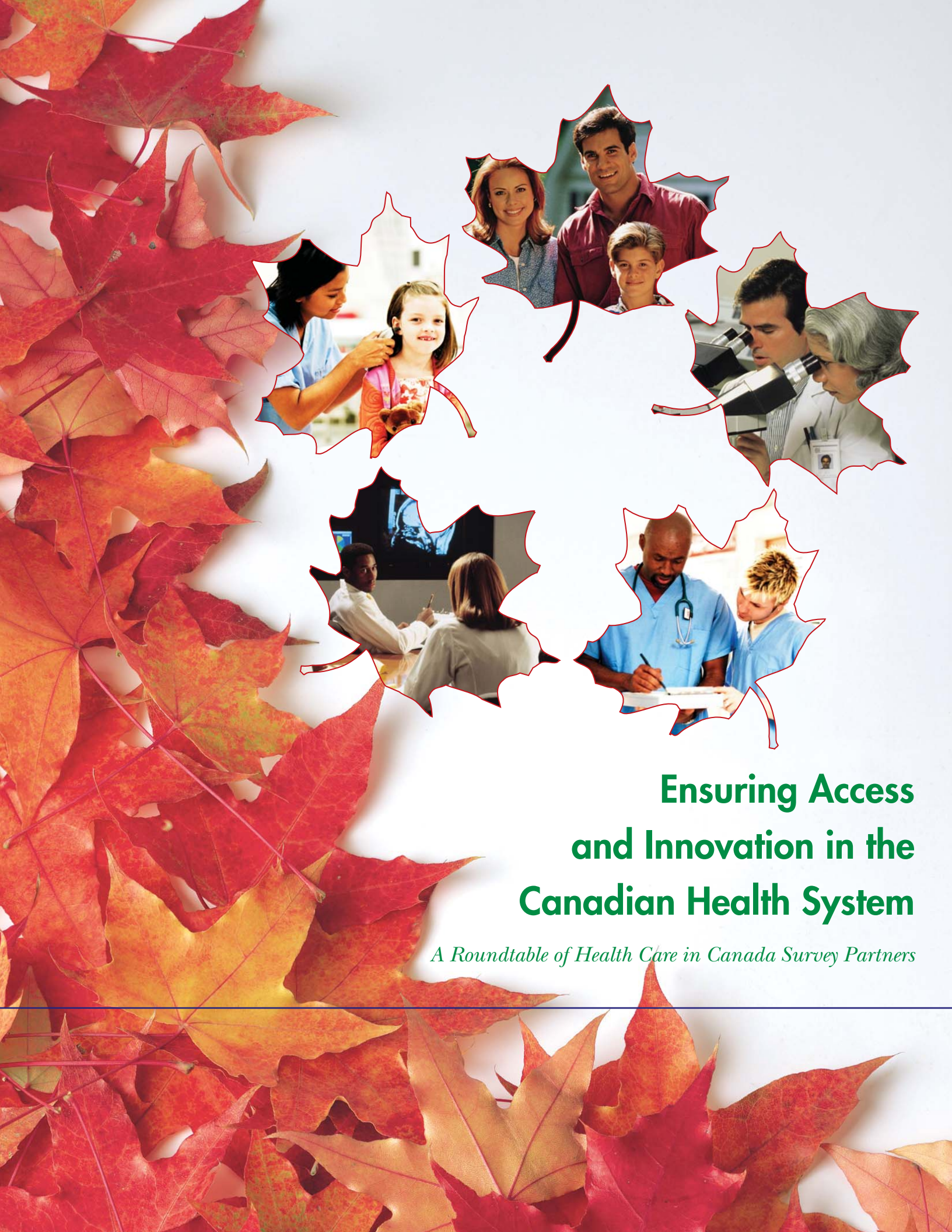

Ensuring Access and Innovation in the Canadian Health System

A Roundtable of Health Care in Canada Survey Partners

Contents

Introduction

The Health Care in Canada (HCIC) survey is a comprehensive annual survey on key health care issues. It has been developed to provide direction for decision makers as they strive to manage health care reform. This is the seventh annual survey of a nationally representative sample of Canadians, health care providers, managers and trustees. One thousand Canadians, 200 physicians, 200 nurses, 200 pharmacists, and 200 managers and trustees from across the country were polled in this survey. Fielding was conducted between October 20th and November 3rd, 2004.

"Ensuring Access and Innovation in the Canadian Health System," a roundtable of the partner organizations, took place on November 29th, 2004. The survey results were discussed and the roundtable was chaired by Celia Milne, of the *Medical Post*. Partner organizations are the Association of Canadian Academic Healthcare Organizations, the Canadian Nurses Association, the Canadian Medical Association, the Canadian College of Health Services Executives, the Canadian Association for Community Care, the Canadian Healthcare Association, the Canadian Home Care Association, the Canadian Public Health Association, the Health Charities Coalition of Canada, the Canadian Pharmacists Association, POLLARA, Merck Frosst Canada Ltd. and Rogers Media.

Some key findings:

- 52 % of Canadians believe the new Federal-Provincial health care deal will improve access to timely quality care.
- 86% of the public say there is a shortage of doctors, 81% say there are not enough nurses and 66% say there are not enough pharmacists.
- The public are very supportive of increased support for health research: 81% support increased public funding and 70% of Canadians support providing incentives for increased private-sector funding for health research.
- 73% of the public oppose restricting the range of health services offered to deal with budgetary shortfalls.
- 53% of public support contracting out of publicly covered services to private clinics.
- 62% of the public oppose allowing people to pay out of their own pocket for quicker access to services.
- The public is supportive of requiring health professionals to work in teams (86% support), register with one doctor (69% support) and work where most needed (79% support).

For complete results, visit the Health Care in Canada Survey website, www.hcic-sssc.ca, or the Pollara Inc. website, www.pollara.ca.

Participants

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What are some key observations that you had from looking at this year's survey results?

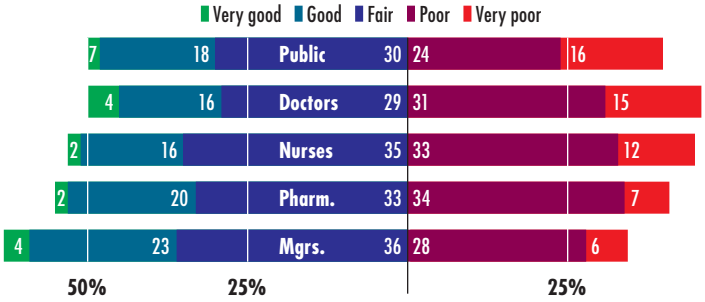
The issue is around accountability and transparency. While governments are very ready to ask that of all of us around this table, I think there is a *quid pro quo* for governments to step up to the plate, too, and demonstrate that to Canadians.

Glenn Brimacombe

My take on the public's and the providers groups' attitudes towards the principles of transparency and accountability is that they see it as a bellwether in terms of gauging what kind of impact the federal government's $41.3 billion investment over ten years will have. For example, 25% of the public think that the governments will do a very good or good job making sure that there's value for money, and roughly the same proportion say that they'll effectively report to us on what is going on. I think those are fairly important findings in the survey that need to be teased out. Importantly, we don't see Canadians looking for another (private sector) alternative. They want to see the system work, they want to see it function effectively, they want to see more reallocated from less important priorities, and they do not want to pay more. But still the issue is around accountability and transparency. While governments are very ready to ask that of all of us around this table, I think there is a *quid pro quo* for governments to step up to the plate, too, and demonstrate that to Canadians.

For the next survey, perhaps the access question could be teased out into different gradations around institutional care as well as specialty care and long-term care. The notion of access is all-encompassing in the survey; it can mean many different things because the system is so complex and layered.

Thinking of the additional funding that will be made available under the new Health Deal, do you believe that the government will do a very good, good, fair, poor or very poor job of making sure that every tax dollar intended for health care will be spent on health care?



Home-care programs often integrate in the delivery of health-care services in the home-care setting with community services.

Murray Nixon

At the CHCA, we define home care as an array of services provided in a home and in a community setting, encompassing health promotion, teaching, curative intervention, end-of-life care, rehab, supportive maintenance, social adaptation, integration, and support for the informal family caregiver. We provide services for everybody: infants, children, adults, seniors.

I'd like to stress that home-care programs often integrate, and that's a really key word, *integrate,* in the delivery of health-care services in the home-care setting with community services such as Meals on Wheels, Day Programs, Respite Care – volunteer services.

In 2004 the Health Care in Canada survey identified a bit of an increase in Canadians' dissatisfaction with health care across the home and community sector. Access to home-care services is really very important. It's affected by an increasing demand; it's certainly affected by the geographic dispersion and the lack of consistency in the scope of services within the regions – major lacks of consistency in what home care provides in various provinces and territories. The current inequities in the availability and access to publicly funded home-care services include variation in the types of services, the amount of service, and the criteria for accessing services in the public system. There are major differences, as there are in service limits, co-payments, the lack of appropriate human resources and waiting lists for therapies.

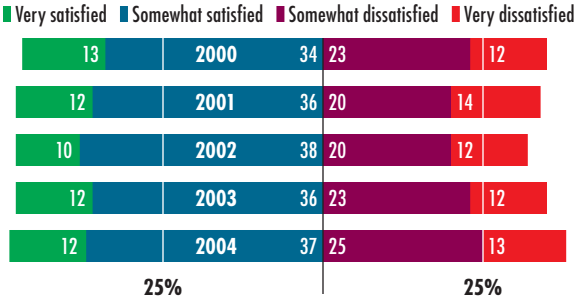
The progressive comparisons of the Health Care in Canada surveys provide very useful data on opinions and trends in human resources, funding, accountability, innovation, and access. This information is

absolutely critical in the development of strategies to address the challenge of providing accessible and responsive home care and community supports, which enable people to stay in their homes and maintain their independence and their degree of control with safety, dignity, and quality of life. In fact, one question that might have been added to the survey would be, "How do you feel about receiving care in the home? What's important to you about receiving home-care services?"

