

# The sustainability of Canadian health care



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# What are the prevailing messages about Canadian Medicare?

- Health Care costs are wildly out of control
- The baby boomers will massively increase costs further over the next 30 years
- The only alternatives are to either cut services, go private, or do both
- We need an “adult conversation” about which public services to cut

**THE END**

The image features the words "THE END" in a bold, 3D, purple font. The letters are rendered with a gradient from a lighter purple on top to a darker purple on the bottom. They are positioned on a dark gray road that recedes into the distance, with white perspective lines on either side. The background is a light gray wall and a light gray sky.

# What's my story?

- Health Care's share of GDP fell in the 1990s rose in the 2000s, fell in 2010 and will continue to fall for the next 3-5 years
- The aging population won't break the bank
- We could get much better value from the current system
- There are affordable solutions to all of Medicare's apparently intractable problems
- The real issue should be how we spread these proven innovations

**“Certainly those who knew the most were the least scared.”**

**Winston Churchill.**

The Second World War. 1949.

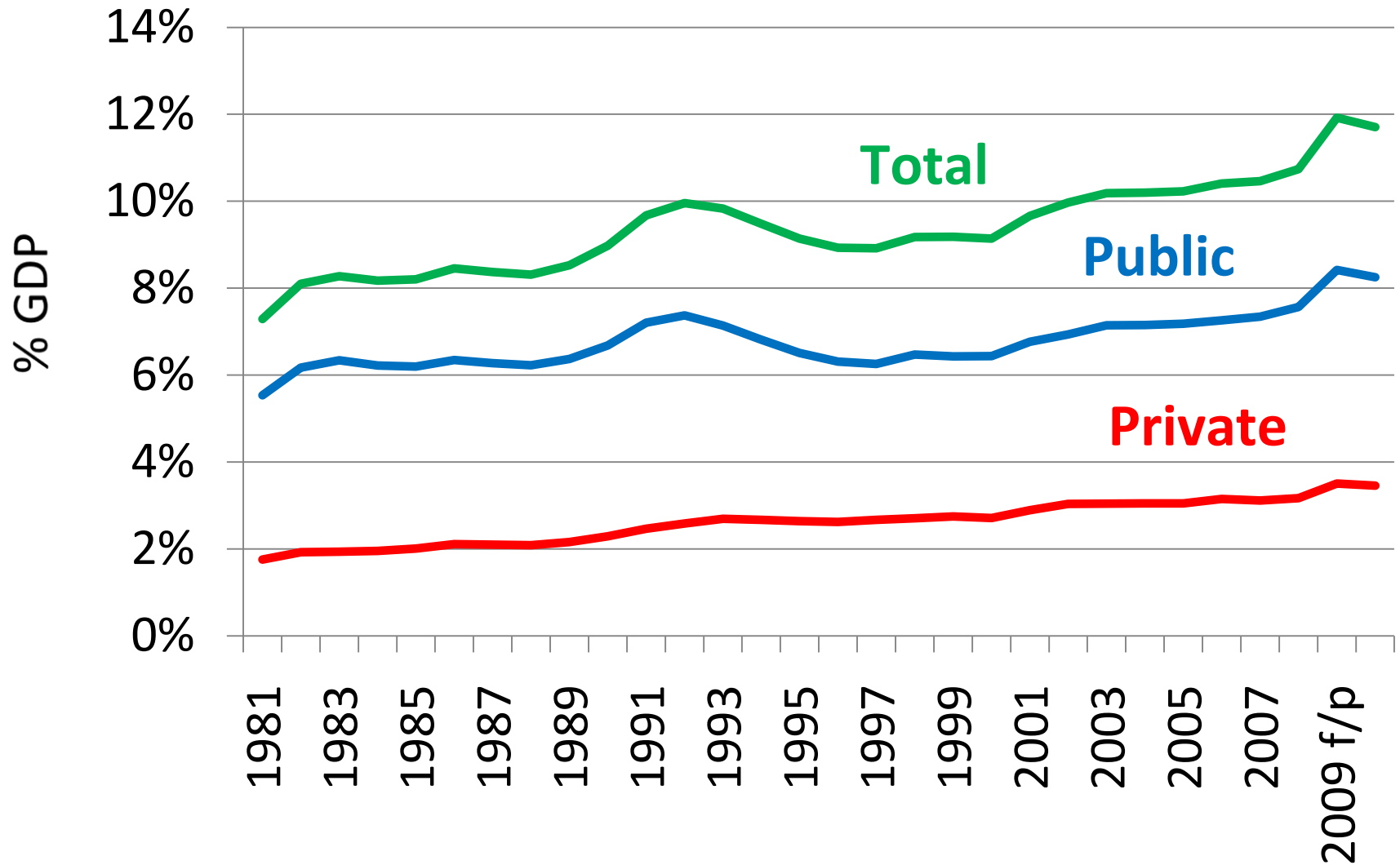
Volume II. Book One. Chapter 14.

