



Canadian Foundation for  
**Healthcare  
Improvement**



# HEALTHCARE PRIORITIES IN CANADA: A BACKGROUNDER

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- Coordinated healthcare: Providing a more coordinated approach to addressing complex health needs.

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## OVERVIEW OF HEALTHCARE IN CANADA

Healthcare in Canada is a complex, diffuse and decentralized arrangement of actors and services. Although we sometimes speak of the ‘Canadian healthcare system,’ there is no single, national health system. Rather, there are 14 single-payer, universal and public systems—10 provinces, three northern territories and the federal government—which deliver primary and supplementary health services to select populations, including First Nations, Inuit and Métis people, federal police, veterans, military personnel and inmates in federal prisons. Collectively, we refer to these systems as ‘medicare,’ each of which grants access to doctors and hospitals, paid for by governments through Canadian tax contributions.

The 1984 *Canada Health Act* (CHA) sets out the primary objective of healthcare: “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (Government of Canada, 1984). Provinces and territories must adhere to the CHA or risk losing federal transfers. The CHA outlines standards for core services through its five principles:

- public, non-profit administration (although facilities and services are not necessarily publicly owned and offered)
- comprehensive coverage (of the physician, hospital and dental services that are deemed ‘medically necessary’)
- universality (everyone is covered and receives the same standards of care)
- portability (everyone is covered wherever they go in the country), and
- accessibility (or free at the point of delivery without co-payments, deductibles or annual limits).

Essentially, medicare provides universal coverage for medically necessary hospital and physician services provided on the basis of need, rather than ability to pay.

### Deep but narrow medicare coverage

With its focus on covering healthcare in hospitals and access to doctors, medicare coverage in Canada is considered to be deep but narrow. Other ‘supplemental’ healthcare costs, such as prescription drugs, dentistry, home care and long-term care, are covered through various mixes of household out-of-pocket payments, commercial and not-for-profit insurance and direct public financing. For these supplemental services, what is covered, how and to what extent, varies by province and territory. Many employers, large and small, cover a range of these supplementary services for their employees through private insurance plans, the costs of which have dramatically increased in recent years. While medicare does provide universal access to hospital-based care and to doctors across all provinces and territories as provided for in the CHA, approximately 15% of Canadians have no employer-provided ‘supplemental’ health insurance for the non-medicare provided ‘extended benefits,’ as they are commonly called in Canada (The Commonwealth Fund, 2010)—hence the ‘deep but narrow’ description of Canadian medicare.

### Care transitions and integration

Due to the deep and narrow nature of publicly financed healthcare in this country, access to non-core services such as rehabilitation and home care is variable, often dependent on income and also contingent on whether provinces choose to wholly or partially fund them. Consequently, transitions between services are often disjointed. Individuals with ongoing care needs, such as the elderly, disabled

or chronically ill, require a range of services and access points. When care is disconnected and where people must pay out-of-pocket for some or all of their care, it can be detrimental to their health and costly to the healthcare system. Alternate Level of Care (ALC) beds—hospital beds for non-acute patients waiting for more appropriate care elsewhere (Velhi, 2010)—remain a big problem in Canadian hospitals where more than 92,000 hospitalizations and 2.4 million hospital days involved ALC stays in 2008 and 2009 alone (CIHI, 2010). In addition, many patients take avoidable trips to the emergency department (ED) and return to hospital for care they should receive at home or in their communities (CIHI, 2010). In some cases, people are relying on hospital-based services as other types of care are unavailable; for example, in the absence of frontline mental health services, people with mental illness or substance abuse often have few access points beyond urgent and emergency care.

## Healthcare spending rises but growth rate slows

The sister policy to the CHA is the Canada Health Transfer (CHT) which sets out the federal financial support (cash contributions and tax transfers) to the provinces and territories (Government of Canada, 2004). Should provinces or territories abandon the CHA principles—for example, by imposing user fees or allowing extra-billing by physicians—the federal government can enforce a statutory dollar-for-dollar penalty in its federal cash contribution (though enforcement of these and other provisions has always been applied with considerable federal discretion). Federal transfer payments to provinces and territories have grown steadily from \$20.3 billion in 2005 to an expected \$28.6 billion in 2012-13 (reflecting an annual growth rate of nearly 6%). In 2011, the federal government announced that the current rate of growth of 6% would continue from 2012-13 to 2017-18 at which time a new federal funding formula would commence for a 10 year period. Under the new formula, federal transfers will increase in line with nominal Gross Domestic Product (GDP) growth plus 1% with a growth floor of at least 3% per year (Di Matteo, 2012). The federal government's stated intent has been to provide provinces and territories with stable, predictable levels of funding for a significant period of time.

On the surface, Canada is like other Organisation for Economic Co-operation and Development (OECD) nations where aggregate healthcare spending has been an upward trajectory. Canada's total public and private health expenditures have risen from \$78.7 billion in 1997 to an estimated \$211 billion (or approximately \$6,000 per person) in 2013. The rate of growth in health spending, however, is slowing and, in recent years, has not kept pace with inflation and population growth for the first time in nearly 15 years. Health spending is expected to increase by 2.6% this year after rising an average of 7% per year from 2000 to 2010. Placed in perspective, after adjusting for inflation and population growth, health spending actually decreased by 0.1% in 2012 and 0.2% in 2013. The recent trend may indicate the start of a 'bending of the spending curve.' Since 2010, health spending growth has been less than growth in the overall economy. As a result, the health expenditure-to-GDP ratio declined from 11.6% in 2009 to 11.2% in 2013 (CIHI, 2013a). By way of context, the rapid growth in healthcare spending that began at the end of the last century coincided with federal and provincial/territorial governments returning to a balanced budget scenario. The recent resolve to contain costs is, arguably, fall-out from the 2008 global economic crisis that led to stimulus spending and deficits. Both levels of government also cut taxes in the 1990s and early 2000s, foregoing a lot of revenue.

