

Canada. Still at the Crossroads



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Canada

Still at the Crossroads.

Canada is rightfully proud of its health system. What started out as hospital insurance for the people of just one province around 50 years ago, has now blossomed into Universal Healthcare for 36 million people. Canadians know its faults, but need only peer over the fence at their American neighbours and reflect on the fact that they spend half as much on healthcare and yet lead longer, healthier lives. Tommy Douglas, founder of its famous Medicare system, is something of a national hero in Canada.

And yet, for a health system so young, it is surprisingly traditional. Canada has been slow to adopt innovations like group-based care, value-based care, even multi-disciplinary team working, and as a result, its workforce struggles to keep up with the demands of an ageing, ailing society. Wait lists are long. Hallway medicine is a problem, and access to a primary care doctor is unavailable to 1 in 6.ⁱ Burnout is rife.

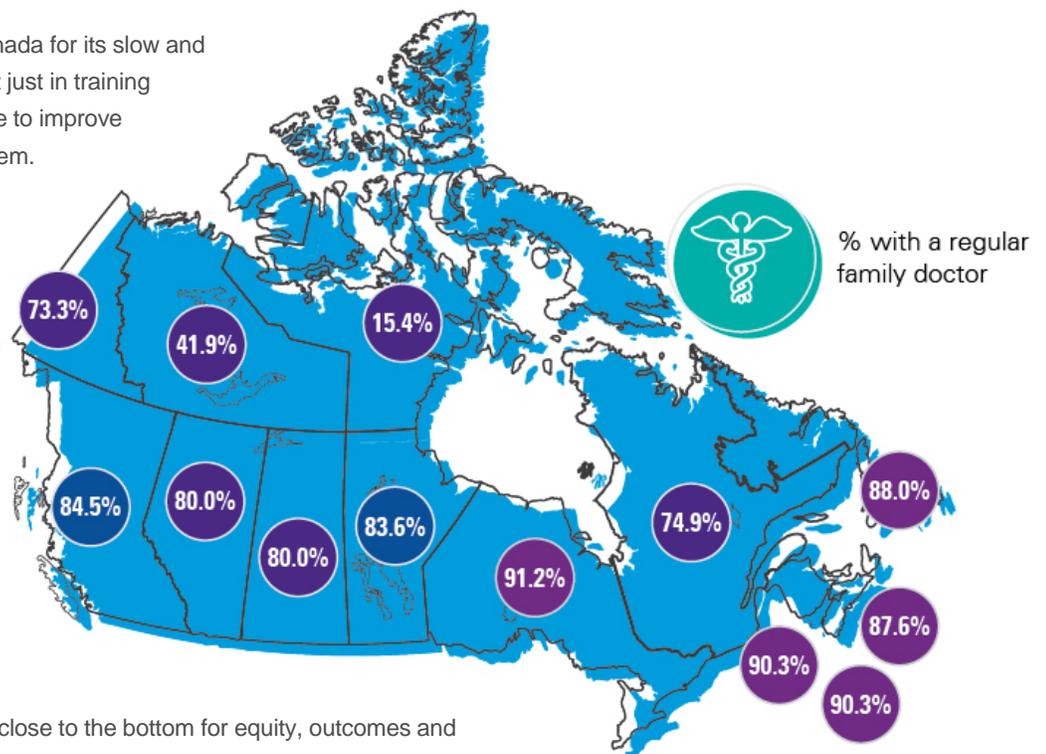
A recent Lancet articleⁱⁱ criticized Canada for its slow and incremental approach to reform – not just in training numbers – but in the work it has done to improve productivity and efficiency in the system.

Canada is not so much a system in crisis it says, as a system in stasis.

For example, 'In Search of the Perfect Health System' (2015), which examined health systems from around the world, included a chapter entitled 'Canada at the Crossroads'. It seems this great nation is still stuck there.

Canada's pride is testament to the power of universal healthcare to generate social cohesion and solidarity, but it must not be complacent. A recent

Commonwealth ranking put Canada close to the bottom for equity, outcomes and access.ⁱⁱⁱ Without bold action to reform their health system, Canada's version of Universal Healthcare could soon be in danger of becoming dangerously stretched.



