make their data interoperable or comparable to the RAI-HC.

Family caregivers also play an important role in home care. Some jurisdictions are creating policies to address caregiver burden and caregiver distress. If the care needs of seniors and the support needs of their caregivers are not adequately addressed, then a further burden will be placed on Canada's health care system. Further, the sole focus on short-term home care in the health accords has meant that long-term home care needs, particularly the needs of seniors with multiple chronic conditions, have not received the same degree of attention.

The Health Council of Canada's April 2012 report on home care, *Seniors in Need, Caregivers in Distress*, noted that Canadians would benefit from expanded efforts to integrate home care with other services in the health care system, particularly hospitals and primary care, and to ensure that family caregivers continue to receive support as needs change. Home care has become an integral part of the health care provided to Canadians and this needs to be recognized. For that reason, continued efforts to provide appropriate care in the appropriate place, particularly for seniors, should be accelerated.

The recently released Standing Senate Committee on Social Affairs, Science and Technology review of the 2004 *10-Year Plan to Strengthen Health Care* noted that although the commitment to provide short-term home care services resulted in an increase in the services offered and individuals served, these short-term commitments did not ensure access to a broad range of services and shifted resources away from those with chronic needs. The Senate committee recommended implementing a continuing care strategy across Canada which would integrate care across sectors and services, as well as a pan-Canadian home care strategy which would include a focus on reducing the barriers faced by caregivers.²¹ The Health Council of Canada believes the Senate committee's recommendation should be pursued by governments.



PROMISING PRACTICE*

Health Quality Ontario's home care indicator reporting

Health Quality Ontario (HOO) is an independent agency dedicated to reporting to the public about the quality of Ontario's publicly funded health system, supporting continuous quality improvement, and promoting health care based on the best scientific evidence available.ⁱ

In December 2008, the Ontario government tasked HOO with measuring and publicly reporting on the quality of home care services and client satisfaction. In 2010, The Ontario Ministry of Health and Long-Term Care's *Excellent Care for All Act* mandated HOO to monitor and report to Ontarians on health services, health status of the population, and health system outcomes, to support continuous quality improvement, and to promote evidence-based health care.ⁱⁱ As a result, Ontario is the first, and currently only, province to report publicly on quality home care indicators through HOO's home care public reporting website.

Most of the data are gathered by the RAI-HC assessment tool, which has been implemented across all Community Care Access Centres (CCAC) in Ontario, and is reported by HOO.ⁱⁱⁱ

The RAI-HC is used by home care professionals to assess the strengths, preferences, and needs of home care clients, so that a person-centred care plan can be developed, and the proper services can be provided. RAI-HC assessments have been tested in several countries, including Canada, and were found to be reliable and valid.^{iv,v}

Indicators are listed by provincial results and by CCAC on the HOO website.^{vi} Most data are only available for long-stay home care clients—46% of all clients—since

they are the only clients who are assessed with the RAI-HC assessment.ⁱⁱⁱ Public reporting on home care indicators encourages transparency and accountability and facilitates quality monitoring.^{vii} These indicators are also reported in HOO's annual report, *Quality Monitor*, along with ideas for improvement and examples of success.^{viii}

Home care data across Ontario have been collected through the RAI-HC since 2005, and have been reported on publicly through the home care website and the *Quality Monitor* for three years. A working group of provincial home care associations, stakeholders, and clinical and scientific experts were consulted through a consensus building process to decide on a set of key home care quality indicators for reporting on the quality of home care services in Ontario. The website was recently refreshed in March 2012 with new information and now includes results for 11 home care quality indicators on important topics such as wait times, falls, and—for the first time ever—client experience.^{ix}

These indicators are reported for the public, providers, and policy makers. The public can use the indicators to understand more about home care services; providers can use them to compare their performance to others and improve their processes; and policy makers can use them to understand trends and inform policy. Although there are currently no plans to evaluate the impact of these indicators on quality improvement processes, there have been continued discussions with the working group which have led to improvements in the way these indicators are reported, including the current goal to report this data at the provider level.^{ix}

**The Health Council of Canada has established criteria to categorize innovative practices as emerging, promising, or leading (healthcouncilcanada.ca/innovativepractices).*

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v Gray, L.C., Berg, K., Fries, B.E., Henrard, J.-C., Hirdes, J.P., Steel, K., & Morris, J.N. (2009). Sharing clinical information across care settings: The birth of an integrated assessment system. *BMC Health Services Research*, 9, 71. doi: 10.1186/1472-6963-9-71

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Health human resources

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

First Ministers direct health ministers to:

- Work on appropriate planning and management of health human resources.
- Undertake collaborative strategies to strengthen the evidence base for national planning, promote interdisciplinary provider education, improve recruitment and retention, and ensure the supply of needed health providers (including nurse practitioners, pharmacists, and diagnostic technologists).

2004 10-Year Plan to Strengthen Health Care

As part of efforts to reduce wait times, First Ministers agree to continue and accelerate their work on health human resources action plans and/or initiatives to ensure an adequate supply and appropriate mix of health care professionals.

