

Improving Accountability in Canada's Health Care System

**The Canadian Medical Association's Presentation
to the Senate Standing Committee on Social Affairs, Science and
Technology**

**2011 Statutory review of the 2004
10-Year Plan to Strengthen Health Care
in Canada**

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A healthy population and a vibrant medical
profession

Une population en santé et une profession médicale dynamique

Introduction

The CMA appreciates the opportunity to appear before this committee as part of your review of the 10-Year Plan to Strengthen Health Care. An understanding of what has worked and what hasn't since 2004 is critical to ensuring the next accord brings about necessary change to the system.

Overview of 2004 Accord

On the positive side of the ledger, the 2004 accord provided the health care system with stable, predictable funding for a decade – something that had been sorely lacking. It also showed that a focused commitment, in this case on wait times, can lead to improvements.

However, little has been done on several other important commitments in the Accord, such as the pledge that was also made in 2003 to address the significant inequity among Canadians in accessing prescription drugs.

Along with the lack of long-term, community and home-based care services, this accounts for a major gap in patient access along the continuum of care.

We also know that accountability provisions in past accords have been lacking in several ways. For instance, there has been little progress in developing common performance indicators set out in previous accord.ⁱ The 2004 accord has no clear terms of reference on accountability for overseeing its provisions.

Vision and principles for 2014

What the 2004 accord lacked was a clear vision. Without a destination, and a commitment to getting there, our health care system cannot be transformed and will never become a truly integrated, high performing health system.

The 2014 Accord is the perfect opportunity to begin this journey, if it is set up in a way that fosters the innovation and improvements that are necessary. By clearly defining the objectives and securing stable, incremental funding, we will know what changes we need to get us there.

Now is the time to articulate the vision– to say loudly and clearly that at the end of the 10-year funding arrangement, by 2025, Canadians will have the best health and health care in the world. With a clear commitment from providers, administrators and governments, this vision can become our destination.

As a first step to begin this long and difficult journey, the CMA has partnered with the Canadian Nurses Association, and together we have solicited support

from over 60 health care organizations for a series of "Principles to Guide Health Care Transformation in Canada."

These principles define a system that would provide equitable access to health care based on clinical need; care that is high quality and patient-centred; and that focuses on empowering patients to attain and maintain wellness.

They call for a system that provides accountability to those who use it and those who fund it; and that is sustainable – by which I mean adequately resourced in terms of financing, infrastructure and human resources, and measured against other high-performing systems, with cost linked to outcomes.

Based on our experience working within the provisions of the 2004 accord, we would like to suggest three strategies to ensure the next accord leads to a sustainable, high-performing health care system.

They are: a focus on quality; support for system innovation; and the establishment of an accountability framework and I will touch briefly on each one.

Focus on quality

First, the crucial need to focus on improving the quality of health care services. The key dimensions of quality, and by extension, the areas that need attention are: safety, effectiveness, patient-centredness, efficiency, timeliness, equity and appropriateness.

Excellence in quality improvement in these areas will be a crucial step towards sustainability.

To date, six provinces have instituted health quality councils. Their mandates and their effectiveness in actually achieving lasting system-wide improvements vary. What is missing and urgently needed is an integrated, pan-Canadian approach to quality improvement in health care that can begin to chart a course to ensure Canadians ultimately have the best health and health care in the world.

Canadians deserve no less and, with the resources at our disposal, there is no reason why this should not be achievable.

The CMA recommends that the federal government fund the establishment and resource the operations of an arms-length Canadian Health Quality Council, with the mandate to be a catalyst for change, a spark for innovation and a facilitator to disseminate evidence-based quality improvement initiatives

so that they become embedded in the fabric of our health systems from coast to coast to coast.

