Fulfilling the Promises of the Current Accords -- What's Possible?

January 15th Round Table

The Background to the Accord Negotiations

- Gradual reduction in leadership role from Ottawa over time

- Previous low point Canadian Health and Social Transfer (CHST) 1995 – lumped social, education, health programs in one transfer; no escalator;

- By 1998-99 Federal contribution to Medicare services down to 14.6%

National Forum 1997 -- Romanow Commission 2002

- **Canadians See Medicare as a national endeavour** – strong federal l leadership needed to ensure stable funding and to take Medicare to the next level
- **Medicare is about more than doctors and hospitals** –Both reports talked about important of home care, national drug plan , primary care reform
- **Canadian want more accountability on how money spent to improve health** – decision making should be evidence based – more opportunities for citizen's input (R).

From the NF -- Dedicated funding to support Primary Care Reform 1997-2000 ($150m) and 2000-2006 ($800 m) almost exclusively for physicians. Resulted in positive, but expensive change.

The Achievements and Shortcomings of the 2003/2004 Health Accords

The 6% escalator provided stable funding for 10 years BUT little progress on the change agenda:

- Targeted funding in first 2 years to provide time limited post-acute home care/ community mental health/ palliative care and catastrophic drugs – **No Tracked**
- Development of a detailed national drug strategy – **Stalled in 2006**
- Established a number of objective (e.g. 50% of Canadians should have 24/7 access to multi-disciplinary primary care teams by 2011) – **No Action**
- Wait time reduction Fund and benchmarks by for five procedural areas -- **Funding and Benchmarks established**

Quote: from Jeff Turnbull, CMA

"Over the decade, the provinces and territories seem to have developed an allergic reaction to any attempt to benchmark their performance against each other despite the commitments made in 2003 and 2004" *(Healthcare Papers, Fall 2011)*

Health Council of Canada – Romanow's Vision

"not intended as another advisory body in the already complex web of committees and expert panels…it should be a new way of doing business"

- Incorporate both the Canadian Institute for Health Information (CIHI) and the Canadian Co-ordinating Office of health Technology Assessment (CCOHTA)
- Goal to establish common indicators to measure health system performance and publicly report on progress of provinces in improving health outcomes, quality and access
- 7 representative for FPT , 3 public representatives, and 4 expert/health policy representatives

What we got instead

- No citizen's representation and all other the represented – both experts and government reps. -- selected by the provinces
- Did not incorporate CIHI or CCOHTA into the Health Council…and so they had very limited resources……no ability to monitor health system performance or health outcomes.
- The FPT developed the indicators NOT the Council
- Mandate of Council to track Accord provisions 2004-6 -- this expectation ended in 2006 with the election of the minority conservative government

In the meantime a number of provinces have developed Quality Councils and they meet informally

Health Councils can do more than just measure and report

Example: Sask. Quality Council established by the NDP

They are also support progressive changes at the local level. Valuable role in ensuring health reform initiatives support care that is both high quality and cost effective

Example: Wait time Initiative :

(+) Wait time Alliance Report 2011 – identified lack of community services as biggest barriers to reducing wait times for surgeries and in emergency

(-) Support improvement in surgical processes to reduce wait times, and improve efficiencies (i.e. from Alberta and the lower mainland of BC)

Other Countries do more to monitor quality and involve the citizenry

Denmark

- One national agency with a mandate to oversee health technology assessments and evaluate system performance evaluations with *an aim of improving quality standards and value for money* in the health system

- Citizen's are included in the agency governance structure, nominated by a wide diversity of community interest groups

Others involve citizen's And involve citizens to have a say

Australia:

- Citizen's are represented at all levels of the health system. The gov't provides funding to support grass roots citizen's groups and a national consumer advocacy group, the Consumer Health Forum (CHF)
- New reforms being introduced in Australia to network hospitals and establish local primary care organization focused on chronic care, prevention, 42/7 access, mental health and care for the aged.
- Citizens will have a role on all of the governance of these new organizations. The Consumer Health Forum (CHF) will be responsible for training the 120 consumers who will sit on the governing boards for the networked hospitals and primary care organizations.

More Evidence and know-how on how to introduce positive changes

There are more examples of “high performing” non-profit regional health systems that have simultaneously improved health outcomes and access and at the same time controlled cost increases.

Poor quality costs more not less. These public health systems have succeeded because:

- Operate more like a system – than a desperate set of services
- focused on quality improvements that are evidence based
- Developed a strong sense of common purpose at all levels of the organization and with the community

Building a more integrated system of care

- Two examples of how to make this work: One from Puget Sound Group Health and another from Northern Health
- In high preforming health systems all the services needed by a particular patient population no matter the location (i.e. whether at home, at their family physician's office, at community care facility or in hospital) are considered together (i.e. have a shared budget)
- One very promising new direction is the development of Patient Report Outcome Measures or PROMS (not four or five clinical guidelines as the provinces suggest)

National (Inter-provincial leadership) Essential

Importance of Progressive Vision and Framework at the National Level:

- To ensure we have one not 13 different health systems
- To benefit from economies of scale in areas such as drug policy, information technology, evidence based medicine (PROMS)
- To counter the very problematic innovations being proposed by others

On positive side, more support from a number of key provider org. than in the past