

# **Getting the Diagnosis Right...**

## **Toward a Sustainable Future for Canadian Health Care Policy**

*(Part One of a two-part brief to the Royal Commission on the Future of Health Care in Canada)*

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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to provide leadership for physicians and to promote the highest standard of health and health care for Canadians.

On behalf of its members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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## EXECUTIVE SUMMARY

### INTRODUCTION

The Canadian Medical Association (CMA) welcomes this opportunity to provide a perspective to the Royal Commission on the Future of Health Care in Canada on behalf of our 50,000 physician members, provincial/territorial divisions and affiliated medical organizations.

Canada's doctors are literally at the coal face of the health care system. Collectively each year our physicians, including licensed physicians, post graduate trainees and medical students have at least one, and often several face-to-face interactions with at least 80% of Canadians. Moreover, on a daily basis we interact with a wide range of other health professionals and agencies.

The striking of the Commission has come at a cross-roads in the evolution of our national health care program. We face a faltering health care system, characterized by no long-term vision or systematic plan. There is a lack of common purpose among the stakeholders, waning public confidence and extremely low provider morale. If we do not act immediately to address these key areas, we will very soon lose the underpinnings of social support for the publicly funded health care system.

This brief is the first of two parts. In medicine it has long been accepted that the key to a successful treatment is to first get the diagnosis right. In Part One we will focus on the "signs and symptoms" leading to a diagnosis and also outline some of the broad pathways to stabilizing our traumatized health care system. In Part Two, which will be completed in the spring of 2002, we will put forward recommended treatments. The overall theme is that we cannot manage our way out via increased efficiency gains alone.

## **SIGNS AND SYMPTOMS OF A “TRAUMATIZED PATIENT”**

As a result of the relentless cost-cutting of the 1990s, we are now in the midst of a crisis of sustainability that has at least five dimensions:

**Crisis of Access** – For those of us who spend increasing amounts of time each day trying to secure diagnostic and treatment resources for our patients, it is clear that we are in a deepening crisis of access to people, to technology, and to the surrounding infrastructure. What were once routine and timely referrals and treatments are now unacceptably long waits for all but the most urgent care.

**Crisis of Provider Morale** – The morale of physicians, nurses and other providers in the system is at an all-time low. Physicians are working harder than ever, with fatigue and burnout becoming more commonplace. We are increasingly frustrated by the growing effort and time required to secure resources for our patients. Moreover, physicians have been largely marginalized in decision making at a system level as a result of the reforms of the 1990s.

**Crisis of Public Confidence** – While Canadians continue to report high satisfaction with the health care they receive, they have lost confidence that the system will be there for them in the future. At the same time, they are being barraged through multiple media about the promise of revolutionary technology that is fueling their expectations about what we as physicians and the health care system are able to provide for them.

**Crisis of Health System Financing** – While the federal government had been paring back its contributions to Medicare since the late 1970s, this was greatly intensified in the mid-1990s and only recently has begun to reverse itself. Health care spending is projected to exceed 40% of provincial/territorial government revenues in the not too distant future. Demographics and technology will continue to put upward pressure on costs. We believe that the top-down supply side management approach to cost containment has been a resounding failure.

**Crisis of Accountability** – There is a growing problem of accountability at several levels. There continues to be bickering between the federal and provincial/territorial governments – is the federal share of Medicare 11% or 34%? At the provincial/territorial level, accountability has been pushed down to regional health authorities while authority continues to be held by the central health ministry. Proposals for reform have targeted providers for increased accountability but have ignored consumers as patients.

We believe that the health care system and those of us who work in it have been seriously traumatized. We believe that these five signs and symptoms will only grow worse in the years ahead unless there is concentrated and timely action.

## **PATHWAYS TO STABILIZING THE TRAUMATIZED PATIENT**

While we are not ready to put forward specific recommended treatments at this time, we would suggest that there are five “pathways” that will help guide the Commission’s work on the stabilization and recovery of this trauma.

**Focus on the “Hows”, not just the “Whats”** – The health reform discussions of the 1990s in Canada have been dominated by the “whats” rather than the “hows”. When the “how” was considered at all, governments generally approached reform with a “big bang” approach. International experts have recognized that this is very unlikely to be successful when there are many stakeholders in a plurality of settings—which is certainly an apt depiction of the Canadian health care landscape. There is a clear need for a collaborative approach to “change management” that is based on early, ongoing and meaningful involvement of all key stakeholders.

**Adopt a Values-Based Approach to Change** – We believe that Canadian Medicare has been largely well-served by its values-based approach, as expressed in the five program criteria of the Canada Health Act. We believe that a modernized Medicare program must continue to be underpinned by basic values such as universality and expressed through national principles. In particular, as physicians, we believe it is fundamental that we must continue to be agents of our patients and moreover that we must continue to uphold the principles of choice between patients and physicians.

**Striking a Better Balance Between Everything and Everyone** – As we contemplate what a vision of Medicare for tomorrow might include we must be mindful that no country in the world has been able to pay for first dollar coverage for timely access to all health services. In light of the rapidly transforming delivery system with a shift from institutional to community-based care, a re-examination of the Medicare “basket” is overdue.

**Generate New Thinking** – The new millennium requires new thinking. We have become complacent about Medicare. We are unlikely to find durable answers as long as discussions are bound by the current scope of application and interpretation of the five principles of the Canada Health Act. We need to reflect on the discussions among provincial/territorial premiers over the past few years and on international experience in order to gain an appreciation of the new consensus that may be emerging. Canada can and must learn from the experience of other countries that have already been forced to deal with, for example, the demographic shifts that Canada is about to encounter. We also need new thinking about the evolving context of the delivery of care in the age of the Internet and the new generation of both consumers and providers.

**Recognize That Better Management (while necessary) Will Not Be Sufficient** – We do not believe that we can simply manage our way out of this crisis. Physicians have supported, indeed led, many innovations such as the implementation of clinical practice guidelines and have participated in primary care reform demonstration projects. Improved efficiency alone, however, cannot meet the demands we expect to see in the future. The system must be properly resourced on a predictable basis.