A numbers game

Canada does indeed have a low density of doctors compared to other OECD countries. With only 2.7 doctors and 9.9 nurses per 1000 people, Canada ranks 26th and 16th respectively for doctor and nurse density out of a total of 36 OECD countries.^{iv}

It was not always so. In the 1970's, Canada had one of the highest physician to population ratios in the world. So much so that in 1992, the Barer-Stoddart report on Human Resources argued there were too many. In response, the Canadian government embarked on a series of measures to reduce physician numbers including a 10% reduction in medical school enrolment, restrictions on the practice of International Medical Graduates, and policies like physician remuneration

caps that led to a significant number of Canadian physicians migrating to the US. By the year 2000, the net inflow of physicians into the national pool had reduced from 1040 annually to just 313.^v A case of 'feast then famine'.

The numbers have picked up since. In response to a steep drop in the physician to population ratio, the government switched tack. Between 2003 and 2013, it oversaw a 48%^{vi} increase in medical places but it is no secret that Canada has relied heavily on International Medical Graduates (IMGs) too. In 2015, over a quarter^{vii} of Canadian physicians had received their MD outside of Canada.

Rural Practice

IMGs have been particularly important in delivering care in rural and remote areas. Whereas almost a fifth of Canada's population lives in rural or remote areas, only about 10% of doctors do^{viii} – and even then, they are spread thinly.

Canada is the second largest country in world by geography with 95% of its landmass rural. In areas such as these, somewhere between 72 and 84% of the physician workforce is made up of family doctors.^{ix} Not only do these doctors provide what we think of as primary care, often they end up providing emergency care, secondary care and at times, tertiary care too – aided by communication with specialists in urban centres.

The work is challenging and not only is physician density low but turnover is high. In 2007, the average length of practice of physicians in rural areas was 9.5 years compared to 12.6 years in urban areas.^x Rural regions have been able to rely on high numbers of IMGs to provide care due to the "return of service" components of their work agreements but while IMGs are more likely to start out in rural practice, they are less likely than Canadian Medical Graduates to stay.

A range of initiatives across rural Canada ensure access to healthcare for its people – regional networks, telemedicine and the expansion of scope of practice for non-physicians – a few warrant special mention.

In Nova Scotia and Saskatchewan for example, doctors are using a combination of standard video-link technology coupled with remotely controlled robotics and diagnostics, to consult, diagnose and monitor patients in hard to reach areas. With the assistance of health workers who are present with the patient during the consultation, doctors are able to use connected diagnostic equipment such as stethoscopes, ultrasounds and electrocardiograms to see, touch and hear the patient from afar, overcoming regional workforce shortages in those communities.^{xi}

In Nunavut, another vast territory populated sparsely with small and largely isolated communities, telehealth is providing a lifeline for children and young people with mental health problems. A partnership between Nunavut Telehealth and the Hospital for SickKids in Toronto, allows patients and mental health workers in Nunavut to connect with specialists in Toronto. Not only are the specialists able to offer expert diagnostic and treatment advice, but they are also able to share their expertise and skills with local care providers improving the capacity to care in regional areas.^{xii}

In terms of more upstream measures to address the regional workforce disparity in Canada, the Northern Ontario School of Medicine, is a good example. Canada's first new medical school in 50 years was created to improve the recruitment and retention of medical graduates into Canadian rural family practice. At this university, 92% of medical students have grown up in Northern Ontario with the remaining 8% coming from other parts of remote or rural Canada. As a result, over 70% of residents stay in a rural community after graduation. Although it is an expensive policy, investing in local community in this way is estimated to have provided an economic boost of between \$122 and \$134 million to the area (2016/2017).^{xiii}

This is something the College of Family Physicians of Canada (CFPC) wants to see more of. In their 2019 Pre-budget Submission to the House of Commons Standing Committee on Finance, they point out that 28% of Canada's employed population live in rural areas and yet health systems in these areas often receive both inadequate and unsuitable support.^{xiv} Policies are often guided by urban healthcare models, and do not meet the needs of local populations – particularly indigenous populations. This can then exacerbate already existing health inequalities.

