



Moving Toward A Quality Health System: Key Challenges and Strategies

Report of a Workshop

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MOVING TOWARD A QUALITY HEALTH SYSTEM: KEY CHALLENGES AND STRATEGIES

*Co-sponsored by Health Canada and
The Canadian Medical Association*

**REPORT OF A WORKSHOP
HELD IN OTTAWA**

June 22, 1998

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INPRO CONSULTING INC.

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MOVING TOWARD A QUALITY HEALTH SYSTEM: KEY CHALLENGES AND STRATEGIES

Introuction

The workshop “ Moving Toward a Quality Health System: Key Challenges and Strategies”, co-sponsored by Health Canada and the Canadian Medical Association, took place on June 22, 1998 in Ottawa. Participants included representatives from federal and provincial ministries of health, health-related nongovernmental organizations, consumer groups, national health professional associations and their provincial counterparts (refer to Appendix A for the list of participants).

The objectives of the workshop were to provide participants the opportunity to:

- Develop a common understanding of what a quality health system includes;
- Identify key issues and concerns related to moving toward a quality health system; and to
- Identify priority areas for action and suggested strategies for moving forward.

This report provides an outline of the workshop and the processes used, as well as a detailed synopsis of the outputs of the day. This participatory workshop was designed and facilitated with the assistance of Pam Thompson of InPro Consulting. See Appendix B for the workshop agenda. The report is intended to be useful to workshop participants, their organizations and others interested in health system development. It is hoped the document will move forward the thinking and work in this area and serve as a catalyst for future collaborative initiatives among the various stakeholders involved.

Welcome and Background to the Day

Barbara Ouellet, Director, Quality Care Group, Health Canada and Dr. Peter Vaughan, Director, Professional Affairs Directorate, Canadian Medical Association, welcomed participants on behalf of their organizations. They both acknowledged the good work that had been done in the quality area to date and the importance of building on this work, and identifying how the various groups in attendance could work together to further advance the development of our health system. They encouraged the group to be open and creative and wished them a stimulating and productive day.

Vision of a Quality Health System

Participants were asked to brainstorm what a quality health system included from their various perspectives. Their brainstormed list is attached in Appendix C. The group noted that a quality Canadian health system is a client-centred, integrated, responsive and cost-effective system that includes the continuum of care from health promotion and prevention to acute and long term care. It enables all consumers to access a range of sensitive practitioners and services of their choice (including alternative practitioners) regardless of geographic location or cultural background. The system is based on a regular assessment of people's needs (versus wants), monitors itself based on a philosophy of continuous quality improvement and has safeguards in place to ensure privacy and confidentiality of health information.

Key Issues and Concerns Related to Moving Toward a Quality Health System

Participants were asked to identify their key issues and concerns related to moving toward the quality health system they had previously visioned. They were asked to preface their responses with "how to" or "I wish". Their brainstormed list of responses is included in Appendix D.

Themes

Participants were then asked to identify the key themes from the previous brainstormed list. They were asked to prioritize the themes based on the following criteria:

- A1 - Critical or Essential for Moving Forward
- A - Very Important
- B - Important
- C - Nice to have; a luxury.

The themes follow categorized as the group prioritized them.

A1:

- Information Systems, Evidence and Evaluation
- Participation, Partnership and Collaboration
- National Vision, Goals, Policy and Measurement (definition of health care and the system; choice of provider and patient/consumer; comprehensiveness and scope; federal leadership)

- Access (getting care where you want it)
- Accountabilities with Rights and Responsibilities

A:

- Financial Issues
- Public Education
- Education, Training and Licensing
- Moral and Ethical Issues (confidentiality and privacy issues)

It is important to note that the group did not identify any “Bs” or “Cs” from the themes above but believed them all of them to be critical or very important for moving forward.

