RECLAIMING AND SUSTAINING CANADA'S HEALTHCARE

fulfilling a 21st century vision of universal healthcare

Interim National Healthcare Working Group Report
DRAFT

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1.0 Executive Summary

Healthcare was a top issue in 2018 provincial elections and will be a top issue in the 2019 federal election. Senior Registered Liberals identified it as such in a 2017 survey, and Liberals voted **Reclaiming and Sustaining Canada's Healthcare** a priority resolution at the 2018 Halifax convention.

Universal healthcare is central to Canadian culture and something about which we like to boast. However, despite world class professionals, Canada is no longer a world leader in healthcare. Canada's system is one of the most expensive, yet its performance is below average, and its incrementalist approach to reform is perceived as ineffective.

Canada Health Act principles include '*reasonable access to medically necessary hospital and physician services without financial or other barriers*' and access '*on uniform terms and conditions*'. There are regional disparities in how these principles are interpreted, with serious inequities, in particular for indigenous peoples. What is meant by *reasonable* and *uniform* is not well understood, in particular with respect to primary care access, and wait times for tests and procedures.

A multitude of Royal Commissions and seminal studies have addressed how to improve Canada's healthcare. Our healthcare challenges include: lack of access by many to primary care; widely varying wait times for tests and procedures, often poorly managed and longer than is safe; innovative pilot projects that aren't widely adopted; areas of continuing poor performance; costly and often inappropriate eldercare; and a focus on administration rather than on what's good for the patient.

Healthcare leadership around the world calls for a culture focused on *patient-centered* healthcare; an infrastructure for learning with continuous quality improvement; a transparency of measurable outcomes; and integration of digital health networks – all made possible by a continuity of vision and funding.

Canadians want 24/7 access and a longitudinal relationship with a primary care team; to know how long they will wait for medical tests and procedures and that those wait times will not further damage their health; and chronic and elder care close to home whenever possible.

They expect their federal government to lead and support jurisdictions in rebuilding a modern healthcare infrastructure that can meet demographic demands and work with evolving technology. They would like to share the goals, as well as a transparency of measurements towards them (based on a patient perspective, not an administrative one).

The government made an excellent start with the 2015 Health Accord and the establishment of a Seniors Ministry. However, there is more to be done, starting with a vision for quantum change that Canadians can share and follow. It's time to shine the spotlight on healthcare reform.

Incremental change does not work. Systemic and cultural change is necessary for reform to take hold and be sustained. ***Real Change, based on innovative and patient-centered models of affordable, equitable care, will create and fulfill a 21st century vision of universal healthcare***.

2.0 Introduction

Canada's middle class cares about healthcare, making it a top issue for the 2019 election.

In 2017, a majority of senior Registered Liberals (through an open ended questionnaire distributed across the country **[Appendix A]**) identified healthcare - access to family doctors; long wait times; and system innovation and cost efficiency - as their primary concern for the 2019 election.

Liberals identified the urgency of *'federal leadership for systemic reform'* via the resolution, **Reclaiming and Sustaining Canada's Healthcare [1]**, as one of their top 15 policy priorities at the 2018 Halifax Convention. They understand that Canada's healthcare infrastructure is aging, and no longer reflects today's demographic reality.

6 out of the 30 policy resolutions submitted by all provinces and territories to the 2018 Convention related to healthcare **[2]**. New services like mental health care and pharmacare were also high priorities **[3]**.

As part of LPC's renewed emphasis on continuous engagement within its policy process, the **Reclaiming and Sustaining Canada's Healthcare** resolution's original national working group continued after the 2018 Convention to write this report, and intends to engage with stakeholders across the country to refine its contents.

Working group members are volunteers with no budget, and healthcare is an extremely complex subject that has already been addressed in a multitude of national and international studies. We do not have the hubris to attempt to suggest quick or easy fixes. A plan for systemic reform will need to be guided by the experts who have already spoken out, and will take time.

Rather, the working group has taken on the perspective of users of the healthcare system, as expressed in the concerns raised in the 2017 SLC senior Registered Liberals' survey. The purpose of this report is to advocate for that point of view and to suggest policy levers that might assure a continuing voice for a *patient-centered* perspective on healthcare reform.

Escalating demands to reclaim our healthcare arise from Canadians' concerns for fairness and timeliness and worry about the healthcare impact of an aging population. The desire for improvement is understandable given the impact of an ailing system on our own well-being and that of our loved ones.

Universal healthcare is central to Canadian culture and something about which we like to boast. The federal government has recently taken positive steps by successfully negotiating Health Accord agreements with the provinces, and many excellent provincial initiatives are underway.

However, despite world class professionals, Canada is no longer a world leader in healthcare. The **2017 International Commonwealth Fund** (ICF) ranking for healthcare delivery in 11 high-income countries rates Canada ninth, close to the bottom-performing USA **[8]**. Canada's system is one of the most expensive, yet its performance is below average.

In February 2018, the Washington Post article, ***Canada's health-care system is a point of national pride. But a study shows it's at risk of becoming outdated*** **[9]**, quoted a Lancet study critical of Canada's long wait times, flagging them as a '*"lightning rod issue" that could undermine support for Medicare among Canadians.*' Also, '*The Lancet series faults Canada's incrementalist approach to health-care changes for Medicare's status as "a system in stasis."*'

What can be done about it? Peer countries with universal health programs have demonstrated that sorely needed improvements can be achieved while still keeping healthcare affordable. In Canada, the fact that healthcare delivery lies in provincial and territorial jurisdictions *does* make reform challenging.

Nevertheless, there is an urgent need for federal leadership to communicate a clear vision, and to support delivery jurisdictions in systemic (*not* incrementalist) reform to Canada's healthcare system, addressing senior Liberals' concerns about *universal primary care access*, *safe wait times*, *and better cost efficiency*; and making the system more *equitable* for all Canadians: remote, rural and urban.

Prominent healthcare journalist André Picard's Twitter hashtag *#CanadaWAITS* **[4]** regularly reports wait times horror stories, mostly from physicians. Dr. Deepa Soni **[5]** asked '*When will politicians stop living for 4 year vote cycles and start caring about what is actually good for our patients health?*'

Rob Ford's populist election platform in Ontario included a '*plan to save Ontario's health-care system, promising to cut wait times for patients, put an end to "hallway medicine" and save both jobs and money.*' **[6]** His election success points to the general awareness of the need for improvements to the system.

A July 25, 2018 email from Parti libéral du Québec informed recipients that a survey of over 3,500 Quebecois flagged healthcare (in particular '*Better access to care*') and the economy as the 2 top issues for the 2018 provincial election. Healthcare is part of their election platform **[86]**.

All these concerned individuals - in all Canadian provinces and territories - will vote in the 2019 federal election.

Federal leadership is needed

Healthcare is a key election issue
Canadian healthcare is ailing
Incremental changes aren't enough
Canadians care about healthcare

3.0 Healthcare Organization

3.1 Governing Act, Accords & Funding

The **Canada Health Act** (CHA) mandates a provincial responsibility for healthcare delivery. CHA principles include '***reasonable access*** *to medically necessary hospital and physician services without financial* ***or*** *other barriers*' and access '*on* ***uniform terms and conditions***'.

Most Canadians believe the Act *guarantees* healthcare access and equity. They expect *fair healthcare*, on a par with access to education, available to all Canadians no matter where they live. In fact, the CHA only guarantees universal access to healthcare insurance and *reasonable access* to services provided by the different jurisdictions, without discrimination regarding income, age or health status.

Reasonable access and *uniform terms and conditions* are not well defined, so that patient (and physician) expectations - of the ability to access primary care, and for wait times that '*do no harm*' – are often unmet. *Universality* in healthcare is lacking when millions of Canadians can't get past the first gate: that is, access to primary care, including to a family doctor.

Canada's healthcare system is predominately public, with 70% of healthcare funding **[Appendix D]** coming from the public-sector and the remaining 30% from the private-sector (a split that has been consistent since the turn of the millennium). Health spending in Canada was estimated at $242 billion in 2017, or approximately 11.5% of GDP **[88]**, the majority going to hospitals, drugs and physician services **[89]**. Health spending has trended upward since 1975.

Spending on healthcare varies across Canada, but on average provinces spend approximately 38% of their total budgets on healthcare. Per capita spending in 2017 for all of Canada was projected to be $6,604, with spending by province ranging from $6,321 in British Columbia to a high of $14,936 in Nunavut **[90]**.

Public healthcare in Canada is funded at both provincial and federal levels. Its financing comes mainly via personal and corporate income taxes. Alberta, British Columbia, and Ontario charge health premiums to supplement health funding. There are also significant donations from foundations and private citizens, often targeting research and capital equipment.

There have been a number of court battles regarding timely access to health care, and relating to the *right to life, liberty and security of the person* in Canada's ***Charter of Rights***. A recent Supreme Court decision '*was seen as requiring that a province had a duty to ensure that people received timely access to insured services*' **[15]**.

There are regional disparities, as Canadian geography creates a tiered system, in which healthcare differs in urban, rural and remote (populated mainly by indigenous Canadians) areas. Medical services for First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants are handled outside the provincial and territorial system. Regarding health inequities for indigenous people, a 2018 Lancet study concludes that they '*suggest a developing world within Canada's borders*.' **[9]**

In 2004, Paul Martin negotiated a 10 year **Health Accord** with provincial and territorial governments. Intended to influence spending priorities, it focused on key indicators, including a handful of wait times. This Accord expired in 2014, after which Canada had its worst performance for wait times in 2016.

In a step backwards in 2013, it was announced that *'The federal Conservative government will stop funding the council created to ensure common standards for health-care across provinces and territories – a move that critics say will fragment the national system of medicare.'* **[18]** The **Health Council** had been established, based on the recommendation of the **2002 Romanow Report** **[12]** on the sustainability of Canadian healthcare.

The Trudeau government negotiated a new 10 year Health Accord with the provinces in 2017, focused on home care, affordable prescription drugs and mental health. While beneficial, these priorities fail to address systemic shortfalls in Canadian healthcare.

3.2 The Canadian Healthcare System

'*Provinces and territories in Canada have primary responsibility for organizing and delivering health services and supervising providers. Many have established regional health authorities that plan and deliver publicly funded services locally. Generally, those authorities are responsible for the funding and delivery of hospital, community, and long-term care, as well as mental and public health services. The federal government cofinances provincial and territorial programs, which must adhere to the Canada Health Act (1985), which in turn sets standards for "medically necessary" hospital, diagnostic, and physician services. The act states that to be eligible to receive full federal cash contributions for health care, each provincial health care insurance plan needs to be: publicly administered, comprehensive in coverage, universal, portable across provinces, and accessible (for example, without user fees).*

The federal government also regulates the safety and efficacy of medical devices, pharmaceuticals, and natural health products; funds health research; administers a range of services for certain populations, including First Nations, Inuit, members of the Canadian Armed Forces, some veterans, resettled refugees and some refugee claimants, and inmates in federal penitentiaries; and administers several public health functions …

The provinces and territories administer their own universal health insurance programs, covering all provincial and territorial residents in accordance with their own residency requirements ...

Private insurance, held by about two-thirds of Canadians, covers services excluded from public reimbursement, such as vision and dental care, prescription drugs, rehabilitation services, home care, and private rooms in hospitals ...

In 2015, there were 2.28 practicing physicians per 1,000 population, about half of whom were general practitioners, or GPs (1.15 per 1,000 population), and the rest specialists (1.13 per 1,000 population) ... Most physicians are self-employed in private practices and paid fee-for-service, although there has been a movement toward group practice and alternative forms of payment, such as capitation ...

Provincial and territorial ministries of health negotiate physician fee schedules (for primary and specialist

care) with provincial and territorial medical associations ...

The majority of physicians and specialists bill provincial governments directly, although some are paid a salary by a hospital or facility.' **[91]**

3.3 Pan-Canadian Health Organizations

Canada currently has 8 pan-Canadian health organizations (PCHOs), as described in the Globe & Mail's 2018 ***Federal health agencies need dramatic overhaul, report says*** by Andre Picard **[17].** This collection of pan-Canadian organizations shows a clear (though fragmented – and toothless) attempt at central leadership to improve different aspects of the Canadian healthcare system. Dr. Danielle Martin aptly calls us '*a nation of pilot projects*' in healthcare **[14]**.

'*Between 1988 and 2007, the federal government created a number of arm's-length agencies to address various health policy issues – among them, developing a mental-health strategy, collecting national data, reviewing the effectiveness of drugs and devices … a housecleaning is needed because "many things aren't working" – to the point it is unclear if the agencies are having any appreciable impact on the health-care system.*'

'*The eight PCHOs (and their 2017-18 budgets) are:*

Canadian Centre on Substance Use and Addiction (CCSA), $8.83-million;
Canadian Agency for Drugs and Technologies in Health (CADTH), $31.1-million;
Canadian Institute for Health Information (CIHI), $109.3-million;
Canadian Foundation for Healthcare Improvement (CFHI), $19.1-million;
Canada Health Infoway (Infoway), $116.8-million;
Canadian Patient Safety Institute (CPSI), $8.6-million;
Canadian Partnership Against Cancer (CPAC), $39.9-million;
Mental Health Commission of Canada (MHCC), $19.54-million.

The external review was commissioned by federal Health Minister Ginette Petitpas Taylor in October, 2017.'

*'The **Canadian Centre on Substance Use and Addiction** was created by Parliament to provide national leadership to address substance use in Canada.'* **[19]**

The **Canadian Agency for Drugs and Technologies in Health: '***CADTH is an independent, not-for-profit organization responsible for providing health care decision-makers with objective evidence to help make informed decisions about the optimal use of health technologies'*. **[20]**

'*The **Canadian Institute for Health Information** (CIHI) is an independent, not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians.'* **[21]**

'*The **Canadian Foundation for Healthcare Improvement** is a not-for-profit organization funded by Health Canada, dedicated to accelerating healthcare improvement. CFHI plays a unique, pan-Canadian role in spreading healthcare innovations.'* **[22]**

*'**Canada Health Infoway** helps to improve the health of Canadians by working with partners to accelerate the development, adoption and effective use of digital health across Canada ... Infoway is an independent, not-for-profit organization funded by the federal government.'* **[23]**

*'Established by Health Canada in 2003, the **Canadian Patient Safety Institute** (CPSI) works with governments, health organizations, leaders, and healthcare providers to inspire extraordinary improvement in patient safety and quality.'* **[24]**

*'The **Canadian Partnership Against Cancer** is an independent organization funded by the federal government to accelerate action on cancer control for all Canadians.'* **[25]**

*'The **Mental Health Commission of Canada** (MHCC) leads the development and dissemination of innovative programs and tools to support the mental health and wellness of Canadians.'* **[26]**

In addition, Canadian Institutes of Health Research (CIHR) **[92]** is the major federal agency responsible for funding health and medical research. It aims to create new health knowledge, and to translate that knowledge from the research setting into real world applications. CIHR consists of 13 *virtual* institutes, which work together to shape a national health research agenda for Canada. The institutes bring together researchers, health professionals and policy-makers from voluntary health organizations, provincial government agencies, international research organizations and industry and patient groups from across the country with a shared interest in improving the health of Canadians.

3.4 An Overview of Healthcare Leadership Around the World

In 2018, the World Health Organization (WHO), the Organisation for Economic Co-operation and Development (OECD) and the World Bank joined efforts to produce a document – ***Delivering quality health services: A global imperative for universal health coverage.*** It reminds us that '*universal health coverage without quality of care is a job half done*', and that quality involves '*providing effective, safe and people-centered services that are timely, equitable, integrated and efficient*.' **[16]**

This is not only of concern for low and middle income countries – for example OECD '*data from high- and middle-income countries show that 19–53% of women aged 50–69 years did not receive mammography screening, and that 27–73% of older adults (age 65 years and above) did not receive influenza vaccination*.'

The report continues: '*To ensure that quality is built into the foundations of systems, governments, policy-makers, health system leaders, patients and clinicians should work together to:*

- *ensure a high-quality health workforce;*
- *ensure excellence across all health care facilities;*
- *ensure safe and effective use of medicines, devices and other technologies;*
- *ensure effective use of health information systems;*
- *develop financing mechanisms that support continuous quality improvement*.'

'*Seven categories of interventions stand out and are routinely considered by health system stakeholders,*

including providers, managers and policy-makers, when trying to improve the quality of the health care system:

- *changing clinical practice at the front line;*
- *setting standards;*
- *engaging and empowering patients, families and communities;*
- *information and education for health care workers, managers and policy-makers;*
- *use of continuous quality improvement programmes and methods;*
- *establishing performance-based incentives (financial and non-financial);*
- *legislation and regulation.*'

'*All health systems should:*

- *implement evidence-based interventions that demonstrate improvement;*
- *benchmark against similar systems that are delivering best performance;*
- *ensure that all people with chronic disease are enabled to minimize its impact on the quality of their lives;*
- *promote the culture systems and practices that will reduce harm to patients;*
- *build resilience to enable prevention, detection and response to health security threats through focused attention on quality;*
- *put in place the infrastructure for learning;*
- *provide technical assistance and knowledge management for improvement*.'

