

The Association of Faculties of Medicine

Young Leaders' Forum

March 28-29, 2007

“As was said” Session Report

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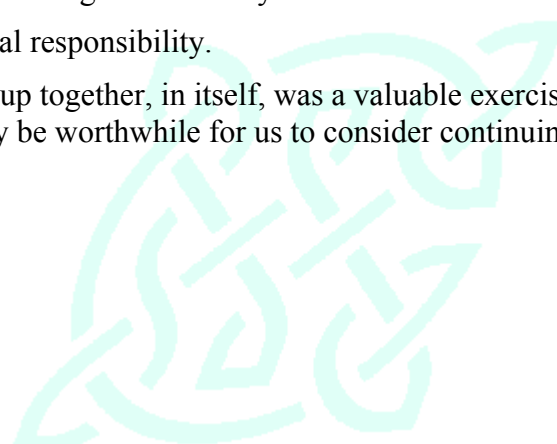
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Key Messages

What are the key messages from this session that we propose to share across our various audiences?

- ⇒ We believe that things are imminently fixable; definitely, the will is there, the motivation is there, the skills are there and the money is there.
- ⇒ We believe in a flexible, fluid world that is readily adaptable to change.
- ⇒ People must be key players in their own health; we have to give them the tools to be responsible and capable of managing their own health.
- ⇒ With respect to government, there needs to be a mind shift from focusing on health care to focussing on health, from dealing with acute care issues to dealing with social determinants of health and other health promotional activities (which is a strategic change that provincial and federal governments have to undergo).
- ⇒ We have to make the decisions required to make this mind shift happen.
- ⇒ We did not focus on the fact that we do not have enough money and that we do not have enough technologies and that we do not have enough people; we presumed that we have enough of that stuff and believe that it is about reorganizing, rethinking and redoing.
- ⇒ The health care system is fairly disorganized and providers are fragmented; therefore, it is surprising that we did not talk a lot about reorganization.
- ⇒ Training and retraining in a new way was a common theme.
- ⇒ We have a global responsibility.
- ⇒ Getting this group together, in itself, was a valuable exercise; there was valuable dialogue (it may be worthwhile for us to consider continuing on with something like this).



Next Steps

In order to maintain momentum from this session, what needs to happen over the next fifteen to forty-five days? What, Who and by When?

What	Who	By When
Deliver the electronic “As Was Said” session report to Irving Gold.	Heather Sterling	April 4, 2007
Distribute the electronic “As Was Said” session report to all participants.	Irving Gold	April 12, 2007
Create and disseminate a summary report based on the results of the forum.	Irving Gold	Spring 2007



Key Focus Areas

To put structure to the issues, challenges and opportunities identified during the “Scoping the Future” (refer to the Appendices) brainstorming exercise, the group established ten themes from which participants established six key focus areas – areas in which efforts within Canada’s health system will need to be focussed between now and 2027. Three of the themes (Demographic Tsunami, Population Health and Coping with Constant Change) were merged and are presented as Key Focus Area #1. For the purposes of this session, the group chose not to further discuss the two themes entitled “First Contact Care” and “Knowledge Tools and Practice”.

Key Focus Area #1: Demographic Tsunami, Population Health and Coping with Constant Change

Summary Vision

By 2027 Canada’s health system will invest equitably in social determinants of health to avoid/minimize the impact of a demographic tsunami on the sustainability of Canada. To achieve this we will need warning indicators, diffusion strategies and response mechanisms to cope with constant change.

Success will have been achieved in this key focus area, when...

...equity exists among Canadians in terms of (warning), for example: health indicators (injury prevention, obesity, smoking, etcetera), SDH (poverty, environment, chronic diagnoses, mental health¹), economic indicators, etcetera.

...education penetration for diffusion of problems has been achieved.²

¹ In response to a concern expressed regarding listing mental health as an example of a social determinant of health, it was clarified that the intention was to highlight the fact that it was likely that the drivers of the health system in the future were going to be those that were determined socially such as suicide, injuries and mental health.

² It was clarified that the intent of this success indicator was to acknowledge that the “tsunami wave” was unavoidable; however, by being ready for a wave, it would be possible to minimize its impact on society. It was noted that it was important to think in terms of diffusing the power of the wave (and possibly even on how to prevent the creation of the tsunami in the first place).

...there is a responsiveness with components of communication magnitude, direction, timeliness.

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Legislate physical activity accountability goals in schools (K-12).
Lead: Provincial government

- ◆ Emulate Canadian tobacco strategy in domain of nutrition.
Lead: Federal government
Provincial government



Key Focus Area #2: People Power

Summary Vision

By 2027 Canada’s health system will be a place where from start to end, health professions are careers of choice. We learn and work together with patients/families and across disciplines. As patients/families/the public, we are all involved in the ways we want to be. This is the new normal.

Success will have been achieved in this key focus area, when...

...health professions are careers of choice.

...there is no mismatch between access and need for access to professionals/services.

...health professionals/providers choose to stay in their careers.

...interprofessional education begins on day one of programs, and remains the norm during one’s career.

...patients and their families are involved in the way(s) they want to be.

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Legislate interprofessional education.³
Lead: Provincial government (provincial pilot program)
- ◆ Implement viable interprofessional education models⁴ into our health professional training programs.
Primary: Health Canada (IECPCP⁵)
Secondary: All the professional organizations and universities

³ Concern was expressed that education was being considered as “a place to start” given that research indicated that within two years students forgot much of what they had been taught and absorbed what was in their own respective milieus.

⁴ It was suggested that there was “a whole background piece” related to interdisciplinary education, including around the notion that at the end of the day different people would have different pay, which could pose as a considerable hurdle. It was further suggested that as an immediate task, it would be important to identify the issues around interprofessional education and determine whether it was even possible to move forward or whether issues were insurmountable.

⁵ It was clarified that this stood for “Interprofessional Education for Collaborative Patient-Centred Practice”.

- ◆ Change the model to redistribute responsibility (i.e.: train health aides to do most care...).⁶
Lead: M.O. Education, MOH

- ◆ Our project is to find out what makes a career in health an ideal career.
Lead: CHSRF
^
Pan-Canadian involvement

- ◆ Increase people's capacity to take care of themselves in the continuum from promotion to cure...
Lead: Ministries of Health-Education...

- ◆ Build "frontier colleges" for health.
Lead: Voluntary sector partnership and community colleges

- ◆ Incentive-based remuneration model for health care professionals.⁷
Lead: Provincial government and professional associations/unions



⁶ It was suggested that there was a significant mismatch between the "load" and the "bearer of the load". It was noted that a fundamental issue would be to properly reshape the way in which a load was matched to a bearer of a load.

⁷ It was noted that while there was a mere handful of literature that focused on physician compensation, there was no question that there was very little motivation in terms of case load as physicians were one of the few professional groups that did not work within the context of providing and receiving incentives.

Key Focus Area #3: Policy and Politics

Summary Vision

Canadian public policy across all sectors will maximize health impact (holistic perspective: bio-psychosocial-mental-functional-personal, etcetera). The Canadian health system will focus on achievable health for all by having a health policy framework that is arm's length⁸ from politics, directly engages the public in informed decision-making, emphasizes the population's responsibility, is responsive and flexible, is not provider/institution centric, maximizes return to society and considers equity/values.

Success will have been achieved in this key focus area, when...

