SLC HEALTH CARE POLICY
BACKGROUND PAPER

08/2017

Table of Contents

HEALTH CARE POLICY LEAD WORKING GROUP
BACKGROUND PAPER
08/2017

56.1% of respondents to the 2017 SLC and Kelowna-Lake Country Policy Questionnaire cited ***Health care*** as the top issue for the 2019 election and the 2018 Biennial Policy convention.

…*"the need to strengthen health care throughout Canada including: better access to family doctors and health care services; reduced wait times for specialists and medical procedures; and innovation to reduce costs and achieve more efficient delivery of services"*

EVIDENCE OF THE ISSUE:

Identifying improved access to family doctors and health care is inclusive of concerns of equity, timeliness, traditions, misconceptions of the Canada Health Act, and anxieties surrounding aging demographics. Quality care touches every Canadian and expectations of perfection are understandable given that the well-being of loved ones and ones' own well-being are involved; but delivery across several jurisdictions makes change fraught with complexities. There exists an urgent need for strategic action. Ignoring the profound changes we face is to invite peril by policy makers. Although the federal government is currently engaged in bilateral health financing agreements, there is a void of debate on a national plan for the future of the Canadian health care system.

Health care is a defining part of the Canadian story. It is central to our culture and something we boast about. However, the 2016 International Commonwealth Fund report on 11 high-income countries, ranked Canada behind Australia, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom; and, on some indicators, behind the bottom-performing US with our worst ever wait times in 2016. [1] Studies suggest Canada's publicly-funded system is one of the most expensive in the world and its performance is significantly below average.

The Canada Health Act 1984 [2] defines the federal role in terms of financial objectives and leaves delivery to the provinces; consequently, we have not one system but a 'system of systems'. Canadian geography dictates a three-tiered system as health care differs in urban, rural and remote (mainly indigenous Canadians) areas. The Canadian Medical Association (CMA) states, [3] 'Geography can cause barriers to access. Rural Canadians have higher health care needs but less access to care. People in northern and rural communities travel great distances for health services as many, especially specialist services, cannot be obtained in their community.' Those living in rural communities are least likely to have a family doctor or to visit a specialist. According to data from the Society of Rural Physicians of Canada, 21% of the population is rural, while only 9.4% of family physicians and 3% of specialists are considered rural.(Canadian Medical Association Position Statement: Ensuring Equitable Access to Care p.2) [4]

The federal government has a mandate and leadership responsibility to address across-the-board deficiencies within the health care system and provide a framework for national quality.

EXISTING LEGISLATION

A 1947 model to solve 2017 issues:

Universal health care was introduced to Saskatchewan by Tommy Douglas in 1947, when the average age was 27 years. The current average is 47 and increasing rapidly. A young population typically presents with acute care needs: illnesses, accidents, etc where centralized hospital care is well-suited. An older population requires a chronic-care model where community-based primary care and prevention is the focus. [5,6] Failure to adjust for changing needs has resulted in upwards of 20% of expensive acute-care beds occupied by patients awaiting transfer to community facilities. [7]

Canada Health Act 1984

The 1984 Canada Health Act (CHA), is, "An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services".[8] It lays out requirements for guaranteeing the universality of health care insurance and limits the federal government to funding transfers, while direct delivery is the prerogative of the provinces and territories. "In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."(Canada Health Act 1984 Universality).

Many Canadians believe the CHA guarantees access and equitable health care when, in fact, it guarantees universal access to insurance and reasonable access to services provided by the jurisdictions in which they live without discrimination on income, age or health status. Other functions include: funding and/or delivery of primary and supplementary services to on-reserve First Nations, Inuit, members of Canadian Forces, eligible veterans, federal inmates and some refugees. The Act focuses on criteria for insurance plans to be met by provinces and territories to receive federal cash transfers. The CHA provides the federal government with few levers to directly affect the health care Canadians receive.

