

The Health Council of Canada: A Speculation on a Constructive Agenda

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Mr. Romanow and Senator Kirby each devoted several years and intense effort to studying the Canadian healthcare system. They both came to the view that a national health council is a good idea. Their shared hope was that a health council could bring evidence and reason to bear on health problems that are often buried in the rhetorical avalanche of intergovernmental combat. One suspects that most Canadians also prefer light to heat in health matters.

A health council is not a panacea. As it turns out, there are few panaceas in life or politics. It will not replace the contentious and difficult challenge of resolving federal-provincial conflicts in the health sector. A council should be seen for what it can be – a trusted source of policy advice outside the field of intergovernmental conflict. Regrettably, the construction of the council has fallen into the very same dysfunctional intergovernmental machinery that Romanow hoped it would counterbalance.

A health council is certainly still worth the effort. It will need, through deed rather than word, to prove itself to be a worthy ally of the Canadian public in improving the health system through constructive recommendations and honesty about real problems faced by patients and providers. It will need to prove itself a worthy ally of the provinces. It will achieve the respect of provinces, but not by becoming their advocate for more federal money. The premiers are well able to articulate that ongoing necessity. The council will come to be respected by the provinces only if it clearly understands their modestly divergent approaches to health reform and supports their most promising changes. It will need to be entirely pragmatic and evidence-driven. The council will need to leave the grand debates of ideology to others and focus on the practical challenge of getting Canadians the healthcare they need and want. The council also has an important

role to play in improving the health of Canadians.

The Council Will Need To Be Neither Big Brother nor Toothless Tiger.

Paul Martin, popular Prime Minister-in-waiting, recently issued a rare press communiqué. He supports the idea of a health council while indicating flexibility in its structure and mandate. His support strongly suggests that the council will come into existence later if not sooner.

More – not less – accountability and transparency is what Canadians want from those guiding their healthcare services. A council, well designed and chosen, offers much on this point. It must be truly national – not a federal organization. The core notion is greater accountability to Canadians, not greater accountability of one level of government to another. This goal is attainable with a bit of generosity of spirit on the part of all governments.

Avoiding Bureaucracy

The council should be lean and of modest budget. Where possible, the council should contract for its data from the Canadian Institute for Health Information and Statistics Canada. Much of the data the council will need is already in production or relatively easy to produce. The council should be constructive in the tone of its work. It should seek to assist the improvement of health and health services through education, analysis and persuasion. There is much constructive work to be done with others rather than in splendid isolation. The council should immunize

itself from the criticism of being too bureaucratic by becoming nimble, flexible and a respected partner. The council should judge its effectiveness by its impact on health and healthcare, not by its size or budget.

Setting an Agenda

Rather than following the winding trail of the council's journey through the machinery of intergovernmental affairs, let us consider what a council could accomplish. Once created, what could such a council usefully do? Are these tasks unique or is some other body already undertaking them? Can bureaucracy be avoided in favour of a lean and effective operation?

The appropriate starting point for a council agenda is the agreement of First Ministers. In both 2000 and 2003, First Ministers achieved agreement on both priorities and massive new dollars to be invested. The dollars were not quite as massive as the provinces had demanded but were still substantial. Even in healthcare, \$34 billion is a sizeable chunk of change.

Improving the Health of the Nation

How healthy are Canadians? This is a question well answered by Statistics Canada in a series of reports based on the Community Health Survey. How we could improve the health of the nation is a question yearning to be addressed by a council. What are the relative merits of tobacco reduction vs. cleaner water vs. better control of infectious diseases vs. better cancer screening and early detection? What would constitute a "Top 10" list of ways to improve the

health of Canadians, including actions by individuals, communities, governments and businesses? What if the council actually measured our annual progress toward health goals?

Improving Aboriginal Health

Aboriginal Canadians enjoy 10 years less life expectancy than the rest of the population. This is a national disgrace and a major challenge for leadership in our national community and within aboriginal communities. A huge opportunity exists for improvement. A health council could undertake the necessary analysis to determine patterns of health across First Nation communities. It could help all levels of government – federal, provincial and First Nation – to separate failed efforts from successful ones. With effort, we could dramatically narrow the gap between the life expectancy of our aboriginal peoples and the rest of the population.

Supporting Early Childhood Development

In the 2000 Accord, First Ministers agreed to an unprecedented investment of \$2.2 billion over five years in the area of early childhood development. Strong and successful advocacy for this investment came from Dr. Fraser Mustard and others.

Have the committed dollars been spent? How? Is there measurement of progress? What are the right indicators? Centrally, are the children of our nation healthier as a result? The council would be well positioned to ask and answer these questions with the help of Statistics Canada and those in the early childhood development field.