## **NEXT STEPS...**

There is no “magic bullet” or quick fix that will put our national health program on a sustainable footing and restore Canadians’ confidence in it. Working harder to make the current system work better will not be sufficient. While there are still gains to be made from efficiencies and integration, we cannot simply manage our way out of this problem. It is time for fundamental change. We should not be discouraged from pressing on with this daunting challenge; it is imperative that we begin to act immediately.

This brief sets out the variety of pressures that render the current health system unsustainable. It also sets out a value-based policy framework that can help guide future deliberations and point us to policies that can help address the rising concerns among both providers and Canadian health consumers.

The brief is not intended to be all-encompassing. Various other medical organizations will be making representations to the Commission. The CMA encourages the Commission to seriously consider the complementary briefs submitted by our sister organizations.

The CMA intends to submit its final recommendations, building on this framework, in the spring of 2002. This second brief will again be the product of our extensive set of discussions with the profession.

## INTRODUCTION

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Canada's doctors are literally at the coal face of the health care system. Collectively each year our physicians, including licensed physicians, post graduate trainees and medical students have at least one, and often several face-to-face interactions with at least 80% of Canadians. Moreover, on a daily basis we interact with a wide range of other health professionals and agencies.

The striking of the Commission has come at a cross-roads in the evolution of our national health care program. We face a faltering health care system, characterized by no long-term vision or systematic plan. There is a lack of common purpose among the stakeholders, waning public confidence and extremely low provider morale. If we do not act immediately to address these key areas, we will very soon lose the underpinnings of social support for the publicly funded health care system.

This brief is the first of two parts. In medicine it has long been accepted that the key to a successful treatment is to first get the diagnosis right. In Part One we will focus on the "signs and symptoms" leading to a diagnosis and also outline some of the broad pathways to stabilizing our traumatized health care system. In Part Two, which will be completed in the Spring of 2002, we will put forward recommended treatments.

The development of this brief has been guided by the policy debates within the CMA over the past few years, including those at General Council in 1994 to 1998 and 2001, and by current deliberations with our Divisions and Affiliates. It has also been informed by the results of a series of Public Dialogue Sessions that were held across Canada in May/June 2001 and a National Report Card Survey that was conducted in late June 2001.

The overall message of this initial submission is that working harder to make the current system work better, while necessary, is not sufficient. While there are still gains to be made from efficiencies and integration, we cannot simply manage our way out of this problem. It is time for fundamental change. Changes must focus, first and foremost, on restoring public confidence and provider morale. They should focus on care and speak to individuals and their needs, rather than being dispassionate at a systems level analysis. As a society, Canadians need a new consensus on the fundamentals of our health and health care system.



## SIGNS AND SYMPTOMS OF A “TRAUMATIZED PATIENT”

### 1. CRISIS OF ACCESS—ACCESSIBILITY MEANS NOTHING WITHOUT AVAILABILITY

Access is a critical dimension of quality care. We are facing a growing crisis of access to timely health care with human, technological and physical infrastructure dimensions. As a result, the ability to provide quality care is suffering.

#### The Health Workforce

While we believe that the health workforce in general is facing a major sustainability challenge, we will focus our discussion on the physician workforce, with which we are most familiar.

For most of the past decade, governments have acted on advice that Canada has too many physicians. Ministers of Health met in Banff in January 1992 to discuss the 1991 Barer-Stoddart report *Toward Integrated Medical Resource Policies for Canada*.<sup>1</sup> Out of the comprehensive set of 53 recommendations in this report, the Ministers clearly “cherry-picked” the one recommendation with a number attached to it – namely the 10% cut in enrolment that was implemented in the Fall of 1993. A year later governments began proposing/introducing a range of punitive measures to promote distribution objectives. Probably the most extreme of these was a proposal by the Ontario government in April of 1993 to discount by 75% the fees of what would have been the majority of new family physicians, paediatricians and psychiatrists.<sup>2</sup>

Undergraduate medical school enrolment was already on the decline when the 10% cut was implemented, so the overall reduction translated into 16% fewer positions by 1997/98 than in 1983/84. Opportunities for young Canadians to enter medical school (relative to the population) decreased at an even greater rate. First year enrolment peaked in 1980 with 1 student per 13,000 citizens but by 1998 this had fallen to 1 per 20,000 (compared to 1 per 12,000 in the UK for example). While there was no decrease in the number of postgraduate new entry positions, re-entry opportunities were less plentiful and fell from 663 positions in 1992 to 152 by 1998.<sup>3</sup>

Against this backdrop one should scarcely wonder why the number of physicians leaving Canada doubled between 1989 and 1994 (384 to 777). Since 1994, the outflow has abated somewhat to just over 400 in 1999. During 1998 and 1999 the number of physicians returning from abroad increased, thus the net loss was reduced to just under 250 physicians in each of those 2 years. In 2000, owing to a significant drop in the number of physicians leaving, the net loss dropped to 164. Nonetheless this is still equivalent to more than 1.5 graduating medical classes.<sup>4</sup> Over the 12 year period from 1989 – 2000, the net loss of physicians to emigration was almost 4,000.

While long term planning is a key element of other large public enterprises in Canada, the same cannot be said for the health workforce.

One of the ten core principles of the United Kingdom National Health Services reads “the NHS will support and value its staff”. An application of this principle may be seen in a recent UK strategy document for the scientists, engineers and technologists working in healthcare science. This 3-point strategy covers pay and career opportunities, working conditions and recruitment.<sup>5</sup>

We would suggest that such a consideration has been largely absent from Canadian health policy over the past decade, certainly at a national level and most probably at the provincial/territorial level. The health workforce received scant attention by the National Forum on Health. The Provincial/Territorial Health Ministers’ 1997 *Renewed Vision for Canada’s Health System* makes only incidental mention of the health workforce.<sup>6</sup>

These examples suggest that the health workforce has largely been taken for granted. By comparison, during the past decade, no fewer than three task forces have been struck to address the renewal of the federal public service. (Public Service 2000, La Relève and the 2001 Task Force on Modernizing Human Resources Management in the Public Service ).<sup>7</sup> We are now paying the price for this neglect.