What is needed, they argue, is the regional capacity to innovate and they recommend two things. Firstly, that funding for rural health be matched to the proportion of the population who live there (ie 18% of the budget for 18% of the population) and secondly, that argue for the development local solutions through a pan-Canadian network of Rural Health Innovation Generators (RHIGs).

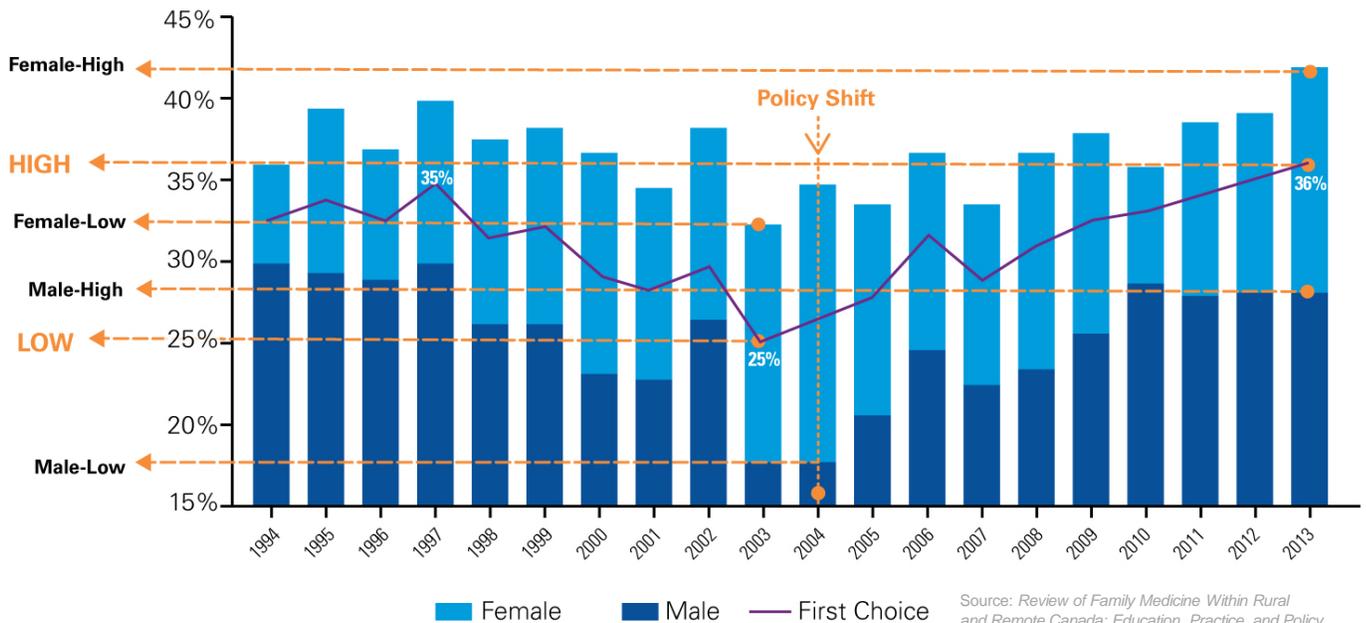
The second special mention in medical education, goes to the CFPC and their Triple C Competency-based Curriculum which aims to realign the skills of health workers with the needs of local populations. Under this initiative, local residency programs define the competencies required for successful practice of family medicine in their area. Although residents must still pass the core curriculum of the CFPC, graduates are better prepared to meet the needs of their local population and better prepared for the challenge of meeting them.

Primary care

But rural practice is not the only area where family doctors are scarce. According to the Canadian Institute of Healthcare Information (CIHI), 1 in 6 Canadians now report they do not have access to a regular family doctor.

The problem is in part, historical. Family medicine has been an unpopular option. Overworked, underpaid and under-appreciated, interest in family medicine as a first choice of specialty declined steadily in the 1990's until 2003 when it bottomed out at around 25% (Figure 1).^{xv}

Figure 1.
Choice of Family Medicine, 1994-2013



Source: Review of Family Medicine Within Rural and Remote Canada: Education, Practice, and Policy

But a policy shift in 2004 saw a number of initiatives launched simultaneously by governments and educators across Canada. These initiatives included measures like engaging mentors for trainee medics, revamped curricula, and the creation of financial incentives. Between 2001 and 2013, the number of residency programs in Canada tripled and applications went up over 10 times (Figure 2).