Monitoring Quality of Care/ Patient Safety

The best available estimates are that as many as 10,000 Canadians may die prematurely each year from failures of quality in our hospitals. How can the recommendations of the Patient Safety Initiative, endorsed by First Ministers, be monitored and corrective efforts measured? The health council, working with others such as the Royal College of Physicians and Surgeons and CIHI, should play a leadership role in educating the public and providers about methods of improving patient safety.

Addressing Waits for Health Care

The single issue of most concern to Canadians is waiting – waiting for diagnostic tests, waiting for cancer treatment. Waiting of any sort is the most upsetting issue for Canadians when it comes to the management of healthcare services. Our measurement of waiting and our ability to assess which waiting does harm is at an early stage. With the council's active participation, not only accurate measurement but also measurable improvements are reasonable goals. Provinces have already started to publish useful indicators in this field. Much could be done to communicate the real picture of waiting to the public.

Providing Home Care

First Ministers agreed to define a minimum set of services for home care by the fall of 2003 and to achieve implementation of this agreed basket of services by 2006. The council should monitor and measure both the current state of home care and progress toward

the goals established. The council could also share insights from the diversity of home-care programs in operation across the country.

Closing Gaps in Drug Coverage

One of the glaring holes in Canada's health insurance coverage has been gaps in drug coverage. First Ministers took up the Romanow and Kirby proposals to address this situation. The goal established in the 2003 Accord is that all Canadians, regardless of where they live, should have reasonable access to catastrophic drug coverage by 2005/06. Measuring progress towards this admirable goal as well as comparing the costs and benefits of drug management initiatives should be a key area for the health council.

Reforming Primary Care

Primary-care reform is a phrase with little meaning for most Canadians. Nevertheless, experts and ministers have supported primary-care reform as the most important change facing our healthcare system. The movement of primary care from a solo practice family doctor setting to a 24/7 multi-professional clinic model is a great dream of reform. First Ministers have pledged that by 2011, fully 50% of Canada's population will have access to these services. This is probably the most difficult challenge to be faced in health reform. Resistance to change is powerful. Misunderstanding is profound and there is plenty of potential for a stalemate. Although the council will need to tread carefully in this minefield, there is a valuable opportunity. Canada's exist-

ing system has a great deal of diversity at the community level. Across Canada, in communities as diverse as Sault Ste. Marie, Notre-Dame de Grace and Saskatoon, there is an array of successful primary-care models. The council could be the body which provides detailed success stories and the learning to replicate success in primary care.

Adopting Health Technologies

The \$1.1 billion allocated to Canada Health Infoway through the two Accords for implementation of the electronic health record is a huge investment intended to trigger a profound movement from paper records in the health system. Much benefit will accrue to patients and providers from automation. How is it going? What progress has been achieved? What obstacles remain to be overcome? A council could provide the public and health ministers with an independent assessment of how well this essential and expensive reform is going.

The Accord of 2000 put up \$1 billion over two years for a medical equipment fund. Because it was widely perceived as a fund for advanced medical diagnostics such as MRIs, the revelation of lawn mower purchases caused public consternation. The 2003 Accord added to the diagnostic/medical equipment fund and also committed First Ministers to a 2004 report on enhancements to diagnostic capacity. There is much good work for a council to do in this field. Convening expert panels to provide advice to hospitals and regional systems on best practices, charting wait times and providing clear guidance on progress are all steps a council might usefully take.

Addressing Human-Resource Supply Issues

There are real problems in the supply of highly skilled personnel within Canadian healthcare. Nurses, pharmacists and physicians are all facing important supply challenges. Canada faces a significant and entirely homegrown shortage of nurses. Reductions of up to 40% in nursing-school enrolments during the 1990s are now being addressed, but the shortage will remain a difficult issue. Physician policies, in the wake of Barer and Stoddard in the mid-1990s, were more carefully considered than nursing supply, but have also missed the mark. Gender changes in the physician workforce and the delay of primary-care reform have left a shortage of physicians in many parts of Canada.

A council could lead efforts to prevent future policy missteps and to develop monitoring of health human-resource supply and demand on a regular basis. Can you imagine the state of employment policy if, instead of the monthly Labour Force survey, we had only two-year-old data on unemployment? Why should health human-resource planning depend on stale-dated data?

Learning from International Comparisons

The council should also work closely with international organizations such as the World Health Organization, the Organization for Economic Cooperation and Development and others. Increasingly, Canada is measured by these international organizations. There is benefit to be derived in a better understanding of how we compare to other nations in the accomplishments and challenges within health and health-care. There are also risks that the indicators chosen may place Canada at an unfair disadvantage.

Conclusion

There is a full and important agenda for a council to take up. There is much worthwhile work to be done. It could even be fun!

The efforts to secure agreement on a health council will continue. Actual implementation may need to await the new Prime Minister if logjams continue. What is of greatest importance is that the health council, once established, move forward rapidly with an ambitious but realistic agenda.



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