The Invasion Problem

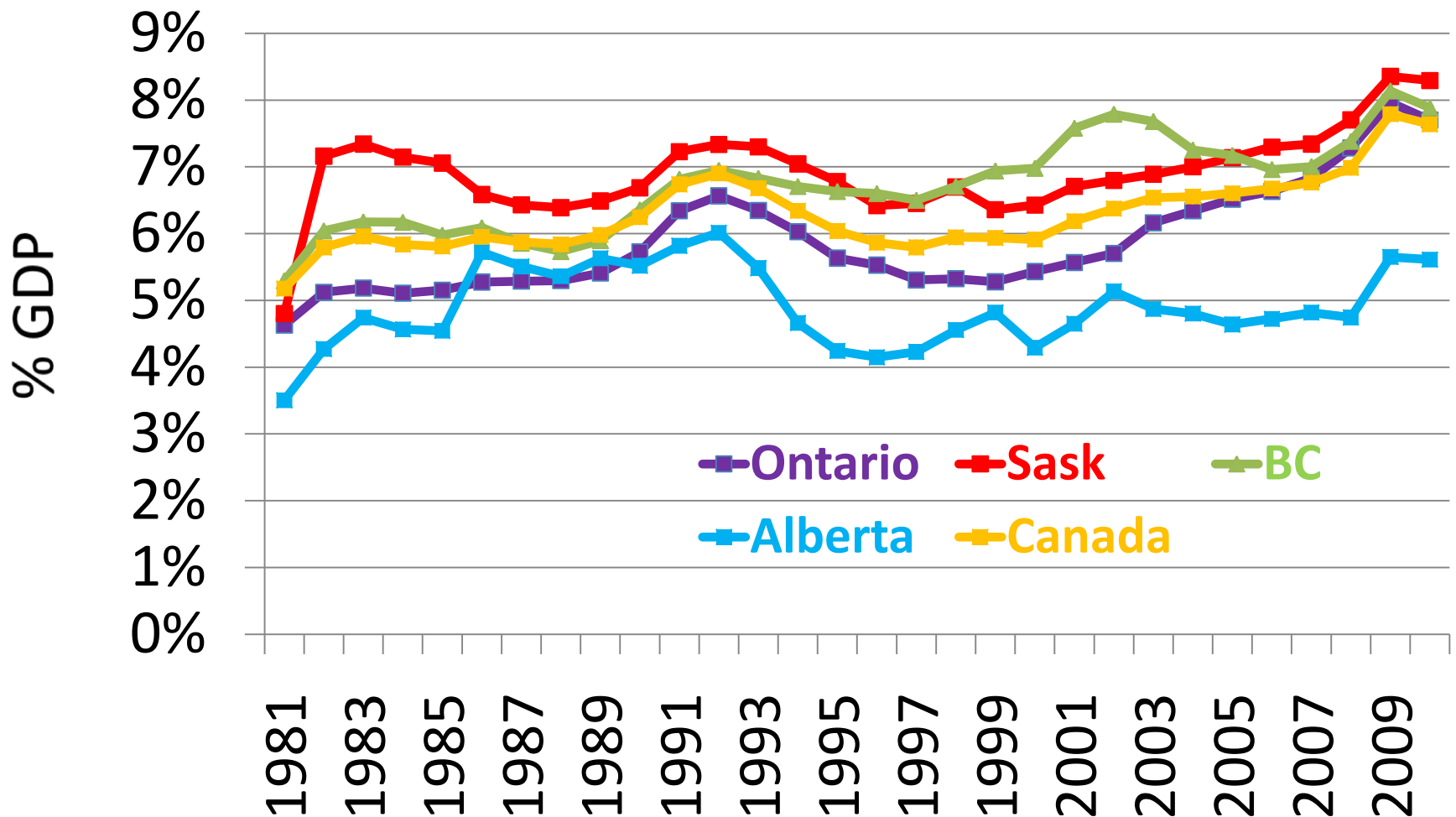
# The sustainability of Medicare

- Health slowly increased its share of Canadian GDP from 2000 to 2008
- Health's share of GDP rose dramatically in 2009 because the economy collapsed.
- In 2010, governments controlled costs, the economy grew again, and health decreased its share of GDP
