Assessing Progress on Health Care Transformation: 2010-2014

May 2014

Health Care Transformation Board Working Group

Canadian Medical Association
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Appendix A: HCT Board Working Group Accomplishments

Appendix B: Publications of Health Care Transformation by Source

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List of Acronyms

ABF – Activity-based funding
CIHI – Canadian Institute for Health Information
CMA – Canadian Medical Association
CNA – Canadian Nurses Association
CW – Choosing Wisely
CWF – The Commonwealth Fund
GC – General Council
HCT – Health Care Transformation
HIT – Health Information Technologies
LTC – Long-Term Care
OECD – Organisation for Economic Co-operation and Development
PCC – Patient-Centred Care
PTMA – Provincial and Territorial Medical Association
P4P – Pay-for-Performance
WHO—World Health Organization
Executive Summary

The purpose of this document is to provide an assessment of progress to date on the Canadian Medical Association’s (CMA) Health Care Transformation (HCT) initiative; specifically progress toward the overall goal of Canada achieving the best health and health care by 2025. The foundational document of CMA’s HCT initiative is *Health Care Transformation in Canada: Change that Works Care that Lasts*, adopted by the CMA Board in July 2010.

It takes time to transform any system including the country’s largest publicly funded program. That is why CMA has set a target of having the best health and health care system by 2025. Progress on HCT is reported two ways: a narrative summary of actions undertaken in support of each HCT principle since 2010; and a review of pertinent health system indicators using 2010 as the base year for comparison—the year the HCT commenced.

An assessment of progress to date is made based on a review of activities undertaken by CMA, governments and other stakeholders since HCT began in 2010, as well as Canada’s overall performance on 41 HCT indicators organized under the six HCT principles.

With respect to the indicators, 46% have shown positive change in Canada since 2010; however, Canada is best in class for only 21% of the 41 indicators (i.e., in top 1/3 of countries). While Canada compares well internationally in regards to patient satisfaction with medical care received and its low levels of smoking, it has a lot of ground to make up in terms of its lack of universal drug coverage, its relatively high levels of out-of-pocket health care spending, its lengthy wait times for a wide range of care and its patient safety rates (e.g., hospital acquired infection rate).

1. Purpose

The purpose of this document is to provide an assessment of progress to date on the Canadian Medical Association’s (CMA) Health Care Transformation (HCT) initiative; specifically progress toward the overall goal of Canada achieving the best health and health care by 2025.

The foundational document of CMA’s HCT initiative is *Health Care Transformation in Canada: Change that Works Care that Lasts*, adopted by the CMA Board in July 2010.¹ The report noted that Canada’s health care system needs to be “massively transformed” given that the current system is unable to meet Canadians’ present and future health care needs. Furthermore, Canada’s health care system performs poorly when compared to health systems in other leading industrialized countries as seen in numerous health care reports:

CIHI, International Comparisons: A Focus on Quality of Care⁡

Provincial and international health care systems are compared in terms of quality of care. CIHI found that the results of these comparisons are mixed, with no province being consistently the best or worst performer across the Organisation for Economic Co-operation and Development (OECD) quality of care indicators.

CIHI, Benchmarking Canada’s Health System: International Comparisons³

CIHI’s report looks at 72 health system performance indicators and reveals large variation in how Canada ranks internationally. It is among the best for some indicators, such as potentially avoidable hospital admissions for diabetes and asthma and overall stroke mortality. However, improvements can be made when looking at patient safety indicators, including obstetric trauma and foreign objects left in after surgery.

Health Council of Canada, Where you live matters: Canadian views on health care quality⁴

Canada shows largely disappointing performance compared to other high-income countries, some of which have made impressive progress. Also, there is considerable variation among provinces.

Conference Board of Canada, How Canada Performs⁵

Canada finished 10th out of 17 peer OECD countries on 11 health indicators (overall grade of “B”).

Euro-Canada Health Consumer Index, 2008⁶

Canada ranked 23rd out of 30 countries on this index; ranked last (30th) in terms of value for money spent on health care (US was not included).

CMA’s HCT initiative has been directed by a Board Working Group (BWG) that was struck in 2009, expanded to include PTMA representation in 2011 and reconstituted annually. See appendix A for a list of activities accomplished by the BWG.

2. Methodology

CMA’s HCT initiative has been organized under the HCT Strategy Map depicted below.

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Accordingly, this report is organized by the HCT Strategy Map headings which are based on the CMA/CNA principles to guide health care transformation in Canada organized under the Institute for Healthcare Improvement’s Triple Aim Framework:

**Best Health Care (Enhance the health care experience)**

P1: Patient-centred

P2: Quality

**Best Health (Improve population health)**

P3: Health promotion and prevention

P4: Health equity

**Best Value (Improve value for money)**

P5: Sustainable

P6: Accountable.\(^7\)

In addition, an assessment is also provided for the following “Learning and Growth” elements to the HCT Strategy Map:

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\(^7\) Canadian Medical Association and Canadian Nurses Association. *Principles to guide health care transformation in Canada.* Ottawa. July, 2011. The definitions of each of these principles are provided in the following sections.

L2: Health human resources
L3: Information and tools (health information technology – HIT).

It is recognized that these categories are interconnected. For instance, improvements in HIT can facilitate actions related to improvements in quality, health promotion and accountability.

There are a number of health system indicator initiatives underway most recently, the Canadian Institute for Health Information’s recently released framework of 15 indicators to assess health system performance (http://ourhealthsystem.ca/). While this work is important, this CMA report is focused on measuring the enablers to support health care transformation and assessing progress toward the overall goal for Canada to achieve the best health and health care by 2025.

Reporting progress on HCT is provided two ways in this report: a narrative summary of actions undertaken in support of each HCT principle since 2010; and a review of pertinent health system indicators using 2010 as the base year for comparison—the year HCT commenced. For the purposes of benchmarking (i.e., working towards a desired target), we identify the leading country and leading Canadian practices since our ultimate goal is for Canada to have the best health and health care system by 2025. It is recognized that it will take several years for Canada to attain this goal so evidence of progress can expect to be gradual.