If we are to continue to maintain health care as a public enterprise in Canada, we believe that there needs to be a high level policy acknowledgement of the value of and commitment to the enhancement and renewal of the health workforce. A recent national consultation on research priorities for health services and policy issues reported that “health human resources was seen as the dominant issue for the next two to five years by policy makers, managers, and clinical organizations. The concerns of policy makers included regulatory frameworks, mechanisms for avoiding cycles of surplus/shortage, and the leadership vacuum within management and policy-making organizations.”<sup>8</sup>

There are some signs that governments have belatedly begun to acknowledge that we are in a shortage situation. In November 1999, the Canadian Medical Forum presented the report of its Task Force on Physician Supply (Task Force One) at a meeting hosted by the co-chairs of the Conference of Federal/Provincial/Territorial Ministers of Health. One of the key recommendations of the report called for an increase to 2000 first year medical school places for 2000.<sup>3</sup> Since that time several provinces have announced increases in undergraduate enrolment and postgraduate training. As of July 2001, these increases numbered 353 undergraduate, 153 postgraduate and 37 re-entry (specialty) training positions.<sup>9</sup> However, these increases will not begin to have an appreciable impact for a minimum of five to six years. Another key recommendation, calling for efforts to repatriate Canadian physicians practising abroad and which would have a more immediate payoff has received no attention that we can discern.

While these enrolment increases are most welcome, they highlight another problem, namely the steep increases in medical tuition and the prospect of tuition deregulation. Already there are reports of cumulative debt loads from undergraduate and medical education that may exceed \$100,000. If this upward trend continues, we fear that this might not only re-ignite an exodus of physicians to the U.S. (where loans may be repaid more quickly), but that access to medical education may be restricted to only the most advantaged Canadians.

Indeed a 1999 study<sup>10</sup> at one Ontario medical school found that the median family income of the 1<sup>st</sup> year intake class following a large tuition increase was significantly higher than the 2<sup>nd</sup> and higher year classes.

A further challenge that is posed by the enrolment increases is in the capacity of the 16 Academic Health Sciences Centres (AHSCs) to provide undergraduate medical education and post-graduate training. There is a tendency to overlook the fact that AHSCs have a threefold mission; to provide teaching, to conduct original research, and to provide all levels of care for the surrounding population and highly specialized care for outlying regions. As the site of training moves increasingly out to the community, it will become necessary to recruit even more teachers from a pool of physicians who are only barely able to cope with their existing workloads. With few exceptions the resources required to fund the expansion of medical education to the community have not been forthcoming.

Another development is that Human Resources Development Canada (HRDC) is in the process of initiating several sectoral studies in health including home care, natural products, nursing, oral health care, pharmacists and physicians.<sup>11</sup> The Canadian Medical Forum, made up of the major national Canadian medical organizations, together with others will be working with HRDC and Health Canada to implement the physician sector study over the next few years. Again, these studies will not produce any short term payoffs toward alleviating the immediate and growing shortages of physicians and other health providers.

Looking to the decades ahead we know that the demographic composition of the profession is going to change markedly. Women now represent more than 50% of our graduating medical classes, and while at present they represent 29% of the practising physician population, by 2021 this is expected to reach 44%. The medical profession is also aging. As of 2001 some 27% of physicians are aged 55 and over; by 2021 this proportion will be 37%. Given the historical (and continued) gap of some eight hours per week between the average work week of male and female physicians, there will be a major challenge in sustaining the volume of service required to meet the needs of our aging population.

### **Information Technology in Service of Health**

The health care system operates within an information intensive environment. However, to date, a substantial portion of the data being collected is gleaned as a derivative of administrative or billing/financial systems. Although this provides useful information for arriving at a “high level” view of the operation of the health care system, it is generally of limited value to health care providers at the interface with their patients.

A detailed costing study prepared by PriceWaterhouse Coopers for the CMA in 2000 estimated the cost of connecting all delivery points in the Canadian health care system at \$4.1 billion. The \$500 million announced in the September 2000 Health Accord is only a modest start.

Health care providers require access to a secure and portable electronic health record (EHR) that provides details of all health services provided to their patient as well as the appropriate decision support tools. An EHR that meets the clinical needs of health care providers when interacting with their patients will serve to benefit not only the health of Canadians, but the overall efficiency and effectiveness of the health care system.<sup>12</sup> A critical aspect of the EHR that remains to be addressed is that of privacy. While the Personal Information Privacy and Electronic Document Act is due to come into force for health information in 2002, the privacy protection afforded to patient and provider interactions is not at all clearly defined. The CMA has ongoing serious concerns about the lack of clarity in the Act. These concerns have recently been exacerbated by a decision of the federal Privacy Commissioner to deem physician information as “professional” rather than personal, thereby making confidential information more accessible. This will not make it any easier for Canadian physicians to embrace information technology in service of health.

### **Capital Infrastructure**

Much of our current infrastructure dates back to the early days of Medicare—forty years ago. In order to provide necessary health services, the health care system must be supported by adequate infrastructure. However, public investment in this area has declined substantially since the late 1980s with the first wave of health care reform initiatives. For example, from 1986-87 to 1993-94, the number of approved public hospital beds decreased by 2.8% annually, and in 1994-95 the decline increased to 7.2% annually after the introduction of the CHST.

In total, over this period the number of approved public hospital beds decreased by 36.1%.<sup>13</sup> While the trend in shorter inpatient days, and therefore an increase in outpatient care, has mitigated the problem of a bed shortage somewhat, there is a need to monitor readmission rates on an ongoing basis. Furthermore, the question of whether Canada has an adequate supply of acute care beds for those who require inpatient care must be addressed. We would also add that this has resulted in considerable offloading to the community in the area of primary care, community based services and informal caregivers without any transfer or infusion of resources to support the community’s efforts.

Further evidence of the disinvestment in health care infrastructure can be seen in the areas of building construction, machinery and equipment. The following considers expenditures in terms of constant 1992 dollars so that levels are adjusted for inflation. Real per capita capital health expenditures by provincial governments have declined by 16.5% from its 1989 peak at over \$63. In terms of new building construction by hospitals, between 1982 and 1998 real per capita expenditures decreased by 5.3% annually. Finally, real investment in new machinery and equipment in the hospital sector has declined annually by 1.8% since 1989.<sup>13</sup>

## 2. CRISIS OF PROVIDER MORALE

We are concerned that this telling comment, written by a physician respondent in the CMA's 2001 Physician Resource Questionnaire (PRQ), reflects the mood of many physicians in Canada today.

