House of Commons
CANADA

Standing Committee on Health

HESA • NUMBER 027 • 2nd SESSION • 39th PARLIAMENT

EVIDENCE

Tuesday, May 6, 2008

Chair

Mrs. Joy Smith

Standing Committee on Health

Tuesday, May 6, 2008

● (1105)

[*English*]

The Vice-Chair (Mr. Lui Temelkovski (Oak Ridges—Markham, Lib.)): I will now call the meeting to order.

Pursuant to Standing Order 108(2) and section 25.9 of the Federal-Provincial Fiscal Arrangements Act, we are looking at a statutory review of the ten-year plan to strengthen health care.

We have a number of witnesses this morning. We have with us, from the Canadian Institute for Health Information, Glenda Yeates, president and chief executive officer; we also have Kathleen Morris, consultant. From the Health Council of Canada we have Jeanne Besner, chair, Donald Juzwishin, chief executive officer, and Albert Fogarty, councillor. Welcome. *Bienvenue.*

We will start our debate with the presentation by Madam Yeates, please, for ten minutes or less.

Ms. Glenda Yeates (President and Chief Executive Officer, Canadian Institute for Health Information): Thank you, and good morning. Thank you for that introduction.

I am Glenda Yeates, the president and CEO of the Canadian Institute for Health Information, or CIHI. Thank you for inviting me to be present before the committee.

As you may be aware, I'm going to focus on the data slides we have presented, which are in front of you. The CIHI is an independent organization that provides accurate, timely, and unbiased health information. It's not our role at CIHI to forecast or to offer recommendations or opinions, and therefore my presentation will focus on data.

What we do at CIHI is collect and process databases and registries. We coordinate and promote the development of data standards across the country, we identify health indicators, and we produce analytical products and reports.

In terms of our relationship to the 2004 health accord, this is an accord that had a series of commitments, one of which was reducing wait times and improving access. CIHI is named specifically in the accord and asked to report on progress on wait times across the jurisdictions.

You'll see that we have produced four reports on wait times since the 2004 accord, between the period of March 2006 and the most recent one this last February 2008.

I'll put some of the information on wait times before you today. I'm going to organize it in two ways. The first is to talk about the volume of activity of procedures in the priority areas and the second is to tell us what we know about wait times, or perhaps changes in wait times.

Slide 6 of our presentation looks at what we know about surgical volumes in the priority areas that are named in the accord. They are listed there.

We look at volumes because our data there is more comprehensive and therefore easier to measure. Also, increasing the volume of activity in these areas has been one of the strategies the provinces have specifically named as they try to move forward to reduce wait times.

● (1110)

[*Translation*]

Generally speaking, our data indicate that the volume of surgery in priority areas, that is, hip and knee replacement, cataract surgery, bypass surgery and cancer surgery, has increased by 13% in Canada, excluding data from Quebec, over the two years following the accord.

[*English*]

Overall, our numbers show that in the priority areas, the volume of surgeries in those areas named in the accord have increased by 13% across Canada over the two-year period following the accord, and that's excluding the volumes from Quebec.

In terms of reporting what those volume increases mean for wait times, what we know now is that most provinces are regularly reporting on wait times for priority areas. There have been improvements in that reporting, so there are more timely, comprehensive data available, but there are still variations in measurement in reporting, and that means interprovincial comparisons are difficult. And the trend data are not available across the board, but they are beginning to emerge for individual provinces.

There's an example from our February 2008 report for joint replacements—one of the priority areas. You can see there that all ten provinces are reporting in the area of hip and knee replacement. We can see the differences in some of the definitions in the provinces, and we note them there, in terms of what those differences in definitions are. You'll see that the reporting in terms of times is included for those two procedures.

The question that people often want answered is what does that mean in terms of wait times? We see that volumes are up. What does it mean for waiting times for individual Canadians? We've put forward the areas for a number of provinces where we feel the definitions have stayed stable enough over the last three years so that we can actually begin to look at trends. So in the area of joint replacement, those provinces would be Ontario, Alberta, and British Columbia. And for those provinces where we think the data are consistent enough, we can see that they report decreases in the median wait times for hip replacements of at least one month for hips and one month and a half for knees.

If you look at cataract surgeries, the story isn't as clear. We see in four provinces that we find the definitions to be consistent enough over that period where we can look at trends. For those provinces, some of them have reported decreases in wait times, but others have not seen decreases.

I will turn next to slide eight. This looks at diagnostic imaging. This is the next area, and another area that was named in the accord. What have the trends been there? Again, the data are stronger on volumes, so you'll see in this that we can look at the volumes of both diagnostic imaging equipment in the areas of MRI and CT scans and the number of exams that have occurred. So we can see between the two periods here, 2003-04 and 2006-07, that there are more scanners—27% more MRIs and 12% more CT scans—and the number of actual exams is up even greater. But what we don't know and aren't able to tell you is what that means for the wait for those procedures. We can see that there are increased volumes. What we don't know is what that impact has been on the waiting times for Canadians.

I will turn next to the access to health care professionals. This was another of the areas that was cited in the access portion of the accord. What we can see there is that there is no comparable indicator for access to health care professionals, so we cannot report on that. That hasn't been determined. But what we can see is CIHI does have data about numbers of practitioners. Here I show you the numbers of physicians and nurses. We can see those numbers are up modestly in the 2004 to 2006 period, but those increases are not particularly significant, given the increase in the population that has also occurred in that time. But we do have data there on the increase in the numbers of health professionals in those two professions.

Another question that has been posed to us about the accord from time to time is the question of whether the new federal money that was committed in the accord was in fact spent on health care, and I've included there the table that is appended to the actual 2004 accord. At CIHI we collect and analyze data on health spending at a national level, so that is a question at the broadest level that we can answer. Our data do show that in 2005 the provincial and territorial governments spent almost $91 billion on health care, which was an increase of about $6.1 billion over the 2004 level. And when you compare that to the accord, you would see that the accord put in $3.1 billion of new money in the 2005-06 period. So we can get some sense of that investment flowing to the health care sector, in terms of the expenditures of provinces and territories.

In conclusion, on the progress on wait times reporting—the task given to us in the accord—we do see increased activity in the priority areas. There are increased diagnostic imaging procedures and there are increases in the surgeries in the priority areas.

● (1115)

We do see improvements in the data. There is much more data than there was three years ago. In terms of the interprovincial comparisons, those are still a challenge, because the data is not collected in precisely the same way or using the same definitions across all the provinces. We do see pockets of trends that are beginning to emerge in individual provinces.

[*Translation*]

In conclusion, what we can say about progress in wait times is that while interprovincial comparisons remain a challenge, we are seeing increased activity in priority areas, improvements overall in wait times data being reported to the public and pockets of trends that are beginning to emerge.

Thank you.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much. And thank you for staying within the time; it is refreshing to see.

We will now move on to Madame Besner.

[*Translation*]

Dr. Jeanne Besner (Chair, Health Council of Canada): Good morning, and thank you for inviting us here this morning.

[*English*]

My name is Jeanne Besner. I am the chair of the Health Council of Canada. In that role I'm pleased to report to the Standing Committee on Health regarding the progress made toward achieving the reforms set out in the 2003 accord on health care renewal and the 2004 ten-year plan to strengthen health care. I am reporting on that as we have observed it.

For those of you who may not be aware, the Health Council of Canada was created out of the 2003 accord to monitor and report on progress made in achieving health care reform based on the elements that were set out in the accords. In 2004 an additional role was given to us to report on health outcomes. I will take it from there.

[*Translation*]

These accords have laudable, much needed and ambitious goals. But have they had the broad national impact that government leaders intended? In short, the answer is no.

[*English*]

Undoubtedly the accords have been a catalyst for change in many areas. In particular, the major purchases of medical equipment and various forms of information technology have helped to increase the number of services delivered. Many if not most jurisdictions have improved the way they manage waiting lists. I think Ms. Yeates made reference to that. Most jurisdictions provide wait time information for some procedures on their public websites. As a result, there's no question that many patients now know better than they did in the past when their cataract surgery or hip or knee replacement is likely to occur. In many cases they undergo their surgical procedures with less waiting than they might have five years ago.

Most Canadians have better access to health information and advice through telephone help lines. Some Canadians have better access to publicly insured prescription drugs, to primary health care teams, and to a range of health services at home or in their communities. Albeit slowly but surely, the health care system is adopting electronic health records, which will help to deliver safer, more efficient, and better-informed care.

In our forthcoming five-year report on health care renewal, which is due for release in June, the Health Council notes many other steps forward on the road to health care renewal.

