Health Council of Canada | Conseil canadien de la santé

Health Care Renewal in Canada:

Accelerating Change

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The Council regrets the untimely death of Councillor J. Camille Gallant in August 2004 and wishes to acknowledge his contributions to the Health Council of Canada.

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Chair, Health Council of Canada 2

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MESSAGE FROM MICHAEL DECTER, CHAIR, HEALTH COUNCIL OF CANADA

Canada's health care system is well established, valued by Canadians and serves a diversity of needs. It provides significant health care to Canadian health care consumers, but its services are being challenged to meet ever-growing public expectations for care.

Canadians are anxious about the future of the health care system. Will quality health care be there when needed? Renewing and strengthening health care is an important issue for Canadians. This means modernizing how we provide services and broadening the services provided.

Canada's federal, provincial and territorial governments and health care community are responding to the challenge. In 2000, the First Ministers began the discussion on priorities to renew our publicly-funded health system. With the 2003 First Ministers' Accord on Health Care Renewal and the 2004 First Ministers' Ten Year Plan, governments provided a national focus, increased funding and a confirmed consensus on the shape of renewal.

Health care professionals and providers have given advice and are working to develop new and innovative approaches to meet the complex health service needs of Canadians. With the policy priorities identified, new funding and the participation of professionals and providers, we can move forward.

The Health Council of Canada was established by First Ministers to monitor and report on the 2003 Accord which focused largely on improving health care services. The only reason to provide health care services is to improve health and therefore, we interpreted our reporting role to include improving the health status of Canadians. The 2004 Ten Year Plan reinforced this idea by specifically asking us to report annually on health status and health outcomes.

We will provide information to Canadians to encourage their participation in determining how best to achieve renewal. Canadians have a pivotal role in ensuring that we get the best value out of the funding in place. Renewal efforts will not be successful unless Canadians are involved.

This first report covers activity across Canada launched or being planned from the 2003 Accord. Priority areas are the health of Canadians, primary health care, drugs, home care, health human resources, and infrastructure to support renewal. The Council believes a significant start towards renewal has been made. We recognize these are early days and progress takes time. However, we believe that the pace of renewal must be accelerated and that there are significant obstacles in the way. There is no guarantee that the admirable plans and directions established by governments and enshrined in three health accords will come to fruition unless the obstacles are addressed.

Historically, we have learned two hard lessons about health care. The first lesson is that change is difficult, even when all the evidence points to its necessity. Health care is a large and complex system. It is easier not to change than to change. The second lesson is that

it is easier to spend more money on health care than it is to get results. It is particularly crucial to be vigilant about getting a return on the investment of tens of billions of dollars flowing into the system in the coming years.

We see our job as one of witness and advisor — to provide a dispassionate view of the pace of progress, to highlight obstacles and to suggest ways to accelerate renewal.

From time to time, our reports and advice may make Canadians, providers and governments uncomfortable. We firmly believe that we will serve no purpose if we do not present an unvarnished view of reality. We will have succeeded if our analyses, supported by defensible logic and good evidence, provokes constructive debate and provides added impetus for improvement. We intend to give voice to the concerns of users of the health care system.

Our work to date has convinced us that there are areas where reforms need to be accelerated. Of note are:

- Health human resources — nurses, doctors, pharmacists, technicians, technologists and others need to be trained in teams in sufficient numbers to meet future demands. This is an urgent priority. Without sufficient providers of care working together, all other efforts will flounder.
- Aboriginal and First Nations health requires focused attention — efforts to bring care closer to home need to be accelerated.
- Primary health care — the first point of contact for patients requires strengthening and restructuring to meet the needs of Canadians.
- Modernization of health records is another area for accelerated action. Our modern banking system has a robust electronic record to support it. Our health system needs a similar capability to bring together all information about a patient at the point of care — an electronic health record.

Over the next year, we will produce a series of public reports to highlight innovative practices in primary health care, home care, pharmaceuticals management, reducing wait times and health human resource planning. As well, we will report on the funds being spent on health care renewal and measure the benefits gained. We will work with governments, providers, managers and Canadians to push for accelerated change.

We welcome your feedback and your input on the directions for renewing Canada's health care system.

Michael Decter

WHO WE ARE

The Prime Minister and the Premiers accepted the advice of the Kirby Report, *The Health of Canadians - the Federal Role*, (October 2002) and the Romanow *Commission on the Future of Health Care in Canada* (November 2002). Both reports identified the value of an independent council informing Canadians on health care matters while promoting accountability and transparency. Canada's First Ministers established the Council in their 2003 Accord on Health Care Renewal and enhanced its role in the 2004 Ten Year Plan.

Funded by the Government of Canada, the Council reports to the Canadian public and operates as a non-profit agency. We have 27 councillors including representatives of federal, provincial and territorial governments, experts and citizen representatives. Councillors have a broad range of experience bringing perspectives from government, health care management, research and community life from across Canada.[1]

WHAT WE DO

The Health Council of Canada is committed to advancing the renewal of Canada's health care system and the health of Canadians. The Council is unique, speaking directly to Canadians, offering a national, system-wide perspective on the status of health care in Canada. The basis of our work is monitoring and reporting independently to Canadians on health care renewal progress and system performance, identifying strategies for improvement and better health for Canadians.

We take our independent role seriously and we will exercise it to benefit Canadians, speaking out constructively on the issues and needs facing Canada's health care system.

To fulfill our mandate, we will inform and engage Canadians striving to understand their health care needs. We will provide insight and evidence-based analysis to explain why improvement is needed and how it can be achieved, drawing on successes in Canada and elsewhere. This information will enable Canada's health care consumers to understand what has been promised and what has been accomplished.

We will be guided by our belief that all efforts and resources should be geared to making a difference: achieving and maintaining a sustainable, accessible, affordable and quality health care system. We recognize the importance of building on the reforms and innovation taking place and the commitment of all partners to improving the health of Canadians.

1 The Province of Quebec, while not a member, has agreed to collaborate with the Health Council of Canada. The Province of Alberta is also not a member.

THE 2003 FIRST MINISTERS' HEALTH ACCORD

The Council's starting point is the September 2003 First Ministers' Accord on Health Care Renewal in which we were given the role of reporting on the implementation of the initiatives listed in the Accord. The Prime Minister and the Premiers stated that the Accord was a covenant to ensure that:

1) All Canadians have timely access to health services on the basis of need, not ability to pay, regardless of where they live or move in Canada;

2) The health care services available to Canadians are of high quality, effective, patient-centred and safe;

3) Our health care system is sustainable and affordable and will be there for Canadians and their children in the future.

Furthermore, the Prime Minister and the Premiers stated that the ultimate purpose of the Accord was to ensure that Canadians:

- have access to a health care provider 24 hours a day, 7 days a week;
- have timely access to diagnostic procedures and treatments;
- do not have to repeat their health histories or undergo the same tests for every provider they see;
- have access to quality home and community care services;
- have access to the drugs they need without undue financial hardship;
- are able to access quality care no matter where they live;
- see their health care system as efficient, responsive and adapting to their changing needs, and those of their families and communities, now and in the future.

Key elements of the Accord included:

- A five-year $16 billion Health Reform Fund targeted to primary health care, home care and catastrophic drug coverage;
- A $1.5 billion Diagnostic/Medical Equipment Fund to improve access to publicly funded diagnostic services;
- $600 million for information technology infrastructure to secure electronic health records which are vital to quality care and patient safety and Telehealth services;
- Funding of $2.5 billion to help relieve immediate system pressures;
- $500 million for research hospitals through the Canada Foundation for Innovation;
- Increased federal funding of $1.3 billion to improve the health of Aboriginal Peoples to close the gap in health status between Aboriginal and non-Aboriginal Canadians through better integration of services;
- $1.6 billion over five years in direct health accord initiatives, including patient safety, Canadian Coordinating Office for Health Technology Assessment, Employment Insurance compassionate care, GST rebate for health institutions, a national immunization strategy, and governance and accountability;
- The establishment of the Health Council of Canada made up of representatives of federal, provincial and territorial governments and leading health care experts to assess system performance and progress towards renewal.

A ten year plan to strengthen health care was agreed to by the First Ministers in September 2004. The main focus was on reducing wait times for health care services. It also dealt with many of the same issues in the 2003 Accord. We have noted in the report where the 2004 agreement further develops the commitments from 2003. We will report fully on the 2004 Ten Year Plan in our next annual report.

Report Organization

This report focuses on progress in implementing the 2003 First Ministers' Accord. It does not cover every aspect of the Accord, but rather is organized around three broad themes, each detailed in a separate section. They are:

1) The health of Canadians: focusing on improving population health, Aboriginal health and patient safety;

2) Access to health care services: focusing on access to different health care services and programs; and

3) Infrastructure to support health care renewal: focusing on the supports required to achieve access to health care services and programs.

The renewal priorities identified in the Accord are organized and discussed within each of these sections. The *Health of Canadians* section includes discussion of strategies to improve population health including, but not limited to immunization, a focus on Aboriginal health and issues of patient safety. The *Access* section includes discussion of primary health care, home care, drugs and wait times for services. The *Infrastructure* section includes discussion of health care workers, information technology, funding to support reforms, and the public reporting of comparable health indicators.

We begin each section with a description of its importance to Canadians and health care. This is followed by a brief survey of its current status, issues and challenges and the benefits of renewal. Each discussion concludes with our advice to advance renewal. Finally, the report ends with a summary of work the Council has planned for the next year.

Extensive information about provincial, territorial and federal activity is included in tables at the end of the report. We have referred to these examples throughout the report.

This report is meant to set the stage for continued discussion over the next year. We plan to release longer reports on primary health care, home care, pharmaceuticals, wait times, health human resources and Aboriginal health throughout 2005.

I. The Health of Canadians

HEALTHY LIVING

The future of Canada's publicly-funded health care system faces many challenges. But the greatest challenge of all, in the long term, is to create effective strategies for health promotion, disease prevention and the recognition of other factors that effect health. One of the greatest contributions governments can make to improving health status is to reduce the number of Canadians who lead disadvantaged lives devoid of opportunity or hope.

Major health disparities exist in Canada and increases in health care spending will not reduce the gap without targeting the needs of people at greatest risk. Research has repeatedly shown that the most important factor contributing to health disparities is socio-economic status: income, education, jobs and a sense of control over one's life. Reducing health disparities would increase economic productivity and decrease the use of health care services, social assistance, subsidized housing and correction services, and improve opportunities for the most disadvantaged in Canadian society.

This is not to say that health care does not have a role to play — better access to and better design of health care can reduce disparities. Investments in other social programs are also key to reducing the health gap.

The 2003 Accord identified a number of actions to improve the health of Canadians. They reflect a balance between individual responsibility for personal health and the collective responsibility of the health system. The Accord directed the Health Ministers to:

- Work on healthy living strategies focused on obesity, promoting physical fitness and improving public and environmental health;
- Work on initiatives to reduce gaps in health status; and,
- Pursue an immunization strategy.

Health Ministers have established a network of individuals and organizations interested in healthy living strategies and have committed to present a Healthy Living Strategy in September 2005. Obesity has been recognized by the World Health Organization as a worldwide epidemic and an increasing problem for both adults and children. Obesity is linked to a range of diseases and can significantly reduce how long people live. The September 2005 Healthy Living Strategy is designed to include action on healthy eating choices and promoting physical activity. The establishment of the new Canadian Public Health Agency will bring further attention to these issues.

Currently, Canada does not have a national immunization strategy. Work is underway on national immunization goals; collaborative assessment and prioritization of new vaccines; vaccine safety; improving the bulk purchase of vaccines; developing immunization registries; developing education and communication programs; and improving monitoring systems.

COUNCIL ADVICE

The First Ministers' focus on reducing health disparities is important and Canada has invested in a number of promising initiatives. This work should be given a high priority and we recommend the following:

1) Broaden the Healthy Living Strategy to move beyond lifestyle issues to focus on health disparities and engage sectors beyond health to contribute to reducing the gap. The contribution of non-health organizations and sectors is central to this discussion. They are necessary partners.

2) Engage Canadians in understanding the importance of non-health care factors in determining individual and community health. Use strong language. Health disparities are the number one health problem in the country and health care alone is powerless to overcome them. The health disparity between groups in Canadian society and the impact of the gap must be reported and highlighted. This is a difficult message to get across in the current environment where the public is pre-occupied with funding for health care. But it needs to be done.

3) Set targets for reducing health disparities and build a health disparity focus into the comparable health indicators process. Place a particular focus on reducing health disparities between Aboriginal and other Canadians.

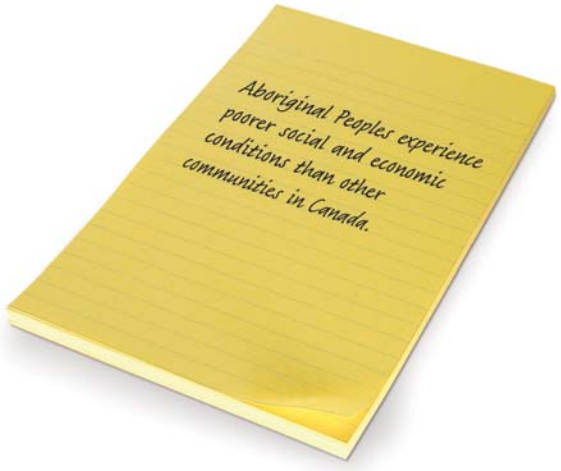
ABORIGINAL HEALTH

The Council decided early on that our work on the health of Canadians would focus on groups most at risk — Aboriginal Peoples, children, the elderly and people with mental health challenges. This report deals only with Aboriginal Peoples. Future reports will focus on other priority groups.

First Ministers recognized the serious challenges facing Aboriginal communities and committed to reducing the gap in health status between Aboriginal and non-Aboriginal Peoples.

Aboriginal Peoples experience poorer social and economic conditions than other communities in Canada. For example:

- Significantly more Aboriginal students do not complete high school as compared to all Canadians (52 per cent versus 33 per cent);
- The official unemployment rate of Aboriginal Peoples is significantly higher than the non-Aboriginal rate (19 per cent versus 7 per cent).



The health of First Nations, Inuit and Métis people is worse than that of the general Canadian population on virtually every measure of health and every health condition. For example:

- Non-Aboriginal men live nine years longer than Aboriginal men living on reserves and four years longer than Aboriginal men living off-reserve; for females the gaps are eight and four years;
- The suicide rate in Inuit communities is three times that of First Nations and six times that of the general Canadian population;
- The infant mortality rate for First Nations is much higher than the Canadian rate (8 per 1000 live births compared to 5.5 in1999);
- Differences exist among First Nations, Inuit and Métis populations. For example, rates of diabetes are highest in First Nations communities whereas rates of tuberculosis are highest in Inuit communities.

Access to health care services is an issue for all Aboriginal communities, whereas we have focused particularly on the situation in Canada's northern and remote communities. We held one of our meetings in Nunavut and heard directly from community members in Iqaluit, Kimmirut and Pangnirtung. They were clear that they wanted services delivered in their communities in their own language, by their own people.

In the North, flying out of the community to get health care causes serious disruption for individuals and families. Added to this is the fact that a significant amount of territorial health spending is currently dedicated to transportation costs. These resources would be better spent on services provided closer to home, by health professionals who understand local needs. Telehealth technology has an important role to play in connecting health professionals in the North to other resources. Nunavut, for example, has placed a high priority on implementing Telehealth technology and is beginning to see benefits for patient care.

The 2004 Ten Year Plan dedicated $700 million for Aboriginal health issues — $100 million is to support health human resources. This is an important investment. There is an acute shortage of Aboriginal health professionals and a concerted effort is required to encourage Aboriginal youth to consider health careers. As well, new training programs are needed that include traditional healing practices in their curriculum. The recent announcement from Manitoba's University College of the North of a degree program in midwifery targeted at Aboriginal Peoples in remote communities is an innovative step forward.

Team based, multidisciplinary care is the stated goal for primary health care in Canada and nowhere is it more relevant than in Aboriginal communities. This broad based approach can deal with the many health, social and economic issues facing Aboriginal Peoples. One of the more successful Canadian primary health care innovations is in the Eskasoni First Nation community in Nova Scotia. An integrated public health and primary care model was created using the services of physicians, a primary care nurse, community health nurses, a prenatal care coordinator, a health educator and a pharmacist. Access to services improved as did community health outcomes and patient satisfaction.