- ***This downward trend of health costs as a share of GDP will likely continue for the next 3-5 years***
- Public spending in 2010 was 0.6% of GDP higher than its previous peak in 1992 (8% in relative terms) vs. private costs which increased by 0.9% of GDP (35% in relative terms)

# Canadian Health Care Costs as % of GDP



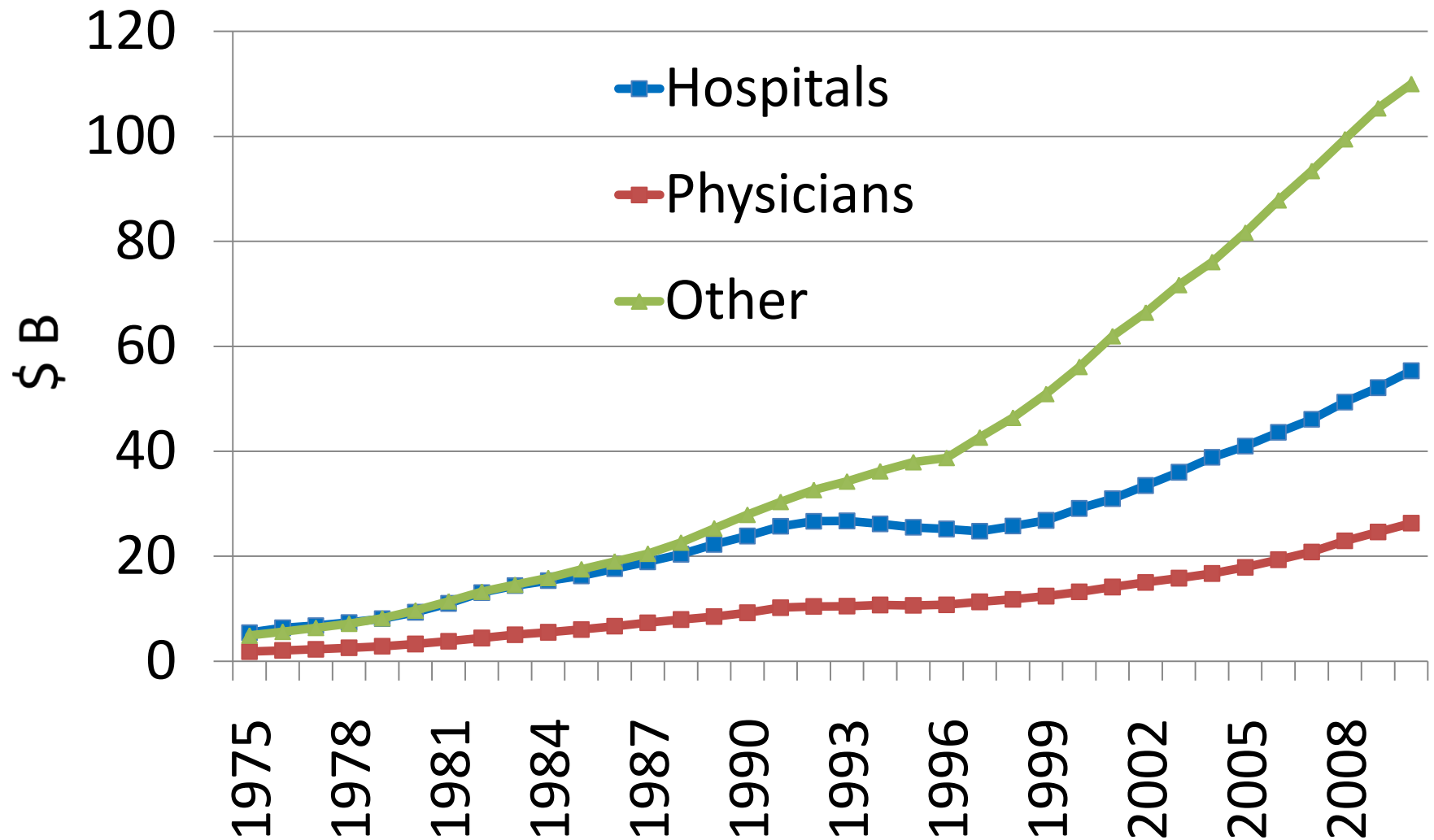
# Provincial health care expenditures as % of GDP



