IMPROVING ACCOUNTABILITY IN HEALTH CARE FOR CANADIANS

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INTRODUCTION

If Canada is defined by any idea, it's the promise of publicly funded health care for all. But for many years, shortcomings have been evident to those within the medical community and those who rely on it. And COVID-19 further exacerbated and exposed the pressure on our health systems. It's now clear that access to health care is no longer equitable or consistent.

RECENT HISTORIC INVESTMENTS

In February, federal, provincial and territorial (FPT) governments agreed on a new health funding arrangement. The federal government will invest more than $196 billion in health care over 10 years, including $19 billion in new funding through the Canada Health Transfer and $25 billion for bilateral health agreements.

Bilateral agreements will be focused on four shared priorities: expanding access to family health services; supporting health workers and reducing backlogs; improving access to mental health and substance use services; and modernizing the health care system with standardized health data and digital tools.
It's good news.

As part of the funding deal, governments also agreed to track progress using eight "headline" indicators — key to accountability for investments in health care.

LEARNING FROM PAST EXPERIENCE

The accountability provisions in the new health funding agreement build on previous health accords. Measurement and reporting of wait times against medically acceptable benchmarks, combined with targeted funding under the 2004 health accord, is one of the more successful examples of pan-Canadian collaboration to improve health care.

Going forward, three key dimensions are critical to accountability for federal health funding:

1. Selecting the right indicators
2. Setting targets to guide action
3. Engaging Canadians in holding leaders accountable

1. Selecting indicators

To provide Canadians with an accurate picture of how the health system is performing and what needs to be improved, metrics should address the patient journey. This includes:

- **Throughput –** how quickly patients go through the system
- **Societal impact –** whether a service improves health outcomes at a population level
- **Personal impact –** whether a service changes a personal disease trajectory; patients no longer require healthcare services, patients require health services less frequently, improvements in length or quality of life
- **Diversion –** shifts from one access point to another (i.e., from the hospital to home care)
- **Coordination/collaboration –** how well providers work together to minimize the touchpoints required to address a patient's problem
- **Ease of navigation –** how hard it is for a patient or provider to find what they need
- **Ease of access –** how hard it is to get on a wait list for health service
- **Timeliness –** how long it takes to get on a wait list and how long it takes to receive service
- **Ineffective referrals –** how frequently patients are put on a waiting list and receive a service that does not address or improve health outcomes
- **Cost –** how much it costs for any of the above measures

The eight headline indicators identified in the new health agreements are a good start. They will help track progress across family health services, treatment backlogs, workforce capacity, mental health and substance use, and digital health. The CMA is proposing five additional indicators to better track improvements in areas such as access to team-based primary care, wait times for surgery, rural access to hospital services, pan-Canadian licensure of health workers and health workforce stress and burnout.

2. Setting targets

A key feature of high-performing health systems is not only tracking performance using a comprehensive set of metrics but using targets to orient investments and decision-making.

As mentioned above, Canada has some experience with health care targets. In the mid-2000s, first ministers agreed to establish benchmarks for medically acceptable wait times. These indicators drove new investments and approaches to managing wait lists, resulting in a steady decline in wait times for priority procedures. Unfortunately, these improvements turned out to be short lived as resources shrunk and the global pandemic forced hospitals to delay or cancel procedures.

The CMA is urging leaders to recommit to targets as a catalyst for system improvements. For each indicator, governments should set discrete three-, five- and 10-year goals. Annual reporting by the Canadian Institute for Health Information (CIHI) — which should commence as soon as possible for existing indicators, and by 2024 for additions — will enable Canadians to monitor their progress.

3. Engaging Canadians

Performance metrics should tell a clear story about how well our health systems are working and where attention is needed most. The objective of that story should be behavior change across the health stakeholder workflow; either increasing investment in existing approaches, stabilizing funding to maintain a status quo, decreasing funding to sunset an approach, or diverting funding to an emerging or existing approach that better suits current needs. Data should track service between regions, as well as provide further nuance in key populations (e.g., seniors, children, low-income families, racialized Canadians and Indigenous Peoples).