The lion's share (93.4%) of public sector spending is accounted for by provincial and territorial governments' spending on healthcare delivery and policy; the minority portion is accounted for by direct federal spending (4.2%) and by municipal governments and Social Security Funds (including workers' compensation boards and premiums in the compulsory Quebec Drug Insurance Fund) (2.4%). Reciprocally, private sector spending has stabilized at 30% of total spending, mainly involving household out-of-pocket expenses and private insurance expenditures for services that are not publicly

insured (as noted above). Out-of-pocket payments, as a percentage of total health expenditures in Canada, was 15% in 2012 which is below the OECD average (19.2%) but higher than the United States (U.S.) (11.6%), United Kingdom (U.K.) (9.9%) and the Netherlands (6%) (OECD, 2013a). Compared with other OECD nations, in 2010, Canada's publicly financed share of total health expenditures (71%)—which has remained relatively stable for 30+ years—was well below the Netherlands, Denmark, the U.K., Sweden, Japan, France, and Germany (ranging from 77 to 86% each); above the U.S. (48%) and Switzerland (65%), and close to par with Australia (68%) (OECD, 2013a).

### **Among top cost drivers: Higher use of prescription drugs and diagnostic imaging**

Contrary to widespread Canadian opinion, population aging is not a major cost driver of healthcare spending. In fact, the three major drivers of public-sector healthcare spending from 1998 to 2008 included provider compensation, increased use of services and an evolution in the types of services provided and used (CIHI, 2011c; Constant et al, 2011). That evolution is especially evident in prescription drug use and diagnostic imaging, where usage surged as Computed Tomography (CT) scanner capacity doubled and Magnetic Resonance Imaging (MRI) capacity increased five-fold from 1997 to 2010. Hospitals continue to account for the greatest proportion of expenditures—taking up an estimated 29.2% (\$60.5 billion) of total healthcare dollars in 2012—but their share has steadily decreased over time (down from 44.7% in 1975). Conversely, prescription and non-prescription drug costs have grown rapidly with their share nearly doubling from approximately 8.5% in the mid-1970s to an estimated 16% (\$33 billion) in 2012, granted their proportion of total spending appears to be leveling off. Most (84%) of these costs are for prescription drugs, less than half of which (45%) are publicly funded. Meanwhile, payments to physicians take up the third largest share of total healthcare dollars (an estimated 14% or \$30 billion in 2012) (CIHI, 2012a), virtually all of which (99%) is publicly funded. This rise in physician payment is partly due to the rapidly growing number of practising physicians (specialists in particular, according to the Royal College of Physicians and Surgeons of Canada's 2013 report, *What's really behind Canada's unemployed specialists? Too many, too few doctors*), with medical school enrolment up by 79% since 1997-98 (RCPSC, 2013; Slade, 2012).

### **Provinces and territories face common management challenges**

In addition to its financial, policy and delivery roles, the federal government is responsible for the collection and provision of health data, major funding of health research, and delivery of some public health programs and health protection (including pharmaceutical regulation). At the provincial/territorial level, where the majority of health services are delivered, many provinces/territories have moved toward regionalization (or decentralization) of their service delivery systems, replacing hospital and other local boards with a regional authority mandated to better integrate and coordinate the provision of services across the continuum of care (Akunov & Verma, 2014a). While there are differences across the provinces and territories—for example, in how healthcare is organized and financed, as well as how quality of care is measured and reported (Akunov & Verma, 2014a, 2014b, 2014c)—provinces and territories face similar management challenges in contending with the parallel authority of privately practising physicians, most of whom legally function as 'independent contractors' outside the regional structures. While the 'health authorities' are in theory responsible for managing the delivery of public healthcare services with budgets provided by each of the provincial/territorial governments, doctors' fees are negotiated directly between each provincial/territorial medical association and the respective provincial/territorial government. The independence of doctors and the limited engagement they have with the administrative authorities creates a relative vacuum in terms of a 'locus of management' in Canadian healthcare, particularly in the community-setting.

Further, with healthcare as the *PacMan* of public spending, eating up almost half of provincial/territorial budgets and with increasing costs of care, provincial/territorial negotiations (or oftentimes, disputes) with doctors and their medical professional associations over fee code and billing schedule adjustments remain a pressing public policy issue.

A small minority of physicians (approximately 2%) have opted out of working in the public system, instead providing their services in a variety of private, for-profit, investor-owned medical clinics, diagnostic imaging facilities and surgical centres across the country. Interestingly, the CHA does not prevent a provincial/territorial government from contracting with these private clinics/centres to provide specific services at mutually agreed upon rates of reimbursement provided that patients are not subject to additional fees or charges. In 2005, the Supreme Court of Canada overturned a Quebec court's ruling that prevented Quebecers from buying private healthcare insurance for publicly insured services (Supreme Court of Canada, 2005). However, since the ruling, not one private policy has been purchased and six provinces did not prohibit the offer of private insurance for core medicare services even before the court challenge. The debate over whether to expand the role of private-for-profit medical care in Canada's public system will undoubtedly continue, particularly as provincial/territorial governments attempt to slow the growth in tax-financed health spending while grappling with fiscal deficits.