***“Considering the state of the profession today, if a young person close to me were to ask my advice concerning their choice of career, I would recommend very strongly that they avoid choosing medicine.”***

Canada's physicians are working harder than ever. According to the 2001 PRQ survey the average work week of a physician is 53.4 hours (not including call). The bulk of this is taken up with direct patient care (35 hours). The remainder is occupied by activities such as indirect patient care, teaching, research, and education. The physician's work week does not end there. Again according to the PRQ, three out of four physicians (74%) report taking shared call for their patients out of hours and those who do report an average of 144 hours (six 24-hour days) per month, during which their activities are constrained to a significant degree.

It is no surprise that more than one out of two (54%) respondents to the 2001 PRQ reported that their workload had increased over the past 12 months, while fewer than one out of ten (9%) reported a decrease. In every age group, physicians were likely to report that their workloads are heavier than they would like – in terms of potentially compromising their ability to provide high quality care to their patients – rising from 53% among those less than 35 years of age to roughly 70% of those in the 35-54 age group, and then declining to 64% among those aged 55-64 and 37% among those 65 and over.<sup>14</sup>

There are at least three main contributing factors to the crisis of physician morale.

The first has been the aforementioned blunt and coercive measures made by governments in the early 1990s to curtail physician numbers and manage distribution. Planning requires taking a longer term view and resisting the temptation to “cherry pick” for short term relief.

A second facet of practice life that has become increasingly burdensome for patients and providers is the increasing amount of time that it takes to arrange for referrals, tests and treatments for our patients. In urgent or life-threatening situations, care is being provided. However, about two thirds or 64% of respondents to the 2001 PRQ reported difficulty in obtaining appropriate resources on behalf of their patients.

The difficulty that Canadian physicians experience in accessing resources on behalf of their patients is further illustrated by the results of a survey conducted by the firm of Harris Interactive, in which physicians were surveyed in 2000 in Australia, Canada, New Zealand, the U.K. and the U.S. Data from this study show that high proportions of Canadian physicians report problems with access to care in their practices, particularly when compared to their U.S. colleagues. While Canadian and U.K. physicians report similar levels of problems, there are dramatic differences between Canada and the U.S.

For example, Canadian physicians are almost eight times more likely to report problems with access to the latest medical and diagnostic equipment than their U.S. colleagues (63% vs. 8%). Similarly, 61% of Canadian physicians reported problems of availability of medical specialists and consultants, compared with 13% of U.S. physicians, while 66% of Canadian physicians reported major problems with long waiting times for surgical or hospital care compared with just 7% of U.S. physicians<sup>15</sup>. This is an avoidable cause of stress on the physician-patient relationship.

Third, when regionalization was implemented during the 1990s, physicians and other providers were generally marginalized in the process. Indeed, in several provinces, health providers were expressly prohibited from serving on regional boards. An early indication of this was gained in the CMA's 1995 Physician Resource Questionnaire. Only 10% of respondents agreed that physicians had been involved or consulted in the implementation of regionalization in their region, and just 21% agreed that the medical profession had any ongoing input. While we have not surveyed our members recently on this, we have little reason to believe that there has been significant change.

The crisis of morale is by no means confined to physicians. The authors of a recent policy synthesis on the benefits of a healthy workplace for nurses, their patients and the system declared that "the Canadian healthcare system is facing a nursing shortage that threatens patient care. Many nurses, physically and mentally exhausted, quit; employers cannot fill those vacancies, while paradoxically other nurses cannot find secure jobs with hours that suit them. Meanwhile, nursing schools cannot keep up with the demand for new recruits."<sup>16</sup>

### 3. CRISIS OF PUBLIC CONFIDENCE

The observation quoted here was made by one of the physician moderators at the CMA's 2001 Public Dialogue Sessions.<sup>17</sup> We believe that, if anything it understates the perilous state of Canadians' confidence in our health care system.

The precipitous decline in Canadians' assessment of our health care system has been tracked by the Ipsos-Reid polling firm over the 1990s. While in May 1991, 61% of Canadians rated our health care system as excellent or good, by January 2000 this has declined to just 26%.<sup>18</sup>

***"Hopeful is not an adjective I believe the majority of Canadians feel towards the health care system. Confused, apprehensive and frustrated are probably more appropriate adjectives of the average Canadian's vision of health care in the future.***

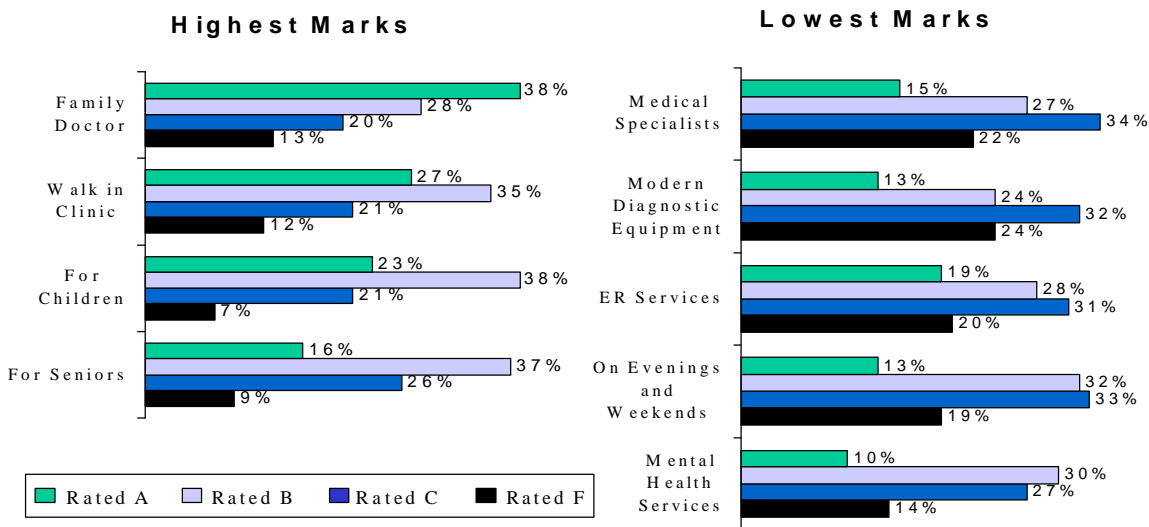
***Many Canadians are able to cite current examples of how the system has not been there for them and are in fear that this erosion will only continue in the future."***

We found further evidence of the dimensions of this concern in the first CMA National Report Card on Health Care Survey, which was carried out on our behalf by Ipsos-Reid in the summer of 2001. In terms of an overall rating, just 21% of Canadians gave the system an “A” grade, 44% “B”, 26% “C”, and 9% “D”.