A learning cycle that includes patient and provider input on indicators, targets and reporting mechanisms is critical. Ultimately, however, accountability for system performance resides with system and government leaders. Reporting by CIHI on health indicators and targets needs to be analysed, contextualized and made available to decision-makers. To support this, the CMA recommends an annual report card.

CONCLUSION

If Canada's health care system is to regain its status as a beacon to the world, we need meaningful change rooted in collective accountability. The 2023 health funding agreement presents a unique opportunity to improve patient access to care in priority areas. The collaboration and buy-in of all jurisdictions, and the watchful eye of citizens, will ensure Canadians have more timely and equitable health care when and where need it.

THE CMA'S PROPOSED INDICATORS AND TARGETS

Improved patient access

The biggest concerns Canadians have about health care are access and timeliness of care. This is reflected in the priorities and headline indicators in the 2023 health funding agreement and should be the central focus of accountability for new federal funding.

Access to primary care

More than six million Canadians don't have access to a regular primary care provider — unacceptable in a country that prides itself on universal care. Primary care is the foundation of an effective health care system. It's the front door for a broad range of preventive and treatment needs, and for referral to more specialized care when required.

> The CMA calls on governments to increase the percentage of Canadians with routine primary care from 85% to 90% within five years, and to 95% within 10 years.

The CMA also calls for expanded access to family health teams. The CMA defines family health teams as a range of primary care providers — for example, physicians, nurse practitioners, physician assistants and social workers — offering longitudinal care to their patients. This model, outlined by the College of Family Physicians of Canada in their vision for a Patient's Medical Home, allows for comprehensive, coordinated and high-quality care. The CMA urges governments to commit to family health teams for 50% of Canadians within five years, and for 80% of the population within 10 years.

Achieving these goals would significantly improve the efficiency and effectiveness of health care delivery, enabling more Canadians to benefit from preventive health services and chronic disease management while reducing pressure on downstream health care services, particularly hospitals.

Wait times for priority procedures

There is a transition point where access delayed becomes access denied. Wait times for priority procedures such as hip, knee and cataract surgeries are the highest in a decade. In 2022, the proportion of patients who received surgery within medically acceptable wait-times was 50% for knee surgery, 57% for hip surgery and 66% for cataract surgery. COVID-19 impacts also caused a backlog of other procedures to build up to unprecedented levels nation-wide; millions of health services and hundreds of thousands of surgeries were delayed as a result of the pandemic.

Jurisdictions must quickly eliminate the COVID-19 backlog and recommit to bringing down wait times for priority procedures to acceptable levels. These include — knee, hip and cataract surgery, cardiac care, cancer treatment and diagnostic imaging, as well as other critical areas such as women's health services. The CMA recommends that governments eliminate the backlog of priority procedures within three years and increase the percentage of priority procedures delivered within medically acceptable wait time benchmarks to 80% within five years and to 90% within 10 years. This will go a long way to restoring public confidence in Canada's health care system.

Emergency room closures

Wait times in hospital emergency rooms (ERs) routinely exceed 12 hours across the country. An increasing number of hospitals in rural areas and small towns were forced to shutter their ERs in rolling or permanent closures last summer in the midst of peak demand, a phenomenon we will likely see again in summer 2023. ERs are the last place patients can depend on for timely, urgent access — particularly when primary care offices are overwhelmed, walk-in clinics are unavailable and virtual care is inappropriate. ER closures force patients to drive long distances to access emergency care. Recognizing the consistent investment needed to solve this problem, the CMA recommends that governments commit to eliminating hospital ER closures within three years.

Access to mental health services

The global pandemic was a fraught and difficult time for so many people. But they were particularly crushing for youth, already navigating school, social pressures, online media and a changing world. Currently, only 61% of adolescents and youth have access to critical mental health and substance use services. The CMA calls on governments to ensure access for 80% of 12- to 24-year-olds within five years and 90% within 10 years.