Figure 2.
Tracking Family Medicine Expansion: 2001-2013

	2001	2013	
Quota offered	469	1,424	➔ 303% Expansion!
Number of programs	29	87*	➔ 300% Expansion!
Number of applications	5,093	49,008	➔ 1,159% Expansion!
Percentage of positions filled	79%	92%†	

* Does not include 38 programs in the IMG stream or 33 programs in military streams
 † After 2nd iteration, 97% positions filled in 2013

Source: Review of Family Medicine Within Rural and Remote Canada: Education, Practice, and Policy

Today, around 38%^{xvi} of medical graduates now choose to specialize in family medicine and around 51%^{xvii} of the physician workforce in Canada are family physicians. Family Medicine doesn't have a numbers problem anymore – it has a productivity problem.

The reasons for the productivity gap are multiple but a physician-centric delivery model with a reimbursement mechanism that encourages volume over value are significant factors.

Family Medicine is physician centric because it relies so heavily on doctors to provide its services. Allied professions like nursing and physiotherapy for example, are under utilized because their services are often not directly billable.

The history of the medical profession's relationship with the single payer insurance system is relevant here. When single payer insurance was introduced to the province of Saskatchewan in 1962, the medical profession opposed it. In fact, they went on strike for 23 days, arguing that working directly for government would compromise their professional autonomy and decision-making. The agreement that was reached, was that doctors would participate in the scheme if they could retain their independent contractor status, remunerated on a Fee-For-Service (FFS) basis (rather than being employed and paid a salary as other health professionals are). The Saskatoon Agreement as it was later known, became the template on which Medicare was spread across Canada and resulted in a model of primary care that has persisted for decades – delivered predominantly by physicians, working alone or in small groups.

That said however, even those practices willing to employ more allied health professionals would find themselves up against different barriers – particularly the law. The issue of what one professional can and can't do can differ markedly between provinces. In Ontario for example, Nurse Practitioners are able to prescribe drugs, order tests and discharge patients – features that have made them invaluable in providing primary care services in rural and

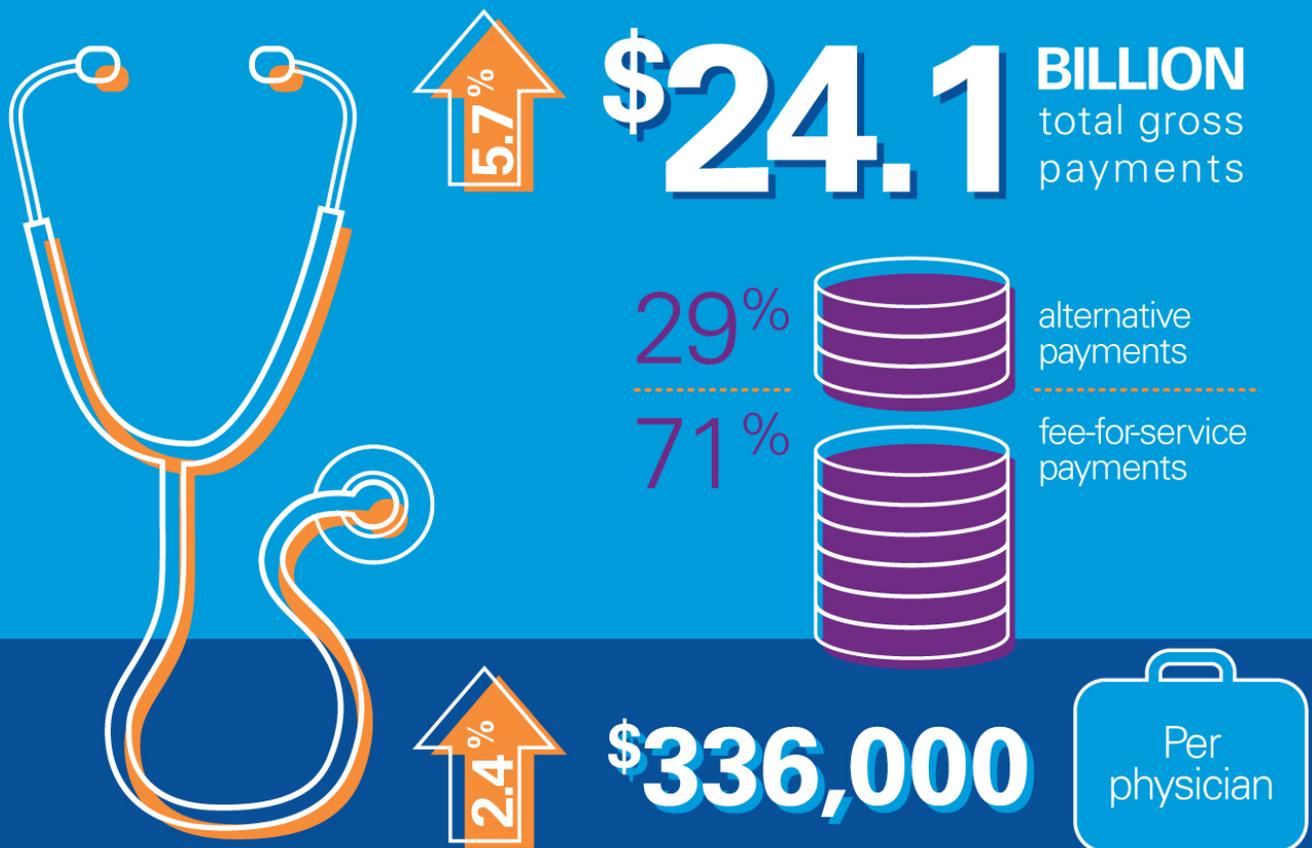
remote regions of the north. In other provinces however, the scope of practice for NPs is more limited. This means, according to Dr. Shamian, Past President of the Canadian Nurses Association, that “we are graduating more [NPs] but the jobs aren't there because the provinces haven't changed their practices and their legislation. We have too many unemployed NPs in Canada and that doesn't make sense when almost 5 million Canadians don't have a primary care provider.”^{xviii}