The Council will release a longer discussion paper on issues of Aboriginal health in the spring of 2005. The paper will focus on the poor state of information about Aboriginal health and on innovative initiatives dedicated to improving community health.

COUNCIL ADVICE

We recommend the following:

1) Develop an Aboriginal health work force to improve service delivery in the North — linguistic and cultural issues can be addressed and services can be provided closer to home.

2) Target education programs at Aboriginal youth to encourage them to consider a health career.

3) Develop health professions training programs that recognize traditional Aboriginal healing practices and are focused on providing services to northern and remote communities.

4) Develop primary health care models to address the broader social determinants of health which are particularly relevant to Aboriginal communities.

5) Accelerate the use of information technology to improve services in Aboriginal communities.

PATIENT SAFETY

Health Ministers were directed in the 2003 Accord to improve patient safety in Canada through the establishment of the Canadian Patient Safety Institute.[2] Canada has a quality health care system that delivers safe and effective care to Canadians every day. However, even with the best systems in place, things sometimes go wrong. The first Canadian study on patient safety found that approximately 185,000 hospital admissions in Canada could be labeled adverse — resulting in injury or death — and that 70,000 of these events were potentially preventable. This included events like medication errors, infections, or falls. In the study, most patients who experienced an adverse event recovered, but 21 per cent died. If these rates are applied across Canada, somewhere between 9,250 and 23,750 people a year experience an adverse event and later die. Added to the human toll is the cost of these events — researchers estimate that more than a million days in hospital could be attributed to adverse events. If the events were prevented, these resources could be used elsewhere.

There is a clear link between patient safety and information technology. Reducing medication error has been achieved through online prescribing programs. Providing access to patient information, such as allergies or records of prescriptions, and automating the medication ordering process, can reduce problems. British Columbia has implemented a province-wide PharmaNet system that records all prescriptions in the province. In one year, 7.9 million prescriptions out of a total of 35.3 million were flagged as potential problems. Twelve per cent of those flagged resulted in action to reduce harm to the patient.

Creating an environment that is open to disclosure and committed to change will improve patient safety. This requires altering the culture of silence and promoting a culture of sharing and learning in which the focus shifts from blaming individuals to addressing the system design problems that underlie the great majority of errors.

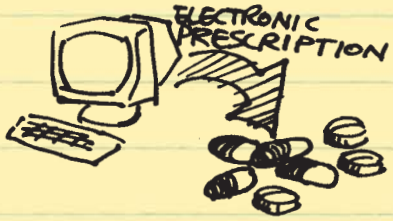
Research shows these adverse events are often associated with staffing levels, workload and shift work. The way our health care personnel are organized in the future will have a significant effect on issues of patient safety.

2 The founding Board of the Canadian Patient Safety Institute was announced in December 2003 and its first business plan is available at www.cpsi-icsp.ca.

COUNCIL ADVICE

There is an urgent need to address patient safety issues in Canada. Lives can be saved, resources can be directed to other health care needs and health care professionals can be supported to provide timely care. The establishment of the Canadian Patient Safety Institute and the widespread implementation of an electronic health record will contribute to improvements.

Electronic prescribing has demonstrated clear benefit for patient safety. We recommend that governments consider mandating electronic prescribing over a reasonable time period with the appropriate financial and educational supports for providers.



II. Access to Health Care Services

Timely access to health care services is one of the key goals of the 2003 Accord. The Council examined four areas to understand progress:

1) Primary health care

2) Home care

3) Pharmaceuticals management

4) Wait times for services.

PRIMARY HEALTH CARE

Primary health care is a foundation of Canada's health care system. It not only provides the entry point of contact for individuals with the health care system, but also serves as the vehicle for ensuring continuity of care across the system. Most definitions of primary health care also recognize health promotion, disease and injury prevention and the importance of placing stronger emphasis on the determinants of health and strategies to advance individual and population health. Through primary health care, short-term health issues are resolved and most chronic conditions are managed.

In Canada, primary care developed through the public funding of individual doctors, usually family physicians. Primary *health* care developed through the inclusion of other models such as community health centres, public health nurses, well baby clinics and the inclusion of non-medical health care providers with a focus on health promotion. As the system grew, a number of concerns emerged, including:

- The disjointed way the various parts of the health care system worked with each other, often leaving patients to move between different providers and institutions;

- The difficulty with integrating primary care providers such as nurse practitioners, pharmacists, social workers or community health workers;

- Increasing evidence that Canadian primary care practices focused on acute or episodic conditions while individuals with chronic conditions such as diabetes, heart disease or hypertension required more comprehensive care;

- The recognition that the increased use of multidisciplinary teams of providers could reduce clinical error, increase provider satisfaction and improve patient outcomes in acute and chronic care settings.

The need for a new approach to primary health care has been acknowledged for a quarter of a century, beginning with the Alma Ata Declaration of the World Health Organization in 1978. This landmark document identified health as being rooted in the community, and primary health care as the foundation

of a comprehensive health system. Canada has featured prominently in the call for reform. The Lalonde Report of 1974 drew attention to the determinants of health. Another report *Achieving Health for All* (1986) reaffirmed these insights and endorsed the main principles of Alma Ata. Numerous provincial and national reports throughout the 1980s and 1990s identified the need to reform the way primary health care services were organized and delivered. A consensus for change emerged with similar priorities for action identified in each jurisdiction. Table A.1 provides examples of the strategies used. Common elements are:

- Improved continuity and coordination of care: greater access to providers 24 hours a day, 7 days a week, the use of multidisciplinary teams and other new ways to organize people to deliver primary health care;
- Early detection and action: a stronger focus on health promotion and prevention and a focus on chronic disease management;
- Better information: the expansion of the electronic health record and Telehealth technologies;
- Incentives to change practice: the use of innovative funding models, the integration of non-medical personnel, and innovative recruitment and retention strategies.

The 2003 Accord set a goal — by 2011, 50 per cent of residents will have access to an appropriate health care provider, 24 hours a day, 7 days a week. Table A.2 describes the considerable activity underway to meet the goal. Some projects are designed to shift the first point of contact with patients to a nurse practitioner or nurse. Most efforts focus on improving support for the family physician as the primary care provider.

The need to implement change in primary health care delivery is also driven partly by the significant change taking place in family medicine in Canada. Recent Canadian studies show that family physicians in practice today provide different services than their colleagues of ten years ago. Fewer deliver babies. They are providing more psychosocial counselling and less hospital based care. Consistently, the rate of family physician participation in surgical services, anesthesia and obstetrical care is declining. In a recent national survey of physicians, 13.1 per cent reported that they plan to reduce the range of services they provide within the next two years.

Family physicians also report increasing concerns over workload and a feeling of burn out. Younger physicians report they are not willing to continue the high workload of their predecessors. They are spending less time on direct patient care than their counterparts did 20 years ago. They want more balance in their lives and more time for family and non-work related priorities. Female physicians have led the way in promoting the importance of work life balance and now that approximately half of medical school graduates are women, future practitioners will not provide as much service to as many patients as their predecessors.

There are other worrisome developments. Historically, about half of all physicians were family physicians. Today, less than 30 per cent of medical students choose family medicine as a career. Sixty per cent of family physicians report that they take a limited number of, or no, new patients. Meanwhile, 14 per cent of the public report that they do not have a family physician. Rates are high even in large cities where the concentration of physicians is high.

The prospects for change are uncertain given the lack of interest by many family physicians in traditional practices in moving towards new delivery models. A recent survey indicates that in the next two years, only 2.7 per cent of family physicians plan to move from solo to group practice, 3.1 per cent plan to change to a multidisciplinary model and 6.7 per cent plan to become part of a practice network.

COUNCIL ADVICE

We applaud governments for recognizing the need to reform primary health care delivery and they clearly recognize the magnitude of the challenge: their target of 50 per cent of the population having access to an appropriate health care provider by 2011 is modest. Given the information provided above, even this target may not be achieved. Further work is required to achieve the goals of the First Ministers. Reforming primary health care is far from done.

It will require changing the way people, money, rules and regulations are organized as well as improving the flow of health information. We need to reconsider who does what and how it has been done elsewhere. Canada has many models being developed and assessed and there are international examples. The National Health Service in the United Kingdom and the Veterans Health Administration in the United States have achieved remarkable results in reorienting their primary health care services. Patient outcomes improved in both systems by focusing on better access to a wider range of services, providing comprehensive disease management programs, supporting teams and mandating measurement and accountability for quality. In both cases, targeted investments were made in expanding the work force, supporting education and training, improving information systems, and redesigning pay scales for some health professions. In the case of the Veterans Health Administration, this was done with a decrease in budget.

Governments have indicated similar visions for Canada. We support this direction and recommend the following:

1) Use common definitions: different terms are being used to describe primary health care services and providers. This makes measuring progress more difficult.

2) Accelerate new delivery models: governments have been slow to support new delivery models even when they have proven successful. There are numerous innovations with positive evaluations, for example, organizations such as the Group Health Centre in Sault Ste. Marie, the Women's Health Centre in Winnipeg and in the community health centres in Quebec .

These and other models go a long way to realizing the ambitions and goals of the 2003 Accord, but they are the exception rather than the rule. They should be pursued aggressively and a forum for sharing innovative practices would support more widespread change.

3) Remove regulatory barriers: Canada's professions are self-regulating. As provinces and territories implement new delivery models, the division of labour among health professions must be addressed. There is no clear consensus on which professions should be mandated to perform which functions.

4) Change education and training models: if collaborative practice in multidisciplinary teams is the vision of the future, then the education and training system for health workers needs to reflect that vision. As well, it would be important for professional development programs for those already in practice to reflect the same philosophy.

5) Accelerate the introduction of information technology: accurate patient information electronically transmitted in a timely fashion is a cornerstone of the future integrated system. Efforts to "wire" the country need to be aggressively supported so that primary care providers can do their jobs.

The Council will release a longer discussion paper on primary health care in the spring of 2005 focused on the definitions and innovative practices across the country.

HOME CARE

Home care services allow individuals with acute and chronic health conditions to live at home while receiving care. These services often prevent, delay or are a substitute for, admission to a hospital or nursing home. Clients of home care programs vary in age and needs and the services delivered range from light personal care to nursing, intravenous medications and care at the end of life. Currently, over a million Canadians use home care services every year. This number is expected to rise as the population ages and technological advances can assist people to stay at home.

Home care services in Canada are not covered under the *Canada Health Act* and jurisdictions have designed their own programs based on policy choices and funding capacity. As a result, home care programs across Canada differ in the types of service provided, eligibility criteria, the health care professional providing the service and the amount of public subsidy available to pay for the service.

The 2003 Accord committed to determining a minimum "basket" of services for short-term acute home care, acute community mental health and end of life care. First Ministers further committed to paying for these services based on assessed need. In September 2004, First Ministers agreed on what services they would pay for and for how long. By 2006, the following should be available to Canadians:

- Short-term acute home care: two weeks of case management (one individual coordinates all aspects of care); intravenous medications; nursing and personal care services;
- Acute community mental health: two weeks of case management and crisis response;
- End of life care: case management, nursing, palliative medications and personal care at the end of life.

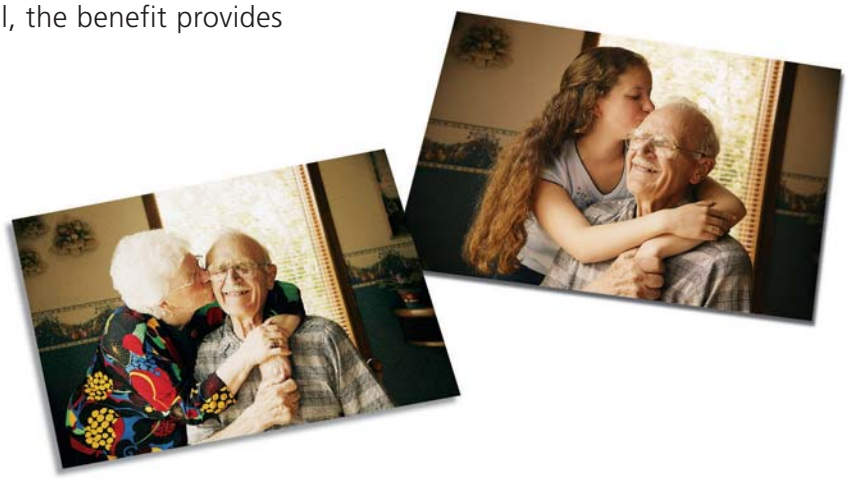
Neither the 2003 Accord nor the 2004 Ten Year Plan addressed home care services for people with chronic conditions.

A number of jurisdictions have put in place innovative programs and Table A.3 describes these in more detail. Programs that have been successful contain the following elements:

- Quick response;
- Range of services suited to client needs;
- Multidisciplinary teams;
- Integrated and comprehensive case management;
- Coordination and integration of preventative services, primary health care and acute care;
- One point of access;
- Access to services 24 hours a day, 7 days a week;
- Linkage to crisis response when required;
- Support for family members when required.

Table A.4 summarizes common strategies being used to advance home care reforms.

In addition to a focus on the services being provided, the 2003 Accord also committed to implementing a compassionate care benefit. This benefit ensures job protection for employees who need to leave their jobs temporarily to care for a gravely ill family member. In January 2004, Canadians became eligible for this new benefit under the *Employment Insurance Act* and the Canada Labour Code was amended to provide federal employees with job protection. On the basis of a physician referral, the benefit provides a maximum of six weeks of employment insurance. Most, but not all, provinces and territories have amended their labour legislation to ensure that their citizens can take advantage of the federal benefit without losing their jobs. Table A.3 summarizes compassionate leave benefits across the country as of October 2004.



COUNCIL ADVICE

The 2003 Accord and the subsequent 2004 Ten Year Plan are important steps towards harmonizing a minimum level of home care services in Canada. However, a major program of research in Canada demonstrated that home care services are a cost-effective alternative to residential long-term care and can help achieve cost savings and improve quality of life. If governments want to maximize efficiencies by, among other things, relying less on institutions, investing in integrated home care makes sense. We recognize the need for some limits around the types of services being covered and the length of time funding will apply; however, significant progress could be made if the following issues are addressed:

1) Treat community mental health home care as part of primary health care programs: it is not clear why community mental health home care has been placed within this basket of services. Mental health issues are generally not limited to two week periods and require more than case management and crisis response.

2) Discuss extending the two week time frame: the two week time limit is a starting point and some jurisdictions already go beyond this. Coverage should be set to maximize the efficiency of the entire system and to optimize patients' recovery.

3) Pay attention to chronic home care needs: many individuals can continue to live in their own homes with ongoing support. A focus only on short-term acute home care does not fully take advantage of the potential for these services to prevent admissions to institutions.

4) Link planning efforts to a health human resource strategy: as a growing sector within health care, home care will require more workers in the future. Ensuring an adequate supply of the right skill sets should be part of recruitment and retention issues at regional, provincial and national levels.

5) Take advantage of information technology: a number of jurisdictions have already established telehome care in rural communities. These innovations, if proven effective, should be replicated in other areas of the country.

The Council will release a longer discussion paper on home care in the spring of 2005 focused on current Canadian research and innovative practices.

PHARMACEUTICALS MANAGEMENT

Drugs are a key part of modern medicine. They can replace invasive forms of treatment such as surgery, reduce costs incurred in other parts of the system such as in hospitals, or provide dramatic benefits such as "break through" therapies for HIV/AIDS. However, there are also serious concerns — some drugs provide only minimal added value because they are similar to existing drugs; costs are increasing; and the recent revelations of serious negative side effects of high volume drugs has highlighted the potential risks of drug therapy.

The *Canada Health Act* mandates public funding of drugs provided in hospital. Drugs prescribed outside of hospital may or may not be covered by governments or by private health insurance. Table A.5 details the 19 publicly funded drug plans in Canada (ten provincial, three territorial and six federal). All have different:

- Definitions of eligibility for coverage;
- Lists of drugs that are paid for; and
- Rules for co-payments, deductibles and thresholds for catastrophic costs.

The public share of pharmaceutical spending in Canada is less than in other countries. In Canada, it stands at 38 per cent, compared to 54 per cent in Australia, 67 per cent in France or 75 per cent in Austria. By contrast, the public share in the United States is 19.5 per cent.