[*Translation*]

But in other respects, progress on the accord commitments is not cause for celebration. The Health Council of Canada is particularly concerned about nine areas of health care renewal where action has been slower, less comprehensive and less collaborative than first ministers originally envisioned in the accords of 2003 and 2004.

[*English*]

First, in terms of drug coverage and appropriate prescribing, governments have not made substantial progress, to the best of our knowledge, in creating the national pharmaceutical strategy. Significant gaps in coverage are still evident across Canada, particularly in the Atlantic provinces. Too many Canadians remain vulnerable to personal hardship from needed drugs that cost more than they can afford. Also, Canadians are not always adequately protected from inappropriate prescribing because we don't have the necessary systems in place to keep health providers and consumers informed about drug safety and effectiveness.

● (1120)

[*Translation*]

With respect to home care, two weeks of publicly-funded home care coverage is not adequate for what many people need, and home care services continue to be poorly integrated with primary medical care in many parts of the country. There are clear disparities in the availability of publicly-funded home care across the country. No matter where people live, home care services that are seamlessly coordinated with other aspects of primary health care should be available.

[*English*]

In terms of aboriginal health, we note that the scope of preventable health problems in many aboriginal communities continues to be of concern across the country. Relatively little funding seems to have flowed from the promising intergovernmental agreements of 2005, the Kelowna communiqué and the blueprint on aboriginal health. Some provinces are working closely with aboriginal communities and the federal government to improve health care and living conditions on a regional basis, but developments are on a much smaller scale than we think were envisioned in those agreements.

[*Translation*]

Growth in the number of inter-professional teams to deliver primary health care is promising, and some parts of the country are on track to meet the target (set in the 2004 10-year plan) of having 50% of people served by teams by 2011. But nation-wide, progress is uneven and difficult to measure. More concerning, too many Canadians don't have timely access to their regular medical provider and too often primary health care services are not coordinated or comprehensive.

[*English*]

In terms of the health care workforce, ensuring that we have the right number of needed health care providers in the right place at the right time was a central component of both accords. There have been substantial increases in admissions to professional schools, more integration of foreign graduates, and some changes in how various kinds of professionals can practise. However, we still note that there are serious mismatches between need and supply in Canada's health care workforce. On the regional level, some provinces and territories are working together to plan and manage their health human resources more effectively, but the nationwide collaboration, the pan-Canadian framework envisioned in 2003 and 2004, doesn't seem yet to have resulted in coordinated planning.

[*Translation*]

The sixth area is electronic health records and information technology. Despite recent investments through Canada Health Infoway, Canadian governments have been slow to make progress in the information systems needed to support the delivery of high-quality care. We are not on track to meet Infoway's goal of 50% of Canadians having a secure electronic health record linked to other aspects of health care delivery by 2010—a goal that the Health Council has said was too modest from the start. Public support for these investments is strong, however, and governments must find ways to fund and accelerate this essential part of health care renewal.

[*English*]

In terms of reporting on progress, current and reliable data are fundamental tools to measure and understand what initiatives to improve health and health care are working and what are not. Today, despite the excellent work of a number of national and regional organizations devoted to health information and research, such as CIHI, Canada has a myriad of health databases, but not a comprehensive pan-Canadian health information system. Beginning in 2000, the governments had agreed to develop and use comparable indicators to report to Canadians their progress in health care renewal. A set of 18 indicators has been developed, but some are not as useful as we might like for reporting on the reform priorities of the accord, while those that are of value are not widely used for public reporting.

[*Translation*]

In 2003, the accord that created the Health Council of Canada also identified the federal/provincial/territorial advisory committee on governance and accountability as a key partner for the Health Council to do its work. However, this intergovernmental committee where governments shared information has been disbanded. Information about how governments spend targeted funds is not easily accessible or, in some cases, not available at all.

● (1125)

[*English*]

In terms of wait times, I think that Ms. Yeates has provided information indicating that a lot of improvements have been made. We note, though, that wait-time benchmarks for diagnostic imaging, which were to have been produced by December 2007, have still not been released.

So why has progress on so many of the commitments not been achieved? The Health Council of Canada sees several reasons. First, we find that some of the key elements in the accords were not sufficiently well described at the outset to make them measurable. For example, while we talk about inter-professional teamwork, it's not clear what we mean by a multidisciplinary primary health care team. Is it a nurse working alongside a family doctor? Is it more professionals, and so on? Unless we are clear about what we are trying to accomplish, it's difficult to know whether or not we have achieved it.

[*Translation*]

Second, as a vehicle for financing change and coordinating reform, the accords have their strengths but also some critical weaknesses. All told, the cumulative new funding committed through the 2003 accord and the 2004 10-year plan will amount to well over $230 billion by 2014. While some of the funding is tied to general health care policy goals, much of it comes with no real strings attached, very few requirements for public reporting, and almost no measurable objectives and outcomes.

[*English*]

Third, it is the reality of health care in Canada that we don't have one health care system; we have at least 14, when we consider the care the federal government delivers or directly funds. Unquestionably, this reality presents challenges for coordinating reform on a large scale, but the accord envisioned that governments would collaborate to solve common problems for the benefit of all Canadians, wherever they live. While respecting the rights and responsibilities of the provinces and territories to deliver care, the Health Council believes that we need to revive the idea of a common or pan-Canadian vision of health and health care, and put mechanisms in place to make this vision a reality.

[*Translation*]

Finally, we are concerned that governments' commitment to the spirit of the accord may be weaning. Many of the commitments have not been honoured or at least not to the degree that Canadians expected. The practical marriage between money and the desire for health care renewal held considerable promise in 2003 and 2004. Governments should either explain what has changed in the interim or signal their recommitment to a clear set of reforms. We encourage governments to renew their vows—to each other and to the citizens.

[*English*]

As we look ahead to the next five years under the ten-year plan to strengthen health care, the Health Council of Canada urges governments to renew their national commitment to system-wide change. We know that Canadians care passionately about their health care system and are eager for reforms that will sustain and improve it. We remain very confident, however, that the public health system can and will deliver more accessible, more equitable, and higher-quality care. We call on governments to rekindle their commitments to health care renewal across Canada.

Thank you.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Madame Besner.

We will start our question and answer period with seven-minute rounds, and Mr. Thibault.

[*Translation*]

Hon. Robert Thibault (West Nova, Lib.): Ms. Besner and Ms. Yeates, thank you for your presentations, which were very informative.

[*English*]

Madame Besner, in the accountability section of your presentation you pointed out that the intergovernmental committee, where governments shared information, had been disbanded. As part of the accord, I presume that committee was created for an exchange of information between the provincial governments and the federal government.

Dr. Jeanne Besner: Yes.

If I answer incorrectly I will ask Kira to explain, but the intergovernmental committee was formed to help develop indicators and measures that would be used to report on elements of the health care reform. They met for approximately a year, I believe, subsequent to the 2003 accord, and, to the best of our knowledge, they were then disbanded. We don't know why.

● (1130)

Hon. Robert Thibault: For what reason were they disbanded?

Dr. Jeanne Besner: I don't have that information.

Kira Leeb, one of our staff members, says it was because of lack of funding.

Hon. Robert Thibault: Lack of funding?

Dr. Jeanne Besner: At least that's what we were told.

Hon. Robert Thibault: As to the responsibility for that, who would have told people they were disbanded, or who would have stopped calling this committee? Would it have been the federal partners within the committee who stopped calling the meetings?

Dr. Jeanne Besner: It was a federal-provincial-territorial committee. I really don't have the answer to that; I don't know.

Hon. Robert Thibault: It would be interesting to know, because the federal government signed on to an agreement, part of which created three agencies for monitoring: the Canadian Institute for Health Information, your agency, and this interprovincial organization.

That it was dropped is interesting.

Dr. Jeanne Besner: As I said in the report, there were 18 indicators developed, and they may have found their work was done. The problem is that not all of them have subsequently used the indicators for reporting, and therefore the comparability of data collected across the country has been rather difficult to establish.

So my assumption would be that they felt the work was done.

Hon. Robert Thibault: I don't know who to pose the question to, but I will start with Madame Besner again.

When we look at wait times, there have been some significant improvements, especially in certain areas, in empirical terms. What is difficult to tell is whether the overall wait-time scenario has improved in the nation, because we see that not all provinces have had to respond to the five critical areas. So some provinces can have a great increase in one area and no change in others. I think it was pointed out in the CIHI report on eye surgery, for example.

The other thing we hear from health professionals on an anecdotal basis is that in order to respond positively on the wait-time report card, there may be other areas of intervention that suffer within the medical system. Has either of you in your research been able to identify any of these?