One significant global initiative is the Primary Health Care Performance Initiative (PHCPI) **[94].**, based on the understanding that '*Effective primary health care serves as the foundation for individual and community health over the lifespan. Strong primary health care makes health systems more responsive and resilient and is the foundation for universal health coverage*.'

'*PHCPI was founded by the Bill & Melinda Gates Foundation, the World Bank Group and the World Health Organization, in partnership with Ariadne Labs and Results for Development. It brings together country policymakers, health system managers, practitioners, advocates and other development partners to catalyze improvements in primary health care in low-and middle-income countries through better measurement and knowledge-sharing*.' Ariadne Labs works '*to build a common language of concepts, ideas and tools for stakeholders around the world to measure and improve primary health care*'.

Such tools and measurements will be of value to high income countries as well, since '*A key focus of PHCPI is making visible the invisible systemic faults in primary care that are responsible for poor performance*.'

So what is happening around the world in Canada's peer countries that aim for universal health coverage?

The United Kingdom

The UK National Health Service has suffered a period of austerity in recent years. Despite that, a recent **Economist** article, ***Jeremy Hunt, the great survivor: Jeremy Hunt is at last reaping the rewards***

of his long tenure as health secretary **[27]**, tells us that this health secretary presided over far-reaching reforms. He focused on *integrating* services, arguing that '*the problem today is dealing with the fact that the number of over-75s will rise by 1m in the next decade. Brief encounters are out, permanent relationships in.*'

He also tackled '*valleys of poor performance ... Inspectors have travelled the country examining hospitals, publicising their results and putting poor performers into special measures ... replacing a "culture of blame with a culture of learning"'. 'He worries that the NHS suffers from repeated periods of feast and famine*' and that '*the rules make manpower-planning difficult.*' Canada faces similar obstacles to improvement.

UK patients have been referred to hospitals in northern France for orthopedic procedures (including recent hip fractures) since the early 2,000s, and the NY Times reports that '*the N.H.S. has been quietly outsourcing some surgeries to three hospitals in France for the last year or so.*' **[30]**

There is growing concern in the UK about healthcare *rationing*, in particular for older patients. In ***NHS 'rationing leaves patients in pain'*** **[101]**, the BBC reports that '*hip and knee replacements and cataract surgery to help restore sight as well as drugs for conditions such as arthritis*' are being cut back because of '*spiralling demand and increasing financial pressures*'.

Australia

Australia is very like Canada in its clustering of urban centers (southern in Canada, coastal in Australia) with extensive rural and remote territories. Both Australia and the United Kingdom allow patients to access private (patient-funded) healthcare.

In Australia, according to ***Reimagining health reform in Australia: Taking a systems approach to health and wellness*** **[28]**: '*states and territories have downsized their centralised health bureaucracies and devolved funding, planning and delivery responsibilities to the local level. The current Federal Government has established a Mental Health Commission, recently announced a "Healthy Medicare" package aimed at reforming care for chronically ill patients, as well as setting up the new Australian Digital Health Agency.*'

The authors of this report emphasize that the challenges of an '*aging population, sedentary lifestyles and an escalating chronic disease burden*', will increase demands on the system and urgently require a new approach.

They recommend systemic reform (not '*tinkering around the edges*') involving 5 policy levers: consumer empowerment and more patient-centered care; an emphasis on prevention; integrated funding and management; integrated care settings with multi-disciplinary teams; and digital health networks.

They tell us that the '*reform journey is often politically perilous*' and '*takes time, typically beyond one election cycle*', statements that apply equally to Canada. They warn how '*ideas designed to reduce costs often run the risk of simply shifting costs*' or resulting in unintended consequences.

They advise that ensuring the *right care, at the right place, at the right time* '*may require investment in increased capacity in some care setting types, for example, sub-acute and home care, and disinvestment in other care setting types, for example, acute public hospital care*', and speak of the need '*to shift from a 20th century hospital-centric system designed to treat acute and infectious disease to one equipped to deal with new challenges of chronic disease and pandemics*.'

Their vision is that '*Australia's health sector can serve as a model for other countries and contribute to economic growth as an export market*.'

The European Union

The EU's challenges in dealing with its 15 member states bear similarities to our federal government's relationships with provinces and territories, in that the EU also provides central leadership and attaches conditions to funds transfer.

From ***Health Care Systems in the EU: A Comparative Study*** (prepared by the European Parliament, Directorate General for Research **[32]**, we learn that in the 1991 Maastricht Treaty *'Joint action with the Member States was identified for health promotion and health protection, the subsidising of medical and health policy research, and the establishment of international information systems.*'

'*In a number of European countries, for example the UK, there is increasing concern about inequality (uneven share) and inequity (unfairness) in health because recent observations have shown that differences in health status (as measured by life expectancy, mortality and morbidity) are increasing between different social classes, generally discriminating against the disadvantaged*.'

'*Observation over time suggests that the health status of the resident population of the EU has improved substantially. This has resulted in aging populations, and has in effect increased the demand for health care. At the same time, with people living longer, patterns of disease have shifted from acute to chronic conditions. These, however are to a large extent avoidable and thus suggest orientation towards more preventive care*.'

'*Innovation in health care technology over time has led to great advances in the prevention, treatment, and cure of diseases and has contributed to increased length and quality of life. Technology innovation for health care promotes the industrial sector and has a tremendous potential to reduce costs. However, health care technology resources are not always deployed in an optimal fashion: wasteful provision and utilisation by those who provide and utilise health care technology is often attributed to a lack of cost-consciousness.*'

'*Priority for social stability will be to secure adequate care of the elderly, in providing a balance of home based, community based and hospital based services. In addition, aging populations imply alterations of disease towards chronic conditions. Thus, increased focus will have to be on those diseases which are readily preventable – with or without medical care. Preventive care potentially offers a cost-effective alternative to high-cost technology medical care*.'

'*Measures are increasingly focused on reshaping health care systems towards measurable outcomes such as quality of health and a high degree of satisfaction among the population served.* '

The United States

The Patient Protection and Affordable Care Act, often shortened to the Affordable Care Act (ACA) or nicknamed *Obamacare* was signed into law in 2010 **[93]. I**t represents the U.S. healthcare system's most significant regulatory overhaul and expansion of coverage since the passage of Medicare and Medicaid in 1965.

The ACA's major provisions came into force in 2014. By 2016, the uninsured share of the population had roughly halved, with estimates ranging from 20–24 million additional people covered during 2016. The increased coverage was due, roughly equally, to an expansion of Medicaid eligibility and to major changes to individual insurance markets. Note that the provision making it mandatory to workers to enroll in Obamacare or face sanctions was recently removed by the Trump Administration.

Though the United States does not have universal healthcare and is an outlier in international peer country comparisons (with higher cost and poorer outcomes), there is still a great deal to learn from them, in particular with respect to innovation and efforts to improve cost efficiency.

Dr. Atul Gawande, surgeon, writer, and acclaimed public health leader, is also CEO of healthcare non-profit **Ariadne Labs**, '*formed by Amazon, Berkshire Hathaway, and JPMorgan Chase to deliver better outcomes, satisfaction, and cost efficiency in care*.' **[34]**

Their successes include a *WHO safe surgery checklist*, used around the world, and they have an ongoing research effort on primary care:

'*Effective primary health care serves as the foundation for individual and community health over the lifespan. Strong primary health care makes health systems more responsive and resilient and is the foundation for universal health coverage.*

At Ariadne Labs, we are building the field of primary care research in order to develop strategies to improve systems around the world. We aim to strengthen the five key functions of primary health care:

- *Serve as the first point of contact for individuals and families when they need care*
- *Provide continuity in care built on a long-term relationship between a patient and a clinician who knows you over your lifetime and understands your needs*
- *Address a comprehensive range of needs, from prenatal care to childhood vaccines to chronic disease management, and treat the whole person, not just a condition.*
- *Coordinate patient care with other specialists or health care providers*
- *Is patient-centered and holistic, building trusting, healing relationships through strong communication.*'

3.5 The Canadian Federal Role

The federal government has a mandate and a leadership responsibility to address across-the-

board deficiencies in the healthcare system and to work with all stakeholders on a framework for systemic reform in order to reclaim national healthcare excellence.

The external review of Canadian PCHOs, commissioned by the federal Health Minister in October, 2017 **[31]**, offered 4 scenarios for change:

'*1.* ***Efficiency****: The creation of an agency to be called Health Quality Canada to promote system-wide improvement in the delivery of health services; it would integrate CPSI, CPAC and CFHI. CIHI, CADTH and Infoway would maintain similar functions. This is essentially the status quo, with some minor changes.*

2. ***Innovation****: Create the Health Innovation Agency of Canada to support the scaling up and adoption of existing innovations; it would absorb CFHI and CPSI. Also create Connected Data Canada to expand on data collection and use; it would be merger of Infoway and CIHI. CADTH would maintain a similar function. (This scenario is similar to one proposed in the 2015 Naylor report on innovation.)*

3. ***Engagement****: Create the Canadian Networks of Health, which would absorb the functions of many of the agencies – but centralized, instead of in rigid, Ottawa-based organizations. This scenario would also include Connected Data Canada and a Canadian Drug Agency, a bolstered version of CADTH.*

4. ***Equity****: Create a Canadian Council for Health Equity, which would focus on modernizing the medicare basket of services (notably by including psychological services) and help provinces and territories determine what is covered by public insurance plans. This, too, would include Connected Data Canada and a Canadian Drug Agency.*

All the scenarios underscore that big data, digital health and prescription drugs (and likely pharmacare) will play an ever-growing role in health care.'

The review also recommends '*a fundamental revamp to eliminate duplication and address yawning policy gaps*' as well as '*more federal-provincial-territorial collaboration and networking and less centralization in Ottawa*.'

3.6 Summary

Healthcare leadership challenges in high-income countries share common threads, in particular the need for:

- a continuity of vision and funding
- an infrastructure for learning, continuous quality improvement
- patient-centered, engaging patients and communities
- transparency of measurable outcomes
- integration of digital health networks, conforming to international standards
- health workforce planning for well placed multi-disciplinary primary care

- fostering of long-term care relationships
- performance-based incentives, interventions for poor performance
- focus on effective primary care and preventive care
- priority on eldercare aimed at effective chronic care
- treat the whole person, not just a condition

Worldwide, systemic reform is politically perilous. To succeed, it needs to follow a long term vision, unhampered by feast and famine cycles of funding. This implies a degree of independence from changing cycles of government.

One possibility for continuity of vision in Canada might be an independent oversight body akin to the Canadian Radio-television and Telecommunications Commission (CRTC), to require that standards of medical care are well understood by Canadians; are met; and fulfill the intent of the Canada Health Act.

Just as the '*CRTC is an administrative tribunal that regulates and supervises broadcasting and telecommunications in the public interest*' **[32]**, a healthcare tribunal might regulate and supervise all aspects of healthcare in the public interest, ensuring that Canadians have access to a world-class healthcare system that promotes innovation and improves their health. This – or any approach that achieves the same objectives - would prevent the badly needed long term healthcare reform focus from being disrupted by changes in government. It is also something that the general public can understand will take time to effect real change.

Clear goals (via setting of standards) are essential, as is an effective system (including patient-derived measurements) of tracking progress towards these goals. Any PCHO structure should also incorporate health workforce planning and the capacity to react to unintended consequences of change, as well as to exploit opportunities for national economic growth.

CHA '***reasonable access***' & '***uniform terms and conditions***' need:

Integrated, standardized digital health networks

A culture centered on patient-centered care
Vision, leadership & funding that survives election cycles
Accountability via measurements & patient surveys
Health workforce planning for care teams

4.0 Canadian Commission Reports & Seminal Studies

There have been a multitude of research projects, Royal Commissions, and books addressing how to improve Canada's healthcare system. What is required is the '*political will to learn from others and put into place a system that works*.' **[10]** The following are extracts from some of the most significant works, from 2001 to 2018. Note how relevant even the earliest of these analyses and their recommendations still are today.

4.1 2001 Kirby Senate Report

The 2001 Senate ***Final Report on The Health of Canadians – The Federal Role*** **[11]** addressed '*The Need for Stability in Federal Funding*', and noted that '*no discretionary penalty for failure to comply with the five national principles of the Act has ever been applied, despite some complaints regarding portability, comprehensiveness and accessibility*'.

It also stated (referring to wait times) that '*The status quo is simply unacceptable*.' The report called for a **Health Care Guarantee**, by which '*For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public. When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country*'.

Also in this report, Dr. Robert McMurtry stressed that '*the fundamental founding principles of the Medical Care Act of 1966 as originally pronounced are still real. What is missing, however, is* ***a unifying vision of the future****. That is something that I feel is imperative if we are to move forward with any effect.*'

4.2 2002 Romanow Report

The 2002 Romanow Report, ***Building on Values: The Future of Health Care in Canada*** **[12]** advised the government to '*Take deliberate steps to measure the quality and performance of Canada's healthcare system and report regularly to Canadians*.' It warned that '*we don't have enough health care workers, or in some cases we don't have them in the right places — to meet the needs of the country*.'

University of Ottawa webpages on **Society, the Individual, and Medicine [29]** summarize 3 themes underlying the report's 47 recommendations:

- *'Strong leadership and improved governance is needed to keep Medicare a national asset.*
- *The system needs to become more responsive and efficient as well as more accountable to Canadians.*
- *We need to make strategic investments over the short term to address priority concerns, as well as over the long term to place the system on a more sustainable footing.*'

The Romanow Report recommended that a *Health Council* of Canada should:

'• *Establish common indicators and measure the performance of the health care system;*

• *Establish benchmarks, collect information and report publicly on efforts to improve quality, access and outcomes in the health care system;*
• *Coordinate existing activities in health technology assessment and conduct independent evaluations of technologies, including their impact on rural and remote delivery and the patterns of practice for various health care providers.*

In the longer term, the Health Council of Canada should provide ongoing advice and coordination in transforming primary health care, developing national strategies for Canada's health workforce, and resolving disputes under a modernized Canada Health Act' , and *'should systematically collect, analyze and regularly report on relevant and necessary information about the Canadian health workforce, including critical issues related to the recruitment, distribution, and remuneration of health care providers.*

The Canada Health Act should be modernized and strengthened by:

• *Confirming the principles of public administration, universality and accessibility, updating the principles of portability and comprehensiveness, and establishing a new principle of accountability;*
• *Expanding insured health services beyond hospital and physician services to immediately include targeted home care services followed by prescription drugs in the longer term;*
• *Clarifying coverage in terms of diagnostic services;*
• *Including an effective dispute resolution process;*
• *Establishing a dedicated health transfer directly connected to the principles and conditions of the Canada Health Act.*
• *Home care services for post-acute patients, including coverage for medication management and rehabilitation services, should be included under the Canada Health Act.*
• *Palliative home care services to support people in their last six months of life should also be included under the Canada Health Act.'*

The Report recommended continuing work on a personal electronic health record for each Canadian, promotion of health literacy, and targeted funding, including for '*a new Rural and Remote Access Fund*'.

Regarding wait times it recommended that '*Provincial and territorial governments should take immediate action to manage wait lists more effectively by implementing centralized approaches, setting standardized criteria, and* ***providing clear information to patients*** *on how long they can expect to wait*.'

4.3 2015 Naylor Report

The federal government mandated the Naylor Panel to identify areas in which government could play a role in enhancing healthcare without adding new funds. The resulting 2015 report, ***Unleashing Innovation: Excellent Healthcare for Canada*** **[13]**, cautioned that: '*absent federal action and investment, and absent political resolve on the part of provinces and territories, the Canadian healthcare system is headed for a continued slow decline in performance relative to peers.'*

Its recommendations include:

- fundamental changes in incentives, culture, accountability
- integration of services
- moving away from fee-for-service
- providing secure electronic health records for safe and seamless care
- organizing around patients' needs
- managing hospital use efficiently
- better value from drug procurement, regulation and reimbursement
- tapping the potential of digital health and precision medicine
- scaling up existing innovations
- nurturing a domestic healthcare industry
- leading technological and social innovation in healthcare

It recommends a **Healthcare Innovation Fund** whose '*broad objectives would be to effect sustainable and systemic changes in the delivery of health services to Canadians. Its general goals would be to: support high-impact initiatives proposed by governments and stakeholders; break down structural barriers to change; and accelerate the spread and scale-up of promising innovations*.'

'*The Panel has also identified an acute need for developing and implementing information tools for patients in two distinct areas. The first is the promotion of* ***health and healthcare literacy****. The second is the scaling-up of best practices in the use of* ***patient portals****, ensuring that patients effectively co-own their health records. Patient engagement and co-ownership of health records would be further facilitated through* ***mobile and digital health solutions*** *that enable virtual care and empower patients, while meeting common standards and interoperability requirements.*'

The report notes that '*Healthcare has become both a social program and an economic asset*', suggesting that '*With Canada's huge landmass and thin population density, as well as our longstanding commitment to telehealth, Canada should lead the world in mobile health and virtual care*.'