The Canadian Home Care Association is very encouraged by the ten-year plan to strengthen health care, as it addresses critical areas with very clear actions. It's a demonstration that federal, provincial, and territorial governments are prepared to work together, hopefully so to move beyond discussion on home-care issues to clear policy developments, action, and funding. A ten-year plan to strengthen health care is a significant step forward in recognizing home care as a key element and hopefully an equal player in our health-care system. That's an important point to stress; sometimes home care is considered to be on the perimeter. While this agreement is important for provinces and territories that currently do not have comprehensive home-care programs, an ongoing commitment from federal, provincial, and territorial governments and long-term investment will ensure an accessible and sustainable home-care program across the country. Canadians will be able to choose to recover in their own homes from acute medical illnesses and from surgery; mental-health patients should be cared for in their communities; seniors and individuals with chronic diseases will have a choice of home care; et cetera. With adequate resources, home care can help manage wait lists. It can play a crucial role in health promotion and family health care. It can provide a cost-effective alternative to managing chronic diseases and supporting the frail elderly in their homes.

The CHCA is proud to be a participant in the Health Care in Canada survey. We strongly endorse the continuation of this important project to collect information on health-care funding, health-care human resources (an activity which is very important to us), collaboration is very important, innovation, and accountability.

Would you say that you are very satisfied, somewhat satisfied, somewhat dissatisfied or very dissatisfied with access to care in the home or community?



Sometimes home care is considered to be on the perimeter.

Kathleen McGovern

After years of inadequate funding for health services due to the federal government not paying their fair share, health managers are cautiously optimistic that the funding put back into the health system through the 2004 health accord will flow through to support necessary reform and medically necessary services. We still believe that one of the major pieces of work that needs to be done is an expanded home-care program supported by a legislative framework.

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Joan Campbell*

As we assess quality in the health system, it is important to consider the hidden costs and unsung benefits of the voluntary efforts of so many Canadians. Canadians who contribute time and money to voluntary and charitable health care organizations. These unpaid and too often unrecognized efforts by volunteers and informal caregivers are essential to keeping the health system going. The increasing burden on informal caregivers and the voluntary sector is an under-reported issue and needs to be addressed.

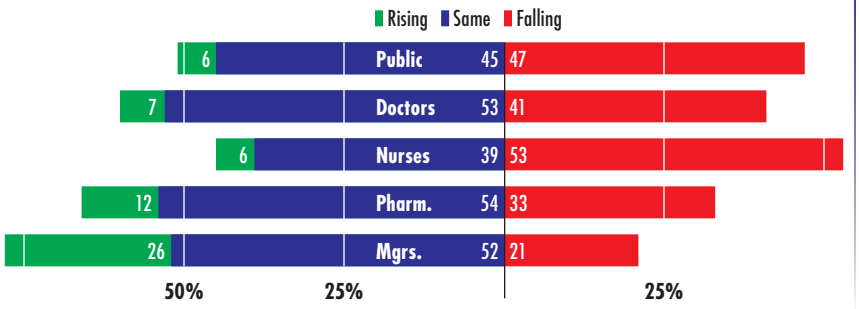
**Joan Campbell is Acting President and CEO of the Canadian Association for Community Care. The comment was provided after the roundtable.*

The health-care professions have been talking about shortages for some time now, and it's really beginning to hit home; the public are recognizing the need.

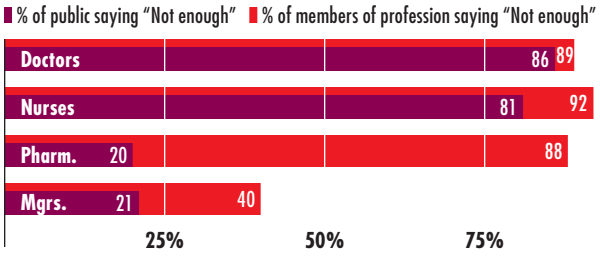
Jeff Poston

One of the things that stood out is the optimism of managers, which is a good sign for us all. There seems to be thought that "next time I've got enough money in the conduit, I hope the optimism isn't misplaced." The critical issue, however, concerns health-care human resources. One of the things it shows is that you have to have experience of human-resources shortages. The public have seen shortages of family physicians; there's a lot of publicity, and most people will know someone who's had difficulty getting access to a family physician. Anybody that's been in hospital or has had a relative in hospital, has visited hospitals, sees the shortages of nurses in hospitals. We also have a significant shortage of pharmacists, but people can still get prescriptions filled, so they haven't experienced the impact of the shortages. Services have been cut in hospitals, but they're still getting medications on the ward. I think one of the things that we're seeing is that the health-care professions have been talking about shortages for some time now, and it's really beginning to hit home; the public are recognizing the need.

Overall, would you say that your confidence in the Canadian health system is rising or falling, or is it about the same as it ever was?



Do you believe that Canada has more than enough, enough, or not enough of each of the following skilled health care professionals to meet our population's needs?



What I thought was interesting with respect to priorities for the Health Council was that pharmacists agreed that there was a need, they're looking to the Health Council to take action on ensuring that there were more doctors. That comes from experience, because community pharmacists are among the first people that see the problems that happen in a community when you don't have a family physician – a lot more stuff gets dumped on them and they actually have to play a major role, usually in the community, in trying to attract a family physician to that community.

Churchill described Russia as a riddle wrapped in a mystery inside an enigma, and understanding Canadians' attitudes towards health care is a bit like that.

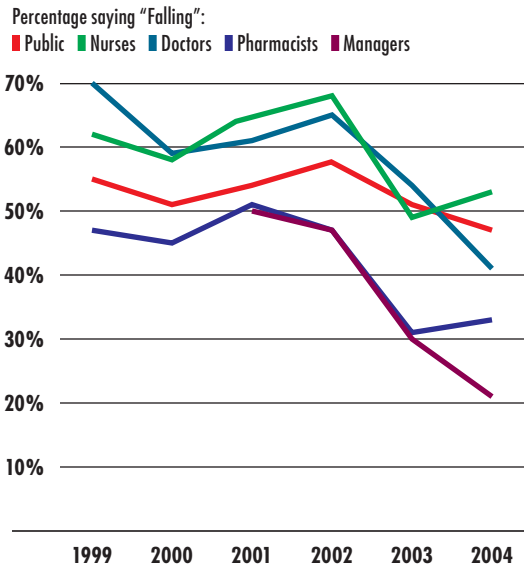
John Hylton

Churchill described Russia as a riddle wrapped in a mystery inside an enigma, and understanding Canadians' attitudes towards health care is a bit like that. It's endlessly fascinating, and it's good that you're doing this work, but I must say I find that there are a number of interesting contradictions or things that don't line up.

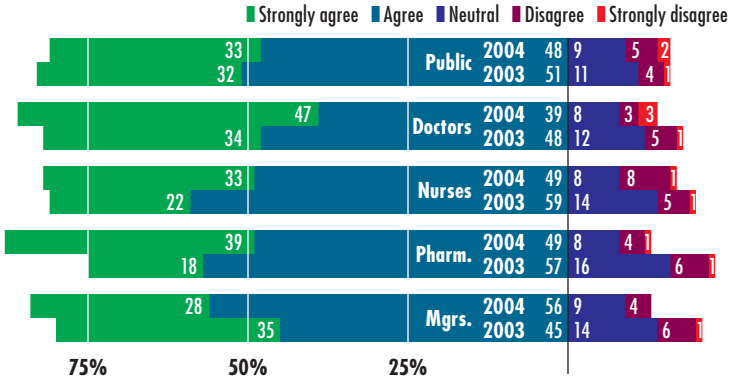
I think a double negative is a positive, and so if you have generally falling support for negative views, I think that turns out to be a gradually rising support for *positive* views about the health-care system, which is a good thing. The main message there is that generally there's growing confidence, and I think that we sensed that through our various organizations. There are plenty of problems still, and in some areas maybe there is increasing concern, but overall it's moving in a positive direction.

I was very curious about the numbers with respect to health-care managers in their attitudes towards the new first-ministers' agreement as well, partly because we did our own straw poll of a couple hundred people who received our electronic newsletter. It was not exactly the

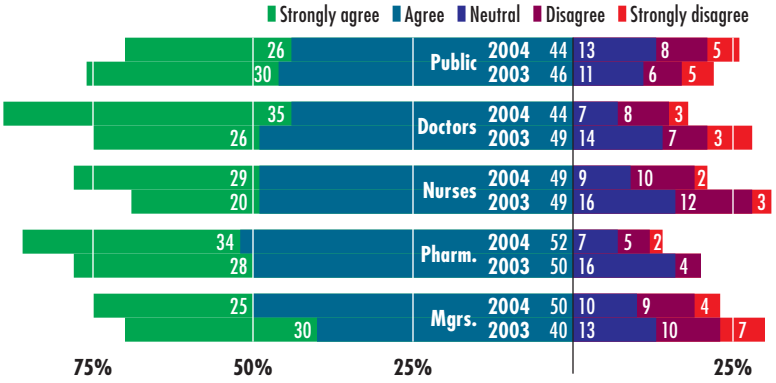
Overall, would you say that your confidence in the Canadian health system is rising or falling, or is it about the same as it ever was?



