UBC CENTRE FOR HEALTH SERVICES AND POLICY RESEARCH

Medicare at a Crossroads
Myths and Realities 50 Years In

Conference Summary

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CHSPR 2022 HEALTH POLICY CONFERENCE

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THE UNIVERSITY OF BRITISH COLUMBIA

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About CHSPR

The Centre for Health Services and Policy Research (CHSPR) is an independent research centre based in the School of Population and Public Health at the University of British Columbia (BC). Our mission is to stimulate scientific enquiry into health system performance, equity, and sustainability.

Our faculty are among Canada's leading experts in primary health care, health care funding and financing, variations in health services utilization, health human resources, and pharmaceutical policy. We promote inter-disciplinarity in our research, training, and knowledge translation activities because contemporary problems in health care systems transcend traditional academic boundaries.

We are active participants in various policy-making forums and are regularly called upon to provide policy advice in BC, other provinces, and abroad.

We receive core funding from the University of BC. Our research is primarily funded through competitive, peer-reviewed grants obtained from Canadian and international funding agencies.

For more information about CHSPR, please visit https://chspr.ubc.ca/.

CHSPR's Health Policy Conferences

CHSPR's annual health policy conference is an opportunity for those interested in health policy issues to hear about emerging research and participate in interactive dialogues with experts in thematic areas shaping Canada's health system. This long-standing conference draws together leaders, researchers, policy-makers, academics, health care providers, and patients, from universities, governments, industry, health authorities, and national organizations across BC, the rest of Canada, and internationally. This document presents highlights from the 2022 conference. For summaries of past conferences, please visit http://chspr.ubc.ca/conference/past-conferences/.

About the Conference

CHSPR held its 34th annual health policy conference on March 31 and April 1, 2022. The conference was held in a hybrid format, with both in-person attendance at the Robert H. Lee Alumni Centre at the University of BC and virtual attendance.

The 50th anniversary of medicare in 2022 provides an opportunity for us to reflect on the past, including on the roots of medicare and the values and principles underpinning the path that led to where we are now. At the same time, it is a chance to consider our hopes for the future and how we should chart the course moving forward. The pandemic has highlighted existing issues in the health system, as well as brought forth new challenges. Many of these decisions depend on our values—for example, values of equity and fairness have informed our health care systems; and these normative decisions should be guided by public involvement.

The 2022 CHSPR Conference brought together research and policy experts, students, patients, members of the public, and care providers from across the health care and social systems, to examine the past, present, and future of medicare in Canada. Key topics included the history and origins of medicare in Canada, the current challenges and shortfalls, opportunities for reforms (for example in primary care, and elder care), health system innovations, and equity. A detailed conference program and presentation materials can be found at https://chspr.ubc.ca/conference/program/.

Supporters and conference organization

This conference was possible because of the financial support of generous supporters, including the Canadian Institutes of Health Research Institute of Health Services and Policy Research, the BC Ministry of Health, Michael Smith Health Research BC, the BC Patient Safety & Quality Council, Healthcare Excellence Canada, and the Canadian Institute for Health Information. This report was possible through support from Health Canada.

Dr. Kim McGrail of CHSPR chaired the program committee. Dawn Mooney and Joyce Huang, also of CHSPR, led the planning committee. We acknowledge that the University of BC Vancouver Point Grey campus is situated on the traditional, ancestral, unceded territory of the Musqueam people. Participants joined us from many places, near and far, and we also acknowledge the traditional owners and caretakers of those lands.

DAY 1 | SESSION 1

Origin Stories

The public health care systems we have now evolved over decades. By 1972 all jurisdictions in Canada had public insurance for hospital and physician services, following principles of "equal terms and conditions" articulated by the Hall Commission (the Royal Commission on Health Services). As we mark a half century of medicare, this session revisited the roots of medicare and the rationale and vision for health care systems in Canada.

The emergence of medicare in Canada: Principles and promise

Speaker: Gregory Marchildon, University of Toronto

Dr. Marchildon delivered a presentation on the history of medicare, setting the stage for further discussion by focusing on its design principles and promise.

Origins of medicare—emergence of principles (and promise): 1944-1959

Dr. Marchildon began by describing the contextual factors in Canada that gave rise to the emergence of the principles of medicare. He emphasized the shock of the Great Depression leading to decline in income and quality of life, including lack of access to health care. This resulted in the rise of independent political parties, especially in the hardest-hit provinces (e.g. Saskatchewan, Alberta). The election of the Co-operative Commonwealth Federation in Saskatchewan in 1944, with Premier Tommy Douglas also becoming the Minister of Health, ensured that health was a priority on the political agenda. Douglas worked on both health system restructuring and offering insurance coverage in Saskatchewan. When the federal government declined to collaborate on a federal package, Saskatchewan proceeded with universal hospital coverage on its own in 1946. Around the same time, Alberta introduced its own hospital coverage scheme based on different design principles. The design principles of the two provincial hospital coverage plans are summarized below:

	Saskatchewan (1947-)	Alberta (1950-1958)
Universality	Universal (compulsory registration)	Partial (voluntary registration)
Governance	Public (single-payer with democratic accountability)	Private (multi-payer with consumer choice)
Breadth of coverage	Single-tier	Multiple-tier
User Charges	No user fees for any covered service	User fees based on hospital length of stay

Saskatchewan faced challenges expanding coverage to other services in the early-mid 1950s (e.g. school-based dental services, mental health reforms) due to fiscal constraints. There was a policy window of opportunity for federal cost-sharing during 1955-1957 through a series of federal-provincial conferences on fiscal relations. The federal government relied on the Saskatchewan hospital plan's design and principles for the *Hospital Insurance and Diagnostic Services Act* passed in 1957, which resulted in single-payer and single-tier coverage.

The introduction of universal medical care coverage: 1960-1968
Federal cost-sharing for hospital insurance allowed Saskatchewan to add physician services (medical care) to covered services. However, Douglas faced immense opposition from doctors, which culminated in the doctors' strike of 1962. The strike ended with an agreement to negotiate, resulting in the Saskatoon Agreement, in which compromises were made by both sides: the government agreed that there would be no change to delivery and payment, and organized medicine would continue to negotiate terms and renumeration, resulting in a dual monopoly. This became the template for how medicare was introduced in the rest of Canada.

At the same time, the Hall Commission from 1961-1964 aligned with the Saskatchewan principles and design (single-payer, single-tier, free at the point of services) as the most effective way to achieve complete coverage. Additionally, the Commission recommended adding physician services, dental care, outpatient drugs, home care, and long-term care to achieve a comprehensive plan as soon as possible. The federal government responded by passing the *Medical Care Act* in 1966.

The best years? 1970s-1980s
The 1970s and 1980s can be considered a high period of medicare, with the passage of the *Canada Health Act* (CHA) in 1984. The population experienced better access and outcomes compared to the United States, while the public felt that people were taken care of and rising public sentiment linked medicare to national identity. However, there was no push to expand universal medicare; the CHA acted as a defensive measure and a tool for the federal government to penalize provincial governments for user charges and extra billings. Meanwhile, provincial programs expanded as targeted subsidies or supports (e.g. for long-term care, prescription drugs), rather than as services under the CHA framework.