4.4 2017 *Better Now: Six Big Ideas To Improve Healthcare for All Canadians*

Roy Romanow, former Royal Commissioner on the ***Future of Health Care in Canada***, says of this book, '*Dr. Danielle Martin has written an outstandingly useful book, for all Canadians, as the nation once again faces the challenges of ensuring effective health care for all. In doing so, Dr. Martin avoids the easy formulae of blanket solutions and properly roots health care's future success in making hard choices on delivery, scope, and structure, based on Canadian values.*'

Dr. Martin warns us, in ***Better Now*** **[14]** that primary care access is the *Achilles heel* of our healthcare system. She emphasizes the importance of relationship based primary care for every Canadian, and the high cost when it is lacking. She warns of the use of too many costly tests and treatments that don't improve health, and in some cases damage it.

Too many healthcare *silos* don't communicate with each other, increasing costs (in particular by causing chronic care patients to cycle in and out of ER's) and reducing quality of treatments. Martin emphasizes the importance of collecting and using data to improve performance, and of information technology to connect healthcare silos.

Danielle Martin's *6 big ideas* are:

1. *Ensure every Canadian has regular access to a family doctor or other primary care provider.*
2. *Bring prescription drugs under medicare.*
3. *Reduce unnecessary tests and interventions.*
4. *Reorganize health care delivery to reduce wait times and improve quality.*
5. *Implement a basic income guarantee to alleviate poverty, which is a major threat to health.*
6. *Scale up successful local innovations to a national level.*

4.5 2017 *Treating Health Care*

In ***Treating Health Care: How the Canadian System Works and How It Could Work Better*** **[15]**, Professor Raisa Deber of the University of Toronto Institute of Health Policy, Management and Evaluation, speaks of Canadians' pride in their health care and '*considerable discomfort when international rankings place Canadian health care in the middle, or even near the bottom, of the pack. We still look very good compared with the United States, but so does everyone else*.'

She addresses a call for reform, based on '*costs, access and quality*'. Her book gives an informative overview of policy in general and health policy in particular; what effects it; and the factors involved in making sound decisions, and trade-offs, making very clear the complexity of the subject, and the trade-offs and ethical considerations involved.

Deber tells us that since 1984, 2 pieces of legislation define federal-provincial arrangements for health care. '*One (currently the CHT) sets out how much money provincial and territorial governments will receive in federal transfers, and the other (the CHA) specifies what, if any, conditions need to be met to receive the money*.' The CHA specifies that if a provincial health plan doesn't meet its criteria, cash transfers can be reduced or withheld.

Deber mentions a number of court battles regarding timely access to health care, and relating to '*the right to life, liberty and security of the person*' in Canada's Charter of Rights; and a Supreme Court decision that '*was seen as requiring that a province had a duty to ensure that people received timely access to insured services*'.

Regarding primary care access, '*Statistics Canada estimated that in 2014, 14.9% of Canadians over age 12 did not have a regular family doctor*' (though half had not looked for one). Also, *timely* primary care '*access can still be a problem, even for people with a regular doctor*' and this has not improved since 2004. These people tend to go to an emergency department for care, which is '*expensive, unpleasant and inefficient*'.

Deber suggests that key targets for policy change to improve healthcare in Canada are '*equity, access to care (including wait times), quality and patient safety, accountability, and cost control*' and describes isolated innovations that have helped with timely connection to primary care.

We are told that the former Health Council of Canada *'called for placing more emphasis on pan-Canadian collaboration ... It viewed* ***leadership, at all levels, as the key lever*** *and noted the difficulty in maintaining policy directions when governments changed'* - ironically, the Council's own funding was

not renewed when governments changed. The author concludes that Canadian '*health care is not terminally ill, but there is clearly room for improvement. However, some treatment suggestions are likely to make things worse*.'

4.6 2018 *Fit for Purpose* Report

The report ***Fit for Purpose: Findings and Recommendations of the External Review of the Pan-Canadian Health Organizations*** (by Dr. Pierre-Gerlier Forest and Dr. Danielle Martin) was commissioned by federal Health Minister Ginette Petitpas Taylor in October, 2017 **[31]**.

It emphasizes the importance of a shared national vision for healthcare and tells us that '*there is a pressing need for the PCHOs to help citizens, providers, administrators, and policy makers address the vulnerabilities of today's health systems. These vulnerabilities include issues related to fragmented and inadequate pharmaceutical policy; the need for robust health data governance and digital infrastructure; the desire to scale-up successful health innovations; the need to modernize the basket of publicly funded services to promote equity; the critical importance of strong primary care systems across the country; the need for more meaningful patient and public engagement in health care; and the imperative of working in partnership with Indigenous organizations and communities to improve Indigenous health outcomes.*

But beyond the vulnerabilities of today, a successful PCHO suite must be designed to support the emergence of health systems of the future across Canada' and '***No matter what the future composition of the suite, meaningful metrics to drive organizational performance and independent evaluations of individual and collective PCHO impact are needed ...*** *Responding meaningfully to the legitimate concerns of Canadians demanding responsive, efficient, and high quality health systems should be an overt objective, and progress towards this goal must be measured for all PCHOs.*'

This report emphasizes that '*The Government of Canada should adopt a long-term vision for the future of Canadian health care and articulate the role it intends to play in pursuing that future*', and suggests that '*In addition to the roles it plays currently, including as a partner to the provinces and territories, a more active, more engaged, more intentional federal government may have the ability to use more direct instruments in health care, based on solid constitutional grounds, should the government choose to do so*.'

2001 Kirby:	'*Health Care Guarantee*'
2002 Romanow:	'*not enough healthcare workers*'
2015 Naylor:	'*healthcare in crisis*'
2017 senior RL's:	'*leadership for systemic reform*'
2017 Martin:	'*primary care access the Achilles heel of healthcare*'
2017 Deber:	'*call to reform costs, access and quality*'
2018 *Fit for Purpose*:	'*a shared national vision, meaningful metrics*'

5.0 The Challenges

5.1 Supply of Family Physicians & Medical Specialists

Family physician Danielle Martin, author of ***Better Now*** **[14]**, deems primary care access the '*Achilles heel*' of Canadian healthcare. She emphasizes, 'there is a cost to the system when this relationship-based primary care is missing.' Ariadne Labs tell us that '*High performing primary care systems are characterized by accessibility, continuity, coordination and comprehensiveness of care*.' **[94]**

A *high performing* health care system is defined in a **Primary Health Care Performance Initiative** fact sheet **[95]** as:

Those who can't easily access primary care either ignore a medical problem until it develops to need more costly care; pay for private care (mainly in cities where this is accessible); or wait in overburdened emergency departments (EDs). Of course, this results in longer and longer waits for everyone, with patients parked in hallways – and contributes to higher costs.

Statscan, in 2014, reported that 14.9% of Canadians aged 12 and older, roughly 4.5 million people, did not have a regular doctor. Statistics compiled by the Canadian Institute for Health Information (CIHI) **[21]** point to significant regional differences.

The percentage without a regular doctor is somewhat less dire in: Newfoundland and Labrador (10.1%), Prince Edward Island (9.5%), Nova Scotia (10.6%), New Brunswick (6.1%) and Ontario (7.5%). On the other hand, Quebec (25.5%), Saskatchewan (20.1%), Alberta (19.9%), Yukon (26.1%), Northwest Territories (57.7%) and Nunavut (82.5%) report much higher numbers of patients without a primary care physician. Manitoba and British Columbia report the national average of about 15%.

The reasons cited for lack of regular access to a family physician included:

i) not looked for one (45.9%)
ii) doctors in their area were not taking new patients (21.5%)
iii) doctor had retired or left the area (20.2%)
iv) no doctors were available in their area (14.4%)
v) no specific reasons given (13.1%)

(*Note: numbers exceed 100% as some respondents gave more than one answer.)*

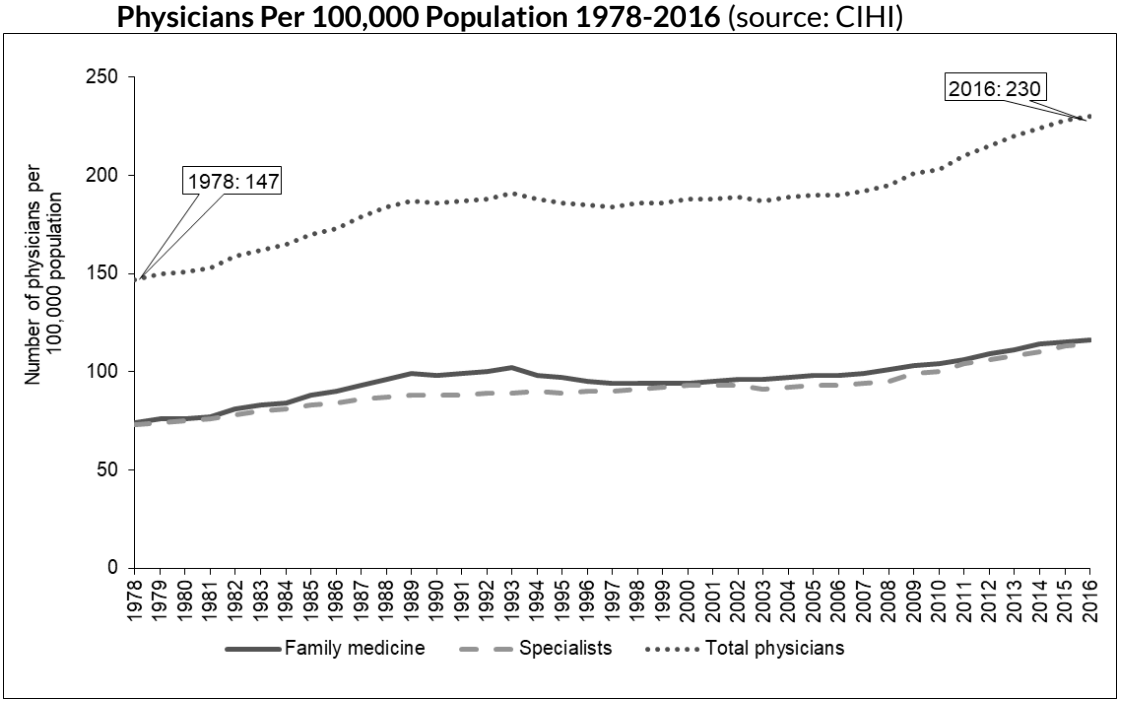
From this data, one might conclude that the solution to patients' lack of access lies in recruiting or graduating more family physicians. However, it's not that simple.

In Canada, the *average* number of physicians (family doctors, specialists, administrators, researchers and academics) per 100,000 population reached its highest level in 2016. In 2001, there was a total of 188 physicians per 100,000 population. In 2016, that ratio increased to 230 per 100,000. This is consistent with an international upward trend in peer, high income countries.

So, how do we compare internationally? According to the 2017 International Commonwealth Fund (ICF) report **[46]**, the number of practicing physicians per 1,000 population ranged from 2.5 in Canada to 4.1 in Germany (which also has the highest population over 65). The US number was 2.6, the UK 2.8, France 3.1 and Australia 3.5.

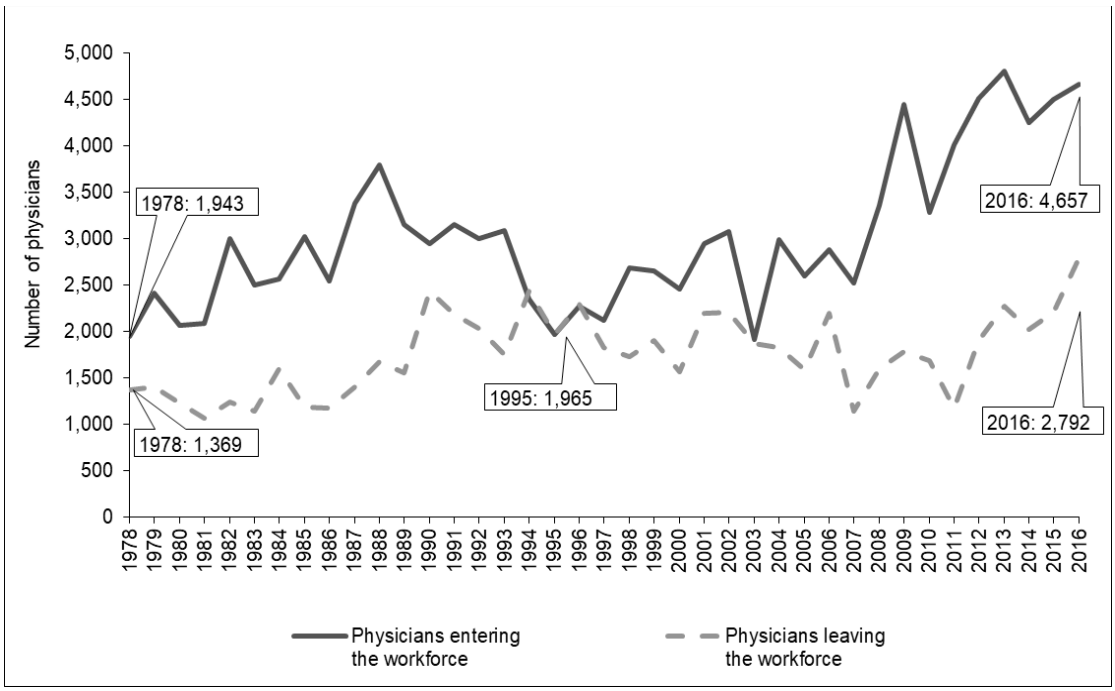
These figures are somewhat misleading as most countries look at '*doctors providing direct care to patients*', while Canada tracks '*professionally active*' doctors, '*including doctors working in the health sector as managers, educators, researchers, etc. (adding another 5-10% of doctors).*' **[47]**.

Physicians Per 100,000 Population 1978-2016 (source: CIHI)



In the last decade, the number of physicians entering the workplace has increased at a much higher rate relative to those leaving the workforce.

Physicians Entering & Leaving the Workforce (source: CIHI)



Who is Entering? Workforce Demographics

The numbers look fairly good, though we're still on the low end of international comparisons. If overall supply is not the problem, what is happening?

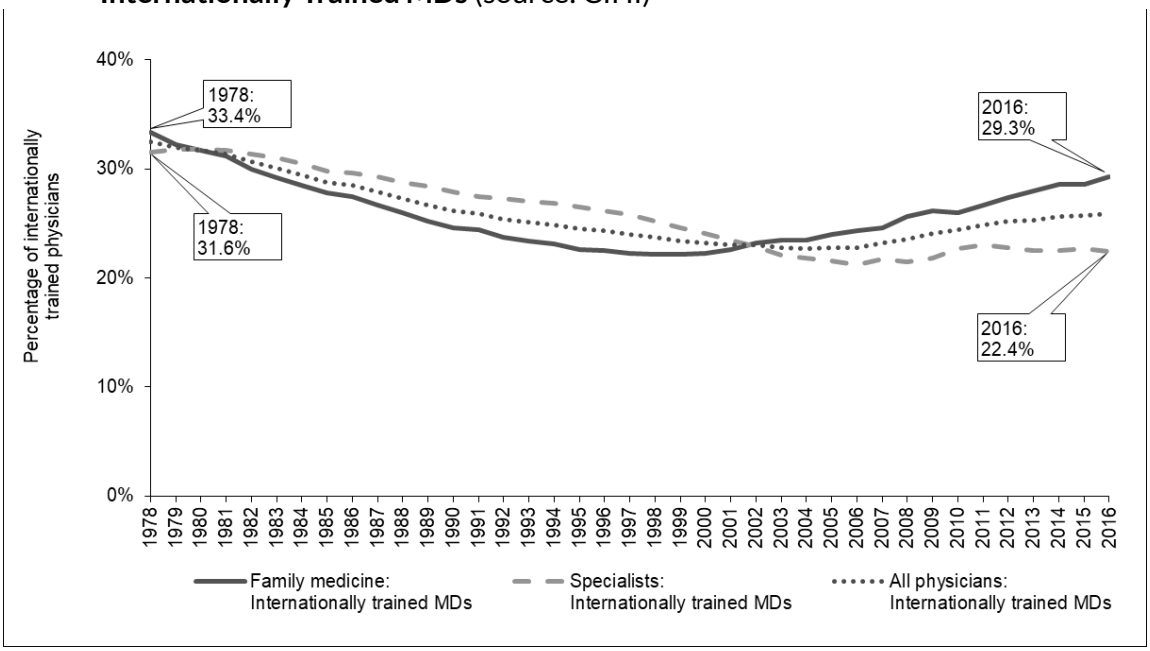
First of all, these numbers reflect *averages* across urban, rural and remote areas of Canada. We already know, from the CIHI report of regional differences, that access is significantly better in Ontario than Saskatchewan, while both have much better access than Nunavut. Some areas have well over 5 doctors per 1,000 population, while others have well under 1 per 1,000. So we cannot simply look at how many physicians the country has, but must also consider how many actually provide direct care to patients, as well as where they choose to live and work.