Ms. Glenda Yeates: In February 2007 we took a look at the question of crowding out, as it's sometimes called. We were able to tell that at that time, when we looked at the volume of surgeries in the priority areas, which represent about 20% of surgical procedures overall, they had gone up in relation to the population by about 7% for that grouping, and the rest of surgeries, the other 80% of surgeries, had gone up slightly or had basically stayed about the same. There was about a 2% increase, but for all intents and purposes, they had stayed about the same. That was at a national level.

So there are two things I would caution about that. One, I think we could answer that question at the national level. That doesn't mean that in particular provinces or in a particular facility there weren't issues. We looked at the broader level where our numbers supported the analysis. We will be redoing that analysis and putting that out in the months to come, because we want to make sure of the situation now. But we did take a look at that one year ago, and we will be continuing to monitor that question.

Hon. Robert Thibault: On the pharmaceutical strategy, one of the areas of great promise was the National Pharmaceutical Strategy. There was the creation of a federal-provincial working group. I understand that group hasn't been very active or hasn't been meeting. Is that your understanding, Madame Besner?

Dr. Jeanne Besner: I am aware that they have been meeting. I don't know what the outcome of their meetings has been.

Hon. Robert Thibault: Have there been changes or improvements in the availability of pharmaceuticals to Canadians following the ten-year agreement or as part of this agreement?

Dr. Jeanne Besner: Go ahead.

Dr. Donald Juzwishin (Chief Executive Officer, Health Council of Canada): In respect to access to pharmaceuticals, there are still challenges ahead of us, but significant progress has been made on a couple of fronts, which I think deserve mention. One is that the Common Drug Review, which was established to provide some form of coordination on behalf of the provinces to deal with those questions about pharmaceuticals that are emerging and that are to be introduced within the provincial context, has provided a valuable service to advance that particular effort.

Another initiative, which is concerned about something we're still concerned about—and I've indicated that in our brief—and which has challenges yet is the optimal prescribing practices of the health care community. Our evidence would suggest that there are still gaps that exist in that area. However, a program called COMPUS, run by the Canadian Agency for Drugs and Technology in Health, is beginning to work with health care professionals across the country to provide best practices in terms of optimizing. So although there's still much work to be done, and access to pharmaceuticals is somewhat fragmented across the country, there is some progress.

● (1135)

Hon. Robert Thibault: But the CDR process you're talking about is about recommending that drugs be put on the provincial formulary and not about financing pharmaceuticals for low-income people or people who can't afford certain drugs. Some of its critics will tell you that the CDR has been a lot more effective at keeping pharmaceuticals off the formulary than at including them on it.

Dr. Donald Juzwishin: Disinvestment is always a challenge, and it continues to be. However, the kinds of analyses and health technology assessments that have been conducted by CADTH, which are shared with the provincial jurisdictions, provide the jurisdictions with some effectiveness studies they can base their policy decisions on. So it's a beginning, and it's a way to start using better evidence to inform decisions around what should be on the formulary and what should come off.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Thibault.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon (Québec, BQ): Thank you for being here today to discuss the 10-year plan to strengthen health care.

My question is for Ms. Besner. In your presentation, you talk about aboriginal health. You say that contributions under the promising intergovernmental accords for 2005 remained relatively modest. We know how much aboriginal people need health care, and we need to be able to meet their needs.

How is it that in a report like this one, the federal government does not have to be accountable and the provinces have to produce status reports on the plan's objectives, for example, on wait times? These people come under the federal government's responsibility, after all.

Aboriginal people are under federal jurisdiction, but there seems to be no willingness to provide them with better health and work with them.

Dr. Jeanne Besner: In my opinion, the Kelowna Accord and the blueprint on aboriginal health are federal-provincial-territorial accords. There have been no progress reports. Our role is to provide oversight and report our findings. We have nothing to report because there has not been much progress, as far as we can see. We do not know who is responsible.

Ms. Christiane Gagnon: These people come under the federal government. We are not talking about the general public here. There are aboriginal people and the military. At National Defence, there is very little information to assess the quality of health care. In her 2007 report, the Auditor General pointed that out.

What difficulties have you had in monitoring this issue?

Dr. Jeanne Besner: As part of our mandate, we have to report on progress. To be able to do that, we need indicators. That is what we are missing.

Ms. Christiane Gagnon: What would you need in order to be able to report these statistics?

What concerns me is that the federal government is responsible for clienteles such as the military, veterans, and federal detainees, but there doesn't seem to be any action. There are often attempts to interfere in provincial areas of jurisdiction in addition to reporting requirements, which Quebec refused to comply with. On the other hand, there are very good results when it comes to follow-up.

So perhaps the federal government is responsible for that and that's working. But according to the Auditor General, there's not much that is working when it comes to the clienteles that report to the federal government.

● (1140)

[*English*]

Dr. Donald Juzwishin: Yes, this is an area of significant challenge. You think of the accord just starting in 2003, but it isn't a great length of time that's been associated with attempting to get these indicators in place.

Despite the challenges, I think there have been some promising results. For example, there was an article in *The Globe and Mail* this morning that identified the initiatives that are taken on the pan-Canadian effort to try to better understand the issues around neonatal mortality within the aboriginal communities. That conversation requires, of course, the clear definition of what is meant by health within the aboriginal communities, as well as taking those definitions, turning them into indicators, and then standardizing them across the country.

That conversation has not yet taken place, and that is something I think this committee may want to encourage facilitation of. Dr. Besner and Ms. Yeates have indicated that we are at the beginning of being able to understand where we are with cataract, hip, and cardiac surgery, so in these other areas we have to make some significant advances and introduce these conversations so that we can provide the information you're seeking.

[*Translation*]

Ms. Christiane Gagnon: Is there a need to be very proactive, to provide more money or better support? If there are delays... The federal government is responsible for meeting objectives in every area where we're supposed to see results, such as in the medical field. It's a bit disappointing to see that you haven't got your ducks in a row. You produce a report, but perhaps it would be better to adopt a different approach based on the different communities that are the federal government's responsibility.

Dr. Jeanne Besner: I've just been told that our staff met federal government representatives to ask basically the same questions. Based on what our staff have said, they've developed their vision and started to define their objectives. But for the time being, we don't have anything to report, although the action plan has been developed. We should have more results in the upcoming years.

Ms. Christiane Gagnon: I was wondering what would be needed for you to submit a more in-depth report, which takes into account all these factors. It's the whole support component that gets me a bit angry. It's not the first time that there have been reports of alarming situations in the aboriginal population.

Dr. Jeanne Besner: We need indicators and measures. We've already met with federal government representatives and we're going to continue our dialogue with them with a view to developing indicators and measures in the future.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Madame Gagnon.

Ms. Priddy.

Ms. Penny Priddy (Surrey North, NDP): Thank you, Mr. Chair.

Thank you to the presenters. Your presentations in some way have made me want to yell “Help!” I'm sitting in for someone today, so I've not sat at this committee table for some time now, but the issues seem to be very similar to ones that were discussed when I was here.

My worry is that we have CIHI collecting the information that they're supposed to collect—fair enough—but indicating that there certainly are some differences in terms of availability of data, how people measure, and all of that across the country. From the Health Council of Canada we have some indicators of really the same sort of thing, either movement that is slower than it ought to be or indicators that we cannot find because they're not there.

None of this is anybody's fault. This isn't a finger-pointing exercise. But if we have two, probably three organizations, if not more, measuring or looking at similar things without the data to support how we do that, how do we fix this? I don't want to be here in six months' time and have the same kind of report: yes, we're moving forward slowly; yes, it's been a catalyst.

I would agree with one of the comments in here that the focus on the accord, at least in any kind of public way, is much, much decreased from what it was when it began, and so is the excitement around it—other than if you speak of wait times for hips, because then you can get people excited.

How do we go about integrating the information that people are gathering, for one thing? There's a lot of hunting and gathering going on out there. How do we integrate all of that information so that when we sit here, we hear something that has some match between the people who have gathered the information? And then, how do we more quickly ensure that there are compatible measurements so that when this information comes forward we know that it is at least empirically similar to what each organization is hearing?

I'm just worried about the lack of integration of the information, the inconsistency of the data that are being collected, the standards under which the data are being collected, and I guess the disappointment of people with the fact that this has not moved forward with more excitement.

Both people, please.

● (1145)

Ms. Glenda Yeates: Perhaps I'll begin.

With regard to improving data, I appreciate the frustration, which I think all of us in the sector share. But if we take a longer view at CIHI.... We began 14 years ago with a few databases in acute care, and we're now up to 27 databases and building more. My sense is that there has been progress in terms of improving the data. It is slow work, as you point out.

In terms of branching out beyond acute care into new areas of home care, pharmaceuticals, and health professionals beyond doctors and nurses, and deepening our understanding of those health professions, we are continuing to build the data. It is never enough data to answer all the questions people have, but I think there is progress.