3. Raising awareness: Making HCT a priority for health system stakeholders

The first step to fix a problem is to admit/identify there is in fact a problem. For years Canada has been self-reporting as having “the best health care system in the world”. But international comparisons have not supported this claim—in fact, Canada has been a middle of the pack performer at best when compared to other leading industrialized countries. The result has been the absence of a “burning platform” in which to drive change.

CMA’s HCT initiative has been successful in helping Canadians and its decision makers recognize that Canada does not have a leading health care system and that change is required to improve it. The significance of this development cannot be overlooked.

The term “health care transformation” is cited now more than ever likely in part due to CMA’s HCT initiative. A search of health care databases and Canadian government websites shows an increase in new articles/content referring to health care transformation from 2009 to 2012. This increase includes documents posted on Government of Canada and provincial government websites (See Appendix B). Furthermore, the report of the Standing Senate Committee on Social Affairs, Science and Technology reviewing the 2004 Health Accord was entitled, *Time for Transformative Change*, while the Ontario

8 Note: Searches included the terms “healthcare”, “health-care” and “health care” AND “transformation.
Ministry of Health and Long-Term Care established a Transformation Secretariat to oversee its HCT activities.

In terms of HCT media coverage, there have been 193 Canadian media stories related to HCT between 2009 and 2012, with a peak of 100 stories in 2010.

CMA’s separate Health Care Transformation website (http://healthcaretransformation.ca/) has also seen increased attention. Starting with 928 visits in 2011, website visits have risen steadily with 33,000 visits in 2012 and 86,000 visits in 2013 (see Appendix B for details).

Anecdotally, federal government officials have commented that CMA’s multi-year focus on HCT has been effective in reaching elected officials and senior bureaucrats.

4. Overall HCT Results

How do we know if progress is occurring with health care transformation? One thing is for certain—it takes time to transform any system including the country’s largest publicly funded program. That is why CMA has set a target of having the best health and health care system by 2025. A five-year goal would be unrealistic.

In Good to Great, Jim Collins illustrated the move from good to great in the form of a flywheel. Collins notes that dramatic transformations are never the result of a single defining action or innovation. Rather, the process usually resembles a number of small efforts pushing a giant heavy flywheel in one direction, turn upon turn, building momentum until a point of breakthrough and beyond when the weight of the flywheel starts working in the desired direction not against it. Each turn of the flywheel builds upon previous efforts.

Still, it is important to monitor progress, however slight it might be. Figure 1 identifies two stages: where we were at before HCT in 2010 and a desired end state that would signal that health care transformation is taking place in Canada.

**Figure 1: Signs of Progress on HCT**

<table>
<thead>
<tr>
<th>FROM (Pre 2010 HCT)</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belief that Canada’s health care system is working well</td>
<td>Recognition that Canada’s health care system is not performing well and requires transformative change</td>
</tr>
<tr>
<td>Patient not at centre of system</td>
<td>Patient at centre of system and more engaged in care process and in system governance</td>
</tr>
<tr>
<td>Health system funding lacking incentives to improve timely access and quality (e.g., global budgets for hospitals)</td>
<td>Incentives in place to support institutions (e.g., activity-based funding) and providers to provide timely access to quality care</td>
</tr>
<tr>
<td>Lack of/uneven access to the full continuum of care, particularly pharmaceuticals and continuing</td>
<td>Sustainable funding programs in place to ensure all Canadians have access to prescription drugs and</td>
</tr>
</tbody>
</table>

10 Tom Collins, Good to Great: Why Some Companies Make the Leap...And Others Don’t. 2001.
care (i.e., home care, residential care) | continuing care (i.e., home care, residential care)  
--- | ---  
**Average performance on key health status indicators compared to peer countries** | Consistent top 5 performer on key health status indicators  
**Lack of awareness of impact of inequities in social determinants of health on health status (e.g., poverty)** | Significant awareness of impact of social determinants on health status; policies in place to reduce inequities  
**Lack of system accountability** | Structures in place to report on health system performance at the national, provincial and territorial levels  
**Inadequate supply/shortages of health human resources** | Greater stability of HHR supply and demand based on population needs through coordinated, long-term planning at the federal, provincial and territorial levels  
**Little adoption of health information technology/directed largely at institutions** | Significant adoption of health information technology, particularly in ambulatory care settings; accelerated exchange of health information  

Changes in each of the above areas onto themselves will not transform our health care system. Moreover, they do not represent an exhaustive list of steps. Rather, we have identified a number of action steps, or pushes to use the flywheel example, that CMA’s HCT initiative can help start the momentum swing in in the right direction such that our system becomes more effective for our patients.

An assessment of progress to date is made based on a review of activities undertaken by CMA, governments and other stakeholders since HCT began in 2010, as well as Canada’s overall performance on 41 HCT indicators organized under the six HCT principles. Table 1 summarizes the results of the indicators as well as identifies some of the developments that have taken place since 2010.