In 2004 Paul Martin introduced a 10 year Health Accord to target federal cash transfers that focused on key indicators negotiated with provincial and territorial governments. This 2004 Accord, which had an impact on reducing wait times, expired in 2014. The Trudeau government is negotiating a new 10 year Health Accord to focus on home care, affordable prescription drugs and mental health. [9]

CHALLENGES

The respondents to the SLC questionnaire identified three key areas of immediate challenge and concern:

Better access to doctors and health care services

According to Statscan, "In 2014, 14.9% of Canadians aged 12 and older, roughly 4.5 million people, reported that they did not have a regular medical doctor". Given that the physician/population ratio has decreased since then that number has increase and we know it's higher is some parts of the country, e.g. 25% for Quebec. https://www.fraserinstitute.org/sites/default/files/canadas-physician-supply-csr-winter-2016.pdf

Primary care is the foundation of any health care system, making this a very serious concern. CMA reports, 'Canada has 2.6 physicians (including residents) per 1,000 population compared to the Organization for Economic Co-Operation and Development (OECD) average of 3.3 (2014). According to the OECD for Canada and France, figures correspond to professionally active doctors, including doctors working in the health sector as managers, educators, researchers, etc (adding another 5-10% doctors) so Canada's ratio is probably even lower than 2.6.

The current makeup of the physician population contains 55% family practitioners whilst new graduates are selecting family medicine at a 36% rate. New graduating classes are made up of more than 55% females and, although highly desirable, it means fewer graduating full-time equivalencies as many females opt for shorter work weeks to balance lifestyle (note that many male graduates are also limiting work schedules compared to their older colleagues). A new model for making comparisons to past equivalencies is required. A family physician requires a minimum 10 years post-secondary education and residency to become certified making national long range planning urgent. [10] Continuing this graduation trend in a rapidly aging population means the traditional physician/hospital/institutional care model will not meet demand. Opportunity exists, however, within an expressed desire by fully 83% of "boomers" to remain in their homes as long as possible as opposed to being cared for in an institutional model (2013 RBC survey). [11]

Reduced wait times for specialists and medical procedures

Wait times were the longest ever recorded in 2016 with considerable variation between provinces http://www.cihi.ca/en/oecd-interactive-tool-international-comparisons-access-to-care

The overall wait time was 9.4 weeks from GP to a specialist and an additional 10.6 weeks to treatment; total 20 weeks. The province of Ontario had the shortest wait times of 7.2 weeks from GP to specialist and an additional 8.4 weeks to treatment; total 15.8 weeks. The province of New Brunswick was the worst with 21.5 weeks wait time from GP to a specialist and an additional 17.4 weeks to treatment; total 38.8 weeks. In Saskatchewan, wait times were second-best on paper at 8.7 weeks from GP to specialist and an additional 7.9 weeks to treatment; total 16.6 weeks. These numbers may be skewed due to the electronic Wait Lists where patients referred to the shortest list may opt not to use that specialist and begin the wait process again.

Wait times for MRIs and CT scans have increased since 2012, although there are provincial variations. Newfoundland and Labrador, New Brunswick, Quebec and British Columbia did not report. In 2016, wait time for CT scan was longest in Alberta at 99 days, followed by Nova Scotia, PEI and Saskatchewan at 51 days. Ontario had the shortest. MRI wait times increased in all provinces except Alberta but that province still had the longest wait time at almost 250 days followed by Saskatchewan at around 220 days, Nova Scotia with a slightly shorter time and Manitoba had almost 200 days. Ontario had the shortest wait time at around 100 days. A comparison by province of extent to which wait time goals were met for key procedures. https://www.cihi.ca/sites/default/files/document/wait-times-report-

2017_en.pdf (p. 7). The long delays in accessing procedures may be side-stepped by overuse of Emergency rooms. [12]
Despite long wait times to see specialists an inordinate number of recent graduate physician specialists are unemployed! Data from the Royal College's 2011 and 2012 employment surveys reveal that employment issues extend across multiple medical specialties. Among those who responded to the surveys of new specialists and subspecialists, 208 (16%) reported being unable to secure employment, compared to 7.1% of all Canadians as of August 2013. Of these, 122 stated they were or would be pursuing further training and 86 reported that they were unemployed and without a training post. Also of note is the significant number of new specialists and subspecialists — 414 (31.2%) — who chose not to enter the job market but instead pursued further subspecialty or fellowship training because they believed such training would make them more employable.