All jurisdictions in Canada operate publicly-funded drug plans for seniors and social assistance recipients. Some cover other individuals with specific diseases. However, coverage varies:

- 89 per cent of Canadians have some form of public or private insurance;
- 9 per cent are considered under-insured — and there is no clear definition of what this means. Thresholds differ across individuals and families. What is catastrophic for one might not be for another. The real question is how much should people have to pay for drugs before public funding applies?
- 2 per cent have no drug insurance at all. This represents approximately 600,000 Canadians, most of whom live in Atlantic Canada.

Costs for drugs are increasing faster than the rate of inflation and population growth. Governments find it increasingly difficult to control the rate of growth in drug spending. Providing reasonable public coverage for the costs of medication is only one of the pressing issues facing governments. Managing prescribing behaviour and drug utilization are equally important. The federal, provincial and territorial governments have

3 This does not include spending on drugs provided in hospital.

undertaken several activities to improve the use of pharmaceuticals in Canada. These activities include:

- Developing pharmaceutical outcome measures to determine the impact of drug therapies on patients and the health care system;
- Developing the National Prescription Drug Utilization Information System (NPDUIS) to allow a detailed examination of the use of drugs across Canada;
- Using pharmacists to provide physicians and patients with evidence-based, impartial information about pharmaceuticals;
- Developing the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) to promote best practices in drug prescribing;
- Supporting the Cochrane Collaboration which provides comprehensive reviews of health care interventions including pharmaceuticals;
- Developing a web-based point of care system for evidence-based drug and therapeutic information for health care providers;
- Developing a Common Drug Review with an Expert Drug Advisory Committee to conduct systematic reviews of clinical and economic information on new drugs. This information is then reviewed to make recommendations to the publicly-funded plans on which drugs should be paid for. Individual drug plans make their own decisions about whether or not to list the products;
- Implementing reference drug pricing which bases reimbursement on the lowest price within similar categories.

First Ministers committed to a collaborative approach on pharmaceutical management initiatives in 2003. The approach was re-affirmed in 2004, but the deadline for completion was extended.

The 2003 Accord committed to ensure reasonable access to catastrophic drug coverage by the end of 2005/06 and to collaborate on promoting optimal drug use, best practices in prescribing and to better manage costs. In September 2004, the First Ministers agreed to establish a ministerial task force to develop and implement a National Pharmaceuticals Strategy and to report by June 30, 2006. For catastrophic drug coverage, the commitment is less specific and does not carry a defined deadline.

The National Pharmaceuticals Strategy is to include options for purchasing, drug safety and effectiveness, influencing prescribing behaviour, electronic prescribing and cost analysis.

COUNCIL ADVICE

As Health Ministers work on the strategy, we recommend the following:

1) Define a minimum standard for drug coverage that applies across the country;

2) Establish a process to review and compare the catalogue of drugs covered by drug programs;

3) Identify drugs that cost more than $5,000 per person a year and assess current levels of public coverage across public plans;

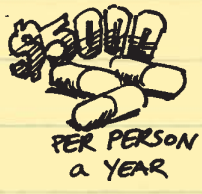
4) Build upon the existing common review process for new products and include existing products;

5) Ensure that a strong evidence base underlies the development of a strategy; rigorous, evidence-based evaluations and policies using multiple approaches will be the most effective;

6) Invest in the development of unbiased, evidence-based drug information for physicians, pharmacists and patients. Excellent programs exist in Canada but they need to be show cased, supported and expanded.

The focus on extending drug coverage has taken up much of the public debate and is worthwhile. However, a focus on the sale, regulation and utilization of medications is also needed and can improve population coverage in the long run. We intend to undertake a comprehensive look at pharmaceutical management practices over the next few years. This will include looking at issues such as:

- The cost effectiveness of new medications;
- The costs, risks, benefits and costs of marketing efforts to professionals and the public; and
- The effectiveness of the regulatory process in ensuring the safety and efficacy of drugs available in Canada including the disclosure of complete and unedited clinical trial information from the manufacturers.



WAIT TIMES

Canadians have identified long waits as their number one barrier in accessing health care services. Responding to this, First Ministers committed to timely access to services in the 2003 Accord and further committed to achieving meaningful reductions in wait times in priority areas in the September 2004 action plan.

Neither the concerns, nor the commitment to improvement, are new. Governments as well as regional health authorities and hospitals have targeted funds to reduce wait times. They have added personnel, equipment and facilities. New management systems have been introduced along with websites to share information with providers, patients and the public (See Table A.6). But the issues associated with waiting for care are complex, and lasting solutions will be difficult to achieve. The challenge is to ensure that resources dedicated to addressing the problem actually have an impact and lead to improvements.

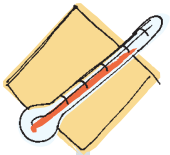
We know that health care is not always easily accessible to those in need, particularly to those in remote and rural regions, for populations with special needs, or in areas where providers and services are in short supply. Even for those living in well-resourced, urban areas, there is a high level of anxiety about waiting for needed care. Canadians are understandably concerned about being placed on a waiting list. They know that waiting too long might harm their health but they are not sure when this might apply to their particular situation.

Waiting too long has implications for the health care system. Deterioration in health status while waiting for care can lead to greater care needs for patients and more pressure on the system. With the system's ability to cope already in question, waiting for care has become a shorthand measure of system sustainability. Excessive waiting undermines Canadians' confidence in the publicly funded, publicly administered health care system.

Having said this, wait times are a normal part of any health care system. No waiting would mean that the system is inefficient. The issue is how to manage wait lists to ensure that patients get care at the right time. Also, not all waits are harmful. Sometimes a limited amount of waiting allows the confirmation of a diagnosis or a second opinion. Sometimes 'watchful waiting' is the best clinical strategy. *These* waits need to be separated from those that cause harm.

When Does Waiting Start ... and End?

Most Canadians only think about the health care system when they — or someone they know or love — experiences symptoms of illness, injury or disease. Some of these people will not use the health care system. Their illness will self-resolve or they will manage the symptoms themselves, at home. But, as illustrated below, for those who do need care, the journey to an improved state of health can be long and winding.



Patient identifies first symptoms

Patient calls primary care provider

Patient visits family doctor

Patient sent for diagnostic tests

Patient returns to family doctor

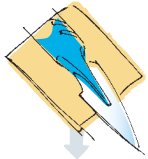
Patient referred to specialist

Patient sees specialist

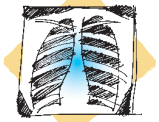
Patient referred to second specialist (e.g. cardiologist to cardiovascular surgeon)

Patient sent for diagnostic tests

Patient booked for surgery

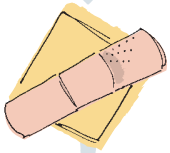


Surgery occurs

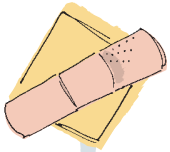


Patient sent for diagnostic tests

Patient booked for follow-up



Patient booked for rehabilitation



Patient receives rehabilitation services

Patient recovers fully ... or begins cycle again

Waiting can occur at each step of the journey for many different reasons:

- The management of the patient journey is uncoordinated — no one person manages each step;
- It is unclear who has responsibility for monitoring the process and who is accountable for delays;
- Clinical judgments about the severity and urgency of patient conditions vary and people get put on the list inconsistently. These variations in practice raise questions of fairness — if patient A received surgery with modest discomfort and patient B waits until there is serious deterioration, fairness is not achieved. Furthermore, they raise the issue of quality in that it is usually a warning signal when people in identical circumstances are treated differently;
- New technology and less invasive surgical procedures have increased the number of people benefiting from treatment, as well as lowering the threshold for treatment;
- The interaction between emergency and non-emergency cases — people coming into hospital through the emergency department "bump" people slated for scheduled surgery off the list;
- There is not enough capacity in the system (physicians, nurses, beds, or diagnostic technology).

Most of these factors can be addressed with coordinated responses to reducing wait times and managing the placement of patients on the waiting list. Patient coordination and consistent assesment of patient needs combined with dedicated investments to improve capacity will achieve improvements. Some issues are sometimes unavoidable such as the bumping of scheduled patients to deal with emergencies. However, some planning is possible — seasonal peaks in traffic accidents or flu cases are predictable.

Waiting Lists

Though taken by the public as an overall measure of the system's performance, waiting lists can be very misleading. If 10,000 people are on a list, but all get served in an appropriate time period, there is no problem. If 100 people are on a list but 30 wait a year, there is a problem.

The distribution of wait times for people on waiting lists illustrates only part of the issue. Most waits for care are within clinical targets. For example, the Saskatchewan Surgical Care Network collects and reports information on wait times for surgical services. Half of all Saskatchewan surgeries performed between January and June of 2004 were done within eight weeks of the surgeon's booking. Ninety per cent of all surgeries were performed within one year of booking. Most people get timely care but public attention goes to those who wait — or appear to wait — too long.

The criteria physicians use for placing patients on waiting lists vary widely; so do their practices for monitoring, reordering the list according to patients' needs and removing people who no longer belong. Some physicians only place patients on a waiting list when they need treatment. Other physicians use waiting lists to identify those patients they wish to monitor closely — patients who may need a service at some point in the future. These patients are on a waiting list for clinical reasons. As long as their status is regularly assessed, and they are routinely informed and engaged in these assessments, their wait poses no therapeutic risk. They do not require an immediate intervention and, indeed, may not need — or choose — to have one at all.

The issue is further complicated because some people are on waiting lists for personal reasons; they may wish to choose a convenient time to receive care or to wait for care from a particular provider. Judging from the research, it is reasonable to assume that at least 20 per cent of people on waiting lists either postpone or cancel their own procedures while others on lists may have moved or died.

Studies in the United Kingdom and New Zealand found significant over-counting of patients on lists, commonly at 30 per cent and sometimes as high as 70 per cent. Unless the system can identify and remove people no longer needing care, they are likely to remain on the waiting list... with what appear to be increasingly long wait times!

Thus, it is not waiting lists that should be of concern but waiting that nobody wants — waits that are uncertain, waits that are unfair, and waits that create greater risk for the patient.

COUNCIL ADVICE

To date, jurisdictions have focused on the provision of web-based reporting of wait times in selected surgical and diagnostic procedures. This has been implemented in British Columbia, Alberta, Saskatchewan, Manitoba, Ontario and Quebec and is planned in Nova Scotia. The information is usually organized by facility and in some cases, by physician. Other efforts exist at the regional and local level where a regional health authority, such as the Capital District Health Region in Nova Scotia, the Montreal Regional Health and Social Services Board in Quebec or a hospital such as the University Health Network in Toronto, posts information.

As well, a number of disease-based initiatives have focused on reducing wait times for specific interventions such as cardiac surgery or cancer treatments.

Important lessons can be drawn from these experiences. The good news is that there are high-impact, low-cost steps that can be taken to improve timely access to care. There are two main issues: defining the need for care fairly with some precision based on clinical judgment and managing the flow of patients through the many steps in the journey. We recommend the following key elements in the creation of a successful wait time measurement, monitoring and management program:

1) Ensure comprehensiveness: a comprehensive approach to the measurement, monitoring and management of wait times and access needs is essential to protecting equity between areas of competing demand for limited health care resources. Competition not only exists between different surgical specialties, but also between community and institutional-based services. Care must be taken to ensure that attention and resources are not solely dedicated to those areas being tracked, such as surgical interventions as opposed to whole patient management.

2) Make information publicly available: reliable and comparable public information on wait times promotes a better understanding of the issues. Centralizing the management of wait time data collection increases the likelihood that it is accurate and comparable.

Standardizing terms and measures — defining when waiting starts and ends and achieving agreement on terms such as thresholds, indications and priorities — is essential for comparability and for performance measurement. Regular reviews of waiting lists must be conducted to ensure that priority assessments are still valid; that people are not waiting excessively long; and, that people come off the list if they no longer need to be there.

3) Evaluate outcomes: health care intervention outcomes must be evaluated to ensure that thresholds are set appropriately and that health care resources are used as cost-effectively as possible. Determining when an intervention is warranted must be based more on science and less on subjective opinion.

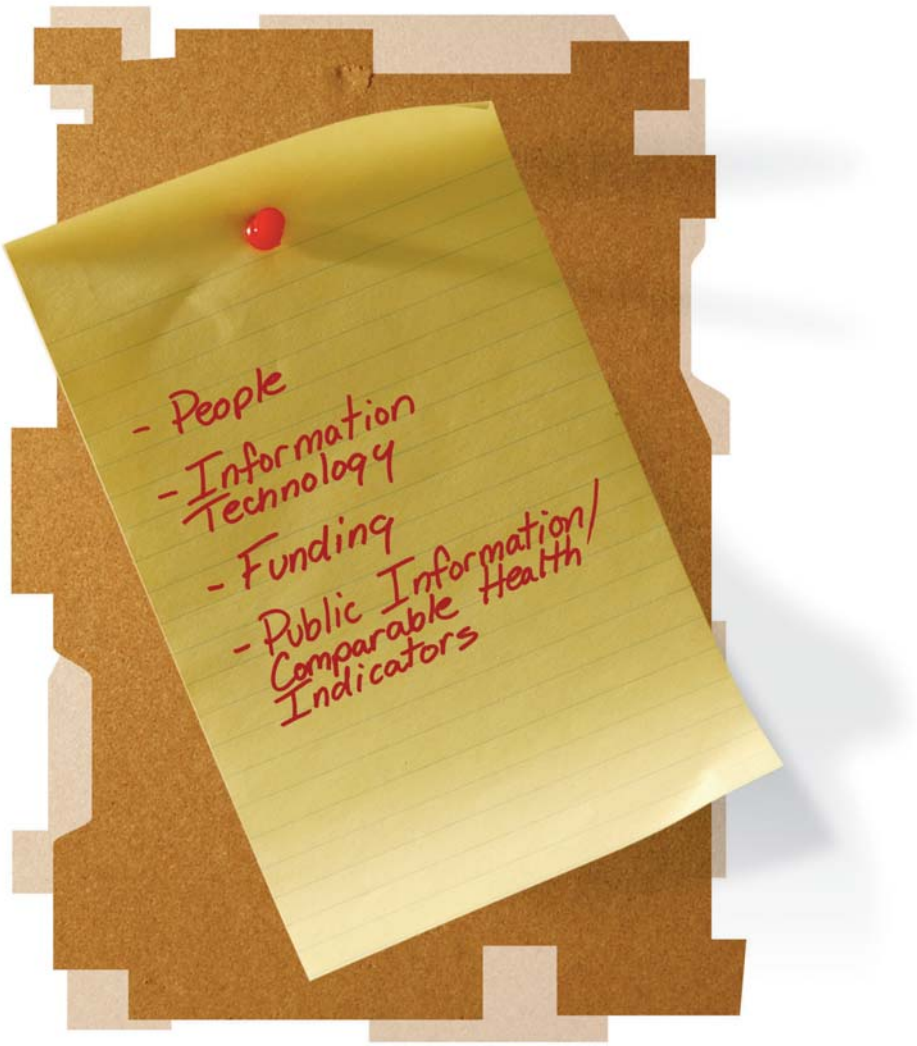
4) Engage key players in simplifying the patient journey: key players should review each step in the treatment journey and simplify, speed up or eliminate processes to dramatically improve wait times. Better information and better management strategies can reduce levels of uncertainty experienced by patients and providers and ensure that emergency and scheduled patients are fairly treated.

5) Align incentives — eliminate disincentives: create appropriate reward systems so that all clinicians, managers and administrators strive for reduced wait times. Take action on those practices that get in the way of reducing wait times. For example, what is the most rational way to organize the distribution of operating room time and what is getting in the way of achieving it?

6) Enhance capacity where needed: new funding must be directed explicitly to reduce wait times to ensure that all resources are coordinated and available at the right time and place.

The Council will release a longer discussion paper on innovative practices to reduce wait times and improve access to care in the spring of 2005.

III. Infrastructure to Support Health Care Renewal



PEOPLE

Health care services are provided by people. The health care labour force in Canada — approximately 800,000 people — includes a wide variety of occupations such as physicians, nurses, nurse practitioners, pharmacists, medical radiation and laboratory technicians, chiropractors, midwives, psychologists, dietitians, occupational therapists, dentists and many others.