Not only has FFS reimbursement driven a physician centric service, it has also driven demand. Of course this is in part because by its very nature, FFS favours volume over value, but in part too it is because FFS creates so few incentives for illness prevention and health promotion. It is said that Tommy Douglas intended to follow his health payment reforms with health service reforms, concentrating on population health and the social determinants of health - but it was not to be achieved in his lifetime.

Primary Care reform

Recognizing the need for reform, the seminal Romanow Report in 2002^{xix} put the case for a model providing 24/7 care with access to inter-professional health teams, and an emphasis on health promotion. In 2004, all federal, provincial and territorial governments committed to ensuring that 50% of Canadians would have access to multidisciplinary teams in primary healthcare by 2011. Romanow suggested provinces be allowed to develop their own unique approach within some federal guiding principles.

In 2018, the North American Observatory on Health Systems and Policies published a report^{xx} assessing the extent to which jurisdictions had delivered on that promise. To evaluate progress, the organization looked at 6 evidence-based criteria ranging from inter-professional team working, through to access, use of IT, remuneration models and physician accountability. The research found that while alternative payment methods such as blended, capitated or salaried models were more prevalent now than in previous years, the old FFS model still prevailed in most Canadian provinces and that most provinces were nowhere near the 50% target of access to multi-professional care.



Source: Canada's Health Care Systems and Health Workforce by the Numbers

That's not to say there aren't islands of innovation and good practice. In Ontario for example, 94% of primary care physicians were remunerated through FFS in 2002 but by 2015, less than a quarter were – and most of those remaining were on FFS for providing specialized services like palliative care or psychotherapy. Their model also showed promising health outcomes. Independent evaluations of Ontario's multi-professional Family Health Teams (FHTs) found improved rates of preventive services like cervical, breast and colorectal cancer screening and better diabetes care than standard primary care services – and all secured with a below average primary care physician density in the province.