Issues emerge: 1990s-2004
By the early to mid-1990s, challenges were emerging in part because of cost-cutting. On one hand, this forced some otherwise difficult reforms like regionalization, but it also damaged infrastructure and some of the workforce. Despite reinvestment in the later 1990s, general dissatisfaction with the health system increased. The Romanow Commission (the Commission on the Future of

Health Care in Canada) published its report in 2002, recommending a realignment and gradual expansion of universal health coverage. However, instead of adopting these recommendations, the Ten-Year Deal passed in 2004 expanded federal investment in health care without any ties to the expansion of the CHA.

Current state: paradigm freeze

In the past couple decades, the system has been in a 'paradigm freeze', in which it has been very difficult to reform/innovate/rebuild health care. There is debate about the source of the problem— for example, the underlying infrastructure of the system versus the organization of delivery.

Final observations

Dr. Marchildon concluded by posing questions for reflection. On the principles of medicare, he asked whether the principles of medicare indeed prevented improvements, and whether those principles can be achieved by different mechanisms. To those opposing these principles, what should be in their place? On the promise of medicare, he asked how do we improve the mechanisms used to achieve comparable quality of services across Canada, and what would encourage innovation in the system?

Compromised origins, potholes on the road to 'where we are now', and the need for integration and innovation
Speaker: David Naylor, COVID-19 Immunity Task Force and University of Toronto

Dr. Naylor began by carrying forward themes from Dr. Marchildon's talk, including the theme of path dependency: the origin story of medicare matters to the current reality. He remarked on how little has changed in the system and emphasized the problem of lack of integration and existence of silos in the system, most notably for hospitals and physician services.

Dr. Naylor then discussed the pre-medicare history of fee-for-service (FFS) physician payments. He described the system as having a strong focus on independent solo-practice physicians. Later, doctors began to organize non-profit insurance plans, which allowed physicians to pool and stabilize incomes while maintaining the model of independent FFS practice. When the Saskatchewan plan, as well as the national legislation, came to pass, the architects did not want to disrupt this core organizing principle, which further entrenched this model of practice.

There are major downfalls of the FFS model of practice that affect our current reality. Dr. Naylor noted that FFS interferes with integration, misaligns incentives by rewarding volume and undervaluing quality of care, provides no compensation for education and research, and does not promote inter-professional collaboration. He acknowledged that all models of physician

renumeration have flaws but emphasized that creating shared accountability and incentives is crucial to a cost-effective health system.

Dr. Naylor then described 'potholes' on the road to the current reality. One pothole was structural challenges with the organization of care, with recommendations to address these published in the 1974 Mustard Report from Ontario. Although there were some excellent suggestions for primary care reform, such as the establishment of community health centres and regionalization, for the most part these did not take off. He remarked that we are still struggling to create optimal practice conditions and incentives for primary care practitioners. He presented evidence from a randomized controlled trial published in 1984 comparing FFS to non-profit multidisciplinary health organization with salaried physicians, which showed a 25% cost reduction with the latter.[1]

Dr. Naylor then described the work of Peggy Leatt,[2,3] on promoting integrated care in Canada, such as non-profit integrated delivery systems similar to the strides being made in the United States. Despite this, little change occurred. Dr. Naylor agreed with Dr. Marchildon that the cost-cutting in the 1990s, combined with the outdated architecture of the system, resulted in lengthened waiting lists and a decline of Canada's reputation internationally.

By 2014, dissatisfaction in the system led to the launch of the Advisory Panel on Healthcare Innovation, which Dr. Naylor chaired. The final report emphasized that although care providers are dedicated, they remain hindered by the architecture of the system and perverse incentives, and the failure to scale innovations. Additionally, he noted that the recommendations made by the Panel had been made numerous times before. The Panel agreed that the lack of integration was the most salient flaw in the system, tied to issues in the way medical practice is organized. They proposed establishing a $1 billion health care innovation fund and the creation of a single innovation agency in Canada to help break through the stasis in the system.

Dr. Naylor also commented on the history of cost-sharing disagreements between the federal and provincial governments. As the federal government became fiscally strained, the deficits were downloaded to provinces, resulting in billions of dollars in cumulative loss for provinces. While three federal health accords saw substantial re-investments, these led to few new initiatives by provinces, mainly because these re-investments acted more as repayments from the federal government.

Dr. Naylor concluded by highlighting some next steps. First, we need a fair and innovation-friendly process for interjurisdictional funding of health systems. Second, he acknowledged that there are many gaps in the system; there are hard choices to make about where to start. The pandemic highlighted health human resource challenges, especially as we consider how to clear

the massive backlog in services. We will need to balance the needs of the workforce and the needs of patients. Finally, he reflected on the trade-offs in investments in health versus investments in other areas that affect health (e.g. social determinants of health), and emphasized the benefit of upstream investments.

Audience Q&A highlights

Why do you think the major commissions and reports over the years had such a minimal impact on the trajectory of our system?

Dr. Marchildon reflected on his own experience during the Romanow Commission. He commented on the brief policy window for changes—once it's missed, it may be a long time before it comes back, but when it does, somebody may be receptive.

Dr. Naylor agreed that policy windows open and close very quickly. He commented that the key to getting things moving is for the community to apply sustained pressure for implementation. For example, the pandemic has posed a huge challenge for health care workforce and revealed many flaws. As such, there is willingness among health professionals for major changes; this is one of the windows where change can occur.

How far do you think Trudeau and Singh's plan will go toward expanding medicare?

Dr. Marchildon remarked that what governments say and what they are willing to do are different. It takes great patience to get plans implemented in an effective way. Even though there is commitment, it is a long enough timeline that if both parties are not held to their promise, it is very possible that not much will have been accomplished by the next election. These reforms require huge public pressure, and there may be other things that take priority. However, this agreement opens a policy window, which could be good news.

Dr. Naylor commented on the difficulties in implementing pharmacare. Provinces may have different priorities, which they want to be funded first. Pharmacare will also need to displace private insurers. Dr. Naylor also commented on other priority areas, such as dental care, home care, and long-term care. This could again end up with silos, when integrating the system is most efficient.

The Reality of Where We Are Now

Our health care systems are described as forming an important piece of our national identity. The principles of medicare, including equity, are held as critical. The system has functioned well in some ways, but falls short in others. Understanding both the successes and failures is an important part of contemplating how we approach the next fifty years.

The promise of medicare and the reality of our experience
Speaker: Danielle Martin, University of Toronto

Dr. Martin began by describing Canadian health care in terms of services, funding, administration, and delivery, and the multiple layers within each category. She emphasized the need to extend thinking beyond funding/financing to focus on delivery of care.