The physician workforce has a different profile from the 1950's *Dr. Marcus Welby*, the kindly, greying man who made home visits. It is now heavily populated by young professionals who often opt to work in team clinics to allow for work hour flexibility and more time with family.

Between 2012 and 2016, the number of female physicians increased by 21.4%, while the number of male physicians increased by 6.1%. In 2016, 40.6% of physicians were women, compared with 37.4% in 2012. The proportion was higher among family physicians (45.3%) and younger physicians (54.0% of those younger than age 40). Women also accounted for 35.9% of specialists. In 2016, 54.0% of Canada's physicians, younger than 40, were women. The rate was highest in Quebec, at 64.1% of younger physicians, and lowest in Manitoba, at 46.7% (source: CIHI).

The most frequently cited solution, next to '*we need to graduate more doctors*', is to attract as immigrants, and/or accredit, more international doctors.

Internationally Trained MDs (source: CIHI)



Reliance on foreign doctors in 2016 at 29.3% of all family physicians, almost matches Canada's previous high of 33.4% in 1978. With many qualified Canadian medical school *hopefuls* unable to secure spots in our universities; resolving staffing issues through more foreign recruitment should only be a stopgap measure.

However, difficulties in Canadian accreditation - both for Canadian physicians who attend medical school overseas and for foreign doctors - should be reassessed. There should also be an adequate number of residency positions made available, in those specialties where physicians are most needed, and especially in Family Practice. Long-term planning for future physician numbers needs careful calculation at the federal level, and means need to be found to encourage placements in the many areas of the country with a shortage of physicians.

Systemic Issues

With supply reaching the highest levels ever, and foreign recruitment almost reaching previous highs – why is it that on average 15% of Canadians still do not have access to a family physician and wait times to see specialists exceed international standards?

1. *Compensation*

Fee for Service has been the traditional payment method across the country. Based on a nominal fee of, on average $30.00 per visit, the doctor must extract overhead for office staff, rental space and equipment. Most physicians graduate with debt loads of upwards to ¼ million dollars after 10-11 years post-secondary education. Long hours and a large patient file are necessary to earn the,

on average, $300,000 income needed to pay this back.

2. *Hospitalists*

Merriam-Webster defines a *hospitalist* as '*a physician who specializes in treating hospitalized patients of other physicians in order to minimize the number of hospital visits by other physicians*'.

Many family physicians are finding solutions to adequate compensation by taking positions as *hospitalists*, or by being hired in Medi-Centres; both of which offer fixed hours, a salary and benefits. These types of position are mainly available in urban areas.

Dr. Richard Gunderman tells us in ***Hospitalists and the Decline of Comprehensive Care*** **[45]**, that '*increasing reliance on hospitalists entails a number of risks and costs for everyone involved in the health care system — most critically, for the patients that system is meant to serve. As the number of physicians caring for a patient increases, the depth of the relationship between patient and physician tends to diminish — a phenomenon of particular concern to those who regard the patient–physician relationship as the core of good medical care. Practically speaking, increasing the number of physicians involved in a patient's care creates opportunities for miscommunication and discoordination, particularly at admission and discharge.*'

The challenge for quality care in this trend lies in the disconnect from the long-term relationship care provided by a family physician who would oversee the patient through hospital or chronic care interventions. The ensuing silos of communication portend poor outcomes, a threat to patient health, and greater costs to the system, as ***Better Now*** **[14]** warns.

3. *Gender Demographics*

With over 54% of Canadian physicians under 40 being women; and with women making up 45% of family physicians; we see a shift to shorter hours and part-time work to accommodate lifestyle and family demands. This is often achieved by setting up team clinics where patients share the doctors within the clinic. A desire for lifestyle balance is shared by all modern physicians, not only women.

4. *Unemployment*

Despite long wait times to see specialists, an inordinate number of recent graduate physician specialists are unemployed. The Royal College's 2011 and 2012 employment surveys reveal issues extending across multiple medical specialties. Among new specialists and sub specialists who responded; 208 (16%) reported being unable to secure employment, compared to 7.1% of all Canadians as of August 2013 **[82].**

5. *Location*

Across the country, under-served areas attempt to attract healthcare professionals in a variety of ways. Approaches include modernizing diagnostic equipment to provide better tools; signing bonuses; salary premiums; free housing; and training locals, who already have roots n the area. It might be worth surveying what has already been tried (successes and failures) and publicizing that information, so that different locales can assess what might work for them.

Solutions

What seems like a straightforward issue of physician shortages is clearly more complicated than simple supply and demand. The issue needs to be examined in the context of the evidence and a long-term vision to address patient access to quality care across the country.

As journalist Andre Picard wrote in a 2018 article, ***Is every medical school graduate entitled to become a doctor?*** [43], '*We have more doctors, in absolute numbers and per capita, than ever before. But we have a growing problem of maldistribution. Everyone wants to be a specialist and everyone wants to practice in a big city – largely because our pay scales tell us that is what is valued ... We don't need more doctors, we need more general practitioners, especially in rural and remote areas.*' For many in such areas, lack of access to a family doctor or a clinic has become the norm [44].

As explained in ***Why young doctors aren't taking over from retiring physicians*** [42], it is not likely we will turn back the clock to days where family physicians were willing to forego family responsibilities, working 80-100 hours a week. Solutions need to examine the fee-for-service model, gender realities, 21st century lifestyles, role responsibilities, places where the need is greatest, and applications of technology. Young doctors in training need to be asked what would encourage them to enter family practice outside of urban centres – relocation and/or tax incentives, assistance with student debt, free housing, a locum for respite … ?

Systemic reforms will extend the reach of individual physicians, with the aid of other health professionals such as nurse practitioners, to manage the care of a greater number of patients. The only way to do that is to make physicians more care managers than the primary contact in the delivery of day-to-day medicine (as has been recommended since the turn of the millennium). This, and exploitation of technology advances in digital information networking and telemedicine, could make the system more efficient, and improve the availability and quality of care - ***if done right***.

The danger to be avoided at all costs is that the necessarily soft evidence of patient satisfaction and quality of care provided in a longitudinal relationship with a family physician might gradually succumb to expected fiscal, and managerial oversight of cost efficiency in team-care. ***The patient must always come first.***

In addition, it is not enough to look at averages regarding access to primary care, wait times etc.. Full measurement ranges need to be assessed and, as was done in the UK, *valleys of poor performance* must be specifically targeted for improvement. Canada should also track: physicians providing direct care to patients, as peer countries do (rather than inflating the number with academics and administrators); the number working in communities versus as hospitalists in acute care facilities; and the number of actual physician hours spent on patient care (given the trend to reduced work weeks and shared practices). Measurements must assess how the healthcare system ***performs for the patient***, rather than for the administrator.

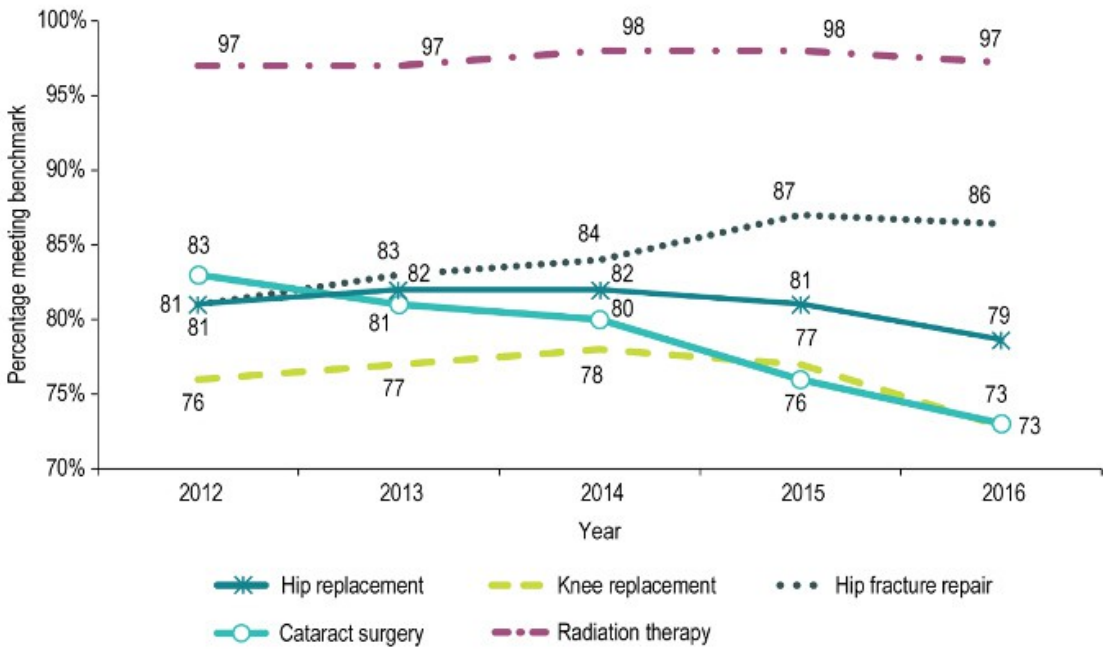
5.2 Need for National Standards

The CHA calls for '*reasonable access*' and '*uniform terms and conditions*' for healthcare delivery. Yet, what is *reasonable*? Who defines it? Where is any accountability? Conditions are by no means

uniform, when Canadians across the country have flagged wide discrepancies as to what kind of access they have to healthcare.

Wait times were the longest ever recorded in 2016, with considerable variation between provinces. The average wait time was 9.4 weeks from family physician to a specialist; an additional 10.6 weeks to treatment; a total of 20 weeks. Wait times for MRIs and CT scans have increased since 2012, again with provincial variations. Long delays in accessing physicians, procedures, and specialists are often side-stepped by overuse of emergency departments. (CIHI)

Generally, 3 out of 4 patients have their *priority medical procedures* done within *benchmark* wait times (*on those procedures tracked by CIHI*), but this varies greatly by jurisdiction. When looking at the trends over time, wait times for hip fracture repair are improving and radiation therapy remains consistently within benchmark time frames, while patients are waiting longer for cataract surgery (CIHI). Since reaching a high performance in 2014, wait times for hip and knee replacements have fallen to their longest ever recorded in 2016.



Is this *reasonable*? We don't really know. What we do know is that multiple-year waits for access to primary care, and waits for tests and procedures that add unnecessary costs to the system and endanger health, are *unreasonable*, as emphasized by respondents to the SLC national questionnaire.

Benchmarks are defined in the CIHI Report, **Wait Times for Priority Procedures in Canada, 2017 [73]** as '*evidence-based goals each province or territory will strive to meet, while balancing other priorities aimed at providing quality care to Canadians. Benchmarks express the amount of time that clinical evidence shows is appropriate to wait for a particular procedure.*'

The **Canada Wait Time Alliance**, a non-profit organization formed by doctors in 2004 (the year the federal government committed to seeing wait times reduced through its 10 year Health Care

Accords with the provinces), began tracking performance and defined benchmarks as '*the maximum amounts of time that a patient should wait for specific treatments, tests, or procedures; beyond that, evidence shows that waiting will likely have adverse effects on a patient's health*.' **[74]**

'*You can think of benchmarks as performance goals for Canada's health care system - if our system is running well, Canadians should be treated within the time indicated. It should also be kept in mind that in many other countries, patients are seen or treated well before these benchmarks, which are intended to show the absolute longest one should wait*'

In ***Wait Times — a medical liability perspective*** **[49]**, the Canadian Medical Protective Association (CMPA) warns that '*the current lack of clarity as to "who is responsible for what" creates potential risk for governments, health-care institutions, physicians, other health-care professionals and, most importantly, for patients.* ***A situation in which everyone is accountable often means, in reality, no one is.*** *The Canadian Medical Protective Association (CMPA) believes an environment in which health-care accountabilities and liabilities are poorly defined is not in the best interest of Canadians*.'

In 2017 the non-profit **Health Standards Organization** (HSO) **[75]** was formed, situated in Ottawa, following consultation with over 700 stakeholders across Canada and around the world. HSO builds world-class standards and innovative assessment programs, new technologies and activation services for accreditation bodies, governments, associations and others. One of their key goals is that '*Patients (and their families), practitioners and policy-makers all play critical roles in achieving quality health services for all; people must be at the center of everything we do*'.

Accreditation Canada (AC) **[76]** is an affiliate of HSO, also committed to delivering objective, credible and outcome assessment programs using the best standards available, and empowering providers to focus on what matters to them in their local context.

HSO and Accreditation Canada are focused on the people that power health systems around the world: patients, providers and policy-makers. '*We strongly believe that our person-centered approach to the design of products, standards and assessments will make a real difference in improving quality and health outcomes*.'

There are multiple agencies concerned with issues of standards for healthcare, operating without any authority for compliance. Is there value in setting performance standards without the teeth to make them happen?

Consider the 2004 Health Accord agreements with performance standards for interventions, such as wait times for hip and knee replacements. The 10 year agreements that extended to 2014 were not renegotiated by the Conservative government in power, and it is apparent, from current data collected by CIHI, that these procedures, when they no longer had a carrot attached, reached their worst level of performance ever recorded, just 2 short years later.

In contrast, in 2013, National Health Services in the UK launched a comprehensive restructuring as their response to concerns about system-wide failures that caused unnecessary suffering and premature death of patients. According to ***Toward a Healthcare Strategy for Canadians*** **[77]**, reform went beyond setting numbers for national standards in key interventions. It was based on three key components:

- An 11-point scorecard reflecting core priorities against which to measure performance.

- The scorecard placed highest emphasis on mechanisms for patient and family feedback, as well as from NHS staff.

- To depoliticize the system, an arm's length entity that functions independently from government was charged with management, budgetary control and oversight authority, while remaining accountable to government.

Romanow, Kirby and Naylor all advocated for a national, independent body to establish common performance indicators and benchmarks, and the issuance of public reports providing independent evaluations. Only tepid responses actually occurred, through the creation of bodies without sufficient authority to make change or obtain compliance.

In his book, ***No More Lethal waits: 10 Steps to Transform Canada's Emergency Departments*** [55], S. Wheatley, MD, acknowledges the role of performance standards but with a caveat, '*Certainly we must improve clinical metrics. But meaningful outcomes for patients are often qualitative, subjective and impossible to measure. How do we measure clinical judgement beyond complication rates? How do we measure communication skills? Reasoning ability? Aptitude in interpreting non-verbal cues? As someone has said, "Not everything we measure matters, and not everything that matters can be measured*.'

'*We need a definition of medicine that starts with the clinical encounter and puts* ***patients' interests at the centre****. We need tough-minded leaders with diverse backgrounds and training who are committed to putting patients before budgets, politics, and ideology in order to sort out the Canadian chaos in healthcare.*'

From the patient perspective, establishing wait times that '*each province or territory will* ***strive*** *to meet'* is not particularly helpful. Patients want to know the maximum times it is *safe* to wait to access tests and procedures referred by their primary caregiver, times that avoid '*adverse effects on a patient's health*.' In addition, long waits to access a primary care team eliminates the opportunity for preventive care, which also endangers their health.

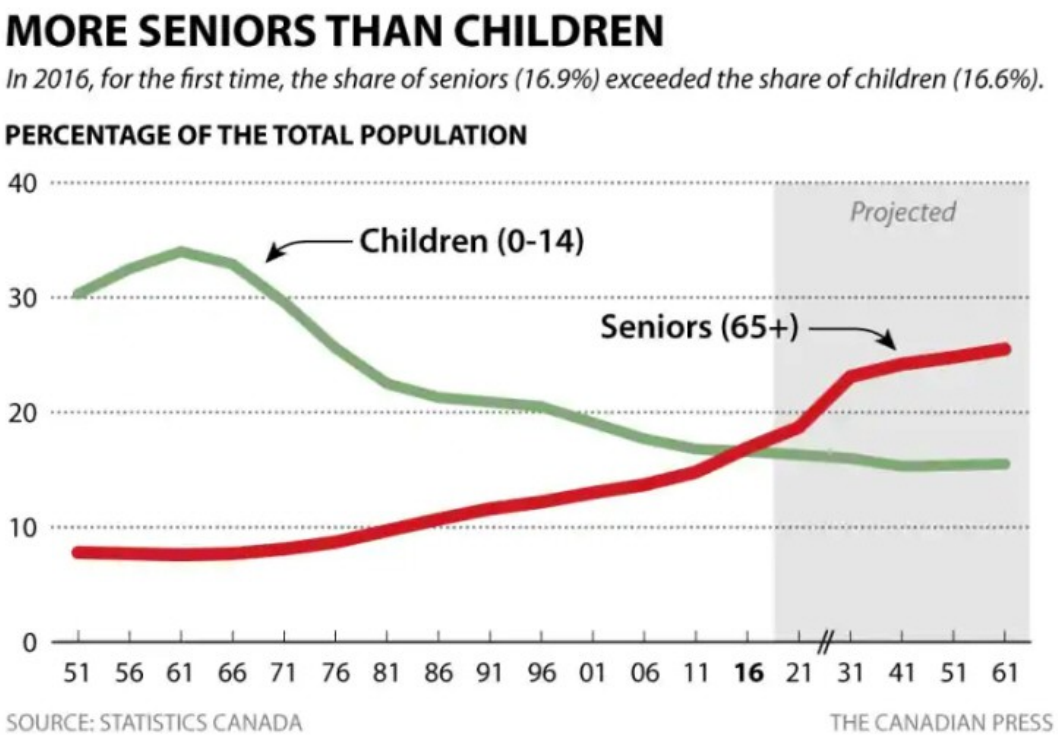
Only an arms-length, oversight body, given full authority to make real change, and requiring cooperative compliance from provinces and territories, can fulfill the role of creator and guardian of effective national standards, that mean something to the patient.