- Plans will build on current work in health labour relations, interdisciplinary training, investments in post-secondary education, and credentialing of health professionals.
- Commit to involving health care providers in their work in this area.
- Acknowledge the need to foster closer collaboration among health, post-secondary education, and labour market sectors.

The federal, provincial and territorial governments agree to increase the supply of health professionals based on their assessment of the gaps, and to make their action plans public—including targets for the training, recruitment, and retention of professionals by December 31, 2005—and report regularly on progress.

The federal government also commits to:

- accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments;
- targeted efforts to increase the supply of health care professionals for Aboriginal communities and Official Languages Minority Communities;
- measures to reduce the financial burden on students in specific health education programs; and
- participate in health human resource planning with interested jurisdictions.

What the Health Council said in 2008

- In a range of professions, more students were learning how to provide team-based care in a growing number of interprofessional education programs.
- Federal and provincial programs were helping more foreign-trained health care professionals to work in Canada.



- Some important activities were being undertaken to help governments and educators meet future health human resources needs:
 - CIHI collected pan-Canadian data on a range of health professions beyond nurses and doctors.
 - Governments created a collaborative action plan, with objectives, actions, and timelines, for health human resources planning that considered population need.
- Federal, provincial, and territorial investments were made to create effective team-based care, e.g., the federal initiative on Inter-professional Education for Collaborative Patient-Centred Practice.
- The Canadian Inter-professional Health Collaborative, located at the University of British Columbia and funded by Health Canada beginning in 2007, was established to serve as a hub for information about interprofessional education, collaboration in health care practice, and patient-centred care.
- The pan-Canadian collaboration envisioned in the 2003 accord to plan for needed health care providers had not resulted in coordinated planning.
- There were some valuable efforts in regional collaboration, but each province and territory did its own fragmented planning without the benefit of pan-Canadian information.

Progress to date

The accords provided direction on the need to undertake collaborative health human resources planning. While many jurisdictions created strategies independently, most did not set out specific supply targets. Over time, many provinces and territories have updated their strategies, though they often do not contain targets. Instead, these strategies speak to the need for action on health human resources with most discussing common themes: increasing health human resources supply through education, recruitment, and retention initiatives; making more effective use of providers' skills; creating healthy and safe workplaces; and improving planning and forecasting.

In addition, there are a variety of health human resources initiatives that support collaborative planning across Canada. For example, the Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources established the *Framework for Pan-Canadian Health Human Resources Planning*, which sets goals to enhance collaborative health human resources planning capacity.²²

Significantly, this framework has become a reference point in many provincial and territorial health human resources strategies, and has raised awareness for needs-based health human resources planning and forecasting, and it serves as a way to share information.²³ Further, one of the goals of the Pan-Canadian Health Human Resources Network, established in 2011 and funded by the Canadian Institutes of Health Research, is the creation of a clearing house of health human resources research and promising practices.²⁴

With respect to reporting and planning, jurisdictions are collecting and providing data to CIHI as part of their common minimum datasets, which are part of larger national databases for selected health care professions. This has made it much easier to compare across jurisdictions for professions such as physicians, nurses, pharmacists, occupational therapists, physiotherapists, medical laboratory technologists, and medical radiation technologists.^{25,26} Most governments are using this information for planning, but there are other health human resources information needs that go beyond those stated in the accord. These issues will have implications on future workforce planning. For example, British Columbia established a registry of home care aides and community health workers working in continuing care, home care, and community care in 2010; Ontario followed a year later with a registry for personal support workers.²⁷ Information from CIHI and other sources reinforce continuing concerns about the aging workforce, the shortage of professionals in rural and remote communities, particularly in the North, and preferences for employment arrangements other than full-time work.²⁸

While the federal government is not responsible for health human resources development in the provinces and territories, it does nonetheless play a collaborative role in health human resources planning and implementation, such as its support for CIHI's development of Health Human Resources Databases for priority professions,²⁶ the Family Medicine Residencies Initiative,²⁹ and the Internationally Educated Health Professionals Initiative.³⁰ Health Canada also funds and delivers a range of health services and programs to First Nations and Inuit in Canada. For example, the Aboriginal Health Human Resources Initiative works to increase the supply of Aboriginal health care professionals.³¹ One of the primary means of accomplishing this goal is through bursaries and scholarships for members of First Nations to train in health professions, so that these individuals can choose to return to their communities to practise. The initiative was

renewed for five years in 2010, with an expanded mandate to increase training and certification of community-based health care workers. The federal government has also been involved with health human resources retention efforts by enacting financial measures that partially forgive Canada Student Loans for new physicians, nurses, and nurse practitioners who practise in underserved rural or remote communities.²³

CIHI has been tracking the numbers of certain health care professionals in Canada since 2006 and, in line with the accord commitments, supply has increased. For example, from 2006 to 2010, the number of physicians increased by nearly 12% to 69,699, the number of registered nurses grew by nearly 6% to 268,512,³² and the number of pharmacists grew by more than 16% to 31,195.³³

For a more detailed account of health human resources progress provincially, territorially, and federally, read the *Jurisdictional profiles on health care renewal* (healthcouncilcanada.ca/pub/progress2012).

