

CMA Submission: REVIEW OF PAN-CANADIAN HEALTH ORGANIZATIONS

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COMMENTARY ON THE REVIEW OF PAN-CANADIAN HEALTH ORGANIZATIONS

The Canadian Medical Association (CMA) welcomes this opportunity to provide input to the review of the Pan-Canadian health organizations (PCHOs). The CMA has had the opportunity to interact with all of them at one time or another. This review is timely, as there is a burning issue: Canada continues to languish near the bottom of the Commonwealth Fund's 11-country rankings, and the leading edge of the baby boom will reach age 75 in 2021, at which point per capita health care costs in Canada will escalate.

We will discuss major unmet needs, make some general observations and offer two recommendations. References are provided in the bibliography.

Unmet needs

National focal point for quality: Our impression is that none of the PCHOs is pursuing a comprehensive approach to quality improvement (QI) consistent with the framework set out by the Institute of Medicine (IOM) in its 2001 report *Crossing the Quality Chasm*. The framework is built around the need for health care to be safe, effective, patient-centred, timely, efficient and equitable. To our knowledge Accreditation Canada is the only national organization that has adopted such a framework, but their QI mandate is to set standards and accredit health care organizations although it could potentially play an expanded role. The Canadian Patient Safety Institute has done an excellent job of highlighting the importance of patient *safety*, but that is only one of the six dimensions outlined in the IOM framework.

Work needs to be done in Canada to address each of the other five dimensions. In terms of *effective* care, although the concept of evidence-based medicine was pioneered in Canada, we do not have a national developer of guidance to clinicians like the United Kingdom's National Institute for Health and Care Excellence (NICE). It is noted that there are some localized efforts in this area, such as Alberta's Toward Optimized Practice program, and the *CMA Infobase* maintained by CMA Joule contains some 1,200 clinical practice guidelines. *Patient-centred* care will be discussed below. Since the expiry of the 2004 Health Accord and the Wait Times Reduction Fund (WTRF), which the CMA spent years trying to get on the policy agenda, *timely* access to care has fallen out of the spotlight. The Wait Time Alliance did its best to promote the expansion and adoption of wait time benchmarks beyond the five treatments initially included in the WTRF, with very limited success. It is no surprise that according to the Commonwealth Fund's 2016 survey of 11 countries, Canadians faced the longest

waiting times for a specialist appointment. In terms of *efficiency* there has been a rapid uptake of the Choosing Wisely Canada initiative by medical organizations, but the campaign could benefit from resources to conduct a thorough evaluation of its impact. The dimension of *equitable* care will be considered below as part of the discussion of social determinants of health. At least six provinces have established health quality councils, and if they had a national focal point for their efforts they could cross-pollinate their expertise and learnings with respect to all six of the Institute of Medicine's dimensions of care.

National patient voice – While it is encouraging to see the emphasis on patient and family-centred care among the PCHOs, the lack of an organized national patient voice is a key gap. Previously the Consumers' Association of Canada provided an articulate patient/consumer voice on health issues, and indeed it was one of the seven charter members of the Health Action Lobby in 1991. However, the association's ability to speak in this capacity was greatly diminished after its federal funding dried up in the 1990s. At present there are various patient groups sponsored by health charities and industry but they tend to focus on specific interests. Patients Canada, an organization established in 2011, is showing promise, but with annual expenditures of just under \$130,000 in 2014 it is insufficiently resourced to function as a national patient voice representing all regions of the country. There is a need for an independent go-to focal point that can speak on behalf of patients on national issues and that can help national health organizations with their advocacy and policy development initiatives. With better resources, Patients Canada might be able to play this role.

Health equity – Given the impact of health inequalities in Canada they have a relatively low profile on the national scene, aside from the inequity between the health status of Canada's Indigenous Peoples and that of the general population. For example, Mackenbach and colleagues estimated that socio-economic inequalities accounted for 20% of health care costs in the European Union in 2004. There is little reason to imagine that the situation in Canada would be much different, but health inequalities have not been a preoccupation of the PCHOs. The Public Health Agency of Canada (PHAC) has done some good work in helping the federal government to meet its commitments in regard to the World Health Organization's 2011 Rio Political Declaration on Social Determinants of Health and it also funds the National Collaborating Centre for Determinants of Health, but these efforts have little profile outside of the public health community. The pronounced socio-economic gradient across virtually all causes of morbidity and mortality tends to be overlooked in the pursuit of strategies to address individual diseases. PHAC's Health Inequalities Data Tool shows that that the Canadian crude mortality rates for circulatory system disease and lung cancer in the lowest income quintile for census metropolitan areas are 1.6 and 1.7 times the rates in the highest income quintile, respectively. There are groups in

Canada such as the Wellesley Institute and Health Providers Against Poverty that focus on health equity issues, and Canada should look at the leadership role being played by Sir Michael Marmot's Institute of Health Equity at University College London in England.