Next, Dr. Martin discussed the importance of primary care as the foundation of all health systems. It is the first point of contact with the health system and provides longitudinal contact. She made a case for focusing on primary care as the future of medicare by pointing out that most people have little contact with hospitals compared with a primary care provider. She stressed that primary care is necessary for a comprehensive, holistic, longitudinal approach to care, and that strong primary care delivers better outcomes more equitably, at lower costs. Dr. Martin presented evidence of relationships between number of general practitioners per capita and quality of care, and the number of general practitioners and lower costs.

Dr. Martin next discussed a paper entitled *The Paradox of Primary Care*[4] about the observation that compared with primary care for any given disease, specialty care delivers higher quality of care, but at the population-level, primary care is associated with better outcomes. She posited that the key lies in integration; the holistic approach to health, where the provider takes care of the whole person rather than a specific problem or disease, explains this observation.

Dr. Martin then summarized the current picture of primary care in Canada. About 85% of Canadians report they have regular, timely access to a family physician. She noted, however, that coverage is not equitably distributed; for example, rural communities face gaps in primary care access. Importantly, individuals without access to primary care then need to access other services like emergency departments and walk-in clinics.

She then described work by Monica Aggarwal and colleagues[5] comparing Canadian provinces and territories that declared primary care as a priority and whether they have the right governance and financing mechanisms in place to support that priority. They found differences across the country, and that there was often disconnect between what is declared a priority and what infrastructure is there to support it. Dr. Martin remarked that medicare has a long way to go to achieve a health system where everyone has access to high-quality, relationship-based, comprehensive, continuous primary care that acts as a front door to the health care system.

Dr. Martin then shifted her discussion to lessons learned from the pandemic. She noted that the cracks in the system that already existed prior to the pandemic have become chasms; particularly how social determinants drive outcomes, how the pandemic response over-relied on hospital services and resulted in a decrease in other specialty services and backlogs, and how job loss was tied to losing access to prescription drugs and mental health services. On the other hand, the pandemic also presented a window of opportunity; for example, there were steps forward in terms of financing, with Covid-related health care, testing, and vaccines covered for everyone, regardless of immigration status. We also saw advances in terms of virtual care, while raising questions about the appropriate uses of virtual care and how it should co-exist with other forms of care. There was also greater recognition of mental health as health, and roll-out to (online) access to mental health services. The pandemic also led to wider acknowledgement across society on the important impacts of the social determinants of health. Finally, the pandemic highlighted the value of community-led public health initiatives, and the need for integration of social services at the point of health service delivery.

Dr. Martin closed by highlighting some of the next promises of medicare, including rising social movements around truth and reconciliation, racial justice, and ways to adapt services to serve across the gender spectrum. Conversations have been sparked around wellness and well-being related to the 'Great Resignation' and 'Great Reorganization' of the health workforce and other sectors of the economy. She argues that all these issues can only be addressed if we first tackle the issue at the beginning, where most of the health care happens: in primary care.

Perspectives on long-term care: The age-old dilemma about old age

Speaker: Amy Hsu, Bruyère Research Institute and University of Ottawa

Dr. Hsu began by discussing the lack of interest in long-term care (LTC) from policy makers and funders prior to the COVID-19 pandemic. As a consequence of the experience during the pandemic, there is now widespread attention to and interest in LTC. Given the media coverage of conditions in LTC during the pandemic, it is not surprising that 44% of Canadians now dread

the thought of having to move into a LTC home or having to place a loved one there. Not only has poor quality of care been highlighted, but we see inadequate staffing and very inconsistent care across the health system between provinces, between health regions, and between urban and rural settings. This is resulting in great inequity in health care outcomes.

Dr. Hsu described the growing need for LTC in our population and the increased level of support needed by LTC residents. Most older adults will need care in some form, whether at home or in a LTC facility. As our population ages, the number of people requiring LTC will increase. This is particularly true for people living with dementia, as they have ten times the likelihood of entering LTC in the last year of life compared to those without dementia. Approximately 60% of individuals entering LTC have a diagnosis of dementia. More generally, the proportion of individuals entering LTC with chronic conditions is increasing. The average newly admitted resident has five chronic conditions at the time of admission, and the proportion of those with seven or more is increasing. As a result, there has been an increase in the level of support needed by residents. Most incoming LTC residents are coming in with high needs to support their activities of daily living, functional health, and cognition. This is important for informing adequate provision of human resources and structuring of our health care system to support the care needs of this population.

Dr. Hsu commented on the systemic and embedded ageism in our health system. Despite already knowing the LTC population includes many highly medically complex individuals who are frail and more susceptible to severe outcomes from infection, we did not properly protect this population at the beginning of the pandemic. This resulted in excess mortality in LTC. Another example of systemic ageism is pneumonia in older adults. Despite respiratory diseases being a regular annual occurrence in this population and pneumonia being one of the leading causes of hospitalization for older adults and a huge cost to the health care system, the system and our society do not pay it much attention.

Dr. Hsu reflected on the future of medicare. She emphasized the need not only to increase funding in LTC but also to think critically about where we invest those funds and how we will restructure the health care system with those funds. Funds should be used to address inequities in outcomes across the sector, and at the provincial and national levels. Some of these inequities stem from institutional characteristics, such as the ownership model; there are important questions about the role for private owners in our publicly funded system. Other characteristics of importance, with clear associations with clinical outcomes, include social determinants of health such as ethnicity, language, and race. For example, Chinese-speaking residents reported lower pain at end-of-life if they lived in a LTC home that offered care in Chinese. This resulted in lower use of opioid medications. We need to pay attention to these dimensions when planning resourcing and care provision.

Dr. Hsu highlighted that we are fortunate to be working in a data-rich environment. She spoke about Project Big Life, which is leveraging population level data to build a risk calculator that can inform risk identification and individually-tailored care planning. Through this work, researchers found that that the top 12% of modifiable risk factors for dementia can be attributed as the main predictor of 40% of incident dementias globally. Thus, theoretically, by focusing on these risk factors, dementia can be prevented or delayed. Using this data and risk calculator, we could potentially reduce incidence of dementia and inform how care is provided.

Dr. Hsu advocated for stronger home and community care, outside of residential LTC, to enable individuals to age safely and independently in the community. She suggested home care and LTC should be brought under the *Canada Health Act*. About 30% of health care spending is concentrated in the last year of life and mostly in the acute care/hospital environment. This can change. We have an opportunity to consider how we can realign funding and care provision with patient preferences to deliver higher quality care and improve outcomes. For example, recent research conducted by Hsu and colleagues found that 70% of individuals who receive end-of-life home care were able to spend their final days of life and die at home. In comparison, the majority (74.8%) of those who do not receive home care die in a hospital setting and the cost to the health care system is greater. By providing more personalized, targeted care through home and community care services, we can reduce the need for hospital services, better align with patient preferences, and reduce overall spending.

In closing, Dr. Hsu reiterated the following key messages:

1. Our society devalues the elderly and places little value on those who work with and care for them. Investment must be made in health human resources and growing the workforce to support our aging population.