The bottom line

- The supply of health care professionals in Canada increased from 2006 to 2010, as agreed to in the health accords.
- Most jurisdictions have health human resources strategies. All jurisdictions are taking some action on health human resources planning.
- There is collaboration within many jurisdictions, but not always integration of health human resources into broader health system plans.

Commentary

The accords did not contain specific targets, but rather spoke in broad terms of increasing health human resources supply. While federal, provincial, and territorial governments should be applauded for their work on health human resources initiatives, as the workforce ages and Canadians' health care needs grow more complex, more can be done.

There are still gaps and challenges that need to be addressed. For example, a 2011 CIHI report noted that health-specific price inflation is a key cost issue for the health system. Managing this cost driver for core medicare goods and services, including doctors, nurses, and other health care professionals, continues to be a challenge for governments, especially with the growth of physician remuneration.³⁴ Another report recently mentioned that the focus on the supply of health care professionals, nurses in this case, has overshadowed the retention and workplace quality issues.³⁵

In 2010, the House of Commons Standing Committee on Health issued a series of recommendations that could help address some of Canada's health human resources issues, including a proposal to create an arm's-length national observatory on health human resources to promote research on best practices, to promote data collection, to act as a knowledge translator, and to identify key priorities for future research.²⁵

In January 2012, Canada's premiers announced the creation of the Health Care Innovation Working Group, comprised of all provincial and territorial health ministers, which will consider scopes of practice and human resources management.²⁴ Their report is due in July 2012.

Canada has achieved gains in the supply of health human resources. However, more attention has to be paid to achieving the right mix of providers and supporting various health care professionals to work to their full scopes of practice in order to strengthen the performance of Canada's health workforce, and ensure the sustainability of the Canadian health care system.



PROMISING PRACTICE*

The Model of Care Initiative in Nova Scotia

In 2008, due to an increasing demand for health services, staff shortages, and fiscal challenges, Nova Scotia reported on a study that concluded that a transformation of its health system, including acute care, was needed. Specific problems in acute care included health care professionals spending time on duties that didn't require their specific training, and a variety of processes that were inefficient or out of date. The Model of Care Initiative in Nova Scotia (MOCINS) was created to address these problems and others.ⁱ

MOCINS was launched as a provincial partnership between the Nova Scotia Department of Health and Wellness, the District Health Authorities, and the IWK Health Centre in Halifax. The mandate was to design, implement, and evaluate a viable provincial model of care for acute care in-patient servicesⁱⁱ that was to be patient centred, high quality, safe, and cost-effective. A provincial interprofessional team was tasked with designing a new model of care, referred to as the Collaborative Care Model.ⁱ

The goal of the Collaborative Care Model is to provide more efficient high quality patient-centred care in hospitals. It is designed to orient providers towards working to their optimal scopes of practice, in a collaborative way as part of an interprofessional team. The model's implementation framework is focused on improving patient care and providing more support to health care providers by targeting four areas: people, processes, information, and technology. This is done through ongoing staff development and mentorship; strong and effective communications; committed

and supportive leadership; and collaboration across the continuum of care.ⁱⁱⁱ

An evaluation conducted by a research team from Dalhousie University/WHO Collaborating Centre on Health Workforce Planning and Research has shown that the implementation of this new model has led to better patient care and increased job satisfaction for health care providers on the first 14 units. For example, on those units where the care was more coordinated and providers' respective roles were clear, there were better outcomes, such as shorter lengths of hospital stay, fewer repeated patient admissions to hospitals, and fewer shifts missed due to staff injury.^{iv} In a related effort, work is being done to create province-wide standardized roles for a variety of health care professionals, to enable more consistent work at a full scope of practice.ⁱⁱ

Nova Scotia has designed and implemented a new model of care and, at the same time, conducted a research-based evaluation of its effects on patients, health care providers, and the health care system. As of January 2012, the District Health Authorities and the IWK were implementing the Collaborative Care Model in approximately 84 units representing the majority of medical, surgical, and maternal child units in Nova Scotia's hospitals. They are also in the planning stages of expanding the implementation of the model in peri-operative and emergency care settings across the province in late 2012. As well, Nova Scotia has been collaborating with two provinces, Prince Edward Island and British Columbia, which have similar work under way.ⁱⁱⁱ

**The Health Council of Canada has established criteria to categorize innovative practices as emerging, promising, or leading (healthcouncilcanada.ca/innovativepractices).*

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Telehealth

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

Improving the accessibility and quality of information is critical to quality care, patient safety, and sustainability, particularly for Canadians who live in rural and remote areas. Better use of information technology can also result in better utilization of resources. First Ministers agreed to place priority on the further development of telehealth applications, which are critical to care in rural and remote areas. The Government of Canada will provide additional support for Canada Health Infoway to achieve this objective.

2004 10-Year Plan to Strengthen Health Care

First Ministers commit to work with Canada Health Infoway to accelerate efforts on telehealth to improve access to remote and rural communities.

What the Health Council said in 2008

The Health Council of Canada did not address Telehealth services in its 2008 report.