Small Group Work

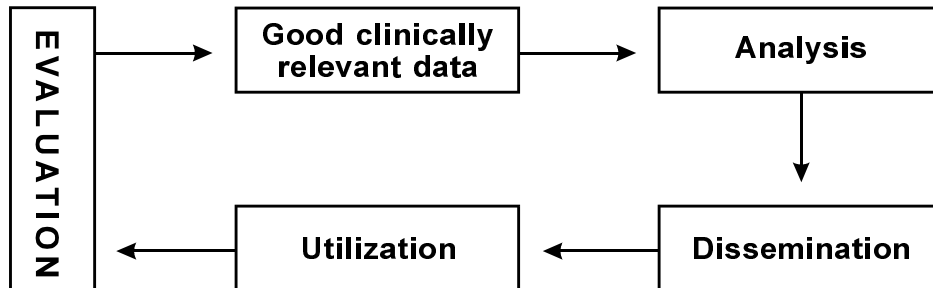
Participants had been pre-assigned to one of five small groups to ensure a mix of sectors and organizations in each group. Each small group also had a trained facilitator and recorder and was assigned one of the A1 themes previously noted.

Each small group began “fleshing out” the group theme (e.g. what it meant), then moved to developing a set of strategies and recommended actions, including who to involve to move forward (in that theme area) toward a quality health system. The following summaries provide highlights of each group’s work.

GROUP 1: *Information Systems, Evidence and Evaluation*

This group acknowledged the need to collect more health information to enhance decision-making and quality in the health system. They saw health information expanding patient/consumer choice, improving practitioner accountability and clarifying expectations/outcomes. They acknowledged the importance, yet difficulty, of collecting qualitative as well as quantitative data. For example, they noted the challenge yet importance of measuring qualitative aspects of care, outcomes, functionality, reduced pain, and patient satisfaction. Getting the right information in the hands of decision makers was emphasized and the need to expand the type of data collected beyond administrative data to encompass a broader view. They noted that evaluation is in the eye of the beholder; (i.e. it depends on your perspective). There is a need to link the information collected with analysis and ensure it is disseminated to the right individuals and utilized to improve the system as depicted in Figure 1 below.

Figure 1



There is a need for evaluation at all levels e.g. macro (federal, provincial, regional and community), meso (within organizations, facilities and institutions), and micro (among health care professionals, other providers and care recipients). Long-term longitudinal data collection, evaluation and analysis is required and there is a need for coordination of the information collected at the national level and making available and communicating that information to all stakeholders.

There is a need to address the role of both the public and private sectors in this area. The question arose as to who should be responsible for evaluating the system. The group felt strongly that reliable, objective, unbiased, third-party armslength evaluator(s) should be used and that the evaluation should be funded by both the public and private sectors.

The privacy and confidentiality of health information and the role for national leadership in this area was discussed. The need to utilize the evidence/data collected (e.g. not just to collect data for its own sake but to analyze and disseminate it in various ways depending on the target audience). There is a need to educate people regarding the value of the collection and analysis of evidence, as this process often has a very long term pay-off or return on investment.