Driving innovation – The Canadian Agency for Drugs and Technologies in Health is widely recognized for its work evaluating drugs and technologies but it is not in the business of promoting system-wide implementation. The Advisory Panel on Healthcare Innovation (David Naylor, Chair) recommended the establishment of a Healthcare Innovation Agency and a Healthcare Innovation Fund with the objective of effecting “sustainable and systemic changes in the delivery of health services to Canadians.” More recently, the Standing Senate Committee on Social Affairs, Science and Technology called for a national conference on robotics, artificial intelligence and 3D printing that would give rise to working groups and a secretariat with a view to integrating these technologies into health care systems across Canada. One can cite examples where Canada has developed innovative technologies but has not made them mainstream. For example, telemedicine was pioneered by the late Dr. Maxwell House in Newfoundland in the mid-1970s. It is now being used regularly for clinical sessions, but the logical extension to telehome monitoring is barely in its infancy. According to the 2015 Canadian Telehealth Report there were 411,778 telehealth clinical sessions in 2014, but there were just 3,803 patients being monitored through telehomecare. Furthermore, the number of telehealth clinical sessions represents just 0.15% of the 270.3 million physician services reported by the Canadian Institute for Health Information (CIHI) in 2015-16. In contrast, Kaiser Permanente reported in 2016 that 52% of the 110 million physician–member interactions in the previous year took place through virtual means.

One example of the use of a fund to bring about sustainable change was the two-step process that began with the establishment of the \$150 million Health Transition Fund following the 1997 report of the National Forum on Health and the \$800 million Primary Health Care Transition Fund that was part of the 2000 Health Accord. These resulted in the sustained adoption of new models of primary care delivery in Ontario and Alberta. It is noteworthy that the Canadian Foundation for Healthcare Improvement is doing interesting work in spreading and scaling up innovative treatment for patients with chronic obstructive pulmonary disease. The need for a dedicated entity to drive innovation is illustrated by the experience of the Health Care Innovation Working Group, which was struck by the premiers in 2012 and which included the unprecedented participation of professional associations including the CMA. The group released an ambitious report in the summer of 2012, but the effort was run by senior bureaucrats and association staff “off the sides of their desks” and has essentially stalled. Such a body could also play a role in sharing innovations across jurisdictions.

Enhanced analytical capability – Since the demise of the Economic Council of Canada (ECC) in the 1990s Canada’s national analytical capability in health care has diminished. The ECC employed health economists like the late Ludwig Auer who undertook detailed analysis of health sector data to examine issues like hospital productivity. CIHI does an excellent job of turning out reports such *National Health Expenditure (NHEX) Trends in Canada*, but these are not sufficient for an in-depth examination of a \$242 billion industry. As journalist André Picard commented on the 2017 NHEX release, “We don’t actually know how much we spend on administration, because it is hidden in places like hospital spending ... nor do we know the cost of labour ... we should certainly have a better idea of how much we spend on nurses, physician assistants, personal support workers, laboratory technologists and technicians and so on.”

Looking ahead, the widespread adoption of electronic medical records is going to present a major analytical opportunity and challenge. In 2008 PHAC provided a grant to the College of Family Physicians of Canada to establish the Canadian Primary Care Sentinel Surveillance Network (CPCSSN) and subsequently provided additional funding until 2015. The goal of CPCSSN was to establish a database on eight chronic diseases and neurologic conditions by extracting de-identified patient information from electronic medical records. As of the last update, in October 2016, CPCSSN now includes 11 university-affiliated primary care research networks and almost 1,200 physicians contributing data from 1.5 million patients. A recent report concludes that CPCSSN’s diagnostic algorithms show excellent sensitivity and specificity for hypertension, diabetes, epilepsy and parkinsonism. The CMA highlighted CPCSSN in its submission to the Advisory Panel on Healthcare Innovation as being worthy of ongoing federal support.

General observations

We would like to make three general observations. First, the future of the PHCOs should not be decided in isolation. Instead, we believe that the big picture of federal funding for the advancement of health and health care should be considered, including the investments that the federal government is making in the Canadian Institutes of Health Research and the Strategy for Patient-Oriented Research.

Second, the CMA’s engagement with the PCHOs has been haphazard. While we have had the opportunity to participate in consultations and technical and working groups with the PCHOs, these interactions have generally fallen short of what we would consider to be early, meaningful and ongoing engagement.

Third, the PCHOs have developed considerable expertise within their mandates and spheres of activity. They could almost certainly harness their potential to mount a synergistic effort to successfully address pressing national issues that might otherwise seem almost impossible to confront, such as seniors care.

Recommendations

The CMA respectfully offers two recommendations:

1. That the government's implementation plan following the PCHO review include mechanisms to address the following needs:
 - for a national focal point that promotes a comprehensive approach to quality health care;
 - for a well-resourced national patient voice that advocates for patient- and family-centred health care;
 - for greater recognition of the importance of the social determinants of health and health equity;
 - for a national mechanism to drive the sustainable adoption of innovative technologies in health care across Canada; and
 - for advanced analytical capabilities to conduct in-depth assessments of funding mechanisms and advance the collection and analysis of data generated by electronic medical records.

2. That the federal government challenge the PCHOs and other federal agencies to work with the provincial/territorial governments and stakeholders to develop and implement a national action plan to address the health and health care of Canada's seniors.

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