Progress to date

The federal government's investment in Canada Health Infoway included \$108 million for telehealth projects, to be cost-shared with provinces and territories.³⁶ All jurisdictions, except Prince Edward Island, have taken advantage of this funding,²³ and several have developed strategic plans for telehealth. Projects funded by Canada Health Infoway will exceed internal targets established with respect to the number of remote northern First Nations and Inuit communities provided with telehealth solutions.³⁷ The provinces and territories are forging ahead with the development, implementation, and accreditation of their own telehealth initiatives and, as a result, they have achieved various levels of progress.

For example, Manitoba is expanding telehealth services to complement health care renewal, particularly by integrating with primary health care and ensuring access to residents without telephones.³⁸⁻⁴⁰ The Ontario Telemedicine Network has a broad strategy to ensure telemedicine is used for health care delivery and health care education.^{41,42} In Nova Scotia, telehealth is an integral part of that province's Better Care Sooner Plan, which focuses on improvements in primary health care and emergency care.^{23,43} Several jurisdictions provide non-emergency telehealth services by phone or the web. These services offer access to nurses, pharmacists, and dietitians, and direct clients to appropriate services or locations.



For its part, Health Canada's First Nations Inuit Health Branch (FNIHB), working together with First Nations and Inuit communities, has made substantial efforts during the past five years to implement telehealth services.^{23,44} For example, Saskatchewan has a memorandum of understanding with the Northern Inter-Tribal Health Authority and FNIHB–Saskatchewan Region to support improved access, quality, and efficiency of services to First Nations and northern residents.²³ In British Columbia, the federal and provincial ministers of health and representatives of BC First Nations signed an agreement for a new governance arrangement for First Nations health in October 2011.^{23,45–47} Under the agreement, a First Nations Health Authority will take on current federal responsibilities for telehealth program design, planning, and delivery.⁴⁵

The jurisdictions share common challenges with expanding telehealth, such as adoption among providers, jurisdictional licensing for health professions, clinical reimbursement, and infrastructure.⁴⁸ However, the jurisdictions are addressing these challenges in different ways.⁴⁸ New Brunswick, for example, has removed barriers to health professionals providing care to patients beyond their provincial borders.²³ Ontario has made significant progress in the area of change management to engage providers and in the development of software-based technology to increase telehealth adoption among community-based physicians.^{18,23}

Some jurisdictions are working collaboratively to deliver telehealth services. British Columbia and the Yukon work together to provide services to Yukon residents through HealthLink BC.¹⁸ Similarly, in Alberta, the Capital and the Calgary health zones extend clinical and scheduling services to British Columbia, the Northwest Territories, Saskatchewan, and the Yukon.⁴⁹ Manitoba provides training and shares best practices with Nunavut. In Atlantic Canada, Nova Scotia, through the IWK Health Centre, provides services to residents in New Brunswick and Prince Edward Island, which minimizes the need for residents to travel to Nova Scotia for health services.²³

Studies on the use of telehealth in home settings demonstrate current and projected benefits in terms of net annual savings resulting from reduced need for home care, increased access to care, reduced hospitalizations, and improved health outcomes.^{48,50,51} Pilot projects are demonstrating a high rate of return on investment for addressing chronic diseases.^{48,50} For example, British Columbia, New Brunswick, Ontario, and Quebec indicated that hospitals or health regions avoided an estimated \$915,000 in emergency department visit costs and about \$20 million in in-patient costs over the telehealth study period.⁴⁸

While telehealth has come a long way since the accords, it is not clear how many Canadians have access to telehealth services, and it has been recommended that a standardized and systematic reporting system be developed to help address this.²¹

For a more detailed account of telehealth progress provincially, territorially, and federally, read the *Jurisdictional profiles on health care renewal* (healthcouncilcanada.ca/pub/progress2012).

The bottom line

- In 2010, 5,710 telehealth sites were being used in at least 1,175 communities across the country; there were close to 260,000 telehealth events held in 2010, including an estimated 94,000 in rural or remote areas.⁴⁸
- The use of telehealth in Canada has grown by 35% annually over the past five years and further growth is projected.⁴⁸ Telehealth and telemedicine provide nearly 80 types of clinical services across Canada.⁵² Mental health services account for more than half of the consultations performed, followed by internal medicine and oncology.⁴⁸
- Making comparisons across jurisdictions can be a challenge due to variations in program structure, services provided, the type of data collected by the programs, and resource capacities.^{48,52} Thus, there is little comparative data on telehealth performance across provinces and territories. However, when it comes to utilization statistics, the *COACH-CTF Canadian Telehealth Report*, which was released by Canada's Health Informatics Association and Canadian Telehealth Forum, should be noted for its efforts to document the use of telehealth, and related issues and trends, in Canada.⁵²