2. There is currently a policy window open, as a result of COVID-19, for reforming LTC and home care services and bringing them under the *Canada Health Act.*

3. We need to consider where to make the investments; there is a lot of research that can inform smart investment into home and community based services to reduce burden on the LTC system, better organize services for older adults, and improve outcomes.

4. There is need for more research to explore inequities in experiences, the drivers of inequities in LTC, and how best to care for our diverse population of older Canadians.

Audience Q&A highlights

What do you make of the quasi-private moves into primary care with annual pay clinics and pay for play remote consultations, and how important do you think these trends are?

Dr. Martin expressed deep concern about these business models. She believes some may be illegal, though that has not been tested in court. In her opinion, they undermine the purpose of a public health care system. However, these models are not new, and executive health clinics have been available for many years in urban centres for those who can pay the fees. Often, individuals seek excess care at these clinics, resulting in overdiagnosis, harms to the individual, and referral back into the public system for incidental findings. The latter affects everyone else awaiting care through the public system. Dr. Martin expressed we should be concerned about these models, and we should aim to build a system that incentivizes staying in the public system. The system should allow providers to provide high quality public care while maintaining high quality of life. She noted the need to monitor carefully the health care workforce burnout and wellness issue that is occurring. In her opinion, pay for play remote consultations are the virtual version of the same issue. It is the same set of problems that will respond to the same incentives and policy solutions.

Do you see a policy window opening for LTC in this next policy cycle?

Dr. Hsu responded 'yes'. The federal government has committed funds to develop national standards for LTC and to support their implementation, so there is opportunity for changing policy in this area federally. However, it cannot be just one time funding and legislation on standards. Rather, we need to be thinking about sustained funding and support to plan for the future. It is Dr. Hsu's recommendation that LTC should be brought under the *Canada Health Act*. Provincially, policy action is also taking place. In Ontario, for example, legislation has been introduced to define minimal staffing levels in LTC.

Health care is not population health. Do we need more than primary care to ensure population health, such as addressing social determinants of health?

Dr. Martin clarified the difference between primary care (e.g. care provided in family medicine clinics) and primary health care. Primary health care is the integration of primary care and intervention services addressing the social determinants of health (e.g., the Local Community Service Centres model in Quebec and the community health centre models across the country). Such models integrate across all services that affect people's health. Many Indigenous models of primary health care are much more inclusive of the social determinants of health. The goal is not to have every service under the same roof and for every doctor to be a social worker and vice versa, but to integrate community-based services in ways that serve at the local level. Medical and social services should be seen as being on a continuum, and we should think about populations, not just individuals. This is a challenge for medical educators, as they train doctors to understand population health principles and engage with public health experts. There are practical ways to integrate social determinants and medical interventions at the individual level, at the practice level, and at the social level. That practice is primary health care.

Canadians outside of major cities have poor access to primary care physicians and LTC. How is this permissible when they pay full tax rates and how can we fix this?

Dr. Hsu suggested we think about the other primary care providers, such as nurse practitioners, that often serve rural and remote areas and expand primary care capacity. In LTC, we know there is a shortage of medical oversight; a lot of LTC homes do not have a medical director or one that is

regularly involved. We need to think about how best to support and provide care for residents. This may be through shared care models or greater involvement of nurse practitioners.

Dr. Martin agreed with Dr. Hsu's response, adding it is not acceptable that people pay taxes and do not have good access to services. If we leave it up to the "market", we will not end up with a system that equitably serves every person. We need to be more purposeful. We need to ensure policy is rooted in evidence and people are paid appropriately through payment models that support the desired outcomes. We need to be innovative and creative (e.g., use virtual care in remote LTC homes to enable support from medical directors for on-site providers).

How do you think primary care and LTC could be better integrated to facilitate better and more appropriate care during transitions and across sectors?

Dr. Hsu observed that during the pandemic we really began involving providers from different sectors in LTC. This includes physicians who primarily provide services in the hospital, primary care providers who are supporting vaccine clinics, nurse practitioners, and nurses who work in the community. Over the course of the pandemic, we have seen providers coming together. Dr. Hsu hopes we continue to move forward in this direction with providers across sectors working side by side to ensure continuity and ensuring information travels with the patient when they move between sectors. In Ontario, there are some promising indications of the Ontario Health Teams working in collaboration with community providers to ensure there is better continuity of care.

Dr. Martin added that the when we think of care of the elderly, in its broadest sense, and really think outside of the institution, the majority of care that older adults receive is in the primary care environment. For this reason, we need to ensure we are training primary care providers—family physicians, nurse practitioners, primary care pharmacists, primary care social workers—to be able to support older Canadians to the fullness of their needs and potentially reduce unneeded transfers into residential LTC.

Summary of Day 1

Speaker: Ruth Lavergne, Dalhousie University

In summarizing the themes from the first day, Dr. Lavergne noted the foundational principle of a single-payer and single-tier system, and the promise that this leads to a sense of solidarity. She also noted the promise of expansion of services beyond hospital and physician coverage to prescription drugs, home care, and LTC.

She observed that there was much discussion about our disjointed health system, where siloed sectors lead to inefficiency and do not meet community needs. Origin stories matter and the sequence of events have durable impact. Evidence of this can be seen in the health insurance

system, the independence of powerful professional groups (e.g. doctors), and the largely fee-for-service payment system. Dr. Lavergne also noted the problem of thinking of medicare as a right of citizenship and national identity, which reinforces its exclusionary policies (e.g., the overlooking of Indigenous sovereignty in the federal-provincial disputes over coverage of Indigenous people; the migrant worker programs in the 1970s which blocked pathways to citizenship and security of status).

Dr. Lavergne added that all these issues matter to equity. In a disjointed system with weak primary care, people need time, knowledge, and personal connections to navigate the health system, which only exacerbates inequity. In turn, these barriers to accessing primary care cause ripple effects throughout the system. In effect, there is a two-tier system of primary care, where some people have access to longitudinal care, and others need to access care through walk-in clinics and emergency departments.

There is deeply embedded ageism and ableism in the system, resulting in a broken LTC system that is now caring for people with increasingly complex needs. There are gaps in providing care that meets linguistic and cultural needs of diverse populations, as well as failures in supporting transitions between settings and preferences for end-of-life care for patients and families.

Dr. Lavergne emphasized that up to now, medicare has failed to address inequities; in fact, in some cases it has widened and entrenched them. She reflected on the fact that medicare began as a compromise, and with what was intended as a minimum. At this crossroads, she suggests that we re-consider what compromises we should be making now (e.g. investment in health care versus other investments that support health), and that the minimum now should be equity in access, experience, and outcomes. We could have a system that delivers health care to everyone who lives here, rather than being tied to residency and immigration status. Dr. Lavergne closed by asking us to imagine medicare as being centered on equity and actively working to deconstruct colonial oppression, racism, ageism, and ableism.

DAY 2 | SESSION 1

Green Shoots in the Current System

There are some promising developments in health care systems in Canada. These are bringing in new perspectives and partnerships, and challenging existing structures. There are likely lessons we can learn and apply in other places.