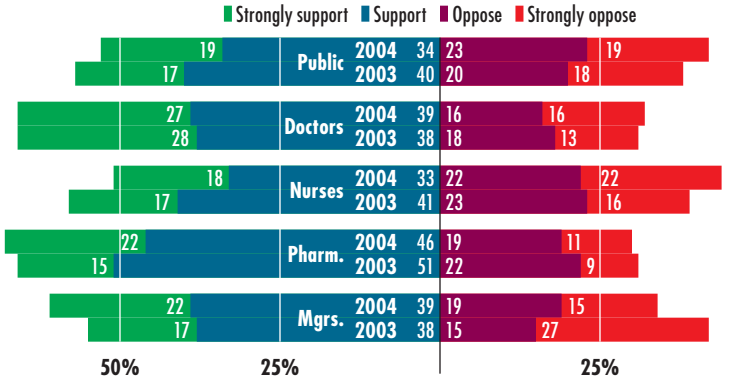
There should be increased public sector funding for health research, such as at universities, teaching hospitals and other not-for-profit organizations.



Incentives should be put in place to encourage more private sector investments in health research such as at universities, teaching hospitals and other not-for-profit organizations.



Do you strongly support, support, oppose or strongly oppose allowing the government to be able to contract out the delivery of publicly covered services to private clinics, for instance having medicare pay for knee surgery at a private clinic rather than a public hospital?



same wording, but the sense was, "Do you think it will make a difference?" Our result was closer to 50/50. If we break down the 71% in the Health Care in Canada survey, there are only 5% of managers who say the agreement is going to significantly improve access for Canadians, so the rest felt it would only slightly improve the situation, so that gives a picture closer to what we found. I don't sense an overwhelming sense of optimism that this is going to be any kind of a nirvana in our community. I think our community is quite sophisticated in understanding that there are various layers of decision making and implementation, and that even if you do get a positive decision at one level, before it actually translates down to make a difference, it's got to go through provincial governments, regional health authorities, and down to programs and to service level. I would say that the optimism that's there is actually much more a cautious optimism.

I'm always fascinated with the support for more doctors and nurses. Partly what fascinates me about it is that the attitudes of the public line up so closely with the attitudes of doctors and nurses themselves. But what it seems to crowd out is that doctors and nurses would support more innovation than the public actually supports. I think there's an understanding and an information gap there. We tot out such things as primary health reform, and I don't think the public really understands that; I think mostly their way of signalling that they want a better system is by saying that more doctors and nurses are needed. What fascinates me is how little room there is, I think even far less room in the public attitudes than doctors and nurses would allow themselves, for allied health professions and more creative and innovative approaches for delivery.

I think mostly the public's way of signalling that they want a better system is by saying that more doctors and nurses are needed.

Generally, I kind of like and take some support from the idea that through many of the statistics, such as the ones concerning public-private partnership, contracting-out, and research, there is generally a little bit of increasing support for the idea of being more innovative in the way that we do things. So, on the one hand, there doesn't seem to be this support, but on the other hand there is, and I take a little bit of hope in the latter statistics than in what I think is quite a conventional, almost knee-jerk, response: "How do you improve things?" "Well, more doctors and nurses." I think we'd all agree that it's a little bit more complicated than that.

Rhonda Hynds

I think it's great news that so many in the public agree that they are motivated to promote their wellness and prevent disease. That's a real significant benefit for health charities. Of concern for us would be that, although the public is indicating that the public sector should increase health-research funding, they also show they're in agreement with incentives to encourage private-sector investments in health research. I think that, with that, there could be some possibilities for, in layman's terms, hidden agendas. If it's done in the right way, clinical trials are registered, there is ethical consideration and precautions are taken in terms of research protocols, that would be great. But there's a concern there that the public isn't quite aware that much of their donations to health charities are actually going to fund health research.

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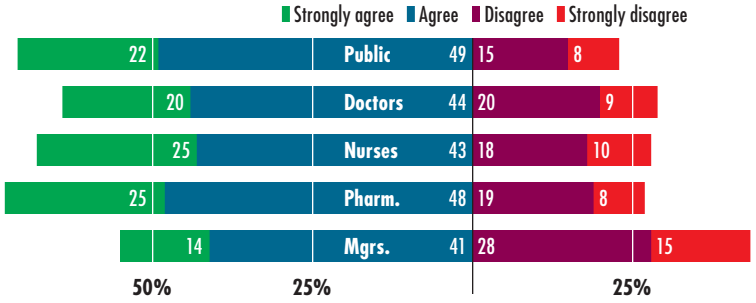
Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree that Canadians are encouraged/motivated to promote wellness and prevent disease?

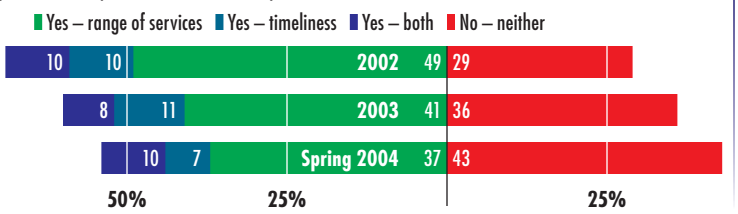


Christina Mills

Public health is the invisible part of the health system. It really only becomes visible when something goes wrong, as in Walkerton, for example. This is reflected in the accord, where there are one and a half pages devoted to this down payment in public health but no actual dollars allocated. The survey is very useful in many ways. I think it could be more useful in understanding the public's support or attitudes towards the actual important work of public health – if the public know what those services are, they might be able to indicate informed opinions about them. For example, it may appear that the survey says there's support for promotion of wellness and disease prevention, but when you look at the actual question, it doesn't say, "Do you support it?" It says, "Do you agree that Canadians are encouraged and motivated?" That 's a descriptive, not a prescriptive, opinion. It doesn't tell us whether they think there should be more of it or less of it or it's about right; all it tells us is that they have observed that there is something that they call promotion of wellness and disease prevention. I would like to see more exploration of some of the specifics about what things are done that actually prevent illness and, in the long term, reduce demand on the health system.

Public health is the invisible part of the health system. It really only becomes visible when something goes wrong.

Would you be willing to pay more, either out-of-pocket or tax payments, to increase the range of services offered or the improve timeliness of care provided by the health care system?



We could have a perfect health-care system with the exact number of health-care professionals of every type that we need, no waiting lists, and wonderful access, but with an aging population, because most chronic diseases are age related, eventually the system will be over-

whelmed with demand again unless we do a better job of preventing those diseases from occurring.

When the survey talks about what could be done to improve access, there is no question about what role better prevention could have in the longer term in improving access. It's all about the more immediate treatment sector. I think people are able to understand that there's a role for prevention in ultimately improving access by reducing demand, and that's not elicited here.

There's a role for prevention in improving access by reducing demand.

Finally, I have a question about the way the question about paying more is stated. It says, "Would you be willing to pay more, either out of pocket or tax payments, to increase the range of services or improved timeliness of care?" That needs to be two different questions because if you ask those questions separately, I think you'll get quite different answers. Those solutions are ideologically and practically quite different. I can't infer anything from that slide as it is now; I need to know how they would answer those questions separately.

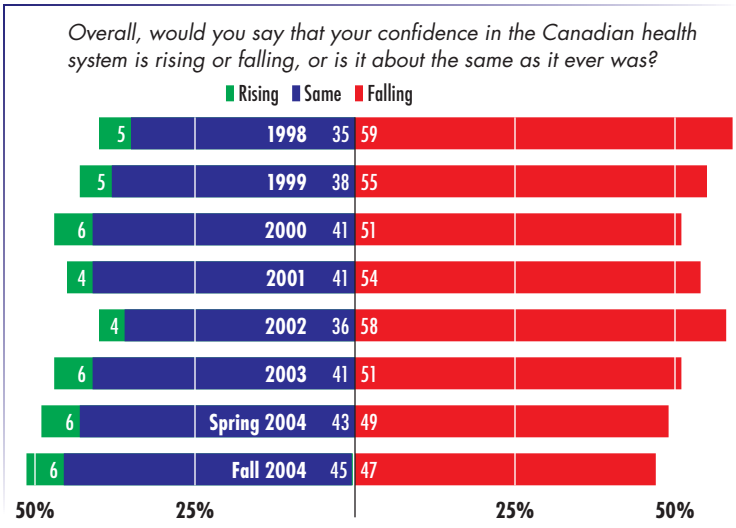
Briane Scharfstein

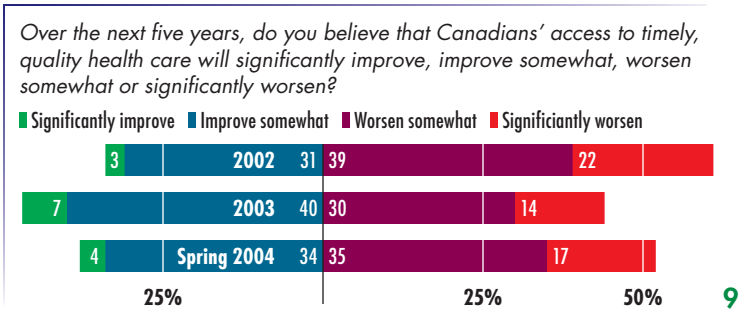
In light of all of the attention that's been paid in the last short while, both financially and otherwise, to improving the health-care system, it's clear that the public hasn't yet accepted that we've solved the sustainability puzzle. It's intriguing that they would be as pessimistic as they are, given the tremendous amount of time, energy, attention, and at least federal money to the problem. So it does prompt one to wonder how far we are away from another sort of crisis in public confidence, should there be either a downturn in the economy or not the kinds of changes in the health-care system that we're proposing.

Of course, there are no benchmarks for what would be acceptable in terms of public confidence. I had my car in for repair the other day, and there was a graph on the wall measuring customer satisfaction. It showed 92% satisfied or very satisfied. And it said, "That's not good enough." It seems odd to me that we seem willing to accept confidence and satisfaction levels at 40%, 50% and 60%, and are feeling maybe optimistic about that, which is care for people, while when it comes to care for our cars, my dealer doesn't think 92% is good enough.