In terms of how to integrate it, we've concluded that there is a challenge in making sure we turn the data—because it is expensive to collect—into indicators and measures that people can actually use. We certainly work with our stakeholders to understand how to simplify and how to produce health indicators that can be used, whether it's in a small regional health authority, in a rural area, or elsewhere.

In terms of making the data comparable, that is, in a sense, a role that we take very seriously, and we do work to enhance the comparability of data. There has been convergence in wait-times data, but it is not yet at the point where we have comparable data, as we mentioned. As we point out the differences, that will help convergence to occur over time.

Ms. Penny Priddy: Thank you.

I'll have a comment in a minute, if I might, but I'd like you to answer this.

Dr. Jeanne Besner: In terms of interpreting data, one of the strategic directions the Health Council has determined it's going to take over the next five years is to actually look at multiple sources of data and try to create more of a story that speaks to Canadians about where there is value for money in the system, about the things that we're doing right, about the areas where we should be doing things differently and so on, and perhaps place less emphasis on trying to collect comparable data when there are none.

I think we can add value to the health system and help inform the public of Canada about choices to be made by working collaboratively with our colleagues from CIHI, Statistics Canada, and many other sources, in terms of gathering data from a variety of places, interpreting it, and beginning to be clear about how we can make decisions about where we need to go. We have to make a lot of choices in the health system, but we also need to get a bit clearer about where it is we're trying to go, because it's pretty hard to develop indicators and measures about everything and anything.

Ms. Penny Priddy: I agree.

Dr. Jeanne Besner: We need to be a bit more focused than we have been.

● (1150)

Ms. Penny Priddy: Thank you, Mr. Chair.

My concluding statement would be that we have.... Yes, it's a long-term project, and I understand that. But there's also money being spent and there are people in crisis. Aboriginal people are in crisis. Our pharmacare program is in crisis, or at least people in certain parts of our country are dying, and they would not be dying if they lived in a different province. Hopefully, where we focus our energy and our resources is on those people who can't wait five years for us to figure out the indicators and figure out all of those things. They are in crisis now, and indeed have been very hopeful about this, that it would bring about changes faster for them.

I will close with that. Thank you.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Ms. Priddy.

Now we'll move on to Mrs. Davidson.

Mrs. Patricia Davidson (Sarnia—Lambton, CPC): Thank you very much, Mr. Chair.

Thanks very much to our presenters for being here this morning.

Certainly it's been interesting to hear the opinions and the progress—or lack thereof in some cases—that you presented to us this morning.

Dr. Besner, I want to ask you a question first. You had outlined nine areas where there were concerns. Then you went on to say there were several reasons why you may have seen some disappointment in meeting some of these commitments, and you talked about key elements not being well defined as the first reason. Then you went on to state two or three more.

What's the mechanism for correcting this? Is there a mechanism to open the accord, or add to it, to add definitions or...? How can this be addressed?

Dr. Jeanne Besner: I think with anything, if you have a vision of where you want to go, that helps. The accord provided an overarching vision of where we wanted to go in terms of health reform, but outcomes don't get achieved very easily. Going from visions to outcomes you have to develop some very clear strategic plans, some strategic activities that need to be followed. In some ways we need to go back to that step, because I don't think it was done well enough to give a really clear sense of movement forward. You can't develop comparable measures if you have different ways of approaching issues and so on. We just need to work more collaboratively in future, and governments do as well, to redefine where they want to go and what the priorities are and translate that into more concrete actions that we can then clearly evaluate.

Mrs. Patricia Davidson: This is something the provincial, territorial, and federal governments can work on underneath the existing framework. It is not something that needs to be opened up, added to, or—

Dr. Jeanne Besner: No, that's right, and I think that's what—

Mrs. Patricia Davidson: How does this get encouraged if some of these groups aren't meeting now? Were they some of the groups that should be looking at this?

Dr. Jeanne Besner: Yes, I would think so.

Dr. Donald Juzwishin: I might just add to Dr. Besner's comments. There have been some very successful initiatives across the country. The difficulty is we haven't had that conversation in a pan-Canadian context, so the Western Healthcare Improvement Network in British Columbia, or the Health Quality Council of Alberta, the Saskatchewan Health Quality Council, the new one announced in New Brunswick, the one in Quebec, all of these are gems of good efforts to try to advance the conversation within the regional context.

What we need now is to provide some cementing of that conversation that can help carry this agenda forward nationally.

Mrs. Patricia Davidson: I gather from this that one of the things this committee could be looking at as a recommendation is further and better cooperation among the different groups.

Dr. Jeanne Besner: That would be extremely helpful, and it reflects the spirit of the accord. There was to be pan-Canadian visioning and collaboration on moving things forward, so yes, reinforcing that would be lovely.

Mrs. Patricia Davidson: I want to ask a question on wait times. It was my understanding that when we entered into this accord the starting point for each province may have differed from province to province. Now each province is pursuing its own priorities and its strategies, I believe, for wait times, so in the five priority areas, how do we compare from province to province or area to area how we are having success or where we're not having success?

● (1155)

Ms. Glenda Yeates: At this point I would answer your question in three ways as per our ability to look at this. In the data limitations we now have we can simply look at the question of volumes. Were more procedures done in the different areas? When you look at those numbers you can see reflected the different priorities in the different areas. You can also look at the different starting points on the rates of procedures. For example, on a population basis, some provinces have much higher rates of cataract surgery or hip replacement surgery going into the accord, so one might expect that looking at rates would be helpful so you can see how one province now compares to others in that way.

Finally, the thing we would like to have is to be able to look at the actual waiting times. Does it take six months? Does it take three months? Does it take three weeks to get a given type of procedure in one part of the country versus the other?

What we can see from the tables we have put together now is that we are closer to that point, no question. You can see the definitions do converge, but it's still not the case that we can say definitively that the same procedure will take two months in Nova Scotia and four months or two weeks in British Columbia. We can see if the reported wait is four weeks in one spot and two weeks in another, if they are including emergency cases or they are not, if they are starting the clock and stopping it in the same period of time. If there are differences, you can at least have some ability to assess where those different definitions might lead you, but at this point there is still a lack of comparison in that third component as we look across the country.

Mrs. Patricia Davidson: Are we on track to evaluate this down the road as we continue with the accord, or do we need to make changes there too?

Ms. Glenda Yeates: I think there has been convergence. Those who are interested in comparable reporting would prefer to see it converge more quickly. I think that would be fair to say.

We all appreciate that these are big changes. Three years ago, many of these lists were kept in physicians' offices. They weren't kept in a facility at all. As these changes come forward across the country, I don't think anyone is underestimating the change management that individual jurisdictions have had to go through. One can therefore appreciate that it may be difficult to say that we all need to collect it in precisely the same way.

We have seen some renewed interest in understanding the differences in definitions. We would hope that this interest would lead to converging on a decision about the same definitions being used. This way, you could actually compare definitions across the country in the future.

Mrs. Patricia Davidson: I'd like to ask about the wait-time benchmark for diagnostic imaging. That was one of the areas that was identified but apparently hadn't been done. Is there any movement there?

Dr. Jeanne Besner: To the best of my knowledge, no.

Dr. Donald Juzwishin: As to coming up with a national benchmark, there are hundreds of diagnostic procedures—MRIs, CT scans, PET scanning, X-rays, nuclear medicine. What's needed is to come together with the provinces and territories to talk about establishing benchmarks that can be used throughout the country, though some could perhaps be customized for particular areas. Other jurisdictions like the United Kingdom and the Netherlands have done this, but it requires that people come together and hammer out the details.

The Vice-Chair (Mr. Lui Temelkovski): Madame Kadis.

Mrs. Susan Kadis (Thornhill, Lib.): Thank you, Mr. Chair, and welcome to all our guests today.

This area is vital to the health of Canadians, particularly in view of the aging population. It becomes much more incumbent upon all of us, and certainly the government, to ensure that the great promise of the health accord is actually realized.

When was the intergovernmental committee disbanded? What was the timeline?

● (1200)

Dr. Jeanne Besner: We asked that question a couple of times, and we didn't get a specific date. It is our understanding that it met for around a year, perhaps a bit more. Oh, June 2006, so I guess it met for more than a year.

Mrs. Susan Kadis: How can we realistically see the promise of this government for guaranteed health wait-times realized if we don't have comparative data? You're saying that it's an ongoing challenge. Is this feasible, or is it more theoretical than practical? If we don't have comparative data from province to province, or if we can't get the data because of the different ways of reporting, is this effort something that's even achievable?