To help expand quality improvement across the country, the Institute for Healthcare Improvement's Triple Aim provides the solid framework. Our health care systems will benefit inordinately from a simultaneous focus on providing better care to individuals and better health to populations, while reducing the per-capita cost. There is ample evidence that quality care is cost effective care. This approach, when adopted and applied as the pan-Canadian framework for any and all structural changes and quality improvement initiatives, will not only serve patients well, but will also enhance the experience of health care providers on the front lines.

System innovation

The second strategy revolves around system innovation. Innovation and quality improvement initiatives are infinitely more likely to be successful and sustained if they arise out of a commitment by frontline providers and administrators to the achievement of a common goal. We need to shift away from compliance models with negative consequences that have little evidence to support their sustainability.

Innovative improvements in health care in Canada are inadequately supported, poorly recognized, and constrained from being shared and put into use more widely. This needs to change. The 2014 accord, with a focus on improving Canadians' health and health care, can facilitate the transformation we all seek.

Building on the success of the 2004 Wait Times Reduction Fund and the 2000 Health Accord Primary Health Care Transition Fund, the CMA proposes the creation of a Canada Health Innovation Fund that would broadly support the uptake of health system innovation initiatives across the country.

A Working Accountability Framework

And, third, there needs to be a working accountability framework. This would work three ways.

To provide accountability to patients – the system will be patient-centred and, along with its providers, will be accountable for the quality of care and the care experience.

To provide accountability to citizens – the system will provide and, along with its administrators and managers, will be accountable for delivering high quality, integrated services across the full continuum of care.

And to provide accountability to taxpayers – the system will optimize its per-capita costs, and along with those providing public funding and financing, will be accountable for the value derived from the money being spent.

We have done all of this because of our profound belief that meaningful change to our health care system is of the essence, and that such change can and must come about through the next health accord.

Therefore I thank this committee for your efforts on this important area. I would be happy to answer your questions.

Appendix A

Issues identified in 2004 Accord and Current Status

Issue	Current Status
Annual 6% escalator in the CHT to March 31, 2014	Has provided health care system with stable, predictable funding for a decade.
Adoption of wait-time benchmarks by December 2005 for five procedural areas	Largely fulfilled. However, no benchmarks were set for diagnostic imaging. The Wait Time Alliance is calling for benchmarks for all specialty care.
Release of health human resource (HHR) action plans by December 2005	Partially fulfilled. Most jurisdictions issued rudimentary HHR plans by the end of 2005; F/P/T Advisory Committee on Health Delivery and Human Resources issued a paper on a pan-Canadian planning HHR framework in September 2005.
First-dollar coverage for home care by 2006	Most provinces offer first-dollar coverage for post-acute home care but service varies across the country for mental health and palliative home care needs.
An objective of 50% of Canadians having 24/7 access to multidisciplinary primary care teams by 2011	Unfulfilled: Health Council of Canada reported in 2009 that only 32 per cent of Canadians had access to more than one primary health care provider.
A 5-year \$150 million Territorial Health Access Fund	Fulfilled: Territorial Health System Sustainability Initiative (THSSI) funding extended until March 31, 2014.
A 9-point National Pharmaceuticals Strategy (NPS)	Largely unfulfilled: A progress report on the NPS was released in 2006 but nothing has been implemented.
Accelerated work on a pan-Canadian Public Health Strategy including goals and targets	F/P/T health ministers (except Quebec) put forward five high-level health goals for Canada in 2005, although they were not accompanied by operational definitions that would lend themselves to setting targets.
Continued federal investments in health innovation	Unknown—no specificity in the 2004 Accord.
Reporting to residents on health system performance and elements of the Accord	P/T governments ceased their public reporting after 2004, and only the federal government has kept its commitment (at least to 2008).
Formalization of the dispute	Done but not yet tested.

advance/resolution mechanism on the <i>CHA</i>	
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¹ P/T governments ceased their public reporting after 2004, and only the federal government has kept its commitment (at least to 2008). Government of Canada. Healthy Canadians: a federal report on comparable health indicators 2008. http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/system-regime/2008-fed-comp-indicat/index-eng.pdf. Accessed 06/21/11.