Innovation to reduce costs and achieve more efficient delivery of services

We have no shortage of quality research projects, innovative ideas and Royal Commissions. What is required is the "political will to learn from others and put into place a system that works." (Britnell," In Search of the Perfect Health Care system") [13] A third party organization established following the 2002 Romanow Report, [14], the Health Council of Canada [15] lost federal funding in 2013, a move decried as having the potential to fragment the national system of medicare; a decision taken even though the Council was reputed to have promoted accountability, oversight, planning and national coordination of the health care system. While operational, its achievements were cited as, "reduced wait times, and encouragement of innovation in the public health system to ensure access across the spectrum and across generations". Canada has more than 13 systems for delivery, making cross-pollination of ideas challenging. In some ways, abundant systems can be frustrating to cohesive change; there is an inherent advantage in having multiple systems that are more regionally adaptive and responsive. What is required is an overall big picture management to maximize and integrate the efficiencies of these complex systems.

In 2015, the federal government mandated the Naylor Panel [16] to identify areas in which government could play a role in enhancing health care in Canada without adding new funds. The report concluded that…"stakeholders and government set a long term vision for healthcare innovation and that the federal government create a 10 year Innovation Fund to effect sustainable and systemic changes in the delivery of health services in Canada to support high-impact initiatives, break down structural barriers to change, and accelerate the scale-up of promising innovation."

CONCLUSIONS

Our literature research and discussions led to the following conclusions and options which, following input from the 66 member 'Working Group At Large', will be used to prepare specific Resolutions.

- Our acute care system serves us well, providing health care services by some of the best-trained medical personnel in the world; however, the model for delivery of health care in Canada has not adapted to shifting demographic demands and geographic disparity that call for more chronic care and prevention.

- Chronic care and prevention are most cost-effectively addressed in community and home.

- A huge quantity of studies, reports and commissions have analyzed these issues. There is no shortage of solutions on paper or in isolated pilot projects. What is now required is the political will and oversight to enact appropriate recommendations across the nation.

- There is extreme urgency to catch up with the shifting demographic realities driving health care to avert a looming crisis. Major shifts in mandate require vision and leadership. Leadership and vision must be created and coordinated from the top.

LIBERAL PLATFORM

A Canadian is a Canadian is a Canadian and equity is a Canadian value.

The Liberal Party has a mandate for leadership to make fundamental change to the health care system based on its platform for Real Change and a Health Accord that states: [21]

'When Canadians are in good physical and mental health, they are able to work better, be more productive, and contribute more fully to our economy while living healthier, happier lives."

"Despite our health care system's value and importance, it has been more than a decade since a Canadian Prime Minister sat down with provincial and territorial Premiers to strengthen the program, and ensure that it can meet current needs and the challenges that come with an aging population."

"We will also develop a pan-Canadian collaboration on health innovation…"

REFERENCES

1. *http://international.commonwealthfund.org/data/2016/*
2. *http://laws-lois.justice.gc.ca/eng/acts/c-6/*
3. *https://www.cma.ca/Assets/assets-library/document/en/advocacy/PD14-04-e.pdf*
4. *https://www.srpc.ca/resources_regional_stats.html*
5. *http://www.chatelaine.com/health/andre-picard-public-health-care-canada/*
6. *https://www.amazon.ca/Matters-Life-Death-Public-Health/dp/1771621540#reader_1771621540*
7. *http://bccare.ca/2017/03/opinion-transferring-health-funding-to-the-community-will-improve-seniors-care-in-british-columbia/*
8. *http://laws-lois.justice.gc.ca/eng/acts/C-6/FullText.html*
9. *https://www.liberal.ca/realchange/a-new-health-accord/*
10. *https://www.cma.ca/En/Pages/basic-physician-facts.aspx*
11. *http://www.cbc.ca/news/business/canadian-boomers-want-to-stay-in-their-homes-as-they-age-1.2224171*
12. *https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2015-report*

13. *https://www.amazon.ca/Search-Perfect-Health-System-ebook/dp/B0163G3IAS/ref=dp_kinw_strp_1*
14. *https://www.med.uottawa.ca/sim/data/Romanow_e.htm*
15. *https://www.theglobeandmail.com/news/politics/advocates-decry-ottawas-decision-to-stop-funding-health-council-of-canada/article11287924/*
16. *https://www.canada.ca/en/health-canada/services/publications/health-system-services/report-advisory-panel-healthcare-innovation.html*

MEMBERSHIP: HEALTH CARE - LEAD WORKING GROUP

Chair: Judy Berg – Kelowna, British Columbia - SLCBC Senior Rep Kelowna-Lake Country; retired Regional Director Public Affairs, Canadian federal government depts: Employment and Immigration, Human Resources Development Canada and Western Economic Development in Alberta/NWT and BC/Yukon
Regions.