### **As healthcare disparities persist and costs rise, the need to work together is reinforced**

While Canada performs relatively well in terms of population health indicators, large disparities remain. Significant indicators associated with health disparities include socioeconomic status, Aboriginal identity, gender and geography. The consequences of health disparities appear most prominent for the lowest 20% on the socioeconomic scale and Aboriginal peoples, including First Nations and Inuit populations. Compared to Canadians overall, Aboriginal people have lower life expectancy, higher infant mortality rates, rising incidence of infants with low birth weight, higher mortality rates, higher rates of suicide, higher rates of sexually transmitted infections, rising rates of diabetes, higher rates of obesity, a shortage of health and homecare services, and higher rates of major mental health disorders (HCC, 2005; NAHO, 2012). It is fair to say that in Canada (as in other countries), inequalities in health status represent a major challenge for policy-makers, requiring multiple, coordinated interventions both within and beyond the healthcare sector.

Healthcare in Canada, as elsewhere, must adapt in order to alleviate inequalities and address the needs of the chronically ill and an aging population, especially at a time of fiscal constraint. Some commentators argue that for Canadian medicare to become more cost effective and efficient, it will require expansion to include a range of services currently covered by (privately insured) extended benefits.

### **Value for money?**

Canada lacks good data and evidence to link healthcare delivery to health outcomes which would provide clues to whether the improvements in the health of the population are worth the additional investments. At a macro level, international comparative studies suggest that Canada's performance on major indicators is adequate at best despite this country's relatively high cost health services (OECD, 2011). A comparison between Canada (11.2% of GDP spent on healthcare in 2011) and the U.S. (17.7% of GDP) might shore up Canadians' pride in their health system, but beyond North America, similar or better health services are being provided at a much lower per capita cost.

Recent research has elucidated the factors that underlie the rise in healthcare expenditures in Canada. For example, population growth, population aging, income growth and inflation are measurable and predictable contributors to expenditure growth. However, in Canada, there remains a substantial amount of unmeasured growth, referred to in the economic literature as the ‘enrichment factor.’

### **Achieving value in the current fiscal climate**

Understanding ‘enrichment’ which is attributed to advances in medical science and technological innovation, changes in disease patterns (e.g. more chronic diseases and mental illnesses), patient behaviours and preferences—and whether the benefits of advances justify its costs—is vital to policy approaches to improve value for money in Canada’s health systems. Among the approaches is health technology assessment which can inform disinvestment strategies, clinical decision-making, reimbursement decisions, prices of new technologies and provider fees. It also takes in redesigning care to respond to the growing need for community care, prevention services, and chronic disease management, as well as accelerating the implementation of coordinated health information technology systems.

### **Collaborating across jurisdictions to improve care and achieve efficiencies**

The fact that Canada consists of not one, but 13 provincial/territorial health systems means that innovations in care are happening provincially/territorially, regionally and locally. The challenge in Canada is to facilitate channels and mechanisms that healthcare decision- and policy-makers require to share these innovations and spread or scale up successful approaches across regions. In response to these challenges, the Canadian Foundation for Healthcare Improvement, a national, not-for-profit organization funded through an agreement with the Government of Canada, has recently stepped into this space to encourage collaboration across regions and to spread proven and promising innovative practices across the country. The provinces and territories are also increasingly collaborating across jurisdictions. For example, in early 2012, Canada’s provincial and territorial premiers (who comprise the Council of the Federation) created a pan-Canadian Healthcare Innovation Working Group, recognizing that when it comes to improving healthcare for Canadians, “more can be done together.” The working group has since released its first report which captures areas where the provinces/territories have started working together (Council of the Federation, 2012a; 2012b). For example, in a move toward increased collaboration, the Council of the Federation recently agreed to the collective bulk purchasing of a limited number of generic drugs.

## **I. CHRONIC DISEASE MANAGEMENT & PREVENTION**

When it was established in the 1950s and 1960s, public healthcare in Canada was purposefully designed to treat patients with acute, episodic care needs, and in many cases, it does this exceptionally well. Canada has been recognized globally for providing hospital and physician services without financial charge at the point of care to all citizens, and for producing health outcomes that have rivalled most other countries in the developed world (The Commonwealth Fund, 2010). But as the burden of chronic conditions and frailty has overtaken episodic needs—and as the metrics to evaluate health system performance have evolved to take these needs into account—the performance of healthcare in Canada has ceased to be the exemplar it once was on the international stage.

Canadians are increasingly in need of community-based, outpatient and ambulatory care, however, the CHA—with its focus on hospital and physician care—arguably makes it legislatively challenging (though not impossible) to adapt to contemporary needs.

## Meeting current health needs

Chronic diseases, such as diabetes, cardiovascular disease, chronic obstructive pulmonary disease and cancer, represent an ever-growing concern worldwide. Advances in medical science and sanitation over the last century have significantly lowered the mortality effect of acute disability and once-deadly infectious diseases. This, in part, has given rise to population growth and improvements in longevity for developed countries. The result has been a marked shift in the burden of ill health from acute disease to longer-term, chronic illness. Making efforts to modernize the ways in which Canada responds to the healthcare needs of its population is one of the greatest challenges facing healthcare in this country.