Data from:

[http://secure.cihi.ca/cihiweb/products/NHEX\\_Trends\\_Report\\_2010\\_final\\_ENG\\_web.pdf](http://secure.cihi.ca/cihiweb/products/NHEX_Trends_Report_2010_final_ENG_web.pdf)

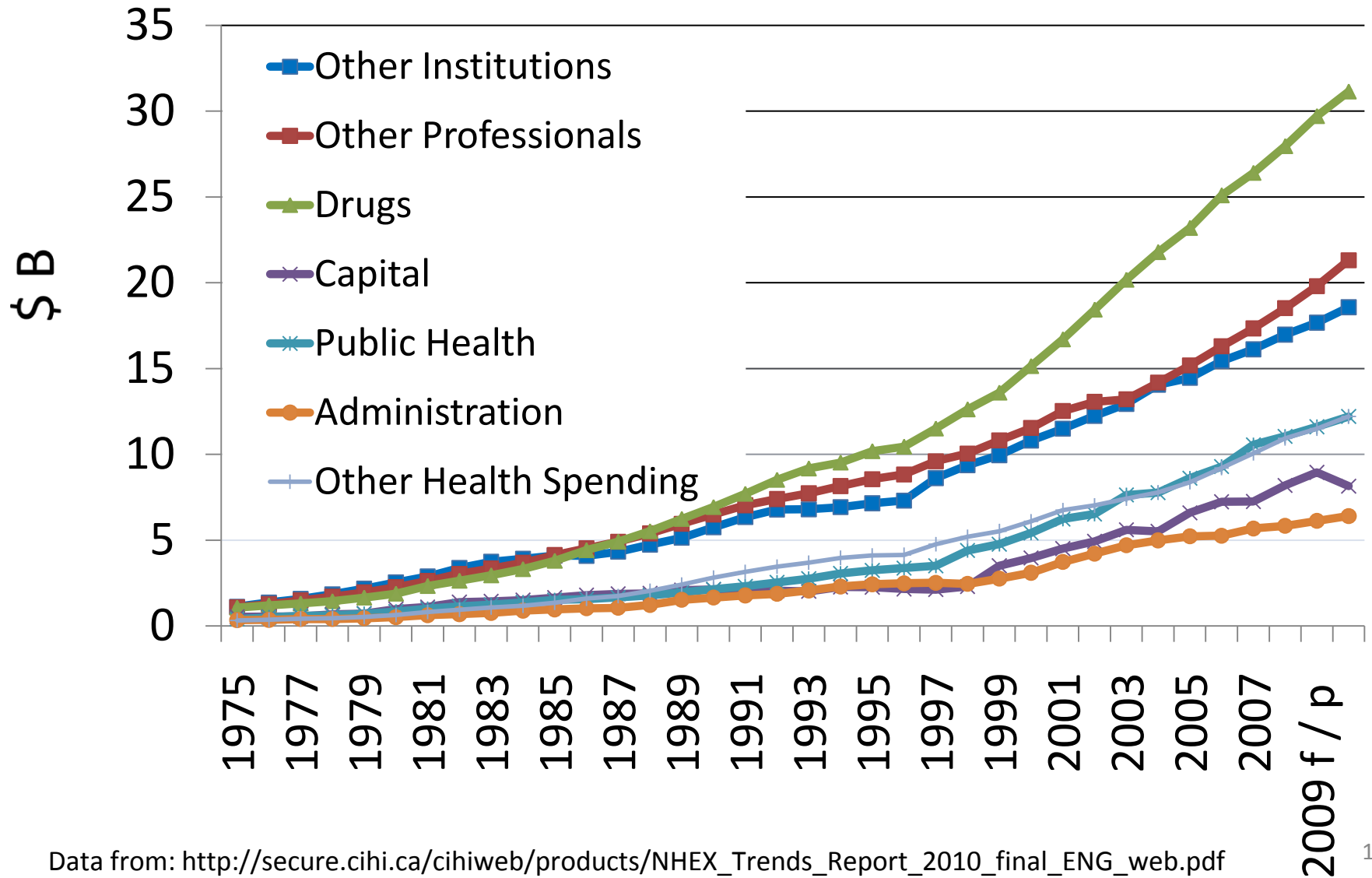
# Total Canadian HC expenditures (\$ B)