It seems odd to me that we seem willing to accept confidence and satisfaction levels at 40%, 50% and 60% for care for people, while when it comes to care for our cars, my dealer doesn't think 92% is good enough.

The public still measure the system by their access to care, and are desperately concerned. We hear that regularly from physicians. It's at every level – it's not just a few high-profile procedures, it's the full spectrum of care, access to all of the providers, all of the therapies, as well as diagnostics. That is the dominant issue, and it links to provider morale – although morale isn't specifically measured in this survey, I can't help but think that provider morale is the linchpin that determines public confidence. And when the providers of care or the workers in the system are either demoralized or unhappy or stressed, it seems to me little wonder that the people who receive care aren't very confident. Perhaps that's still something that we haven't been very good at finding solutions to. For the next survey you could probe a little more deeply into provider morale in addition to just the sense of confidence, and exactly what it is that's





Provider morale is the linchpin that determines public confidence.

troubling or not. It might also be interesting to engage the public a bit more in their thinking about things like benchmarks and reasonable access to care and what they think that would be. So, rather than just asking, "Are you confident or concerned or satisfied?" it might be of some value to know what they might themselves think are reasonable timeframes for waiting to see a family physician, a specialist, a procedure, a diagnostic test; where do they find the greatest difficulties in access; what types of providers (home care, therapists, other types as well); and maybe some thought about what their sense of care guarantees.

The other issue is the question of the public/private mix. It seems that the public's interested and willing to engage in the conversation. A better sense of what they really think about the options would be of some value.

Michael Villeneuve

There seem to be such a fundamental split between satisfied and dissatisfied on some of the most key issues that I wonder if we're just asking the wrong questions and whether the access to an emergency room or a diagnostic procedure, for example, can be quite different. People walk into emergency and get immediate, fantastic care and come away and say the health-care system is great, but Joe Blow who says "I'll stay at home and wait in pain" thinks the system doesn't respond quickly enough.

The dissatisfaction and demoralization of physicians and nurses seems at odds with this vote of confidence from the people who manage them.

There are two areas that I was really struck by. One is what seems to me to be a fundamental disconnect between what a lot of managers think and what the people providing the care in the system think. The absolutely appalling level of dissatisfaction and demoralization of physicians and nurses especially seems at odds with this vote of confidence from the people who manage them and manage the system. I would be interested to know who those various respondents are.

The second thing that I'm struck by is the fairly strong correlation between what nurses and the public think. I'm never sure, as a nurse, that that's a good thing or a bad thing. There seems to be a lot of consistency with regard to wait times, access, and accountability, but the fact that they also didn't know about the Health Council leaves me to wonder whether they're just uninformed, not interested, out of the loop, whether we make assumptions, why are doctors so well informed about this and not intelligent, registered nurses in the country. Again, I've no idea what that means. There's often that difference between physicians and nurses that rattles us, and we think, How are they connecting? Is it the way they communicate? Is it their interests? I'd like to know what the answer is.

Do we equate access to care with access to a physician?

My final question is, do we equate access to care with access to a physician? If what people need is certain kinds of health services, that may be a fundamentally different thing from how long we have to wait for a family physician. And the questions almost seem to be undergirded by an assumption that to the doctor will be the access point. I would hope in the future that maybe some of the access and entry point questions might be adapted to be a little bit more open.

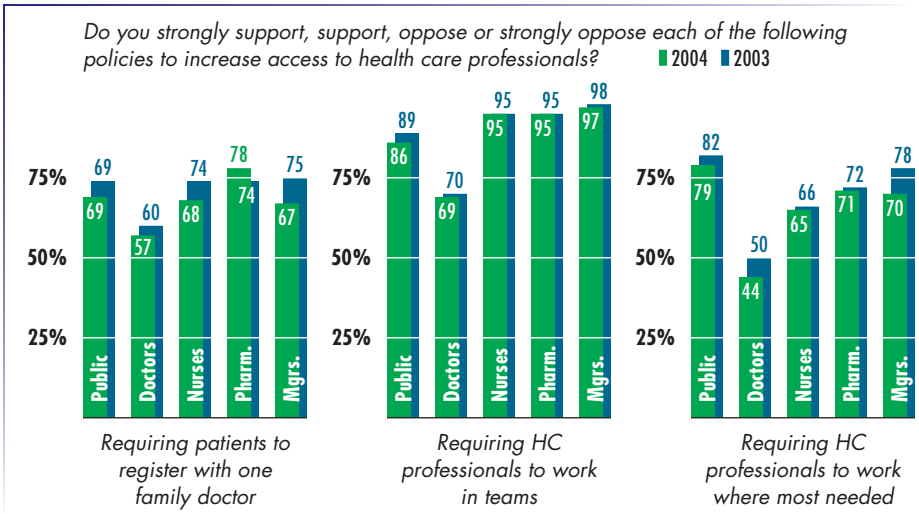
Terry Montague

It strikes me that the survey focuses on three drivers in health care: cost, quality, and access. And it strikes me also that there are no disinterested parties, both from the survey results and also from the

comments that I'm hearing around the table here today. There are, however, variances in the agreement and disagreement levels in some of the contextual areas. There seems to be a lot of agreement, and even optimism, about the need for a renewal in the system, the desirability for increased research support, the desirability of private investment increasing. However, like Michael, I think the very top-of-mind thing that strikes me is this dichotomy between the field-based people and the people in the rear echelon in administration.

I spent twenty years in the army, and this is a phenomenon that is not unique to health care, this dichotomy between field-based and headquarters-based people. And I'm not surprised, either, that the nurses come closest to the public if the public are representing the patients or the potential patients and their families. If there's a soul in the health-care system, it may well be with nurses; they are definitely the bridge between patients and a lot of the health-care system, particularly in the acute area where I worked for most of my clinical life in hospitals. I'm not surprised that they identify most with the public. I'm very concerned that nurses, public, and, to some degree, physicians too, are much closer to the nurses than they are to the administrators – I'm bothered by that, and I think it's one area that needs further definition.

If there's a soul in the health-care system, it may well be with nurses; they are definitely the bridge between patients and a lot of the health-care system.



I'm also a little bothered by a couple of other concerns, and I would put those forth for further consideration, too. One of them is the relative undervaluing by physicians of teamwork. I think they're swimming upstream on this one, and if there's ever a time where we need it to work with all of the other groups, it's now when we have so few of all of the other groups. I think that's worth tracking as we go forward. And I'm concerned that the patients or the public are undervaluing wellness and public health issues. 71% of them think that there's enough; everybody else is down around 50%. I think it's more than just a quantitative difference.

I'm concerned that the public are undervaluing wellness and public health issues.

If we have a dichotomy, administrators focusing on administrative things like costs, and patients and some of the providers, the physicians and nurses, focusing on quality and access, we should measure more specifically some of these quality and access issues, things like the care gap, the difference between best care and usual care for major disease states. That will also satisfy some of that administrative push to get more accountability, because if you're measuring things, you are making yourself accountable. One of the solutions to this dichotomy is to have people sitting around the table so that you don't see health care in some sort of a headquarters vacuum or too much in the trenches. Having everybody concerned with the same issues is a very valuable thing, and that's kind of what you've got here.

The other thing that I advocate is to start measuring around cross-functional communication, period. How much of this is going on? Are we training people in teamness? Are there projects that are sponsoring it? Are people having experiences in it?

It's the politics of team-based care that has been very worrisome to physicians: "Are we looking for the least-cost provider, not the best possible provider?"

Briane Scharfstein

I feel the need to respond to the comment that the physicians didn't seem too interested in innovations. In fact, 70% support the statement that we should *require* team-based medicine. I was surprised at how high that is, given the evolution of the concept of team-based care and the implied threat that physicians have seen historically, though not today. When you talk to people about what they really mean, it isn't that threatening in terms of working together, collaboratively, in teams, and providing good patient care. It's the politics of team-based care that has been very worrisome to physicians: "Are we looking for the least-cost provider, not the best possible provider?" Physicians, I think, are concerned that that might be what it is, and I think nurses have been, as well, in hospitals. What I have heard and seen amongst my colleagues is that they're very interested in collaborative practice arrangements, but they are concerned about some of those other political nuances: "How am I going to be paid? Am I going to be employed? Am I going to have freedom to practise and worry about my patients specifically?" Those are probably more significant than the idea they're not interested in teamwork.

Jeff Poston

Was the physician's sample family physicians or hospital or both? Do we know? And the same for the nurse population and the pharmacist population, what was the mix? On these, I find, for example, hospital physicians and family physicians have very different approaches to multidisciplinary health-care teams because of their experiences. Your results look as though the physicians do not really support innovation in health-care delivery. That's perhaps the response that you would expect from family physicians, whereas I think you'll find hospital physicians are usually a lot more supportive of innovation.

Glenn Brimacombe

I think the issue of "public" as distinct from "patient" is important. The public gives impressions, but the patients give experiences. Public impressions are important, but it would give us a better sense of the issues if we can actually distinguish between the two in subsequent surveys.

Celia Milne

Yes, I think that's come out in previous surveys where a patient will give the system high marks, whereas a person just reading headlines who hasn't been actually in the system is giving quite poor marks.

Kathleen McGovern

What I think is missing and what we might like to see next time would be some of the perceived barriers to the reform that there appears to be consensus on.

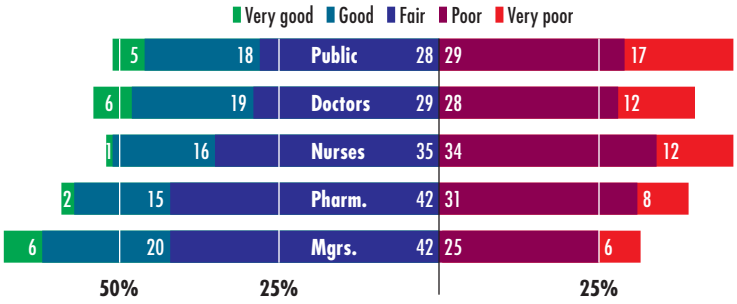
What should the new Health Council of Canada be doing?