- ...the economic burden for the population is reduced (related to health care).
- ...there is minimal waste within the health care system.
- ...people use and need less/fewer health services versus people use less acute health services (that is: more public and preventative investment and services).
- ...people have a clear understanding of what achievable health is and people take ownership for achieving it.
- ...more people are involved in defining health and the health care system.
- ...there is no increase in private expenditure for health care services.
- ...we know and agree on a common goal for achieving health (system, public health, etcetera).
- ...we have clear objectives for reaching our common goal.
- ...we are able to track our progress vis-à-vis our common goal.
- ...elected people work to vision and strategically plan for health goals; management is extricated from the political realm and work is done/directed by managers.
- ...members of the population are linked to an integrated health team before states of illness.
- ...the system has shifted from being institutional and provider-driven to individual-driven/responsive.

⁸ It was clarified that the idea being expressed was that politicians should not meddle into small managerial issues and managers should have the freedom to make difficult decisions that were necessary for the health system.

...decisions are based upon overall episode cost rather than component costs, for example: hip replacement → intensive intervention, rehabilitation results in a release of health care system burden rather than its escalation (for example: they end up in long-term care, co-morbidity).

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Develop a strategy to engage the public/media/politicians in discussions regarding evidence to encourage informed decision-making.
Lead: Provinces
CHSRF

- ◆ Develop a health care change manifesto outlining the new principles for health public policy.
Lead: Health Council with provincial/federal signing



Key Focus Area #4: Equity and Sustainability

Summary Vision

By 2027 Canada's health system will be affordable, functional and accessible with equitable allocation of resources based on population needs with a broader commitment to health equity beyond our borders. This system will be driven by decisions regarding allocation of resources that account for opportunity costs. The system will be predominantly publicly-funded.

Success will have been achieved in this key focus area, when...

...we still have a predominantly public funded health care system that is affordable and functional.

...a population needs-based funding formula is in place, allowing for equitable (possibly not equal) allocation of resources and access to care.

...Canada's commitment to equity extends beyond its borders.

...decisions regarding allocation of resources will account for opportunity costs.

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Restructure systems so that there is greater financial integration between, for example, hospitals, LTC facilities, community clinics, etc. with a view to making informed investment decisions.
- ◆ Develop the data and tools to facilitate population health-based planning, including investments in health care manager training.
- ◆ Provide real support to develop a more diversified HHR workforce, including patients.
- ◆ Review and recommit to the Canada Health Act and its principles.

Key Focus Area #5: Matching our Behaviour to our Values**Summary Vision**

By 2027 Canada's health system will walk the talk. We proactively seize opportunities to improve health and health care, rather than responding to events. Decisions maximize health gains and minimize the risk of harm. Turf battles are obsolete. Cooperation is more in the interests of players in the system than destructive interaction.

Success will have been achieved in this key focus area, when...

...the various players within the system value cooperation above destructive interaction.

...every decision made contributes to better health.

...we promise and do everything possible to reduce risks of harms.

...we seize opportunities to improve health and health care.

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Train health professionals in negotiation/communication skills (put into required curriculum).
Lead: Colleges (professional)
Support: AFMC, etc.
- ◆ Create/leverage arm's length endowed foundation(s) with change mandate.
Lead: Federal government
- ◆ Systematic process to review what works and at what cost (non-technology). Value for \$.
Lead: CIHR
CADTH
Treasury/Management Boards

Key Focus Area #6: It's a Small World after all – Meta Matters

Summary Vision

By 2027 Canada's health system will be defined within a global context. The global health care system will be a reciprocal, equitable and ethical one that is linked to population/patient needs. It will recognize and be responsive to the complex web that characterizes the interrelationships of the broad determinants of health (for example: environment, education, income). To remain sustainable the health care system will be flexible, fluid, responsive, self-evaluating and resilient in meeting the needs of the global health community.

Success will have been achieved in this key focus area, when...

...there is a global health care system.

...there is a health care system that is reciprocal, equitable and ethical.

...the health care system is linked to population/patient needs.

...the health care system recognizes and responds to broad determinants of health.

...the health care system is flexible, fluid, responsive, self-evaluating and resilient.

RECOMMENDED KEY ACTIONS/ACTIVITIES/INITIATIVES

- ◆ Canada must build a demonstration site for a health system without borders (region/town/island).
- ◆ International baccalaureate for health professionals.
Lead: WHO/International Federation of Licensing Bodies
- ◆ Interoperable health information system.
Lead: IMIA (International Medical Informatics Association)
IHE (Interoperable Health Enterprise)
Canada Health Infoway
- ◆ “Health services points” market (bartering health miles = aeroplane).
Lead: Minister of Finance
World Bank
Visa/PayPal

- ◆ Reciprocal agreements (no barriers, such as for Visa, travels everywhere and immigration visa too!)

Lead: WHO/U.N.



Appendices



Scoping the Future

As we think about what the Canadian health system might look like in 2027, what are some of the issues, challenges and opportunities that come to mind?

COPING WITH CONSTANT CHANGE

22. How will innovation affect the ethical framework of the health care system?
29. Increasing prominence of mental health issues/concerns.
42. Responding to changing public and patient expectations and values.
47. How do we build a system that is flexible over time?
51. We need to think way, way out of the box – as our challenges will be nothing like we imagine.
54. We must monitor and meet our kids' expectations.
67. In an “information age” economy, disease/disorders that affect cognition are increasingly important.
82. Dealing with constant change.

DEMOGRAPHIC TSUNAMI

5. We are not ready for a demographic tsunami.
15. Health care demands of baby boomers.
19. Many elderly patients with no solid, safe, compassionate system to care for them.
33. Issue: Aging of the population, that is: twenty percent of the population is going to be over sixty-five by 2025.
46. With diminishing cause-specific mortality, increasing chronic disease co-morbidity leading to new challenges.
61. Patients (or us) will either be very, very fat or very, very thin!
My vision of 2027 is that something really wacky is going to happen which is that we will all continue to get fat or some bizarre drug will come on the market and we will all be very thin. It is the crazy side of medicine.
74. Constant change + stress + poor relationships = more mental health issues.
Canadians more wealthy but not happy.
75. Changed social networks will need new approaches.

EQUITY AND SUSTAINABILITY

1. Like the U.S. with all of its challenges!

It is just a reflection on what I think the health care system would look like. I think we will have all the challenges like they do in the United States.

14. Affording today's system in twenty years.
20. Enhancing accessibility, for example: drug coverage, rural areas, cultural sensitivity, other barriers.
32. Achieving health system equity.
 - ↓
 - urban/rural public/private
45. \$
Who will pay? (And how?)
49. More health care or more of something else?
59. Opportunity cost will be the new commodity.

FIRST CONTACT CARE

4. An evolution towards more individualized health care delivery.
11. Organize primary care practices (system integration).
35. Opportunity: Reforming primary care!
43. Involving entire populations in health-maintenance and self-care.

IT'S A SMALL WORLD AFTER ALL – META MATTERS

3. There is no Canadian health care system only a global health system including education, IT, drugs and care delivery.
56. The country that is first to become “globally” accountable. We will be funding and engaging in health care as leaders in the developing world.
66. Global accountability means we need to share our “limited” resources.
69. A system which is resilient and responsive to major health crises:
 - pandemics
 - mass casualty (natural disasters)
 and has measures to prevent.
70. We must celebrate our failures.