Similarly, in the rural regions of Northwest Territories and Nunavut, alternative payment methods have helped facilitate nurse-led community health centres (CHCs) where nurses provide the majority of primary health services supported by physicians offering remote support and consultations and occasional visits. In Manitoba, Quick Care Clinics are set up to manage low-complexity primary health needs like rashes, sprains, immunizations and birth control, and are staffed entirely by nurses and nurse practitioners.^{xxi}

Innovation is everywhere you look in Canada's health system but scaling it across provincial borders is harder. In theory, a single payer system would make it easier for innovation to spread, but the reality is that federal-provincial-territorial collaboration is poor. This well recognized phenomenon prompted one former Health Minister to dub Canada "the land of perpetual pilot projects."

The Pan-Canadian Health Organizations (there are 9 of them) are Arm's Length Bodies (ALBs) of the federal government designed to ensure that the experience of healthcare is equal across the country. They set standards, spread best practice and perform national duties that it would not make sense to be repeated 13 times over. An external review of their functions in 2018 however, concluded that aspiration was not being fully realized.^{xxii} Rather than a set of recommendations, the report set out four possible futures for the ALB's, each focused on a different guiding principle - efficiency, innovation, engagement or equity. It's an interesting document. It remains to be seen, what the Federal Health Minister chooses to do with its advice.

Secondary care

Similar issues with productivity are seen in secondary care too – a problem that quickly becomes visible when it results in long wait lists and people being treated in hospital hallways. In outpatient and elective care for example, it is now estimated that 30% of those waiting for specialist referral wait longer than 2 months and 18% of those waiting for elective non-urgent surgery wait more than 4 months.^{xxiii}

It's tempting to frame the problem in terms of a lack of specialist staff but evidence suggests otherwise. A recent study by the Royal College of Physicians and Surgeons of Canada (RCFSC) reported growing under- and unemployment of specialists in Canada - with around 16% of newly certified specialists stating they could not find work after graduation and around 21% of subspecialists saying the same.^{xxiv} The report says it's unclear whether this is due to a saturation of the market or an inadequacy of resources to hire specialists (or both) but what is clear, is that training more specialists is not the answer to this particular problem.

Making better use of their time however, just might be. The Alberta Bone and Joint Institute in Calgary is a good example of this. Their organization managed to reduce the wait time for hip and knee consultations from 145 to just 21 days by standardizing work practices, adopting more inter-professional working and improving flow through the hospital.^{xxv} It is a lesson in operational excellence but such examples are rare in Canada. Reassessing work practices in this way requires significant physician engagement as autonomy is inevitably eroded. At times, governments seeking to engage physicians in this process have had to “buy their buy-in” – by 2012, the Ontario government was spending \$1billion a year on primary care reform^{xxvi} – a large portion of which was increased physician remuneration.

Physicians often worry too that operational excellence and new models of care are simply ways of working them harder but in fact, its aim is the opposite. Gigi Osler, President of the Canadian Medical Association (CMA), believes that addressing organizational stressors at work are far more effective at addressing burnout than providing so called resiliency training, though it is harder, and more expensive. A shifting wind may be afoot. The CMA recently renewed their strategic plan, putting patients at the centre of its mission, and medical associations in at least two provinces have committed to health system reform with governments.

Where is most of the money being spent?



Hospitals

29.5%
of health spending



\$1,804
per capita



0.9%
Growth



Drugs

15.7%
of health spending



\$959
per capita



0.7%
Growth



Physicians

15.5%
of health spending



\$946
per capita



2.2%
Growth

Growth per capita has outpaced that for hospitals or drugs since 2007

Source: Canada's Health Care Systems and Health Workforce by the Numbers

Integrated care

Lets hope they mean it. The next step, integrating primary, secondary and community services will challenge their working models even further. Ontario (again) is at the forefront of this work. A pilot project at the North York General Hospital found that not only was there a reduction in the frequency of hospital readmissions for patients when their care was integrated, but overall length of stay was reduced as well. Ontario now plans to merge 20 health providers in the province employing more than 10,000 people in total, into an organization called Ontario Health. Of course, merging organizations isn't the same as integrating healthcare. Our work on integration globally suggests there are 9 prerequisites for successful population health management.

It is a grand project already said to be pushing the boundaries of the terms and conditions set out in the Saskatoon Agreement. But unless Canada takes bold action to address productivity, it will never have enough clinicians to staff it – and its noble ambition to provide universal, equitable and portable coverage, free at the point of use, could falter.

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