CFMS FEMC
Canadian Federation of Medical Students
FÉdÉration des ...tudiants et des ...tudiantes en mÉdecine du Canada

Health Care Transformation

A Nationwide Discussion

Introduction

The Canada Health Act (CHA) is the federal legislation that governs the operation of health care insurance in Canada. Under Canada's constitutional framework, health care policy falls predominantly under provincial authority and jurisdiction. However, the federal government plays a significant role in health care policy due to its constitutional spending powers. Broad consultations are occurring across the country as we approach the expiration of the 2014 Health Accord. Input from the future physicians of Canada is of immeasurable importance to the process of health care transformation, in addition to valuable input from the other parties. Indeed, health care transformation and its utility in enhancing the health care system is founded on such discussion.

The sustainability of our publicly funded system may be in jeopardy if left to the status quo. The Canadian Medical Association (CMA) has acknowledged many of Medicare's flaws by initiating its Health Care Transformation (HCT) project, and has created a framework for its transformation into an efficient, high-functioning, and patient-focused system. Based on the founding principles of the Canada Health Act – public administration, comprehensiveness, universality, portability, and accessibility – the CMA has recommended five pillars for sustainable change. These are the following:

1) Building a culture of patient-centered care;
2) Incentives for enhancing access and improving quality of care;
3) Enhancing patient access along the continuum of care;
4) Helping providers help patients, and
5) Building accountability/responsibility at all levels.

The Health Accord is set to expire on March 31, 2014, creating a window of opportunity to urge the federal government to take action. Medical students and future physicians have an opportunity to influence the care that will be delivered to patients. To this end, the Political Advocacy Committee (PAC) of the Canadian Federation of Medical Students (CFMS) hosted town hall discussions across the country during the 2011-2012 period in order to engage the medical leaders of tomorrow. The three broadly defined topics that were discussed at these town hall meetings were the following:

1) Targeted initiatives to enhance the health care system,
2) Sustainable health and human resources, and
3) Funding strategies.

This document provides an overview of key findings from each symposium, outlines the voice of Canadian students, and is intended as a vehicle for advocacy, leadership, and education surrounding Health Care Transformation.

Overview

The health care transformation symposia were meant to be an opportunity for participants to engage in a dialogue surrounding the challenges faced by the Canadian health care system, and to wrestle with ideas about how to create effective change at the levels of medical professionals, policy, and patient populations. Leaders in the medical field from across the country came together at 14 of Canada's medical institutions to shed light, insights, and experience on the various aspects of health care transformation.[1]

The conversations across the country all concluded that transformation of the current system at various levels is essential. Increasing the quality of care would improve the overall health and quality of life in Canada. The following five themes were highlighted: 1) improving collaboration, 2) implementing innovations, 3) increasing services provided, 4) promoting preventative health and wellbeing, and 5) improving responsible health expenditures. Recommendations under each theme have been subsequently made taking into account targeted initiatives, health and human resources, and funding strategies.

1) Improving Collaboration

Improving interdisciplinary collaboration was stressed across the town hall events. Professional collaboration was defined as including all members of the health care team (family physicians, generalists, physician assistants, nurses, social workers, occupational therapists, physiotherapists, dieticians and others). Discussion ensued about increasing physician understanding of the scope of practice of different health care professionals, as to increase the efficiency and decrease the costs of patient care. Creation of undergraduate medical education (UGME) curriculum that exposes medical students early to the needs of society would help facilitate this.

Moreover, patient-centered care was identified as an issue that required improvement. Though our medical tradition has shifted towards a patient-centered practice, better collaboration among family physicians, specialists and other health professionals could be a means of solidifying the model. Furthermore, an increase in the number of nurse practitioners and physician assistants could help improve patient-centered care, as their scope of practice involves spending more time with patients.

[1] An overview of event details is provided in Appendix A.

Finally, our system was criticized as being too hospital-centered. Further collaboration among physicians could help in alleviating the burden on tertiary care centers. For example, most of our mental health services are delivered in a hospital setting, even though evidence has shown that hospitals are not the best setting for delivering care in mental health. Further collaboration among psychiatrists, family physicians and emergentologists could ensure a better care environment for patients with mental illness.

Recommendations:

- Preferential funding for collaborative practices in hospitals and within the primary care setting;
- Increases in the number of nurses and physician assistants to enhance patient-centered care;
- Increasing interprofessional education (IPE) during undergraduate medical training.