The statistics paint a telling picture. In 1999, chronic diseases accounted for almost half of all diseases globally and their share is expected to grow steadily to 60% by 2020 (WHO, 2014b). In 2010, chronic (non-communicable) diseases accounted for 89% of all deaths in Canada (WHO, 2011).

There is wide variability across provinces and territories in the proportion of people living with chronic diseases and other health conditions. In 2011, more than half (56%) of all Canadians aged 12 or older reported living with at least one chronic condition (PHAC, 2013). The economic toll of these diseases is astonishing. More than half (58%) of all annual healthcare spending in Canada is on chronic diseases, at a cost of \$68 billion per year (PHAC, 2011). Accounting for indirect factors beyond healthcare (e.g. loss of workforce productivity), chronic disease in Canada is estimated to cost a total of \$190 billion annually (PHAC, 2011)—almost as much as the country's entire annual healthcare bill in 2013 (CIHI, 2013a).

## Innovations and transformative change

The physician- and hospital-centric model of healthcare in Canada was not designed to prevent disease or help patients manage chronic conditions. On the contrary, it is optimally designed to treat acute illness over brief periods of time. Without an adequate alternative, many patients with long-term care needs find themselves stranded within hospital walls—too sick to be discharged but not acutely ill enough to benefit from the interventions a hospital can offer. Moreover, the care provided within hospitals is vastly more expensive than the care delivered in the community or on an outpatient basis. At best, chronically ill patients in hospitals are blocking access for those with acute care needs; at worst, these chronically ill patients are receiving a level of care that is inconsistent with their wishes and needs, and are being unnecessarily subjected to health risks.

## II. POPULATION & PUBLIC HEALTH

Canada devotes the lion's share of its program spending to healthcare (CIHI, 2011a). Vast amounts of financial and human capital are invested each year in delivering healthcare services to the population. However, while modern medicine continues to achieve incredible feats (such as mapping the human genome and finding cures for once untreatable diseases), decades of research has shown that our health is primarily influenced by factors that lie outside the traditional realm of healthcare.

Especially as the population ages and experiences increasing rates of chronic disease, the advanced medical care available in healthcare systems in Canada and around the world has less and less impact on overall population health status. The population and public health movement in Canada began in earnest in the 1970s with the release of the federal government's white paper, *A New Perspective on the Health of Canadians*. This was bolstered in the 1986 Ottawa Charter for Health Promotion. In fact, it can be argued that Canada has literally 'written the book' on population health. However, putting

that book into practice has been much less effective. Research into the non-medical determinants of health, early childhood development and the importance of an effective system of public health led to an expanded definition of population health as being “influenced by social, economic and physical environments, personal health practices, individual capacity and coping skills, human biology, early childhood development, and health services” (FPT Advisory Committee on Population Health, 1997). Again, in terms of population and public health, Canadian research and science in these areas has been world-leading.

## The population’s health

Advances in our understanding of public health interventions, including evidence-based approaches to preventing illness and promoting healthy lifestyles, have garnered measured improvements in Canadians’ health status and concomitant reductions in risk factors. In 2009, life expectancy at birth in Canada (80.7 years of age) stood above the OECD average (79.5 years of age) and on par with the U.K. (80.4), the Netherlands (80.6), New Zealand (80.8) and France (81.0) (OECD, 2011). Due in part to world renowned smoking cessation programs (e.g. The Ottawa Model), an abundance of policy initiatives that aim to prevent people from starting to smoke (e.g. advertising bans and increased taxation) and public health campaigns (e.g. to raise awareness of the problem of “social smoking”), Canada has made huge strides in reducing tobacco consumption. Over the past 30 years, the number of habitually smoking adults has more than halved (from 34% in 1979 to 15.7% in 2011) (OECD, 2013a).

While some statistics show improvement, others show persistent worsening. For example, obesity rates, a growing concern for all developed countries, continue to rise. In 2010, a quarter of all Canadians were considered to be obese. The research indicates that this issue will further frustrate efforts to stem the tide of chronic health conditions, such as diabetes and cardiovascular diseases (OECD, 2013a).

Canada has shown great leadership in the science of population health. Yet improvements are needed in our collaboration across and between governments to better address the determinants of health, enhance health promotion efforts and tackle the population health needs of Canadians.

## III. CARE OF THE FRAIL ELDERLY

In almost every country, the proportion of people aged 60 years and older is growing faster than any other age group as a result of both longer life expectancy and declining fertility rates (WHO, 2014a). This demographic shift presents new healthcare challenges (WHO, 2014a). By 2015, Canada will already have more people aged 65 and older than people aged 15 and younger. And by 2050, the proportion of Canada’s elderly is estimated to be one in four persons (Statistics Canada, 2008).

### The cost of aging

As would be expected, seniors (aged 65 years and over) use more healthcare services than younger Canadians. They are more likely than younger people to have chronic conditions (and more of them), such as heart disease, dementia and diabetes, which require longer hospital stays and more physician visits (Denton & Spencer, 2010). Having multiple chronic conditions may also involve the use of many different drugs to treat each condition separately. These complex treatment regimens are often not managed well, leading to adverse drug reactions and further hospitalizations (CIHI, 2011b). The latest figures (from 2011) reveal that Canada is spending \$11,794 per year per senior on healthcare versus \$2,097 per year per person under the age of 65 (CIHI, 2013a). As seniors age, these figures rise:

seniors who are 80 years of age and older cost the health system \$20,387 per capita, more than three times the cost of younger seniors (CIHI, 2013a), and an 80-year-old person today is twice as likely to have cataract surgery, knee replacement and/or coronary bypass surgery than in 1990 (Lee, 2007). Consider what this means given the population will continue to age in the decades to come—in 2009, the Canadian population had 1.3 million very old persons (aged 80 years or over), twice as many as in 1990, and in the coming years, the over 65 population is expected to increase 2.6 times to reach 3.3 million by 2036, and increase 3.9 times to be more than 5.1 million by 2061 (Statistics Canada, 2010).