Ms. Glenda Yeates: We have made significant progress in other areas, so I believe that we can achieve comparable data across the country. It is always a challenge, given the decentralized nature of health care delivery. It will take a lot of energy and work to standardize practices, even from one hospital across the city to another, never mind from one jurisdiction to another. I would not say it is easy; I would say it will take ongoing vigilance. But I think it is something that over time we can achieve.

Mrs. Susan Kadis: The impression we're getting today from our various witnesses is that there is no current pan-Canadian vision for health care or wait-times by the current government, and that interest and commitment in this area has been flagging, as was shown by the disbanding of the intergovernmental committee. So how can we actually achieve this goal?

We're all concerned that the health care wait-time reductions will not take place in a substantive way soon enough for people to have their health improved. We are concerned about the human suffering and health care costs of not having these reductions take place. Leadership is required. It was there initially. It doesn't seem to be there now, not with the same gusto and commitment.

Dr. Jeanne Besner: Obviously there are many, many initiatives and a lot of effort in terms of health care renewal going on across the country. So individual jurisdictions are moving forward—there's no question of that—and progress is being made. I think the point we were trying to make was is there the pan-Canadian vision, the working together, to be clear that we're moving together, without disadvantaging particular jurisdictions and others? I think that's what needs to be recommitted to.

Mrs. Susan Kadis: When you talk about reviving, it sounds like something is dead or something has gone by the wayside. It's of great concern, I'm sure, to all of us here today, because I think with everybody in every province working in various capacities on these vital areas, we won't reach our objectives if there isn't this overarching commitment by the current federal government, or by a federal government per se.

Dr. Jeanne Besner: I would say the commitment has to be made on the part of all governments.

Mrs. Susan Kadis: There seems to be a roadblock or an impediment to achieving these very important objectives.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

I would remind members that we have other panellists here with some special experiences and strengths. Maybe you can move your questions in that direction as well.

Mr. Brown.

Mr. Patrick Brown (Barrie, CPC): Thank you, Mr. Chair.

I want to touch upon a few things.

I always hear from my local hospital about some of the accomplishments they've had with wait-time reductions. They speak about the local examples and Ontario examples. As an Ontario MP, I'm interested in you sharing with us some of the successes that any of you have witnessed in the province of Ontario specifically with the reduction of wait times.

Ms. Glenda Yeates: I'll begin and then ask my colleague to speak to that situation.

We have seen, as I mentioned, significantly improved reporting from the province of Ontario in the time period that we've been looking at wait times. Certainly there is much better data. Again, in some of the examples that I raised, the data has stayed relatively constant in terms of the definitions in the province of Ontario. For example, for hip and knee replacements, certainly we do see improvements in those areas. We have seen a tremendous focus in that province, and that's reflected in our reporting.

I'll ask my colleague to expand on that.

● (1205)

Ms. Kathleen Morris (Consultant, Canadian Institute for Health Information): I think we've seen a number of changes in Ontario over the three-year period when we looked at reported wait times, specifically, as Glenda mentioned, in joint replacements. We've seen similar dramatic decreases in cataract surgery waits as well.

Some of the other areas have been challenging in terms of definitions. I think there have been more stable reported waits in those areas. Those would include cardiac care and cancer surgery.

I think an ongoing challenge in Ontario is wait times for diagnostic imaging, particularly MRI.

Mr. Patrick Brown: One thing I've heard from my local hospital that I found interesting is that from 2004 to today they've gone from a waiting time for an MRI of 54 weeks to seven weeks. Is there any evidence of additional MRI hours being available across Canada or across Ontario? Is that one of the causes of the success you're seeing?

Ms. Glenda Yeates: Certainly one of the things we do know about MRIs and CTs is that there are increased volumes. There are significantly more scanners in place and operating now, and we do see significantly increased numbers of exams. In some cases that's because of additional machines that have been put in place. In other cases it's because those machines are working longer hours or they're machines that have greater efficiencies and can do more scans each hour. Whatever the combination, what we do know is that there has been an increase of some significance across the country in terms of MRI scans over the last number of years.

Mr. Patrick Brown: I know in the case of my local hospital, the additional funding allowed them to go to a 24-hour service, which previously wasn't available.

In the ten-year health accord, I know there's a part of it on medical equipment. Could you touch upon the type of medical equipment that has been made available and how it is has contributed to wait-time reductions?

Dr. Jeanne Besner: A lot of that was MRIs, CT scans, and all the rest of that. I don't remember offhand the amount of money, but a significant amount of money that was invested in 2003 or 2004—I forget which, I think 2003—was specifically targeted at improving the amount of diagnostic equipment across the country. I think that's why we're seeing an increase in the numbers.

Dr. Donald Juzwishin: There has been a significant increase, as Dr. Besner has indicated. One of the really important questions to ask as well is are all of those particular diagnostic procedures appropriate or necessary?

Clinical guidelines around developing the indications for how to prioritize and how to actually undertake these in a much more efficient fashion is something the hospital you're probably speaking of is taking much more seriously as well, so things that are maybe not appropriate are not on that list. There have been some significant advances on that front.

I might also mention that tomorrow the Ontario cancer strategy, you'll be interested to know, is releasing their list of 38 indicators around cancer care in the province. Those indicators will be available to all of the public on the web.

I think there have been some great strides made with examples like that. The trick now is to advance that diffusion of activity to other parts of the country as well.

Mr. Patrick Brown: Given these successes, I know I asked my local hospital what the challenges are. One of the challenges I was informed of is capacity. Did you find that to be a broad issue nationally? I know that with proposed surgery, the limiting factor in my local hospital is that they're always at 96% or 98% capacity, so it's very difficult to find space.

Has there been any thought given to how to meet this challenge around the country?

Dr. Jeanne Besner: I don't know.... Yes, everybody is dealing with capacity pressures and capacity issues, but do we have a pan-Canadian approach? Not that I'm aware of.

From a personal perspective, that's an area in which I work, and I think that a lot of our capacity issues are also related to how we work together. It's not only about not enough beds or not enough money or whatever. I think we need to start working very differently in order to address many of our capacity issues, and I think many organizations are doing that.

● (1210)

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

Monsieur Malo.

[*Translation*]

Mr. Luc Malo (Verchères—Les Patriotes, BQ): Thank you, Mr. Chairman. Thank you for being here with us this morning.

A document entitled "Health Care Renewal in Canada: Measuring Up?"—the question mark is interesting—states that it is not clear to what extent progress has been made in terms of the commitments and promised measures to deal with health-related problems faced by aboriginals people. And you actually alluded to this very clearly in your answers a little earlier, Dr. Besner.

When we considered this issue at a previous meeting, I asked the Department of Health to explain why there is no clarity around this issue, and I didn't really get an answer. However, you started to tell us members of your staff are currently in discussions with the department to clarify a number of commitments they've made and progress in terms of the various proposed measures.

Is a delay of five years normal for a commitment announced with such great fanfare, that is the question. Is it right that they should have to wait five years?

Dr. Jeanne Besner: I can't—

Mr. Luc Malo: Is that too long to wait?

Dr. Jeanne Besner: What you need to understand—

Mr. Luc Malo: I'm talking about wait times in the health care system. Is a five-year wait—

Dr. Jeanne Besner: We're embarking upon our fifth year. You need to understand that we face quite formidable challenges. It's the first time that there has been a pan-Canadian strategy that focuses on cooperating in an attempt to meet set objectives. And that takes time. Our system is huge. And this doesn't happen overnight. I can't tell you whether it's normal or not. The process is underway, and that is better than nothing at all.

Mr. Luc Malo: Do you play an influential role, compared with your other partners? Can you ask questions, and require answers? Is your role limited to waiting for reports to be sent to you, which you can then analyze and comment upon?

Dr. Jeanne Besner: I believe that we can have an impact—several of our reports have up till now—by giving examples of programs, of ways of doing things that have been successful in several areas of our country or elsewhere. We can give examples. Can we work with governments in order to have a direct influence? No, that is not our role.

Mr. Luc Malo: Could you be more specific and tell us about some changes that you have made that were received with great enthusiasm and that were followed up with tangible steps?

Dr. Jeanne Besner: No, I could not say that... Nothing comes to mind immediately.

Mr. Luc Malo: All right.

Ms. Yeates, is your role limited simply to collecting information and presenting it in the form of graphs and charts in order to follow progress over time? Do you play a more proactive role in the implementation and application of different measures?

Ms. Glenda Yeates: Our role is to provide databases and information to contribute to the debate of those who manage the health care system and are making decisions for this sector. Therefore, for us this is important. We make no recommendations and we take no positions. We hope that the databases and information that we provide will be relevant. However, it is not our role to state an opinion.

● (1215)

Mr. Luc Malo: Very well.