Briane Scharfstein

However we report to the public, it has to be clear, simple, and understandable. A thousand-page treatise on the review of the health-care system is completely useless. As a matter of fact, I would suggest it's even disingenuous. If you want to make sure that the public can't find out whether we performed well or not, give them a thousand-page summary of measurements of performance. There need to be simple and clear indicators that make sense to the public, that are linked to some sense of their input in the first place as what would be reasonable. Pick a few that resonate with the public and then objectively measure them and report really simply. If you can't do the summary in a report-card fashion in one or two or four pages, it probably is meaningless to the public. And it needs to be done by a credible organization or group. We're waiting to see whether the Health Council will fulfill that role. It will be critical to maintain absolute independence. If the Health Council is perceived as simply being a branch or an arm of the government when they report on performance, I think the public will be less trusting of what they say.

If you want to make sure that the public can't find out whether we performed well or not, give them a thousand-page summary of measurements of performance.

Thinking of the additional funding that will be made available under the new Health Deal, do you believe that the government will do a very good, good, fair, poor or very poor job of reporting to Canadians the results of how those health care dollars are spent?



Glenn Brimacombe

I agree with Briane: keep it simple, stick to the facts where they exist, and avoid any kind of bipartisan or ideological filter to interpret events. Also, identify gaps that we need to focus on; there are lots of grey areas in public policy making where perhaps we need more evidence, more information, to try and clarify some of the policy options and subsequent decisions.

I think it's important to focus on where the "wins" exist in terms of renewal of the system, where innovations have been constructive, for example, where access has been improved or average length of stay has been reduced. Improved health outcomes also need to be recognized and addressed by the Health Council. I also think it is important to highlight the role of health research – which is the oxygen of an evidence-based system.

Nadine Henningsen

We should challenge the Health Council to go beyond reporting and one-way communication and look at two-way communication. If they're going to report to the general public and to providers and organizations, they also need to get feedback through vehicles like this survey or through focus groups.

Rhonda Hynds

The priority has to be on the patient and on the consumer. The Health Council needs to have that accountability back to Canadians, and there are a number of different models that they can include. Our perspective would be that the lay representatives are on that council and that their forces are strongly heard. I agree with what's been said in terms of identified objectives and clearly stated measurables. I think

The priority has to be on the patient and on the consumer.

there's also an opportunity for the Health Council to do leadership through partnership. Around this table, we bring a number of voices together, and I certainly think that the Canadian public trust us. The Health Council can certainly leverage that trust.

Christina Mills

I very much agree that the indicators need to be simple, clear, meaningful, and relevant to both providers and the public, and the only way to make sure they are meaningful and relevant is to involve the providers and public in the actual development of the indicators. It should not be a technocratic exercise where a bunch of health economists and bio-statisticians and epidemiologists sit in a conference room and say what the indicators are going to be. They should actually involve the people who need to understand them for their own decisions, whether as policy or program people or in developing their own personal decisions about their health.

In 2004 the Health Council of Canada was formed to report to Canadians on the progress of health reforms in Canada. Their first report will be in January 2005. What do you think the priorities of the council should be?

	Public	Nurses	Doctors	Pharm.	Mgrs.
Shorter waiting times	16%	14%	18%	14%	12%
Accountability	15%	16%	13%	20%	24%
Better access	13%	15%	12%	6%	21%
Improve/reorganize system	11%	23%	8%	7%	18%
More doctors	10%	8%	7%	11%	2%
Promote health education/prevention	7%	4%	10%	8%	8%
Watchdog needed	1%	10%	1%	1%	5%

Murray Nixon

There's so much data, the public and health-care providers are completely inundated by what's happening in health care, and the Health Council has just been incorporated as one little component. I think the very first thing is that the Health Council has to very capably demonstrate its role and its capabilities. This Health Council has a major opportunity now to really accomplish something with its leadership role. But to be respected, it has to demonstrate its abilities and its competencies and how it's going to do it. Do that first, and then get on with what they're going to recommend.

The Health Council really has to get some public profile of its own that shows that it's distinct from government.

Jeff Poston

I think the Health Council has a huge credibility problem already. It's been now seven months since it's been announced; it's not out of the gate. It really has to get some public profile of its own that shows that it's distinct from government. We don't even trust the government to give us decent figures on the balance of trade and get them right. We don't think the Canadian government will come clean with the Canadian public on what the current balance of the budget is. So I think that because there's so much lack of simplicity and transparency in so many areas, if the Health Council is going to be able to do a good job, they have to get out there and assert some authority and some status and some independence. And the longer that they leave taking any action or getting any visibility, the more difficult it's going to get for them.

It would be a huge mistake for us to have expectations that are out of keeping with the resources that the Health Council have available to them and their mandate.

John Hylton

I think there is a huge credibility issue, and part of it is structural, because the Health Council is made up of people who were appointed by governments; it's not made up by public representatives or any other groups. They are government representatives and they're appointed to represent their governments, and indeed, at the moment, two governments aren't participating. They have very limited resources. I think it would be a huge mistake for us to have

expectations that are out of keeping with the resources that they have available to them and their mandate. They've been set up with a very specific purpose, and that is to monitor the commitments that were made by governments to each other in health-reform process. I think they need to stick with that. I think they can identify and promote best practices, I think they can work to develop some consensus around some key performance indicators for our health system, but they're going to have 12 staff and maybe 15 when they've finished; they'll be able to leverage some other resources from some other agencies, but let's get realistic. This isn't going to be panacea or a fix for all the issues in the health-care system. In a way, it's a disadvantage that they've been created right at a time when there are so many issues in our health system that need to be dealt with, because there is a tendency for people to look to them and feel that they'll be the solution to every issue.

I think it would be very useful for them and for all of us to have some monitoring of opinion in regard to their performance. Their first report will be coming out in January or February; they'll have some reports after that. I'm sure they will be interested in knowing, and we will be interested in seeing, how well we think they are doing. I'm not sure how informed the public will be in evaluating this a very complex mandate, but I think people who are involved in the health-care system have an idea of what it is that they can achieve and would be in a position, and I think would want, to provide feedback as they proceed to develop their mandate.

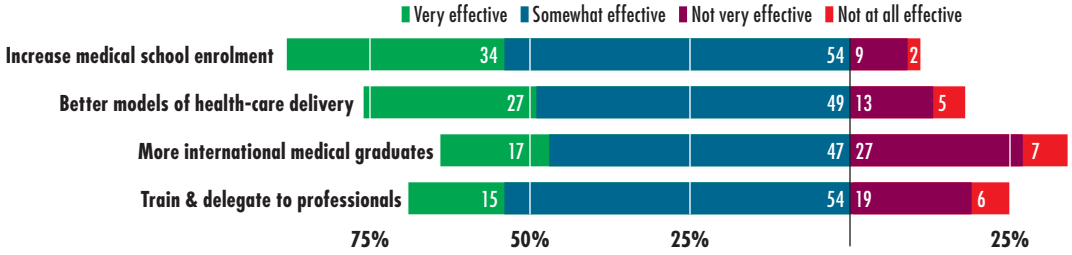
How do we make the best use of health-care professionals?

Within nursing there is about a 75% overlap in scope between practical nurses and registered nurses, and there's a similarly large overlap in scope between nurses and first-level physicians.

Michael Villeneuve

The question of shortages needs to be split out into whether we're talking about the number of people, the participation rates of those people in the profession, and/or their productivity while they're in it. One of the questions on the survey was about whether more doctors, or more nurses etc., count, as opposed to what they do when they're there. In terms of innovation, we're struck by two areas. One relates to scope of practice. In a situation of alleged shortage and real shortage, we are troubled by the fact that within nursing there is about a 75% overlap in scope between practical nurses and registered nurses, and there's a similarly large overlap in scope between nurses and first-level physicians, family doctors. I think we haven't come even close to the discussion of how we could pull those apart a little more to provide more services for people, rather than so many of us doing very similar kinds of things.

Asked of doctors: *How effective would you say the following options would be in providing a sustainable solution to address Canada's physician shortage?*



The other area is how we use or don't use technology. Every time I go into Shoppers Drug Mart, I see people sitting with their arm in the blood-pressure machine; then I go to my physician, who complains "Oh, I'm so busy!" while he takes my blood pressure. I think, "Why are you doing this task if you're that busy, when there are other people that could do it or there are machines that could do it?" Why do we have $75,000-a-year, baccalaureate-prepared, registered nurses in critical care units cleaning up messes on the floor, when someone who's paid vastly less and has less education could do that? I don't think we've even begun to pull apart what people are actually doing on the ground versus what we senior policy people at CNA and in the government think they should be doing.

Why do we have $75,000-a-year, baccalaureate-prepared, registered nurses in critical care units cleaning up messes on the floor, when someone who's paid vastly less and has less education could do that?

Asked of pharmacists: *To what extent do you agree with the following statements, on a 10-point scale where 1 means Totally Disagree and 10 means Totally Agree:*

Pharmacists should play an integral part in providing medication services to patients receiving care at home: 8.7

Pharmacists should have greater role in choosing the appropriate prescription medications for patients: 8.2

Terry Montague

I have an optimistic view. I do believe things can be better in health care and particularly in the outcomes of our health care. I think there is a role for everybody, and there is a lot of power in the communities that's untapped. I think a lot of physicians don't know what pharmacists can do to facilitate and accent their care in their patients' outcomes. In specific programs for diseases, like heart disease, diabetes or osteoporosis, where there are large gaps between what best care could and should be and what it actually is, we can improve things. We have to measure some things to make sure that we're doing the right things, that we're getting the goals that we want. One of the very first people who started talking like this was Florence Nightingale in 1856; she recommended during the Crimean War that the British Army medical service link their outcomes to their care. I think that's basically what we're trying to talk about: to measure the right things, the facile things that will be meaningful to all the people in the professions and also to the patients.