While the report card confirms previous findings that those who have used the system are generally satisfied (30% “A”, 38% “B”) the ratings of access to most health care services are distressing (Figure 1). While access to family physicians receives an “A” rating, the ratings of most specialized services are dismal. Just 15% of Canadians rate access to medical specialists as “A”, while 22% assign it a failing “F” grade.<sup>19</sup>

Figure 1

### Rating of Access to Healthcare Services



Similarly, our Public Dialogue Sessions from the summer made it clear that Canadians believe that the quality of health services has declined in Canada and many fear that it will get worse before it gets better. Six out of ten Canadians (64%) reported that the overall quality of health care services in their community had deteriorated over the past 10-15 years. Looking ahead, 37% of Canadians expect health services to be worse in five years, outnumbering the 30% who think they will get better. As one of our Public Dialogue participants put it this summer, “It will get worse—nursing homes have long waiting lists. Hospital beds are plugged up with people waiting to get into nursing homes. With our aging population—it’s only going to get worse.”<sup>17</sup>

Although we do not have much quantitative evidence yet, we believe that patient expectations will continue to increase, as Canadians are bombarded by news of promising new developments through multiple channels. The growth of health information on the Internet has been a chief contributor to this. In the CMA’s 2000 PRQ survey, 84% of physicians reported that patients had at least occasionally presented medical information to them that they had found on the Internet.<sup>20</sup>

Also worrisome is the vast array of sources of medical information that can be found on the world wide web – information that is not always from credible sources nor based on scientific evidence.

In summary, we are deeply concerned that Canadians’ confidence in our system is hovering at a level that threatens the sustainability of the social consensus that underlies our current Medicare program. Clearly this must be addressed before we attempt to strike a new one.

#### **4. CRISIS OF HEALTH SYSTEM FINANCING**

When Tommy Douglas’ government implemented Medicare in Saskatchewan in 1962, he said at the time, “all we want to do is pay the bills”. It was not too long after Medicare was implemented nationally in 1971, however, that governments started thinking about ways of controlling costs, and before the decade was out, under the Established Programs Financing (EPF) arrangements, 50:50 cost sharing had been replaced by a combination of tax points and cash contributions linked to economic growth.

Clearly, policy thinking has been dominated by top-down supply side management for the past two decades. In a commentary on Justice Emmett Hall’s second (1980) report, noted Canadian health economist Roderick Fraser warned, “the size of the Canadian health care sector in relation to the current health status of Canadians and in particular to the current lifestyle of Canadians, hazardous as it is to health status, leads one to wonder if we have been over-sold on cost-containment.”<sup>21</sup>

When EPF was merged with the Canada Assistance Plan (CAP) in the 1995 federal budget, creating the Canada Health and Social Transfer (CHST), total federal contributions to health care became impossible to distinguish from contributions to social assistance and services and post-secondary education. Latterly, this has resulted in ongoing feuding between the federal and provincial/territorial governments over the respective shares of health financing.

Not only is the portion of the CHST allocated to health care variable and indistinguishable from other social programs, the amount of the CHST itself has been unstable since its introduction. In the two fiscal years beginning April 1996, government cut CHST cash by 33%. It will not be until 2002-03 that the CHST cash floor will equal its 1994-95 level, with no adjustment for the increasing health care needs of Canadians, inflation or economic growth.<sup>12</sup>

A five year \$11.5 billion cumulative reinvestment in health care announced in 1999 and an additional one-time unearmarked investment of \$2.5 billion in 2000 are a combination of increases to the CHST cash floor and one-time supplements. These CHST supplements, totalling \$3.5 billion over three years starting in 1999 and \$2.5 billion over four years starting in 2000 are not included in the CHST cash floor, nor are they intended to grow over time through an escalator. These multi-year supplements are charged to the preceding year’s budget. Once allocated and spent, the money is gone. These supplements are merely “tentative half-measures” and by no means a substitute for fostering short-, medium- and/or long-term planning.<sup>12</sup>



The effect of the squeeze on public health care finance in Canada is clearly evident in international comparative perspective. During the 1980s and early 1990s, governments were fond of calling Canada the “silver medalist” in health expenditures as we were second only to the U.S. in terms of total per capita expenditures. As of 1998, however, Canada ranks fourth among OECD countries and much lower when we consider just the public component. In 1998, Canada ranked 8<sup>th</sup> with respect to public per capita spending (the “private system” U.S. ranked third and indeed recorded per capita public spending that was 13% higher than Canada). When public expenditure is considered as a percentage of total health expenditure, Canada was much closer to the bottom, ranking 23<sup>rd</sup> out of 30.<sup>22</sup> These rankings are not generally well-known and governments are generally not interested in getting this information out to Canadians.

## Demographics

The issue of demography has been widely discussed in recent years and a variety of scenarios regarding the impact of the aging Canadian population has been presented. It was featured in the CMA (1982) report as one of two major pressures on the system, along with technology (see below). According to a 1998 Report of the Auditor General of Canada, the number of people 65 years of age and over is expected to more than double from 3.6 million in 1996 to almost 9 million by 2031.<sup>23</sup> The implication for health care is substantial. On average, per capita public spending on health for those aged 65 and over is almost five times greater than per capita spending on the rest of the population.<sup>23</sup>

In our 2000 research, we identified four schools of thought:

- ?? The first, and the one that has probably received the greatest attention, posits that as a result of population aging, total health costs will increase significantly and will require an increased relative share of GDP.
- ?? The second argues that total health costs will increase, but only gradually, and this increase will be absorbed by GDP growth and reallocations from other sectors.
- ?? The third school believes that population aging will result in an increase in the demand for health care, but that we will be able to contain costs by delivering health care more efficiently.
- ?? The fourth school holds that the demand for health care will decrease because the future population, and in particular the future elderly population, will enjoy better health status.