We have been rewarded for being successful and we are not rewarded for taking risks and failing. In fact, we all put our failures under the rug and we are missing tremendous opportunities to learn from each other what not to do. We end up repeating each other's mistakes. We are making decisions on the basis of not knowing what has not worked.
71. Can we design a future system with today's knowledge?
77. Link between health and climate change.
79. Health 2007 ≠ health 2027.

It has to do with, “What is health?” And, what do we feel about what is healthy today versus what people think healthy is in 2027 which we have no idea what that looks like.

KNOWLEDGE TOOLS AND PRACTICE

2. High gloss technology veneer.
There is lots of high-tech development in health care; but, I am just concerned when we peel back the layers on the gloss veneer is it really working? It is about the technology and all the challenges it brings for depersonalization such as patient care as well as cost.
10. We need to make better use of IT and research for the “betterment” of Canadians.
23. How will technology affect health care delivery?
36. “Commodification” of health care.
I am referring to the growing presence of promises for magical repair work; as people get older there are more things we can do so they can live longer, feel better: tests for the worried well, predicting if you will have cancer in five years.
40. Getting a clinically and management-relevant information system.
41. Closing the gap between what we know works and what we do.
44. Role of science in reforming the health system.
52. Most patient/client interaction with the health system will be via some IT/IM interface not people.

MATCHING OUR BEHAVIOUR TO OUR VALUES

24. Promising and delivering safe, people-centred care.
55. We must bridge the gap between what we say and what we do (that is: person centric...).
57. A health system that is really about health!
58. We (the zillions of organizations in the system) need to play better together.
68. We should discourage passive aggressive behaviour.
It is a combination of procrastination, wilful incompetence and any possible effort to frustrate people who want to get things done either because of fear of change or because of a fear of loss of control. It is stopping change, essentially.
72. We should stop pretending to be nice, caring and open.
76. Appreciative inquiry = opportunity.
It is an approach the business people came up with. Appreciative inquiry says, “Let’s see what works and how can we make more things work like that?” It starts with the positive.
81. Need to change god complex? Docs open to input from other professionals.

PEOPLE POWER

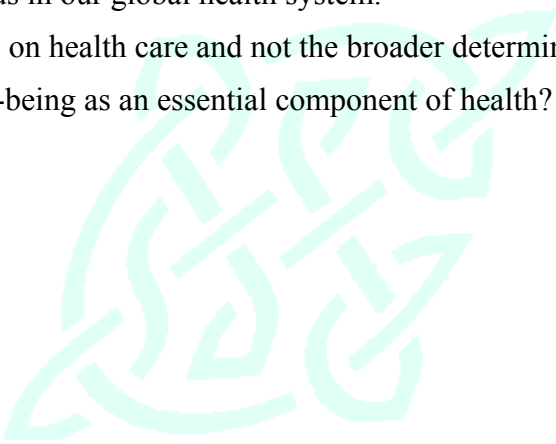
8. Human resource availability – and the ability to attract people into health professions.
9. Workforce planning.
17. Shortages (especially rural and remote areas).
18. Interdisciplinary care (new delivery models).
25. Leadership: Will we be the only ones out there?
I was trying to be humorous about this group trying to come together to paint a picture of what it will look like in 2027. There seems to be a feeling, from folks in the organization where I work, that a lot of people look towards leadership positions as to who would want to do that.
30. We should work hard to become dispensable.
It can go in different words. One, how about a world with no faculties of medicine? How about a world in which physicians are just enablers to a population that is really autonomous and able to make responsible, sensible decisions? We are only a last resort. So, we work hard to put ourselves out of a job then we can discover what our essence is. Now we are doing too many things.
34. Challenge: Providing care across the care continuum.
38. Lack of interprofessional education and mentorship.
53. Roles and scopes of practice will be challenged as people will be far more knowledgeable and will question the status quo.
60. Developing transversal competencies.
Competencies not related to clinical relevance but all the other aspects of being a health professional. It is a challenge to teach them and develop them on a broad scheme.
62. How will we educate our health providers including: family, volunteers, regulated and all others?

POLICY AND POLITICS

6. Too many problems. Too many solutions...and never the twain shall meet!
7. Ethical issues related to who should get what services as costs soar and resources are scarce.
16. De-politicize health care management retain democratic design.
Basically, health management should not be scrutinized by politics as much as it is at the moment. Involvement of elected decision-makers; but, managers should have more leeway in how to take appropriate actions.
31. Managing expectations about what the system can possibly achieve.
39. No destination defined and no roadmap for how to get there.

- 48. Public interest – will we take the system for granted?
- 50. Everyone wants to make it work!
- 63. Urban health systems – inspired by coherent rural systems.
- 64. Opportunity: There are strengths in the current system to build upon.
- 65. Who can/will speak – expanding “gag orders” on public debate for those in system.
- 73. Health system must be accountable to Joe and Jane Canadian.
- 78. Canadian health system(s).
The Canadian health system or Canadian health systems. It is just that the pressure comes from different places, different populations with different values, common values of course, too. It is a challenge to maintain homogeneity.

POPULATION HEALTH

- 12. Adjust for low literacy = poorer health.
 - 13. Become better at health promotion.
 - 21. Emphasis on prevention – multiple determinants on health.
 - 26. Will we be successful in shifting focus from disease management to promotion? Will public take responsibility?
 - 27. Narrowing gaps in health (individuals and populations).
 - 28. Public health (that is: health prevention/promotion and infectious disease) is the number one focus in our global health system.
 - 37. Continued focus on health care and not the broader determinants of health.
 - 80. How about well-being as an essential component of health?
- 

Assumptions

As we contemplate the future of the Canadian health system, what are some practical assumptions we can make about the environment (business, economic, regulatory) in which we currently operate?

REGULATORY

- ◆ Current framework will be irrelevant (regulatory, health care system, globalization and societal empowerment)

We divided our wonderful page into three categories. I will start with the regulatory environment. Basically, what we said, and there were common themes across all three, the current framework that we have whether for providers, medical supplies and devices, will be largely irrelevant in the future partly driven by increasing globalization, partly driven by increasing consumer involvement and the political environment as well.

- ◆ Universal access to core services will continue

However, there were some givens that we put down. A lot of people said it is a given that universal access to core services will continue...

- ◆ Ongoing tensions between governments and between providers

...and that there will be ongoing tensions whether or not the regulatory environment is changing between governments themselves, between provider groups and we will not immediately solve that problem.

- ◆ Reorganization of the system from individual entrepreneurs and to organizations

SOCIETY

- ◆ Consumer demand, compounded by demographics and expectations

On the societal side we talked about the growth of consumer demand and changing expectations and that being compounded by demographics, not just aging but the changing mix of our population.

- ◆ ↑ need for accountability and ↑ standardization

We talked about the increasing push for accountability and standardization not just on the regulatory side but more broadly. Seeing an attractive market in Canada, or whether it is the movement of professionals, a more mobile population and health care providers.

- ◆ Thinking globally, Canadians may be happy with less health care and be willing to share resources but divide rural/urban
- ◆ More mobile population and health care providers
- ◆ New health issues (new HIV, new SARS, etc.)

We also said a given was there would be new health issues emerging. We do not know what they look like but they will be there. We need to be ready to respond.

- ◆ Demographics is more than age: ethnicity, diversity

\$/BUSINESS

- ◆ More market involved in health care (pharmacy, employers, insurance, etc.)

On business and dollars, we think there will be more market involvement in health care from a variety of perspectives. This could be in terms of more involvement from pharmaceutical companies, insurance companies and potentially more involvement from employers – different benefit packages and ways of getting involved in the health sector.