Needs of an Aging Population

According to Statistics Canada census data released in 2016, for the first time ever, seniors outnumber children, after the population experienced its greatest increase in the proportion of older people. In 2017 there were 5.9 million Canadian seniors (people over 65), compared to 5.8 million Canadians aged 14 or younger. The aging of the population is due to the first baby boomers turning 65 over the last five years, as well as the increasing life expectancy of Canadians and a low fertility rate.

Projections suggest this imbalance in the population will only grow. By 2031, about 23 per cent of

Canadians could be over 65, similar to Japan, the world's oldest country. By 2061, there might be 12 million seniors and just eight million children in Canada. The increase in the proportion of the very oldest Canadians is even bigger — up 19.4 per cent for those over 85, and up 41.3 per cent among those over 100. In 2017, there were 8,230 Canadians over the age of 100. From a gender perspective, women continue to outnumber men (50.9% vs 49.1), and the ratio of women to men increases with age - in 2017 there were twice as many women over 85 as men.



According to ***How Canada Compares: Results From The Commonwealth Fund's 2017 International Health Policy Survey of Seniors*** **[50],** '*A third live with at least 3 chronic conditions*' and '*Close to two-thirds (62%) of Canadian seniors had difficulty getting medical care after hours without going to the hospital emergency department (ED). Consequently, almost a third (31%) reported that the last time they went to the ED, it was for a condition that could have been treated by their regular doctor.*'

There are obvious implications of these demographics and chronic care costs **[48]**:

- An increased need for healthcare - as people get older, more of them need healthcare, chronic care, and home care. Seniors often have multiple health problems that typically consume more time and resources than those of younger patients.

- Needs of an aging population, in particular chronic care costs, will put increasing demands on government spending and other social services as the percentage of seniors in the population increases.

- Managing healthcare spending is becoming a major fiscal policy challenge for the government at a time of a shrinking labour market. There is a decrease in the amount of govern-

ment tax revenues, with fewer taxpayers entering the labour market compared to those retiring (4.3 million between 15-24 vs 4.9 million of 55-64 in 2017).

- A changing housing market - due to the aging population, 1.2 per cent of Canadians now live in nursing homes or seniors' residences; a share that Statistics Canada says will only increase over time.

- The opportunity to significantly reduce chronic care costs by providing patients with primary care after hours, and providing seniors with chronic care support outside hospitals.

Case Study:

Anne, a very active 94 year old, although with early dementia, was admitted to hospital following a fall. A stroke or a brain bleed was ruled out. Within one week she walked a short distance with the aid of a physiotherapist. The prognosis was a return to her previous level of functioning. Her need for acute care ended.

For the next 38 days she remained in hospital. Her stay was prolonged by bouts of delirium seemingly arising from medications (Ativan and Seroquil) prescribed for suspected urinary tract infection, suspected pneumonia, seizure prevention, night time calming.

A Trauma and Critical Care surgeon (a family member) objected to the use of these medications for the elderly and they were discontinued. As they left her system, Anne emerged from a state in which she required a swing lift, was unable to feed herself and did not qualify for rehabilitation; to walking with a walker, toileting with little supervision and feeding herself. She was discharged to a Rehab hospital.

Her extended stay in hospital resulted in muscle atrophy and confusion, and cost an estimated $38,000. Better options for chronic care would have had significant cost savings. Awareness of the effects of medications on the elderly through increased emphasis on gerontology would have prevented the delay in her recovery and saved her from days of profound stupor and loss of dignity.

Universal healthcare was introduced to Saskatchewan by Tommy Douglas in 1947 when the average age of Canadians was 27 years. A young population mainly presents with acute care needs such as accidents, illnesses, etc., well-suited to hospital care. Our healthcare system was built on this 1947 model. The current average age of Canadians is 47 years, and that average is getting steadily higher.

Chronic care (for patients of all ages) accounts for the highest costs in healthcare systems around the world. For example, '*Studies have established that 5 percent of U.S. patients account for nearly 50 percent of spending in the U.S.*' **[49]** Young people requiring chronic care will generally need it for longer (and are living longer). But seniors needing chronic care are too. An older population requires a different model to address increasing chronic care needs.

As the percentage of seniors in the population increases, so will the chronic care stress on healthcare and other social services. Being a senior does not imply a burden on the system (most

are not), but that burgeoning population as a whole will increase costs in many areas. Note that it will also provide job opportunities and a key area of economic growth (eldercare technologies and services).

In particular, '*The number of Canadian seniors living with Alzheimer's disease and other forms of dementia is rising steadily, and so is the demand on their caregivers and health care systems across the country.*' **[51]**

Dealing with these needs with an out-of-date model of care has resulted in upwards of 20% of expensive acute-care beds being occupied by patients awaiting transfer (their recovery delayed as they wait) to less expensive community facilities (that could offer more appropriate care). As well as harming the patient, this contributes to higher costs and bottlenecks in the system.

The increased prevalence of chronic-degenerative diseases susceptible to frequent exacerbation make the elderly regular users of emergency departments. However, the emergency department triage system (which has come under general attack recently **[55]**) is ill prepared to adequately respond to elderly patients, whose complex needs require specific skills, tools/instruments, and models of emergency care.

5.4 Cost Efficiency Considerations

Right now, Canada pays *more for less* in healthcare. According to the **2017 International Commonwealth Fund** (ICF) ranking for healthcare delivery in 11 high-income countries **[5]**, Canada's publicly-funded system is one of the most expensive, yet its performance is below average.

Drivers of those high costs, as described in ***Better Now*** **[14]** include too many costly tests and treatments that don't improve, and in some cases hurt, health; replication of tests because electronic records are unavailable; delays in needed treatment or tests, that result in more radical (and costly) treatments; and many patients' inability to pay for prescription medicines, causing them to cycle in and out of emergency departments.

Canada does not lend itself to one size fits all solutions. Distances, climatic and cultural variance, public acceptance all create a complex scenario. When *top down* solutions have been tried in the past, they have failed, e.g. the costly and ineffective push to reduce elective surgery wait times. There are however broad brush areas where the federal government can be of great assistance to jurisdictions in effecting cost savings, as long as enough, properly trained healthcare teams are made available to implement them.

Home Care

Home care, *especially for the increasing number of patients needing chronic care*, costs less, and has very low capital costs. As described in a National Public Radio article **[35]**, home care is increasingly being extended to acute care patients who traditionally would have been treated in hospitals (at great cost, and often doing harm):

'*A wireless patch, a little bigger than her index finger, would be affixed to her skin to track her vital signs and send a steady stream of data to the hospital. If she had any questions, she could talk face-to-face via video chat anytime with a nurse or doctor at the hospital*.' '*Hospitals are germy and noisy places, putting acutely ill, frail patients at risk for infection, sleeplessness and delirium, among other problems. "Your resistance is low," the doctor told Petruzelli, who turns 71 this week. "If you come to the hospital, you don't know what might happen. You're a perfect candidate for this.*"'

The Commonwealth Fund tells us **[36]** that '*Hospital at home programs that enable patients to receive acute care at home have proven effective in reducing complications while cutting the cost of care by 30 percent or more*'. ***Canadian boomers want to stay in their homes as they age*** **[37]** tells us that '*When they look ahead to future living arrangements that go with aging, Canada's baby boomers see staying in their own homes and paying for home care as the best option*'.

Keeping people out of hospitals, where possible **[65]** , not only saves money, but it makes them happier and keeps them healthier. If such programs were readily available, it would reduce the demand on eldercare facilities, and hospitals – most likely to the point where spill over effects would reduce waiting times for everyone .

Team Care

Quality team care is done in many jurisdictions that outperform Canada in healthcare. We do have a cultural problem, both in terms of institutional/professional bias and public acceptance that is stuck in the old physician/hospital model. However that is changing, and more people are accepting team care – provided that the physician/hospital is available when absolutely needed. As an example, the British Columbia *First Nations Health Authority* **[69]** is heavily reliant on nurse practitioners and nurses for front line care, and BC recently announced '*its vision for an integrated system of primary care across the province', focused on 'team-based primary care that connects a range of specialized and standard services within the community*' **[96].**

How Broader Primary Care Teams Can Decrease Healthcare Costs **[38]**, describes how '*researchers advised healthcare organizations to add community health workers, community paramedics, dietitians, mental health providers, pharmacists, healthcare stewards (e.g. care coordinators and navigators), and family caregivers to primary care teams. Including these non-physician providers could significantly reduce healthcare costs*.' Note that it is critical that team care remains '*Organized around the health needs and expectations of people rather than diseases*' and that it continues to connect '*people with trusted providers who address their ongoing health needs throughout their lives*'. **[95]**

Patient-centered Care

Too often our healthcare systems are driven mainly by institutional and professional biases, and far less by what the patient really needs. This is akin to an entrepreneurial entity saying to their customers something like '*we make chocolate ice cream – so that's all you can have.*' Such an enterprise would probably go broke.

If we look at the Home Care example, we see a big push to build more eldercare facilities, yet 83%

of the aging population would prefer the less costly option of home care. Home cared seniors tend to be happier and healthier – at lower cost!

If an eldercare facility is the only option being provided, then the apparent demand is actually much larger than the real demand. *The entrepreneur who offers only chocolate ice cream might face a demand for 1,000 cones a day – but if vanilla and strawberry become available, then that apparent demand might fall to an actual 400 per day.* The only way to find out is to ask the customer – in the healthcare context, the patient.

Predominantly, studies show that patient-centered care lowers costs. Patient-centered care starts with measuring - *and continuing to measure* - what patients want. What they want will shift with experience and time as they are exposed to other options.

Example:

In private business, some injured employees are exposed to health care coordinators (often a contracted RN). Their experience with a coordinator is positive, they get better and expedited care, and so they would be amenable or even happy to have such an RN coordinator as a primary care point of contact. That option can reduce the workload of physicians, both helping to alleviate the shortfall in physician availability and at the same time reducing costs – while improving patient outcomes.

Here's an outcome of a lack of patient-centered care, described in ***The Cost Conundrum: What a Texas town can teach us about health care*** **[97]**. Two economists '*found that the more money Medicare spent per person in a given state the lower that state's quality ranking tended to be ... patients in high-cost areas were actually less likely to receive low-cost preventive services, such as flu and pneumonia vaccines, faced longer waits at doctor and emergency-room visits, and were less likely to have a primary-care physician. They got more of the stuff that cost more, but not more of what they needed … The lesson of the high-quality, low-cost communities is that someone has to be accountable for the totality of care*.'

In looking at higher performing healthcare systems (those that provide both better access to healthcare, and at lower costs), the commonality is that they all incorporate *3 pillars* - **Home Care**, **Patient-centered Care**, and **Team Care**. In *customer* language this is providing the service where, how, and when the customer wants it – and team approaches are more efficient and responsive.

5.5 Spreading the Word on Innovations

The list of possible innovations (see **Appendix E** for Canadian examples) to improve healthcare delivery is long. One of the difficulties with application of innovations is that Canadian context is so variable. What works in Vancouver, might not work in Aquanish, P.Q..

Many innovations show great promise in pilot programs (sometimes providing both better care and lower costs), but when the pilot funding goes away, so does the innovation. An innovation that does take hold and provide benefits in say, Saskatchewan, often does not spread to other jurisdictions. Innovations are changes. Resistance to change is common. Organizational inertia - from professional, managerial, and institutional bias - is a barrier to change.

One healthcare organization that has demonstrated continued success with innovation is the Mayo Clinic, whose core value (set in 1910) is: '*The best interest of the patient is the only interest to be considered*.' In ***Why Innovation Thrives at the Mayo Clinic*** **[81]**, the Harvard Business Review tell us that:

"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."

'*Three conditions in particular formed the climate that endures today:*

Limited Resources ... Interestingly, scarcity of resources shows up in our database as the single strongest driver of innovation in organizations in general.

Connectedness. The brothers established a place where teamwork was paramount yet where "cooperative individualism" would thrive ...

Internally, Mayo has achieved a high level of connectedness among employees with systems and processes that enable — and oblige — everyone across the organization to find and connect with the expertise they need at any moment. Such systems are often associated with excellence in service and outcomes. Our research underscores that they also enhance innovation, by focusing attention, from multiple perspectives, on new problems and ideas.

Diversity. The brothers established and promoted the country's first real "group practice" concept where physicians in different disciplines would collaborate on the care of patients.'

Successful innovations can spread nationally - and internationally, as discussed in **Piloting Health Care Delivery Innovations from Abroad: A Systematic Approach** [**87]**: '*In January 2015, the Institute for Healthcare Improvement (IHI) and the Commonwealth Fund launched the IHI/Commonwealth Fund International Program for U.S. Health Care Delivery System Innovation to stimulate the transfer of health care delivery innovations from other developed countries to the U.S.* '

LEAN Methodology & Continuous Improvement

Revolutionary changes in organizations, to make them more adaptable, are very rarely successful.

Evolutionary changes are more successful and can be made to stick. The primary direction of the Naylor Report **[13]** - ***Unleashing Innovation: Excellent Healthcare for Canada*** - is on strategies and tactics found in managerial tools such as LEAN manufacturing. This involves *a culture of continuous improvement* focused on desired results, without explicitly dictating them. Some jurisdictions in Canada's healthcare are already employing elements of LEAN methodology. This makes sense in such a complex scenario.

What is missing is the right kind of top level leadership. That is, leadership focused on enabling change by fostering a culture of improvement – not dictating specific improvements (one size rarely fits all!) We have elements of this in efforts already made to improve Canada's healthcare systems, but ad hoc at best. It needs to be institutionalized, with the very top level priorities

indicated (but not dictated) by the federal government.

Entrepreneurial organizations generally have staff responsible for continuous improvement - spreading the word about best practices - and coordinating a consistent push to improve. This shows up in the Naylor report recommendation to '*Create the Healthcare Innovation Agency of Canada*'. A resource body is needed to drive a coordinated and continuous improvement effort across jurisdictions.

The pragmatic reality is that Canada is not in a position to keep throwing money at healthcare. How can top level leadership in change and innovation help deal with that reality? It must include more focus on providing value for Canadians.

Entrepreneurial organizations must (for their survival) focus on efficiency of delivery (whether it be a product or a service). Healthcare cannot strictly follow that path. Human lives do not come with a price. Some innovations will add cost, but save lives, clear value added. However, efficiency in healthcare delivery is also a value added for Canadians. The discussion above identified 3 broad areas to create cost efficiency while adding value for Canadians in terms of better healthcare: *Home care*, *Patient-centered care*, and *Team care*.

Fostering cost efficiency, where such win-win opportunities exist, will free up capacity elsewhere, as well as funding for further innovations to Canadian healthcare. As an example, freeing up "X" percent of hospital capacity (inefficiently utilized for chronic care patients) through properly implemented Home care, will help reduce wait times in hospitals, without additional hospital costs.

A big part of the mandate for a *Health Care Innovation Agency* (or similar body) would need to be '*efficiency of care*'. Since, generally speaking, matters like procedure costing details are a *third rail* in healthcare, measuring efficiency of care is challenging. However, that could be circumvented through voluntary spot checks – for example, if a given jurisdiction focuses on Home care, and sees successes, then that jurisdiction will probably be amenable to cost analysis.

Measurement: The Challenge of Evidence-based Policy-Making in Healthcare

Aside from those wrinkles, a key element in driving positive change is measurement, which focuses attention, can create constructive competition, and provides the rewards of visible progress and results. No group wants to be last, and many will want to be first. Measurements need to be objective, trusted, comparative and focused on the goal(s). At the same time, measurements should not be set up to create a time consuming burden on those actually performing the tasks.

Measurement is relatively straightforward in entrepreneurial organizations where the overall goal is return on investment. In the context of healthcare, it becomes much more difficult. Many of the relevant measurements are subject to institutional, professional, managerial, and other biases as many are *soft* measurements.