Although consistent, standardized measures of the supply and distribution of health care personnel are not currently in place, there is clearly a link between access and the perceived shortages of personnel. Most provinces and territories report that they are experiencing shortages. Nowhere is this more apparent than in the Aboriginal health work force. As noted in the section on Aboriginal Health, $100 million was allocated in September 2004 to develop health professionals from the Aboriginal, Inuit and Métis populations.

Health care providers report increased workload pressures and burn out. Statistics Canada reports that Canadians experience some difficulties in accessing health care services, despite the fact that over 85 per cent of Canadians have a family physician.

Health care professionals in Canada are organized by professions which are educated, trained, regulated, and usually funded independently of each other. Funding and the organization of health care delivery is left largely to governments. Education and training is left largely to post-secondary educational institutions and, to a lesser extent, employers. Professions are largely self-defining and self-regulating. Policies governing their behaviour are left to professional associations and regulatory bodies. Recruitment and retention initiatives are undertaken by different levels of government sometimes competing against each other. Parts of the health care work force are unionized, whereas other parts are not. No one group holds all the levers and cooperation across all groups is needed to effect change.

In the 2003 Accord, the First Ministers committed to work on collaborative strategies to strengthen the evidence base of national planning, promote interdisciplinary education, improve recruitment and retention and ensure the supply of needed health providers.

Strengthen the Evidence Base for National Planning

A number of reports have recommended a coordinated approach to health human resource planning at the national level. In 2003, the Federal Government committed $85 million to support national planning efforts and provider development and education programs.

Health Canada reports there is a pan-Canadian Health Human Resources Planning Initiative to support jurisdictional and nation wide activities. Simultaneously, Human Resources and Skills Development Canada is funding a number of health sector and occupational studies, some of which are geared toward generating a human resources strategy. The studies are organized by health care professions — physicians, nursing, dental health, pharmacy and by delivery sector — home care.

At present, planning for the future workforce of Canadian health care is left largely to the provinces and territories. This creates variability, and in some cases, imbalances, in the availability of health care personnel in Canadian communities. Differences exist across provinces — for example, British Columbia had 672 registered nurses per 100,000 population in 2001, whereas Newfoundland had 1,023 per 100,000. Yet the number of family physicians in each province was similar: 110 per 100,000 in BC and 113 per 100,000 in Newfoundland. Differences also exist within provinces and territories. For example, an Ontario study showed Toronto had almost double the number of family physicians per 10,000 population compared to communities in northern and rural parts of the province. There is not a "right" number but the differences raise the question of appropriate levels of access to care.

Canada is not self-sufficient in producing health care professionals and we continue to rely on a pool of internationally trained individuals. As an example, 52 per cent of the active physician population in Saskatchewan are international graduates. The Canadian average is 23 per cent.

There is significant health human resources planning activity underway as outlined in Table A.7 but the focus is largely on physicians and nurses. Planning for some other health professions is under development but hindered by a lack of data.

A relatively new development is a regional approach to health human resource planning. There is a Western Health Human Resource Forum and an Atlantic Advisory Council on Health Human Resources dedicated to sharing best practice information and discussion of areas of common concern.

Despite all this activity, Canada does *not* have a national health human resource strategy. Jurisdictions that do, have linked their health human resource strategies to a clear picture of future delivery models. For example, when the United Kingdom announced its work force plan, it was linked to a modernization plan for the National Health Service. Explicit targets were set to improve access to services and tied to

increased investments in personnel. No mechanism or planning group exists in Canada to draw together key leaders with responsibility for educating, employing, regulating or funding part of the health care labour force to undertake such a discussion.

A focus on the planning alone may leave the impression that if numbers can be accurately forecast, the problem is solved. Our problem is much deeper than that. As discussed in the primary health care section of this report, the division of labour among health professions must be addressed. There is no clear consensus on which professions should be mandated to perform which functions. Different practices exist across the provinces and territories. Without engaging in this fundamental discussion, planning processes are compromised.

Promote Interdisciplinary Education

Health care delivery models of the future clearly envision teams of health care providers working together to meet patient needs. Therefore, there is interest in looking at collective education and training opportunities. The 2003 Accord committed governments to the promotion of interdisciplinary education. In 2003/04, Health Canada commissioned a series of papers to identify emerging issues, and trends and practices on the integration of inter-professional education within education and health systems. In September 2004, Health Canada announced multi-year funding for projects addressing key issues in inter-professional education for collaborative patient-centred practice.

Most jurisdictions have not linked inter-professional education to health human resource planning. Some provinces report exploring models. For example, Nova Scotia used inter-professional education to combine essential physician and nursing skills for service provision in rural and remote communities.

A number of academic institutions are taking a lead in exploring models for inclusion in their health science programs. For example, the College of Health Disciplines at the University of British Columbia and the Centre for Collaborative Health Professional Education at Memorial University in Newfoundland and Labrador, offer elective courses in inter-professional education. The Health Sciences Council at the University of Alberta requires health sciences students to take a course in inter-professional education.

But these are small steps. Health science education needs to be transformed by integrating parts of what are now separate academic programs and by a focus on team-building. Equally important is the development of collaborative work places so that there are appropriate places for students to work. If not, health science graduates will have little choice but to work in status quo work environments that reinforce the old way of doing things. As well, training opportunities are needed for those already working to support their ability to work effectively in teams.

Complicating the discussion of inter-professional education is a trend towards raising the minimum educational requirements for health professions. What once required a diploma now requires a Bachelor's degree. Similarly, what once required a Bachelor's degree now needs a Master's degree. In some cases, there is evidence to demonstrate the increased academic requirement will benefit patients. In other cases, evidence is lacking. What is needed is a careful review of these changing educational requirements to ensure they can be supported by evidence of cost effectiveness.

More work is needed between governments and academic institutions to accelerate changing models of undergraduate education and training opportunities for health professions to match the future vision of a reformed health system.

Improve Recruitment and Retention

Provinces and territories report they are making significant commitments in recruitment and retention programs focused on financial incentives to attract health care professionals over the short-term. They also report that increased attention is focused on assessing the skills of internationally trained health workers living in Canada but not working in their fields.

Existing initiatives include: advertising available jobs, tuition reimbursement, loan or bursary assistance, education enrolment opportunities, locum support and fee differentials to locate in remote communities.

Jurisdictions are clearly investing in recruitment and retention initiatives (See Table A.8). Those jurisdictions with greater purchasing power have greater success in attracting personnel. However, survey data of younger health professionals report that financial opportunities are only one consideration in a location decision. Spousal employment opportunities, the availability of high quality education and recreation programs for children, and cultural fit are all cited as important elements in a decision. These are not policy levers directly available to Departments of Health. Thus, recruitment and retention efforts should include other public resources and organizations to create a broader array of incentives for health professionals in the future.

COUNCIL ADVICE

Often, reports about health human resources are linked to lack of funding. We believe that solutions to the problems of health human resources are much more complex than adding more dollars. Dealing with unacceptable wait times for surgery, building community-based home care services or implementing chronic disease management programs through primary health care teams requires a different approach.

As Health Ministers work on their plans following from the September 2004 Action Plan, we recommend:

1) A team focus: planning linked to the vision of future health care delivery is required. Planning efforts need to focus on teams and the support required to facilitate the team rather than on individual health professions. Existing planning models will generate the wrong results if they continue to be supply-based and specific to each health profession. Planners cannot continue to assume that health services will continue to be delivered as they are now. Serious effort is required to shift the planning focus towards teams.

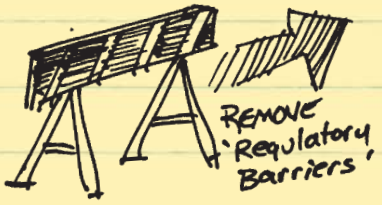
2) Remove barriers: many recent reviews have noted the presence of "regulatory barriers" and issues of "scopes of practice" which get in the way of changing the way different health professions work in Canada. It is time to eliminate these barriers. Legislative reform would help to enable multidisciplinary team care. Some jurisdictions currently have health professions legislation that enables shared care, others do not. Within regulated health care professions, there are differences across the country in terms of what the profession is allowed to do. And some professions remain regulated in some provinces and unregulated in others, e.g., Midwifery.

3) Transform health professions education programs: education programs need to be integrated and students need to train in teams. This will enable them to work in the kinds of collaborative practice environments envisioned for the future.

4) Support existing health professionals: doctors, nurse practitioners and other professionals need team training opportunities to learn to work effectively together.

5) Develop non-financial recruitment and retention incentives: governments and other groups interested in recruitment and retention of health professionals must recognize that issues other than money contribute to an individual's decision to locate or stay in a community such as: spousal employment, technology support and recreational opportunities for children.

6) Plan collaboratively: we believe strongly that the health care renewal goals established by the First Ministers cannot be achieved without collaborative health human resource planning amongst the jurisdictions. To this end, we will convene a National Health Human Resources Summit in 2005 to help to achieve progress on these issues.



INFORMATION TECHNOLOGY

Many of the health care reforms committed to by First Ministers depend upon rapid transmission of accurate patient information among health care providers working in different locations. An electronic health record is pivotal for success and Canada Health Infoway has been given the task of implementing an electronic health record across the country with a goal that 50 per cent of Canada will have an accessible electronic health record by the end of 2009.

Electronic health records have a number of advantages:

- Improved patient safety by avoiding errors due to incomplete records;
- More timely access to care by reducing wait times and transferring information across large distances;
- Improved efficiency by reducing duplication of tests and multiple copies of paper records;
- Improved information sharing and support for team-based care.

Canadians understand these benefits and in a recent survey, over 80 per cent strongly believed that electronic health records would improve the ability of health care providers to provide quality care.

Despite the evidence and strong support for change, the majority of physicians and other care givers have not implemented electronic health records or stored key patient data electronically. Why? Historically, the incentives to change have largely been financial. Other barriers such as education and training for new users had not been addressed. Providers are also concerned with the confidentiality of patient information and may perceive electronic storage and access to information as less secure. More recently, funders have recognized the need for these supports and are offering tool kits as part of their implementation package.

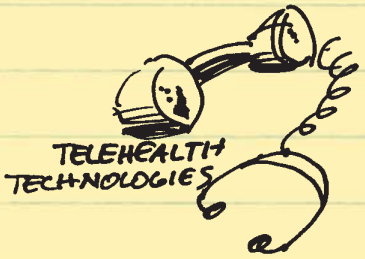
The fact remains that the process is voluntary. Providers have not had to adopt these systems; governments have not required their adoption; and, patients have not demanded the sharing of information to improve the safety and quality of care.

Telehealth technologies, where video and broadband networks are used to link experts to remote communities, have tremendous potential for changing the way health care is delivered as patients no longer have to leave their community to access care. In particular, rural, remote and northern communities are rapidly adopting Telehealth technologies for diagnostic and consultative services. For example, as of December 2004, Nunavut's program — Care Closer to Home — has all remote communities linked through its Telehealth network.

Progress is being made. Canada Health Infoway has created a $1.2 billion strategic investment plan to meet the goal of 50 per cent of Canada being able to access electronic health records by 2009. It is also creating an investment plan to support a Telehealth strategy.

COUNCIL ADVICE

The value of electronic health records and Telehealth technologies as tools to improve access, quality and comprehensiveness of care should be reinforced so that the public clearly understands the benefits and demands their introduction. We recommend that providers, governments and the public jointly commit to the rapid adoption of these tools.



FUNDING

Health care spending in Canada is expected to reach $130 billion in 2004 or $4,078 per person. Roughly 70 per cent is public funding ($91 billion) and 30 per cent is private funding ($39 billion). The money is spent on:

- Hospitals (30 per cent);
- Drugs (16 per cent);
- Physicians (13 per cent);
- Other health care professionals (12 per cent);
- Other institutions (9 per cent);
- Other spending (9 per cent);
- Public health and administration (7 per cent);
- Capital (4 per cent).

Funding comes from many sources but the largest amount comes from the provincial and territorial governments. The federal government contributes through the direct transfer of funding to the provinces and territories — it also has direct responsibility for health services to groups such as First Nations and Inuit communities, the armed forces and the RCMP. Some of the money is tied to specific reforms and some of it is not.

The 2003 Accord allocated funding in a number of ways to support the renewal goals. Some money was put into specific funds:

- A five-year $16 billion Health Reform Fund targeted to primary health care, home care, and catastrophic drug coverage;
- A $1.5 billion Diagnostic/Medical Equipment Fund to improve access to publicly-funded diagnostic services.

Other money was provided through a general transfer:

- $2.5 billion to help relieve immediate system pressures;
- $1.3 billion to improve the health of Aboriginal Peoples;
- $1.6 billion over five years in direct health accord initiatives.

Further money was provided to specific organizations:

- $600 million to Canada Health Infoway for information technology infrastructure to secure electronic health records;
- $500 million for research hospitals through the Canada Foundation for Innovation.

Governments are making significant investments in health care. How will Canadians know whether the money is being spent on health care renewal?

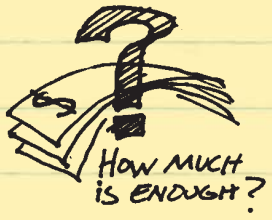
The 2003 Accord directed Health Ministers to prepare an annual public report to their residents on primary health care, home care and drugs, and to inform Canadians on current programs and expenditures — providing a baseline against which new investments can be tracked. The Government of Saskatchewan has released a separate account of its investments based on the 2004 Ten Year Plan priority areas. It outlined that it would spend the additional $66 million it received in federal funding to reduce surgical backlogs and expand diagnostic capacity ($30 million); retain health providers by providing safer, high quality workplaces, continuing education and training ($11 million); replace and upgrade capital equipment and infrastructure ($14 million); buy change with quality improvements, efficiency reviews and investments in information technology ($11 million).

The Ontario Government developed a template for reporting on its investments in the diagnostic and medical equipment area. It described the criteria used to allocate the money, who received it and how it was spent. It provided a careful accounting of how many machines, pieces of equipment and other patient care accessories were purchased annually.

COUNCIL ADVICE

The money is important. Canadians want to know whether the increased investments in health care are supporting the kind of change governments have agreed to implement. The templates used by the Government of Saskatchewan and the Government of Ontario are useful starting points for describing **how** the money has been spent. We believe the public has a right to know how the money has been spent across the country. We will report on the funding in our next annual report.

There is another fundamental issue attached to the money question. How much is enough? How much is too much? Health care consumes an increasing share of government spending at the expense of other sectors that contribute to health such as education. We believe Canada needs a public debate on whether additional investments in health care versus other social programs would be most beneficial. We will commission a report for public discussion in 2005.



PUBLIC INFORMATION/COMPARABLE HEALTH INDICATORS

Governments decided in 2000 that they would create a common list of indicators about health status and health care. These indicators would then be reported in a similar way by each jurisdiction. This would give Canadians comparable information about their own health and the performance of the health care system.

In September 2002, the Government of Canada and all the provincial and territorial governments released reports containing 67 indicators. These included different rates of disease, lifestyle choices such as smoking or exercise, wait times for health care services and outcome information, such as mortality rates for different types of cancer.

The 2003 Accord directed Health Ministers to develop further indicators for reporting on progress in 2004. Work was undertaken and 70 indicators were identified for public reporting by the Canadian Institute for Health Information. This time, 18 were selected for reporting by each jurisdiction.The jurisdictional reports were released at the end of November 2004 and can be found on respective government web sites and at *www.cihi.ca*. The 18 indicators focus on access to primary health care, drug coverage, diagnostic and medical equipment, health human resources, and the general health of the population.

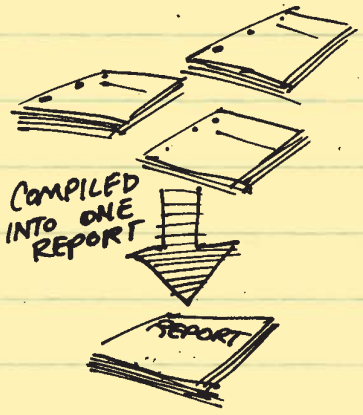
The Council recognizes the enormous effort behind developing the comparable health indicators framework and producing ongoing data for public release. The next step is to assess the extent to which the data are useful to policy makers, planners, health care providers and others working in the system. It is similarily important to learn whether they are useful for the general public as a way of understanding whether progress is being made in implementing health care renewal. Despite the fact that jurisdictions have agreed to report on the same information, the way they are reporting varies greatly. For example, one province produced a four page report while another province produced 196 pages. This begs the questions — what is the purpose of the reporting exercise?