- ◆ Economy will grow, but slower

The economy will continue to grow but likely at a smaller rate that may have implications for how we divide the pot. Will it be things that may contribute to health and well-being outside the health sector that would cause demands on our overall resources?

- ◆ Shareholders will ↑ determining health care provided

There will be continued pressure for health spending; but, there will be tensions around that.

- ◆ More business opportunities → within Canada (contracting out) export to the world therefore need education on how to do it but could be bought out by others too

There are increasing business opportunities, as well, particularly in this context the export markets, biotechnology, some of the other kinds of developments that are happening; but, to really exploit those types of opportunities we would have to think about how we are developing that sector, how we are educating people to take advantage of that. A warning, a caveat, is that we can be bought out by others, too.

- ◆ More unnecessary D_x and R_x options with ↓ returns/↑ cost
- ◆ Resource constraints ↑ cost/↓ taxes and opportunity cost

INTERVIEW MATRIX DATA

- ◆ Business: public health system will increasingly be driven by consumer demand. There will be increasing need for accountability in public funded care. There will be increasing dependence of private funded care to respond to desire of shareholders.
- ◆ Economic: there will be resource constraints on health systems because of need to lower or maintain taxation levels despite increasing needs. More private care will emerge and there will be more contracting out of public services.
- ◆ Economic: system already not affordable for government capacities and reduces our capability to invest in prevention.
- ◆ Business: more market-driven care in the health care system.

- Regulatory: there will be more policy-making for professionals but less regulation by governments.
- System will be consumer-driven → more like U.S. system.
- Health insurance → will have stronger role in system.
- Pharma companies: more drugs that we do not need.
- Globalization impacting mobility of users/providers/services.
- Health an increasing priority for populations.
- Costs will go up in the future.
- Increasingly technology-driven despite diminishing return.
- Diversity of population will redefine health.
- Business increasingly involved, private sector will influence the future, private health insurance will increase.
- Regulatory pressure on duality and safety.
- Increasing strains to educational system and pressure towards changing their orientation.
- Publicly funded system will continue into the future.
- Access to the care that Canadians need, when they need it.
- The money allocated for health care in Canada will be greater (i.e.: bigger piece of the pie).
- 150 billion is too attractive a market for people, groups in other countries to resist (we will be bought out by private operators). Increasing levels of dissatisfaction Canadians will facilitate this take-over. But, at the same time, services could be provided better elsewhere (i.e.: asynchronous telehealth will be a growing market). For example, take blood pressure: send it to India for interpretation. We are hostages of the current system. We are not “free”, when millions have no family MD. Non-MD health professionals will do most of the work. Current MD will be left with <50% of what they currently do. Hospitals will not be the centre of the system. Current regulatory framework will be irrelevant (i.e.: you can buy drugs off internet, provincial regulatory colleges will look “stupid” and parochial). There will be lots of self-help opportunities (i.e.: pregnancy test, shopping malls offering walk in check-ups).
- Very little working well. At least we are doing well enough to have interprofessional discussions. But, the pace of electronic tools is abysmally slow. At least we are talking about improvement and the need to shift away from an acute episodic treatment system to a more synchronous.
- Health care demand will increase (chronic diseases, undiagnosed).
- Cost of drugs will not ↓ therefore burden of drug cost will continue to have impact on system.
- Redefining of the way health care is provided (public versus private funding and delivery).
- Technology will have greater role in acute medical care and, perhaps, prevention.
- Changing of roles of health care team – change the regulatory framework and the way people interact with system.
- Cost of health services will increase.
- Redefining of boundaries – provincial versus federal versus global.

- Increasing litigious behaviour re: acute care (e.g.: paranoia regarding possibility of legal action).
- Demographics will change – aging, ethnic mix → this will have impact on health care system design.
- Trend toward urbanization therefore ↑ pressures on rural areas.
- Can we continue to expect the use of technology to ↑ and afford the system at the same time?
- Can public expectations = affordability of the system?
- Cost will continue to ↑.
- Emergence of new health issues at a population level (e.g.: obesity) and individual level (e.g.: mental health).
- Role of science/research in delivering care is ↑ – use of evidence does not mean system can afford – how to balance affordability, waste and best available care.
- Canada Health Act will continue to remain in place (regulatory, payment).
- Continued investment in health care but cannot assume it will be sufficient or efficiently allocated.
- Increased standardization (accreditation, licensing, training for example).
- IT and pharmaceuticals will be increasing sector in health care economy.
- Assume coordination at federal and provincial levels.
- Continue to be tension between levels of authority as well as between health care providers.
- Tension around public expectations – try to manage expectations versus meeting all.
- ↓ regulatory affairs with current federal government.
- Provincial regulatory affairs dependent on political stripe of government.
- Economy will grow but at ↓ rate than 90s.
- Economy linked to U.S. but ↑ Asian markets.
- ↑ Asian middle class will impact HHR and technology exports (health and biotech) and graduates (now will also go to Asia).
- ↑ business opportunities in health field.
- Need to educate Canadian health sector to exploit/commercialize research.
- Have basic tools but do not do translational business applications.
- Trend to ↑ substantive hybrid health system (e.g.: “hotel services” in hospitals).
- Publicly funded system.
- Balance demand with what we have (resources).
- Health care professionals will be regulated/accountable to public and will ↑.
- Can economy support current trends?
- To support research endeavours to “fix people” costs will ↑.
- Assume people need to be accountable for own actions that affect health (cannot be done for you) – what is role in own health?
- ↑ collaboration public/private to maintain health.
- ↑ engagement with regulatory colleges – trend to examine all scopes of practice – needs to be pushed.
- Acceptance of what public can own.
- Patients becoming ↑ informed – can be a bad thing (advertising does not always give accurate information/advice).
- Can assume advertising will ↑.

- Scientific literacy among public is ↓ and dangerous if taking ↑ responsibility – but focus on this now so may ↑.
- Employers could do a lot to help ↑ health (e.g.: physical activity promotion) but many jobs do not include benefits and those in these jobs may be ↑ at risk (problematic because not encouraged to be active). ? opportunities to not tie these types of benefits to employment (but great employers see health as important).



Trends

What are the current and emerging trends that will shape the future of Canada's health system?

- ◆ Demographics of the population are changing: age, literacy, culture, etc.

One is something that was also quite prominent in our discussion yesterday, it is that the demographics of the population will be changing predictably and that this will create a need for response from the health system. The needs the system is attempting to deal with will be changing over time. The additional comment I would make is the discussion is not just about age but there are also other trends. The main growth of population will come through immigration. There may be populations where literacy is a challenge, cultural barriers. Demographic change.

- ◆ Lifestyles: a focus on health rather than health care; at the same time, it is increasingly difficult, costly to counter the market trends which sustain poor lifestyle behaviours; marketing health behaviours

We talked about the issue of lifestyle. There was a perception that there is an increasing value behind, placed on lifestyle as a manifestation of health. I think that would be a fair way to put it. People were not just concerned with treatment for diseases; that lifestyle would be sort of an important issue and that the health system would increasingly be sort of a player in that arena. We talked about smoking as an example of a situation where the health system had responded to a lifestyle issue and seemed to be succeeding and that that trend, in that specific example of interplay between the health system and lifestyle, would need to, in the future, be extended into other areas like nutrition, exercise, as well.