With respect to the indicators, 46% of them have shown positive change in Canada since 2010; however, Canada is best in class for only 21% of the 41 indicators (i.e., in top 1/3 of countries). While Canada compares well internationally in regards to patient satisfaction with medical care received and its low levels of smoking, it has a lot of ground to make up in terms of its lack of universal drug coverage, its relatively high levels of out-of-pocket health care spending, its lengthy wait times for a wide range of care and its patient safety rates (e.g., hospital acquired infection rate).
Table 1: Summary table on HCT progress since 2010\textsuperscript{11}

<table>
<thead>
<tr>
<th>Category</th>
<th>Improvements since 2010 (# of indicators that are trending favourably based on available data)</th>
<th># of best in class performances with comparator countries</th>
<th>Examples of progress/improvements</th>
<th>Areas lacking progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centred</td>
<td>1/2</td>
<td>1/5</td>
<td>Patient Charter in Alberta to be finalized; CMA’s development of HCT principles and creation of Patient Forum</td>
<td>Need for wider adoption of patient charters</td>
</tr>
<tr>
<td>Quality</td>
<td>4/7</td>
<td>4/13</td>
<td>Activity-based funding underway in some provinces; CMA launch of Choosing Wisely in Canada</td>
<td>Continued lengthy wait times for patients; high rates of hospital readmissions</td>
</tr>
<tr>
<td>Health promotion and prevention (HP&amp;P)</td>
<td>3/5</td>
<td>1/6</td>
<td>Development of several health promotion policies by CMA; Tobacco consumption continues to decrease</td>
<td>Rising obesity levels; lack of strategy to integrate HP&amp;P in health care system</td>
</tr>
<tr>
<td>Health equity</td>
<td>0/2</td>
<td>1/3</td>
<td>CMA raising awareness of social determinants of health (e.g., 2013 Town Hall meetings)</td>
<td>Need for adoption of healthy public policy framework at federal level</td>
</tr>
<tr>
<td>Sustainable</td>
<td>1/3</td>
<td>0/2</td>
<td>CMA call for pan-Canadian Seniors Strategy; approval of plan in New Brunswick to cover drug costs for uninsured</td>
<td>Gaps in drug and LTC coverage across Canada</td>
</tr>
<tr>
<td>Accountable</td>
<td>1/1</td>
<td>0/1</td>
<td>CIHI’s performance framework; Wait Time Alliance and CMA annual report cards</td>
<td>Lack of national body to oversee health system performance</td>
</tr>
<tr>
<td>Health human resources</td>
<td>1/3</td>
<td>Na</td>
<td>Increased supply of physicians since 2010; development of CMA action plan on physician human resources.</td>
<td>No national HHR planning process</td>
</tr>
<tr>
<td>Health information technology (HIT)</td>
<td>1/1</td>
<td>0/3</td>
<td>Increased spread of EMRs by physicians</td>
<td>Need for better integration of ambulatory care settings; e-prescribing</td>
</tr>
</tbody>
</table>

\textsuperscript{11} Based on available data. See Appendix C for sources of data.
Summary of progress by category

A. Patient-Centred Care

The patient must be at the centre of health care. Patient-centred care is seamless access to the continuum of care in a timely manner, based on need and not the ability to pay, that takes into consideration the individual needs and preferences of the patient and his/her family, and treats the patient with respect and dignity. Improving the patient experience and the health of Canadians must be at the heart of any reforms.

A strong primary health care foundation as well as collaboration and communication within and between health professional disciplines along the continuum are essential to achieving patient-centred care.12

The key action recommended by CMA to build a culture of patient-centred care (PCC) was the adoption of a PCC charter. A model charter was included in CMA’s 2010 HCT report. Patient charters have been implemented in a number of countries, most notably by England’s National Health Service.13

In Canada, progress toward the adoption of a PCC charter has been very limited. Saskatchewan’s Patient First initiative has been influential in shaping that province’s health quality efforts to be patient-centred including the Saskatchewan Surgical Initiative – Putting the Patient First. However, no patient charter has been adopted in that province as of yet.

The Alberta Health Act was passed in 2010 and provides for the creation of a health charter and the position of a health advocate to monitor it. The Act subsequently came into force on January 1, 2014. One of the objectives of the newly appointed public health advocate will be to finalize the actual wording for the patient charter. It is hoped that this development will provide significant impetus for advocacy in other jurisdictions to initiate a PCC Charter.

Patient-centred care was one of six principles developed by CMA in partnership with the Canadian Nurses Association in 2011 to guide HCT and which serves as the framework for this report. The principles have been adopted by 134 organizations, many of which are patient advocacy organizations. Moreover, CMA has been active in establishing and supporting a Patient Forum comprised of over 50 patient-representative groups from across Canada.

Six indicators were used to assess Canada’s performance on patient-centred care. The indicators are shown in Table 2.

### Table 2: Patient Centred Care (PCC) Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to Date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Canadian jurisdictions that have implemented a patient charter</td>
<td>1 (in process) Alberta’s newly established public health advocate is to finalize a patient charter</td>
<td>NHS Constitution - England</td>
</tr>
<tr>
<td>Doctor explains things to me in a way that is easy to understand (CWF 2013)</td>
<td>67%</td>
<td>81% - Germany</td>
</tr>
<tr>
<td>% of primary care physicians reporting that patients can electronically request appointments or referrals online (CWF 2012)</td>
<td>7%</td>
<td>66% - Sweden</td>
</tr>
<tr>
<td>Practice has arrangement for patients after-hours care to see doctor or nurse (CWF 2012)</td>
<td>45%</td>
<td>95% - United Kingdom</td>
</tr>
<tr>
<td>Doctor/medical staff always involve me as much as I want to be in decisions about my care/treatment (CWF 2013)</td>
<td>60%</td>
<td>76% - New Zealand</td>
</tr>
<tr>
<td>Regular doctor spent enough time with me in consultation (CWF 2010)</td>
<td>81%</td>
<td>93% - New Zealand</td>
</tr>
</tbody>
</table>

### B. Quality

Canadians deserve quality services that are appropriate for patient needs, respect individual choice and are delivered in a manner that is timely, safe, effective and according to the most currently available scientific knowledge. Services should also be provided in a manner that ensures continuity of care. Quality must encompass both the processes and the outcomes of care. More attention needs to be given to ensuring a system-wide approach to quality.  