2) Implementing Innovation

This was an issue highlighted at every town hall event. Students and panelists stressed that innovation itself is insufficient in Canada; the implementation of innovation is required to enhance quality of care. Canada was identified as a country that is good at generating research, but poor at disseminating it. Our system was generally described as "risk-aversive." Consequently, slow implementation of innovative technologies was identified as a key barrier in the improvement of health care delivery.

Electronic Medical Records (EMRs) are an example of innovative technology that has been slow in implementation. Increasing the penetration of EMRs and providing continuity of systems will help increase the efficiency of the current system. This technology could also be used to monitor populations that have less access to direct specialty care. However, physicians themselves have been part of the problem, identified as being slow and resistant to change.

Students also discussed the need for innovative methods in addressing our national problem of physician distribution. Medical students advocated the need for more sustainable pipeline programs for rural high school students, encouraging them to not only consider medicine as a career option, but also providing them with the mentorship and resources required to succeed with admissions. Evidence has shown that students from rural backgrounds are more likely to practice in a rural setting. Hence, training more rural physicians will help address the issue of underserved rural populations.

Furthermore, students discussed increasing incentives for medical students to

train in family medicine. Such incentives include debt forgiveness programs that begin at the start of residency training, increased remuneration for family physicians, and general reform to the primary care funding model.

Finally, a novel idea brought forth from the HCT symposia was that of physicians offering medical services in different languages, given Canada's multicultural patient population. The creation of an information bank that would allow patients access to physicians willing to offer services in different languages would greatly increase quality of care by fostering better communication and cultural understanding between patients and physicians.

Recommendations:

- Implementing a nationwide mandatory shift to EMRs within the next five years, and providing the upfront funding to do so;
- Creation of incentives to increase interest in family medicine training including debt forgiveness (beginning at the start of residency) and increased remuneration for family physicians;
- Considering a salary-based funding model in primary care;
- Creation of an information bank that provides details about physician practices willing to provide medical service in languages other than English. This bank should be accessible to both physicians and patients.

3) Increasing Services Provided

The general consensus among medical students is to increase the scope of practice and scope of care provided to patients. Though health care costs will initially increase upon implementation of such policies, universal access to services such as Pharmacare, ophthalmology, optometry and dental care will result in better long-term health within the population, decreasing long-term costs for our system. Moreover, students feel that the above-mentioned services are part of basic health care, and subsequently fall under the Canada Health Act stipulations of care.

Recommendation:

- Adding Pharmacare, ophthalmology, optometry and dental care to the scope of care covered under provincial insurance policies.

4) Promoting Preventive Health and Well-Being

Focusing on preventative medicine was a recurrent theme at the majority of the town halls. The benefits of preventative medicine are far reaching, both to the patient population as well as to the health care system. A number of different ways that

preventative medicine can be incorporated into our medical system were discussed at the symposia. One such example would be the employment of other health-related professionals (for example, nutritionists) to monitor and screen for diseases. This will improve morbidity and mortality in the patient population, and will concurrently relieve the government of extra expenditures related to disease management.

Students also indicated the need for increased patient accountability. There are various directions that this can be taken, including tax incentives for healthy measures, or small fees incurred by patients presenting to emergency departments to deter abuse of our publicly funded system. Patient education is another huge area that needs to be further explored. Better patient education would teach patients how to manage their own health and prevent unnecessary visits, allowing for better allocation of resources and decreased wait times. Targeting children in preventive health initiatives was emphasized, with a focus on nutrition and exercise at middle school and high school levels. The implementation of laws surrounding school cafeteria food options, regulation of food labels, increased taxation on fast foods and public service announcements that emphasize healthy living and routine yearly check-ups are all options to be considered.

There is also general consensus regarding the poor management of chronic disease in our aging population. Some schools suggested finding a unified strategy for managing chronic disease more effectively.

Finally, one possible angle that could be taken to address Canada's well-known physician shortage is to increase the number of nurse practitioners and physician assistants. There was unanimous consent that more evidence-based discussion is required in this area.

Recommendations:

- Increase the number of nurse practitioners and physician assistants;
- Shift focus to preventative medicine;
- Implement preventative medicine curriculum during undergraduate medical training;
- Invest in patient education about healthy living at the middle and secondary school levels;
- Increase the number of public service announcements on television and social media advertisements targeting healthy living and routine yearly check-ups.

5) <u>Improving Responsible Health Expenditures</u>

Medical students perceive the problem with our health care system as one of efficiency, not one of sustainability. The general consensus among students is that our public system is preferable to a private or two-tiered system. However, improvements to

our current system are necessary in order to increase its efficiency.