At the macro level, the impact that these rising costs (attributable to aging) will have is modest in comparison to that of other cost drivers, such as inflation, intensity of service provision, and technological innovation (Evans, 2010; Constant et al, 2011). Economic models suggest that growth in healthcare costs due to population aging will be about 1% per year between 2010 and 2036 (Mackenzie & Rachlis, 2010). Some might argue that a 1% growth still translates into considerable expenditures given that the public share of healthcare spending topped \$140 billion in 2013 (CIHI, 2013a). Then again, it is also a growth rate that cannot be controlled while other (more significant) cost drivers conceivably can be.

### Restructuring care for seniors

When it comes to caring for seniors aged 65 years and over, Canada ranks in the middle of the pack among OECD countries. In 2009, Canada had 55.9 beds in residential long-term care facilities per 1,000 persons and spent an average of 1.2% of its GDP (between 2006-10) on long-term care, as compared to Switzerland (68.9 beds per 1,000 persons; 1.2% of GDP), the Netherlands (64.9 beds per 1,000 persons; 2.3% of GDP), the U.K. (51.7 beds per 1,000 persons; 0.9% of GDP) and the U.S. (40.2 beds per 1,000 persons and spending 0.6% of its GDP) (OECD, 2013b; 2013c). Meanwhile, when it comes to home care, Canadian primary care physicians are among the least likely of the Commonwealth countries to make home visits—in fact, over half (58%) indicate it is unlikely they will make any home visits (HCC, 2013c). Canadians indicate they want improved access to home- and community based care to help them stay at home longer (CMA, 2013).

Without changes in policy, care delivery, prevention or treatment, the economic implications of greater healthcare use among seniors could be considerable. There are too many seniors in costly acute care settings because less expensive community supports (such as residential care, assisted living or home care) are not available. Canada's reliance on Alternate Level of Care (ALC) beds demonstrates the need for stronger continuing care supports. A move toward integrated continuing care delivery also holds promise for producing sizeable cost savings, creating efficiencies, and improving the quality of care and caregiver satisfaction (Denton and Spencer, 2010; Hollander and Chappell, 2002; Hollander, Chappell, Prince and Shapiro, 2007). Supporting the education, recruitment and retention of caregivers to help with home support is an essential element of a broader labour strategy to meet seniors' care needs while controlling costs.

## IV. ACCESS TO CARE & WAIT TIMES

Canada is an outlier among other single-payer public systems with respect to wait times and access to care—many perceive the lengthy wait times and poor access to care as the major drawbacks or Achilles' heels of healthcare in this country. Federal, provincial and territorial governments have paid particular attention to, and made considerable investments in, issues regarding access to care. As a result, Canada has improved access in some areas (e.g. reduced waits for cataract and hip replacement surgery). However, progress in other areas is lagging (e.g. knee replacement surgery was seeing gains

through reduced wait times, however, more recently, wait times are not declining) and access gaps persist in other areas (e.g. timely discharge from acute care to home care and residential long-term care, wait time from primary care referral to specialist care, and timely mental health services).

### **The old adage—‘what gets measured, matters’—falls short**

Many provinces and territories have wait list registries and management systems with publicly available wait times data for high priority services. These investments followed the 2004 First Minister’s Meeting on the Future of Health Care which saw a \$5.5 billion fund established to assist provincial/territorial efforts to reduce wait times. That meeting also led to the federal government’s “five in five” proposal which aimed to significantly reduce wait times in five key areas over five years. In December 2005, medically recommended wait time benchmarks were established in five priority areas: cancer care, cardiac care, diagnostic imaging (DI), joint (hip and knee) replacement, and sight restoration (cataract surgery) (Government of Canada, 2004). Specifically, provinces and territories committed to the following wait time benchmarks, respectively: radiation therapy for cancer within four weeks of patients being ready for treatment; coronary artery bypass surgery within two weeks for level 1 urgency, six weeks for level 2 urgency, and 26 weeks for level 3 urgency; a commitment to develop benchmarks for DI; hip/knee replacement within 26 weeks and hip fracture repair within 48 hours; and cataract surgery within 16 weeks for those at high risk (CIHI, 2012d).

In March 2012, the Canadian Institute for Health Information (CIHI) reported that, across the five priority areas, wait times have generally improved with at least 80% of patients being treated within benchmark wait times, albeit with the caveat that (except radiation therapy) few provinces/territories have attained the 90% progress threshold, and most recently, the number of Canadians receiving care within the benchmarks has, in some instances, actually fallen (CIHI, 2012c). Arguably, these benchmarks are modest at best, ignoring the “long tail” of wait times (missing a benchmark target by one week is certainly not the same as missing it by 18 weeks, for example). The province of Saskatchewan took measures similar to that of the U.K., setting absolute maximum targets, rather than relying solely on the 90%-within-benchmark targets that make more statistical but less practical sense for patients. For example, as part of the Saskatchewan Surgical Initiative (2010), the health minister cited the target “to reduce surgical waits to no more than three months” by 2015. Recent progress shows the targets are having a positive impact: for example, of the patients waiting for surgery on January 31, 2014, there were 4,608 patients who had waited more than three months for surgery, reflecting a decrease of 70% (or 10,755 fewer patients) since the launch of the Saskatchewan Surgical Initiative (Government of Saskatchewan, 2014).