After the decade-plus preoccupation with the access dimension of quality there is growing interest in a comprehensive quality agenda. To date, there are a total of eight health care quality and patient safety councils in Canada – Canadian Patient Safety Institute (CPSI), Saskatchewan Health Quality Council (HQC), the British Columbia Patient Safety and Quality Council (BCPSQC), the Health Quality Council of Alberta (HQCA), Manitoba Institute for Patient Safety (MIPS), Health Quality Ontario (HQO), Quebec

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Health and Welfare Commissioner, and New Brunswick Health Council – and four health quality reporting agencies that have some affiliation with quality reporting – CIHI, Canadian Institute for Health Research, (CIHR), Statistics Canada, and the Health Council of Canada (until March 31 2014).

While national agencies such as the Canadian Patient Safety Institute address aspects of quality there is no national organization with a mandate to drive quality improvement such as the U.S. Institute for Healthcare Improvement (IHI). In the past several years several provincial and territorial medical associations (PTMAs) have invested significantly in practice redesign and this is an area of recent activity at CMA.

**Timely access to care**

Progress on improving timely access to care has been inconsistent. Wait time reductions vary considerably across the country and in regions within provinces. For the past two years, the Wait Time Alliance (WTA) has reported a lack of progress on wait times for the list of procedures identified in the 2004 Health Accord (hip and knee replacement, CABG, cataract surgery, radiation therapy, and diagnostic imaging) as well as on a wider array of other services such as emergency department wait times.

A number of wait-time initiatives have taken place since 2010 to address structural issues contributing to wait times including increased use of centralized-intake systems and the pooling of wait lists. CMA has developed a referral and consultation process toolbox that showcases successful Canadian initiatives that have reduced waits for specialist referrals and consultations and shares lessons learned.15

In addition, there has been some progress toward implementing funding models that enhance timely access to care. Activity-Based Funding (ABF) for hospitals and other institutions has almost taken on a life of its own. The Canadian Institute for Health Information has convened two national meetings, and BC has launched into ABF in a significant way. Other jurisdictions are showing active interest as well. In terms of Pay-for-Performance (P4P) for physicians, implementation has occurred in some form in several provinces (e.g. British Columbia, Saskatchewan, Ontario and Nova Scotia).

**Appropriate care**

Another key dimension of quality is appropriate care. The issue of improving the delivery of appropriate care has received considerable attention by provincial/territorial governments and providers alike. CMA has been playing a lead role in the area of appropriateness by developing a Canadian version of the US Choosing Wisely (CW) initiative. CW engages specialty societies in collaboration with Consumer Reports to identify a “top 5” list of interventions that have been shown not to benefit a substantial proportion of patients receiving them and which a patient and physician should discuss before proceeding. To date, the Canadian effort known as Choosing Wisely Canada16, has engaged eight specialty societies plus the CMA’s Forum on General and Family Practice Issues (GP Forum) in a first wave of procedures and tests released on April 2, 2014. Several more specialty societies will be releasing additional lists this fall.

15 [http://www.cma.ca/referrals](http://www.cma.ca/referrals)

16 [www.choosingwiselycanada.org](http://www.choosingwiselycanada.org)
A number of indicators were used to assess Canada’s performance on quality care. Canada performed well in terms of patient satisfaction on medical care received in the past 12 months; however, there is a sizeable gap between Canada and best-in-class countries on several other indicators.

Table 3: Quality Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to Date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Satisfaction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Received excellent or very good medical care from my doctor/clinic in past 12 months (CWF 2013)</td>
<td>74%</td>
<td>85% - New Zealand</td>
</tr>
<tr>
<td><strong>Access</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Move to adopt activity-based funding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adoption of P4P initiatives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients reporting same/next day FP visit (CWF 2013)</td>
<td>41% (Highest: 46% in BC; lowest: 31% in NL)</td>
<td>76% - Germany; Canada is last among 11 countries</td>
</tr>
<tr>
<td>Patients reporting waited 4 hours or more in ED (CWF 2013)</td>
<td>26%</td>
<td>1% - Netherlands</td>
</tr>
<tr>
<td>Patients reporting waited more than 1 month to see specialist (CWF 2013)</td>
<td>59%</td>
<td>17% - United Kingdom</td>
</tr>
<tr>
<td><strong>Appropriateness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Readmissions (CIHI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidable hospital admissions (per 100,000)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• COPD</td>
<td>199.5</td>
<td>23.5 - Japan</td>
</tr>
<tr>
<td>• Asthma</td>
<td>14</td>
<td>11.4 - Italy</td>
</tr>
<tr>
<td>• Diabetes</td>
<td>81</td>
<td>54.2 - Italy</td>
</tr>
<tr>
<td>Mental health patients with at least three hospital stays in a year (CIHI)</td>
<td>10.9% (2010-11)</td>
<td></td>
</tr>
<tr>
<td>Caesarean section rate (inpatient per 1,000 live births) OECD</td>
<td>261 (2010)</td>
<td>161 - Finland, 2011</td>
</tr>
<tr>
<td>Safety</td>
<td>Decreasing: 100 in 2009-10; 89 in 2012-13</td>
<td>A doctor or pharmacist has reviewed all of my medications with me in past 12 months (CWF 2013)</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospital Deaths (Hospital Standardized Mortality Ratio) (CIHI)</td>
<td></td>
<td>Hospital acquired infection rate (WHO)</td>
</tr>
<tr>
<td>Rate of a foreign body left inside the body during a procedure, per 100,000 medical and surgical discharges (age 15+) (OECD)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### C. Health promotion and prevention

There is a significant toll that preventable mortality and morbidity – from tobacco use, injury, lack of physical activity and many other causes – take on Canadians. They are also a major threat to the sustainability of Canada’s health care system. For instance, the Canadian Diabetes Association estimates that diabetes will cost Canada nearly $17 billion a year by 2020 – up from $6.3 billion in 2000. Ninety per cent of all diabetes is the so-called Type 2, which is almost entirely due to preventable risk factors such as poor diet, obesity and lack of physical activity. Type 2 diabetes is only one of a number of major diseases whose impact on Canada could be reduced by a focus on prevention and health promotion.⁴⁸

In its 2012 brief to the House of Commons Standing Committee on Health, the CMA noted it is very important that both governments and the health sector define the ideal role for health promotion and disease prevention in Canada’s health care system and develop a strategy to implement that role. This strategy should include public policies that support health (healthy public policy), education to Canadians on how to live a healthy lifestyle, and action to reduce the social and economic conditions that create health inequities.