The proportion of the broader population with unmet mental health needs is also unacceptably high, currently sitting at 45%. A reasonable target is to reduce this ratio to 25% within five years, and to 10% within 10 years. Similarly, median wait times for community-based mental health services — currently ranging from four to 62 days across provinces and territories — need to go down. Patients and their families also need navigation support to find available services with their communities or online. Within the next five years, we should collectively aim for a maximum two-week wait for these services, and within a decade, our goal must be to bring median wait times down to a single week.

Healthy workforce

Supply of primary care workers

To stop the cycle of hospital overcrowding, we need to focus on preventive medicine. It's healthier. It's faster. It saves money. But again, to achieve it, Canadians need greater access to family health teams — and new physicians, nurses and nurse practitioners to join them.

Between 2010 and 2020, Canada's supply of family doctors increased by an average of 1,100 per year — including new Canadian and internationally trained family doctors minus retirements and departures from the profession. Over the next 10 years, we need to increase the output of medical schools and make family medicine a more attractive area of specialization, with a particular focus on providing longitudinal care to patients and families. Within five years, Canada needs 7,500 net new family physicians; 15,000 within 10 years. The supply of other primary care providers — including nurse practitioners, nurses, and physician assistants — needs to increase in tandem.

Canada's health care system also requires new health workers to better support an aging population, and to address drastically underserved populations in remote, rural and northern areas to ensure the country's increasing populace has equitable access.

Pan-Canadian licensure of health professionals

Currently, health workers must go through a separate license application and pay a separate fee for each jurisdiction where they practice, creating unnecessary barriers to labour mobility. As part of the 2023 health funding agreement, provinces and territories agreed to streamline foreign credential recognition processes for internationally educated health professionals, and to advance health workforce mobility within Canada, starting with multi-jurisdictional credential recognition for key health professionals. Key steps have been taken in this direction, including the first regional physician licensure program: the Atlantic Registry.

Pan-Canadian licensure of doctors and other health professionals would go even further to alleviate the pressure on the medical workforce in rural and remote communities, enable a more efficient response to emergencies, and support virtual care across provincial and territorial borders. It would also provide urgently needed support for physician work-life balance and health and wellness, potentially improving retention rates by making it easier for doctors and hospitals to fill locums for holidays, parental and educational leaves.

Within three years, the CMA urges governments to commit to implementing pan-Canadian licensure for physicians and other key health professionals.

Mental health and wellness of health workers

The dedication physicians, nurses and other health professionals showed throughout the pandemic continues as clinics and hospitals struggle to restore health services and reduce significant backlogs in procedures. But the cumulative effect is intense burnout that's driving some health workers to cut back hours, take leaves of absence, quit, or take early retirement.

According to a 2022 report by the Canadian Federation of Nurses Unions, an alarming 94% of nurses are experiencing burnout. More than half of respondents to the CMA's 2021 National Physician Health Survey (NPHS) reported symptoms of burnout (1.7 times higher compared with pre-pandemic) and positive screens for depression rose by 14% (from 34% to 48%)

More than half of NPHS respondents said they were likely or very likely to reduce clinical work hours in the next 24 months. More broadly, a recent survey by the Organization for Health Action, or HEAL, found that 40% of healthcare providers are considering leaving the field, citing mental health and well-being, working conditions and resource shortages as their main points of concern.

Going forward, we need to do a better job of monitoring the health of the health workforce and set significant targets to improve these metrics. The resiliency and sustainability of our health care system depends on it.

The CMA recommends that governments target a 40% reduction in burnout rates within three years (to pre-pandemic level) and a 60% reduction within five years.

Modernized health system

Patient access to electronic health records

The world is becoming increasingly digital, but Canada's health system remains stubbornly analog, to our own detriment. Only marginally more than a quarter of Canadians can access their own electronic health records (EHRs). It's time we maximize our capacity not just to deliver virtual health care, but to support it with interoperable electronic health records that can be securely shared with patients and all health professionals in their circle of care. When Canadians have access to their own records, they can take ownership of their health journey. This facilitates early identification and follow-up management of chronic diseases, including mental health issues. A major push by governments combined with pan-Canadian alignment of national data standards and policies can deliver access to EHRs for 75% of Canadians within five years, and to 90% within a decade.