SUGGESTED ACTIONS: INFORMATION SYSTEMS, EVIDENCE AND EVALUATION

SUGGESTED ACTIONS/STRATEGIES	WHO TO INVOLVE
<ul style="list-style-type: none"> • Create a national population health institute or network to analyze, draw conclusions and make recommendations for future action. 	<ul style="list-style-type: none"> • Build on Canadian Institute for Health Information (CIHI), Statistics Canada and provincial organizations like the Institute for Clinical & Evaluative Sciences (ICES). Providers, consumers, patients, NGOs, not-for-profit groups, research organizations, & regional health authorities should be involved in the governance structure.
<ul style="list-style-type: none"> • Conduct a nation-wide survey on Alternative Health. 	<ul style="list-style-type: none"> • Statistics Canada
<ul style="list-style-type: none"> • Put information into hands of providers, patients, consumers, decision-makers. 	<ul style="list-style-type: none"> • CIHI, Stats Canada, ICES, providers, consumers, NGOs, not-for-profit groups, research organizations & regional health authorities
<ul style="list-style-type: none"> • Conduct research on alternative methods of health care (because the hypothesis is that it is more cost-effective) e.g. 1) Research on effectiveness; 2) Baseline population information. 	<ul style="list-style-type: none"> • As above
<ul style="list-style-type: none"> • Develop strategies for developing standards for patient records and information systems and health infrastructure systems. 	<ul style="list-style-type: none"> • CIHI, Stats Canada, ICES, providers, consumers, NGOs, not-for-profit groups, research organizations & regional health authorities
<ul style="list-style-type: none"> • Enact national privacy legislation. 	<ul style="list-style-type: none"> • As above
<ul style="list-style-type: none"> • Build a web site that provides access to relevant, user-friendly health information/data in real-time to the public, health providers, researchers, decision-makers. 	<ul style="list-style-type: none"> • As above
<ul style="list-style-type: none"> • Determine what strategies work best for the dissemination and utilization of information/evidence. 	<ul style="list-style-type: none"> • As above

GROUP 2: *Participation, Partnership, and Collaboration*

The need for broad based participation in the development of a quality health system was noted as well as being transparent (with no “hidden” agendas), having clear objectives and depoliticizing the process if possible.

The importance of developing some guiding principles that would underpin any consultation process regarding the health system was emphasized by this group. Two such principles might be:

- Not all consumers will have the same expectations; therefore, the system must be flexible.
- Consultation should be founded on an evidence base.

SUGGESTED ACTIONS: PARTICIPATION, PARTNERSHIP AND COLLABORATION

SUGGESTED ACTIONS/ STRATEGIES	WHO TO INVOLVE
<ul style="list-style-type: none">• Obtain feedback from the public on what fundamentals should be included in a public health system.	<ul style="list-style-type: none">• Impartial agency or optimal combination of agencies
<ul style="list-style-type: none">• Decide who should obtain this feedback and who should be asked for it.	<ul style="list-style-type: none">• “Super champions” to be determined
<ul style="list-style-type: none">• Define the process of collaboration, including barriers to the process.	<ul style="list-style-type: none">• The champions (i.e. key influencers who take up a particular cause and vigorously promote it within their circle of influence)
<ul style="list-style-type: none">• Gather information through a variety of innovative methods: (e.g. focus groups, polling, surveys, the Internet, non-traditional organizations, town hall meetings).	<ul style="list-style-type: none">• The champions

GROUP 3: *National Vision, Goals, Policy and Measurement*

This group acknowledged that a number of vision papers had been drafted by various provinces and other groups; however, there was a need to develop a national vision of the health system that had broad involvement in its development. A consultative, consensus-building process should be used to develop the vision that involves asking the Canadian public (as well as other groups) what they really want to improve their health and what the delivery structure might look like. The new vision would need to reflect the perspectives of all key constituencies.

It was believed the new vision should go beyond the Canada Health Act and be broader than insured services including Home care, Pharmacare and Long Term Care, various prevention and health promotion services, as well as a range and choice of providers. It should also take into consideration the growth of complementary medicine.

The group acknowledged the challenge of “getting” a national vision down to the provincial and regional levels; going “beyond the concepts” and making it “real” to people. They noted that turf wars make implementing visions difficult. After the vision is developed, there is a need to implement key aspects of the vision and that will involve clearly defined roles and responsibilities at federal as well as provincial and local levels. In addition, indicators and evidence should be linked to funding; (e.g. the fund based on population in Saskatchewan). The group recommended a set of national standards and a number of performance indicators (rather than outcome indicators) as part of a monitoring system that were both system-wide and program/sector specific such as: mortality and morbidity rates, waiting times, patient satisfaction. They noted a need to set short, medium, and long term goals plus accountabilities and timeframes, as well as a need for incentives in the system.