If the intention is to provide regular information to document system improvements — are these the right indicators? How are they connected to the stated renewal goals of the 2003 Accord and subsequent 2004 Ten Year Plan? Are the indicators in-depth enough to answer questions about successful or unsuccessful improvement efforts? Should there be fewer core indicators with a more in-depth look at one aspect of system renewal for each reporting cycle?

As noted earlier in the report, these indicators are not reported by socio-economic status and therefore, do not contribute to an understanding of health disparities in Canada.

COUNCIL ADVICE

We recommend that Health Ministers take another look at their approach to generating these indicator reports. They have the potential to become a useful public tool for assessing system improvement if governments are clear about their purpose. We also recommend that the information be compiled into one report so that the public can understand differences and similarities across the country. Furthermore, we recommend the inclusion of socio-economic factors in the health indicator framework.



LOOKING AHEAD

First Ministers have agreed to change the way health care is delivered in Canada. Change is unfolding and, in our judgment, is in the right direction. There is more receptivity to change and the will to accomplish it is greater than in the past.

The question now is the pace at which Canadians can expect renewal. Barriers still exist which make progress slow in some areas — particularly in primary health care and a new approach to health human resources. These barriers need to be better understood and eliminated so that change can accelerate. Addressing these barriers will be one of the areas we will work on in the coming year.

In 2005, we will continue to monitor and report on progress in renewing Canada's health care system. Specific activity will include:

- Releasing a series of background papers on primary health care, home care, pharmaceuticals, wait times, health human resources and Aboriginal health issues;
- Identifying and promoting innovative practices in each of the areas above;
- Commissioning research on industry practices in the pharmaceutical sector, such as the effects of marketing, research investments and the disclosure of clinical trial results;
- Participating in efforts to develop indicators to measure implementation of health care renewal that are meaningful to the public;
- Sponsoring a National Health Human Resources Summit focused on impediments to multidisciplinary care, including the impact of education and training;
- Generating a template for reporting on funding dedicated to health care renewal and reporting on the funds;
- Commissioning a report on the costs and benefits of additional investments in health care;
- Engaging Canadians in an ongoing discussion on health care renewal based on their expectations as consumers and including the information they want reported publicly on an annual basis;
- Providing information and support to jurisdictions, health care professionals and providers to facilitate their efforts.

OUR FINAL THOUGHTS

Canada is at an important juncture in the development of its social infrastructure. Health care has received the lion's share of public attention and investment. As we look to the future, certain realities need to be faced:

- Investments in health services alone cannot solve the country's health problems. Equal attention has to be given to investments in other social programs and reducing the gaps in health status. More money for health services may not be the answer.
- We need to ensure that Canadians are getting good value for the money we currently invest in health care. Are we getting the most from our $130 billion spent annually?
- Canada's future health system is dependent upon the modernization of primary health care which is directly linked to a different approach to educating and training health personnel. The current pace of change is slow and needs to be accelerated. If we do not undertake this modernization, we will not improve access to services, we will not reduce health disparities and we will not improve the health of Canadians.

A Note to Our Readers

An extensive list of the references and documents used to generate this report can be found on our web site — **www.healthcouncilcanada.ca** or **www.conseilcanadiendelasante.ca**.

We would like to thank you for taking the time to read this report and encourage you to tell us what you found valuable about it. Please visit our website and give us your opinion.

If you do not have access to the Internet, please write to us:

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Appendix A — Information Tables

A.1 **Common Strategies for Advancing Primary Health Care Reforms**

A.2 **Summary of Primary Health Care Initiatives by Jurisdiction**

A.3 **Summary of Home Care Initiatives by Jurisdiction**

A.4 **Common Strategies for Advancing Home Care Reforms**

A.5 **Provincial and Territorial Drug Programs (2001)**

A.6 **Selected Examples of Access to Web-based Wait Times Initiatives Across Canada (October 2001)**

A.7 **Summary of Health Human Resource Initiatives by Jurisdiction**

A.8 **Health Human Resources Recruitment and Retention by Jurisdiction**

A.1: Common Strategies for Advancing Primary Health Care Reforms

Building Blocks	Common Strategies
Improved continuity and coordination of care	**Enhancement of use of multi-disciplinary teams and organizations** **Development and expansion of a range of primary health care organizations and models (e.g., physician health networks, family health groups, health service organizations, community health centres).** **British Columbia** has established a range of options for Health Authorities to choose the best approach for their population, including fee for service and blended funding models. Blended funding sites are funded according to the characteristics of the population served. **Saskatchewan** has mandated each Regional Health Authority to develop a network of care provider teams to deliver primary health care services and to provide case management to coordinate services. In **Ontario**, contracts between the Ministry of Health and Long-term Care and Health Service Organizations, Community Health Centres, the Group Health Centre, Primary Care Networks, Family Health Networks, and Family Health Groups and other primary care models specify minimum numbers of office hours per week, 24/7 on call availability and a defined basket of services. In 2003, Ontario announced a commitment to establish 150 inter-disciplinary Family Health Teams as a new primary health care delivery model by 2008. These family health teams will encompass key elements of Ontario's Primary Health Care Transformation Strategy including: inter-disciplinary teams; expanded access to care through extended hours and access to a province-wide telephone health advisory service; co-ordinated health care system access and navigation; health promotion; disease prevention; screening; acute care and chronic disease management guided by local health needs; active support for patients' self-care responsibilities; and, integrated clinical management systems. In **Quebec**, health and social services centres have been created by merging local community health centres, residential and long-term care centres, and general and specialized hospital centres. **Development of local primary health care proposals by Regional Health Authorities.** These plans build on provincial frameworks and focus on: • Expanding provincial or regional tele-health systems. For example, 100% of **New Brunswick** is served through the TeleCare tele-triage service; • Enabling local priority-setting and decision-making related to implementation of the best primary health care practice models to meet community needs; • Establishing more collaborative teams to meet community needs; and, • Overseeing the development and implementation of an electronic patient health record.

A.1: Common Strategies for Advancing Primary Health Care Reforms — cont'd

Building Blocks	Common Strategies
Early detection and action	**Development of provincial chronic disease management strategies focused on high-risk populations and specific chronic diseases (e.g., diabetes).** For example, **British Columbia** has developed a Chronic Disease Management Toolkit for practitioners that offers a range of functions including web-based access to clinical guidelines for treating conditions such as diabetes, depression, and congestive heart failure. It enables practitioners to complete patient flow-sheets electronically — automatically integrating relevant clinical guidelines. British Columbia is also sponsoring the Electronic Medical Summary Project to develop the province-wide means to enable electronic exchange of patient information among practitioners when sharing the care of individual patients. **Ontario** has committed to establishing a chronic disease prevention and management framework in the next few years. In addition, key elements of Ontario's Primary Health Care Transformation Strategy are health promotion, disease prevention, screening, acute care and chronic disease management, guided by local health needs and active support for patients' self-care responsibilities. **Nova Scotia** contracted Dalhousie University to work with partners to draft a long-term strategy to advise government on chronic disease prevention. **Prince Edward Island** is creating a set of best practice clinical protocols for use in Family Health Centres where teams of physicians and registered nurses practice collaboratively for chronic disease management. **Nunavut** has created a toolkit to be used by Community Health Representatives as front line staff in promoting community participation. This toolkit entitled *Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut* is meant to encourage the emergence of more engaged citizens in Nunavut.

A.1: Common Strategies for Advancing Primary Health Care Reforms — cont'd

Building Blocks	Common Strategies
Better information on needs and outcomes	**Planning and implementation of shared electronic health record initiatives.** **British Columbia** has a comprehensive plan for the province wide implementation of the electronic health record. The implementation of the plan is governed by a provincial steering committee with representation from the senior executives of the health authorities, providers, Chief Information Officers, and members of the Ministry of Health Services executive. The **Alberta** Electronic Health Record was implemented in 2004. It stores pertinent clinical patient information on-line that links physicians, pharmacists, hospitals, home care and other providers by computer. **Quebec**'s information technology system, le Réseau de télécommunications sociosanitaire, links all public health services: hospitals; local community health centres; long-term care centres; rehabilitation centres; the 18 régies régionales; and, other services. Since January 2002, the Family Medical Groups can also access the system. **Nova Scotia** is implementing a province-wide hospital information system that supports a shared electronic health record across levels of care. The related Nova Scotia Health System Interoperability Project will allow primary health care teams to electronically link to client health information including lab and diagnostic imaging results. **New Brunswick** is implementing electronic patient records for Community Health Centres. **Prince Edward Island** has implemented a province wide Integrated Service Management information system linking community programs such as home care, mental health, diabetes education, child and family services to support continuity of care. **Federal and/or provincial research support to strengthen information related to Primary Health Care reform strategies.** **British Columbia** has provided support to the Centre for Health Services Policy Research to build capacity for primary health care evaluation. The Centre has developed a primary health care evaluation framework and is developing an administrative database system that will provide profiles and information on primary health care from health authority, patient and provider perspectives. The Manitoba Centre for Health Policy is developing health indicators to support community needs assessments; health plans; performance agreements and deliverables. **Manitoba** is also piloting an electronic application in 21 communities for standardized client assessment and care planning. The Centre developed the Population Health Research Data Repository — a comprehensive database that holds records for all Manitobans' contacts with physicians, hospitals, home care, nursing homes and prescriptions. Administrative data from the database is being used to help physicians improve the quality of care they deliver based on assessment against a series of quality indicators. Through the e-Physician Project and improved clinical information systems, **Ontario** will become increasingly able to monitor needs and measure patient outcomes in the area of primary health care. Through its Primary Health Care Transition Fund, Ontario has funded a number of evaluation and planning projects that will provide guidance to the Ministry on its primary health care strategies. **Nova Scotia** is enhancing its primary health care evaluation and research capacity through the development of an evaluation framework building on a February 2004 workshop. The First Nations and Inuit Health Branch of **Health Canada** is piloting an electronic application in 21 communities to standardize client assessment and care planning.

A.1: Common Strategies for Advancing Primary Health Care Reforms — cont'd

Building Blocks	Common Strategies
New and stronger incentives	**Development of new funding and remuneration methods including alternative payment plans for physicians such as contracts, rosters, or salaries.** In **British Columbia**, the 2004 Working Agreement with the BC Medical Association includes initiatives to support full service family practice, including chronic disease management, maternity care, improved access and quality of care for the frail elderly. Twenty-five million dollars has been allocated to support system-level primary health care renewal by providing funding for: change management or restructuring; development and implementation of new practice governance structures; training and skills development; and, information technology enhancements. British Columbia has also developed a blended funding model based on the characteristics of the population served which supports interdisciplinary practice. In **Alberta**, an eight-year agreement has been signed by the government, the Alberta Medical Association and the regional health authorities to provide $100 million over three years to improve access to primary care services. **Newfoundland and Labrador** has developed a new model for family practice physicians — $70 million has been negotiated. **Exploration and implementation of changes to scopes of practice.** Some of these changes focus on changing incentives for providers to encourage them to work in a more seamless system of delivery by changing remuneration models for physicians and other practitioners to support a primary health care delivery approach. Nurse Practitioners are now licensed to practice in **New Brunswick** and are working in various health care environments including physicians' offices and Community Health Centres. **Development of new recruitment and retention strategies.** **Manitoba** has developed an Office of Rural and Northern Health focused on development of a Primary Care Physician Recruitment and Retention Strategy and Nurse Practitioners Strategy.

A.1: Common Strategies for Advancing Primary Health Care Reforms — cont'd

Building Blocks	Common Strategies
New and stronger incentives — cont'd	In **Ontario**, the Ministry of Health and Long-term Care is increasing supply of human resources in health care by: • Increasing the proportion of family medicine positions in the postgraduate medical training system from the current proportion of 38% to up to 43%; • Working with medical schools to ensure that the family medicine training program is attractive and consistent with the skills and knowledge required to deliver comprehensive primary care; • More than doubling the number of training positions for international medical graduates to 200 from 90 with an emphasis on positions in family medicine; • Implementing return of service commitments for physicians who access ministry funded postgraduate training, which will include return of service in communities where Family Health Teams are to be located; • Doubling the number of clinical education spaces for nurse practitioners to 150 from 75 spaces in three years; • Increasing the number of postgraduate trained nurses needed for key faculty positions to educate more nurses; • Removing barriers faced by internationally educated health care providers so they may practice in Ontario; • Increasing the annual enrolment in pharmacy to 240 in 2005, which is double the 2000 enrolment level; and, • Enrolling up to 60 new applicants in midwifery education programs in 2004 with a plan to be developed in 2004/05 for possible future expansion. As part of its primary health care strategy, Ontario is also committed to increasing the number of nurse practitioners, nurses, pharmacists and other health care providers working in primary care practices. A joint initiative of **Nova Scotia**, **Prince Edward Island**, **New Brunswick** and **Newfoundland and Labrador** delivers continuing professional education to primary health care providers.

A.2: Summary of Primary Health Care Initiatives by Jurisdiction

Jurisdiction	Priorities	Target Date	Status
British Columbia	Engage 4,000 family practitioners via professional quality improvement process; implement primary health care structured collaborative	2006	In progress
	Implement 4 provincial chronic disease management collaboratives; support with IT and patient self-management initiative	2006	Ongoing
	Pilot group patient clinical visits	2005	In progress
	Develop clinical practice guidelines	2005	6 complete; 3 under development
	Implement incentives for full service family practice	2006	Ongoing
	Establish Primary Health Care Transition Fund framework to provide regional health authorities with a range of new practice models	2003	Completed
	Enable 100% of population able to receive health information from registered nurses and pharmacists through phone access. (BC Nurseline)	2003	Completed
	Convert projects initiated as demonstrations to permanent primary health care organizations	2003	Completed
	Establish a blended funding model for primary health care organizations	1997 – ongoing	Established
	Create 11 primary health care organizations; 5 community health centres (sites owned by regional health authorities); 4 shared care initiatives (specialists and general practitioners managing complex patients together); 1 patient care network (practitioners are not in same site but share patient information, after hours care and on-call coverage)	2004	Established
	Expand midwifery by initiating a training program within the Faculty of Medicine at University of BC	2005	First students to graduate in 2005
	Develop legislation for nurse practitioners	2004	Completed. Students to graduate in 2005
	Initiate training program for nurse practitioners in 2 universities	2004	First graduates in 2005
	Document successful nursing models for interdisciplinary care	2005	Under development
	Establish nurse managed care in 6 rural/remote communities	2004	Under development
	Develop electronic medical summary	2006	Under development

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Alberta	Develop province-wide access to telephone based health information	2003	Established
	Implement Alberta electronic health record	2004	March 2004 — 5,500 users are on line
Saskatchewan	Province-wide access to telephone advice	2003	Completed
	Develop a primary health care memorandum of understanding and model contract for physicians	December 2004	In progress
	Create health services networks and teams available 24/7 to 100% of population	2011	27 teams established covering a population of 18% Registered nurse practitioners now licensable in Saskatchewan. Facilitators for team development in each Regional Health Authority
	All regional health authorities to develop primary health care plans	2004	Completed. Each regional health authority has an identified director of primary health care and a multidisciplinary steering committee for primary health care
	Develop primary health care evaluation	2005	In progress
	80% of family physicians to participate in primary health care models	2011	In progress
Manitoba	Regions to develop primary health care plan, based on provincial policy framework	2004	Completed
	Establish Health Access Centres		Ongoing. Two are established with additional centres in the planning stages
	Implement primary care physician recruitment strategy		Ongoing
	Establish office of rural and northern health		Established
	Expand telehealth		More than 20 sites are in operation with planning underway for additional sites

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Ontario	Implement nurse practitioner initiative		The most recent initiative funded 115 positions in small, rural and under serviced areas. The Ministry is exploring opportunities for nurse practitioners in Family Health Teams and other primary care settings. In total, the Ministry funds over 400 nurse practitioner positions. Upgrading 87 nursing positions to nurse practitioners and creating 34 new nurse practitioner positions in community based settings
	Implement Family Health Teams	2008	Plan to establish 150 Family Health Teams by 2008 45 to be announced by March 31, 2005
	Align the following existing innovative primary care models along common elements: The Group Health Centre, Community Health Centres, Primary Care Networks, Family Health Networks, Health Service Organizations, Northern Group Funding Plans, and Community Sponsored Contracts		Over the next few years, Ontario will align existing primary care models along key common elements including extended hours of care; Telephone Health Advisory Service; inter-disciplinary collaborative care; co-ordinated system access and navigation; health promotion; disease prevention; screening; acute care and chronic disease management guided by local health needs; active support for patients' self-care responsibilities; and integrated clinical management systems