Physicians and other health professionals promote health and prevent disease by providing lifestyle counseling, behavioural support and clinical preventive services such as immunization and cancer screening. However, the capacity of Canada’s health care system to provide health promotion and

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disease prevention services needs to be enhanced in a number of ways beginning with ensuring all Canadians have access to a primary care provider.\textsuperscript{19}

Canada’s health Ministers have adopted a \textit{Declaration on Prevention and Promotion} and a framework to address childhood obesity but have not yet established a resourced action plan that engages stakeholders at the national and provincial/territorial levels.

CMA’s long tradition of engagement in health promotion and illness prevention issues has continued under HCT. Under the stewardship of its Committee on Health Care and Promotion (CHCP) a number of new policies have been adopted since 2010 including:

- The Built Environment and Health;
- Impact of Chemical Contamination on Human Health;
- Climate Change and Human Health;
- Health and Health Care for an Aging Population;
- Medication Use and Seniors;
- Body Checking in Youth Ice Hockey, Head Injury and Sport;
- Restricting Marketing of Unhealthy Foods and Beverages to Children and Youth in Canada;
- Joint statement on the Role of Health Professionals in Tobacco Cessation; and
- Recommended Guidelines for Low Risk Drinking.

CMA has also endorsed a Pan Canadian Framework on the Prevention and Control of Hypertension, and a Joint Statement on Sexual and Reproductive Health, Rights and Realities and Access to Services for First Nations, Inuit and Metis Peoples in Canada. The CHCP is also engaged in a number of continuing health promotion policy areas such as antibiotic resistance, mental health, impact of the processed food industry on health, and a revision of the physical activity and healthy eating policy to reflect a broader approach to healthy living.

CMA often works in partnership with other national health care organizations and participates on topic-specific coalitions related to health promotion and illness prevention. This work has increased since 2010 allowing CMA to advance policy positions in collaboration with others. The Canadian Concussion Collaborative is working to improve awareness of the risks of concussion in sport, and the education of health professionals in the management and treatment concussion. The Hypertension Advisory Committee has focused its work on food and nutrition factors that impact cardiovascular disease with an emphasis on the marketing of unhealthy food and beverages to children, the role of sodium in chronic disease, and advocacy for better regulation on nutrient ingredients and food labelling. The Canadian Alliance on Mental Illness and Mental Health is advocating for a stronger mental health care system in Canada. The Canadian Coalition for Public Health in the 21\textsuperscript{st} Century continues to advocate for more investment and human resources in the public health system. CMA’s work with Immunize Canada emphasizes the importance of immunization through advocacy for government funding of new NACI

approved vaccines, and public education. In 2012 CMA joined the Chronic Disease Prevention Alliance of Canada. Its key issues are the role of the social determinants of health related to chronic disease and advocating the adoption of a health impact assessment process.

Table 4: Health promotion and prevention indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to Date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily smokers (OECD)</td>
<td>15.7% (2011) 17.5% (2008)</td>
<td>13.1% Sweden</td>
</tr>
<tr>
<td>Obesity (body mass index greater than 30) 2011</td>
<td>17.7%</td>
<td>2.1% - Korea; 11% - Sweden</td>
</tr>
<tr>
<td>Infant mortality per 1,000 live births (OECD)</td>
<td>4.9 (2009) 5.4 (2005)</td>
<td>0.9 – Iceland; 2.1 – Sweden (2011)</td>
</tr>
<tr>
<td>Received flu shot in the past year (CWF 2013)</td>
<td>35%</td>
<td>49% - US</td>
</tr>
<tr>
<td>Potential years of life lost–females (deaths before 70 years of age per 100,000) (OECD)</td>
<td>2505 (2009)</td>
<td>1790 – Spain (2011)</td>
</tr>
<tr>
<td>Potential years of life lost – males (deaths before 70 years of age per 100,000) (OECD)</td>
<td>3926 (2009)</td>
<td>3029 - Switzerland (2011)</td>
</tr>
</tbody>
</table>

D. Health equity

Improve equitable access to quality care and strengthen advocacy for multi-sectoral policies to address the social determinants of health.20

Ensuring equitable access to effective and appropriate health care services is one strategy which can help mitigate health inequities resulting from differences in the social and economic conditions of Canadians. Yet, there is far ranging evidence indicating that access to care is not equitable in Canada. Those with higher socio-economic status have increased access for almost every health service available, despite having a generally higher health status and therefore a decreased need for health

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care. This includes insured services (such as surgery), as well as un-insured services such as pharmaceuticals and long-term care.

Barriers to equitable access occur on both the patient, and health care system or supply side. To tackle barriers on the patient side there is a need to reduce barriers such as lack of transportation and the prohibitive cost of some medically necessary services. Further, there is a need to increase the health literacy of patients and their families/caregivers as well as increasing the ability of health care providers to contribute to a culturally secure client-provider interaction to ensure that all patients are able to be active participants in the management of their care.

On the system side the strategies for action fall into four main categories: patient-centred primary care which focuses on chronic disease management; better care coordination and access to necessary medical services along the continuum of care; quality improvement initiatives which incorporate considerations of equity as part of their mandate; and health system planning and assessment which prioritizes equitable access to care.

While these strategies offer some hope, these actions alone will not be sufficient to increase the overall health of the Canadian population. Action is still required to tackle the underlying social and economic factors which lead to the disparities in the health of Canadians.

CMA has undertaken a number of initiatives aimed at addressing health equity. A policy on the role of the medical profession in addressing health equity was approved in 2012. Research was completed the same year on actions on health equity that could be undertaken at the clinical level. A paper on equitable access to care was approved by the Board in December 2013. Additionally, work is continuing on an online CME module on addressing poverty in practice. This will be completed in early 2014. CMA has also begun preliminary work on developing a health equity tool-kit for physicians.