The issue of affordability was raised, what the public purse can afford, and who will make this decision. Public input was required to make this decision.

There is a need to define core* and comprehensive ** services; and to develop to a process to do this {*evidence - based; includes pilot projects, transparency; affordability; **accountability}.

SUGGESTED ACTIONS: NATIONAL VISION, GOALS, POLICY AND MEASUREMENT

SUGGESTED ACTIONS/ STRATEGIES	WHO TO INVOLVE
<ul style="list-style-type: none"> • Conduct a broad based consultation process to develop a national vision of the health system. 	<ul style="list-style-type: none"> • Provincial and federal governments • Consumers • Health providers • Health and information system experts • Key national organizations
<ul style="list-style-type: none"> • Develop a set of national performance indicators to assist in implementing the vision. 	<ul style="list-style-type: none"> • Provincial and federal governments • Health providers
<ul style="list-style-type: none"> • Educate the public/empower patients regarding the performance indicators. • Conduct pilots/evaluation studies. 	
<ul style="list-style-type: none"> • Put in place an accreditation process for the health system that is packaged as indicators that would be available to the public. 	

GROUP 4: *Access*

The group defined access as the ease with which the client/community obtains required/desired services in the most appropriate setting within a timely and reasonable timeframe. They noted that ease means different things to different people and groups; that programs that discourage access must be recognized; and needs assessments should be conducted across population groups. They identified that one can't assume access is always positive for some clients; it can be problematic. It is important to have a balance between services that are demanded and those that are needed.

The group approached the issues related to Access by discussing: who needs access, to what, why, how and when. Their key points are noted below.

Who: all sectors of the population; a geographic mix; the disadvantaged/disabled (e.g. people living in poverty); well people; different ethnocultural groups; and transgenerational groups.

What is a system (all key stakeholders/sectors). It includes:

- Hospital and physician services
- Community based services (e.g. public health; community services)
- Non-insured services
- other well being services.

Why: because of the Canada Health Act; it is ethically and morally right; equitable; to provide choice; to prevent illness, injury; therefore, it is cost effective. Access is important:

- To maintain health; and
- To restore health.

How: various settings and types of services (e.g. primary health care; institutional care; alternative care; community health system)

When: necessary; appropriate medical interpretation of patient needs is often not accurate and should not be the only assessment (e.g. with mental health clients); early identification and intervention; prevention and promotion (before illness or injury occurs); readily accessible.

The group acknowledged that Access for them meant ready access to the right source on time; NOT on demand, at any cost.

WHAT ACCESS IS AND ISN'T

Isn't	Is
<ul style="list-style-type: none"> • At any cost • On demand • Advantageous to one section of the population • Constrained by jurisdictions 	<ul style="list-style-type: none"> • Ready access to right services on time • Denied to those who don't need it • Able to accommodate choices within a range of options • Able to recognize the role of all sectors of the system • Practical