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Quebec	100 family medicine groups to offer 24/7 services	2003	
	Community health centres to be open 7 days a week for a minimum of 70 hours a week	2003	In 2004, the community health centres were merged with residential, long term care and general and specialised hospital centres
Nova Scotia	Evaluate multidisciplinary health care teams	2003	Established 4 demonstration sites and completed evaluation
	Establish and support collaborative practice teams	2006	Ongoing. Nurse practitioners already incorporated into teams in 14 communities
	Deliver training for primary health care providers	2006	Ongoing joint initiative of the Atlantic provinces to deliver continuing professional education modules to primary health care providers in all 4 provinces
	Develop a telecare phone line, interactive web site and audio tapes in partnership with other Atlantic provinces	2003	Phase 1 underway. Implementation is targeted for 2005/06
	Implement a province wide information system that supports shared electronic health record across levels of care	2005	Scheduled for completion in 2005/06
	Advance electronic health record initiative	2006	Ongoing
	Incorporate diversity and social inclusion in primary health care	2006	Ongoing

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
New Brunswick	Establish 5 Community Health Centres	2004	Community Health Centres established and operating in Saint John, Minto, Doaktown, Lamequé, and Riverside-Albert
	Establish 4 additional Community Health Centres	2008	Planning under way for the establishment of Community Health Centres for Plaster Rock, St-Quentin, Dalhousie and Caraquet
	Implement Tele-Care	1999	100% of New Brunswick served through Tele-Care teletriage service New Brunswick is also working with Atlantic partners on expanding this service on a regional basis
	Implement collaborative practices	2004	Individual collaborative practices (in physicians' offices) in place in Edmundston, Bathurst and Moncton Collaborative practice clinic now in place for Fredericton
	Focus on interdisciplinary training	2006	Ongoing. Joint initiative of Atlantic Provinces to deliver continuing professional education to primary health care providers
	Engage nurse practitioners	2002	Nurse practitioners now licensed to practice in New Brunswick; working in various health care environments including physicians' offices and Community Health Centres
	Implement electronic health record for Community Health Centres	2008	Ongoing. To implement electronic patient record for Community Health Centres
	Enhance ambulance service		Ongoing. To enhance the capabilities and skills of ambulance attendants to improve access to health care

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Newfoundland and Labrador	100% of residents to be registered with a primary health care network	2007	Ongoing. 25% of population will have access by 2005
	Develop a Tele-Care phone line and interactive phone line and audio tapes in partnership with other Atlantic provinces	2005	Phase 1 underway. Implementation is targeted for 2005/06
	Evaluate a shared electronic health record across primary health care	2005	Ongoing
	Increase participation of family practice physicians in primary health care teams	2006	Ongoing. Full physician participation in 8 projects
	Make available 24/7 primary care within 60 minutes to 95% of people	2007	Ongoing. 90% access as of 2004.
Prince Edward Island	Develop a Tele-Care business case with the other Atlantic provinces for teletriage	2005	Phase 1 business case developed
	Create Family Health Centers with core staff of salaried physicians and registered nurses working collaboratively	2002 – 2005	5 of the 6 sites established and being evaluated
	Create a Healthy Living Strategy of 22 partner organizations that focuses on active living, healthy eating and tobacco reduction	2002 – 2005	22 organizations with social marketing plans
	Create local networks of community services that organize activities that promote the Healthy Living Strategy	2003 – 2005	4 co-coordinators hired regionally to implement the local networks

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Northwest Territories	Publish and distribute a self-care handbook to all households	2003	Completed
	Establish a 1 800 family health and social supports call centre	2004	Launched May 2004
	Formalize integrated health and social services delivery model and establish demonstration projects	2003	Plans are completed. Implementation to be phased in dependent upon resources and priorities
	Establish alternate service delivery teams	2010	
	Integrate nurse practitioners into primary care		New nursing act proclaimed January 2004 provides for regulation of nurse practitioners Nurse practitioners are to be placed in each community health center and hospital emergency department (minimum 29 positions)
	Integrate midwifery services	2005	Coming into force with the *Midwifery Profession Act* January 2005
Yukon	Promote Healthy Living	2006	Ongoing
	Support active living, including an ongoing walking program		
	Provide parenting information: implement a positive parenting social marketing campaign		
	Provide health information: • Yukon Health Guide — information book for all Yukon households • Web Access — link to on-line health information through British Columbia • Program Information — improved on-line information on Yukon programs and services • Update disability handbook		
	Enhance Information Technology support: • Public Health information system • Mental Health information system • Client registry • Drug information system Strengthen Information Management as part of overall planning and coordination		

A.2: Summary of Primary Health Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Priorities	Target Date	Status
Nunavut	Use primary health care funds to promote multi-disciplinary approaches to health care delivery and to train Inuit service providers	Ongoing	
	Focus on better-integrated addiction and mental health services		
	Develop and implement a toolkit entitled "Engaging Nunavummiut: A Guide to Strengthening Community in Nunavut" to be used by Community Health Representatives		
	Develop: • Training materials for use by regional mental health training teams, • Poster series on mental health awareness (anxiety, depression, post-traumatic stress disorder)		
	Establish Mental Health Worker Diploma Program		
	Establish a pilot project to train Community Health Representatives in Nunavut for 3 months in dental and nutrition programs with the goal of awarding a diploma in Community Health Promotion Specialist in Dental Health and Nutrition		
	Provide on-going training for Community Health Representatives in needs assessment and presentation skills		
	Establish the first collaborative family practice clinic in Iqalwit	2005	

A.3: Summary of Home Care Initiatives by Jurisdiction

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
Federal Government (Veterans Affairs; Indian And Northern Affairs; RCMP)	Veterans Affairs has Veterans Independence Program with full acute home care services available but meant to supplement other programs (no specific short-term program). Indian and Northern Affairs has a First Nations and Inuit Home and Continuing Care Program, which provides a wide range of services/supplies subject to availability of providers. RCMP has no standardized program. Each RCMP unit contracts with a home care provider agency. Coverage is for regular members.	Veterans Affairs does not fund this category separately, but some necessary services may be accessible under the Veterans Independence Program. Indian and Northern Affairs — Several partial program initiatives are being brought under a more coherent program with a network of service providers. Services may be provided, where available, under the Non-Insured Benefits Program. RCMP — no specific information was provided.	Veterans Affairs policy is that the client should access whatever plan or program services may be available and then provides other component required services, drugs and supplies under a palliative care plan.	In 2003 the federal government amended the *Employment Insurance Act* [S.C. 2003, c.15, s.19] and the *Canada Labour Code* [S.C. 2003, c.15, s.27] to allow for compassionate care leave of up to 8 weeks (with EI benefits for up to 6 weeks) to care for a family member who has been medically diagnosed as being at significant risk of death within 26 weeks.
British Columbia	Professional services provided without charge. Medical supplies provided at no charge for 2 weeks. Effective April/05, home support based on need will be provided without charge for 2 weeks.	No specific program but all regional health authorities must provide a comprehensive continuum of care, including in-home for mental health and addictions both long and short term.	B.C. Palliative Care Benefits Program. Eligibility is determined by a physician and includes those with a life expectancy of up to 6 months and who have consented to the care plan — focus being palliative rather than curative. Drugs, supplies and equipment are covered under the program.	As of October 31/04 no amendments made.

A.3: Summary of Home Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
Alberta	Information not available.	Information not available.	Regional Health Authorities deliver services under the Community Care Services Program, which provides subsidized drugs and medical supplies with a maximum $1,000 as the contribution by the client.	As of October 31/04 no amendments made.
Saskatchewan	Home care services provided based on need and risk. Professional services, medical equipment and supplies provided at no charge. Drugs, personal care, and meals involve user fee or co-payment.	No specific short term program but many services may be delivered according to assessed need by the Regional Health Authorities under their mental health programs.	Palliative care services are part of core primary health care services delivered by the Regional Health Authorities. There are no charges for home care for end-stage palliative care clients and no charges for drugs.	June/04 *Labour Standards Act* amended to provide for up to 12 weeks unpaid compassionate leave (up to 16 weeks where provincial and federal statutes apply jointly).
Manitoba	Regional Health Authorities deliver wide range of publicly funded services based on individual assessment.	Services delivered by Regional Health Authorities but not under Home Care Program. Many specific short term services available (Mobile Crisis Units; Crisis Stabilization Units; Safe Houses; Critical Incident Stress De-briefing Teams) based on assessed need.	Regional Health Authorities deliver palliative care services as a sub-program under the Home Care Program. Both drugs and services are publicly funded for those with a prognosis of less than 6 months, diagnosed and referred by physician and no longer receiving aggressive treatment.	December/03 *Employment Standards Code* amended — up to 8 weeks unpaid compassionate leave.

A.3: Summary of Home Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
Ontario	All Ontarians eligible for publicly-funded home care services based on need. No separate program for short-term acute clients. Services: case management, nursing, personal support and homemaking, physiotherapy, occupational therapy, speech and language pathology, social work, dietetics, medical equipment and supplies and access to a drug card. Service maximums for nursing and personal support/ homemaking are outlined in legislation.	Wide range of programs and services provided, but not province wide. Such things as Mobile Crisis Teams and Assertive Community Treatment Teams provide timely interventions. Provision of services under the province's home care program delivered by the Community Care Access Centers but not consistently. June/04 — Minister of Health and Long-Term Care announces $583 million over 4 years for mental health.	Community Care Access Centres provide a range of palliative care services. Access Centre palliative care clients do not pay for services or drugs except for a $2.00 co-payment.	June/04 *Employment Standards Act*, 2000, amended — up to 8 weeks unpaid family medical leave.
Quebec	Information not available.	Information not available.	Information not available.	Legislation existed prior to federal amendment. Up to 12 weeks of unpaid compassionate leave permitted in cases where employee has at least 3 months of uninterrupted service.

A.3: Summary of Home Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
New Brunswick	Extra-Mural Program run by Regional Health Authorities. Physician referral to program required. Program mandate is to lessen need for hospital admissions, shorten hospital stays and provide rehabilitation services. Wide range of services/supplies provided, including drugs, but the program is not payer of last resort for all drugs.	No specific information provided.	The Extra-Mural Program provides comprehensive home care services for palliative care clients and is delivered by the Regional Health Authorities following referral. The Extra-Mural Program provides a full range of services and supplies, but is the payer of last resort for drugs.	December/03 *Employment Standards Act* amended — up to 8 weeks unpaid compassionate leave.
Nova Scotia	Clients must have diagnosis/prognosis suggesting resolution of condition within 15 days. Client's physician determines medical suitability and stability for home care. $2,000.00 maximum for 15 days for medical supplies and services (not medical equipment). Care may be extended in home with authorization.	Mental Health Services, funded by the Department of Health, are delivered by 9 District Health Authorities and the I.W.Killam Health Centre. Authorities administer 50 community-based clinics, inpatient beds, crisis and emergency services, day treatment centres and clubhouse psychosocial rehabilitation programs and offer acute and longer term treatment and support.	Nova Scotia participated in a pilot palliative care project, supported by the federal Health Transition Fund in 2001. The pilot included inter-disciplinary team consultation, enhanced home care services in the last 3 months of life, and specialized training for professionals in the team. This palliative care approach has continued. Nova Scotia is currently working to develop a provincial approach to palliative care.	May/04 *Labour Standards Code* amended — up to 8 weeks unpaid compassionate leave.

A.3: Summary of Home Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
Prince Edward Island	General home care eligibility criteria used to assess short-term needs. Professional services provided. Visiting homemaker services provided on sliding scale. Medical equipment and supplies not publicly funded. No separate drug program.	Regional Health Authorities provide services through Community Mental Health Centers or partners, e.g., Canadian Mental Health Association. Services are publicly funded (essential personal care services involves co-pay). Waiting period for some services, but not crisis intervention.	Palliative care services are provided under global budgeting to the four regional authorities with an integrated palliative care program. Professional services and home support services are provided, but drugs, medical equipment and supplies are not publicly funded if the client remains in home.	December/03 *Employment Standards Act* amended — up to 8 weeks unpaid compassionate leave.
Newfoundland and Labrador	Clients admitted to home support program on emergency basis. Professional services provided on basis of need and availability. Medical supplies provided to limited degree. Medical equipment subject to means test. Drugs not covered. Rehabilitation services may have 2-3 week wait. Nursing services usually provided within 24 hours post discharge.	Province acknowledges under-servicing in this area due to budgetary limitations. Services only available to a limited degree and only when coupled with other concurrent services delivered. Province proposes future program development as a continuum based on concept of primary health care teams, including mental health managers.	Delivery of services is not consistent province-wide. Although care assessment and management are publicly funded, nursing and allied health professional services are limited. Equipment is means tested and limited. Personal care is means tested. Drugs are not publicly funded.	As of October 31/04 no amendments made.

A.3: Summary of Home Care Initiatives by Jurisdiction — cont'd

Jurisdiction	Short Term Acute Care	Acute Community Mental Health	End-of-life/ Palliative Care	Compassionate Care Leave and Benefits Legislation
Yukon	Fully funded services up to 3 months, based on assessed need. Drugs and equipment covered for those over 65, on social assistance, or on Chronic Disease Program. Short term (2 weeks maximum) medical supplies available for those waiting for private coverage.	Mental Health Services delivers home based services (outreach). Provided on an as-needed basis. Drugs are funded under the Chronic Disease Program. No current wait list for services and newly referred individuals are seen as soon as possible.	Clients with a palliative diagnosis are eligible for home care services based on assessed need. Health Services covers up to one year of public funding for drugs, supplies and medical equipment, subject only to the ability to deliver what is needed to remote communities.	November/03 *Employment Standards Act* amended — up to 8 weeks unpaid compassionate leave.
Northwest Territories	Acute home care available to all and is publicly-funded based on assessed need. Limitations are financial and the availability of service deliverers.	Services are provided to anyone assessed by a mental health counselor, psychiatrist or therapist as being in need. Short or long term distinction not made. Drugs funded under other programs. There are no user fees and no limits on services.	Full public funding is provided for in-home care for palliative clients. This includes professional services, drugs, supplies and medical equipment.	As of October 31/04 no amendments made, but Department of Justice has stated in a consultation paper on the *Labour Standards Act* that the Department recommends an amendment to provide for up to 8 weeks of unpaid compassionate leave.
Nunavut	Short term acute home care is publicly funded for those with acute health or post-surgical conditions with clearly identified and predictable outcomes or expected recovery. No waiting list for services, but weather and geography may delay equipment delivery.	No specific program but necessary services may be provided under generic home care assessment criteria. Those services provided, where available, are publicly funded.	Public funding is provided for those diagnosed with a non-curative disease with a short-term life expectancy. The only limitation on service delivery is budgetary, i.e., no provision has been made for over-time. Also, shortages of service providers may lead to interruptions in continuity of service.	November/03 *Labour Standards Act* amended — up to 8 weeks unpaid compassionate leave.