The way around that is a focus on measurements direct from patients.

In the entrepreneurial context, if you go to branch operations and ask them how good their

customer service is, the typical response will be *excellent* - and they may genuinely believe that. The real answer comes from the customers themselves. Thus many entrepreneurial organizations use mechanisms like *customer satisfaction* surveys.

In the healthcare field, the *customers* are the patients. Measurements that come directly from patients can determine many factors to drive innovation/change priorities. The federal government already has the objective, trusted, and arm's length organization to effect and publicize such pan-Canadian measurements at low cost and with virtually zero burden on healthcare providers - Statistics Canada.

Simply having Statistics Canada do bi-annual, pan-Canadian patient surveys would offer an opportunity for the federal government to begin driving *patient-centered care*. It has the side benefits of transparency; engaging Canadians in a healthcare vision at a grass roots level; and beginning a process of empowering patients. The federal government, in cooperation with provinces and territories, might also use such measurements (what you measure focuses efforts) to gently steer efforts toward the win-win situations of improved healthcare and efficiency of delivery.

As an example, asking patients something like "*have you experienced Team Health Care, and if so please rate your experience*" accomplishes many things. First, it would create curiosity, and acceptance that *Team Health Care* is a legitimate approach. Second, it would focus jurisdictions/institutions/professional organizations on Team Care. Third, results would provide guidance as to where Team Care is actually benefiting patients, and so focus efforts.

Targeted Resources

Another key element in driving innovation/change from the top level is the provision of resources. This does not mean shoveling out money for more of the same. To a very large extent it should be anticipatory, in the sense of making sure that the resources for desired changes and innovations are available, as suggested in the Romanow Report **[12]** recommendation of targeted funding. In essence, the patient care survey suggested above would give direction to innovation/change.

If, for example, the government agrees that Team Care is a desirable innovation for Canadian healthcare, it can provide necessary resources. Such a shift in healthcare will require more supporting personnel - nurse practitioners, nurses, midwives, home care workers etc.. A devolution of responsibilities might require expansion of responsibilities for ancillary healthcare related professionals, such as pharmacists (should that be a direction that comes up from the bottom, the process being bottom up). Regulatory improvements might also be required.

By anticipating needs to get to the end goal, the federal government can, cooperatively with the other jurisdictions, provide the necessary framework flexibility and resources to get the healthcare system to the desired result.

On a simplistic level, if the federal government increases resources for the education and training of nurse practitioners, nurses, home care workers, etc., then (given the shortage of primary care physicians in areas where they are needed), systems will gravitate toward Team Care and Home Care. Such an effort might include increasing resources for immigrant professionals to become

certified in Canada.

On other levels, the federal government might look at options to improve equity of care. Given that rural and remote areas have difficulty in attracting healthcare professionals, it might help, in concert with the other jurisdictions, to consider the development and funding of education and training for '*Rural care specialty*' or '*Health care coordinator*' nurse practitioners .

There also needs to be contingency for unanticipated capital expenditures. If a particular jurisdiction chooses to go full bore ahead with a desired innovation/change, then that needs to be encouraged with financial resources to build/acquire necessary infrastructure.

Summary

In summary, it appears that there are 3 primary elements where the federal government, in cooperation with other jurisdictions, can have an impact in making Canadian healthcare both better and more cost efficient through innovation/change:

- *a coordinating body for continuous improvement*
- *patient-centered measurements and reporting*
- *anticipatory resource supply*

Perhaps the most critical element is patient-centered measurement, done and published consistently at least twice per year. Designed properly, it could focus efforts. At the same time, patient input would shift the questions asked, and highlight regions of the country that need attention in specific areas.

Such patient-centered measurements would function, in part, as an ongoing conversation with what should always be the top priority in healthcare – the patients.

5.6 National Healthcare Triage

There are significant challenges in provision of patient-centered care in outlying areas. For example, the Northwest Territories (57.7%) and Nunavut (82.5%) report much higher numbers of patients without a primary care physician than the Canadian national average of 15%.

Arguably, from a patient perspective, Canada currently has a 4-tiered system, the top tier being those in urban centres who have signed up with private clinics that guarantee immediate access to primary care when needed. Below that comes urban healthcare with a relatively high physician/patient ratio, access to clinics, hospitals and the best diagnostic equipment. Next comes rural healthcare, with a lower physician/patient ratio, fewer clinics, and sparse hospitals with less diagnostic equipment. Finally we have remote healthcare, with less of all the above.

Triage (from the French *trier*, meaning to sort, to separate) in the context of medical emergencies is the process of determining the priority of patients' treatments based on the severity of their condition. Triage may result in determining the order and priority of emergency treatment, the

order and priority of emergency transport, or the transport destination for the patient.

Does our healthcare system need a *national triage*? Canadians pay the same taxes, a portion of which go to healthcare services, but there are continuing news reports of those who are second or third class citizens with respect to the services delivered.

For example, ***Women in northern and rural Sask. travel nearly 900 km to give birth: Elders concerned circle of life is not complete because some communities only see death, not birth*** **[52]**. This incurs both physical and emotional costs, as well as affecting the community as a whole. Can't we do better in 2018?

A short distance from our country's capital, ***Outaouais health system woefully underfunded, study shows*** **[53]**. A Gatineau family physician calls it a *chronic condition*, and informs us that '*We are missing resources in staff, in infrastructure, in financing to offer the same healthcare level that other regions can*.'

There was the tragic and avoidable case where a ***Mi'kmaq woman's death after leaving MUHC without treatment highlights systemic problem, doctors say*** **[98]**. The Indigenous woman was denied urgently needed treatment because she did not have a a valid Quebec medicare card.

Yes, healthcare delivery is a provincial/territorial responsibility, but the federal government also has a responsibility to Canadian citizens who are not receiving the services for which they pay provincial *and* federal taxes. Such users of the healthcare system - aside from those who can afford private healthcare in or outside Canada - currently have no recourse for this poorer treatment.

What can be done at the federal level? In the long term, establishing a *coordinating body for continuous improvement*, *patient-centered measurements* and an *anticipatory resource supply of healthcare teams* (including midwives in one of the examples above) will certainly alleviate the problems. Publicizing measurements that show steady gains over the years to come might reduce Canadians' frustration in areas with poorer service, and also maintain political pressure for further improvement, which would be proven to be possible.

Also worth considering are the '*Rural and Remote Access Fund'* recommended in the 2002 Romanow Report **[12];** supporting regional approaches akin to that of UK health secretary Jeremy Hunt in tackling '*valleys of poor performance*' **[27]**; and the notion of a health ombudsman (local and/or national) suggested in the resolution put forward by the Indigenous Peoples' Commission, ***Indigenous Health Care Auditor and Indigenous Health Ombudsman*** **[54].**

Note that Ontario has already established a Patient Ombudman Office **[83}**: *'As of July 4, 2016, the Patient Ombudsman office will be able to receive and respond to complaints from patients about public hospitals, long-term care homes and Community Care Access Centres (CCACs)*'.

Physicians strive to '*do no harm*'. Healthcare policy must take this to heart. Policies designed to increase overall healthcare efficiency tend to focus on the urban situation and can worsen the access to care of our rural/remote communities (as has also happened in Australia). Any system reform must be evaluated to make sure that it *does no harm*.

An arms-length coordinating body for continuous improvement

Addressing ***access to family doctors; long wait times; innovation & cost efficiency***:

Well placed, multidisciplinary healthcare teams
Patient centered measurements and reporting
Home care for chronic conditions
An anticipatory resource supply
A national healthcare triage

6.0 What Canadians Expect

Canadians expect *fair healthcare*, interpreting that to be the *intent* of the Canada Health Act.

Canadians feel good, and rightly so, about our emergency care for the critically ill (though not about emergency department waits for less serious conditions). Some, especially those who compare us with the United States, still feel very pleased with their healthcare.

According to the Huffington Post **[66]**, '*Infant mortality is lower, people live longer and we are less at risk of cardiovascular disease than Americans.*' Also, in an international ranking, '*Canada performs better than the peer-country average on seven indicators: life expectancy, self-reported health status, premature mortality, mortality due to circulatory diseases, mortality due to respiratory diseases, mortality due to mental disorders, and mortality due to medical misadventures.*' **[67]**

Urban Canadians who have had the same family doctor for over a decade, and remain in fairly good health, are not typically exposed to the problems that others experience until their health worsens; they move and can't find a doctor; or their doctor retires. Though they don't mean to say, '*I'm all right, Jack*', that's essentially what they're doing to their fellows.

Canada's acute care/emergency care system is impressive, but our chronic care (needed more and more for an aging society) is increasingly challenged. A growing number of Canadians (including a majority of senior Registered Liberals) recognize that our healthcare infrastructure is weakening and outdated. They understand and support the need for reform.

However, they aren't interested in the specifics (detailed in decades of reports) of problems caused by uncommunicative silos, or in the pros and cons of different pay systems in healthcare.

They do care greatly about what can be expected in terms of end results for primary care access, healthcare wait times, quality, consistency and cost efficiency. They would like to know that their government has mapped a path forward to *reclaim and sustain* the national healthcare that still makes them proud to be Canadian.

They would welcome involvement in regular surveys of the healthcare they are receiving and of their ongoing needs for personalized, patient-centered healthcare. An arms-length, oversight body, possibly involving a healthcare ombudsman would create the opportunity to highlight '*valleys of poor performance*' and serious inequities in Canadian healthcare – and to do something about them.

Most Canadians would welcome sharing a vision for our healthcare future that they could help make happen. Full transparency of measurements would let them know how their own locale is doing and what fellow Canadians are experiencing. They would like to celebrate the successes – and share learning from the failures – of innovation pilots. They would like to see progress in continuing improvement.

Canadians expect their federal government to take the lead in ***fulfilling a 21st century vision of universal healthcare*** - and to allow them to be an important part of it.

6.1 Access to Physician-led Primary Care

'*Effective primary health care serves as the foundation for individual and community health over the lifespan. Strong primary health care makes health systems more responsive and resilient and is the foundation for universal health coverage.*' **[94]**

Canadians view access to primary care on a par with access to education, and expect it to be readily available throughout the country. They understand that *universality* in healthcare is lacking when a large number of Canadians can't get continuing access to primary care from the same family physician or care team.

Canadians want to own their electronic records, and to share full access to with their healthcare team, in a manner that continues to support their privacy.

The Naylor report **[13]** recommended '*mobile and digital health solutions that enable virtual care and empower patients, while meeting common standards and interoperability requirements*.' National technical standards (of digital health record content and format), that conform to any developing international standards, are key to making this work.

Canadians want access to primary care after hours, to avoid the need to go to a hospital emergency department (ED), and face a long, exhausting, stressful wait. The joke in Montreal for years has been that, '*unless you are already very close to death, take a sleeping bag and packed cooler with you if you have to go to a hospital ED – you'll need both!*'

If their primary care is accessed via telemedicine, Canadians would like to be assured that its delivery conforms to national and CMA standards of care – this would include urban Canadians who opt for that approach (as in the MAPLE example **[63]**), as well as those in rural and remote areas who have no other choice. The latter already sometimes involves a local team of healthcare professionals working via telemedicine with a remote family physician and/or specialist.

The Naylor report **[13]** included a recommendation to promote health and healthcare literacy. Elder Canadians, in particular, want to be recognized partners in their own *preventive care*. A great many already play a part by researching ailments on the Internet (unfortunately often accessing false or misleading information). For some, this avoids doctors' visits. For others, it results in unnecessary ones.

The young and the old are the most vulnerable to health problems in our society. There is a great deal of information available on prevention and home care for childhood illnesses. Our society's elders don't have the same support system and safety net. For example, many are unaware of when it's advisable to have a colonoscopy or bone density test. Some painful problems that develop with the feet can be avoided by knowing about proper footwear, etc. etc..

There is limited information relating to chronic diseases that affect elders (cancer, cardiovascular, respiratory, diabetes, neurological). **[70]** According to ***Preventive Health Care for the Elderly*** **[71]**, '*Demographic, economic and humanitarian considerations dictate that effective preventive health care be provided to the elderly. A disease-specific approach to geriatric preventive health care will not suffice; measures to enhance or maintain physical, mental and social function must also be emphasized.*

Unfortunately, the effectiveness of many preventive care procedures has not been adequately investigated in the elderly. Research is urgently needed to determine the efficacy of and appropriate target population for various geriatric preventive health care measures.'

Of course, preventive care will not happen without access to a primary care team, which should be prioritized for the most vulnerable sectors of the population.

Canadians also expect to receive care in either of Canada's official languages – if that is not feasible, but is possible in a nearby province, then they should have the option to seek care there, without barriers (to either the patient or the physician who provides the care) - and that should include the possibility to access specialist care, when needed.

6.2 Safe Wait Times for Medical Procedures & Specialist Care

The most frequently cited issue in the over 4,000 responses to the 2017 SLC questionnaire to senior Registered Liberals **[Appendix A]** was reasonable access to medical procedures and specialist care.

As seniors, respondents told us they were most concerned about unsafe wait times. Their conditions can deteriorate quickly, causing significant personal hardship, or they can morph into worse problems requiring ever more complex interventions, ultimately escalating costs in treatment times and procedures. Delays in diagnosis and treatment also add to mortality rates.

Unreasonable wait times were noted in all areas of access to greater or lesser degrees depending upon jurisdiction; from crowded emergency departments, to placement in appropriate facilities. Significant differences exist across jurisdictions and between urban, rural and remote Canadians.

Canadians want and expect the timely healthcare that their peers in most high-income countries enjoy. They expect to receive needed tests and treatments without excessive and stressful delays that might endanger their health. If that means traveling to have tests or treatment done sooner, most would find that acceptable, though cost is still a barrier for many.

Wait times were the longest ever recorded in 2016 with considerable variation between provinces. The average wait time was 9.4 weeks from family physician to a specialist; an additional 10.6 weeks to treatment; a total of 20 weeks. Wait times for MRIs and CT scans have increased since 2012, again with provincial variations. Long delays in accessing doctors, procedures, and specialists are often side-stepped by overuse of emergency departments. (CIHI)

Generally, 3 out of 4 patients have their *priority medical procedures* done within benchmark wait times. We know this for those procedures tracked by CIHI, but what about those that are not? Tracking measurements creates a focus on what is measured and a pressure for improvement in those specific areas. Has this increased wait times for procedures that are not tracked? That would certainly agree with anecdotal reports.

Note that CIHI sets wait time '*goals each province or territory will **strive** to meet*'. The Wait Time Alliance approach of defining *maximum* wait times, beyond which there might be adverse effects

on health, certainly seems more patient-centered.

The Romanow report **[12]** recommended that '*Provincial and territorial governments should take immediate action to manage wait lists more effectively by implementing centralized approaches, setting standardized criteria, and providing clear information to patients on how long they can expect to wait.*'

Canadians would like transparency regarding what are *and are not* safe wait times for the most common tests and procedures. Most understand that waiting for a matter of months for a hip replacement is not unreasonable, yet waiting for months to have a cancer diagnosis confirmed might be deadly.

Their concerns would be alleviated by the addition to the CHA of the Kirby Senate report's recommendation of a **Health Care Guarantee**, by which '*For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public. When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction*'.

In general, Canadians want, and deserve, more information – on how the country is doing in improving wait times; full access to their own records; as well as access to, and updates on, wait lists for tests and procedures and in emergency departments. This seems to be happening more, but in many jurisdictions, patients are still highly stressed by knowing that they are scheduled for a test or procedure, but getting no information on whether the wait will be days, weeks, months, or even years .

Canadians want to be asked about their own healthcare and that of those close to them. If measurements are only derived from physicians' data, then those who don't have a primary care team are excluded. Also, physicians and their patients often have very different perspectives on what matters in their care. Both points of view have value, and the patient perspective needs to be heard much more clearly.

'*Increased rates of emergency use are also directly correlated with a lack of regular primary care from a family physician. Strategies to attach patients to timely access to a primary health care provider, tied to after-hours care provision, are one way to address this issue.*' **[*99*]**

We know there are a high number of hospital beds taken up by patients awaiting transfer to more suitable facilities. This impacts every process in the hospital from crowded waiting rooms, to canceled surgeries. Given the demographics, this will only worsen over time, with more chronic care patients held in expensive hospital beds due to a shortage of placement options.

Solving this would free up considerable funds when patients are moved in a timely fashion from the most expensive care beds, at a rate of, on average, $1,000 per day to approximately $300 a day in long term care – and give those patients care much better suited to their needs, without the further risk to their health that often occurs in hospitals.

Canadians recognize that hospitals can be dangerous to their health and, aside from emergencies, prefer home care. They would like even more support for elder healthcare *close to home*, avoiding often inappropriate and very expensive care in hospitals whenever possible. However, they do not want home care to be the only alternative, if there aren't adequate resources (for example

personal support workers) available to give safe, quality care.