[*English*]

Dr. Donald Juzwishin: I can be very enthusiastic about the identification of the introduction of compassionate care. For those family members who may have a loved one, a friend, or relative who has become ill, we took the cause of promulgating and encouraging governments across Canada to look at introducing that, and through EI legislation it is now an option for people to actually take two weeks off work. Maybe it's not enough, that's true, but we are proud of having signalled the Canadian public and governments to the importance of that particular program.

[*Translation*]

Mr. Luc Malo: Thank you.

Thank you, Mr. Chairman.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you.

Mr. Tilson.

Mr. David Tilson (Dufferin—Caledon, CPC): Thank you, Mr. Chairman.

I have a question for Ms. Besner. As I understand it, the Alberta and Quebec governments have never participated in the Health Council. So my question is how much, if any, of this has constrained your work?

Dr. Jeanne Besner: Although they are not members of the Health Council, they have both identified liaison individuals with whom we interact. The executive director of the Health Quality Council of Alberta, Dr. John Cowell, is our liaison to Alberta. In Quebec, although perhaps it's not quite as formal, we have had interactions with Dr. Robert Salois, who is their commissioner for health and social.... I don't know the exact title. We have been able to access the data that are published on the public websites in Quebec, so when we've done our reporting we have certainly used website data where we could make comparisons with other jurisdictions and so on.

Mr. David Tilson: So this has not constrained you, or has it constrained you to some degree?

Dr. Jeanne Besner: It has not constrained us a whole lot. We've had difficulty in doing comparable reporting across the country in any case, because we don't have comparable indicators in other areas.

Mr. David Tilson: With respect to wait times, the starting point for each of the provinces has been different and they've pursued their own priorities and strategies. Can you provide examples of where there have been significant wait-time reductions in some of the five priority areas?

Dr. Jeanne Besner: I think I should defer. Ms. Yeates has more information.

Ms. Glenda Yeates: The starting points are different because different provinces chose different priorities.

As I understand it, the choice of priorities in the most recent round of negotiations and money that was furnished for wait times is not something we've commented on specifically in our reports. What we have attempted to do in each case is to look at what the overall situation is in the provinces, as we understand it from the reported data. Where there are trends, we've been able to report those, and we will be continuing to monitor that as it goes forward. But it is true that we see the starting points being very different, if you look at rates of surgery going into the 2004 accord. Regarding the emphasis that different provinces have placed, some have focused very much on hip replacements and knee replacements; others have found the need in their jurisdiction to be cataract surgery, for example, and have put their focus there.

So we do see in the data, certainly, evidence of different provincial priorities being pursued.

Mr. David Tilson: Ms. Yeates, could you elaborate somewhat on slide 8 of your presentation, which has to do with diagnostic imaging? I look at the change in the number of scanners and the change in the number of exams. I assume doctors are ordering more exams and in fact are probably performing more operations. I assume that; I don't know whether it's a right assumption.

● (1220)

Ms. Glenda Yeates: Yes.

Mr. David Tilson: I assume that's what this chart tells us. Therefore, I ask this question. If that assumption is correct, is there a change in the waiting lists?

Ms. Glenda Yeates: I think one of the lessons we've learned, as a country, in the last number of years is about the complexity of the relationship between doing additional volumes and the impact on waiting times and waiting lists. It is absolutely the case that we are doing additional volumes of scans, as well as surgeries, in the priority areas. I think that's very clear.

The impact that would have on times is less clear. It may be the case that the ability to do surgeries in a more timely way draws out more demand, as some have speculated. There may have been suppressed demand, where people felt the list was too long. I've heard some physicians express the view that perhaps they weren't suggesting surgery because it was simply too long a wait or they were waiting until they felt there was greater access. So there may be increased demand coming forward because of the increased volumes.

What individual jurisdictions are looking at is the complexity. We are doing more, but that doesn't necessarily mean in all cases that there's a corresponding immediate decrease in the waiting times. We are seeing those emerge in some places, but in other places we see increased volumes and yet the time remains relatively stable, and that may be because of increased demand.

So I think it's important to look at the volumes. It will also be important for us to track the information on waiting times over time.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Tilson. Your ten minutes is up.

Ms. Priddy.

Ms. Penny Priddy: Thank you, Mr. Chair.

First, let me ask this. One of the items you've looked at, in terms of progress, is around the health care workforce. Can you tell me who in the health care workforce you've looked at?

Ms. Glenda Yeates: We have data on physicians and nurses. And when I say "nurses", I mean we have information on RNs, licensed practical nurses, as well as registered psychiatric nurses. We are expanding now. We've just begun databases in five new areas where we're collecting data: pharmacists, occupational therapists, physiotherapists, and we are developing databases for medical radiation technologists and lab technologists. So those are the five that are under development currently.

Ms. Penny Priddy: I see. Okay. I was concerned about the fact that it's fairly narrow, and I would think about adding things like dieticians and physician assistants, which is a smaller but growing population.

When you looked at nurses, did you look at nurse practitioners?

Ms. Glenda Yeates: Yes. Now a component of the nurse database is nurse practitioners.

Ms. Penny Priddy: That is a much broader base than the doctors and nurses.

I want to go back to something that was said earlier, which is about whether they will will get to the stage, and whether we should get to the stage that it simply is not possible to do comparable data; that, no matter how hard we try, we can't get it.

I don't want to find us waiting to do things, as I said earlier, for people who are literally, as aboriginal people are, dying while waiting for movement in the area, for instance, of aboriginal health or pharmacare. Is that a consideration or a discussion that the committee has had: that we might get to the stage where you say—I don't care who answers it—we tried; we looked, and it's not possible; let's move on and find a different way to get some of these improvements out to people, without forever chasing something that we've now decided is impossible to be caught, or will be simply a work of process for the sake of the process?

I would hope we would all agree that process is really about outcome, because those people who are dying for not having drugs or potable drinking water or health care in their communities at some stage will stop being very interested in our comparable data.

Somebody—anybody—have you had this discussion?

● (1225)

Dr. Donald Juzwishin: I'd like to point out that I became associated with the field of health informatics at the University of Victoria in the mid-eighties. It is an emerging area, and it is an absolutely essential area. Since the Hospital Insurance and Diagnostic Services Act was passed in 1958, and then the Medical Care Act in 1968, followed with the continuing care work during the 1970s, we've been very much institutionally focused, so we've been counting a lot of widgets, a lot of activity in that way.

There is a paradigm that is emerging now, which is turning our attention to exactly the words you have used: what are the outcomes? Because we're in the very early days at the moment, it seems hopeless, but I can assure you it is not. There are material ways of being able to have conversations around what it is we want to measure, coming up with those indicators, and agreeing on what they ought to be across the country.

From my perspective, the conversation you've facilitated here is the beginning of advancing that agenda. I think it's an important one.

Ms. Penny Priddy: Thank you.

Ms. Glenda Yeates: The only thing I would add is that we see the advantage of comparable data for looking at things such as outcomes, and for understanding what we are producing, and whether, if you measure one set of activities in the same way as others, you can then compare it with others. Some of those comparisons are what can lead us to understand outcomes.

This is the reason we've reported wait times as we have them now, even though they're not perfectly comparable. We believe that when we put the information there, noting the differences, it's still very valuable and useful information. I think comparability is the gold standard, and we should certainly strive towards it, but I think we can gather information and use it and make decisions on it even when it's not perfectly comparable.

Ms. Penny Priddy: That would be my hope, in spite of the fact that the first question I asked you was about comparability of data.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much.

Ms. Penny Priddy: Are we done?

The Vice-Chair (Mr. Lui Temelkovski): Yes. Thank you.

We'll move on to Mr. Fletcher.

Mr. Steven Fletcher (Charleswood—St. James—Assiniboia, CPC): Thank you, Mr. Chair.

I'd like to thank the witnesses for being here today.

There has been talk about pan-Canadian initiatives, and I'd like to seek your views on the fact that the government has invested over $1 billion in public health across the country. We also had some mention about disseminating information on cancer—for example, the Canadian Partnership Against Cancer, which is a unique structure that has the buy-in and participation of all the cancer agencies in Canada, and the Canadian Cancer Society, the cancer care community in each province. They are tasked with doing exactly that. Part of their mandate is ensuring best practice and disseminating information. I wonder if you could comment on that.

We also have the cardiovascular steering committee, which is coming up with a plan that will likely be similar to the Canadian Partnership Against Cancer. They're meeting right now. So there is activity taking place in that realm.

Moreover, there is also the Mental Health Commission— $100 million going into mental health. And though it's a taboo subject, it's something that affects one in four Canadians at least once in their life. It's very important. I'd be interested in your comments on that and perhaps the unintended positive consequences of these types of programs.