From the 2000 discussion paper it was evident that there is no clear consensus on the prospects for sustainability.<sup>24</sup> In July 2000, Ipsos-Reid polled the Canadian public on behalf of the CMA, with respect to their agreement on the likelihood that each school will play out over the next 20 years. The results are shown in Table 1 (with exact wording).<sup>25</sup> Clearly, Canadians are skeptical about our ability to sustain an affordable health care system. We share their concern.

<b>School of thought</b>	<b>% reporting agreement</b>
1. Healthcare costs will rise sharply, thereby increasing demands for public funds for health care	45
2. Healthcare costs will rise gradually, the increase will be manageable due to growth in the economy	19
3. The demand for healthcare will increase but we will be able to contain costs by operating the healthcare system more efficiently	29
4. The demand for healthcare will decrease because the population will enjoy better health status	11

A September 2001 OECD study has compiled the most recent projections of aging related to public expenditures over the 2000-2050 period, and in general, significant health care cost increases associated with population aging are expected. “The average increase over the 2000-2050 period for the 14 countries where this information is available is 3 to 3.5 percentage points of GDP. But for five countries (Australia, Canada, the Netherlands, New Zealand and the United States), increases of 4 percentage points or more are projected.”<sup>26</sup> For Canada specifically, the study estimates that the 2000 level of 6.5% of GDP allocated for public health expenditures will increase to roughly 10.5% over the 2000-2050 period—more than the current GDP share of total health expenditures (9.3% in 2000).

Similarly, according to a recent study by the Conference Board of Canada, “public health expenditures are projected to rise from 31% in 2000 to 42% by 2020 as a share of total provincial and territorial government revenues.”<sup>27</sup> This would clearly squeeze other categories of social spending and public expenditure. While to a certain degree these projection studies are intended to be “self-defeating prophecies”, in our judgement, when these are factored in to the overall context of what the demographic shift will mean for the aging workforce and social security generally, there is reason for profound concern.

### **Health Technology**

Over the past few decades, technology has made a great contribution toward pushing back the frontiers of Medicare. Based on a 2001 survey of U.S. general internists of their assessment of 30 of the most significant innovations over the past 25 years, Fuchs and Sox reported that the most important innovation by a considerable margin is magnetic resonance imaging (MRI) and computed tomography (CT) scanning.<sup>28</sup>

The potential of CT and MRI technology for screening, diagnosis and the image-guided treatment of cardiovascular and cerebrovascular diseases and cancer has been documented by Industry Canada’s Medical Imaging Technology Roadmap Steering Committee.<sup>29</sup>

In terms of keeping pace with developments in technology, Canada is woefully behind other OECD countries for selected diagnostic and treatment technology, except for radiation therapy equipment (Table 2).<sup>30</sup> The CMA has estimated that, for the technologies listed in Table 2 (plus positron emission tomography, for which data are not available from the OECD), it would require an overall capital cost of \$1 billion plus an operating cost of \$0.74 billion (for a three-year period) to bring Canada up to the standard of access to medical technology of developed countries with a similar level of per capital income.

Selected Technology	Canada		OECD countries reporting		
	Level; units per million pop.	Rank	No. of countries	Avg. level; units per million pop.	First rank; units per million pop.
Computed tomography	8.1	12	15	12.7	24.9
Magnetic Resonance Imaging	1.7	11	13	3.7	8.4
Lithotripter	0.5	10	11	1.9	3.7
Radiation therapy	7	5	13	6.1	14.8

The Canadian Coordinating Office for Health Technology (CCOHTA) has just completed a national inventory of several types of imaging equipment, which will form a useful basis for further discussion. If we relate the numbers of units to the July 2001 population<sup>31</sup>, the only significant shift since 1997 has been in MRI scanners, where the rate has more than doubled to 3.6 units per million population – still below the 1997 OECD average of 3.7. The 2001 level of CT scanners of 9.7 per million is still significantly below the 1997 OECD average of 12.7, and there has been no change in the relative availability of lithotripters.<sup>32</sup>

The September 10, 2000 10-point health accord that was concluded by First Ministers<sup>33</sup> did include a \$1 billion fund to modernize technology, however, no accountability measures were attached to it and so a year later we really do not know how much of it has actually been spent on the purchase of new equipment that has been put into the service of patients. More generally, the Canadian Association of Radiologists (CAR) has expressed concerns about aging equipment that may be providing unreliable diagnostic information.<sup>34</sup>

In summary, the CMA supports the efforts of CCOHTA to date, while suggesting that the introduction, diffusion and replacement of medical technology is still occurring across Canada in too haphazard a fashion. The need for better planning has been well put by the Industry Canada Committee, which stated that “The health-care system needs to develop budgetary tools and financial systems which permit and facilitate cost-effective technological innovation. Health-care funding, including capital cost amortization, needs to be stable and predictable, and independent of political uncertainties.”<sup>29</sup>

## 5. CRISIS OF ACCOUNTABILITY . . . COOPERATIVE MECHANISMS

Why is it that those who know the most about health and health care – practitioners – have the least opportunity to participate in the key decisions about health and health care? This is the key to re-establishing accountability in the system. We believe that the crisis of accountability is due in large measure to a profound problem in the governance of Canada's health system. If we may define governance as the process of effective coordination when knowledge and power are distributed, there are at least three axes in Canada along which power and knowledge are distributed:

- a. between federal/provincial/territorial and regional authority/municipal levels of government/administration;
- b. along the east-west array of provinces and territories; and
- c. among a range of stakeholders, including government, non-governmental agencies (NGOs) and citizens.

There has been a substantial and growing imbalance among these axes over the past decade; it seems that at any given time it is difficult to achieve concerted direction on more than one of them. For much of the past decade, the tension between the federal/provincial/territorial governments in relation to healthcare has been very pronounced. For example, the provinces and territories did not generally participate in the National Forum on Health. Conversely, when the provincial/territorial Health Ministers produced their 1997 Renewed Vision for Canada's Health System (Conference of Provincial/Territorial Ministers of Health 1997), the report received very little attention at the federal level.<sup>6</sup> In both cases, the admonitions of the health care community went largely unheeded.