A.4: Common Strategies for Advancing Home Care Reforms

Building Blocks	Common Strategies
Improved continuity and coordination of care	**Enhancement of use of multi-disciplinary teams and organizations in Short-Term Acute Home Care** Quick Response Programs divert people from hospitals to suitable community-based care. In **British Columbia** the Quick Response Team, launched by the Victoria Health Project, provides crisis intervention to people in their homes, with services available from 8 a.m. to 11 p.m., 365 days a year. Providers are from a variety of disciplines, including nursing, physiotherapy, social work, medicine, and pharmacy. The Comprehensive Home Option of Integrated Care for the Elderly was developed in January 1996 in Edmonton, **Alberta,** through partnership between the Good Samaritan Society and Capital Health Group. The umbrella program assists seniors to continue living independently and in their own home longer, by managing all their health requirements. Enrollees come to one of the Capital Care Choice day centres from one to five days a week, where a full range of medical, psychological, social and supportive services are available from an interdisciplinary team. Hours of operation are 8:00 a.m. to 4:15 p.m. with emergency response available 24/7. In **Ontario,** the Toronto Community Care Access Centres Wound Care Framework implemented in June 2004, involves nine Community Care Access Centres and contracted service providers. The framework supports the provision of quality wound care service by ensuring a standardized approach to assessment, decision-making, service planning, service delivery and evaluation. Unique aspects of the framework include guidelines for case managers, a focus on clients and caregivers involvement and a wound care monitoring system. The East York Telehomecare Project is a partnership between the East York Community Care Access Centre and the East York General Hospital, originally funded by the federal CANARIE Inc. fund for advanced Internet development and the Ontario Innovation Trust. Telehomecare allows the client to access health care provider services 24 hours per day without leaving home — through a two-way live audio/visual visit. **New Brunswick**'s Extra-Mural Program, founded in 1981, provides hospital services at home to a level compatible with tertiary home care, along with long-term continuous health care and rehabilitation to those requiring chronic care, palliative care, and to persons with disabilities. **Enhancement of use of multi-disciplinary teams and organizations in Acute Community Mental Health** In Taber, **Alberta**, the Mental Health Community Care Pilot Project created a service delivery model that is a three-way partnership with the client/family, the Mental Health Program, and the Community Care Program to provide assessment, planning, delivery and evaluation of home-based services. Despite the small number of participants in the pilot, the evaluation indicated that the integrated home care and mental health services with a mental health outreach component was an effective way to meet the home care needs of people with mental illness, particularly in rural settings where services are limited and isolation is a critical issue.

A.4: Common Strategies for Advancing Home Care Reforms — cont'd

Building Blocks	Common Strategies
Improved continuity and coordination of care — cont'd	In **Manitoba,** the Program for Assertive Community Treatment introduced in 2000 consists of a team of mental health service providers that uses an integrated package of intensive care options to deliver treatment, rehabilitation and support services at the community level. Key benefits of the program include increased mental stability and time out of hospital for individuals, reduced hospital costs and enhanced home life stability. The Hamilton, **Ontario,** Crisis Outreach and Support Team program and one at St. Michael's Hospital are examples of Crisis Outreach Programs. They are community-based programs with a partnership between the police and mental health workers/case managers, designed to assist the police in their interactions with the mentally ill and thus reduce hospital days and jail time. In the mobile outreach component, workers ride along with the police and respond to calls, attempt to defuse crisis situations and develop a support plan for follow-up management/treatment. In **Nova Scotia**, Capital Health's Case Management Services closely follows best practices in psychiatric rehabilitation. This program provides a range of case management activities based upon assertive community treatment and intensive case management models. The teams provide service to individuals living in the community with severe and persistent mental illness, which has had a major impact on various aspects of their lives. The Supportive Community Outreach Team serves adults who have difficulty living independently. The Intensive Case Management Team is mandated to use growth and recovery-oriented principles. The I.W. Killam Health Centre and the Cape Breton District Health Authority's Intensive Community Based Treatment Teams are examples of best practices in psychiatric rehabilitation for youth. **Newfoundland and Labrador** has contributed to a pilot project in the St. John's Region, which provides case management and home support to a limited number of individuals who have complex mental health needs and who have been involved with the justice system. The outcome for these individuals has been very positive. Need for hospitalization and conflicts with the legal system have been reduced. **Enhancement of use of multidisciplinary teams and organizations in End-of-Life Care** Several health authorities in **British Columbia** have established Palliative Care Coordinators and Palliative Response Teams. Palliative Care Coordinators coordinate the provision of professional and non-professional services to support clients who wish to die at home, including services such as physician, nursing, and home support. Palliative Response Teams provide crisis support and specialized care to help front line caregivers and family caregivers support an at-home death. In **Alberta,** the Edmonton Regional Palliative Care Program began in 1995 and is a community-based model of palliative care services. The program attempts to shift the main arena of end-of-life care from acute care, to home and hospice (hospices are in continuing or long-term care facilities). The components of care — home care and family physicians, outpatient clinics, palliative hospice, regional consultants, acute care (referral hospitals) and tertiary palliative care units — are centrally coordinated by the regional office. Patients and their families have access to palliative care consultants regardless of the care setting.

A.4: Common Strategies for Advancing Home Care Reforms — cont'd

Building Blocks	Common Strategies
Improved continuity and coordination of care — cont'd	In **Ontario**, an innovative model of home palliative care coordination and delivery, called Hospice Palliative Care Network Project, began in April 1999. The Project is a joint effort of Mount Sinai Hospital Palliative Care Centre and the Toronto Community Care Access Centre, working with a number of community organizations, as well as the Ontario Ministry of Health and Long-Term Care. Services include pain and symptom management; case management; consultation services to primary caregivers; and practical and emotional support. The Palliative Care Integration Project Southeastern Ontario is another example of an integrated end-of-life service delivery model. This project has cross-sectoral support of community health care service providers, community providers of hospice/palliative services, long-term care homes, hospitals (acute, rehabilitation and complex continuing care), regional cancer centre, family physicians and associations concerned with specific diagnoses (HIV/AIDS regional services). In 2001, the Mission in Ottawa opened a residential hospice to help the homeless who have a terminal illness, the first palliative care home linked to a shelter for the homeless. The commitment grew out of a growing number of requests from clients who wanted to die in the shelter, which they considered home. The hospice has 14 hospice beds, is open to both men and women and can service approximately 50 people a year. Care is provided 24 hours a day, 7 days a week. **Quebec** has specialized services such as intravenous therapy, home chemotherapy and palliative care coordinated by its Local Community Service Centres. Between 1998 and 2000, the Health Transition Fund supported a palliative care initiative, Toward a Continuum in Care and Services for Terminally Ill Adult Users. A partnership of five Montreal Local Community Service Centres provided on-call nursing, medical and drug services, home care services, a dedicated phone line, and psychological, social and bereavement support. Some of these services were available around the clock. Patients had access to day hospitals as well. In **Prince Edward Island** and **Nova Scotia** an evaluation of the Rural Palliative Home Care Model project revealed that clients and caregivers were generally satisfied with the care provided, and especially its improved coordination. Factors that contributed to the success of the model included: collaboration among disciplines and agencies; common standards for care; a single access point for services; a clinical team with expertise in palliative care; and coverage for medications in cases of financial need (**Nova Scotia** site only) In addition to the Rural Palliative Home Care Model project, **Prince Edward Island** has implemented the West Prince Telehospice pilot project to provide support to a dying person at home 24 hours per day. Using a telephone line and fully interactive audio visual equipment, nurses and other health professionals can monitor and assess the health/vital signs of clients and provide education to clients living at home. Integrated Palliative Care is also an initiative under **Prince Edward Island's** Primary Health Care Re-Design Fund Strategy and has resulted in palliative care programs in each of the four health regions.

A.4: Common Strategies for Advancing Home Care Reforms — cont'd

Building Blocks	Common Strategies
Early detection and action	**Acute Community Mental Health** In **British Columbia**, the Fraser Health Region's Early Psychosis Intervention program is a collaborative initiative between Fraser Health and Ministry of Children and Family Development, Child and Youth Mental Health, and began operating in May 2000 in the south health service area of Fraser Health. The goal of the Early Psychosis Intervention program is to recognize the signs and symptoms of psychosis early so that effective treatment can be started as soon as possible. Treating psychosis involves education, medication, close monitoring of symptoms, stress management and creating a strong, supportive environment. **Ontario** has established Early Intervention in Psychosis (also known as First Episode Psychosis) to ensure that people receive appropriate treatment and support as soon as possible following an episode of psychosis. The Centre for Addictions and Mental Health in Toronto began a First Episode Psychosis Program in 1992.
Better information on needs and outcomes	**Planning and/or implementation of shared electronic health record initiatives.** **Acute Community Mental Health** In **Nova Scotia,** a Telehealth network links all mental health programs in the nine district health authorities and the I.W. Killam Health Centre. This service provides for consultation and education while facilitating discharge planning across the province. **End-of-Life Care** In **Ontario** a common patient chart, the Record of Care, has been developed in collaboration with 33 nursing, hospice and homemaking agencies and has proven to be vital to collaboration, communication, and the development of integrated goals and care planning. The Record of Care has also been translated into French, through the support of the Toronto District Health Council. Caregivers — including physicians, nurses, care coordinators, counsellors, and hospice coordinators — use hand held computers in the community. This has helped to build a database with remote access interface.

A.5: Provincial and Territorial Drug Programs (2001)

British Columbia

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Fair PharmaCare	All eligible Seniors not covered by other plans	None	Based on family net income: $0 <$33K 1% $33K to $50K 2% >$50K	PharmaCare pays 75%	1.25% <$33K 2% $33K to $50K 3% >$50K
	All eligible non-senior British Columbia citizens	None	Based on family net income: $0 <$15K 2% $15K to $30K 3% >$30K	PharmaCare pays 70%	2% <$15K 3% $15K to $30K 4% >$30K
PharmaCare Plan B	Residents of Long-Term Care facilities	None	None	None	N/A
PharmaCare Plan C	Social Assistance Recipients	None	None	None	N/A
PharmaCare Plan D	Cystic Fibrosis Patients	None	None	None	N/A
PharmaCare Plan F	Severely-Handicapped Children-At-Home Program	None	None	None	N/A
PharmaCare Plan G	Mental Health Centre Clients	None	None	None	N/A
Cancer Agency	Patients of Cancer Agency	None	None	None	N/A
Palliative Drug Program	Clients of Palliative Care Program	None	None	None	N/A
End-Stage Renal Disease	Patients attending Renal Society clinics	None	None	None	N/A
Centre of Excellence for HIV/AIDS	Patients attending St Paul's Hospital HIV/AIDS clinic	None	None	None	N/A
Transplant Society	Patients prior to and following solid organ transplant surgery	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Alberta

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Seniors	Seniors and eligible dependants	None	None	30% of prescription to a maximum of $25.00 per prescription plus additional cost if higher-cost product is selected	N/A
Widows	Residents aged 55 to 64 who qualify for Alberta Widows' Pension and eligible dependants	None	None	30% of prescription to a maximum of $25.00 per prescription plus additional cost if higher-cost product is selected	N/A
Palliative	Palliative residents treated at home	None	None	30% of prescription to a maximum of $25.00 per prescription plus additional cost if higher-cost product is selected	The maximum amount palliative patients pay out-of-pocket is $1,000.00
Group 1	A universal plan available to all residents under the age of 65	Quarterly rate is $61.50 for singles and $123.00 for families. Subsidized rates are available at $43.05 for singles and $86.10 for families	None	30% of prescription to a maximum of $25.00 per prescription plus additional cost if higher-cost product is selected	N/A
Assured Income for the Severely Handicapped (AISH) an income support program for adults with a permanent disability that severely impairs their ability to earn a living	Residents receiving AISH and eligible dependants	None	None	$2.00 per prescription for first three prescriptions each month	N/A
Alberta Child Health Benefit	Children in low-income families	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Saskatchewan

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Saskatchewan Drug Plan	All residents with Saskatchewan Health coverage	None	Income-tested (annual threshold based on 3.4% of adjusted family income)	Income-tested (based on benefit drug costs, to help spread cost out evenly over the year)	N/A
	Seniors receiving the Saskatchewan Income Plan supplement or receiving the federal Guaranteed Income Supplement and residing in a special care home automatically receive this deductible and co-pay but may also apply for income-tested coverage	None	$100.00 semi-annual family deductible	35% consumer co-payment after deductible has been paid	N/A
	Seniors receiving the Saskatchewan Income Plan supplement and residing in special care homes are often nominated to receive Plan 3 coverage and receive their prescriptions for no charge	None	None	None	N/A
	Seniors receiving the Guaranteed Income Supplement and living in the community automatically receive this deductible and co-pay but may also apply for income-tested coverage	None	$200.00 semi-annual family deductible. They may apply for income-tested coverage	35% consumer co-payment after deductible has been paid	N/A
	Seniors receiving the Guaranteed Income Supplement and the Saskatchewan Income Plan Supplement living in the community automatically receive this deductible and co-pay but may also apply for income-tested coverage	None	$100.00 semi-annual family deductible. They may apply for income-tested coverage	35% consumer co-payment after deductible has been paid	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Saskatchewan — cont'd

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Saskatchewan Drug Plan — cont'd	Emergency Assistance Program	Residents who require immediate treatment with covered prescription drugs and are unable to cover their share of the cost. This is a one-time benefit, and individuals are encouraged to apply for income-tested coverage for future assistance.	None	None	The level of assistance provided is in accordance with the consumer's ability to pay.
Family Health Benefits	Eligibility is established by the Department of Social Services, based on the number of children in the family and the family's annual income. They automatically receive this deductible and co-pay but may also apply for income-tested coverage.	None	$100.00 semi-annual family deductible	No charge for benefit prescriptions for children; 35% consumer co-payment after deductible has been paid for adult benefit prescriptions.	N/A
Supplementary Health	Persons nominated by Saskatchewan Social Services for special coverage, including persons on Social Assistance, wards, inmates, etc.	None	None	Up to $2.00 per prescription; Some drugs are covered at no charge; individuals under 18 and certain other categories receive benefit prescriptions at no charge	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Saskatchewan — cont'd

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Saskatchewan Aids to Independent Living (SAIL)	Persons registered under the following SAIL programs receive formulary and approved non-formulary drugs at no charge: Paraplegia Program; Cystic Fibrosis Program; and Chronic End Stage Renal Disease Program	None	None	None	N/A
Drug Plan Palliative Care Program	Residents who are in the late stages of a terminal illness	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Manitoba

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Pharmacare	All provincial residents who are eligible for benefits under Manitoba Health's Provincial Drug Program, with the exception of residents covered under other Statutes	None	Based on total adjusted family income; 2.32% of <=$15,000, 3.48% of >$15,000 <=$40,000; 4% of >$40,000 <=$75,000; 5% of >$75,000; credit of $3,000 for spouse and dependent under 18 years; minimum of $100.00 deductible is applicable	None	N/A
Family Services	Individual Manitobans that are receiving drug benefits pursuant to the Social Assistance Health Services Drug Program	None	None	None	N/A
Personal Care Home	Manitoba residents of Personal Care Homes	None	None	None	N/A
Palliative Care	Residents who are terminally ill and wish to remain at home	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Ontario

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Ontario Drug Benefit Program	Seniors (aged 65 and older)	None	$100.00 for seniors with single net income of $16,018.00 or higher, couple net income of $24,175.00 or higher otherwise $0.00	After deductible, up to $6.11 per prescription, up to $2.00 per prescription for those not paying deductible	N/A
	Residents of long-term care facilities	None	None	Up to $2.00 per prescription	N/A
	Residents of Homes for Special Care	None	None	Up to $2.00 per prescription	N/A
	Residents receiving professional services under the Home Care program	None	None	Up to $2.00 per prescription	N/A
	Residents receiving social assistance	None	None	Up to $2.00 per prescription	N/A
Trillium Drug Program	Residents with high drug costs in relation to income	None	Income-based	After deductible, up to $2.00 per prescription	N/A
Special Drugs Program	Residents with valid Ontario Health Insurance. Coverage is product-specific for a limited number of diseases or conditions.	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Quebec

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Régime général d'assurance-médicaments du Québec (RGAM)	Employment Assistance (welfare) Recipients (EAR) and other holders of a carnet de réclamation (claim slip)	None	$8.33 per month	25% of prescription costs	$16.66 per month;. no deductibles and co-pay for EAR with severe employment constraints
	Seniors (65 and over) receiving at least 94% of the maximum Guaranteed Income Supplement	None	$8.33 per month	25% of prescription costs	$16.66 per month
	Seniors (65 and over) receiving less than 94% of the maximum Guaranteed Income Supplement (partial Guaranteed Income Supplement)	$0 to $460.00 per adult per year, depending on income	$9.60 per month	28% of prescription costs	$46.17 per month
	Seniors (65 and over) without Guaranteed Income Supplement	$0 to $460.00 per adult per year, depending on income	$9.60 per month	28% of drug costs	$69.92 per month
	General clientele (Residents under 65 years without access to a group plan)	$0 to $460.00 per adult per year, depending on income	$9.60 per month	28% of prescription costs	$69.92 per month