In recent years, progress on reducing wait times has indeed stalled. In a 2013 report, the Health Council of Canada (HCC) highlighted three pressing examples: 1) for knee replacement surgery, the proportion of patients receiving care within benchmarks is decreasing; 2) for diagnostic imaging, there is still a need to set evidence-based benchmarks; and 3) for coronary artery bypass graft surgery, a lack of standardized data on wait times across jurisdictions prevents meaningful comparisons (HCC, 2013d).

### **Still waiting for improvement: Canada’s sub-par performance**

Beyond the five priority areas, Canada’s wait time performance has been sub-par compared with other countries (CIHI, 2012d). The Commonwealth Fund’s 2010 survey of 11 countries reported that “Canada had the highest proportion (25%) of patients reporting a wait of four months or more for elective surgery (this proportion is similar to that of the U.K. (21%) but much higher than for Germany (almost 0%) and the U.S. (7%))” (Schoen & Osborn, 2010). The survey also found that less than half of Canadian respondents reported same or next day access to physicians when sick (tied

with Norway for last place), two-thirds reported difficulty getting care after hours without going to an Emergency Department (similar to France, Sweden and the U.S.), and only 41% reported waiting less than four weeks for a specialist appointment, ranking last among the 11 countries. As well, Canada has the largest proportion of adults waiting four hours or more in the emergency department before being treated (in fact, Canada is 18 percentage points worse than the international average—26% of Canadians reported waiting 4+ hours versus the 8% OECD average) (HCC, 2014).

There are also problematic delays in arranging discharge of patients from acute care hospitals to home and long-term residential care. Persons with symptoms of dementia, those requiring palliative care and others with complex care needs are all most likely to experience lengthy waits in acute care prior to being admitted to home or specialized residential care (CIHI, 2012b).

These troublesome waits extend beyond specialist, home and residential care to primary healthcare too. Compared to their counterparts in nine Commonwealth countries, Canadian primary care physicians are the least likely (45%) to report routinely providing their patients same- or next-day appointments (as compared to Australia (65%), France (62%), New Zealand (78%), Switzerland (93%), the U.K. (70%) and the U.S. (57%)) (The Commonwealth Fund, 2011). There are also financial and system barriers to care, with about half (51%) of Canadian primary care physicians reporting their patients often have trouble paying for medication or other out-of-pocket healthcare costs; over half (58%) indicate they are unlikely to make home visits or have after-hours arrangements so that patients can avoid going to a hospital emergency department (46%). Access to specialized diagnostics is also challenged—overall, 38% of primary care physicians reported having trouble booking these tests for their patients, far more than in the top performing countries: Switzerland (3%), the Netherlands (7%), and Norway (10%) (HCC, 2013c).

## Future prospects

While provincial and territorial governments are working to reduce wait times across the entire continuum of care, much remains to be done. In its most recent review, CIHI identified four priority areas where future work should be focused: 1) implementing proven strategies to help address known waits (leveraging demonstrated benefits from pilot studies featuring various financial incentives, human resource policies and technologies to improve patient flow); 2) collecting and reporting on comparable data across the continuum, and evaluating waits against benchmarks; 3) promoting prevention as a (longer term) means of reducing demand for health services by adopting recommendations made by The Canadian Task Force on Preventive Care; and 4) taking a patient-centred focus and improving coordination of care across the continuum (CIHI, 2012c). Similarly, the HCC suggests focused efforts to: 1) address wait times in specialty care, emergency departments and long-term care; 2) undertake research and development of evidence-based and patient-centred pan-Canadian benchmarks; and 3) collaborate to share best practices in reducing wait times (HCC, 2013b). Meanwhile, Canadians and their caregivers will undoubtedly keep wait times on the political agenda, providing the anecdotal evidence that reflects poorly on system performance and reinforces the pressure for improvements in the well-known trouble spots.

## V. HEALTH HUMAN RESOURCE PLANNING

The healthcare workforce in Canada comprises more than 1.5 million regulated and unregulated caregivers; physicians and registered nurses comprise the two largest groups. Compared to other OECD nations in 2011, Canada's supply of (professionally active) physicians per 1,000 persons was 2.4, which is close to the U.S. (2.5), New Zealand (2.6) and the U.K. (2.8), but well below Australia

(3.3), France (3.3), Germany (3.8) and Switzerland (3.8). For (professionally active) nurses, Canada's ratio of 9.3 per 1,000 persons was quite close to the U.K. (9.6) and France (8.7), but lower than New Zealand (10.0), Australia (10.1), the U.S. (11.1), Germany (11.4), the Netherlands (11.8 in 2010) and Switzerland (16.6) (OECD, 2013a).

There are multiple factors—such as distribution between rural and urban areas, demographics, supply and demand trends, age of retirement, wage and salary rates, preferences for other than full-time work, scope of practice limitations and migration patterns—that influence the number of health professionals who will be available to meet the future healthcare needs of Canadians. For example, the physician and nursing workforces are aging. From 2004 to 2009, the average age of physicians increased by 1.2 years, yielding approximately the same number older than age 60 as under 40. In nursing, 57% of the 2009 workforce consisted of “older” workers aged 40 to 60 (CIHI, 2010). Further complicating matters are the work patterns of young physicians who, for example, work fewer hours than their predecessors and have less interest in pursuing general practice and some specialties, such as geriatrics.