Data from:

[http://secure.cihi.ca/cihiweb/products/NHEX\\_Trends\\_Report\\_2010\\_final\\_ENG\\_web.pdf](http://secure.cihi.ca/cihiweb/products/NHEX_Trends_Report_2010_final_ENG_web.pdf)

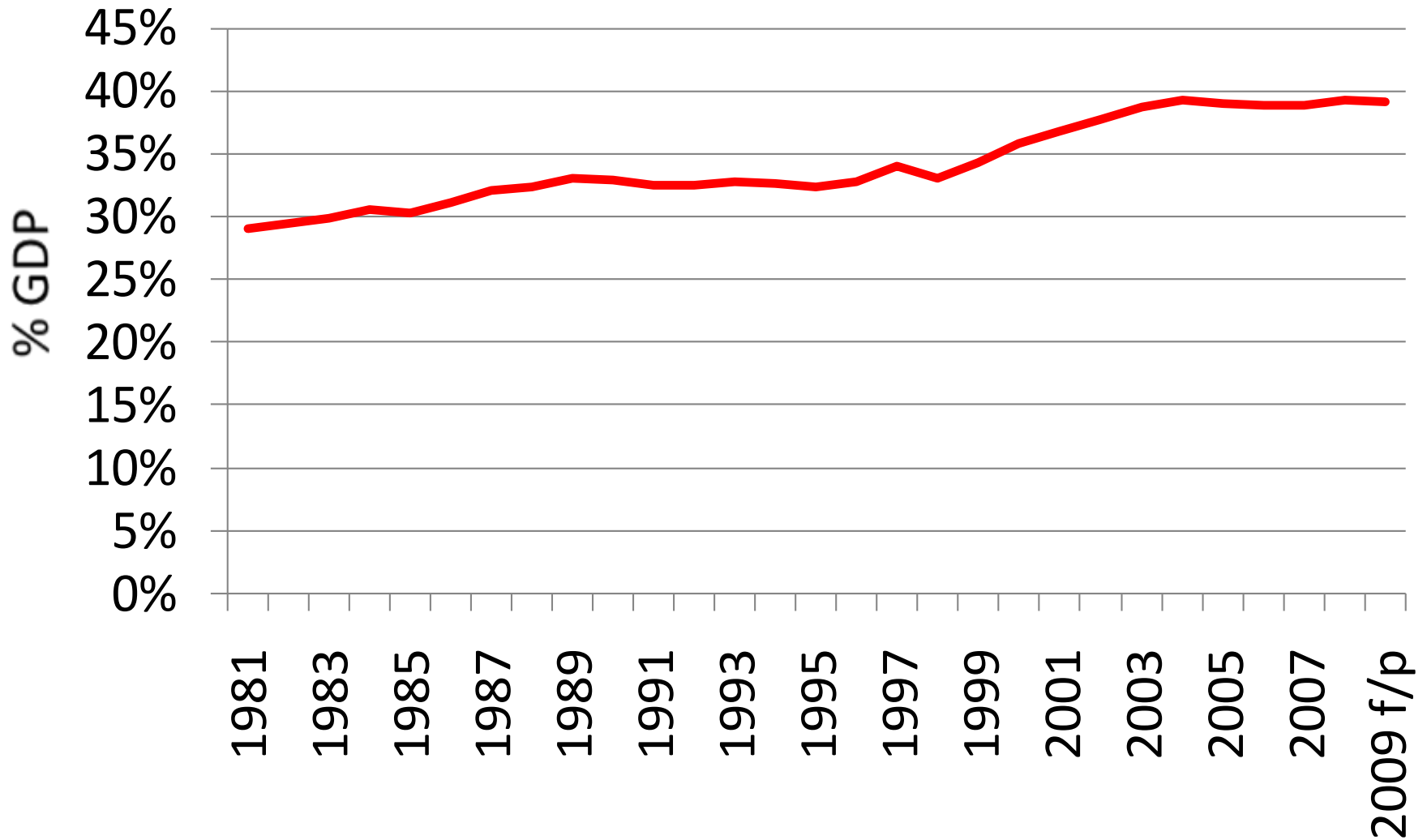
# Canadian Non hospital or MD expenditures (\$B)