- ◆ Suppression of innovation which may be contrary to commercial interests

There was a related issue that we discussed that was about situations where commercial interests might run counter to those of the health system; for example, around nutrition where we may have very specific ideas about what health nutrition might mean but there may be other commercial interests that are trying to market other contrary types of food. But, we were not so pessimistic about that. Our view was that the health system has to get into the arena of competing with commercial interests that would be contrary to health.

- ◆ Focus on evidence-based medicine

There was a current trend towards an increasing focus on evidence-based medicine which was viewed in the discussion, it seems as a good thing but also as a pendulum swinging phenomenon. There is also a need for the health system to get back some of what it may have lost in terms of interacting on a human level. That there needs to be a balance between evidence-based care and the human side of medicine.

- ◆ Interest in interprofessional education and practice...and alignment of institutional practices

We talked about the future, likely meaning a trend towards, it was pointed out that this would be an extension of a current trend, to continue to grow towards more interprofessional education. If we are talking about the future health problems, we would need to have professionals not working in silos but working together. We talked about the challenges involved there. There will need to be evolving structures in the health care system to facilitate professional care delivery.

◆ Consumer-driven health care – “What I want”

We agreed with a trend towards more consumer input into health care. And, again, we saw it as something that the system will need to evolve and struggle with. That can be a very positive thing but there could also be a negative side to that, as well.

◆ Globalization: where health care is accessed, impacts on health human resources

We talked a little bit about globalization. I think that also connected with, we were talking not just about globalization of market forces but the workforce increasing, the health workforce increasingly coming from new Canadian populations and also that the population itself with immigrant roots, sort of more of a global village in Canada that the health system will need to react to.

◆ Increasing role of private sector involvement and hidden costs of public private interaction; e.g.: Chaoulli decision

We talked about also the growth of the private sector and when we were thinking of the health system in terms of the public health system that it would need to evolve in ways that it can interact productively with the private sector.

◆ Health system change must be mirrored by health professional education change

◆ Optimizing competencies of health care professions – scopes of practice

◆ Technology and its impact on health care expectations: “instant health care”

◆ Technology’s impact on what people perceive they need, e.g.: erectile dysfunction, aesthetically oriented interventions

◆ The leverage of involving the public in health promotion strategies: national standards are needed → e.g.: Headstart > lack of universality of standards

One thing that we talked about, too, is we found ourselves talking about changes the system was making and needed to make in the future. We also wanted to highlight the point that that also involves health education. We talked about interprofessional practice. We cannot just assume that professionals will come out of their own discipline ready to do that. Everything needs to be reflected at the level of education if the health system is going to be ready to respond. This would involve changes in scopes of practices, changes related to technology. We talked about changes in technology increasingly driving the perceived needs of the population. It is not just about smart people and government setting priorities and rolling it out through the system. When new drugs are invented that creates a perception of need that was not there; or, when new technologies are created that creates priorities in the minds of consumers that do not coincide with government: botox injections, etcetera. And, we had a positive sense that we were learning. We were beginning to learn that good

ideas would often come from the community and that this would be an increasing trend that the health system would evolve in a way that it was a better mix of top down expertise and bottom up wisdom in the population.

INTERVIEW MATRIX DATA

- Demographic shift.
- The IT wave: the increased level of information acumen of the general public.
- A globalization (multifaceted) both within the health field and also the impacts of globalization on disease burden; globalization and health human resources.
- Changing demographics: HHR trends will affect the health system: will today's HHR responses address future needs?
- The expectation by the public → what ought to be provided, what are realistic health outcomes.
- Increased awareness of equity issues within both the health sector and societally → how will sustainability be achieved?
- The physical environment (climate change, pollution, etc.).
- Incentives: how will incentives for the health care team affect delivery, efficiency?
- Demographic shift: the aging of the population, the mix of ethnic groups > these will affect the health system's ability to meet needs.
- Emergence of social diseases: suicide, mental health, injuries; current system is not equipped to address this increased burden.
- Role of technology on how the health system will work.
- The increase in inequality will impact how the future health system will meet the needs of the population (assuming we have a public system).
- Urbanization: how will this affect health care delivery, especially for rural populations?
- Affordability: with the increasing role of technology in the health system, how will this be afforded?
- Globalization – how will this be felt here and other places.
- Health promotion and disease prevention.
- Demographics – aging of the population and affect on services and service provision/providers.
- Rural efflux of people to urban centres “Fort McMurray phenomenon” → who is left behind/how is care provided.
- Open discussion (increasingly) on the role of private funding/delivery.
- The role of technology → “instant health care”.
- The role of health providers is changing the culture of health care workers (e.g.: balanced lifestyle).
- Patient advocacy/awareness → patients have more/equivalent knowledge of some conditions.
- The public takes health care system for granted.
- People are living longer.
- People can travel to where health care is: shopping around for health care.
- Interest in interprofessional education by governments, academic centres. Alignment among stakeholders.

- Strategies for reforming primary health care.
- Growing presence of chronic disease, e.g.: obesity, cardiovascular disease.
- Keeping alive longer:
 - but not well physically/mentally,
 - elder mental health,
 - long-term residential care.
- EMR/EHR
- Exodus of health human resources (retirement, etc.).
- Scope of practice.
- Public accountability – public reporting.
- Quality/safety/patient centeredness.
- Aging of population (including HHR).
- Sustainability of current health care system.
- Strengthening of social networks that do not recognize traditional boundaries (institutional, provincial, national sites).
- Tools that allow people to search, find and use resources to solve problems by themselves.
- Growing levels of dissatisfaction with current roles and workflows.
- Inability of the system to handle complex chronic problems (as opposed to simple acute ones).
- Large investments in electronic health information systems worldwide.
- Interest in Canada as a market by groups in other countries.
- Consolidation of chronic illnesses as the biggest burden for systems. Co-morbidity.
- ↑ in costs. Governments have problems in containing costs.
- Increases in technologies with reducing marginal returns.
- Environmental problems are going to become big drivers of change – will create increase in disease.
- Increase/developing information successes. If it continues it will have great impact on system.
- Economic globalization – reducing government capacity to act on health care.
- Increasing economic inequalities pushing the wealthy for more liberties to buy health care for themselves.
- Aging population, aging workforce.
- Increasing “stressors” 2^o to ↑ diversity, e.g.: ethnic.
- ↓ hierarchical orientation, ↑ diversity of providers – e.g.: more “complementary” providers.
- ↑ use of technology for long distance care delivery.
- Need for large changes in education, 2^o to technology.
- Need to respond to issues related to low health literacy.
- Need to respond to ↑ challenges of new Canadians/language barriers → e.g.: better labels.
- Assumption that existing social structures will support the goals of the health care system → but the social networks are changing/weakening.
- (Above bullet) → private sector will jump in with proprietary services – creating new costs, e.g.: caregivers.
- The human aspects of disease need to be rethought.