In the long term, I think the solution to improving our care is actually based in education, not in health care. It's based in the education of health-care people perhaps, but it's based in education. I know of no school or endeavour in the country where all the people who are at this table today would go to the same school and have the same class. We're suggesting that teamwork is valuable but we're not teaching anybody that that's an important role. The reason I think it's important and it be done at the undergraduate level is based on research that we've been doing over the years at both the University of Alberta and Merck. Physicians practise on evidence better closer to their undergraduate years. It tops experience. They value more, it seems, what they learned in undergraduate training. So I'm making an assumption that that may be true for all of the professions, and if it is true, it warrants confirmation. If it is true, then creating the forum where all these people can have at least one common area of communication and formal training would go a long way toward solving our health-care problems.

I know of no school or endeavour in the country where all the people who are at this table today would go to the same school and have the same class.

Briane Scharfstein

I would think I can speak on behalf of the vast majority of physicians in saying, "Yes, we could make better use of our health-care professionals." In my experience in talking with physicians who have become more involved in collaborative practice, to a person they are happy with the arrangement, other than in relation to the management/funding politics of the arrangements, where there are always issues. When it's about the delivery of care, I have not yet talked to a physician who found that a collaborative arrangement wasn't a much better way to do business. There are numerous examples of physician-pharmacist interaction, particularly when they're in smaller communities where they get to know each other, where we didn't have to teach them scopes of practice; it just happens, they understand how to do that. And nurses as well. There are far more good examples than not. What has ruined the environment to some extent is the politics of the issue, whether it's the interrelationship with government in regard to funding, where it's about how we pay doctors, not what they do, whether it's about concerns about saving money, about inappropriate substitution of scopes, etc. When you remove that and just put health-care workers together in an environment and say, "Can we figure out a way to meet the patient or public need better?" it is almost a no-brainer to some extent, and it works.

In talking with physicians who have become more involved in collaborative practice, to a person they are happy with the arrangement, other than in relation to the management/funding politics.

So, to some extent I think the challenge is to get away from the politics that has created a high degree of angst amongst physicians. It has been truly an obstacle to implementing some of the changes that have been proposed. Also to get away from the ambiguity – every time I start to discuss primary care reform in a meeting, I start by asking what we're talking about, because there are as many visions and versions of primary care reform as there are individuals involved in it. The trick is to promote those and solve some of the other relatively unrelated issues such as funding and how you pay physicians, and deal with that at a separate table.

The example I've used regularly is pre-hospital care, where some of the most vocal advocates to expand the scope of practice of other providers have been physicians. I was involved with that in trying to expand the scope of what the pre-hospital providers and paramedics do. It was a very positive working relationship that achieved that, and I think that's a model that could work elsewhere.

They said, "We're not supposed to meet," and we said, "Well, we're going to let you meet."

Nadine Henningsen

I'm cautious, when we talk about health-care professionals, to challenge how far we're looking. There are physicians, there are nurses, there are home-support workers, there are therapists. It's a very broad list, particularly in the home-care field, and a lot of health care is shifting towards home and community. There it's the home-support worker that is our key health professional and one whose scope of practice we definitely want to look at. So we need to make sure that we're looking broad.

It's interesting that sometimes we have set up administrative structures that stop our health professionals from working together. At the Canadian Home Care Association, we're doing a project where we're having home-care case managers work with family physicians. A home-care case manager had never met the family physician, yet the two of them were looking after the same client. So we broke the structure, because they said, "We're not supposed to meet," and we said, "Well, we're going to let you meet." We put them in a room, and all of a sudden they started talking and realizing how they could help each other. So I think we need to challenge some of those old structures and say, "In this new model we've got to get rid of all that old administrative stuff."

Fee-for-service is not a model that supports and promotes the best use of skills for prevention and community-wide health.

Christina Mills

I really support what Terry was saying about getting people to work together as teams at a much earlier stage so that they learn to value the contributions that other members make. And Briane and Nadine reinforced the need to get public health and clinical people to communicate – that could start much earlier – and have people understand their respective roles and contributions. I think we saw an example in the way the SARS epidemic evolved: there were definite problems in the way clinicians and public health people communicated with one another, to the detriment of public health.

I did want to say something generally about this section of statistics: the way it's presented, it makes it look like innovation is mostly about how you pay for stuff. There's one lonely question about the actual restructuring of how we deliver things. There are models which would promote teamwork and making better use of other disciplines more, say, than a bald fee-for-service model. Having that much focus on the payment issues and relatively little attention on the ways of delivering things might have a tendency to bias what we're able to infer from the results. I think a collaborative model, where people with different professional expertise are contributing to a team and they're paid on a capitation or a global basis or something which is other than fee-for-service, and which really supports other professionals being part of the team, could also enable them to participate in, say, community-wide coalitions for disease prevention – a nutritionist being able to contribute to a community chronic-disease coalition, for example. If you are on an entrepreneurial fee-for-service basis, there's no support for that kind of function in the community. Even if there is, there might be some for clinical nutrition if there's an actual referral, but it's not a model that supports and promotes the best use of those kinds of skills for the prevention and community-wide parts.

Glenn Brimacombe

In many respects, when we talk about innovation, we also talk about how we want to sustain the system – that is dynamic in nature – over the short-, medium- and longer-term. The concept of sustainability is

not just about the level of funding; it has to do with other component parts, such as a critical mass of health human resources.

It also about investing in different forms of infrastructure, such as information technologies, medical equipment and physical capital. If there's one critical piece aside from what has been raised so far, it's how we invest in information management systems. It's absolutely critical to how we navigate patients through the system and the information that follows them. And also, when you think about the kind of money that is on the table with the Wait Times Reduction Fund and what many regions are doing right now in terms of trying to better manage the order and speed of patients through the system, I.T. is an essential piece to making that happen.

Briane Scharfstein

A physician who was involved in a very innovative collaborative practice and primary care arrangement categorically stated as recently as six months ago that far and away the number one obstacle to communication and collaborative practice was inadequate information management systems. It was such a huge obstacle that nothing else really mattered that much. Training and understanding, scopes of practice, all of the other things they were doing, paled in comparison. Whatever could be done to enhance the information systems is probably critical to allowing collaborative practice to work. It just strikes me that health care is actually a knowledge industry, and it's amazing how little R&D is being done in knowledge industry. The rest of the business world long ago, even those that aren't in the knowledge business, determined that we won't be successful without reinvesting 5%, 10%, or more to be an innovative company and survive. And in a knowledge industry we're not reaching that. It's a critical underinvestment, including in information technology.

Far and away the number one obstacle to communication and collaborative practice is inadequate information management systems.

Murray Nixon

Further surveys and the health-care system generally should consider the increasing regionalization within our country as an asset for interdisciplinary understanding. Prospective home care now is often meeting with its partners in the other components of health-care regions to recognize more how it can associate and collaborate. Beyond that, respect and understand what the community health boards are doing, because they're a voice for the community. And go beyond the actual health-care deliverers and providers to all the components and determinants of health to look at health promotion and prevention.

Terry Montague

In a nutshell, I think the power is in the communities. I've recently written a book where I look at some of the outcomes that have come out of the Improving Cardiovascular Outcomes in Nova Scotia (ICONS) project. A lot of them are not surprising to me. They were able to increase utilization of the evidence-based therapies markedly over the period of the first five years, and those increases in the proven therapies for heart attack, heart failure, and unstable angina are incontrovertibly related to the survival outcomes. That's what you would predict in evidence-based medicine: what works in these large clinical studies will work in the whole population risk. There are a few other outcomes, though, that are important to our society, like readmission, where when you do the logistic regression, utilization of the proven therapies is not related to the decreased readmission rates that occurred for all three of those major diseases.

The power is in the communities.

Patients may have to be part of this definition of the health professions if we give them the right tools.

Dr. Robert Thivierge, from the University of Montreal, has been a lifelong advocate and expert in continuing education for physicians. He uses a diagram of an iceberg with the water level showing the one-tenth above and the nine-tenths below. The one-tenth above is explicit knowledge gain in exchange, and the nine-tenths is implicit or tacit knowledge. His impression is that that nine-tenths is underrated and undervalued by everybody, but it has a lot to do with driving the improvements and the advances in the innovations. With the ICONS project, where we see a 20% reduction in the admission rates, despite an increase of about 20% in the burden for each of these diseases over that timeframe, I believe that part of the power that drove it was patient-to-patient health management. So we might think first of nurses, physicians, pharmacists and administrators, but the informed patient starts to take better care of themself and produces a valuable contribution to improved health outcomes. So I think that the patients may have to be part of this definition of the health professions if we give them the right tools.

There does need to be a structure that will ensure that buildings get built, people get paid, and there are mechanisms of accountability.

Jeff Poston

We're seeing a lot of experimentation in Canada at the moment, such as *Act 25*, which is a major reform of structure of the health-care system in Quebec, and yet, as Nadine points out, there are problems with structure. Community and home care has been the classic model of a more socially broad approach to health care. We have to have a structure that is responsible – you can hang services off at the community level, but that structure has to be a part of the community in some ways. There was a project in Sault-Ste-Marie where the community formed a not-for-profit, and so they had a structure that they hung their services and funding off. The UK is going through what's determined to be a fairly successful major reform of the health-care system, where they've created primary care trusts that become the local structure that you hang services off.

I certainly agree with Briane: put pharmacists, nurses, patient groups, local community together to work out what needs to be done. They can usually produce something fairly special. But still at the end of the day there does need to be a structure that will ensure that buildings get built, people get paid, and there are mechanisms of accountability. It doesn't need to be overly bureaucratic or administrative. Structure is the difficult piece, I think, in terms of getting innovation right.