Instead of introducing a private sector, our current system can be modified in several ways. Increasing accountability and transparency in provincial health care spending with better auditing at the hospital level is key. Students discussed the need for quality criteria to direct funds dispensed from the federal government to the provinces and territories. Many students raised concerns regarding the federal government's unwillingness to engage in dialogue with the provinces regarding specific goals of health care spending. Hospitals need to be incentivized to reduce wastage that occurs due to cost pressures. One of the ways to achieve this is by providing result-oriented government subsidies. The government incurs huge costs due to nosocomial infections and unnecessary/liberal testing by health care practitioners. Hospitals need to be incentivized to modify their behaviour so as to reduce costs on the system via subsidies for achieving goals such as minimal hospital-acquired infections, lower 'average-inpatient-days' for a given treatment, etc. Specific markers of outcome can be further explored. Ultimately, such a system effectively creates 'competition' between hospitals, prompting them to improve their performance. The federal government needs to engage in a dialogue with the provinces, audit hospital expenditures, provide incentives for efficiency, and incorporate an annual review of Medicare expenditures. Funding to the provinces should be revised annually based on their savings and performance.

To maximize efficiency, the scope of practice of health care professionals should also be clearly defined, and it should be ensured that there is no overlap between services provided by the different health care professionals. One of the suggestions made was implementing a national-mandated program in which the federal government purchases health care supplies in bulk as to lower the overhead costs associated with individual hospitals. Moreover, implementation of preferential funding for collaborative teams would entice community health teams to serve patient populations—a model that has been shown to be effective and efficient in Ontario, for example.

Increased funding to increase recruitment of students from underserved rural and remote communities and for integrated rural clerkships will promote interest in community based medicine within medical students. This has great potential not only to improve the health of patients in these areas, but to also increase retention, addressing key issues of health human resources.

The general consensus among students regarding physician pay models emphasized striking a balance between rewarding physicians for the volume of patients seen (fee-for-service model) and rewarding them for the quality of care they provide (salaried model). The end goal is to assess and enhance quality of care. An interesting model that was brought up was that of the Cuban health system that incorporates a population health approach in physician remuneration. Physicians are 'assigned' the

health of a community and are compensated based on the health outcomes of that specific population. The inherent flaws within such a model include difficulties in standardizing and measuring health care outcomes, differences in baseline population characteristics and biases in physician recruitment of patients, with preference given to healthy individuals.

A number of alternative funding strategies for medical professionals that would enhance performance included rostering for primary care, and finding a balance between both fee-for-service and salaried payment models. An alternative mechanism of hospital billing aimed at increasing efficiency would be to bill per procedure, instead of receiving lump sums by the provincial government. This model would incentivize hospitals to perform at a higher standard in order to attract more patients, and subsequently increase their funding. However, such a model falls short if the number of procedures needed surpasses the financial resources available to the system. Also, the model is not ideal for rural settings.

Recommendations:

- Incentivize hospitals to reduce waste by introducing result-oriented subsidies;
- Incentivize citizens to act more responsibly towards their health through increasing taxation on unhealthy foods/tobacco/alcohol;
- Increase the number of rural clerkship training programs to encourage medical students to pursue community/rural practice;
- Explore alternative models for physician remuneration, such as a mixed fee-for-service and salaried model;
- Provide preferential funding for collaborative health care teams;
- Audit and revise federal budget to the provinces more frequently based on performance.

Conclusions

In summary, the town hall symposia incited great dialogue between medical experts and students. The nationwide conversation resulted in a number of key conclusions on health care transformation for years to come that are listed below.

Increased collaboration was emphasized throughout the country amongst health care professionals. Various methods of achieving patient-centered care include increasing the number of nurse practitioners and physician assistants and providing preferential funding for collaborative practices.

The implementation of innovation in Canada is required to enhance the quality of care. Electronic Medical Records, innovative strategies to address physician distribution discrepancies, and the creation of pipeline projects for rural students were

identified as three major areas of focus. Providing incentives for medical students to train in family medicine was also encouraged nationwide.

Students advocated for universal access to Pharmacare, ophthalmology, optometry and dental care, which should be provided under provincial insurance policies.

Preventative health can both circumvent excess government expenditures and lead to an overall healthier population. As such, resources should be allocated to increase public awareness of healthy living.