- Consumer driven system – lots of care/no responsibility.
- Aging population/workforce – increasing expectations.
- Globalization – all new growth in immigration.
- Increased reliance on international caregivers (foreign knee replacement).
- Consumers will be drivers of care.
- Increasing reliance on geography.
- More under-serviced populations.
- Huge pressure on health education.
- Faculty/workforce getting older.
- Consumer driven input – desire going to be different than health care system → losing weight/tight skin.
- Globalization → serving different needs.
- Globalization → patients → Asia → N.A.
- Flagrant misuse of \$.
- Constant inflationary growth of costs.
- Policy-making will take.
- Consumer driven demands. More informed/need more take responsibility.
- We should be learning from the past – how system was originally set-up.
- Chaoulli decision → concern of access to system – concern on trend to limit access dependent on economic means.
- Focus on timely care → want list program focus. How this will impact future – better to train more professionals versus queue jumping.
- Scientific trends – genetics, etc. – could further strain resources.
- Trend toward government versus governance – focus on profit not what is right.
- Unevenness of access – trend to bigger gaps – need for national standards implementation.
- Focus on evidence machine, keeping in mind “art” of medicine.
- Over prescription of drugs – focus on pharmaceutical answers to medical problem.
- Public health focus – ex.: no smoking in public places.
- Chronic disease trends – diabetes/heart disease.
- Aging population – further stress on stressed system.
- Decrease in population.
- Manpower – people not as attracted to health care field.
- Fiscal – research funding – increase cost to the system.
- People do not accept “no” – want a cure for everything – there may not be an answer.
- People focussed on health – talked about more/key political point.
- Demographics.
- Lifestyle focus – opportunities for improvement.
- Resource management.
- “Gag orders”
 - people in system not participating or being able to participate in public debate,
 - interest group debate.
- Dysfunctional provincial-federal relationship – worsening trend and between provinces – breakdown of Council of Confederation – need coordinated actions and may not have.
- Public focus on health and health care.

- Private performance measures in public system.



Strengths, Weakness, Opportunities, Threats

What do we perceive as the strengths of our current Canadian health system?

- ◆ Universal health care system – tax-based

One of the things that was mentioned by almost everybody is the fact that we have a universal health care system that draws from a tax base rather than another base like an insurance base because this was seen as an equitable way to have a health care system organized.

- ◆ HHR – skilled, dedicated, compassionate

Many people discussed that the health human resources were a strength of the Canadian system both because of their skill and also because they care. They are dedicated and compassionate.

- ◆ Acute care delivery

Our ability to deal with acute care is a strength...

- ◆ Research capacity

...as well as the research capacity. Researchers are internationally respected.

- ◆ Population → generally healthy; philosophically engaged

Health relative to the population, the population is generally healthy and it is also philosophically engaged. So, health matters to Canadians. This was seen as a strength to the system.

- ◆ Well positioned to play a global role

Canada was considered to be well positioned to play a global role, to be a global leader in many areas of health care.

- ◆ Money

That we are a relatively rich country and we have money. This was seen as both a strength and a weakness...

What do we perceive as the weaknesses of our current Canadian health system?

- ◆ Waste

...It is a weakness because the presence of money can sometimes lead to waste or mismanaging of funds.

- ◆ Fragmentation (mistrust, competition)

Another weakness is the system is fragmented and there is mistrust between the provinces and federal government and different sectors within the health care system and different professional systems. It is not just that it is fragmented but that there is mistrust.

- ◆ Good macro data; poor micro data to connect providers and assist delivery on frontlines; lack of EHR

Another weakness is that we have good macro data but poor micro data to connect the providers. We have data about, as an example, the neonatal death rate in Aboriginal populations but there is no data about what to do about that or how to implement change.

- ◆ Too much focus on hospitals, disease, physicians (shift to population, health versus health care)

Another weakness is that there is too much focus on hospitals, diseases and physicians but not enough focus on population health and the differences between health and health care.

- ◆ Universality → costs; rationing → “medicalization” of issues

Universality was also seen as a weakness. Both a strength and weakness because it leads to high costs and rationing. Also, it leads to the “medicalization” of issues. Since there is a universal health care system it takes up a lot of the budget. One of the best ways to get a problem dealt with is to get it considered a medical problem rather than a social or other problem.

What are the threats?

- ◆ Shortage in labour:
 - ◆ within Canada
 - ◆ beyond Canada → attracting HHR to other countries

A threat was the shortage in labour. This is true within Canada but also in other countries such as Asia which is becoming a very strong player; in other countries that might attract some of our health human resources to those countries.

- ◆ Demographic shift (health needs and current planning, e.g.: LTC)

The demographic shift was seen as a strength but also a threat as we have not been planning beyond the demographic shift. We are thinking about the demographic change that is happening but not what to do afterwards, for example: long-term care facilities after baby boomers have passed away.

- ◆ ↑ privatization (this will ↑ \$ and ↓ access)

Another threat is increased privation which will increase costs and decrease access.

- ◆ Chronic disease presence

A threat is the chronic disease presence...

- ◆ Inappropriate fiscal management

...and inappropriate fiscal management.

- ◆ New technology → MB < MC; uncontrolled diffusion (once it is there; it is hard to take away)

Marginal benefits, another threat is that new technologies are emerging and they have marginal benefits. The costs exceed the benefits. There is uncontrolled diffusion so there is no framework for saying, "No" to the introduction of new technologies. Once it is there it is hard to remove it.

- ◆ Public frustration ≠ good public policy (reactive)

The last threat was public frustration. A lot of policy is reactive so the public reacts to that.

What are the opportunities?

- ◆ Trust in the system

Opportunities were that there is a lot of trust in the system. The Canadian public does trust the health care system; that gives us an opportunity for building a better system.

- ◆ Able to influence public health (e.g.: smoking policy)

We are able to influence the public because of this philosophical engagement. An example of this is the smoking policy so we are able to move the public in a direction.

- ◆ Health matters – significant public interest → (opportunity to be the healthiest population)

Once again, health matters to Canadian. This leads to an opportunity to be the healthiest population in the world.

- ◆ Resource \$ abundance → better global citizens

Once again, because we have a lot of money, there is a resource abundance and we have the opportunity to be better global citizens and have better engagement with health problems in other countries.

INTERVIEW MATRIX DATA

- ◆ Strengths
 - All access (everyone).
 - Really ill resources available.
 - Regardless of socioeconomic can get health care.
 - Well-trained professionals highly competitive in world market.
- ◆ Weaknesses
 - Costs continue to escalate beyond means.
 - Public demand continues to grow.
 - No framework for refusing – regardless of efficacy – rare for something not to be approved.
- ◆ Opportunities
 - Crossroad for whole system – can shape it for future so it is sustainable.
 - Engage across generation, gain experience from elderly with experiences of the system can use this feedback.
- ◆ Threats

- Manpower → not enough people to fill required needs.
- Could end up with 2-tier system which removes current strengths.
- Strengths
 - Reservoir of public confidence and support for HCS.
 - HC P/W care – we do not always tap into this.
 - Health population relative to other countries.
 - Strong knowledge base.
- Weaknesses
 - Mistrust – unhealthy for all (interpersonal trust but competition between groups lack of trust).
 - Institutionally focussed not necessarily where opportunities are.
 - Not open to other ways – change is hard in health care.
 - “Siloed” – do not talk to each other – inhibits solutions that bridge professional groups, sectors, etc.
 - Accept the average too easily.
- Opportunities
 - Trust in system allows us to build a better and more responsive system than other countries.
 - Move population health (not exclusively through HCS).
- Strengths
 - Universal.
 - National legislation.
 - Well educated providers.
 - Internationally recognized research community.
 - Financial resource investment (federal and provincial) per capita.
- Weaknesses
 - Too much geography to meet CHA therefore inequity results.
 - Interprovincial inequities in ancillary health care (CHA not comprehensive).
 - Patient/public expectations that cannot be met.
 - Have not thought outside the box on how to deal with fiscal constraints in a constructive manner.
 - Granting councils have slow, tedious processes do not provide \$ quickly enough.
- Opportunities
 - World leaders in many areas of research (basic science and clinical medicine).
 - Could be healthiest population on earth.
- Threats
 - Inappropriate structure for managing fiscal resources.
 - Childhood obesity, chronic disease problem (first time generation of children will not live as long as parents).
 - Not enough HIP for population.
 - No anticipation for after baby boom.
- Strength: universal access; high quality health care.
- Weakness: access, issues, public health and tertiary care system not integrated well.
- Strength: public and not-for-profit.