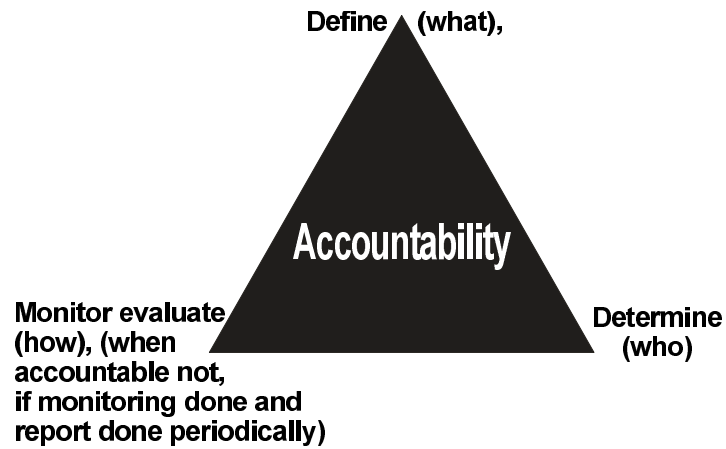
SUGGESTED ACTIONS: ACCESS

SUGGESTED ACTIONS/ STRATEGIES	WHO TO INVOLVE
<ul style="list-style-type: none"> • Develop a human resources plan to provide appropriate health services (e.g. services available within a safe and reasonable time). 	<ul style="list-style-type: none"> • Planners, policy makers, funders, health care providers
<ul style="list-style-type: none"> • Ensure physical facilities are accessible for the disabled. 	<ul style="list-style-type: none"> • Planners, policy makers, funders, health care providers
<ul style="list-style-type: none"> • Remove attitudinal barriers (on the part of providers) related to disabled persons and other disadvantaged groups. 	<ul style="list-style-type: none"> • Providers, health care professionals, educators
<ul style="list-style-type: none"> • Deter unnecessary access through public education regarding the use of services and the importance of prevention. 	<ul style="list-style-type: none"> • Planners, health care professionals, policy makers
<ul style="list-style-type: none"> • Make the system culturally sensitive/ appropriate to improve access (i.e. reduce language barriers) 	<ul style="list-style-type: none"> • Planners, policy makers, ethno-cultural groups

GROUP 5: *Accountabilities with Rights and Responsibilities*

This group noted it was important to understand and be aware of who is accountable for what within the health system. For example there are certain accountabilities and responsibilities for providers, for patients, for communities and for governments. They believe that currently some patients are “slipping through the cracks” because the system does not have clearly defined accountabilities and there is a lack of integration between the various services and providers. They identified a need to change our current health system philosophy from “practitioner-focused” accountability to “client-centred” accountability. The group discussed that due to the complexity of the current health system the accountabilities have been diluted. They identified the need to monitor and regularly report to the public on the state of the health system in language the public can understand. Figure 2 below depicts the 3 main aspects of a “client-centred” accountability system.

Figure 2



SUGGESTED ACTIONS: ACCOUNTABILITIES WITH RIGHTS AND RESPONSIBILITIES

SUGGESTED ACTIONS/ STRATEGIES	WHO TO INVOLVE
<ul style="list-style-type: none"> • Develop a national report card that translates to regional, provincial and national levels. 	<ul style="list-style-type: none"> • Use existing provincial resources/information or create a body at another level.
<ul style="list-style-type: none"> • Name an independent auditor (independent of government) who would provide leadership in the development of the criteria on which a set of indicators for monitoring the health system would be based. 	<ul style="list-style-type: none"> • Nominated by federal and provincial jurisdictions.
<ul style="list-style-type: none"> • Develop a set of indicators to monitor the health system. 	<ul style="list-style-type: none"> • Expert working group develops indicators that are then validated by the public in a consultation process.
<ul style="list-style-type: none"> • Inform/educate the public about the indicators • Regularly monitor the health system and ensure that changes are made based on evaluation findings. 	<ul style="list-style-type: none"> • All levels of government and existing nongovernmental organizations involved in measurement.

Collective Next Steps

Following presentations by each small group, a plenary session was facilitated that invited participants to identify collaborative activities that could be undertaken within the next year to move toward a quality health system. What follows is a list of collective actions the group developed with accountabilities included.

Activity	Accountability	Timeframe
<ul style="list-style-type: none"> • Conduct research that examines models (e.g. consultation processes and participatory evaluations) that effectively involve multiple stakeholders (preferably models that have been evaluated). Want something practical rather than academic. 	Funded by Federal and Provincial governments but do an open call	Within next 12 months i.e. by June 30/99
<ul style="list-style-type: none"> • Expand the mandate of CIHI to encompass a national population health institute or network incorporating the capacity of Stats Canada, provincial health research centres (e.g. the Institute of Clinical Evaluative Sciences) that are armslength from government. 	To governance body and funded by Federal, Provincial and Territorial governments	Within the next 12 months
<ul style="list-style-type: none"> • Develop a process to agree on national data architecture (framework for computer hardware and software) standards. 	Federal, Provincial and Territorial governments and data providers (e.g. hospitals, national health professional associations, hardware and software vendors)	Within the next 12 months