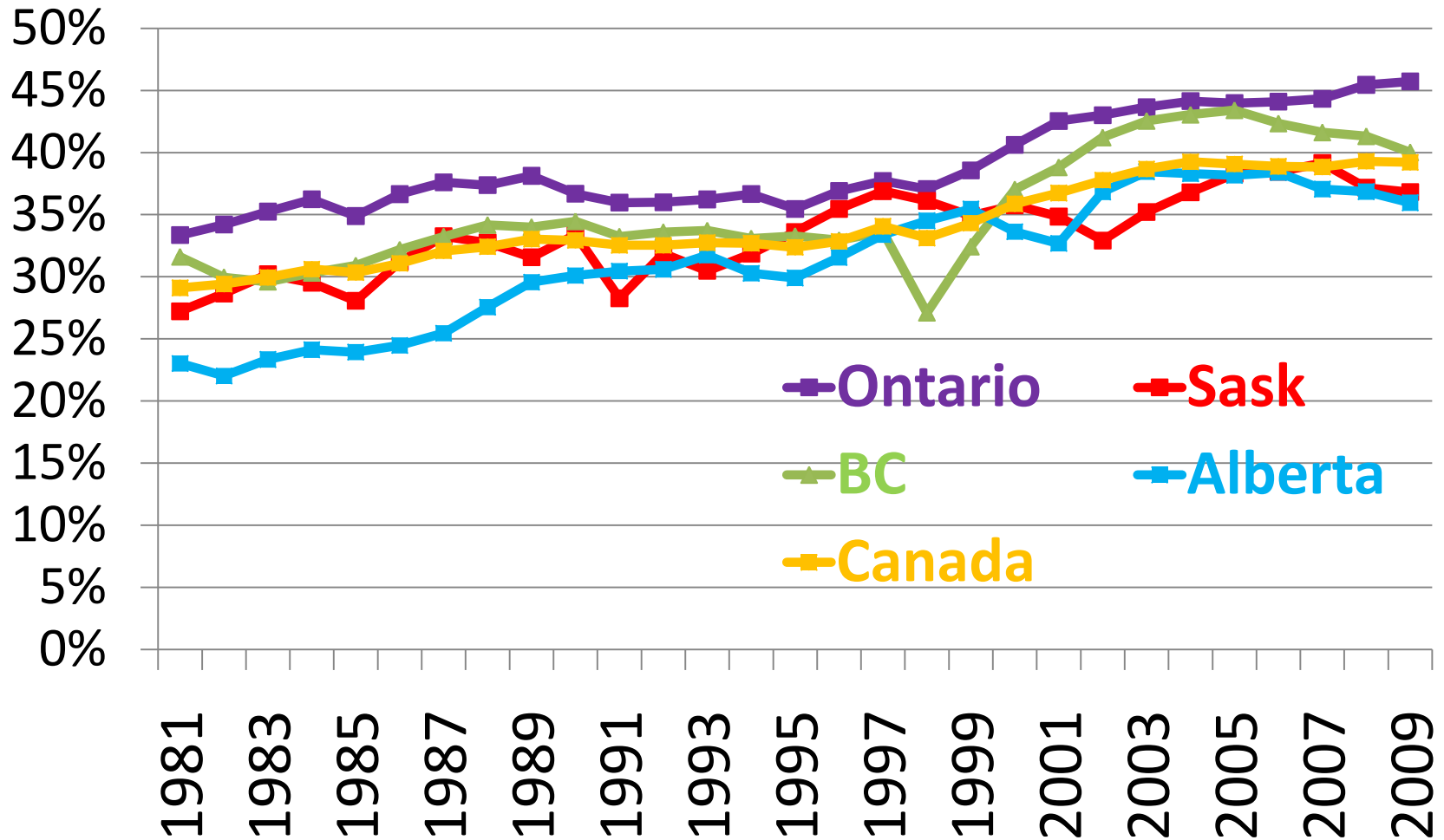
# Provincial health care costs have not put as much pressure on other priorities as have cuts in government revenue.