Supporting an innovation platform for Indigenous primary health care in Alberta

Speakers: Stephanie Montesanti, University of Alberta and Pamela Roach, University of Calgary

Drs. Montesanti and Roach described the Indigenous Primary Health Care and Policy Research (IPHCPR) Network, which was designed by stakeholders to address limitations associated with Indigenous primary health care services in Alberta, and encourage a renewed and transformed primary health care system that can promote Indigenous health equity, as aligned with principles advocated by the Truth and Reconciliation Commission of Canada. To achieve this vision, the IPHCPR Network aims to advance research that can link knowledge to policy and practice, and encourage evidence-based structural and policy innovations rooted in Indigenous Ways of Knowing. A key aspect of the Network's strategy to catalyze innovation is the close collaboration with frontline primary health care providers to understand their perspectives and offer evidence-based guidance to help them advance innovative practices within their own work.

The key organizing questions that guide the work of the IPHCPR Network focus on exploring the nature of transdisciplinary knowledge that can transform primary health care. This includes: identifying strategies to better equip primary health care to address the upstream social causes of poor health; understanding what is needed for primary health care to play a key role in healing from multi-generational adverse life experiences; finding the most effective approaches for exchange and sharing primary health care policy knowledge innovations; and discovering the best ways to measure the impact of emerging primary health care and policy knowledge innovations.

Objectives of the IPHCPR Network

- To foster Indigenous primary care policy research collaborations

- To establish a knowledge platform of theory, process and methods for Indigenous primary health care and policy research

- To advance Indigenous primary health care and policy research capacity through training and mentorship opportunities

- To support meaningful Indigenous community-based research

- To advocate for Indigenous health care system transformation through strategic knowledge sharing.

The IPHCPR Network produced an implementation framework for advancing and guiding Indigenous primary health care innovation and primary health care models in the province of Alberta. The framework provides a strong foundation for understanding the key implementation considerations for developing and implementing primary health care programs, services or interventions within Indigenous communities or Indigenous health service organizations. The framework's two key themes include that implementation should be guided by an Indigenous-centered care approach, and that partnership and trust is essential in ensuring implementation effectiveness and health equity. Other key implementation considerations include continuous quality improvement, interdisciplinary collaboration, ensuring organization and practice readiness, relational co-design to include Indigenous voices in the design and delivery of programs, flexibility of funding models or health infrastructure to promote Indigenous practices and safety in clinical settings, and decolonizing health systems by shifting existing mindsets, knowledge and awareness of Indigenous health care.

Innovative initiatives

The innovative work that the Network is conducting in Alberta includes a patient medical home (PMH) model, which aims to ensure that there is appropriate health care infrastructure, as well as equitable allocation and administration of funding and resources. The key pillars of the PMH include ensuring that health care is accessible and family-centered, providing continuity of care, advancing comprehensive team-based care approaches, promoting community adaptiveness and social accountability, and ensuring ongoing quality improvement and development with respect to generating knowledge.

Informed by discussions among key actors within Alberta, the Network identified the following key elements for an Indigenous PMH model: building relationships; culturally appropriate care; customized access to care; incorporating traditional Indigenous knowledge and Ways of Knowing to ensure the model is rooted in Indigenous values; and developing community-based funding models or alternative payment models that are in line with improving quality.

Another innovative initiative developed by the IPHCPR Network focuses on enhancing Indigenous virtual primary care. Developed in collaboration with Indigenous advisors, this project's objectives addressed two main questions:

1. How do Indigenous patients accessing virtual and/or remote based primary care during COVID-19 define high-quality virtual primary health care experience?

2. How can high-quality virtual and/or remote based primary care with Indigenous patients be monitored and measured to facilitate ongoing continuous improvement in primary health care practice?

Data for this project was collected through qualitative interviews with patients attending the Alberta Indigenous virtual care clinic and the Elbow River Healing Lodge in Calgary. The main themes that emerged from these interviews included access to safe and non-discriminatory health care, relationship and trust, time and travel, improved follow-up, and health self-maintenance. The themes were then used to inform a patient experience tool that can be used to increase understanding of factors contributing to quality Indigenous virtual care. The tool was co-developed with participants and an Indigenous advisory group and included strength-based questions grounded in the voice of Indigenous patients, and was triangulated with the experience of health care providers within the primary health care system. As such, the tool aims to inform the quality improvement and the development of Indigenous-specific services that can increase safety and the ability to give feedback. The next step of this project involves implementing the tool in a pilot program aiming to support ongoing program evaluation between 2022 and 2023.

Putting People First: Yukon's Health and Social Services Transformation
Speaker: Stephen Samis, former Deputy Minister, Yukon Health and Social Services (2017-2022)

Mr. Samis outlined the First Nations-led health care transformation efforts that are underway in the Yukon. He described the Yukon government's expanding efforts to work collaboratively with First Nations communities to create a different governance model within the territory. Considering Yukon's high rates of population growth and rapidly increasing health and social care budgetary spending, the Yukon government appointed an Independent Expert Panel in 2018 to undertake a comprehensive review of health and social care services in the territory. The five-person panel aimed to address the Quadruple Aim—improve health outcomes, improve the experience of care for people providing as well as people receiving health care, and better manage Yukon's growing financial costs for health and social care.

The first part of the review was guided by stakeholder engagement that involved 40 meetings attended by over 200 individuals and organizations, including people with lived experience, non-governmental organizations, and health care providers. The second phase of the review involved an online public survey and 34 in-person meetings that engaged members of every Yukon community. Key concerns highlighted in these meetings were related to cultural safety, racism, appropriateness of care, the siloed nature of care delivery with a lack of continuity of care, the need for reconciliation within a colonial system of care, lack of patient-centered care, and low investment in prevention.

The report published by Yukon's Independent Expert Panel in 2020, Putting People First. The final report of the comprehensive review of Yukon's health and social programs and services, outlines 76 recommendations that are rooted in the Quadruple Aim.

Recommendation highlights

- Focus on primary care reform

- Care closest to community

- Culturally safe services, delivered with humility

- Engage people with lived experience

- Connected services—people at the centre

- Create a health authority—Wellness Yukon

Mr. Samis also remarked that the Yukon government fully endorsed "Putting People First", and that 12 of the report's 76 recommendations have been fully implemented, 31 are in progress, and 33 are being planned in a phased implementation approach.

Implementation highlights

Implementation achievements include achieving universal childcare, enhancing access to medical travel assistance, hiring additional nurse practitioners and mental wellness workers, implementing a mental wellness strategy using a hub and spoke model to increase mental wellness support throughout the territory, expanding eligibility for vaccines, creating unlimited free access to pre-exposure prophylaxis to prevent HIV, expanding palliative care and end-of-life support services, offering better support to Indigenous residents by hiring an Indigenous engagement lead in long term care facilities to enhance cultural safety, and creating an evidence and evaluation unit and an innovation quality and performance division within the Government of Yukon.