Activity	Accountability	Timeframe
<ul style="list-style-type: none"> Examine whether there is a demand arising for report cards (e.g. where the demand is coming from and whether it will be necessary in the future. Conduct a “think tank” to decide relevance of report cards, how to proceed and what should be included.) 	CCHSA, Health Canada	Within next 12 months
<ul style="list-style-type: none"> Consolidate and build on existing evidence regarding Canadians’ expectations and values for a publicly funded health care system (e.g. what the system should include and be responsible for) <i>Build transparency and objectivity into the process.</i> 	Funded by government but accountable to an objective Board	Within next 12 months
<ul style="list-style-type: none"> Develop processes for: <ol style="list-style-type: none"> Establishing National health goals Establishing national health care standards Tracking wait times in key* program areas (e.g. emergency departments & continuing care) <p>* strategic points of system; not all</p>	<ul style="list-style-type: none"> Health Canada with broad-based participation Health Canada in partnership with provinces Provincial governments with Health Canada playing a coordinating role and regions, clinicians and consumer groups playing a contributory role. 	<p>Complete by June 1999</p> <p>Process in place within 12 months</p> <p>Process in place within 12 months</p>
<ul style="list-style-type: none"> Develop strategies for information sharing (what we know) among stakeholders involved in health care in Canada. 	All groups involved in today’s workshop	Within next 12 months

Activity	Accountability	Timeframe
<ul style="list-style-type: none"> • Begin to find new ways of sharing information to ensure everyone is on a level playing field; (e.g. Health Canada's commissioned research synthesis projects) with consumers, providers, data collection agencies, governments (e.g. Highlight and make some sense of important, existing information) 		<p>Within next 12 months</p>
<ul style="list-style-type: none"> • Identify gaps in the provision of health care services and quality health information for: <ul style="list-style-type: none"> ... Rural/remote populations (build on regional work on community health needs assessments; Manitoba) ... Disabled, disadvantaged groups ... Ethnically diverse populations ... Aboriginal populations 	<ul style="list-style-type: none"> • Society of Rural Physicians of Canada • Community groups (e.g. ARCH, Council of Canadians with Disabilities) • Canadian Council on Multicultural Health • Aboriginal Nurses Association, Assembly of First Nations, Women's organizations, Community Resource Centres 	<p>ALL below within next 12 months</p>

Participatory Evaluation

A group evaluation of the workshop was facilitated in plenary and what follows is the group's feedback.

What I liked	Concerns	Suggestions for the future
<ul style="list-style-type: none">• Opportunity to meet variety of people from across the country (confirmed and increased my confidence regarding this area)• Issue Analysis• Energy level of facilitator	<ul style="list-style-type: none">• Didn't help us understand the complexity/depth of the issues• Difficult to assign accountabilities to issues	<ul style="list-style-type: none">• Possible future workshop in one year to move the agenda forward• Get Industry involved in this discussion• Increase focus of agenda to consider smaller questions in greater depth

Concluding Remarks

Dr. Peter Vaughan and Barbara Ouellet thanked the group for their participation and shared their enthusiasm about the day. They also acknowledged that the report of today's workshop would be distributed to participants in late August, early September. They encouraged participants to share the document with colleagues and looked forward to further discussion and collaboration on a number of the activities and suggestions offered by participants.