### **Physician supply versus distribution and deployment**

Arguments abound about the present and future adequacy of Canada's physician workforce with the Canadian Medical Association citing the need for significant increases (CMA, 2009), while some research evidence suggests a surplus, particularly of specialists (Evans and McGrail, 2008; RCPSC, 2013). Important to, but not decisive in, the continuing debate are two facts: 1) medical school enrolment has increased drastically in the last decade (for example, in 2011, Canadian faculties of medicine awarded a record 2,533 medical degrees, up 59% over the 1,594 awarded in 1999 while the Royal College of Physicians and Surgeons of Canada reported an 84% higher medical school enrolment in 2013 compared to 1997 (RCPSC, 2013); and 2) there are now more physicians in Canada than ever before and they are growing in number three times faster than the general population (CIHI, 2012e). There can be no denying that “achieving a balance in the supply, mix and distribution of health care providers to meet current and future needs is complex” (CIHI, 2013b).

### **Chronic care requires a team approach but progress not keeping pace with need**

As more professionals reach the age of retirement, recruitment strategies will become increasingly important in Canada. Enhancement of Health Human Resource (HHR) data and modeling, including developing new models for staffing and practice, particularly collaborative care models, are key in responding to this pressing issue (Health Canada, 2012). Although inter-professional teams are proliferating (particularly in response to a growing need for care of patients living with multiple chronic diseases), roles remain unclear and teams often tend to be ‘physician-centric’ rather than patient- and family-centric (HCC, 2013a). In addition, physicians in many areas remain in traditional silos and allied professionals are typically not included in teams or in dialogues about primary healthcare reform (HCC, 2013b). The extent to which emerging HHR strategies will embrace new models of care that emphasize interdisciplinary teamwork aiming to maximize the scope of practice of all qualified professionals remains to be seen. These changes have been slow in coming, partly due to the unwillingness of professional groups to relinquish their traditional professional boundaries. As well, medical education programs and accreditation bodies have been slow to act in this regard.

So far, the dominant policy response to perceived HHR shortages has been to increase university enrolment, particularly in medicine and nursing. It is unclear how this approach aligns with calls for increased inter-professional collaborative practice, an examination of scope of practice, or boosts to

productivity (Evans, Schneider, and Barer, 2010)—the definition of which is contested when applied to HHR. Meanwhile, another approach gaining attention for addressing HHR capacity problems focuses on the organizational and operational adaptations that contribute to improved patient flow and quality of care.

## VI. HEALTH INFORMATION TECHNOLOGY

The developed world is in the midst of a data-driven healthcare revolution. The use of information technology (IT) in healthcare is widely regarded as the next frontier in efficiency and quality improvement. In response to consumer demands, nimble technology companies are churning out a multitude of health and wellness products—such as smart phone applications and at-home genetic testing—to help individuals understand, track and monitor their health. On the other hand, health systems are being challenged to keep pace. At a population level, electronic health records (systematically collected and electronically stored health information) have been the centerpiece of most health systems' IT strategies. But the reality is that electronic health records (EHR) development has been occurring at a snail's pace. Compared to its cohorts in the OECD, Canada ranks last in the implementation of EHR. Canadian primary care doctors had the lowest use of electronic medical records in their practices—37% in Canada as compared to 46% in the U.S. and above 90% in seven countries (Australia, Italy, Netherlands, New Zealand, Norway, Sweden, and the U.K.) (The Commonwealth Fund, 2011). Although the 2004 *10-Year Plan to Strengthen Health Care* identified EHR as a priority for primary healthcare reform, a significant proportion of the current system remains largely fragmented and paper-based. For the average adult Canadian, it is not uncommon to have a health record composed of paper, medical images and handwritten hospital charts.

Despite incremental progress toward scaling up innovation in this area, the conversion to EHR and more timely flow of information among healthcare providers remains a challenge. For example, significant variation exists among provinces/territories in the number of primary care providers who are subsequently alerted when one of their patients has been treated in an emergency department (ranging from 8% to 69%) (HCC, 2013c).

### The future of health information technology in Canada

Although ranking poorly compared to similar countries that have implemented EHR, Canada's usage of EHR has nearly doubled since 2006 (HCC, 2013e). Ensuring that this expansion leads to health quality improvement will require enhanced data linkage and interoperability, training in the advanced functionality of EHR (to avoid the use of EHR as 'electronic paper records'), and improvements to data capture and quality. Some provinces/territories are farther along in these areas than others, and some organizations are spearheading innovative EHR systems. For example, Alberta has a real-time, province-wide EHR that creates secure linkages among physicians, hospitals and other healthcare providers. Healthcare providers can see and update a patient's file, including information on allergies, prescriptions, and lab test results. The province of Alberta also provides a number of tools to support clinical decision-making. The Canadian Primary Care Sentinel Surveillance Network is the first pan-Canadian multi-disease EHR surveillance system. It collects data from the EHRs of participating primary care providers. Data capture is focused on five chronic and mental health conditions, including hypertension, osteoarthritis, diabetes, chronic obstructive pulmonary disease, and depression, as well as three neurologic conditions, including Alzheimer's and related dementias, epilepsy and Parkinson's disease.