6.3 Innovation and Cost Efficiency

In ***Managing the Myths of Health Care: Bridging the Separations between Care, Cure, Control, and Community*** **[72]**, Henry Mintzberg warns that '*Health care is not failing but succeeding, expensively, and we don't want to pay for it. So the administrations, public and private alike, intervene to cut costs, and herein lies the failure*', and that '*Management in health care should be about dedicated and continuous care more than interventionist and episodic cures.*'

Canadians want all levels of government to pay attention to cost efficiency and good fiscal management, while keeping access, quality, and timely delivery for the patient as the primary healthcare focus. They have seen too many attempts to band-aid symptoms of systemic healthcare ailments, and are ready to support a longer term vision for a cure.

They especially do not want requirements placed on healthcare professionals that take up excessive time in reporting and form-filling. They would support a culture of continuous quality improvement, but the bean counters must not run the healthcare system, which needs to be always patient-centered.

They have seen that throwing more money into various healthcare pots has not always helped, and are ready to hear what the government's long-term (beyond one election cycle) vision is for Canadian patient-centered healthcare.

6.4 Federal Vision & LEAN Leadership

The Naylor report **[13]** promotes **LEAN** leadership. This does not start with specifics. It starts with measuring and identifying areas that have potential for improvement or are problematic. It does not start with '*do this, that, and the other.*' It basically says, '*think about this, and see if you can come with a better way*'.

For effective LEAN leadership, the government would set goals and assume the role of coach, mentor and facilitator of a continuous improvement in healthcare that responds more quickly to identified needs and deficiencies than has happened in the past.

That doesn't mean that the federal government would tell Quebec, or New Brunswick, or BC what to do. Each province would maintain its autonomy to adjust for regional/cultural differences. Quebec might choose a right handed solution, while New Brunswick finds the left handed approach better for them.

For example, any level of government would not say to physicians, '*we are changing the way we compensate you*'. Instead it might suggest to a medical association that '*we would like you to look at methods of compensation for family physicians that will provide them the flexibility to fill the role of care team managers - if they so choose*'. Then the medical association would provide the compensation model, and initiate a discussion of how they see the concept working.

Given that *healthcare and eldercare are* strategic (and growing) sectors of the Canadian economy, Canadians will respond positively to federal investment in growth – with the associated increase in jobs – of these sectors.

Health innovator Zayna Khayat saw in the Netherlands *'a country with about the same population as Ontario, with a system-wide goal of bringing health care into the modern age … by setting 3 huge goals, to be met by 2019; 100% of frail seniors or people with a chronic disease must have full digital access to all their health data, they must be able to contact any health professional, in any modality they want (text, video, in-person), and they must be able to have their symptoms monitored remotely (blood pressure, heart rate, lung capacity).'*

She reminds us that '*The future of health will be predictive/proactive, personalized, decentralized, continuous, people-powered, and value-based*.' **[68]** That – and a government vision for 21st century healthcare - is what Canadians want and expect.

A patient-centered 21st century vision :

Fair healthcare
Universal access to care teams
Primary care after hours

Telemedicine care standards
Eldercare close to home

Expected wait updates

Safe wait times defined
Health Care Guarantee

Standardized electronic records

Shared electronic records
A preventive partnership
Care in official languages

Sound fiscal management

Patient consultation
Transparency of measurements
A national healthcare triage
LEAN leadership

7.0 2019 Liberal Party Platform

In a Canadian Association of Retired Persons survey on healthcare prior to the 2017 Ontario election, '*47% of adults cited health care as their number one election issue, with wait-times for procedures and hospital overcrowding topping the list; and 46% of adults aged 50 and older believed that things will get worse and the next generation will have even worse access to health care.*' **[7]**

It is a top issue for the 2018 provincial Quebec election **[86]** and statements are already being made in advance of the 2019 federal election, regarding healthcare achievements.

Vaudreuil-Soulanges MP Peter Schiefke says in ***Retiring With Dignity: Investing in Our Seniors*** [84]: '*In addition to the existing challenges relating to affordable housing, an issue of concern addressed by seniors is the state of health care services across Canada. To ensure provinces and territories are better equipped to meet the increase in demand, we have* ***provided $500 million in NEW money for health care transfers in the last two years alone and increased overall transfers to Quebec by more than 10% over the same period to support the government in their effort to provide quality social and health care services, something that we, as Quebecers, deserve.*** *Also, recognizing the increasing demand for mental health services, our government announced an* ***unprecedented $11 billion in new targeted funding over the next decade to better support mental health services and home care for Canada's aging population.***'

These are consistent with concerns expressed by senior Registered Liberals in the 2017 national SLC questionnaire **[Appendix A]**.

Liberal Party Conventions have placed healthcare in their top 15 policy issues as far back as 2005, when an Alberta-sponsored resolution appealed for adoption of the **2002 Romanow Report** [12] recommendations. A common thread in the subsequent five conventions was for federal leadership to engage provinces, territories and municipal governments in establishing, implementing, measuring and enforcing national standards; and applying innovation and cost-efficiency to healthcare delivery. These earlier resolutions also included the request for specific policies on seniors' health, home care, pharmacare, mental health care, and medical assistance in dying.

On this latter list, the Liberal government has already taken, or initiated, action. The 2015 Health Accord (part of the Party Platform) advocated for signed agreements with all provinces and territories, committed to, '*making home care more available, prescription drugs more affordable and mental health care more accessible*' **[85]**.

Excellent work has been done towards keeping this promise, resulting in the signing of 10 year agreements to bring needed change. The government also recently appointed a Minister of Seniors, whose mandate letter [100] included: '*Work with the Ministers of Health and Families, Children and Social Development on initiatives to promote healthy aging. This includes learning from and building on federally supported programs that have proven successful in supporting the needs of seniors and their families, as well as ensuring the government's investments in home care, palliative care and community care are well coordinated and are having intended impacts.*'

This is a welcome development which one assumes will be attentive to the demographic impact on

healthcare delivery as the Canadian population ages.

In comments on health in the 2015 Party Platform, the Liberal Party stated : '*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*'. The Party, therefore, recognizes and places value on the importance of a sound healthcare system as integral to a healthy economy.

The Party also acknowledged that, '*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*.'

Much has been accomplished on healthcare but there is important work still to be done. The 2015 commitment was to *restart* the dialogue between the federal and provincial governments. By bringing forward the 2015 Health Accords for signing, the promise for dialogue and change in the areas of homecare, pharmacare and mental health is underway. But that was a *restart*.

Real and ongoing change is needed. Federal (LEAN) leadership and dialogue with provinces and stakeholders is essential in order to tackle the full scope of the problem. National standards for uniform access, wait times, innovation and cost-efficiencies are left unaddressed. S*ystemic change is still needed to prepare our healthcare infrastructure to support current and anticipated demands on it.* Meaningful and cultural change takes time to achieve.

Canadians have been applying pressure on the healthcare status quo for more than a decade, and have watched incremental changes fail to address systemic problems. Now is the time for *quantum change*, as attempted in the Netherlands **[68]**, but focused on goals relevant to the Canadian context. Canadians would welcome federal leadership to reclaim their country's position as a world-class leader in universal healthcare.

2019 is exactly the right time to shine the spotlight on healthcare reform. A strong, long range vision for excellence would capture the imagination of Canadians, ignite enthusiasm in stakeholders, and be well-received in the 2019 election campaign. With political will and courage, this can be achieved. True healthcare reform should be the cornerstone for a winning Platform in 2019.

2019 Platform: Quantum change to healthcare

Shine a light on healthcare reform to win in 2019
Healthcare is a top issue in provincial elections
Prioritized at Liberal conventions since 2005
2015 Health Accord was only a beginning

8.0 Recommendations

Reclaiming and Sustaining Canada's Healthcare will require jurisdictions to make an innovative systemic redesign that examines and modernizes governing authorities, pay schedules, budgets, supply of medical personnel, etc., to address the shift that has occurred from the acute care priorities of 50 years ago to today's demands for prevention and chronic care, where economical, lasting solutions will be found. Success will be declared when Canada's international ranking rises from 9th to the top 3 of peer high income countries in the delivery of healthcare services, and when this improvement is confirmed through patient surveys.

RECOMMENDATION 1

Create a Vision for 21st Century Canadian Healthcare, developed with, and shared by all stakeholders (including patients); a vision for quantum change that will survive through election cycles and that builds on recommendations from existing reports and studies, such as the Naylor report. There is no need for more study. What is required is to repeat what Tommy Douglas did in 1962 by distilling existing expert studies into a 21st century vision of *truly universal* healthcare that all Canadians can understand and fall behind. Such a shared, patient-centered vision will energize and mobilize all jurisdictions towards implementation.

RECOMMENDATION 2

Establish and mandate an arms-length, oversight body, with full authority to make real change, and requiring cooperative compliance from provinces and territories. Such a body would act as creator and guardian of national standards, and the accompanying reform necessary to implement the 21st century healthcare vision and operate in the best possible interests of all Canadians. Its mandate would be to apply LEAN leadership, in order to make Canadian healthcare responsive to real patient needs, and achieve:

1. medically safe wait times for procedures.
2. cleared backlogs in diagnostics.
3. reduced costs per patient vs. outcomes (currently we pay more, yet get less).
4. enhanced access to primary care, with attention to regional and demographic differences (note that, in rural and remote areas, Internet infrastructure is a key facilitator).
5. adaptation to changing patient needs, especially in chronic and eldercare.
6. creative solutions for adequate supply and efficient use of physical and human resources.

RECOMMENDATION 3

Instill and institutionalize a culture of adaptability and continuous improvement. The 3 broad brush areas where the federal government can begin to make that happen are **patient-centered care and measurement, team care and home care**. Naylor Panel recommendations for the application of LEAN management systems should be employed to achieve these cultural changes.

RECOMMENDATION 4

Routinely record and publicly report on patient-derived measurements of progress on reforms to achieve the 21st century vision of universal healthcare, in order to maintain pressure for continuing improvement across the country. This important Recommendation advocates for strengthening evidence-based policy-making in the Health Sector by redirecting or increasing resources in R&D and data collection, efforts which the Federal Government is already doing and should maintain. This should include responsibilities to:

1. Define primary care access, eldercare access, and maximum procedure/test wait times that meet the *full intent* of the Canada Health Act. Canadians need a much better understanding of what the CHA's '***reasonable access***' and '***uniform terms and conditions***' really mean. This would let them know where they stand, and when they should (or should not) be demanding better service from local bodies. A *Health Care Guarantee* would be optimal.

2. Measure what's actually happening, in particular patient-derived surveys and a full range of measurements (not just averages) and share that information with all Canadians.

3. Forecast and report on the supply of multidisciplinary healthcare professionals in the places where they are most needed.

4. Perform a national healthcare triage and target '*valleys of poor performance*', especially for lack of access to primary care and unsafe wait times.

5. Work with the new Seniors' Ministry regarding innovative solutions to the growing and novel eldercare demands on the system, in particular with respect to home care for chronic conditions, and eldercare close to home whenever possible; support health literacy and preventive partnerships.

6. Develop national standards (and work with international standards bodies) for digital health networks, and digital records to be shared with patients.

7. Work with the CMA and other stakeholders to assure the development of sound standards for quality practice in telemedicine.

8. Involve patients in decision making at all levels.

9. Plan for what's ahead in medical and technological breakthroughs.

10. Keep a national focus on a long-term healthcare vision, whose top priority is *first and foremost the patient*.

Incremental change does not work. Systemic and cultural change is necessary for reform to take hold and be sustained. *Real Change*, based on innovative and patient-centered models of affordable, equitable care, will ***create and fulfill a 21st century vision of universal healthcare***.

9.0 Appendices

Appendix A: 2017 National Questionnaire of Registered Senior Liberals

The following is the 2 part survey that was sent to all Senior Registered Liberals.

Senior Liberals' Commission of the Liberal Party of Canada
Policy Questionnaire 2017 Part 1
WELCOME AND INTRODUCTION

Do you have 5 minutes to identify issues that the Liberal Party of Canada should consider? This is an opportunity to have input into recommendations for new LPC policies.

The next Liberal Party of Canada (LPC) Biennial Policy Conference will be held in Halifax April 19-21, 2018. It is time therefore to begin developing our Senior Liberal Commission (SLC) policy resolutions for consideration at this Biennial. Policies approved at the Biennial will help to inform the 2019 Liberal election platform. For more information about the role of the SLC, please click on this link: http://slc-cal.liberal.ca/

This questionnaire is Part 1 of a two-part SLC policy questionnaire seeking your your ideas as to the issues that you consider likely to be important during the 2019 federal election. It is being distributed to members of the SLC (Registered Liberals over 65 years old) and who have provided an email address to the LPC.

The SLC Policy Committee will analyze the responses to Part 1 to determine what issues are most commonly identified by participants completing the questionnaire. These results will then be shared with SLC members in Part 2 of the Questionnaire that will be distributed in a few weeks. In Part 2, you will be asked to prioritize what you think are the most important issues identified in this first questionnaire. These prioritized issues from Part 2 will then be used to inform the development of the SLC policy resolutions for considered in the lead-up to the 2018 Policy Conference.

This questionnaire provides an opportunity for you to identify three issues. To begin the survey, please click on the NEXT button below. You will be given a list of themes. Please pick the theme that best captures the first issue that you wish to describe. After clicking NEXT, you will be taken to a page on which to can describe your issue and include any specific concerns related to it. This cycle will be repeated two more times to allow you to describe two more issues.

The last page of the questionnaire asks for some basic demographic information that will be used to help us to understand the differences in issues that are top of mind for seniors in various regions of the country as well as whether these issues are different for various age groups or gender. You are under no obligation to provides responses to those demographic questions.

PLEASE NOTE: All information collected in this questionnaire will remain anonymous and cannot be associated or linked with you.

If you have any questions regarding this questionnaire, please contact:
Doug McDonald
SLC Policy Chair
dekita10@telus.net

Your issue #1

Please select the THEME that best fits the #1 ISSUE that you think will be important during the 2019 federal election. This will help us to analyse the responses to this questionnaire.

1. Select the THEME that best fits your FIRST issue and then click NEXT below.
- Democratic Process
- Economy
- Education
- Environment
- Health Care
- Housing (other than senior's housing)
- Immigration
- International Relations
- Media/Information
- Seniors
- Social Programs
- Other Theme

Your second issue

Please select the THEME that best fits the SECOND issue that you think will be important during the 2019 federal election and then click NEXT below.
NOTE: If appropriate, you can use the same theme as for your first issue.

2. Select the THEME that best fits your SECOND issue.
- Democratic Process
- Economy
- Education
- Environment
- Health Care
- Housing (other than senior's housing)
- Immigration
- International Relations
- Media/Information
- Seniors
- Social Programs
- Other Theme

Your third issue

Please select the THEME that best fits the THIRD issue that you think will be important during the 2019 federal election and then click NEXT below.
NOTE: If appropriate, you can use the same theme as for your first issue.

3. Select the THEME that best fits your THIRD issue.
- Democratic Process
- Economy
- Education
- Environment
- Health Care
- Housing (other than senior's housing)

- Immigration
- International Relations
- Media/Information
- Seniors
- Social Programs
- Other Theme

XXX #1

You have selected the XXX theme for your FIRST issue. Please describe your issue in the following two text boxes.

4. Please provide responses in both text boxes below

Describe the XXX issue that you believe will be important during the 2019 election campaign. Maximum 10 words — TEXT BOX

More specifically, I think the government should address the following concerns. Maximum 20 words — TEXT BOX

YYY #2

You have selected the YYY theme for your SECOND issue. Please describe your issue in the following two text boxes.

5. Please provide responses in both text boxes below

Describe the XXX issue that you believe will be important during the 2019 election campaign. Maximum 10 words — TEXT BOX

More specifically, I think the government should address the following concerns. Maximum 20 words — TEXT BOX

ZZZ #3

You have selected the ZZZ theme for your LAST issue. Please describe your issue in the following two text boxes.

6. Please provide responses in both text boxes below

Describe the XXX issue that you believe will be important during the 2019 election campaign. Maximum 10 words — TEXT BOX

More specifically, I think the government should address the following concerns. Maximum 20 words words — TEXT BOX

ABOUT YOU

Thank you for taking time to provide your suggestions to the above questions. They will be considered as we analyze the results to develop Part 2 of this questionnaire that will be distributed in a few weeks time.

Please note that the information and ideas that you are sharing in this questionnaire have been collected

anonymously and can not and will not be attributed to you.

To assist with the analysis, we will appreciate if you provide responses to the following questions. As mentioned in the introduction, there may be differences in critical issues by province/territory, age and sex. These questions will help us understand your specific interests.

40. In what province/territory are you living? In order to assure that we are getting responses from all parts of Canada, we will appreciate you provide an answer to this question.

41. What is your postal code?

42. What is your sex?
- Female
- Male

43. What is your age range?
- under 60
- 60 to 64
- 65 to 80
- over 80

44. Please provide any additional comments that you wish to share with us.

Thank you for completing our questionnaire. Watch for the Part 2 followup in a few weeks. Click Done to finish and learn more about the Senior Liberals' Commission.