Dr. David Geen – Kelowna British Columbia – retired -33 years family physician in home community of Rutland, British Columbia. Graduate of UBC Medical School; Family Residency U of C. Locums in New Zealand; served on Board of Family Practice in the 1990s and as President of Board in 2000-01. Mentor in Okanagan UBC family residency program.

Dr. John Casey – Kelowna, British Columbia – retired - born in Saskatchewan, moved to Alberta, Whitehorse, Yukon, Nelson, BC and settled in Kelowna, BC in 2004. Taught high school in Calgary, AB, responsible for developing a 2-year Yukon College, Whitehorse, Yukon; Vice President, Canadian International College, Nelson/North Vancouver, BC; Board Member, Mount St. Francis Hospital, Nelson, BC

Doug Hargitt – Kelowna, British Columbia – retired Operations Manager (Industrial)

Dr. Ann Grahame – Regina, Saskatchewan - retired Dermatologist, Clinical Assistant Professor, University of Saskatchewan, (1980 - 2011). Previously practiced for 16 years in the National Health Service in England and Scotland before immigrating to Canada in 1977.

Hilary Williamson – Outaouais, Quebec - Retired computer scientist, with a background in telecommunications R&D at Bell-Northern Research, Ottawa, managing the development of early email and network applications in the 70s and 80s; Managing editor of bookloons.com, 2000 - present.

EX Officio – Doug McDonald, SLC Policy Chair

THOUGHTS ARISING FROM DISCUSSIONS - LEAD WORKING GROUP

APPENDIX A – Options for Change

Innovation to reduce costs and achieve more efficient delivery of services

- **The federal government must urgently assume leadership to set forward a world-class pan-Canadian health care vision, enabling a demographically-demanded "move emphasis from the 1947 model of acute care, to a 2017 model with our demographic and cultural changes to include community-based care; to a multidisciplinary chronic care/prevention community care approach where every Canadian has timely access to a family physician or appropriate health care provider.**

- To ensure success, the vision will include: establishment of national goals, standards and innovative practices that are monitored, measured, promoted and publicized.

- Nationally, promotion of best practices, cost reduction accomplishments, and innovation. Keep national attention on progress (or lack of it) towards goals across the country and innovation success stories.

- Publicize Canada's ranking against international standards and performance against the 'new vision'

- Allocate funding for innovation that has the potential to be 'franchise-able'

- Encourage the use of LEAN methodology (creating more value for customers with fewer resources) for patient-centered models of bottom-up change and innovation.

- Revisit doctor's claim codes to ensure that their application of changes and innovations remains billable.

- Review recommendations from previous reports, papers and commissions to select, fund and encourage innovation that will drive the shift to a embrace a chronic care and prevention model.

Better Access to doctors and health care services:

- Set national goals for access: health care team, considerate of distance and availability; access to specialists, elective surgery, supportive diagnostic services, and home care

- Place emphasis on a *Primary Health Care Team/Family Care Centre* model to enable a shift from acute care/hospital/institutional reliance to a multidisciplinary

prevention/chronic community care approach where every Canadian has timely access to a family physician or appropriate health care provider. For rural and remote areas, internet infrastructure is a key facilitator. Infrastructure initiatives might be considered as a means to erect Family Care Centres with electronic systems to support extended physician care and wait lists via the internet.

- Conduct a national assessment of issues faced by rural and remote communities using perks such as relocation and or tax incentives, free housing and provision of a locum for respite to attract medical professionals to resolve resource shortages.

- Develop a national personnel forecast for the future supply/needs of physicians, specialists, medical personnel to population: urban, rural and remote. succession planning; consider training duration for each medical specialty; review Student Loan programs to address systemic barriers. Ensure appropriate spaces in medical schools

- Consider exemptions for low income Canadians, including seniors and those under sixteen years, from health care fees in provinces where they are charged

- Respect patients' rights to accessing files without being unduly impeded in their requests. Hospital files made available upon discharge.