## VII. PATIENT ENGAGEMENT FOR IMPROVEMENT

Healthcare organizations in Canada are just starting to focus on the important role that patients and their families play in guiding health quality improvement and the delivery of relevant and higher quality healthcare. This shift to incorporating the patient experience recognizes that patients' expertise about themselves, their health and the care they have received are an essential part of improvement efforts. A wide range of strategies are available for obtaining insight into the needs, expectations and experiences of patients, including focus groups and interviews, hand-held devices for use at the bedside and kiosks set up in hospitals (CFHI, 2014). However, patient information is not consistently gathered, synthesized or analyzed, and even where this exists, its potential to drive improvement efforts is often not maximized (CFHI, 2009).

### Starting to measure demonstrates room to grow

International comparisons show 61% of Canadian patients had a positive shared decision-making experience with a specialist physician. This ranking places Canada seventh out of eleven Commonwealth countries, most of which hover around the two-thirds mark, with Switzerland (80%) and the U.K. (79%) separating themselves as the leaders of the pack (Schoen and Osborn, 2011b). When patients across provinces/territories were asked if they were involved in clinical decisions about their own healthcare, 71% cited “always or usually”—though this proportion appears high, it is likely best to curb our enthusiasm as being involved in clinical decisions is just the tip of the iceberg, barely a step beyond informed consent and a far cry from experience-based co-designed healthcare (Schoen and Osborn, 2011a).

### Patient-centredness: The need for a cultural shift

Patient- and family-centredness has been garnering increased attention in recent years across Canada. One provincial initiative began in November 2008 when the province of Saskatchewan kicked off its Patient First Review. Although patient- and family-centred approaches to healthcare have been a major force in the improvement of healthcare quality for several decades, this review was the first of its kind in Canada (Government of Saskatchewan, 2008). Major components of the review were an investigation of the healthcare system from the patient's perspective, as well as the delivery of actionable recommendations for change based on scrupulous patient, family and citizen consultations. The review culminated in a number of recommendations, primarily to initiate a cultural shift toward patient-centredness—to “make patient- and family-centred care the foundation and principal aim of the Saskatchewan health system, through a broad policy framework to be adopted system-wide” (Government of Saskatchewan, 2009). Shortly thereafter, the Canadian Medical Association (CMA) embarked on a patient initiative that involved drafting a Patient Quality Charter in which healthcare providers (professionals and their organizations) could be held accountable for truly understanding patients' needs and respecting patients' time, preferences and intelligence (CMA, 2010). While the charter may be regarded as an important step, it cannot spur the cultural shift required, captured well by expert health policy consultant, Steven Lewis:

“Healthcare does not face the grim prospect of collapse due to the loss of customers. It can and does keep the customers it fails, because there is no other place to go. Most of the failures are not catastrophic. They are, rather, the failures of disrespect, inconvenience, poor communication and fragmentation. Put most simply, the system has been designed for the providers more than for the users of services, and it shows” (Lewis, 2009).

International healthcare improvement expert, Don Berwick, also cites the need for a shift from a provider to patient focus, having said “for better or worse, I have come to believe that we—patients, families, clinicians, and the health care system as a whole—would all be far better off if we professionals recalibrated our work such that we behaved with patients and families not as hosts in the care system, but as guests in their lives” (Berwick, 2009).

There are other examples across Canada which show promise. For example, since 2003, the Health Quality Council of Alberta (HQCA) has conducted biennial surveys of the public’s experience with healthcare (HQCA, 2013), and the Ontario Ministry of Health and Long-Term Care implemented patient satisfaction surveys and a patient relations process as key requirements in the new *Excellent Care for All Act* (2010) legislation (Government of Ontario, 2010).

### **Patient engagement for improvement—a way forward**

One of the challenges of increasing patient engagement is a lack of empirical evidence regarding the ‘how to’ and the ‘so what.’ In 2009, the Canadian Foundation for Healthcare Improvement (CFHI) commenced a pan-Canadian initiative called the Patient Engagement Projects (PEP) initiative which consisted of 17 teams across the country implementing patient engagement initiatives in provinces, regional health authorities, disease-focused agencies and institutions, complemented by a third-party research initiative intended to measure the quantitative and qualitative results—and all using patient engagement as a lever for health system transformation and improvement (CFHI, 2009). The main driver of PEP was understanding how and what would be gained through involving patients, families and caregivers in the design, delivery and evaluation of health services (CFHI, 2009). One notable PEP that brought together patients, families and front-line providers to co-design care processes had significant results. Demonstrated outcomes from the Montreal-based McGill University Health Centre project, *Patients and professionals partner to redesign inpatient care systems: Improving safety, access and work environment* included:

- reduced mental health admission time from 4.3 hours to 1
- major clinical efficiency gains via equipment and supply re-location
- improved two-way communication between patients/families and staff
- standardization of educational tools, documentation systems and handoff processes
- shortened bed turnover time
- 50% reduction in medication interruptions and 60% reduction in medication transcription errors
- 8% increase in registered nurse time in direct care, significant decrease in waste and non-value added activities
- decreases in voluntary staff turnover and overtime
- 20% improvement in responsiveness of care providers, 10% improvement in communication about medications and pain management (Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys)
- new competencies of frontline staff and patient representatives to co-design quality processes.

Based on these and other PEP results, CFHI launched a new pan-Canadian collaborative focused on Patient and Family Engagement entitled *Partnering with Patients and Families for Quality Improvement* in April 2014.

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