From February-May 2013, CMA in conjunction with Macleans’ magazine, CPAC and L’actualité hosted a series of town halls on the social determinants of health. Sessions were held in Winnipeg, Hamilton, Charlottetown, Calgary, Montreal, and St. John’s. CMA hosted an online component to these town halls as well. The website www.healthcaretransformation.ca carried a series of articles and developed two infographics to educate the public about the importance of the social determinants for their overall health. Once the CMA town halls were completed, a final report was produced which provided an overview of the consultations.
Table 5: Health equity indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to Date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of patients 12 years and older reporting they had a regular medical doctor (Statistics Canada)</td>
<td>85.1% (Highest: 93% in NB; Lowest: 17.9% in Nunavut, 75.2% in Que.)</td>
<td>100% - Netherlands</td>
</tr>
<tr>
<td>Unable to fill prescription or skipped dosages due to cost (CWF 2013)</td>
<td>8% (Highest: 14.5% - NB; lowest: 5% Sask/QC)</td>
<td>2% - United Kingdom</td>
</tr>
<tr>
<td>% of adults who did not see doctor when sick or did not get recommended care because of cost (CWF 2013)</td>
<td>5%</td>
<td>2% - United Kingdom</td>
</tr>
<tr>
<td>Awareness of the social determinants of health—% of Canadians rating the following as having a great impact on a person’s health:</td>
<td></td>
<td>28% - US; 16% New Zealand</td>
</tr>
<tr>
<td>• Employment status</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>• Education level</td>
<td>24%</td>
<td></td>
</tr>
<tr>
<td>• Income level (Ipsos Reid, 2012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

E. Sustainable

For the purposes of this review, sustainability is viewed as ensuring universal quality health services along the full continuum are adequately resourced and delivered in a timely and cost-effective manner. In recent years, attention has been given to increasing access to two important services: pharmaceutical coverage and continuing care (home care and residential care), both of which largely fall outside of the publicly insured Medicare basket.

Since 2010, CMA has been actively developing policy options to expand Canadians’ access to pharmaceuticals and home and residential care. This work has involved collaborating with a number of key stakeholders.

Continuing care
Home care has received scarce national policy attention over the past decade and residential care or long-term care (LTC) virtually none. This is likely to change toward the end of this decade, as the leading

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edge of the baby boom will reach age 75 in 2021, the age beyond which health care use increases dramatically.

There is evidence of wide variation across jurisdictions on indicators of home care and LTC. Data compiled by the Conference Board estimate almost three-fold variation across provinces in public per capita home care spending in 2010, ranging from $138 in New Brunswick to $48 in BC. To date a handful of countries have introduced a social insurance approach for long-term care. These include the Netherlands, Germany and Japan. However the health care systems of those countries are built on a social insurance (Bismarck) model.

The Canadian Life and Health Association has estimated that there will be a funding shortfall of $590 billion over the next 35 years in LTC costs and has recommended that the federal government introduce a vehicle like the Registered Education Savings Plan (sheltered after-tax income with a federal grant component) or else provide tax incentives for the purchase of LTC insurance.

General Council 2013 adopted a resolution calling on CMA to advocate for a pan-Canadian seniors strategy based on the guiding principles for HCT:

- Keep seniors at home as long as possible (e.g. fiscal measures to support community care organizations, increased support for informal caregivers, support for seniors’ home renovation; fall prevention strategy);
- Improve access to long-term care facilities (as part of the next Building Canada Plan, allocate funds to build and/or retrofit existing facilities); and
- Provide compassionate care at the end of life (National Dementia Strategy, increased funding for palliative care training for a range of providers).

The CMA has since called for the establishment of a pan-Canadian seniors care strategy to ensure seniors have timely access to necessary services across the full continuum of care. This strategy must include adequate supports for informal caregivers.

The federal government did announce modest tax breaks for informal family caregivers in 2011 but the maximum yearly amount of a $300 tax credit can only be viewed as a start at best.

**Prescription drugs**
Presently, Quebec is the only province to have mandated universal prescription drug coverage for its residents, either through private insurance or a public plan that it introduced in 1997.

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Research conducted for the CMA in 2012 showed that almost one in five households (18%) does not have supplementary insurance coverage that would cover prescription drugs.\(^{24}\) The Canadian Life and Health Insurance Association estimates that the industry provides supplementary coverage to more than 23 million Canadians which is roughly 2 out of 3.\(^{25}\) Moreover, in the absence of progress on a catastrophic drug program per the 2004 Health Accord commitments the life and health insurance industry announced a risk pooling initiative in 2012 that will protect fully insured private drug plans from the full financial impact of high cost drugs.\(^{26}\)

Internationally, many other countries in the Organization for Economic Cooperation and Development (OECD) provide some form of drug coverage for their citizens although not first dollar coverage. In the English National Health Service for example the current prescription charge is £ 7.65, although it is possible to get assistance.\(^{27}\)

In the second Parliamentary review of the 2004 Health Accord, the Standing Senate Committee on Social Affairs Science and Technology noted that lack of progress on catastrophic drug coverage. It put forward the following recommendation:

> That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate uses; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary.\(^{28}\)

Provinces have started to take action to address drug coverage in the past few years such as lowering the prices of generic drugs beginning with Ontario. New Brunswick has recently approved a plan to cover prescription drugs for uninsured residents.