I also have a question for Ms. Besner. On page 2 of your report, you talk about the Kelowna communiqué. Could you explain the difference between a communiqué and an accord?

Dr. Jeanne Besner: I can't answer the last question, the difference between the communiqué and the accord. I'm sorry.

Mr. Steven Fletcher: You obviously had deliberate wording. Why is the wording different?

Dr. Jeanne Besner: I'll ask one of my team members.

It was not an established accord, it was a communiqué.

● (1230)

Mr. Steven Fletcher: So what does that mean? Could you elaborate on that? Explain that to me a bit.

Dr. Donald Juzwishin: If I were to think about the context in which that had been communicated, it would be an opportunity in which individuals came together to try to deal with a common problem. The result of that communication would simply have been put with the label of “communiqué”, just as one can have a letter of understanding, for example, or a memorandum of intention, or a social or health accord. I think these labels are a way of simply identifying them. I don't know that there was any specific definitional reason.

Mr. Steven Fletcher: So there was no legal ground, and no money attached or any ultimate commitment. I just wanted to be clear on that.

And on the other....

Dr. Jeanne Besner: To go back to your first comment, I think there are a lot of initiatives going on across the country that do reflect a pan-Canadian focus. We were charged with the responsibility of monitoring and reporting on the elements of the accord where there was agreement to develop, collaboratively, particular types of indicators, establish benchmarks to do whatever. We were only speaking in relation to those specific elements of the accord. We do not have a mandate, nor was I trying to reflect all that is going on across the country. We're just focusing on the work we were asked to report on.

Mr. Steven Fletcher: Donald—I hope you don't mind my using your first name, because there are challenges with the last name for me—you did raise the issue of disseminating information across the country. You used Ontario as an example. Based on what you know of the Canadian Partnership Against Cancer, would you agree that it is a good initiative? It is unique, and a lot of organizations are looking at that as a model. It's really important that we understand your views on initiatives like that.

Dr. Donald Juzwishin: Yes, it is, and we've been very fortunate to have been invited to participate in the conversation on Dr. Eldon Smith's initiative on cardiovascular disease across Canada. We've engaged in conversations with Dr. David Butler-Jones with respect to the Public Health Agency of Canada's initiative to address and advance efforts across the country.

The Health Council of Canada is extremely committed to facilitating the kinds of conversations that will help advance Canadians' understanding of the health care services they are receiving. And we are committed to identifying best practices in other parts of the country that might be adopted in areas that would be interested in doing so. Any of those kinds of initiatives that generate synergy to improve delivery of care to Canadians we, of course, are very supportive of.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Juzwishin and Mr. Fletcher.

We will now continue with Dr. Fry.

Hon. Hedy Fry (Vancouver Centre, Lib.): Thank you very much.

This is a very interesting report. I want to ask Ms. Yeates, from CIHI, a question.

You stated that the variation in measurement approaches still prevents interprovincial comparisons. You are speaking to a federal body here. These are all MPs. The whole idea that there was a commitment to this in the first place from the federal government and from the provincial governments was to ensure that Canadians would not have disparities, depending on the province they lived in. So you are saying that you don't even know whether that's happening and whether Canadians are in fact suffering disparities in terms of wait times based on where they live, because you don't have the ability to do that tracking. Is that what you said?

Ms. Glenda Yeates: I think it's clear that even within provinces there are disparities. We know from all the wait-time information, even if you measure median waits, that there are people who get in very quickly. The first 10% of people make it in quite quickly, and the last 10% of people may wait a long time. So it's clear that regardless of procedure, even if you live in the same city, there will be disparities.

The question is whether can we compare the extent of those disparities between one province and another. Often the definitions that are used are quite different, so at this stage we are not saying that we can compare across the country.

● (1235)

Hon. Hedy Fry: I understand that. Basically what is needed in order to pull together some sort of database that is pan-Canadian, to pull together some kind of clearing house with that data, and to look at what we're comparing—and whether we're comparing apples to apples and oranges to oranges—is some leadership from the federal part of the team .

So what I think I'm hearing is that this leadership hasn't surfaced.

I also wanted to talk to Dr. Besner and ask her a question. You stated very clearly on page 1, and I quote, that “The Health Council of Canada is particularly concerned about nine areas of health care renewal where action has been slower, less comprehensive, and less collaborative than First Ministers originally envisioned in the accords of 2003 and 2004”.

You also stated that in June 2006 the interprovincial group was disbanded. Then you went on to list the nine areas that concern you. Again, what I'm hearing is that there doesn't seem to be a commitment to the collaborative approach to the vision for moving this agenda forward that was put forward in 2003 and 2004 by provinces and the federal government .

Your Infoway goal of 50% of Canadians having a secure electronic health record, you tell me, is not on track. How far is it off track?

Dr. Donald Juzwishin: Canada Health Infoway is going to be releasing their annual report in June of this year, so we will have that data available at that time.

The numbers reflected in Jeanne's data to this point are for 2007. The others will be forthcoming.

Hon. Hedy Fry: But you said here, clearly, that they're not on track. You said that we are not on track to meet Infoway's goal of 50% of Canadians.

Dr. Donald Juzwishin: Right.

Dr. Jeanne Besner: The data we have shows that as of March 2007, approximately 5% of Canadians have an interoperable electronic health record.

Hon. Hedy Fry: Yes, good.

Here is one final question. You talked about wait times, and I wanted to congratulate you for bringing up the idea of clinical guidelines, because obviously something that most people don't talk about is that in order to bring your wait times down you've got to use your resources appropriately.

Can you tell me if there are any other groups working on clinical guidelines for appropriate use of care and appropriate use of diagnostics?

Dr. Donald Juzwishin: I would be prepared to answer that. In my experience, there are some real jewels of success across the country. If we go to the Calgary Health Region, we probably see one of the pre-eminent programs for the delivery of hip and knee surgery in the country. The program that was developed there was done on the basis of very, very specific kinds of indications and included developing care plans with pre-admission activities that took place and made sure that when people were discharged from that program, they would be cared for appropriately in the home. That particular initiative, I think, is a model of clinical guideline development that would be a marvellous one to be looked at.

Those are then checkered with other initiatives that are undertaken in other parts of the country. Saskatoon has developed an initiative facilitating care in urology associated with specific maps so that when patients come in for their treatments, they know exactly what to expect, when they're going to get out, and what's going to be required in post-treatments.

So there are some real positive things to be looking at.

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Mr. Juzwishin.

Now we will move on to Mr. Clarke.

Mr. Rob Clarke (Desnethé—Missinippi—Churchill River, CPC): Thank you, Mr. Chair.

I'm just trying to grasp a couple of things here. First of all, I'm first nations. I have lived on a reserve. I've worked on the reserve. I've seen health issues on reserve, from my day-to-day job activities as a law enforcement officer with the RCMP.

The Kelowna communiqué.... This is the difference here. I'm just trying to grasp this. Was there any funding or anything like that with regard to first nations, or is this just...? I just want some clarification here, if you don't mind, on the difference between the Kelowna communiqué and the accord.

● (1240)

Dr. Jeanne Besner: I'm trying to remember the specific elements of aboriginal health in the accord. I think there was a particular focus on trying to look at healthy populations or the health of populations with a particular focus in the accord on aboriginals. I don't remember that there were specific allocations of funding targeting that.

There were?

I just don't know the answer to that.

Dr. Donald Juzwishin: I can give you one example that has been undertaken. That is where the health care delivery mechanisms and social delivery mechanisms, which were taking place in isolated kinds of ways from different departments within health, have now been developed into an integrated structure, facilitating easier movement of individuals between the different types and levels of service that are available. So that's one specific thing that I do recall having been introduced just within the last several years.

Mr. Rob Clarke: Living on the reserve and working there, I was always under the impression that there was funding for this coming forward. So you're just saying there's a communiqué. There's no funding.

Dr. Jeanne Besner: According to our staff member, yes, there was money, but it was not substantial. It was about $5 million.

The Vice-Chair (Mr. Lui Temelkovski): Anyone else? Mr. Tilson, do you want to pitch in? You've got a couple of minutes.

Mr. David Tilson: A couple of minutes, yes.

Ms. Yeates, I find the chart with respect to physicians and nurses interesting. The percentage increase is actually encouraging, because certainly in my community that's one of the favourite subjects for questions: the shortage of doctors, the shortage of nurses. So that's an encouraging response.

Has your organization gone into this issue further, looking at doctors returning to Canada from the United States, doctors anticipating retiring, whether or not there has been an increase in foreign doctors, and qualification of foreign doctors? In other words, have you gone into a complete analysis of this issue?

Finally, is there a time when we as a government or governments need to be concerned that there might really be a shortage of doctors because of the issue of retirement, the issue of the age of medical practitioners?