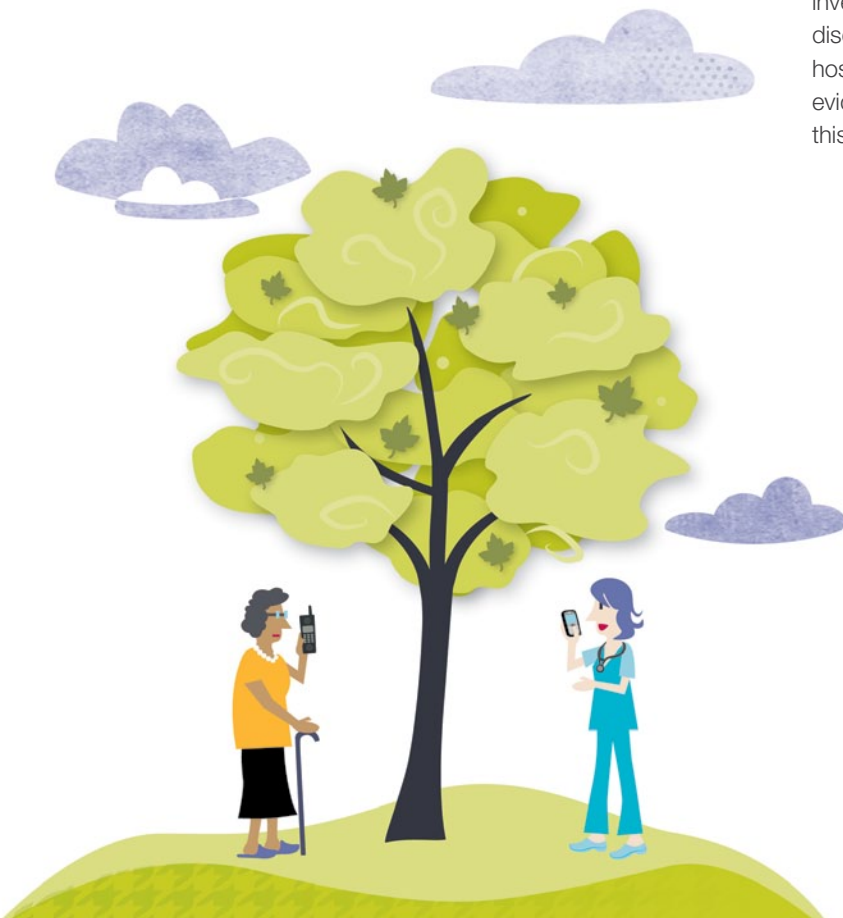
- The jurisdictions are at various stages of addressing what Canada Health Infoway calls the “critical success factors required for telehealth to achieve mainstream penetration and benefits realization.”⁴⁸ Dealing effectively with issues such as clinical reimbursement, professional development, technology implementation, licensing and other regulatory issues, governance and policy, change management and adoption, and benefits realization and measurement is fundamental to enabling the sustained use and expansion of telehealth.⁴⁸
- The use of telehealth reduces travel by patients, families, and health care providers, particularly those in rural or remote locations, which also leads to savings for governments in subsidized travel costs, and savings to patients and their families by not forcing them to travel for their care.^{18,23,48}
- Benefits of telehealth include improved care coordination, skill development, timeliness of care, equitable access to specialized clinical services, and support for the application of leading practices.⁴⁸

Commentary

Canada, with its widespread, remote populations, has a long history of using information and communications technologies to improve access to health care, particularly in rural and remote communities, beginning with telemedicine and telehealth. Today, telehealth is an important tool that enables federal, provincial, and territorial governments to deliver health care services to Canadians living in these and other communities. In the last few years, jurisdictions have made noticeably greater efforts to accelerate and expand the use of telehealth services for their citizens, in line with their priorities.

Canada is at the forefront of telehealth in some areas, such as video technology; on par internationally in other areas, such as home health monitoring; and less advanced in other areas.⁴⁸ However, consideration needs to be given to how to transform Canada’s many successful pilot projects into sustained initiatives.⁴⁸

The accord commitments were not target specific. However, it is essential to establish realistic targets and methods to assess how telehealth programs are achieving their projected benefits and sustaining the adoption of telehealth in each jurisdiction. More evaluations are needed, along the same vein as telehomecare demonstrator projects in Ontario and New Brunswick, which have yielded high rates of return on investment by enabling patient self-management of chronic disease, collaboration and integration of staff, and fewer hospital and emergency department visits. With additional evidence, governments may be prepared to invest more in this cost-effective approach to health care delivery.



PROMISING PRACTICE*

Telehealth success for First Nations in Manitoba

First Nations communities across Manitoba are greatly benefiting from telehealth, mainly because of partnerships among First Nations communities and leadership, health care facilities and providers, the provincial government, Health Canada, Canada Health Infoway, and Broadband Communications North.^{i,ii}

In Manitoba, roughly half of the on-reserve population lives in isolated communities with limited or no road access, and another 10% lives in semi-isolated communities hours away from physician services.ⁱⁱ Telehealth bridges geographic and jurisdictional divides, giving these remote populations access to patient education, primary health care, and specialties such as psychology, respiratory (using digital stethoscopes), oncology, dermatology, psychiatry, nephrology, and surgical pre-admission screening.^{i,ii} Telehealth also improves education and professional development for health care providers and supports contact between patients in hospital in the three major cities in Manitoba—Winnipeg, Brandon, and Thompson—and family members back home.ⁱ

The Manitoba experience demonstrates how it is possible to overcome many challenges, such as the lack of broadband coverage in remote locations; staff not being familiar with the technology; not having enough staff to handle the workload; the high initial cost of establishing telehealth sites; and the difficulties of working across jurisdictions (First Nations, federal, provincial, regional health authority).^{i,ii} These barriers were generally overcome by adhering to a series of guiding principles:^{i,ii}