Table 6: System sustainability indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel system works well and only minor changes are necessary (CWF 2013)</td>
<td>42% (38% in 2010)</td>
<td>63% - United Kingdom</td>
</tr>
<tr>
<td>% of Canadians covered by a drug plan</td>
<td>TBC</td>
<td>100% in most countries with universal health care systems</td>
</tr>
<tr>
<td>Out of pocket spending per capita (US PPP) (OECD, 2012)</td>
<td>$667</td>
<td>$298 – Netherlands</td>
</tr>
<tr>
<td>Establishment of arm’s length mechanism to monitor the financing of</td>
<td>Parliamentary Budget Office has</td>
<td>US – National Health Expenditure Accounts</td>
</tr>
<tr>
<td>health care programs for federal and provincial/territorial levels; assess</td>
<td>produced reports at the federal</td>
<td>produced by the Centers for Medicare and Medicaid Services</td>
</tr>
<tr>
<td>comparability of coverage across jurisdictions; assess value for money</td>
<td>level.</td>
<td></td>
</tr>
<tr>
<td>and make necessary recommendations to fund continuum of care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

F. Accountable

Another major pillar of the 2010 HCT report was the need to strengthen system accountability through good governance, responsible use of resources, public reporting and enforcement.

Pan-Canadian public reporting on health system performance is still a work in progress despite the vast number of performance indicators that currently exists. A number of organizations report on health system performance including the CMA through its annual report cards and the Wait Time Alliance that issues annual report cards on wait times by province.

There is a need to strengthen and unify the health system performance reporting in Canada to eliminate indicator chaos and to ensure that reporting actually supports the improvement efforts across the country. In response, CIHI initiated a three-year initiative in 2012 to de-cluster the indicators and to establish a structured and coordinated pan-Canadian reporting system that is tailored to the information needs of different audiences. This health system performance (HSP) initiative consists of a focused set of cascading metrics that provides meaningful and useful information to the respective audiences, and a revised framework for measuring HSP that is better suited to support jurisdictional

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improvement projects by demonstrating the interconnectivity among the various indicators and their roles in the larger picture (http://ourhealthsystem.ca/).

Following the December 19, 2011 announcement by the federal finance minister of a new fiscal framework for the Canadian Health Transfer, the federal health minister wrote to her provincial and territorial counterparts on two occasions to invite them to participate in the development of common performance metrics. However, there is no evidence that there have been any takers. The demise of the Health Council of Canada casts further doubt on these prospects.

The Health Council of Canada released a report on 2012 on improving the measurement and reporting of health system performance in Canada. As a first step, it recommended the need for alignment of provincial and territorial reporting on health system performance within a national framework beginning with aligned goals. The report also called for independent monitoring and reporting on health system performance to enable the public to hold health system leaders accountable for achieving their performance targets.30

### Table 7: Accountability indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved public reporting on health system performance</td>
<td>CIHI’s performance framework and international benchmarking reports</td>
<td>Australia</td>
</tr>
<tr>
<td></td>
<td>(Note: Demise of Health Council of Canada could have negative impact)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wait Time Alliance annual reports; CMA annual report card (released at GC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Provincial reports of Health Quality Councils</td>
<td></td>
</tr>
</tbody>
</table>

G. Health human resources

Achieving an adequate supply of health human resources was a key strategy in the 2010 HCT report. An adequate supply ensures that the supply of human resources is able to meet Canadians’ health care needs within a transformed health system, beginning with a strong primary care system. To this end, it is important to have a coordinated federal-provincial-territorial planning approach to attract, retain and develop a health workforce to meet the requirements of a transformed health care system.

Evidence continues to mount from anecdotal and survey sources that there is a sizeable amount of Canadians who do not have a family physician and there is an emerging imbalance between the supply of physicians in various specialties/sub-specialties and the availability of opportunities for new professionals.

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graduates. With respect to the latter issue, the most commonly cited reason for such difficulties is a lack of infrastructure support such as access to OR time, and not a lack of demand for their services. In the past few years, concerns have been expressed about the appropriateness of the mix of postgraduate training positions relative to population needs and service requirements. In terms of population needs, the anticipated requirement for geriatric care has been noted in Canada and elsewhere, to cite one example. There has only ever been one comprehensive national review of anticipated physician requirements related to the mix of training positions in Canada—in 1975.  

It continues to be the case that only Quebec, PEI and New Brunswick have a physician resource plan in place. More recently Ontario and Nova Scotia have completed projection models that address both supply and demand and BC and Saskatchewan are about to embark on the process.

In December 2013, the CMA Board agreed to proceed with a 10-point Action Plan on Physician Human Resource that will address training, employment and policy matters to reduce physician under- and unemployment in Canada. One of the plan’s actions is to advocate for wider integration of physician assistants and hospitalists into the health care system.

With funding from Health Canada, the Association of Faculties of Medicine of Canada and the Ontario Ministry of Health are co-chairing a three-year multi-stakeholder initiative that is intended to develop a pan-Canadian physician resource planning tool. CMA is represented on the Task Force.

Table 8: Health human resources indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>National health human resource planning mechanism</td>
<td>Nothing in place</td>
<td>UK—Centre for Workforce Intelligence</td>
</tr>
<tr>
<td># of provinces that have a long-term plan to project future demand and supply of health human resources</td>
<td>Nova Scotia and Ontario</td>
<td></td>
</tr>
<tr>
<td># of provinces that regulate or enable physician assistants</td>
<td>2 – Manitoba and Ontario</td>
<td>Department of National Defense</td>
</tr>
</tbody>
</table>

A more effective adoption of health information technology (HIT) including electronic medical records (EMRs) and information systems was a key element in CMA’s 2010 HCT report. The digitization of our health care system is a key enabler to improvements in quality, safety and the continuity of patient care for all Canadians.

Canada continues to make progress in the adoption of HIT. It is forecast that 70% of physicians will have an electronic medical record (EMR) system in place by 2014. Almost 90% of the most common radiology examinations and reports in Canada’s acute care hospitals are now digital, up from approximately 38% only six years ago.