Ms. Glenda Yeates: Certainly we know this is an area of critical interest in terms of the health sector, and we do look at a number of these questions. We do not have perfect information about all the questions, as we would like, but we do have a number of points I can respond to in terms of the points you raised.

We know the ratio of positions to population was increasing until about the early nineties, and then it fell a bit and has remained fairly stagnant. We do know that we have about the same number of physicians per population as we did ten years ago, but at the same time we know that medicine has changed: it's increasingly specialized, and we use physicians in a different way. We've seen the increased volumes of activity, so we can understand why, when you look at those ratios, you can feel the pressures we feel as a health system in terms of the numbers.

We also know that internationally Canada has fewer physicians in relation to its population than a number of the other similar countries in the OECD, for example.

We do have the breakdown in terms of those who are immigrating and registering as physicians in Canada, those who have come back to the country, and those who leave. For the last couple of years that we have been measuring this, the number of physicians who are returning to Canada from abroad is in excess of those Canadian physicians who are leaving Canada, so there is a good-news story there.

My understanding, in terms of the numbers of foreign physicians as a proportion of the foreign-trained physicians and as a proportion of the total number of physicians in the population, is that it is relatively stable; it's around the 18% mark, and that at the moment is relatively stable.

With regard to your question about retirement, we do know the physician workforce is aging, and we're tracking an increasing average age of physicians. While we don't know precisely when they will retire, we do know this is certainly an issue that planners need to take into account, as well as the increasing feminization of the workforce because the younger physicians do not work in the same way as the older physicians did.

These are all things we're documenting and trying to provide to health care planners for their benefit and for their purposes.

● (1245)

The Vice-Chair (Mr. Lui Temelkovski): Thank you, Madam Yeates.

Madame Gagnon.

[*Translation*]

Ms. Christiane Gagnon: Thank you.

Ms. Yeates, according to the Wait Time Alliance Report Card, Quebec, Ontario and British Columbia seem to be performing better, because they have As and Bs as far as reduction of wait times are concerned for the hip and knee replacements and for cancers.

Saskatchewan and New Brunswick are underperforming. I do not want to criticize them, but I would like to know why Saskatchewan and New Brunswick have Cs, Ds and Fs for reducing wait times. Why is there such a variation from one province to another? Are some provinces better equipped?

My colleague spoke to this issue earlier on. Can you influence the government or the provinces to do things differently so that they would be more proactive?

Ms. Glenda Yeates: First of all, I must say that the grades given in that document are not ours. They are attributed by the Wait Time Alliance.

Ms. Christiane Gagnon: What do you think of this data?

Ms. Glenda Yeates: We make no judgments as to whether one province is better than another. We do not give out any A, B, C or Ds. You would have to ask the alliance what they base those marks on.

The provinces have various strategies. One would emphasize one kind of surgery over another. The organization and concentrations of health care are different. Occupational groups also differ from province to province. There are several explanations for the differences between the provinces.

Ms. Christiane Gagnon: You can make mention of the differences in data from one province to another, but you do not rate them as the Wait Time Alliance does in handing out marks of A, B, C, D, E, and F. This tells us that for some surgeries, for exemple, one would have reason to be worried in New Brunswick.

Do you value this data?

Ms. Glenda Yeates: Many organizations are studying wait lists as well as other aspects of the health care system, and they are giving samples. Many things could change in these sectors from one organization to the next, especially if they emphasize any one particular perspective. Therefore, the levels can vary according to the values and the choices that are made. We try to give out the information and to be clear regarding the limits and the definitions, so that people can see for themselves.

● (1250)

Ms. Christiane Gagnon: Thank you.

Ms. Besner, you say that in general, the wait time for certain interventions—cataract operations, hip or knee replacements, for instance—is not as long as it was five years ago. This is how you explain it: “Most Canadians have better access to health information and advice through telephone help lines.” However, you do not say what this network is, how large it is or how many calls it receives.

Do you have anything to support this statement you made in your presentation? It was on page 1, at about the middle of the second paragraph.

Dr. Jeanne Besner: The information lines...

Ms. Christiane Gagnon: Do all the provinces have them? Is there equal access? Give me an idea of how this proceeds on the ground.

Dr. Jeanne Besner: I think that almost every province has them. Most of them are available 24 hours a day and 7 days a week. Some of them are a part of the medical services, others are not. I cannot give you any figures now, but I can send them to you, if you are interested. In most cases, it was one way of ensuring that 50% of the population could access medical services 24 hours a day and 7 days a week. It was a way of reaching this objective. I think that all the provinces have them, but I do not have the precise figures with me.

[*English*]

The Vice-Chair (Mr. Lui Temelkovski): Thank you very much, Madame Gagnon.

Now we'll move on to Mr. Fletcher.

Mr. Steven Fletcher: Thank you, Mr. Chair.

This is turning into a very interesting conversation with the witnesses. I'll just make a comment on some of the previous testimony.

I found it astounding that only one one-thousandth of the money that the former prime minister claimed did come out of that Kelowna communiqué. He's been going around the country stating there was a $5-billion agreement, but now we know, as we've always suspected, it was just a non-binding agreement with no impact. No money was set aside, and only one one-thousandth of the money ever flowed. That is very helpful, and I'd like to thank the Health Council of Canada for bringing that out today.

My question is to Ms. Yeates. I trust you've seen the Wait Time Alliance report card that came out a few weeks ago. There are a couple of tables in there, and I'm going to ask for your comments.

Table 2 talks about hip, knee, and a bunch of other procedures. There are areas for improvement, but it looks pretty good. Ontario gets five A's, Manitoba gets three A's and a couple of B's. On table 3, where it's talking about progress on the 10-year plan to strengthen health care—this accord we're talking about—the trends are up. It goes from a D to a C-plus, and from a C to a C-plus. So the trends are improving, it seems, according to the Wait Time Alliance report.

I'd like you to have an opportunity to comment on this report.

Ms. Glenda Yeates: In general, we gather information, validate it, and put it out for others to use. We do this for committees such as this, for similar committees in the provinces, hospitals, and professional associations, and for groups like the Wait Time Alliance. Some of the sources they cite are from the data we have put out. But the opinions expressed about the data, their evaluations of it, are their own. We are pleased that many people across the country use our data. Some people come to different conclusions using the same data, and that's understandable. We put out the information so that groups who are passionate about this topic will have facts to draw their conclusions from. We don't comment on whether or not we agree with their conclusions.

● (1255)

Mr. Steven Fletcher: It's heartening to see that there is improvement. In so many areas, there is work to be done, and I think everyone recognizes it. But there have been significant improvements according to this arm's-length, independent audit.

Ms. Glenda Yeates: The trends are not clear in all cases. The data are not comparable in all cases, but we see some cases where they are starting to be comparable, and we see some areas of improvement in our own data. We're not shy about where we think the data are comparable. There are other cases where it's still too early to tell, and still other cases where we see no improvement yet.

Mr. Steven Fletcher: Thank you, Mr. Chair.

The Vice-Chair (Mr. Lui Temelkovski): Ms. Priddy.

Ms. Penny Priddy: When you're looking at comparable data.... I'll go back to that just for a minute. I don't want to pursue the concept of that. When we look at the changes in wait times, undeniably they are there. The piece that is always hard to find is the narrative around the outcome. Are we simply doing more faster? Are people doing well at home, or are they coming back in faster as a result of moving through surgery more quickly? The challenge that I don't think we ever solved through data is the outcome part, other than the outcome being that we completed the surgery. But we don't know the quality of the outcome or the narrative that goes around it. Is there any way to get at that?

Ms. Glenda Yeates: It's a challenging question to ask overall. The data lend themselves to some aspects of it. For a number of years now, we have routinely indicated readmission rates for certain procedures—stroke and cardiac, for example. In a recent analysis we looked at readmission rates for hip and knee replacements, so we can see what the circumstances are in these cases. But that's not the only outcome. You would want to know how people are doing at home on an ongoing basis. But there are some points of analysis, like readmissions, that try to get at the question of outcomes.

Ms. Penny Priddy: Thank you.

Dr. Jeanne Besner: I have nothing to add.

The Vice-Chair (Mr. Lui Temelkovski): That concludes our meeting.

My thanks to all the presenters. The report will be coming out many, many weeks after we conclude.

I have a point of information for the committee: The Wait Time Alliance will be here next week, so prepare your questions accordingly.

The meeting is adjourned.

Published under the authority of the Speaker of the House of Commons

Publié en conformité de l'autorité du Président de la Chambre des communes

Also available on the Parliament of Canada Web Site at the following address:
Aussi disponible sur le site Web du Parlement du Canada à l'adresse suivante :
http://www.parl.gc.ca