What we do an incredibly lousy job of is managing performance in our health system.

John Hylton

The fact of the matter is that there are best practices; we all know what those best practices are. We spend a lot of time through an incredible investment in research – we'd all agree it isn't big enough, but it's the biggest per capita investment in research – identifying and evaluating best practices. What we do an incredibly lousy job of, though, is managing performance in our health system. What we don't do is identify a best practice and then create the incentives and disincentives in our health-care system so those best practices spread across the system. Sault-Ste-Marie is doing great things; why isn't everyone doing the great things that Sault-Ste-Marie is doing in a particular area? And can't we identify all of those best practices in a more systematic way and then create the incentives for those best practices to be adopted, at the same time as we create the disincentives for programs and approaches and systems that are suboptimal? If we went into any organization and we wanted to improve the

performance of the organization, the first thing we'd have a discussion about is what are the objectives and how do we monitor them and what are we going to do to manage the performance of that organization so it's more effective. Show me where we do that in the health-care system. We do it a lot within facilities and programs and specific geographic areas, but show me where we do that as a system and show me where we're even building the blocks to do that. I think that's the single most important thing that we could do: identify best practices and provide incentives and disincentives to see those spread across our health-care system.

How should we approach investment in health R&D?

Nationally, there have been substantial investments by the federal government into health research, and as a result there are concerns about what kind of "fatigue" is on the horizon since they have already made a significant contribution.

Glenn Brimacombe

If you look at the survey results, all groups are strongly in favour of increasing health R&D – and have been so for the past few years. So, to the extent that we're increasing funding, we're already building on a strong foundation. Nationally, there have been substantial investments by the federal government into health research, and as a result there are concerns about what kind of "fatigue" is on the horizon since they have already made a significant contribution.

To continue the momentum to invest in Canada's health research enterprise means we need to continue to educate the public and politicians about the value of health research in its dimensions; that is, how it makes our overall health care system more effective and efficient in terms of the way in which we deliver care with better outcomes; how it improves our individual and collective health status, and contributes to our economic prosperity.

Rhonda Hynds

I agree totally with what's been said, and I know that the health charities in particular that are co-funders of health research look to continued support and investment by other funders, which includes the federal government. But what we've been looking at and struggling to identify is a more integrated approach of funding health research within Canada. We have a strong centre of excellence in terms of the research that has been done to date, and moving forward, there are opportunities that the funders of research could collaborate in terms of looking at the Genome Project, the research chairs, CIHR, all the various research institutions, and working collaboratively with that and identifying the long-term strategies of what research is currently being invested and where's it going and what can then be further invested to come to the end goal. So, I think truly an integrated approach is what is required. How do we come to that? We're still working on it. And then sharing that information with the public is of value, too. I don't think there's a lot of knowledge transfer of what research is being done and what the protocols are and then what is happening. Health charities oftentimes take that role of translating the research information to clear, succinct language for their patients and consumers at their end.

It's Canada against the global competition and our standard in the world, because there's a direct link between research and development and our standard of living.

Terry Montague

I think investment in R&D is very important. By my calculations, the United States, for example, is a major benchmark for us in everything that we do; they are about twenty to forty times ahead of us in terms of innovation in health care as a medical industry. That's an enormous gap, and the $44 billion that they spent last year in the United States is equally split between private and public sources. Both their government and their private enterprise are spending much more on health as a knowledge industry than we are. This is something we can't afford to look inward on; it's not Toronto versus Montreal, or U. of T. versus York here. It's Canada against the global competition and our standard in the world, because there's a direct link between research and development and our standard of living. I don't have all the answers, but I'm wondering if communication isn't an answer here too: telling people about this and having stories appearing in the *Globe*

and Mail the way they appear in the *New York Times* about this. This is a point of pride for Americans, and I think perhaps it should become that way for us as well.

In terms of increasing the private component of it, things like the Canadian standard against the global standard of intellectual property protection access in the infrastructure that provides the people who work in these industries – for example the scientists – are the main points of interest for a company in determining whether they are going to invest in medical research in one company or another. A lot of the companies are global, so Canada is competing with Europe or the United States, and if those countries make the investment look more attractive, then that's where the money will go.

Christina Mills

I think it's critical that there be substantial and increasing public investment in R&D. It's a social responsibility, and it does affect our standard of living. Beyond that, there are things which probably will never have a profit incentive that, as a society, if we want to see happen, there has to be public support for. I think of support for the Canadian Institutes of Health Research, which incidentally has a pretty good record in its fairly short life of promoting collaborations with NGOs and other partners to do more integrated strategies for research. I think we definitely need the curiosity-driven research for discovery and innovation; we also need targeted research to be able to answer the important questions that if we wait for an organic evolutionary process of research to answer, there'll be a whole lot of preventable morbidity and death that will happen while we're waiting. We want to do the right thing on purpose, not accidentally.

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Are we well prepared to protect public health in Canada?

You have to admit that you have a problem before you can actually do anything about it.

The budget talked about the investment in the public health agency for Canada as a "down payment." It's a good start, but let's see the rest of the investment.

Christina Mills

Compared to how we were before SARS, I think we're a bit better prepared to protect public health. At least we're aware of what the problems are in our system – in our communication system, in our information system, in the way that clinical and the public health systems deal with each other. We haven't actually seen the money flow to the public health system front ranks to actually make the changes that have been identified as necessary, but awareness is the first step. Like they say in the 12-step programs, you have to admit that you have a problem before you can actually do anything about it. And all the things we've talking about, the need for better multidisciplinary and interdisciplinary collaboration, integrating systems, all those point to ways that we could be doing things better than we have in the past. I think it seems like such an immense challenge when you think of how complex our system is, but people in Sault-Ste-Marie and other communities across Canada are actually doing experiments to show how things can work better. I think if we take John's comments about the vital function of knowledge translation and transfer into account, it will go a long way towards improving things in that area.

Basically, though, I get back to the first thing I said: public health is the invisible part of the system. And unless we recognize it for the vital foundation that it is for the sustainability of the whole system, we aren't going to see the investment. So I would like to see the Health Council of Canada actually monitoring the proportion of that new health investment which is going to basic public health functions; I'd like to see a public-health, human-resource strategy be integral to the health human-resource strategy. Unless that foundational side of it is attended to while we're attending to the treatment sector, in the long term we're not going to be any better off. I do see opportunities in primary health-care reform for integrating population approaches to the clinical approach. I think we've got a lot of potential, but it remains to be seen how well we'll actually follow through on what we've said is important. Report after report has indicated the importance of primary prevention of chronic diseases, and health promotion, injury prevention, and so forth in terms of reducing longer-term demand on our system, and we've got to keep that on the decision-makers' agenda and make sure that the investments follow. The budget talked about the investment in the public health agency for Canada as a "down payment." Well, that's great, it's a good start, but let's see the rest of the investment.





How well does the system promote health and prevent disease?

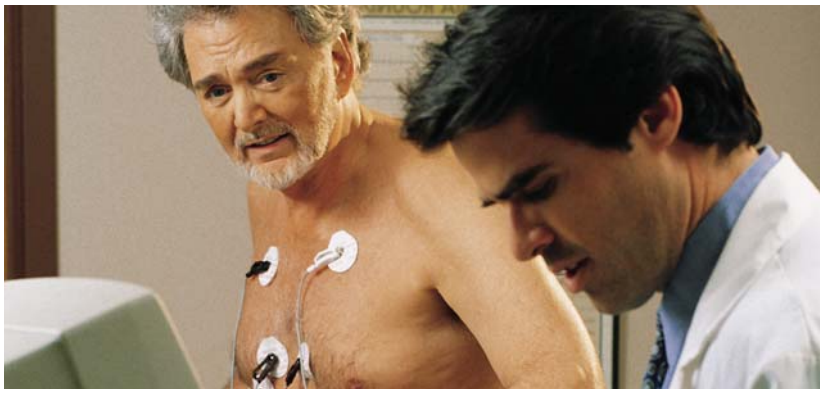
Michael Villeneuve

I hate to use clichés, so please forgive me, but I think we in nursing would argue that the system is still very good at protecting illness recovery or disease recovery; we do emergency care and critical care and that end of the system quite well. I think it remains to be seen whether we can predict public health well. We think investments in preventive care are great, but certainly in my career, which is 25 years now, it's been chipping away rather than anything major – we did things like paramedics in pre-hospital care, and nurse practitioners, but to turn from acute care to preventive care, I don't see a lot of evidence; I see a lot of talk and good intention, but we think we've got a long way to go.

Jeff Poston

We had the Lalonde Report in 1974, which was to make Canada the world leader in terms of health promotion and disease prevention, and thirty years later we're now investing in a Canadian public health agency, and there's a general sense that we haven't necessarily done that much. I think John actually nailed the number one issue facing the Canadian health-care system: what's the mix of incentives and disincentives to drive behaviour to do the right things? One of the challenges in disease prevention and health promotion is that we've relied on values. I was meeting with a community health council here in Ottawa a couple of weeks ago, and one of their big issues is affordable public housing. In the community they serve, the average family income is $25,000 a year. It's largely new immigrants to Canada; they're highly qualified, highly educated, but a lot of them don't have a job in the system. And for the health of that community, affordable housing is a huge issue. So the way that they're structured, they work in a salaried environment, and yet in their volunteer time, they're working on affordable housing. That's a values-driven thing that they see as absolutely critical to their community, which is great, but what are the incentives for health-care providers to be practising in a way that focuses on disease prevention? We're beginning to see some models evolve in that, but a big piece is going to be identifying the incentives to drive best practices in health promotion and disease prevention.

What's the mix of incentives and disincentives to drive behaviour to do the right things?