Reduced wait times for specialists and medical procedures

- Conduct a study to determine the reasons for provincial/regional differences in wait times

- Set national standards for access to specialists; elective surgery; diagnostic services;

- Measure and compare progress towards goals both within Canada and internationally. Given the urgency of improvement, publish results regularly.

- Communicate publicly on performance achievements on a regular basis

- Eliminate unnecessary medical procedures and diagnostic testing that evidence indicates are no longer needed or not as frequently needed

- Enable privately-run Surgical Facilities, where appropriate for the jurisdiction and equitably accessible for all constituents, staffed by experienced surgeons and anesthesiologists who are paid by the Medical Claim Insurance Branch. In Saskatchewan, this has reduced the wait time for many procedures, at a reasonable cost.

APPENDIX
B - AN AGENCY DRIVEN MODEL

The working group was asked to focus on the urgent need for:

i) Better access to doctors and health care services
Reduced wait times for specialists and medical procedures
Innovation to reduce costs and achieve more efficient delivery of services

To address these issues and challenges, as is so badly needed and as Canadians strongly prioritize, we recommend that the federal government urgently take leadership in establishing a world-class pan-Canadian (monitoring, measuring, promoting and publicizing) Health Agency, to frame and direct progress towards specific goals.

To this effect, the body should review the detailed recommendations from experts in the field as captured in the 2015 Naylor report as well as the proposal of a Health Care Guarantee in the 2002 Senate Report, The Health of Canadians – The Federal Role.

The agency's mandate would include:

Set goals for access to a health care team (distance and availability), access to a specialist; access to elective surgery; access to supportive diagnostic services; access to home care (add access to assisted dying?) - to return Canada to health care excellence in relation to its peers, and give Canadians the national health care guarantee that they expect.

Use Statistics Canada to measure and compare progress towards goals both within Canada and internationally. Given the urgency of improvement, publish results quarterly.

Promote best practice and cost reduction accomplishments and innovations. Keep national attention on progress (or lack of it) towards goals across the country, and on innovation success stories.

Additional specific recommendations of this working group to such a health agency are:

Promote the Primary Health Care Team/Family Care Centre model to enable a shift from acute care/hospital/institutional reliance to a multidisciplinary prevention/chronic community care approach where every Canadian has timely access to a family physician or appropriate health care provider. For rural and remote areas, internet infrastructure is a key facilitator.

Fund infrastructure projects to create Family Care Centres with electronic systems to support extended physician care and wait lists via the internet.

Assess the needs and quality of care in rural and remote areas, which appear to have been hit hardest by Canada's slipping in international medical comparisons. In addition to use of Family Care Centres, consider such perks as relocation and/or tax incentives, free housing and provision of a locum tenens for respite, to attract medical professionals. Examine the need for modified medical training for these settings.

Within the context of the new health agency, develop a national forecast of the future supply/needs of physicians/specialists/medical personnel relative to population: urban, rural and remote. Include succession planning; consideration of the training duration for each medical specialty; and a review of Student Loan programs to address systemic barriers. Note that the Canadian Medical Association is currently demanding that the Federal Government set up a new National Database.

Give urgent consideration to the following specifics:

Assess how all of this ties in to the move towards seniors' Home Care, with consideration for the differences between urban, rural and remote areas.

Fund franchise-able innovation.

Consider exemption for low income Canadians, all those under sixteen years of age, and seniors, from health care fees in provinces where they are charged.
Apply LEAN methodology (creating more value for customers with fewer resources) for patient-centered models of bottom-up change and innovation.
Revisit doctor's claim codes to ensure that their application of changes and innovations remains billable.

Respect patients' rights to their files without being unduly impeded in their requests. Hospital files made available upon discharge.

Eliminate unnecessary procedures that evidence indicates are no longer needed such as PAP tests for women under 21 or over 65 yrs.
Enable privately-run Surgical Facilities, staffed by experienced surgeons and anesthesiologists who are paid by the Medical Claim Insurance Branch. In Saskatchewan, this has reduced the wait time for many procedures, at a reasonable cost.