Mr. Samis indicated that potential green shoots catalyzed by this report include the opportunity to work together with Yukon First Nations to address anti-Indigenous racism and promote cultural safety and humility in the health system by leveraging legislative efforts to advance quality of health and social care. This resulted in the co-creation of a new *Child and Family Services Act* that can meaningfully address important determinants of health for Indigenous people and for First Nations people and communities in Yukon. The *Act to Amend the Child and Family Services Act* (2022) was developed by the Ministry of Health and Social Services in partnership with the Yukon First Nations and Yukon government. He also discussed future challenges within the Yukon context, which are primarily related to advancing primary care reform.

Future opportunities

Building on the report's recommendations and vision, Mr. Samis mentioned the opportunity to create a scalable design for new integrated community health centres that will involve health and social care providers under one roof. Such a centre is currently being developed in the First Nations community of Old Crow. Future efforts will also include opening a supervised consumption site to address concerns related to substance use and launching a new dental program for the uninsured.

Mr. Samis concluded by emphasizing the valuable opportunity available in the Yukon to de-colonize the health care system and co-create a health and social system that is more inclusive and equitable.

Audience Q&A highlights

How do current structures of primary care service delivery affect the speed/quality of efforts to address racism and develop better care for Indigenous people?

Dr. Montesanti remarked that the current structures reflect the way health care services are organized and provided, which can affect patients' experience of care and how (or whether) they navigate the health system safely. She also noted that the knowledge of primary health care providers around social, historic and cultural realities of Indigenous patients is critical in transforming and shaping the way care is delivered, which ultimately can lead to important and significant outcomes around quality of care, and how that care is experienced by Indigenous patients.

Do you think the features of a medical home model desired by Indigenous patients differs from features desired by non-Indigenous patients?

Dr. Roach highlighted that the current health care system includes individuals that this system was not designed for, which is relevant when discussing concepts of equity, diversity and inclusion as applied to health care structures such as the patient medical home model. Therefore, it is important to develop patient medical home models by integrating concepts grounded in Indigenous Ways of Knowing and Being.

Dr. Montesanti noted that the patient medical home model was never intended to be a "one size fits all" solution, and that it can be implemented with variability across the province. Nonetheless, this model is built upon understanding supporting structures to enable primary health care practice and delivery, and the model's core pillars can be adapted for Indigenous primary health care. To explore how primary health care services are organized and delivered, it is important to consider health care team dynamics, how integrated teams are across health and social care structures, and how Indigenous models of care and wellbeing can be incorporated within current practices.

From a policy perspective, how do we recognize the value of Indigenous healing practices and integrate some strength-based values and ways in which we can integrate Indigenous healers and Elders?

Mr. Samis remarked that, to ensure structures that integrate Indigenous perspectives, First Nations peoples need to work with the government as true partners in the care planning process, rather than simply as stakeholders or consultants. For example, the Health and Social Development Commission in the Yukon, which includes self-governing First Nations Health and Social directors and non-self-governing First Nations people, have invited the Yukon government to discuss and learn about First Nations peoples' needs and strategies for change. He also noted that such initiatives need to go further into a co-governance model that involves the co-development and co-design of health authorities by Indigenous peoples in collaboration with the colonial government.

Rooting our Values in Post-Pandemic Health Systems

All health systems are now facing choices, both about how to address long-standing issues and how to recover from the broad effects of the pandemic. The desire for different outcomes will require different choices, and challenging the status quo.

Responsible innovation in health and lessons for sustainable health systems

Speaker: Pascale Lehoux, Université de Montréal

Dr. Lehoux described how to encourage responsible innovation. Using her definition, innovation may or may not involve a technology component. It refers to newness of products, processes, and services. That newness is linked to a context of use and the historical context. It always comes with some form of entrepreneurial activity, which may or may not be for profit. Innovation is a nonlinear process, so we need to think about the pathways from ideation to production, commercialization, dissemination, adaptation, use, and withdrawal.

Dr. Lehoux delivered two key messages:

1. If we want medicare to fulfill its key aims in the near future, we need to enable three industries that are not currently aligned with health system needs and challenges: the prescription drug, pharmaceutical device, and digital industries.

2. Post-pandemic health systems should rely on a 21st century innovation system that rewards more responsible innovation and entrepreneurial practices.

Recovering from the pandemic—lessons learned about innovation and health systems

Quebec experienced a very deadly and inequitable first wave of the pandemic. Key challenges in the Quebec health system during the pandemic were surveillance, the workforce, infrastructure and medical supplies, governance, communication mechanisms, and trust. Each of these were addressed through different innovations. Information systems were created almost from scratch to support surveillance. Workforce training, safety, and protection were implemented. Shortages of ventilators and other supplies required patients and providers to grapple with ethical dilemmas. The federal and provincial governments were pushed to produce evidence, accelerate approvals, and distribute tests, vaccines and drugs quickly. Social media acted as a digital amplifier and successfully created polarization within communities and groups. Canada was quite successful in deploying telehealth rapidly and garnering public trust in those systems; however, there was less trust in COVID-19 tracking apps, which combined personal data and a form of surveillance.

The ability to provide systemic and global responses relied on dynamics established prior to the pandemic. Canada had a high dependence on the medical devices and pharmaceutical industries. These industries have quasi-monopolistic, globalized supply chains, and "rules of the game" that affect who has access to innovation. The digital industry was thriving with little, or at least less, regulation. We were caught in power relations in vaccine production and distribution, which impeded their scaling in developing countries. Dr. Lehoux noted that Canada played a weak role in deciding where vaccines would be produced and distributed around the globe.

Dr. Lehoux summarized key takeaways:

1. COVID-19 showed us that health and social systems are resilient when they are already strong.

2. We were capable of innovating, but we were not always capable of bringing forward the right innovations at the right place and the right time.

3. Beyond the rate of innovation, its direction also influences health outcomes.

Challenging the status quo in innovation systems—why and how?

When we take stock of the kind of innovations we value and reward, we see that we produce high tech devices that are targeted at medical specialists in large urban centres, which increase challenges related to access to services. These tech devices affect the nature and scope of work/skills required by other workers around medical specialists in these urban centres. This challenges our capacity to train and retain human resources. Finally, we need to recognize how the ways in which we designate and reimburse these technologies affect costs and can make health systems unsustainable.

Innovations are prioritized by the government's budget and innovation branch, the private sector, capital holders, and enterprises. Universities and academic teaching centres sit at the intersection of these parties. They create innovations, which we are often unable to absorb into the health system. The existing systems of innovation were created in the 1980s and mimic the American system with key pillars for innovation including intellectual property and financialization. Dr. Lehoux stated that these systems are too old for the challenges we are now facing because they rely on sector-focused economic development policies and discovery-oriented research, which make us very path dependent. We tend to fund and continue to do what we have already been doing, when what we really need is an innovation system that addresses 21st century challenges and brings us closer to solutions for those challenges. Examples of such challenges are climate change, aging, resurgences of infectious disease, inclusive growth, and resilient communities. The public sector must shape and direct markets for problem-solving innovations.