- having a shared vision and common goal among the partnership members, while being respectful and valuing multiple perspectives;
- actively engaging and supporting local health care providers and community leaders early in the readiness assessment and implementation processes;
- providing ongoing support to the telehealth users and being responsive to arising issues and concerns;
- acting quickly and efficiently on short-term funding opportunities when available;
- keeping senior leadership apprised of progress, with transparency and accountability to parent organizations;
- providing accurate and timely statistics on service utilization;
- integrating with MBTelehealth (shared service rather than duplication);
- having First Nations and Health Canada representation on the provincial telehealth advisory committee; and
- investing substantially in connectivity provision by Broadband Communications North, an Aboriginal service provider dedicated and committed to supporting broadband needs of remote and rural First Nations communities, and the Provincial Data Network managed by the Province of Manitoba.

With more than 1,500 clinical telehealth sessions in the last year spread over 26 sites in First Nations communities, and with more under development, telehealth in Manitoba is expected to continue to grow.ⁱ

**The Health Council of Canada has established criteria to categorize innovative practices as emerging, promising, or leading (healthcouncilcanada.ca/innovativepractices).*

i Federal/Provincial/Territorial Health Ministry/Department feedback on draft Progress Report 2012. (2012, February). Unpublished data.

ii Sagan, M. (2011, November). *eHealth in Manitoba First Nations*. Presentation at the 2011 Health Canada Science Forum, Ottawa, ON.

Access to care in the North

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

This accord did not specifically mention access to care in the North.

2004 10-Year Plan to Strengthen Health Care

Access to family and community-based health care services is a particular challenge in northern communities, where the system's capacity to provide timely health care services to a remote population can be limited. The federal government has agreed to help to address the unique challenges facing the development and delivery of health care services in the North on a priority basis, including the costs of medical transportation as follows:

- The federal government proposes to increase funding to the territories totalling \$150 million over five years through a Territorial Health Access Fund, targeted at facilitating long-term health reforms, and establish a federal/territorial working group to support the management of the fund, and additional direct funding for medical transportation costs.

- Recognizing the enormous potential of the North, the Government of Canada and the territories will jointly develop a vision for the North.

What the Health Council said in 2008

The Health Council of Canada did not address access to care in the North in its 2008 report.

Progress to date

In the 2004 *10-Year Plan to Strengthen Health Care*, the federal government committed to a \$150 million health access fund to improve services in the North, to be divided among the three territories over five years. The federal government met this commitment in the form of the Territorial Health System Sustainability Initiative (THSSI), which it put in place in 2005. The 2010 federal budget included a two-year, \$60 million extension of the THSSI to “consolidate the progress made in reducing the reliance on outside health care systems and medical travel.”⁵³ In 2011, the Government of Canada further extended THSSI with an additional \$60 million over two years (2012–2014).⁵⁴ The extension will provide territorial governments with resources to continue health system reforms, participate in pan-territorial health initiatives, and offset medical transportation expenses.

The THSSI funds are administered through agreements with the territorial governments, and are composed of (a) the Medical Travel Fund to offset or help pay for medical transportation; (b) the Territorial Health Access Fund to reduce reliance over time on the health care system, strengthen community-level services, and build territorial capacity to provide services; and (c) the Operational Secretariat Fund to support a Federal/Territorial Assistant Deputy Minister Working Group, fund several pan-territorial projects, and provide resources to manage funding commitments.⁵⁵

An evaluation of THSSI, which covered the Territorial Health Access Fund and the Operational Secretariat Fund, was conducted in 2010. Further, THSSI has oversight mechanisms, including the Federal/Territorial Assistant Deputy Minister Working Group, territorial work plans (which require the approval of territorial governments and Health Canada), and an annual report to territorial and federal deputy health ministers outlining territorial successes.¹⁸ A recent report from the Standing Senate Committee on Social Affairs, Science and Technology recommended that THSSI funding be extended beyond 2014 in a “manner that is both sustainable and predictable.”²¹



The Yukon receives \$5.9 million per year in THSSI funding.⁵⁵ This includes \$4.3 million per year through the Territorial Health Access Fund and \$1.6 million through the Medical Travel Fund, which has supported government investments in a range of initiatives including developing a social inclusion strategy, strategies on wellness and healthy aging, and a mental health framework.^{18,56} The Yukon is looking at ways to improve the medical travel program, including by examining referrals from rural areas to Whitehorse and by developing their data collection capabilities.¹⁸

The Northwest Territories receives \$7.5 million per year in THSSI funding.⁵⁵ This includes \$3.2 million per year from the Medical Travel Fund to offset or reduce the costs of medical travel and \$4.3 million per year from the Territorial Health Access Fund.⁵⁵ The Territorial Health Access Fund has supported government investments in a range of initiatives, including investments in community nursing, expanding kidney dialysis, and several health promotion activities. New community health nurse and nurse practitioner positions have been created, and an integrated chronic disease management model is being developed.⁵⁵