Finally, various funding models were discussed throughout the country, with a general consensus that a balance must be achieved between the fee-for-service model and the salary model in order to maximize quality of care. Overall, Canadian medical students showed support for our currently publicly funded system over a two-tiered or private system. Providing incentives t hospitals and physicians to maximize health outcomes and minimize costs was a key component of the posited financial models. Federal government compensation for increased performance (as measured by pre-determined markers) at the provincial level will foster competition between hospitals, resulting in better health outcomes.

As representatives of the Political Advocacy Committee, we hope that this document will inform future policy surrounding health care transformation.

Appendix A - Event Details

1. University of Manitoba
Date of HCT Symposium: January 10, 2012
Speaker(s): Dr. Michael Rachlis
Moderator: Sarah van Gaalen
Number of attendees: 60

2. University of British Columbia
Date of HCT Symposium: February 2, 2012
Speaker(s):

- Dr. Barry Turchen, Chair of BCMA Communication and Public Affairs Council and CMA Political Action Committee
- Robert Hulyk, BCMA Director of Communications and Public Affairs

3. Dalhousie University
Date of HCT Symposium: January 24, 2012
Speaker(s):

- Kevin McNamara, Nova Scotia Deputy Minister of Health & Wellness
- Dr. Jane Brooks, Chair of Board, Doctors NS
- Dr. Tom Marrie, Dean of Medicine, Dalhousie University
- Dr. Ron Stewart, Founder & director of Music-in-Medicine, Dalhousie Medical Humanities
- Dr. Preston Smith, Senior Associate Dean, Regional and Rural Medical Education, Dalhousie University

Moderators: Nada Ismaiel and Haley Augustine
Number of attendees: 70

4. University of Alberta
Date of HCT Symposium: January 19, 2012
Speaker(s):

- Linda Duncan, MP Edmonton-Strathcona
- Dr. Linda Slocombe, AMA president
- Dr. Roger Palmer, ex-Deputy Minister of Health and Wellness

Moderator: Roshan Abraham
Number of attendees: 30

5. University of Calgary
Date of HCT Symposium: February 2, 2012

Speaker(s):

- Dr. Tom Noseworthy
- Dr. Bill Ghali
- Dr. David Swann
- Dr. Kabir Jivraj

Moderator: Yan Yu
Number of attendees: 30

6. **University of Western Ontario, London Campus**
Date of HCT Symposium: February 2, 2012
Speaker(s):

- Dr. Mark MacLeod
- Dr. Anne Snowdon
- Dr. Silvia Orsini

Moderator: Chris Byrne
Number of attendees: 60

7. University of Western Ontario, Windsor Campus
Date of HCT Symposium: February 1, 2012
Speaker(s):

- Dr. Albert Schumacher
- Dr. Anne Snowdon

Moderator: Linna Li
Number of attendees: 34

8. University of Ottawa
Date of HCT Symposium: March 7, 2012
Speaker(s):

- Hon. Dr. Carolyn Bennett
- Opening Remarks: Dr. Melissa Forgie, Associate Dean Undergraduate Medical Education
- Closing Remarks: Chloe Ward, VP Advocacy CFMS

Moderator: Jemy Joseph
Number of attendees: 66

9. Queen's University
Date of HCT Symposium: April 23, 2012
Speaker: Dr. Jeffrey Turnbull
Moderators: Michelle Khan, Negine Nahiddi

10. Memorial University
Date of HCT Symposium: February 28, 2012
Speakers(s):

- Dr. John Haggie
- Dr.Gerard Farrell
- Kevin McNamara, Nova Scotia Deputy Minister of Health & Wellness

Moderator: Lindsey Ward
Number of Attendees: 45

11. Northern Ontario School of Medicine
Date of HCT Symposium: 6 March 2012
Speaker: Dr. David Marsh
Moderator: Mike Perry
Number of Attendees: 27

12. University of Saskatchewan
Date of HCT Symposium: January 26, 2012
Speaker: Dr. Ryan Meili
Moderators: Sarah Miller and Jessica Lydiate
Number of attendees: 30

13. McMaster University
Date of HCT Symposium: February 8, 2012
Speaker(s):

- Dr. Scott Wooder, Chairman of the Board of Directors of OMA
- Dr. Brian Hutchison, Past Director of the McMaster University Centre for Health Economics and Policy Analysis
- Dr. Christopher Mackie, Board Member Canadian Doctors for Medicare

Number of Attendees: 25

14. University of Toronto
Date of HCT Symposium: January 18, January 25
Speakers (s):

- Dr. Andrew Pinto, Inner City Health Expert
- Ms Noa Aviv, Lawyer for Canadian Civil Liberties Association
- Dr. Michael Stephenson, Access Alliance

Number of Attendees: 65