- Weakness: huge HHR issue re: nurse, physician and allied especially rural. Not training enough geriatricians. Systems need greater equity re: reimbursement. This is why some professions are less desirable.
- Threat: competing priorities, competition for resources.
- Opportunity/strength: public commitment to health care.
- Threat: public expectations.
- Weakness: preparedness for demographic shift.
- Strength: use of evidence-based decisions.
- Strength: shift from disease management to health promotion.
- Threat: sustainability of resource use; geography shifts, moving populations.
- Opportunity: people getting into self-care.
- Weakness: federal versus provincial dynamics.
- Opportunity: use of technology.
- Threat: portion of health care budget used by drugs → sustainable?
- Strength: universality of system and access.
- Weakness: increasing private health care; cost of drugs and sustainability of further increase; ability to address public issues (e.g.: diabetes, obesity, heart disease).
- Threat: total collapse of public system due to rising costs.
- Strength: we are a relatively health population.
- Weakness: wait times, efficiency of system, reacting rather than proactive planning. Federal/provincial issues → how do you coordinate/plan in a system that is fragmented by design?
- Opportunity: IT.
- Lots of money (it could be too much) – this could be a strength and a weakness.
- Waste a lot.
- Too much emphasis on hospitals, disease and physicians. Shift to people, health versus health care. Need to think of “communities”.
- We spend <2% on non disease.
- Fragmentation at all levels. Health systems at small system. Archaic regulatory systems (MD in Montreal not an MD in Calgary).
- Huge investment in electronic information systems.
- Committed health workforce; highly trained population is increasingly interested and able to handle health care issues.
- Strengths
 - Universal; all get the care they need.
 - Committed health workforce including policy-makers.
 - Research capacity; focus on evidence-based health care.
 - System that strives to be integrated.
- Weaknesses
 - Perhaps a resting on our laurels with respect to universality.
 - Absence of accountability both within provinces and across provinces (e.g.: drug coverage, cancer care).
 - Still do not do enough evidence-based decision-making.
- Strengths
 - Health human resources.
 - More interdisciplinary care.

- Approaching/trying new delivery models.
- More work on optimizing competencies across health professionals.
- Weaknesses
 - Shortage of labour → constraints, rigidity in rules with respect to labour mobility.
 - Insufficient funding for renewing primary health care.
 - Not enough work done to retain health professionals – both within Canada and beyond.
 - Not enough electronic health information infrastructure.
 - Lack of accountability – not enough public reporting.
- Strengths
 - Basis is universal access.
 - Mission/philosophy allows us to have globally responsible roles.
- Weaknesses
 - Current pace/models unavailable.
 - ↑ # of PT with unequal access.
- Threats
 - More privatization with and access to those who need it.
 - Chronic disease – promotion/prevention.
 - ↳ will use whole budget
- Strengths
 - Good acute care.
 - Equity – intention of universal coverage.
- Weaknesses
 - Terrible at promotion/prevention and investing in education. Our education \$ versus McDonalds and Frito Lay.
 - Weak on CDM compared to acute.
 - Our universal access = ↑ cost, ↓ access (wait times).
- Threats
 - Public frustration = political hot shots and political changes versus where needed.
 - Some political parties work to help low SES, others do not.
- Opportunities
 - Good infrastructure.
 - High profile with health and desire to improve.
 - Good care for middle SES.
- Strengths
 - Tax-based funding for health is most progressive.
 - Good data on population health.
- Weaknesses
 - Our population data is macro and not linked to information for health providers.
 - Very fragmented especially primary care, no network compared to U.S.A. HMO.
 - Prevention not a focus PT not engaged/participating in prevention.
 - We look at tech one at a time and on individual level only.

- Opportunities
 - Primary care reform – need more
- Threats
 - Privatization will ↑ cost, pull docs out of public system = ↑ inequality.
 - New tech with ↑↑ cost and ↓ MR, uncontrolled tech diffusion.



Building on What is Working

As we contemplate the future of the Canadian health system, what is currently working well that needs to continue (and that can be successfully built on)?

- ▲ High level of commitment to making it work
- ▲ Commitment to evaluate

Many of our issues were covered already. The fact that there is interdisciplinary commitment is a good thing; that we have a well established research capacity. Two new angles to what is working well is our commitment to evaluation. It does not mean we are doing it well; but, there is commitment...

- ▲ Increasing interdisciplinary commitment
- ▲ Canada Health Act is a good framework

...and that the Canadian Health Act is a good framework. It is not perfect; it may need to be revisited. And, for sure we have a very committed population not only of members of the public but members of the profession and people trying to make the system work.

- ▲ Well trained health professionals
- ▲ Well established research capacity

In the context of improving the Canadian health system what do we need to do more of?

- ▲ Investment in research that matters to the public

Investment in research that matters to the public, not just research that matters to a researcher. The need to commercialize research.

- ▲ Health information systems that support decisions that optimize health for the public

That health information systems need to be designed in ways that support decisions that optimize health for the public; not just gadgets for the sake of gadgets or, as have been designed until now, more for transactional purposes. We need more decision support geared to health.

- ▲ To strengthen interprofessional dialogue and work
- ▲ More of primary prevention
- ▲ Optimization of competencies

We need to optimize competencies because our roles may not be the same. The roles we need to perform as physicians or nurses or any other health care providers or even the public have changed.

- ▲ Tailoring systems and services to meet the needs of local population

We have a risk of having too generic solutions thrown at local environments with very little flexibility to adapt to the needs of the local populations.

▲ Harmonization of health system policy within a national and global policy

We need to harmonize more the health system policy within a national and global framework. The fact that, for example, somebody from Alberta flies to British Columbia and cannot practice does not make much sense.

▲ Sharing of resources and knowledge

Sharing of resources and knowledge should be encouraged as well as the fact that having everybody trying to reinvent the wheel is not a good thing.

In the context of improving the Canadian health system what do we need to do less of?

▼ Less focus on volume driven outcomes and put more focus on health driven outcomes

▼ Less investment in acute conditions

▼ Less inequity within all aspects of the system

By default more emphasis on disadvantaged populations.

▼ Less reliance on pharmaceutical solutions.

▼ Less glamour medicine.

▼ Less complaining, more doing

The most consistent message is that we need less complaining than we are doing now.

INTERVIEW MATRIX DATA

- Control of costs – working well but challenge is restrictions on resources.
- Restrictions on private care have allowed cost control.
- Rural health care more integrated and can inform urban integration.
- We need to “organize” private providers outside the public system → instead of having them driven by what patients think they need.
- Push forward with primary care reform such that it ↑ promotion, prevention, etc.
- Need to better integrate the different levels of health care – there are too many barriers at this time.
- Better financial integration – more role for health professionals to allocate funds in relation to patient needs.
- Poor information systems to educate MDs about who they need to be treating.
- Involve target audience in information you want to disseminate.
- More of “looking after” the “whole” patient not just pill pushing.
- More multidisciplinary care delivery – this will solve our ↑ burden of disease – our system is not conducive to that.
- MD reimbursement not tied to multidisciplinary approach.
- Health promotion strategies coming (will soon) from community/patients themselves.
- Need to seize the opportunity for public participation (we are regionalized and should take advantage of that system).