While there has been progress along this front, as evidenced by the February 1999 Social Union Framework Agreement (Canadian Intergovernmental Conference Secretariat 1999) and the September 2000 health accord, this highlights a second problem. In general, governments have discounted the role that NGOs and citizens might play in policy-making and in promoting policy among its members. The recent federal/provincial/territorial agreements have been negotiated by government officials behind closed doors (executive federalism), and yet it is the providers and patients who are expected to implement and live with the results. This is in keeping with the lack of openness and transparency of the entire federal/provincial/territorial policy process.

To highlight one problem that this has caused, the acute shortage of physicians in many places across Canada is due, in part, to the unilateral decision by Health Ministers in 1992 to reduce undergraduate medical enrolment by 10%. These problems are exacerbated by the rapid turnover of both Health Ministers and Deputy Ministers. Again, the admonitions of the health community went largely unheeded.

Clearly, Canadians are unimpressed with the back and forth squabbling between levels of government. We believe this is partly reflected in the findings of our 2001 Report Card Survey. When asked to rate the federal government's performance in dealing with health care in Canada, Canadians were six times as likely to give it a failing "F" grade (30%) than they were to give an excellent "A" grade (5%). Similarly, 35% of Canadians gave their provincial government an "F" grade while just 6% gave it an "A" grade.<sup>19</sup>

If we are to achieve a vision for a sustainable Medicare program in the challenging decades ahead, it will be critical to resolve the imbalances along these axes. Governments must begin to work collaboratively with other stakeholders, including citizens.

Prior to the Health Ministers meeting in September 2000, the Canadian Health Care Association, Canadian Nurses Association and the CMA put forward a proposal to them for a Council on Health System Renewal based on the principles of consultation and collaboration.<sup>35</sup> A year later we have yet to hear a response. Perhaps there may be lessons to learn from the Council of Ministers of Education, which has been meeting since 1967. While this Council does not include formal NGO representation, it does sponsor events such as a symposium that involve key stakeholders.<sup>36</sup>

## PATHWAYS TO STABILIZING THE TRAUMATIZED PATIENT

The traumatized patient of "Medicare" needs to be stabilized. The Health Accord (September 2000) goes part of the way. What remains is to set out some of the parameters of change that can ensure that we keep the best of what we have but also progress the system to address the challenges set out in the previous section. Five such parameters of change are set out below.

### 1. FOCUS ON THE "HOWS"(not just the "whats")

The health reform discussions of the 1990s in Canada have been dominated by questions of what we need to do, e.g. expand benefits to include pharmacare and home care. Discussions did not deal with the "hows". When the "how" was considered at all, governments generally approached reform with a "big bang" approach. International experts have recognized that this is very unlikely to be successful when there are many stakeholders in a plurality of settings—which is certainly an apt depiction of the Canadian health care landscape. There is a clear need for a collaborative approach to "change management" that is based on early, ongoing and meaningful involvement of all key stakeholders.

In approaching change management there are two important principles to keep in mind. The first is the need for **evidenced-based decision-making**. This is adapted from the concept of evidenced-based medicine, which stresses the examination of evidence from clinical research based on a range of quantitative and qualitative approaches.<sup>37</sup>

The second would be to reaffirm the Canadian way of approaching change, namely: **evolution not revolution**. By this we mean that we should build on the best of what we have in the current Canadian system

## 2. ADOPT A VALUES-BASED APPROACH TO CHANGE

After much discussion, the CMA is of the view that any proposed changes should be assessed in relation to a limited number of first principles. For the purposes of this paper, Medicare as we know it today consists of those services that are covered by the five program criteria of the Canada Health Act; essentially medically necessary services provided in hospitals and doctors' offices. As we reflect on where we have come in Medicare and where Canada might go, as physicians we believe that the following first principles underpin any new and sustainable policy direction.

- ?? **Patient-centered focus** – reforms must focus on meeting the needs of the patient rather than the system
- ?? **Inclusivity** – to truly achieve buy-in to change all key stakeholders; payors, providers and patients; must be engaged in early, ongoing and meaningful consultation
- ?? **Accountability** – all stakeholders must assume some level of accountability for the health care system
- ?? **Universality** – we believe that health care must be available and accessible to all Canadians and that health resources should be allocated on the basis of relative medical need. We would underscore that Medicare is the last remaining universal program in Canada and needs to be preserved and protected.
- ?? **Choice** – one of the hallmarks of Medicare is that patients have the freedom to choose their physician, to switch with another physician and/or to seek a second opinion. We believe it is essential that the principle of choice between physicians and patients must be sustained.
- ?? **Physician as Agent of the Patient** – we believe that Medicare has promoted the concept of the physician as agent of the patient and that this must continue.
- ?? **Quality** – we believe that the Canadian health care system must continuously strive to provide quality care. By quality care we mean services that are evidenced-based, appropriate for patient needs and delivered in a manner that is timely, safe and effective.

In summary, we believe that these principles can serve to guide the “modernization” of our health care system for the future, while at the same time building on the best of our current system.

### 3. STRIKING A BETTER BALANCE BETWEEN EVERYTHING AND EVERYONE

As we contemplate the future of Medicare it is useful to begin by establishing a frame of reference for the Canadian system. Historically, Canada has distinguished itself in terms of health system design by essentially subsuming the demand side of the market (i.e. public financing) while leaving the supply side alone (e.g. fee-for-service payment methods). Canada has also chosen to provide everyone with first dollar coverage for a somewhat limited range of benefits (unlike our European counterparts).

Accordingly, there are two broad dimensions that may be used to describe publicly financed or regulated health care systems in the developed or industrialized world:

- ?? *Universality Dimension...Coverage of Everybody* – the extent to which the public program covers the entire population over all health services; and
- ?? *Comprehensiveness Dimension...Coverage of Everything* – the range of services that are included in the public program and the extent of that coverage. An overall proxy measure of comprehensiveness is the share of total health expenditures that come from the public purse.