Can we meet growing demands or do we have to lower expectations?

If we had been doing better ten, twenty years back in controlling smoking and promoting physical activity and healthy eating, there wouldn't have been as many people chronically ill to have the extreme complications of SARS.

Christina Mills

I would not be happy talking about trying to reduce people's expectations until I'm confident that we're doing everything we can to prevent that portion of disease which is preventable, and obviously we're not doing that yet. Even in the shorter term, look at SARS: most of the people who died from SARS, who were severely affected by SARS, had some kind of preventable chronic disease. If we had been doing better ten, twenty years back in controlling smoking and promoting physical activity and healthy eating, there wouldn't have been as many people chronically ill to have the extreme complications of SARS. There isn't a tidy divide between the infectious disease, which you prevent by immunization and infection control, and the chronic disease, which you prevent by socio-behavioural and policy interventions. They're linked, and we can have a direct impact on the burden on the treatment system by doing a better job of prevention. Another example where investing in public health can save burden on the treatment system is immunization. Immunization can reduce emergency visits and it can reduce seniors' hospitalizations. Even if you look at just that small slice of the prevention pie, there's definite scope for net savings if we do it appropriately, comprehensively, as some people have called, with the preventive dose. If we really make the service equally available in every community in the country, we will see benefits in these other indicators.

We want it all, and even then, it's not enough. At the same time, we are moving closer to the tipping point for some of the sensitive policy decisions we are going to have to make about covering everybody versus everything.

Glenn Brimacombe

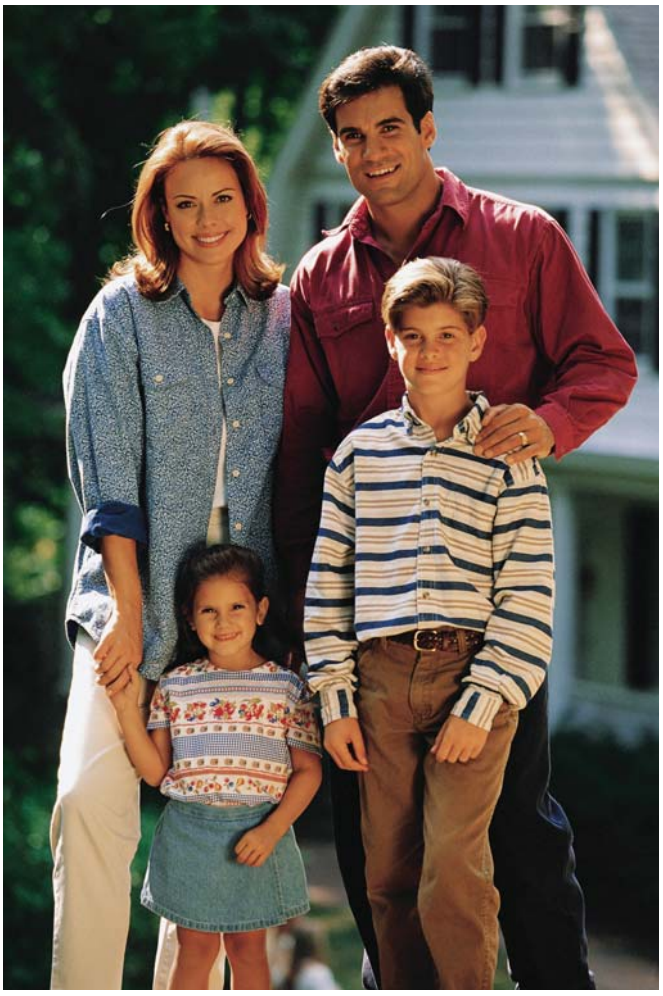
My sense is that it is impossible to lower expectations given the world in which we live – which is a modern 21st century economy and society. How do we manage and better adapt expectations is the challenge. We're going to have to start making some difficult trade-offs or choices at some point. We want it all, and even then, it's not enough. At the same time, we are moving closer to the tipping point for some of the sensitive policy decisions we are going to have to make about covering everybody versus everything. We're not there yet, and the public is saying, "Before we get to any decision on that, you take from the military, you take from education, you take from child care, you reallocate as much as you can into health care so I don't (yet) have to make that decision. Let's postpone it until the absolute end or until there is a real crisis that we have to deal with. Only then am I prepared to make some touch choices about everybody versus everything." And that goes back to the issue that Briane raised earlier about the public/private mix, because at some point we're going to have to engage in a much more direct discussion about what we are going to leave in and what we are going to leave out.

Briane Scharfstein

We have areas of health care with much worse access than doctors and hospitals. I would think of mental-health services, drugs to some extent, dental care; there are children who are going without adequate dental care, children going without their eyeglasses, and there's no "crisis." We don't seem to be talking about managing the public's expectations or even suggesting their expectation of access to these other services is in some way unreasonable or inappropriate. I think it's very much a system problem here. I would agree with Glenn. It's not that the public's unreasonable in what they expect; we've created a system that would be guaranteed to create a disconnect. We have a system where we've said that doctor and hospital care shall be available, but the point of service free of any charge. This is laudable and has been an achievable goal, but it therefore creates expectations which are different than you get in any other system. And we have trouble managing that.

We have areas of health care with much worse access than doctors and hospitals. There are children who are going without adequate dental care, children going without their eyeglasses, and there's no "crisis."

It seems we're distorting to some extent some of the things we're thinking of doing, because of that inherent imbalance between limited supply and unlimited demand because of the way the system is set up. And yet it doesn't seem to be a problem. It was dramatic for me, sitting around a table once with a whole variety of other health-care providers and talking about the crisis in access, and the optometrist and some of the others said, "Well, we don't have that same sense of that." Of course, from the public's perspective, it might well have been. So, I do think there is some need to start dealing more specifically with those questions to sort of restore equilibrium in the system, whatever the solution, and it has to involve the public discussing it.



Concluding remarks

Terry Montague

This has been very positive, and, on behalf of Merck, I want to thank everyone for the growing partnership, which began about seven years ago and has been growing gradually ever since, from three at the start to 13 now. It's been very co-operative, the response has been good and it's been a useful coalition. Hopefully we can do some really interesting things in the next year particularly. We've been working with Rogers in perhaps doing some outreach to communities and discussion with the public on issues where the groups use it as platform for debate. I think a good slogan for us to use is "Patients First."

Headlines for 2010

The participants were asked, "What would you like the front-page headline to read in 2010 if we continued the survey?" They gave quite a variety of suggestions:

Canada finds cure for cancer.
Investing in health research drives economic growth
Canada's system healthiest, says the United Nations
— Glenn Brimacombe

80% of Canadians express satisfaction with access to health care in home and community.
— Nadine Henningsen

There's no place like home.
— Murray Nixon

Medicare successfully reinvents itself, then comes back stronger.
— Kathleen McGovern

Drug use safer than ever.
— Jeff Poston

2010 marks fifth consecutive year of improving satisfaction with Canada's health system.
— John Hylton

Canadians investing in health research increases.
Canadians recognize prevention as cure.
Canada is the research centre of excellence.
— Rhonda Hynds

Extra! Read all about it! No one got sick or died of a preventable disease or injury today.
It's Monday, November 29, and all are well.
— Christina Mills

World Health Organization ranks Canada's health system number one.
— Owen Adams

The Rogers–POLLARA poll indicates public confidence and provider morale at an all-time high.
— Briane Scharfstein

WHO says Canada top saver of health dollars through public health investment.
Canada healthiest country in the world, says WHO.
— Christina Mills

Health care solved, Sea Kings replaced.
Things are better, and it's all about prevention.
— Terry Montague

What do you think?

Fax us your comments on the Health Care in Canada 2004 Survey.

Photocopy this page and fax it with your comments to ***416.383.0005*** *or email* ***comments@hcic-sssc.ca***

Name

Affiliation

Telephone number

Email address

Comments on this year's survey

What questions would you like to see in next year's survey?

The Health Care in Canada (HCIC) survey is a comprehensive annual survey on key health care issues. It has been developed to provide direction for decision makers as they strive to manage health care reform. This is the seventh annual survey of a nationally representative sample of Canadians, health care providers, managers and trustees. One thousand Canadians, 200 physicians, 200 nurses, 200 pharmacists, and 200 managers and trustees from across the country were polled in this survey. Fielding was conducted between October 20th and November 3rd, 2004.

"Ensuring Access and Innovation in the Canadian Health System," a roundtable of the partner organizations, took place on November 29th, 2004. The survey results were discussed and the roundtable was chaired by Celia Milne, of the *Medical Post*. Partner organizations are the Association of Canadian Academic Healthcare Organizations, the Canadian Nurses Association, the Canadian Medical Association, the Canadian College of Health Services Executives, the Canadian Association for Community Care, the Canadian Healthcare Association, the Canadian Home Care Association, the Canadian Public Health Association, the Health Charities Coalition of Canada, the Canadian Pharmacists Association, POLLARA, Merck Frosst Canada Ltd. and Rogers Media.

Some key findings:

- 52 % of Canadians believe the new Federal-Provincial health care deal will improve access to timely quality care.
- 86% of the public say there is a shortage of doctors, 81% say there are not enough nurses and 66% say there are not enough pharmacists.
- The public are very supportive of increased support for health research: 81% support increased public funding and 70% of Canadians support providing incentives for increased private-sector funding for health research.
- 73% of the public oppose restricting the range of health services offered to deal with budgetary shortfalls.
- 53% of public support contracting out of publicly covered services to private clinics.
- 62% of the public oppose allowing people to pay out of their own pocket for quicker access to services.
- The public is supportive of requiring health professionals to work in teams (86% support), register with one doctor (69% support) and work where most needed (79% support).

For complete results, visit the Health Care in Canada Survey website, www.hcic-sssc.ca, or the Pollara Inc. website, www.pollara.ca.