- Very little is working well but dialogue around interprofessional education is a positive step.
- Pace of electronic information systems is too slow.
- We are not aligning opportunities with incentives – public reporting/accountability.
- Shifting from system centred to patient centred.
- Need much more recognition of how we blend strategies/policy from outside the health care system.
- Integration.
- Working well
 - Publicly funded system that needs to be celebrated. It is aware of the patient as its core. Not perfect, though.
 - For the most part, it is universal. Does not turn people away.
 - High levels of commitment by health workers.
 - The system makes efforts to support evidence-based practice. At the policy level there is also recognition of this. We are at early stages.
- Doing more
 - Willing to see the deficiencies of the system, to go back to fundamental principles and refine it.
 - Take a global perspective and share resources more.
 - Evidence-informed collaborative decision-making with public involvement.
- Working well
 - Interprofessionalism (view through projects).
 - Health promotion (Public Health Agency of Canada).
 - Development of new delivery models.
- Doing more
 - Strengthening interprofessional teamwork.
 - Optimization of competencies of health professionals.
 - Electronic health records.
- Doing less
 - Talking about policies (rather than doing).
- Doing less
 - Heavy investment in acute conditions.
 - Focus on the individual (more on populations).
 - Non-beneficial, expensive end-of-line care not linked to improving quality of life.
 - Complaining that there are no answers.
 - Focus on success (more on learning from failures).
 - Emphasis on the middle and upper class (more on marginalized groups where role is far greater).
 - Looking at Canada as a unique isolated player (more recognition of our role as members of a global community).
 - Assumption that all technology is inherently beneficial.
- Working well – most health care providers committed to patients – do not always recognize this.
- High level of public engagement, support, confidence.
- Strong knowledge base.

- More focus applying the things we know are effective now.
- Less of silos, walls we cannot get through to work together.
- More listening to patients, family, staff.
- Soaring at excellence.
- Complacency in the system not acceptable.
- High mistrust in the system, i.e.: those people over there.
- We train well health care professionals (i.e.: docs, nurses, etc.).
- We provide acute care high level timely manner focus on centre of excellence well and strategically.
- We do not incorporate private partnerships to do research.
- We have not focused on public health and issues of public health.
- We have not figured out how to deal with vulnerable societies, i.e.: Aboriginal.
- We should not fund health care more.
- We do not have a good system for managing what we have.
- We have not educated health care professionals to be leaders of what we have.
- Good at encouraging foreign graduates to come to work, not great at incorporating them in the system.
- Universality kept, early efforts on focussing on quality and safety.
- Move towards informing patients and making them partners in care.
- Recognition on behalf of government/universities on interprofessional education and care.
- Hospitals working towards accommodating patients' personal values in health.
- Better interprovincial services, i.e.: drug in one province not another.
- More on public accountability and reporting.
- Certain ways to be innovative, i.e.: midwives to deal with fiscal constraint.
- Less physician influence on decisions that would be better for the system.
- More information.
- Less marketing.
- Working Well
 - Interdisciplinary education for health professions.
 - Options for delivery that can be built on, e.g.: publicly paid but privately delivered.
 - Building on activities started by health promotion, i.e.: promoting primary prevention.
 - Role of evidence in practice and policy.
- Improvement
 - Allowing flexibility in health the systems that meet local needs.
 - Less complaining about the system.
- Working Well
 - Universality of the access to health care services.
 - Quality of care is good.
 - Quality of health professional training is exceptional.
 - Capacity to innovate in health research but at the same time it is under-funded.
- Not Working Well
 - Lack of investment in health promotion and we need to do it well.
 - Increasing consumption and costs of pharmaceuticals.

- Structure of primary health care towards meeting the needs of the population who deliver health research, i.e.: commercialization or needs of the populations
- Level of commitment of public and health care system itself. There is genuine desire for it to work. The provider wants to provide best care. People willing to pay and regulatory authorities committed to their mandate.
- Our effort to measure and evaluate the performance of the system.
- We have a good framework in Canada Health Act but needs continued updating.



Session Expectations

What needs to happen between now and the end of tomorrow for this session to be worthwhile?

- ☞ I would like to get to know more people; this is an opportunity to network.
- ☞ I would like to look back at the two days and know I had fun.
- ☞ I hope to have very candid conversations. I hope there is a boldness to our conversations.
- ☞ It is an opportunity to validate what some of my own thoughts might be with other peers who say what their concerns might be.
- ☞ I want to walk away with something new that I do not know now.
- ☞ I want to be engaged in socializing and be able to pronounce Karen's last name. ☺



Session Evaluation

What were you surprised or intrigued by?

- ◆ To be called “young”!
- ◆ It was intentionally kept small in number which I think was a huge asset.
- ◆ I think just the breadth of experience in the room for a group that is considered “young” in their careers.
- ◆ The breadth of what has been done, I feel. I like those key messages; but, there is value in all the specific points (somebody can think about those things later). A lot has been said in a very short time.
- ◆ The realm of possibility. When I saw an invite for sixteen people I was quite fascinated by the potential to influence what health care will look like.
- ◆ I was intrigued that the Association of Faculties of Medicine was instrumental in getting this off the ground because they come from a very particular sector. I thought that was quite innovative.
- ◆ I was surprised at how few times I heard, “It is hard”.
- ◆ It was not narrowed to faculties of medicine and this was sponsored by the Association of Faculties of Medicine so I expected a much more narrowed discussion.
- ◆ I was surprised, or impressed by, although we may have different ideologies we still have very similar values in terms of what we want to see.

Where were you frustrated?

- ◆ Moving the dirt.
- ◆ A little bit more time because some of these things are things that you want to mull over and some of this discussion might have been done in small groups over coffee and we could have come back.
- ◆ I am concerned that there are things that have not come out. A few I tried to write and wondered, “Is it a new idea?” “Is it something we are already trying to do?” Maybe we did miss things. At some points I was a bit sceptical.
- ◆ We needed more time to get to know each other because we had little opportunity to do that.
- ◆ I think there are people from more marginalized communities within our respective professions that might have been serviced to be present here, like First Nations people, and maybe some of the ethnic minorities or more challenged communities in this country that would have offered a particular insight that might have been portrayed here but could have been portrayed more vividly.
- ◆ I found the group was a little bit tame. There is a lack of debate in health care. We do not like to disagree with each other because it is not a nice thing to do; but, other

organizations encourage that and people stay civil. I would like to see more of that happen. There is about forty percent up on the walls that I completely disagree with. It worries me that this will go out as a report that I participated in when it does not reflect what I think. There is only so much you can pull out of a day. All that said, this was a productive day.

What is the significance of this event to you?

- ◆ Meeting other individuals.
- ◆ It is too soon to say.
- ◆ The significance is having had the chance to sit with you and throw out ideas because it is really very helpful to tap into the minds of other people. I do not get that chance very often and that is invaluable to me. It does cause you to think about other people's ideas. This is the kind of stuff that is really difficult to find a place to go look up. I think that is invaluable; but, it is also part of the frustration. There are so many valuable areas here; but, there is not necessarily receptivity on the other side.
- ◆ I did not know any of you before coming here. For me, it was bridging a distance. There is a disconnect between Quebec and the rest of Canada – for many reasons. So, that was the meaning for me. I hope it is a start between us for dialogue and discussion.



Participants

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