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

New Brunswick

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Prescription Drug Program Plan A	Seniors with Guaranteed Income Supplement	None	None	$9.05 for each prescription	$250.00
	Seniors without Guaranteed Income Supplement who qualify for benefits based on an annual income as follows: a single senior with an annual income of $17,198.00 or less; a senior couple with one spouse over 65, with a combined annual income of $26,955.00 or less; a senior with spouse under 65, with a combined annual income of $32,390.00 or less	None	None	$15.00 per prescription	N/A
Prescription Drug Program Plan B	Cystic fibrosis patients or patients with juvenile or infant sclerosis of the pancreas	$50.00 yearly registra-tion fee	None	20% prescription cost up to a maximum of $20.00	$500.00 per family
Prescription Drug Program Plan E	Individuals residing in a licensed residential facility who hold a valid health card for prescription drugs issued by the Department of Family and Community Services	None	None	$4.00 for each prescription	$250.00
Prescription Drug Program Plan F	Individuals holding a valid health card for prescription drugs issued by the Department of Family and Community Services	None	None	$4.00 per prescription for adults (18 and over) and $2.00 for children (under 18 years)	$250.00 per family unit in a fiscal year
Prescription Drug Program Plan G	Special needs children and children under the care of the Minister of Family and Community Services	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

New Brunswick — cont'd

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Prescription Drug Program Plan H	Residents who must pay for specific Multiple Sclerosis medications	$50.00 yearly registration fee	None	Income-tested Ranges from 0-100%	N/A
Prescription Drug Program. Plan R	Organ transplant recipients who are registered and qualify with the Prescription Drug Program	$50.00 yearly registration fee	None	20% prescription cost up to a maximum of $20.00	$500.00 per family
Prescription Drug Program Plan T	Individuals with growth hormone deficiency or hypo-pituitarism who are registered and qualify with the Prescription Drug Program	$50.00 yearly registration fee	None	20% prescription cost up to a maximum of $20.00	$500.00 per family
Prescription Drug Program Plan U	Individuals who are HIV positive and are registered with the Prescription Drug Program	$50.00 yearly registration fee	None	20% prescription cost up to a maximum of $20.00	$500.00 per family
Prescription Drug Program Plan V	Individuals who reside in a registered nursing home	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Nova Scotia

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Seniors Pharmacare Program	Seniors (65 and older) receiving Guaranteed Income Supplement and covered by Medical Services Insurance and not having coverage through Veterans Affairs Canada, First Nations, and Inuit Health, or a private drug plan	None	None	33% prescription cost ($3.00 minimum and $30.00 maximum)	$350.00
	Seniors (65 and older) not receiving Guaranteed Income Supplement and covered by Medical Services Insurance and not having coverage through Veterans Affairs Canada, First Nations and Inuit Health, or a private drug plan	Up to $390.00 per year	None	33% prescription cost ($3.00 minimum and $30.00 maximum)	$350.00
Department of Community Services Programs	Eligible clients and their dependents in receipt of Income Assistance, any client and/or dependent having access to another drug plan, be it from a public or private entity, will be required to use that plan and will not be eligible for the Pharmacare program	None	None	All income assistance clients and dependents are required to co-pay a flat fee of $5.00 per prescription, unless the client or dependent is eligible for co-pay exemption	N/A
Drug Assistance for Cancer Patients	Residents having a gross family income no greater than $15,720.00 per year, and not eligible for coverage under other drug programs	None	None	None	N/A
Multiple Sclerosis Drug Funding Assistance	Residents who meet established multiple sclerosis criteria and who do not have other drug coverage	None	None	$9.35 per prescription	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Prince Edward Island

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Seniors Drug Cost Assistance Plan	Seniors 65 years of age or older and eligible for Medicare	None	None	First $10.00 of the medication cost plus the pharmacy professional fee for each prescription	N/A
Financial Assistance Program	Persons whose eligibility is determined by the Social Assistance Act and Regulations	None	None	None	N/A
Family Health Benefit Program	Families eligible for Medicare, with one or more children under 18 years of age, a total annual net family income of $20,000.00 or less, and approved by the program	None	None	The pharmacy professional fee for each prescription	N/A
Children-In-Care Program	Persons under 18 years of age in temporary or permanent custody of the Director of Child Welfare	None	None	None	N/A
Diabetes Control Program	Persons with diabetes eligible for Medicare and who are registered with the program	None	None	Insulin: $8.00 per 10 mL vial of insulin or box of 1.5 mL insulin cartridges; $16.00 per box of 3.0 mL insulin cartridges	N/A
Multiple Sclerosis Medications Program	Persons eligible for Medicare, diagnosed with relapsing-remitting or secondary progressive multiple sclerosis, and approved by the program	None	None	Income tested co-pay plus the pharmacy professional fee for each prescription	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Prince Edward Island — cont'd

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Nursing Home and Institutional Pharmacy Programs	Residents in government manors and private nursing homes eligible for coverage under the Social Assistance Act and Regulations	None	None	None	N/A
Disease Specific Programs (e.g. AIDS/HIV, Cystic Fibrosis, Growth Hormone, Hepatitis, and Transplant Drug Programs delivered through the Provincial Pharmacy)	Persons diagnosed with specific medical conditions	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Newfoundland and Labrador

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
The Senior Citizens Drug Subsidy Program	Seniors (65 and older) who are in receipt of the Guaranteed Income Supplement and who are registered for the Old Age Security benefits	None	None	Mark-up and professional fee for identified benefits	N/A
The Income Support Program	Residents of the province who qualify for full benefit coverage under the Department of Human Resources, Labour and Employment	None	None	None	N/A
	Residents who, due to the high cost of their medications, may qualify for drug card only benefits	None	None	None	N/A
The Special Needs Program	Resident patients with cystic fibrosis or growth hormone	None	None	None, for identified benefits	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Yukon Territory

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Pharmacare	Seniors 65 years of age or older and seniors' spouses aged 60 years and older registered with Yukon Health Care Insurance Plan and not having coverage through First Nations and Inuit Health	None	None	None	N/A
Chronic Disease Program	Residents who have a chronic disease or a serious functional disability as provided under the Chronic Disease and Disability Benefits Regulations, and who are not eligible for Non-Insured Health Benefits or other Federal Government programs. Residents must use private insurance plans first	None	Maximum $250.00 per individual and $500.00 per family	None	N/A
Children's Drug & Optical Program	Children under the age of 19 years from low-income families	None	Maximum $250.00 per child and $500.00 per family	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Northwest Territories

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Extended Health Benefits Program for Specified Diseases	Resident, Non-Native or Metis and have a specified disease condition	None	None	None	N/A
Senior's Benefit Program	Métis and Non-Native residents who are 60 years of age and older	None	None	None	N/A
Métis Health Benefits	Eligible Métis 59 years old and younger	None	None	None	N/A
Indigent Health Benefits Program	Indigent individuals or families residing in the Northwest Territories, who meet the eligibility requirements according to the Indigent Health Benefits Policy	None	None	None	N/A

A.5: Provincial and Territorial Drug Programs (2001) — cont'd

Nunavut

Program/Plan	Beneficiary	Premium	Deductible	Co-Pay	Maximum Annual Co-Pay
Extended Health Benefits Program	All Metis and Non-Aboriginal residents, including Seniors, who have a specific chronic condition or have reached the age of 60	None	None	None	N/A
Indigent Health Benefits Program	All residents who do not have access to other programs	None	None	None	N/A

A.6: Selected Examples of Access to Web-based Wait Times Initiatives Across Canada (October 2004)

Jurisdiction	Area of Focus	Description of Activities
British Columbia	Wait times for surgery and cancer radiotherapy treatments for selected hospitals in British Columbia. **www.healthservices.gov.bc.ca/waitlist/**	Web-based information to be used by patients and physicians to plan where to obtain surgical services. Provides information by type of surgery, hospital and by physician.
Alberta	Wait times for surgery and diagnostic tests for selected facilities in Alberta. **www.health.gov.ab.ca/waitlist/WaitListPublicHome.jsp**	Web-based information to be used by patients and physicians to plan where to obtain surgical and diagnostic services. Provides information by facility and by physician.
Saskatchewan	Wait times for surgery in Saskatchewan (currently 7 of 10 regions that provide surgical services are reporting into the database. This represents 95% of all surgery in the province). **www.sasksurgery.ca**	Web-based information to be used by patients and physicians to plan where to obtain surgery. Provides information by region and surgical centre.
Manitoba	Wait times for diagnostic imaging tests, cardiac surgery and radiation therapy for cancer in Manitoba. **www.gov.mb.ca/health/waitlist/index.html**	Web-based information to be used by patients and physicians to plan where to obtain services. Provides information by facility.
Ontario	Wait times for cancer services by regional cancer centre in Ontario. **www.cancercare.on.ca**	Web-based information to be used by patients and physicians to plan where to obtain services. Provides information by regional cancer centre for specific types of cancer.
Ontario	Wait times for selected cardiac care services by hospital in Ontario. **www.ccn.on.ca**	Web-based information to be used by patients and physicians to plan where to receive services. Provides information on specific cardiac services by cardiac centre.
Quebec	Wait times for surgery and other medical procedures in Quebec. **www.msss.gouv.qc.ca/en/sujets/organization/waiting_lists/html**	Web-based information for nine procedures for patients and physicians to plan where to obtain services. Provides information by procedure, region and hospital.

A.7: Summary of Health Human Resources Initiatives by Jurisdiction

Jurisdiction	Health Human Resources Plan	Interdisciplinary Education	Recruitment and Retention Initiatives
Federal	Plan is under development — pan-Canadian Health Human Resources Initiative will develop models and a planning framework.	Funding projects, through a call for proposals, to look at the benefits and facilitate sharing of information.	Healthy Workplace Initiative for Health Care Workers (Targeted Funding Projects)
British Columbia	Plan is completed — part of health goals and separate 10 year plan on Health Human Resources.	Interprofessional Rural Placement Program was established in 2003 to foster rural recruitment of health professionals and to cultivate interprofessional education for client-centered collaborative care. College of Health Disciplines established at University of BC to foster interdisciplinary training and practice in the health sector. Steering committee for above project was led by College of Health Disciplines.	Yes (physicians, nurses and allied health professionals)
Alberta	Plan is completed — work force plan developed with Alberta Learning and regional health authorities. Projection model developed by Alberta Health and the Alberta Medical Association.	Interdisciplinary education is not a current priority.	Yes (physicians and nurses)
Saskatchewan	A provincial *Action Plan for Saskatchewan Health Care*, in 2001 included a plan to retain, recruit and train health care providers. The annual accountability document with Regional Health Authorities sets out human resource indicators and reporting requirements for the Authorities.	Beginning to look at ways to facilitate interprofessional education.	Yes (physicians, nurses, allied health disciplines)

A.7: Summary of Health Human Resources Initiatives by Jurisdiction — cont'd

Jurisdiction	Health Human Resources Plan	Interdisciplinary Education	Recruitment and Retention Initiatives
Manitoba	Plan is completed for nurses and physicians, and under development for other provider groups.	Initiatives for interdisciplinary education are in early stages of development. Collaborative Practice Training initiative is under development. The University of Manitoba is setting up a Health Sciences Council to examine interprofessional education.	Yes (multiple disciplines)
Ontario	Completed specific plans for physicians and nurses. Broader Health Human Resources strategy is under development.	Ontario has funded a joint project with the Ministry of Health and Long-Term Care, McMaster University and University of Toronto to design a collaborative service delivery model and interdisciplinary educational curricula for family physicians, nurse practitioners and pharmacists. The new Northern Ontario School of Medicine incorporates interdisciplinary learning with students from a range of health professions. A number of proposals are presently under consideration which support primary health care and interdisciplinary family health teams. A number of demonstration projects are underway through Ontario's Primary Health Care Transition Fund initiatives.	Yes (physicians, nurse practitioners, nurses and other professions)
Quebec	A plan is under development and linked to a health system redesign currently underway.	Interdisciplinary education is not a current priority.	Yes (largely nurses, some physicians)

A.7: Summary of Health Human Resources Initiatives by Jurisdiction — cont'd

Jurisdiction	Health Human Resources Plan	Interdisciplinary Education	Recruitment and Retention Initiatives
Nova Scotia	Phase one of Health Human Resources strategy is completed for 30 occupations. Phase two is underway with the Atlantic Advisory Council on Health Human Resources.	Programs at Dalhousie University provide opportunities between the faculties of dentistry, health professions and medicine and pharmacy.	Yes (physicians and nurses, medical laboratory technologists)
New Brunswick	Province has completed supply forecast models for all health care professions, including physicians, and is participating in the development of an Atlantic education and training forecasting model.	The Province is working with its Atlantic partners on providing interdisciplinary training to health professionals. This program, "Building a Better Tomorrow", is funded through the regional projects envelope of the Primary Care Health Transfer Fund.	Yes (physicians and nurses) Developing plans for other professions
Newfoundland and Labrador	A comprehensive skill mix framework is being developed. Recommendations for developing a Health Human Resources planning model are being implemented.	Memorial University is leading discussions through the Centre for Collaborative Health Professional Education. Projects are being developed.	Yes (physicians, nurses, allied health professions)
Prince Edward Island	Phase one is completed to profile all health and social service professions. Phase two implementation is underway. Five-Year Health Human Resources Plan for the Health System is in the final draft stages.	PEI has adopted more of a focus on collaboration at the work place, as the province does not have a medical school to facilitate interprofessional education.	Yes (physicians, nurses, radiation technologists, radiation therapists, and medical laboratory technicians)
Northwest Territories	Five Year Human Resources plan has been developed.	Interdisciplinary education is not a current priority.	Yes (physicians, nurses and hard to recruit health professionals such as Pharmacists and Audiologists. Emphasis is on the development of Community Health Nurses.)
Yukon	Focus is on recruitment and retention.	Focus is on collaboration in the workplace and interdisciplinary management of chronic diseases.	Yes (physicians and nurses)
Nunavut	Focus is on telehealth and recruitment.		Yes (primarily nurses), although, with recruitment, the physician complement has been increased by three.

A.8: Health Human Resources Recruitment and Retention Initiatives by Jurisdiction

A. Recruitment	BC	AB	SK	MB	ON	QC	NS	NB	PE	NL	YK	NT	NU
IMGs	√	√	√	√	√	√	√	√	√	√			
Financial assistance for immigration							√						
Advertisement (i.e. website, job fairs)	√	√	√	√	√		√	√	√	√	√	√	√
Tuition reimbursement	√		√	√	√				√			√	√
Loan assistance	√				√		√				√		
Bursary	√		√	√	√		√	√	√	√	√	√	√
Accommodations					√		√	√					√
Incentives — education programs enrolment	√		√	√			√	√	√	√	√	√	√
Summer jobs for students	√	√	√		√	√		√	√	√		√	√
Locum support	√		√	√	√		√	√	√		√	√	√
Full-time jobs for graduates	√*				√	√	√	√	√	√		√	
Encourage flexible workload	√		√						√				√
Aboriginal strategy	√	√	√	√	√							√	√
Relocation assistance	√			√	√		√		√	√	√	√	√
Nurse Practitioners — implementation in process	√			√	√	√	√	√	√	√	√	√	√
Recruiting Officer/Planner	√			√	√		√	√	√	√		√	√
Rural strategy	√	√		√	√		√	√	√				

A.8: Health Human Resources Recruitment and Retention Initiatives by Jurisdiction — cont'd

B. Retention	BC	AB	SK	MB	ON	QC	NS	NB	PE	NL	YK	NT	NU
Research/analysis of workforce data	√		√	√	√		√	√	√	√			√
Job satisfaction survey	√		√					√			√		
Recognition incentives	√*					√							√
Supporting continuing education	√*		√	√	√		√		√	√	√	√	√
Address quality of work life issues	√		√	√	√				√	√	√		
Career laddering	√		√		√				√	√		√	
Mentorship	√		√		√			√			√	√	√
Skills upgrade/professional development	√		√		√	√		√	√	√	√	√	√
Creating multi-skilled positions						√						√	
Creating full-time float pools	√*		√		√						√	√*	√
Job share	√*				√		√	√			√	√	√
Recruitment luncheons	√*							√	√				
Unlimited casual work	√*						√					√	√
Leadership funding	√		√		√								

*BC Implemented in some Health Authorities
*NL Items checked are largely coordinated and implemented by employers, not Government. Summer jobs vary by professional group and location. Availability of full time jobs varies by professional groups and locations and fluctuates during the year.
*NT Maximizing northern employment — the development of a northern workforce (including aboriginals).