WELCOME AND INTRODUCTION
Senior Liberals' Commission of the Liberal Party of Canada
La Commission des aînés libéraux du Parti libéral du Canada
Policy Questionnaire 2017 Part 2
Questionnaire sur les politiques 2017 - Partie 2

The next Liberal Party of Canada (LPC) Biennial Policy Conference will be held in Halifax April 19-21, 2018. Policies approved at the Biennial will help to inform the 2019 Liberal election platform. For more information about the role of the SLC, please click on this link: http://slccal.liberal.ca/

A big thank you to all of you who responded to Part 1 of our 2017 SLC Policy Questionnaire. We had over 4,000 responses. Over 70% of the responses identified issues within four themes – health care, economy, seniors' challenges and environment. A small team has gone through all of the responses to identify the major issues that were identified most frequently by you, our members.

There were a number of you who were surprised by the short time that the questionnaire was open to input. For this I apologise. Since this is the first time that the SLC has undertaken such a questionnaire, we had no idea how quickly we would receive responses. However, during the first 48 hours, we received over 90% of all responses. The number of responses then dropped significantly over the next several days. We concluded that we should close the Questionnaire after one week and begin the time consuming analysis of the results ensure that our National Priority Issues would be available to all by early June. We will attempt to do better in the future in providing advance notice of the closing date.

We noted in the Introduction of Part 1 that we would followup with Part 2 of our 2017 Policy Questionnaire. In this Part 2, we have listed the 14 issues that were most often identified by you in Part 1. One of the criteria established for the LPC Policy Process is that policy resolutions should not replicate the 2015 election platform commitments or priority resolutions from the 2016 and 2014 National Conventions. As a result, several important issues including electoral reform and action on the infrastructure program that were identified in Part 1 are not included in this list.

Your task in this Part 2 is to help us rank the issues by choosing the three issues from the list on the next page that you believe will be the MOST important during the next election. We will tally the number of votes for each of these issues and the most dominant ones will become the SLC National Priority Issues for which we will solicit specific policy resolutions in accordance with our SLC Policy Development Manual 2017-18 and the individual SLC Section procedures. The SLC Policy Development Manual, which includes the available SLC Section Procedures as schedules, can be accessed from the SLC website at http://slc-cal.liberal.ca/

We are asking that you provide some demographic data about yourself to assist us to analyse the results and determine if there are significant differences across Canada, by age or other factors. Other than your province, please note that is your choice whether to answer the other demographic questions.

PLEASE NOTE: All information collected in this questionnaire will remain anonymous and cannot be associated or linked with you.

This questionnaire will remain open for input until May 27, 2017. Thank you for your participation.

If you have any questions regarding this questionnaire, please contact:

Doug McDonald
SLC Policy Chair
slcpolicy@dekita.ca

Prioritization of Major Policy Issues from Part 1 Responses

The following list contains those issues that were referenced the greatest number of times by the respondents to Part 1 of the 2017 SLC Policy Questionnaire and that are consistent with the criteria associated with the LPC Policy Process.

We now wish to identify the top five or six that senior Registered Liberals across Canada consider to be the MOST likely to be of significance during the 2019 election campaign. These national priority issues will form the basis on which the SLC will seek specific policy resolutions.

We ask you to help rank these issues by selecting the three issues that you consider MOST likely to be of significance during the 2019 election campaign. The ranking will be based on the number of votes received from each issue. The top ranked issues will become the National Priority Issues. We are also asking that you provide some demographic data about yourself to assist us to analyse the results and determine if there are significant differences across Canada, by province, age or other factors.

We invite you to express your interest to participate in working groups that will be established to develop background papers and policy resolutions on specific priority issues. Finally, so that we can share the result directly with you and followup your interest in participating in the working groups, we are asking you to provide your name and email address. We undertake to not associate your specific responses with you personally beyond following up with you if you indicate an interest to be involved in developing specific policy resolutions.

*2. Please select three issues, from the list below, that you consider will be the MOST important during the 2019 federal election. Then click NEXT

- Direct program initiatives to strengthen economic growth that results in more equitable sharing of benefits
- Restructuring the economy to address the emerging challenges of the 21st Century
- Need to control government spending and reduce/eliminate deficit
- Stronger efforts to create stable, quality jobs for all Canadians with an emphasis on real opportunities for the younger generation
- Address the challenge of low income seniors many of whom are dependent on OAS and GIS and struggling to meet basic needs
- A continuum of affordable housing for seniors, from expanded home care service, to senior care and dementia care facilities, including the need for better trained staff.
- Strengthen health care throughout Canada, including better access to family doctors and health care services, reducing wait times for specialists and medical procedures, innovating to reduce costs and achieve more efficient delivery of services
- National housing strategy addressing need for quality affordable housing for young families, including rental units, and for lower income and homeless Canadians
- Fair and properly funded social programs targeting low income and at risk Canadians and those living in poverty
- Addressing education outcomes that target 21st century skills requirements; reducing costs of post secondary education
- Greater support for child care, day care and early childhood education
- Reinforce democratic principles and good governance including parliamentary reform addressing integrity, honesty, decorum and giving elected representatives more independence
- Community and social supports for seniors
- Government leadership in addressing all aspects of environmental sustainability, not just mitigation

5. What is your sex?
Quel est votre sexe ?

- Female/Femme
- Male/Homme

6. What is your age range?
Quelle est votre catégorie d'âge ?

- under 60/ moins de 60 ans
- 60 to 64/ de 60 à 64
- 65 to 80/ de 65 à 80
- over 80/ plus de 80

7. Please indicate your interest to participate in a working group developing policy resolutions related to one or more specific issues. Click on the drop down menu to select.

8. What is your name?
Quel est votre nom?

9. Please share your email address:
Veuillez fournir votre adresse courriel :

Appendix B: LPC Policy Resolution

Reclaiming and Sustaining Canada's Healthcare

Moved by Senior Liberals' Commission, LPC(BC)

WHEREAS:

- in 2014, over 4 million Canadians had no family doctor;
- waitlists for specialists and surgical procedures are among the highest they have ever been, with significant regional disparities, including for rural areas and indigenous peoples;
- in 2017, the International Commonwealth Fund ranked Canada's health care ninth among eleven high-income countries;
- the Federal Government commissioned the Advisory Panel on Health Care Innovation, (2015) chaired by Dr. David Naylor, to identify "areas of innovation that have potential to sustainably reduce growth in health spending while leading to improvements in the quality and accessibility of care";
- the panel reported Canadian healthcare "in crisis", and identified numerous areas for systemic improvement;
- in 2017 a majority of senior Registered Liberals identified an urgent need for:
  - better access to family doctors and healthcare services
  - reduced wait times for specialists and medical procedures
  - innovation for service delivery efficiency and cost reduction;

BE IT RESOLVED the Liberal Party of Canada urge the federal government to:

- accept the Naylor Report's recommendations to lead systemic reform of healthcare;
- in cooperation with provinces, territories, and professional organizations, identify and implement methods to:
  - provide every Canadian access to family physician supervised primary care
  - eliminate wait times to access specialists and surgical procedures that adversely affect Canadian's health
  - foster continuing innovation to reduce costs, enhance efficiency and ensure consistent health care delivery throughout Canada;
  - Report regularly to Canadians on progress toward achieving the above improvements including data based on patient-derived metrics.

Appendix C: LPC National Policy Committee Working Group: Overview & Members

Authors of the **Reclaiming and Sustaining Canada's Healthcare** resolution and this National Healthcare Policy Report dedicate our work to Doug McDonald (1930-2018), acknowledging his extraordinary role as a mentor and a policy innovator. Doug's untimely passing in the middle of this process was a great loss, but a loss that strengthened our commitment to continue his work in ensuring that policy in the Liberal Party of Canada reflects the grassroots thinking of Canadians.

Doug's engagement with policy in the Liberal Party goes back several decades to the establishment of the first SLC in Alberta. After moving to British Columbia, Doug became a founding member of SLCBC. He stated, '*right from the beginning I felt I had found a home in the Senior Liberals' Commission*'. He honored that home through his service for the Liberal Party, including terms of office as Policy Chair SLC and Policy Chair SLCBC. Doug tagged the phrase '*Policy is the Future of Liberalism in Canada*' that appeared on all his correspondence.

It is rare to work with someone with vision – who sees possibilities while slugging through the trees of what seems like a dense forest. Doug's passion and desire for change might at times be expressed in a forceful and feisty manner, but throughout, he remained soft on people and hard on issues. The success of his relentless work in grassroots policy was reflected in the acceptance of 3 SLC Resolutions in the top 15 at the 2018 Halifax convention. He also championed successful resolutions in the 2014 and 2016 biennial conventions. From his hospital bed, he continued to guide us in the preparation of this report, enacting the continuous engagement stage of the new policy process.

Our greatest gift is our impact on the lives of others. Doug's wisdom and vision for this process will make a difference to Canadians for generations to come. We are committed to continuing what he started, and to making what he envisioned happen.

MEMBERS OF HEALTHCARE RESOLUTION WORKING GR0UP

CO-CHAIRS:
Judy Berg, Kelowna-Lake Country EDA; Hilary Williamson, Pontiac EDA

MEMBERS:
Doug Hargitt, Kelowna-Lake Country EDA
Dr. David Geen, Kelowna – Lake Country EDA
Dr. Ann Grahame, Regina EDA

LPC NATIONAL HEATHCARE POLICY WORKING GROUP:
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SPECIAL THANKS: CONSULTATION INDIVIDUALS/GROUPS (to follow)

Appendix D: Healthcare Funding in Canada

Healthcare in Canada is funded at both provincial and federal levels. Its financing comes via taxation from personal and corporate income taxes. Additional funds from other sources are used by some provinces, and Alberta, British Columbia, and Ontario also charge health premiums to supplement health funding. In addition, there are significant donations from foundations and private citizens, often targeting research and capital equipment.

Healthcare expenditures in Canada topped $100 billion in 2001. Approximately 11.5% of Canada's gross domestic product is spent on healthcare. **[40]** At a provincial level, funding is between one-third and one-half of what provinces spend on social programs. **[39]**

According to CIHI's ***National Health Expenditure Trends, 1975 to 2017*** **[40]**, total health expenditure was expected to reach $242.0 billion or $6,604 per Canadian in 2017, the split including: Hospitals (28.3%), drugs (16.4%) and physician services (15.4%).

The Canada Health Transfer (CHT) consists of a cash transfer as well as revenue from tax points. The cash allocation procedure since 2014-15 is on an equal per capita cash basis. In 2016-17, the value of the Canada Health Transfer was $36.068 billion **[41]**.

'There has been a positive relationship between economic growth and health care spending growth in Canada since the mid-1970s. In general, with more economic growth and thus income, more has been spent on health care. The exception is the fiscal restraint period from 1993 to 1996, when governments attempted to reduce or eliminate budget deficits.' **[40]**

'While Canadians age 65 and older account for about 16% of the Canadian population, they use almost 46% of all public-sector health care dollars spent by the provinces and territories. However, seniors are a diverse group. In 2015 (the latest available year for data broken down by age group), per-person spending for seniors increased with age: $6,607 for those age 65 to 69, $8,495 for those 70 to 74, $11,570 for those 75 to 79, and $21,407 for those 80 and older.' **[40]**

'Overall, population aging is a modest driver of increasing health care costs, estimated at 0.9% per year. The share of public-sector health care dollars spent on Canadian seniors has not changed significantly over the past decade — from 44.3% in 2005 to 46.0% in 2015. During the same time period, the percentage of seniors in the population grew from 13.1% to 16.1%.' **[40]**

Since 1984, 2 pieces of legislation define federal-provincial arrangements for health care. '*One (currently the CHT) sets out how much money provincial and territorial governments will receive in federal transfers, and the other (the CHA) specifies what, if any, conditions need to be met to receive the money.*' [***15***]

'Nearly two-thirds of Canadians have supplemental private insurance or employer-sponsored plans to cover the costs of prescription drugs, dentistry, vision care, rehabilitative service and home health care.' 'In almost one-quarter of Canadian households, someone is not taking medications because of an inability to pay'. **[9]**

Appendix E: Canadian Healthcare Innovation Examples

There is much to learn from both those that work well and those that are flawed. The following are fairly recent examples of innovations and pilot programs. The list is by no means complete and is simply provided to give a sense of some of the excellent efforts ongoing around the country.

'***Choosing Wisely Canada*** *is a campaign to help clinicians and patients engage in conversations about unnecessary tests and treatments, and make smart and effective care choices.*' **[56]**

According to the International Commonwealth Fund **[60],** '*Provinces and territories have introduced several initiatives to improve integration and coordination of care for chronically ill patients with complex needs. These include Divisions of Family Practice (British Columbia), the Regulated Health Professions Network (Nova Scotia), and Health Links (Ontario). Also, Ontario has long-standing alternative community-based and multidisciplinary primary care models including Community Health Centres and Aboriginal Health Access Centres. Also in Ontario, a pilot program that bundles payments across different providers is being expanded (from one to six communities) to improve coordination of care for patients as they transition from hospital to the community.*'

In British Columbia *'Rapid Access to Consultative Expertise (RACE) is a program that provides family physicians with rapid telephone access to a wide range of specialist services for patient consults.*' **[57]**

Also in BC, 2 oncologists in a mid size city were able to care for far more patients in rural/remote areas because with telemedicine they weren't wasting their time traveling. Follow ups were done at local clinics, with the assistance of a nurse. On average, between the two, they conduct 1,150 telemedicine consultations every year, allowing them to handle many many more patients, and the sick patients don't have the stress of travel. **[ref]**

Health Quality Ontario is '*the provincial advisor on the quality of health care*', addressing *'a health system that is not equitable nor sustainable.*' **[58]** The organization speaks of '*a pattern of gaps in health care, gaps that carry significant negative consequences for patients: difficulty accessing primary care; long waits for specialty care; critical safety events in health care institutions; poor access to medically necessary prescription medicine. Variations in care that, by any measure, are frightening to contemplate and that have tragic consequences for patients*.' Health Quality Ontario tracks wait times for different procedures - and this kind of visibility creates a pressure for improvement, which would also be effective at the national level.

Dr. Samir Sinha in Toronto has changed Mount Sinai Hospital's approach to caring for elderly patients, and has succeeded in both lowering costs and improving quality of care. **[59]**

In Ottawa, a ***New Pilot Project Could Deliver a New Level of Health Care to Seniors*** **[65]** , addressing the problem that '*the elderly and frail lose strength in hospital settings and tend to take longer to recover: "A day in hospital where you're not moving is like a week that it takes to recover and get that strength back … We miss that early and important window of getting people back home."* '

Also in Ontario, midwives are helping with the rebirth of Indigenous pregnancy care **[61]** : '*For generations, First Nations women have been forced to leave their communities to give birth, which can put babies' health at risk and fray social and cultural ties for families. Now, a revival of home births and*

midwifery is changing that'.

Looking further at multidisciplinary care, **SCOPE (Social Work Competencies on Palliative Education) [62]** : tells us that '*Social Workers have been recognized by the Canadian Hospice Palliative Care Association (CHPCA) as core members of the inter-professional palliative care team in all settings of care-residential hospice, acute and long-term care facilities, cancer centres and community care.*'

On a more controversial note, the private Maple service in Ontario **[63]** has been called '*uber for Healthcare*'. The appeal is obvious for anyone without access to a family doctor, or who is unwilling to wait for an appointment for a known, easily treated problem. But the approach lacks the continuity of care (and access to patient records) that a consistent primary care team provides, resulting in suboptimal care in situations where knowledge of medical history and rapport with the patient is key – and this is especially the case for patients with chronic conditions, or for patients with multiple conditions.

Another promising area for innovation is that of triage, typically done by a hospital nurse in an emergency department setting, in just five to eight minutes **[78]**. The aging of the population and the increased prevalence of chronic-degenerative diseases, make the elderly frequent users of emergency departments, the healthcare patient dispatching system. However, it is not clear whether the system is prepared to adequately respond to elderly patients. Specific skills, tools/instruments and organizational models of emergency care are needed to look after their complex needs. Various professionals (Dr. S. Whatley **[49]**, Dr. R. Bukata **[79]** and Drs. Helman and Ovens **[80]**) advocate for new and better ways of handling triage.

It's hard to mention innovation in healthcare without considering where artificial intelligence might take us, both in services to patients and for economic growth. This is addressed in a 2018 Globe & Mail article, ***How artificial intelligence can completely revolutionize Canadian health care*** **[64].** It addresses machine learning to improve diagnostic accuracy, as well as technologies to augment the care of the elderly, and to liberate physicians from tedious paperwork. The article also notes that '*the U.S. Bureau of Labor Statistics reported that health care was the largest source of jobs in 2017 and is predicted to be the largest contributor to job growth in the next decade.*'

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