From a national perspective, physician and hospital services are essentially both universal and comprehensive programs. The universality and comprehensiveness of other health services varies between the provinces and territories.

With respect to comprehensiveness as it relates to the total health care system, the Canadian system comes in at 70% public coverage – an amount not dissimilar from most industrialized nations.<sup>22</sup> Where Canada differs from other countries is in the distribution of that coverage. Canada has provided extensive public coverage in physician and hospital services (over 90% public payment), with less attention to other services such as home care and prescription drugs (e.g. less than 60% of prescription drug expenditures were public in 1998<sup>38</sup>). Other countries tend to spread the extent of public coverage more evenly across the broad spectrum of health services.

As we think of the future of Medicare, a key challenge will be to determine whether the uneven distribution of public coverage is a significant issue. It is the view of the CMA that this issue does require serious consideration for a number of reasons:

- ?? Canadians can point to the fact that the allocation of physician and hospital resources is predominantly based on patient need. This same principle, however, does not extend to patients whose condition requires access to other kinds of services – out-patient prescription drugs, community mental health care and home care being three examples where economic factors may play a greater role in access decisions. We must consider the equity issues of this dichotomy, acknowledging that there are practical constraints.

- ?? Where there are treatment alternatives, the lack of comprehensive coverage may lead to biases that increase costs. Physicians faced with decisions about separation from acute care facilities must factor in the availability of home care programs which are often less than adequate. Some drug treatments are simply outside the reach of many Canadian families, though this may be the most efficacious and cost-efficient route.
- ?? The problems cited above have been intensifying due to the changing nature of health service delivery, such as the movement of care to the community and the growth in drug therapies.
- ?? Canadian provinces do not all have the same ability to expand beyond physician and hospital services and there are no generally accepted principles to govern that expansion. As a result, there is a patchwork quilt of coverage across the country with widely varying services.

If the Commission determines that a more comprehensive range of services is required, then the question will become how this can be achieved. There are several alternatives that can be considered, and there will be a need for new thinking.

#### **4. GENERATE NEW THINKING**

In Canada, Medicare has been defined by five principles that, taken together, embody the collective value or sense that we are all in the same health lifeboat. Over the years the five program criteria or principles of the Canada Health Act (CHA) have been effective in preserving the publicly funded character of hospital and physician services, although there has been a growing crisis of access. The delivery of health care has been markedly transformed.

Treatment methods provided today are often quite different from those provided in the past for the same conditions. This affects the extent to which their care is publicly insured, which is dependent upon how they are treated, who treats them, and where they are treated.

During the past few years a number of questions have been raised about the values that underlie health care systems both in Canada and internationally. In the Canadian context we can think of the following three critical questions. First, what range of services should be covered by national principles? Second, are the five principles that currently apply to Medicare sufficient? Third, having defined a range of services whose provision is assured by a set of principles, how do we pay for them?

One example of an attempt at new thinking may be seen in the 1995 report of the provincial/territorial Ministerial Council on Social Policy Reform and Renewal which sets out 15 principles along four themes, namely that social programs must be accessible and serve the basic needs of all Canadians; reflect individual and collective responsibility; be affordable, effective and accountable; and be flexible, responsive and reasonably comparable across Canada.<sup>39</sup>

In our view, this language promotes a flexibility of interpretation that reflects our modern diversity and allows for a realignment of priorities as they may change over time.



To summarize, in our view the language and content of the principles put out over the past few years are a reflection of the following points:

- ?? the principles that have defined Medicare to date cover a declining share of the delivery of health care
- ?? the existing CHA principles are increasingly inadequate in respect of assuring Canadians a reasonable (i.e. timely) access to medically necessary services
- ?? internationally, it appears that there is a move to adopt guiding principles that cover a broader range of the continuum of care and which rebalance individual and collective responsibility in some measure.

We have grown complacent while the rest of the world has experimented. Indeed, to some extent our national health insurance system has forced out innovation. On the other hand, because provinces are reasonably autonomous regarding health, we have had the benefit of interprovincial comparisons.

We are also on the leading edge of both a health information and a bio-technological revolution that is going to fundamentally change the practice of medicine and the nature of the patient-physician relationship. We will need to promote flexibility and adaptability in an era of diversity and rapid change.

## **5. RECOGNIZE THAT BETTER MANAGEMENT (WHILE NECESSARY) WILL NOT BE SUFFICIENT**

Up to the present, the reports of the federal and provincial/territorial task forces and commissions since the 1980s have concluded that we can manage our way out of the sustainability crisis by introducing a series of supply side measures to control costs. In Canada, these initiatives have included the wave of regionalization (and rationalization), physician controls and numerous proposals for primary care reform. The multi-faceted crisis that we are now experiencing is clear evidence of the inadequacy of these strategies.

We suspect that many in the health policy community continue to believe that major efficiency gains remain to be squeezed out of the system. After four consecutive years of negative real growth in public sector health spending (1992 to 1996 inclusive)<sup>38</sup>, the CMA cannot accept the premise that working harder or smarter is going to solve the problems of the system. Strategic reinvestments in health are clearly required.

We do not believe that we can simply manage our way out of this crisis. Physicians have supported many innovations such as the implementation of clinical practice guidelines and have participated in primary care reform demonstration projects. Improved efficiency alone, however, cannot meet the demands we expect to see in the future. The system must be properly resourced on a predictable basis.

## **NEXT STEPS ...**

There is no “magic bullet” or quick fix that will put our national health program on a sustainable footing and restore Canadians’ confidence in it. Working harder to make the current system work better will not be sufficient. While there are still gains to be made from efficiencies and integration, we cannot simply manage our way out of this problem. It is time for fundamental change. We should not be discouraged from pressing on with this daunting challenge; it is imperative that we begin to act immediately.

This brief sets out the variety of pressures that render the current health system unsustainable. It also sets out a value-based policy framework that can help guide future deliberations and point us to policies that can help address the rising concerns among both providers and Canadian health consumers.

The brief is not intended to be all-encompassing. Various other medical organizations will be making representations to the Commission. The CMA encourages the Commission to seriously consider the complementary briefs submitted by our sister organizations.

The CMA intends to submit its final recommendations, building on this framework, in the spring of 2002. This second brief will again be the product of our extensive set of discussions with the profession.

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