Valuing different outcomes—responsible innovation in health

Dr. Lehoux stated that value is not to be found in the innovation itself—it lies with how users perceive its ability to expand their skills and range of activities, such as their ability to make a diagnosis or fix a broken arm. The innovations we create reflect our values, beliefs, and prejudices. Once these values and prejudices are embedded in innovations, these innovations tend to prioritize what we value and do next, while continuing to ignore what we do not value sufficiently or what we do poorly.

Responsible Innovation in Health (RIH) focuses on expanding the skills and actions that will make health systems more equitable, economically sustainable, and environmentally sustainable. Responsible Research and Innovation (RRI), which gained traction in European research policy, draws attention to innovations' likely impacts, but also to their purposes. Responsible innovation means taking care of the future through a collective stewardship of science and innovation in the present. It should anticipate risks, be reflective about social norms and biases, be inclusive of those who are too easily left aside, and be responsive when the innovation is not exactly what we need. RRI should consider process-, product-, and organization-level dimensions, be based in health

system needs and challenges, incorporate innovators' and entrepreneurs' views and practices, and be evidence-informed.

Dr. Lehoux defined RIH as a collaborative endeavor wherein stakeholders commit to clarify and meet a set of ethical, economic, social and environmental principles, values and requirements when they design, finance, produce, distribute, use and discard sociotechnical solutions to address the needs and challenges of health systems in a sustainable way. The application of this framework to health systems relies on five value domains: population health value (health relevance, mitigation of ethical, legal and social issues, and effect on inequities); health system value (inclusiveness, responsiveness to current challenges, level and intensity of care, where and who in the health system); economic value (frugality, affordability, usability); organizational value (value of the business model for the innovation and society); and environmental value (eco-responsibility and effect on the carbon footprint of health systems).

Dr. Lehoux and her team developed a RIH assessment tool, which is a score card that measures the degree of responsibility of an innovation with high reliability. Dr. Lehoux hopes this tool will make measurable characteristics of innovations more tangible, help innovators know for which characteristics to aim, and help create measurable and responsible innovations that address systemic needs.

Summary

COVID-19 created unique conditions for innovations in health and social care. The drug, pharmaceutical device, and digital industries are not aligned with current health system needs and challenges. We were able to deploy innovations during the pandemic, but we were not always able to do so in a systemic and global way. To root our values in post-pandemic health systems, we need to have an innovation system that is built for 21st century challenges, and one in which health policy makers and managers shape a clear system-level demand for innovation. We need policies and regulations that reward RIH qualities, such as environmentally responsible innovation.

Taking equity seriously in health system planning
Speaker: Kwame McKenzie, Wellesley Institute

Dr. McKenzie began by highlighting a phrase that was commonly used throughout the COVID-19 pandemic, which states that: "The pandemic exacerbated existing health inequities". He explained that we have taken for granted that this is a truth. In that truth we can understand: (1) health inequalities are avoidable differences in health—thus the existing inequalities were avoidable; and (2) we set up a pandemic response that widened those avoidable health differences that we had

already allowed to persist. This short, common phrase is actually a significant condemnation of our health system, of the health differences we have allowed to persist, and of medicare.

Our system of medicare, which consists of different systems for each of the provinces and territories and co-funding from the federal government, created a significantly inequitable system prior to the pandemic. Through the pandemic, we have seen differences in health effects for racialized populations, black populations, Indigenous populations, and low-income people. To have an equitable health system, medicare will need to transform to deal with inequities caused by the pandemic and inequities linked to its own inability to deliver equitable care.

Despite this, Dr. McKenzie described reasons for optimism. The health system was nimble and able to pivot, and new links were made across sectors to deal with the pandemic. We saw incredible innovation throughout the pandemic, including equity-based innovations including digital health care and the federal government creating social policy such as the Canada Emergency Response Benefit. These are reasons to be optimistic when thinking about the future of medicare.

Changes needed to take equity seriously

Dr. McKenzie highlighted three key changes we need to make to take equity seriously:

1. **We can't stay in the middle**

   We need to choose a side: the side of equity. Typically, governments and policymakers take the approach that, to solve contentious issues, we need to meet in the middle. However, this is not the right approach for many current issues—staying in the middle or staying agnostic is seen by communities on both sides as choosing the other side and/ or being against equity. Good examples of this are within the Black Lives Matter, Me Too, and Defund the Police movements. The same can be said about medicare funding, which is agnostic around equity. The medicare reform movement must proactively choose equity-informed strategies and take deliberate action to put in place organizations and infrastructure that address inequity. Without such action, we will continue to "stay in the middle" and signal to equity-seeking groups that medicare does not take equity seriously.

2. **Innovation should be community-based and data-driven**

   Dr. McKenzie shared an example of a successful equity-driven pandemic strategy. Five percent of Ontario's population is Black. This community has more exposure to social determinants of health, worse health outcomes, and more pre-existing health problems that could have been exacerbated by the pandemic. The Ontario-based Black Health Equity Working Group, which is organized by Black health sector leaders and health equity experts, pushed for a data-driven quantification of disparities in order to inform interventions and monitor their effectiveness. Disparities in the city of Toronto

were clear in the data, so the city asked the community directly what they should do, and began working with the communities to develop a strategy. This included pop-up testing, multilingual public health campaigns, free voluntary isolation sites, food security, eviction prevention and advocacy, emergency child care, culturally appropriate multilingual counselling, and free masks and sanitizers. Most of these things were not covered by medicare, but there is evidence that they worked. Racialized groups had significantly higher rates of COVID-19 than white people, but once the above interventions were implemented, there was a significant reduction in the relative rates of COVID-19. Though inequity persisted, its effects were lessened. This community-based, data-driven response worked.

3. **We need to hardwire equity into our health care system**

When thinking about the future of medicare, the question is not "how do we create a system that can produce more equity?" but rather "how do we hardwire equity in to ensure it endures?" One way is through legislative reform. As an example, Dr. McKenzie described the story of Stephen Lawrence, a young United Kingdom (UK) teenager who was beaten and killed in a racist attack in 1993. The attacker was known and there was a lot of evidence, but police were unable to secure a conviction due to a poor investigation. The subsequent inquiry found no single racist act in the investigation, but rather institutional racism that resulted in poor resource allocation and investigation. This recognition of institutional racism led to calls for a systemic response and changes in the UK's *Race Relations Act*. This Act covers all public services, including health, and changes called for institutions to promote racial equality, establish a plan for promoting and achieving racial equality, and monitor progress. By law, institutions, including hospitals, had to collect aggregated data on health equity. This data could be used by the public, and it could be used in court with no upper limit on institutional fines. The audit office found that this legislative change, the *Race Relations Amendment Act,* was the most important intervention there had ever been in the UK health system for health equity. It led to increased health equity and decreased inequities because public bodies started taking equity seriously.

Addressing health inequity in medicare

Dr. McKenzie stated that, in Canada, we are lucky to have many people looking into how to create health equity and decrease the differential risk of health problems for equity-seeking groups. Various models exist. One model is to take action on differential risk either through all policies or policies specific to social determinants of health. Another approach is to improve health systems by building staff capacity, building equitable interventions, and building equitable health systems. To build equitable health systems, we must consider which funding models can ensure they are equitable.