Nunavut receives \$14.5 million per year in THSSI funding.⁵⁵ This includes \$10.2 million per year from the Medical Travel Fund to offset or reduce the costs of medical travel and \$4.3 million per year from the Territorial Health Access Fund.⁵⁵ The Territorial Health Access Fund has supported Nunavut's investments in a range of initiatives, including an expansion of midwifery services, training for health care professionals in areas such as mental health, improving the management of the medical travel system, and hiring a full-time pediatrician. Nunavut is working on updating a mental health framework.^{18,55} Of the three territories, Nunavut receives the largest federal transfer under the Medical Travel Fund due to the remoteness of its 26 communities.⁵⁵

While the accords were focused on the territories, work has been done to improve access to health care within provinces with northern populations, namely Alberta, British Columbia, Saskatchewan, Manitoba, Ontario, and Newfoundland and Labrador. For example, British Columbia's Travel Assistance Program helps alleviate some of the transportation costs for eligible residents who must travel within the province for non-emergency medical specialist services not available in their own community. Ontario's Northern Health Travel Grant assists residents seeking specialty care not available locally. Saskatchewan has a Northern Medical Transportation Program to provide funding for emergent and non-emergent medical transportation in northern Saskatchewan.¹⁸

For a more detailed account of access to care in the North progress provincially, territorially, and federally, read the *Jurisdictional profiles on health care renewal* (healthcouncilcanada.ca/pub/progress2012).

The bottom line

- In establishing THSSI, the federal and territorial governments agreed to some important goals, such as decreasing reliance on the health care system and strengthening community-level services. However, it is difficult to say whether progress has been made on these objectives. Performance reporting in the territories is scant, and THSSI evaluations and annual reports are not public documents.
- Due to the extreme remoteness of northern communities, territorial governments require innovative ways of providing care, such as through telehealth.
- All three territorial governments have studied their spending on medical travel, both within and outside the territories. They are taking steps to support and guide health care workers in communities to decide when and where medical travel is appropriate.
- All three territories face significant challenges in the recruitment and retention of health professionals.

Commentary

The three territories account for just over 0.3% of the Canadian population,⁵⁷ yet their combined populations are spread over a northern landscape that accounts for almost 40% of the country's land mass.⁵⁸ As a result, access to care in the North poses a particular challenge in Canada. While the commitments in the health accords were vague, THSSI has nonetheless helped the territories deliver health care services and develop health promotion strategies.

The direction in the health accords for access to care in the North was focused on Canada's northern territories, but there is a need to extend that focus to northern communities across many of the provinces that face similar access to care challenges, so that all Canadians have equitable access to health care.



Comparable health indicators

Accord commitments

2003 First Ministers' Accord on Health Care Renewal

First Ministers agree to use comparable indicators and to develop the necessary data infrastructure for these reports. This reporting will inform Canadians on progress achieved and key outcomes. It will also inform Canadians on current programs and expenditures, providing a baseline against which new investments can be tracked, as well as on service levels and outcomes.

First Ministers agree that Canadians are entitled to better and more fully comparable information on the timeliness and quality of health care services. Enhanced accountability to Canadians and improved performance reporting are essential to reassuring Canadians that reforms are occurring. To this end, First Ministers agree that:

- each jurisdiction will report to its constituents on its use of all health care dollars spent on an annual basis;
- each jurisdiction will continue to provide comprehensive and regular public reporting on the health programs and services it delivers as well as on health system performance, health outcomes, and health status;
- these reports will include the indicators set out in the September 2000 communiqué as well as additional comparable indicators, to be developed by health ministers, on the themes of quality, access, system efficiency, and effectiveness based on Annex A of this Accord; and
- jurisdictions will develop the necessary data infrastructure and collect the data needed for quality reporting.
- This will enable the development of nationally comparable information for Canadians on the themes of access, quality, system efficiency, and effectiveness, and on reform priorities and objectives set out in this accord.

2004 10-Year Plan to Strengthen Health Care

First Ministers have come together and agreed on an action plan based on the following principles:

- continued accountability and provision of information to make progress transparent to citizens.

All governments agree to report to their residents on health system performance, including the elements set out in this plan. Governments agree to seek advice from experts and health providers on the most appropriate indicators to measures of health system performance. All funding arrangements require that jurisdictions comply with the reporting provisions of this plan.

What the Health Council said in 2008

- Regular jurisdictional reporting on comparable indicators has stopped. The provincial and territorial reports that are produced are not necessarily comparable.
- Due to the lack of data and data systems, some accord commitments aren't being reported on.
- There is a lack of public reporting on the quality of health care services, incident reporting, and adverse events.
- The reporting that is occurring tends to be in isolation and is not standardized.