However, there is still a long way to go in order to share information more effectively among caregivers, enable patient access to clinical information, and optimize the use of these systems. Areas where progress has stalled include: refocusing HIT investments to support frontline health care delivery (where 85% of care is delivered), specialist EMR needs, applied research, local interoperability, decision support tools, and analytical tools. E-prescribing is still in its early stages in Canada. A joint statement on e-prescribing (Vision for e-Prescribing) was ratified by the boards of CMA and the Canadian Pharmacist Association (CPhA) in 2012. Discussions continue to explore opportunities of putting the statement to the test.

Stalled progress in these areas has meant Canadians are not benefiting at the point of care such as allowing comparisons between patients within a practice, comparing across practices, facilitating sentinel disease surveillance and a population health approach to primary care, and allowing patients to get consistent, more understandable information from their providers electronically through portals, emails and other e-routes.

As we look to the future there is a need to reframe the discussion from building HIT infrastructure to deriving benefits. To this end, investment is required to ensure that the efforts to date are fully utilized and support improved patient outcomes.

In September 2010, the Canadian Medical Association (CMA) released a policy statement on the HIT investment program that the organization felt would bring more immediate value to Canadians. This document, Toward Patient-Centred Care: Digitizing Health Care Delivery, has guided the CMA’s efforts advocating for health information technology that will help transform the health care system to better serve all Canadians.

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Table 9: Health information technology (HIT) indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Progress to date in Canada</th>
<th>Current Best in Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of primary care physicians reporting they use an EMR (CWF 2012)</td>
<td>56% (37% in 2009)</td>
<td>98% - Netherlands</td>
</tr>
<tr>
<td>(Highest: 74% Alta; lowest: 26% in NB)</td>
<td>10%</td>
<td>68% - United Kingdom</td>
</tr>
<tr>
<td>% of physicians with multifunctional health IT capacity</td>
<td>14%</td>
<td>55% - New Zealand</td>
</tr>
<tr>
<td>capacity (Uses at least 2 electronic functions (order entry management,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>generating patient information, generating panel information, routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>clinical decision support (CWF 2012)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of primary care physicians who can electronically exchange patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>summaries and test results with doctors outside their practice (CWF 2012)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(CWF 2012)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix A

### HCT Board Working Group Accomplishments

<table>
<thead>
<tr>
<th>Year</th>
<th>Chair</th>
<th>Accomplishments/Activities</th>
</tr>
</thead>
</table>
| 2012-2013  | Dr. John Haggie        | - Joint statement with Canadian Pharmacists Association (CPhA) on e-prescribing  
- Development of a HCT Strategy Map and possible indicators to assess progress on HCT, as well mechanisms to facilitate the dissemination of promising innovations that are being deployed locally  
- Under the leadership of Dr. Anna Reid, released the research report *Physicians and Health Equity: Opportunities in Practice* and conducted a series of town hall meetings to ask Canadians about the impact of the social determinants on their health and the health of their communities. This culminated in the CMA report, *What Makes us Sick?*, that included a series of recommendations for action on the social determinants of health.  
- Oversaw CMA’s activities on health equity as directed by GC 2012 including providing input into policy statement on *Ensuring Equitable Access to Health Care: Strategies for the Medical Profession*  
- Recommended CMA send letter to CoF Health Care Innovation Working Group in support of it placing greater emphasis on illness prevention and health promotion  
- Further examination of options for funding the continuum of care  
- Provided input into draft policy statement on efficiency and input into concept paper on appropriateness |
| 2011-2012  | Dr. Jeffrey Turnbull   | - Joint working group with the CPhA struck to advance e-prescribing  
- Followed up on the 10 recommendations of the Advisory Panel (as directed by GC delegates at 2011 meeting):  
  o Developed an overview of how efficiency is/might be applied in Canada linking in with work of the Council of the Federation Health Care Innovation Working Group  
  o Prepared discussion paper on funding the continuum of care  
  o Oversaw development of policy paper on the physician and health equity |
| 2010-2011  | Dr. Jeffrey Turnbull   | - Identified a more comprehensive notion of sustainability  
- Held national dialogue on sustainability  
- Developed principles to guide HCT (released June 2011)  
- Establishment of Advisory Panel on Resourcing Options for Sustainable Health Care in Canada |
| 2009-2010  | Dr. Robert Ouellet     | - Oversaw the development of CMA’s policy document *Health Care Transformation in Canada: Change that Works. Care that Lasts*  
- Supported development of Charter on Patient-Centred Care under leadership of Dr. Anne Doig  
- Considered strategies to accelerate the adoption of the HCT directions |
Appendix B

Publications of Health Care Transformation by Source

PubMed covers the fields of medicine, nursing, dentistry, veterinary medicine, the health care system, and the preclinical sciences, such as molecular biology. PubMed contains bibliographic citations from about 4,600 biomedical journals.

Search results for HCT on PubMed, 2009-2012 (Key words "healthcare" AND "transformation" found as Textword)

Search results for HCT on Government of Canada websites, 2009-2012 ("health care" and "transformation"; site domain .gc.ca using Google Advanced)

Note: Searches included the terms “healthcare”, “health-care” and “health care” AND “transformation.”
Health Care Transformation in Canada media coverage (# of stories)

2009: 26
2010: 100
2011: 28
2012: 39

Total: 193

# of hits on CMA’s Health Care Transformation website (http://healthcaretransformation.ca/)

2009: NA
2010: NA
2011: 928 visits
2012: 33,000 visits
2013: 86,000 visits
Appendix C

Primary Data Sources Used for Indicator Reporting

Canadian Institute for Health Information (CIHI):


The Commonwealth Fund (CWF):

2013 Commonwealth Fund International Health Policy Survey

2012 International survey of primary care physicians

http://www.healthcouncilcanada.ca/content_lm.php?mnu=2&mnu1=48&mnu2=30&mnu3=56

http://www.oecd.org/health/health-systems/health-at-a-glance.htm

Statistics Canada, Health Indicators. http://www.statcan.gc.ca/pub/82-221-x/82-221-x2013001-eng.htm