Appendix A: **List of Participants**

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Appendix B

Agenda – June 22, 1998, Chateau Laurier

8:30-9:00	Coffee and Muffins
9:00-9:15	Welcome and Background to the Day (Barbara Ouellet, Director, Health Systems, Health Canada and Dr. Peter Vaughan, Director, Professional Affairs, Canadian Medical Association) Introduction of Facilitator Objectives and “Roadmap” for the Day (Pam Thompson, President, InPro Consulting Inc.)
9:15-10:00	Vision of a Quality Health System e.g. <i>what a Quality Health System includes building on pre-circulated documentation</i>
10:00-10:15	BREAK
10:15-11:30	Issue Analysis: “What are the key issues and concerns related to moving toward a Quality Health System?” (structured brainstorm followed by theming and prioritization of themes)
11:30-12:30	Small Group Activity (5 predetermined groups representing a mix of sectors in each with a preassigned facilitator and recorder)
12:30-1:30	LUNCH (together)
1:30-2:45	Small Group Activity (cont’d)
2:45-3:15	Plenary Session: Feedback from Small Groups (<i>5" per group and introduced by Pam Thompson</i>)
3:15-3:30	BREAK
3:30-4:05	The Collective Next Steps (<i>Facilitated by Pam</i>)
4:05-4:15	Concluding Remarks (Barbara Ouellet and Dr. Peter Vaughan)
4:15-4:30	Participatory Evaluation (<i>Facilitated</i>)

Appendix C

Vision of a Quality Health System

A quality health system includes:

- Each Canadian having equal and timely access to our health system regardless of where they live (e.g. urban, rural, etc.)
- An overall guiding vision of health grounded upon the determinants of health
- A balance and integration of services that spans curative, preventive and social care
- Adequate funding
- Standards
- Clear accountabilities
- Being democratic and representative (i.e. everyone at the table including Labour and citizens groups)
- One in which consumers are satisfied with the services they receive
- Incorporates evidence-based decision-making into service provision
- Removing barriers that prevent people with disabilities and other disadvantaged groups from having access to services
- Using measures of quality that reflect people's own values and the quality of their lives, not a third party's interpretation
- A responsive system; responsive to the needs of people accessing the system and also to changes in the environment
- Competency; we need to know how to do things in the best way possible (e.g. from a provider perspective, what's done to help the public contribute to care; and what's done to assist decision-makers)
- Creating three collector lanes: **PEOPLE** (well trained, well-motivated professionals), **PLACES** (well equipped and well managed institutions, homes and work places) and **THINGS** (state of the art technology, including information technology)
- Stimulating and challenging choice (e.g. of **providers** such as physicians, nurse practitioners, midwives, and alternative providers of **settings** and **locations** (e.g. Community Health clinics, solo practices ...)
- Cost-effectiveness

- Depoliticization (i.e. being sensitive to public needs and not based on the interests of politicians); (also depoliticizing the relationship between providers and health care agencies)
- Sensitivity and compassion
- A system that: has boundaries that make it distinctive; has some means of integrating and regulating itself; has multiple constituencies; those constituencies have a common goal or goals
- Support and encouragement of alternative healing practices recognizing that causes of disease are often psycho-spiritual as well as physical; and consumers who take responsibility for doing healing in alternative ways using preventive strategies (e.g. chiropractic) are saving money in the long-term
- Recognizes that there are dozens of alternative healing methods and includes those
- A clear and acceptable definition of health (e.g. WHO definition)
- Health care not just sickness care
- Being outcome-oriented; capable of monitoring itself and measuring its outputs
- Data used for monitoring that is valid and clinically relevant; not just based on administrative data
- A process to continuously improve quality and incentives within the system for doing so
- Appropriate safeguards for privacy and confidentiality of health information
- Adequate federal cash funding to ensure provincial compliance with principles of the Canada Health Act (CHA)
- Moving from an insurance system to an investment system (i.e. moving away from a philosophy that insures against catastrophic costs associated with illness towards one that invests in health; therefore involves making different choices)
- Links between outcomes and clinical relevance and access (to improve access to things that are most important, on the basis of relevance)
- Mechanisms built in for evaluating and improving its efficiency and effectiveness
- A system based on needs versus wants
- Reminding itself there is a place called rural Canada
- Respect and recognition of complementary/alternative medicine (recognizes the cultural mosaic of the Canadian population)
- Practitioners who have been educated about how to prevent and deal with common medical problems and to promote health from standardized medical curricula across Canada