Progress to date

The development of comparable health indicators, and subsequent reporting on them by the provinces and territories, was fundamental to the 2003 *First Ministers' Accord on Health Care Renewal*, which outlined an initial process in Annex A of the accord.¹ From an initial set of 70 potential indicators that addressed priority areas from the 2003 accord, the federal, provincial, and territorial governments agreed to report on 18 featured indicators in 2004.⁵⁹ The jurisdictions have since commented that those 18 indicators, while useful, needed to be augmented by jurisdiction-specific indicators to serve their own health planning, performance monitoring, or accountability needs.¹⁸ Displaying an increased understanding and awareness of health indicators, and of the need for measurement, many provinces and territories report publicly in a manner that is consistent with the spirit of the accords. However, this reporting—often done through annual reports, business plans, and ministry, department, or regional health authority websites—may involve using various measures or different methods. In some provinces, reporting on programs, service, and quality is often done through provincial health quality councils, such as the Health Quality Council of Saskatchewan, the New Brunswick Health Council, and Health Quality Ontario.

One of the major developments since 2004 is that reporting on comparable indicators has been taken up by national agencies, including CIHI, Statistics Canada, Health Canada, and the Public Health Agency of Canada (PHAC).⁶⁰ *Healthy Canadians: A Federal Report on Comparable Health Indicators* has been released every two years since 2002 by Health Canada.⁶⁰ *Healthy Canadians: A Federal Report on Comparable Health Indicators 2010*, released in December 2011, presented results for 52 comparable indicators. The report highlighted the need for comparable indicators that “can be used by public health professionals, policy makers, and individuals to monitor trends in a particular area,” and “can also be used to plan and evaluate health-related programs aimed at helping Canadians maintain and improve their health.”⁶¹ Another national report, *Health Indicators*, an e-publication produced by CIHI and Statistics Canada, presents comparable indicators according to a Health Indicator Framework developed by the two agencies.^{62,63}

A recent report from the Standing Senate Committee on Social Affairs, Science and Technology recommended that CIHI work with “provincial and territorial governments and relevant stakeholders to develop a pan-Canadian patient-centred comparable-health-indicator framework to measure the quality and performance of health care systems in Canada.”²¹

For a more detailed account of comparable health indicators progress provincially, territorially, and federally, read the *Jurisdictional profiles on health care renewal* (healthcouncilcanada.ca/pub/progress2012).

The bottom line

- Eighteen featured indicators were agreed to by all jurisdictions at the conclusion of the consultative process that was mandated by the 2003 accord.
- National agencies publicly report on these and other comparable indicators, with CIHI and Statistics Canada's *Health Indicators 2011* and Health Canada's *Healthy Canadians 2010* providing the most recent comparative indicator data.
- In addition to these national reports, provinces and territories have developed their own reporting mechanisms tailored to their own needs, whether for planning, measuring performance, or accountability. These have resulted in a range of reporting systems that account for the use of public funding, the status of health care reform, health outcomes, and the health status of the population.
- While all jurisdictions report to the public, the level and detail of reporting, particularly health system reporting, varies significantly. This is due in large part to their capacity to collect, interpret, and report on health data.
- Overall, some jurisdictions have made strides in assessing and comparing performance internally, but their public reporting is often done in a manner that limits external comparability.

Commentary

Public reporting on the comparable health indicators that were agreed to following the 2003 *First Ministers' Accord on Health Care Renewal* has been taken up by CIHI, Statistics Canada, Health Canada, and PHAC on behalf of the provinces and territories.⁶⁰ The jurisdictions indicated that these featured health indicators weren't sufficient for their own planning, performance monitoring, and accountability needs, and have, in many cases, expanded the use of jurisdiction-specific health indicators.¹⁸ To maximize shared learning across the country, there is a need for more comparable pan-Canadian indicator reporting on health system performance. Health indicator reporting must be aligned so that provinces and territories report in a way that is consistent, comparable, and internally and externally useful. Such indicator reporting would also help organizations, such as the Health Council of Canada, improve their health care reporting to Canadians. The Health Council of Canada's recent review of health system performance measurement and reporting approaches in Canada, *Measuring and reporting on health system performance in Canada: Opportunities for improvement*, provides more details on provincial and territorial efforts to report on health system performance and compares Canada's approach with some key international examples.⁶⁴



Conclusion

Our examination of progress in home and community care, health human resources, telehealth, access to care in the North, and comparable health indicators shows that when accords set out specific goals, by and large, the federal, provincial, and territorial governments met them. In fact, the provinces and territories met most of what was expected of them. The question is, could more have been achieved?

The evidence suggests that the accords were designed more to put all provinces and territories on an equal footing than to push them consistently toward excellence in health care. While vague commitments coupled with low expectations may facilitate agreement among different jurisdictions, they do not represent a good recipe for yielding improvements in health system performance. As a result, in the areas that this report covers, the accords have not brought about the large scale change that was envisioned when they were created. While these accords were intended to deal with the health care challenges at the time, the country is still grappling with many of the same challenges today.

Despite this, the Health Council of Canada is pleased to see greater collaboration among the provinces and territories, such as the Health Care Innovation Working Group established by the premiers in January 2012. Encouragingly, the exchange of innovative practices is enabling provinces and territories to learn from each other to improve the health care system as a whole. This is an area in which the Health Council of Canada will focus its attention in future reporting.


As the 2004 *10-Year Plan to Strengthen Health Care* draws to a close and a new chapter begins in Canada's health care system, there is an important need to reflect on what we have learned and what we still need to know to facilitate and achieve improvements. While there is much left to do, the individual and collective efforts of governments, while never fast enough, are moving in the right direction.

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