Dr. McKenzie suggested that more flexibility in medicare funding may be needed to promote equity. During the pandemic, we needed flexible funding models that covered much more than what medicare covered at the time. More flexibility in how the funding works will be needed to achieve community-based, social determinants-informed implementation of care.

Final observations

Dr. McKenzie concluded with questions for discussion: Should we be thinking about legislation that ensures that we do not have gross inequities in health access and outcomes? Should there be more strings attached to federal funding of health or targeting to ensure equity? Should the adoption of new health technologies and social policy be linked to promotion of health equity? Notably, most health technologies, many social policies, and many innovations actually increase inequities, unless they are specifically organized and focused on reducing inequities. These questions highlight three important elements that may be interesting when we are thinking about medicare reform going forward: an instrument for communities to look at health providers and their health systems, federal responsibility, and focusing innovation on stopping inequities, not creating them.

Medicare could be an agent to give us a fair and equitable health service, but we need to make significant change.

Audience Q&A highlights

How do you suggest that we hardwire equity into the innovation space, and how can governments ensure that the private sector delivers value and equity?

Dr. Lehoux replied that there are many ways of making sure that equity can be hardwired into innovation, including by designing solutions that can reduce risk factors associated with health inequalities, or by using design strategies to reach those who are least likely to access innovation easily. For example, innovative strategies can be applied in different geographical contexts in both high and low-resource settings by broadening the variety of target users and making sure the innovation is affordable, easy to use, and requires low infrastructure. She also noted that it is novel to bring equity to innovation, and innovators will respond, because they want to solve problems, create new technologies, and have a market for these tools.

What would you propose as key performance indicators for equity for medicare for Canadian health care? What can we set as a priority and how do we measure progress?

Dr. McKenzie remarked that there is no "one size fits all" system, and that we need to have a measurable plan to demonstrate progress. This includes clearly understanding the population of interest, the significant health disparities in the context of interest, and the plan to reduce these disparities. He also mentioned the concept of the health equity audit cycle, which is a model used around the world implying that, to decrease health inequities, it is essential to measure them, collaborate with stakeholders and community, identify the most important goals to achieve over a specific time period, and the type of high impact interventions that can be targeted. This can inform

the development of key performance indicators (KPIs), which are used to monitor progress. Once the KPIs are achieved, another target can be established, and so on.

How should research engage with policy, when it must take a stance on values?

Dr. McKenzie highlighted that research is always taking a position on values, and that research and policy are related in different ways. He remarked that many researchers believe that their work is based on objective numbers and that values do not play an essential role in their work, and therefore it is important to have a conversation about values in research. He highlighted that the architecture in which Canadian researchers work needs to promote, understand, offer training, and function in ways that promote equity, and that we need a system approach that allows researchers to do what they are good at within the system, while ensuring that what they are doing reflects Canadian values.

Dr. Lehoux responded that it is important to discuss values and how values are mobilized to structure research. She added that the integration of values is challenging because it involves changing the status quo and altering the current priorities.

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Summary of Day 2

Speaker: Ruth Lavergne, Dalhousie University

Dr. Lavergne offered a series of reflections on the Day 2 sessions, and on the conference as a whole:

- We heard that medicare was compromised from the start and always intended as a minimum and a starting point. We can consider what we might set as our minimum starting point now and consider ourselves at a crossroads.

- Medicare has not only failed to address inequities, it has also widened and entrenched them. We were further reminded that health care systems can be (negative) determinants of health, especially when they are culturally unsafe. Medicare as a national identify can continue to erode Indigenous identities.

- We considered what health systems might look like if they were centered on equity and actively working to dismantle colonialism, oppression, racism, ageism and ableism. Through the discussions we perhaps have a path forward.

- Many of the solutions and changes we know would strengthen health systems are old. The existing reports and recommendations call for health system integration, workforce modernization, and technological change. Perhaps more importantly, many of the changes have been called for repeatedly by communities. We really need to focus on new ideas, scaling up things that work, and listening to what communities tell us they need.

- We have seen innovation in health care recently and witnessed shifts to virtual care. The availability of new technological platforms for secure phone and video conferencing have meant your primary care provider can now have a phone call with you. We need to pay attention to innovation systems and especially how we "shape the game" for innovation.

- A key point we heard is that innovation prioritizes what we value and do, and it ignores what we do not sufficiently value or do poorly. This is important because it both diagnoses the problem with innovations that have not actually improved health systems, and it points us in the direction towards doing innovation better. This idea hinges on who is included in "we". Who is included determines what is valued and done.

- We saw exciting examples of community-driven innovation and Indigenous led primary health care. Some of the key implementation considerations that underscore this work are partnership, trust, community voice, agency, reflexivity, interdisciplinary collaboration, recognizing relationships, and the relational nature of work. We need to decolonize health care and, by extension, health research and innovation systems that inform it.

- We heard about developing the capacity to measure strengths-based domains of Indigenous patient experiences, asking a fundamental question that we should be asking all the time: how do patients and communities define quality? How can we measure that? We also heard about new ideas for integration of service provision and establishing health and social systems and structures for partnership, dialogue, and learning.

- Clearly, data in the hands of communities could support equity focused initiatives as part of pandemic response. This is one potential role for research. We should consider how and who we identify as relevant stakeholders in health systems research. We can consider how we might evolve from patients to community oriented research, which may in term support better hypothesis-driven research.

- The discussions have generated moments of optimism. We saw examples of innovation, where services are made accountable to specific known communities and served with attention to how the communities articulate needs and define quality. This was done within a system that is not aligned to be accountable in this way, easily. There is nothing in the principles of medicare that prevents these sorts of innovations at local, regional and provincial or territorial levels. We are at a moment where health systems are top of mind, and when health system actors may be more aligned than in the past. Finally, there is increased recognition that health systems that are not producing the population outcomes we would hope are also unhealthy for clinicians and other workers within them.

- Along with this optimism, a note of caution: Innovation can just as easily widen gaps. Staying in the middle, on health system innovation, will continue to entrench inequities. In health systems, this means innovation cannot be focused on places and settings that are deemed ready, or a coalition of the willing. We need to offer support, according to need so that all settings and communities are ready to share in productive innovation. There are great impacts when communities are positioned to lead initiatives for innovation. Just as we strive to more carefully shape the rules of the game for medical device, pharmaceutical, and digital industries, we should create space, flexible funding, and support so that communities can be sources of innovation.

To conclude, Dr. Lavergne reflected back on the question about the minimum starting point for medicare. At a minimum, we need clear plans to achieve equity and monitor impacts. Reasonable access, equal terms and conditions, coverages and standards have proven to be inadequate. We can be serious about legislative mechanisms, federal leadership, and approaches to innovation bound to the promotion of health equity. As we navigate this crossroads as researchers, clinicians, system planners and community members, staying in the middle simply is not an option.

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