- Fair application of all the principles of the CHA and compliance with all provisions
- Dispute resolution built into the system
- Complementary medicine that is evidence-based
- Safety, efficacy and standardization of alternative remedies
- Determinants of health (e.g. employment for all; housing; social determinants)
- Good information, available in real time and transparent (i.e. available to everyone)
- Informed (educated and knowledgeable) patients able to choose the right providers
- A transparent decision-making process
- A regular assessment of changing population needs
- Always putting the best interests of the patient first.

Appendix D

Key Issues and Concerns Related to Moving Toward a Quality Health System

- How to set (health) goals for Canada (Canada one of few countries that doesn't have them)
- How to develop a system to measure and monitor the attainment of health goals
- I wish we had a joint vision for the health system in Canada and could get the parties together around the goals and objectives
- I wish the federal government would become more relevant by providing leadership in terms of the establishment of national health policy and national health care standards
- I wish we could restore public confidence in the health system
- How to inform and communicate with the public to restore that confidence
- How to understand what it is we really want the system to do (e.g. health promotion; illness care...)
- How to find a process that will help us to rationalize between need and affordability
- I wish the health system would recognize how important it is to work with other sectors to improve health
- How to effectively work intersectorally
- How to validate and legitimize consumer's knowledge and expertise
- I wish we had equal access to a broad system of services
- How to develop a system of evaluation that is truly inclusive and values all people (e.g. disabled and other disadvantaged groups)
- How to enable provider-related organizations to engage in quality-related activities; (e.g. to understand quality and have the resources to permit their meaningful involvement in quality related activities)
- How to educate the medical profession on alternative methods of healing
- How to create funding for research on alternative practices

- How to create cross-referrals between medical and alternative practitioners
- I wish to recognize violence as a health issue
- I wish to disempower the vested interests of the corporate profit motive from defining the reality of health care
- I wish the system remains publicly funded and increasingly publicly delivered
- I wish provincial departments would leave the sanctity of the CHA intact
- I wish the federal government would restore the funding to the federal transfers (CHST) that have been cut
- I wish the health care system could eliminate the constraints of silo budgeting to recognize the cost-effectiveness of various services that transcend a specific budget
- How to develop a true system of integrated health information
- I wish to have a coordinated process of disseminating reliable and valid data and information to support the public in improving and managing their health
- I wish to ensure health care professionals, caregivers, patient advocates and patients have access to decision support tools based on evidence (e.g. clinical practice guidelines and health information)
- I wish the system can develop a mechanism that is fair, sensible, and effective to evaluate the training and qualifications of foreign trained care providers
- I wish stakeholders would stop assuming there is a direct and consistent relationship between funding and quality
- I wish I understood why evidence does not always translate into practice
- I wish there was better coordination of services both within and across the different boundaries of the health care system (e.g. from hospitals to various different care settings)
- I wish our health care system was based more on a consumer focus rather than a provider focus
- I wish we were more proactive than reactive in our health care system (e.g. more need for preventive and screening programs)
- I wish the relationship between health care professionals and pharmaceutical companies was governed by a code of ethics and was adhered to.

- I wish there was a means for consumers to get more involved in the quality assurance loop rather than relying solely on litigation or filing complaints
- I wish for a clear definition of Medicare in terms of the system, its process and outcomes
- I wish for a clearly written statement of consumer rights and expectations within the health system/Medicare
- How to define a full range of necessary or core services for the purpose of public funding and ensure that the process is adaptable or responsive
- How to engage in meaningful public dialogue that goes beyond special interest groups
- I wish the educational curricula of health care professionals was revised to make it more culturally sensitive.