Secure sharing of electronic health information

Beyond backlogs and under-resourcing, medical staff are overloaded by growing administrative work that absorbs valuable time they could otherwise be devoting to patients. Over the course of a year, Canadian doctors spend 18 million hours on administrative tasks that could be handled by properly designed IT systems. According to the NPHS, physicians average more than an extra workday per week (10 hours) on administrative tasks, with those spending the most time reporting higher levels of burnout. Secure sharing of health information between doctors, family health teams, specialists and pharmacists through EHRs would streamline many processes, reduce administrative burden, eliminate redundant requests for patient history, limit human error, save funds and provide speedier, more efficient transitions for patients. Significant progress could be made in this area in a short period of time. Within five years, 75% of health professionals should be able to share patient health information electronically. Within 10 years, government targets should be set to 90%.

This report was prepared by health policy consultant Marcel Saulnier.

ANNEX A – PROPOSED INDICATORS AND TARGETS

INDICATOR	BASELINE	TARGET	STATUS
Improved Patient Access			
1. **Percentage of Canadians who report access to a regular primary care provider**	• 85% (Statistics Canada CCHS)	• 90% by 2028 • 95% by 2033	Headline indicator
2. **Percentage of Canadians who report access to a family health team**	• Less than 30% in Ontario	• 50% by 2028 • 80% by 2033	Proposed new indicator
3. **Size of COVID-19 surgery backlog**	• CIHI reported 937,000 fewer surgeries compared with performance before the pandemic	• Down to 0 within three years	Headline indicator
4. **Percentage of wait times for priority procedures within medically-acceptable benchmarks**	• 50% for knee surgery • 57% for hip surgery • 66% for cataract surgery	• 80% by 2028 • 90% by 2033	Proposed new indicator (data already collected by CIHI)
5. **Number of hospital ER closures per year**	• Media reports in 2022: BC (16), AB (30), ON (158), QC (6)	• 0 within three years	Proposed new indicator
6. **Percentage of youth aged 12-24 with access to integrated youth services for mental health and substance use**	• 61% (Statistics Canada CCHS)	• 80% by 2028 • 90% by 2033	Headline indicator
7. **Percentage of Canadians with a mental disorder who have an unmet mental health care need**	• 45% (Statistics Canada CCHS)	• 25% by 2028 • 10% by 2033	Headline indicator
8. **Median wait times for community mental health and substance use services**	• Ranges from four to 62 days across P/Ts (CIHI)	• Two weeks by 2028 • One week by 2033	Headline indicator

INDICATOR	BASELINE	TARGET	STATUS
Healthy Workforce			
9. Net new family physicians, nurses, and nurse practitioners	• Between 2010 and 2020, average annual increase in family physicians was 1,143	• 7,500 net new family physicians by 2028* • 15,000 net new family physicians by 2033* * working in longitudinal care and alongside other professions	Headline indicator
10. Pan-Canadian licensure of health workers	• Atlantic provinces moving forward with Atlantic Registry	• Implementation of pan-Canadian licensure for physicians and other key health professions within three years	Proposed new indicator
11. Percentage of health workers reporting burnout	• 94% of nurses are experiencing symptoms of burnout (2022 CFNU) • 53% of physicians report a high level of emotional exhaustion (2021 National Physician Survey)	• 40% reduction in burnout rates within three years (to pre-pandemic level) • 60% reduction within five years	Proposed new indicator
Modernized Health System			
12. Percentage of Canadians who can access their own comprehensive health record electronically	• 27% (Canada Health Infoway)	• 75% by 2028 • 90% by 2033	Headline indicator
13. Percentage of family health service providers and other health professionals (e.g., pharmacists, specialists, etc.) who can share patient health information electronically	• 22% of Canadian doctors can exchange patient clinical summaries with doctors outside of practice (2019 Commonwealth Fund survey)	• 75% by 2028 • 90% by 2033	Headline indicator

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