- Health care's share of provincial program spending was fairly stable at 33% from 1987 to 1998.
- Health care's share of program spending went up to 39% from 1998 to 2003.
- This was mainly due to cuts in other areas of government rather than increases in health spending
- The share of Provincial government program spending going to health care has been flat for six years.
- Ontario performs slightly worse than the national average

# Canadian Provincial Healthcare Expenditures as % of Program spending



# Provincial HC expenditures as % of Program Expenditures



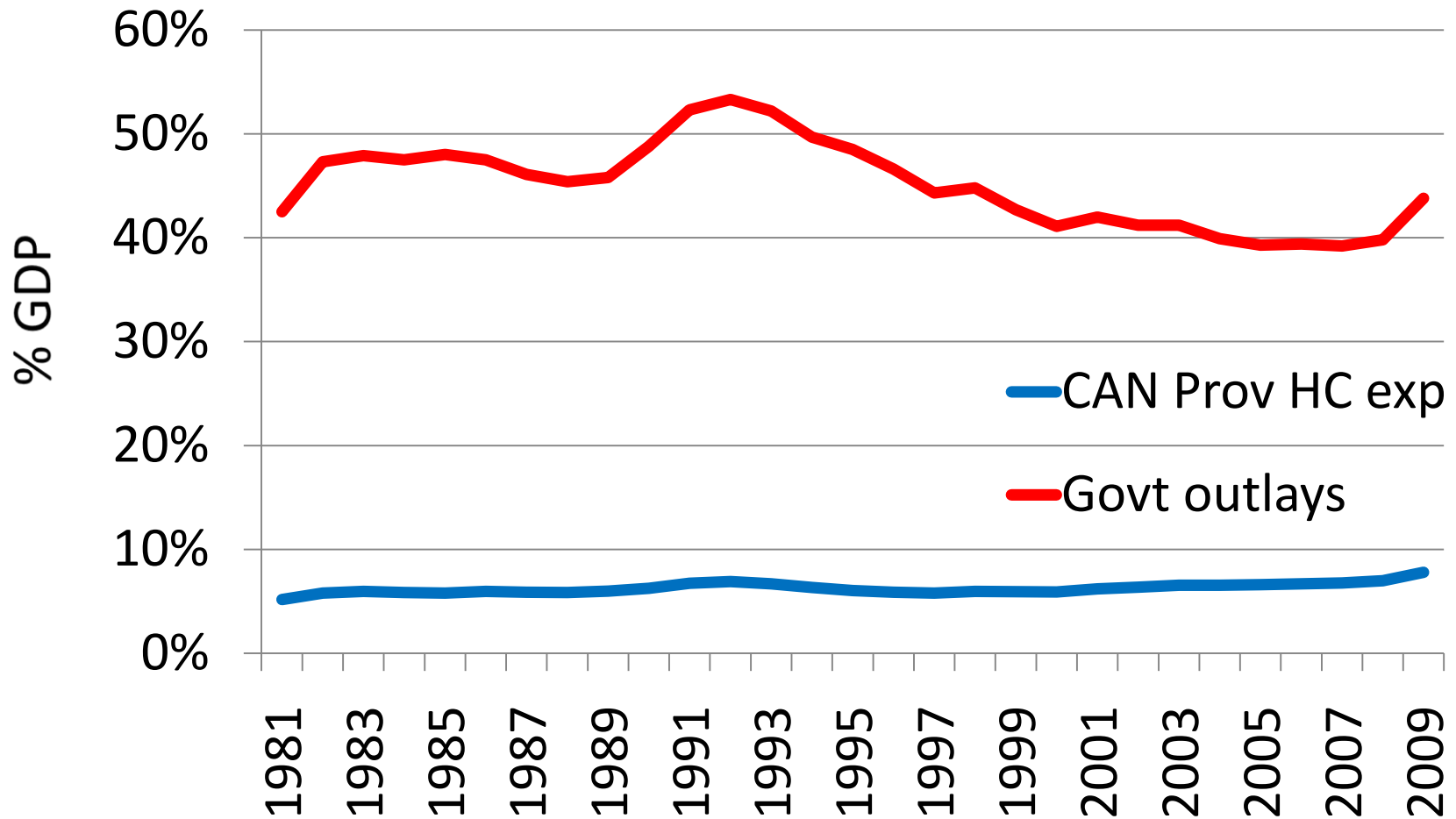
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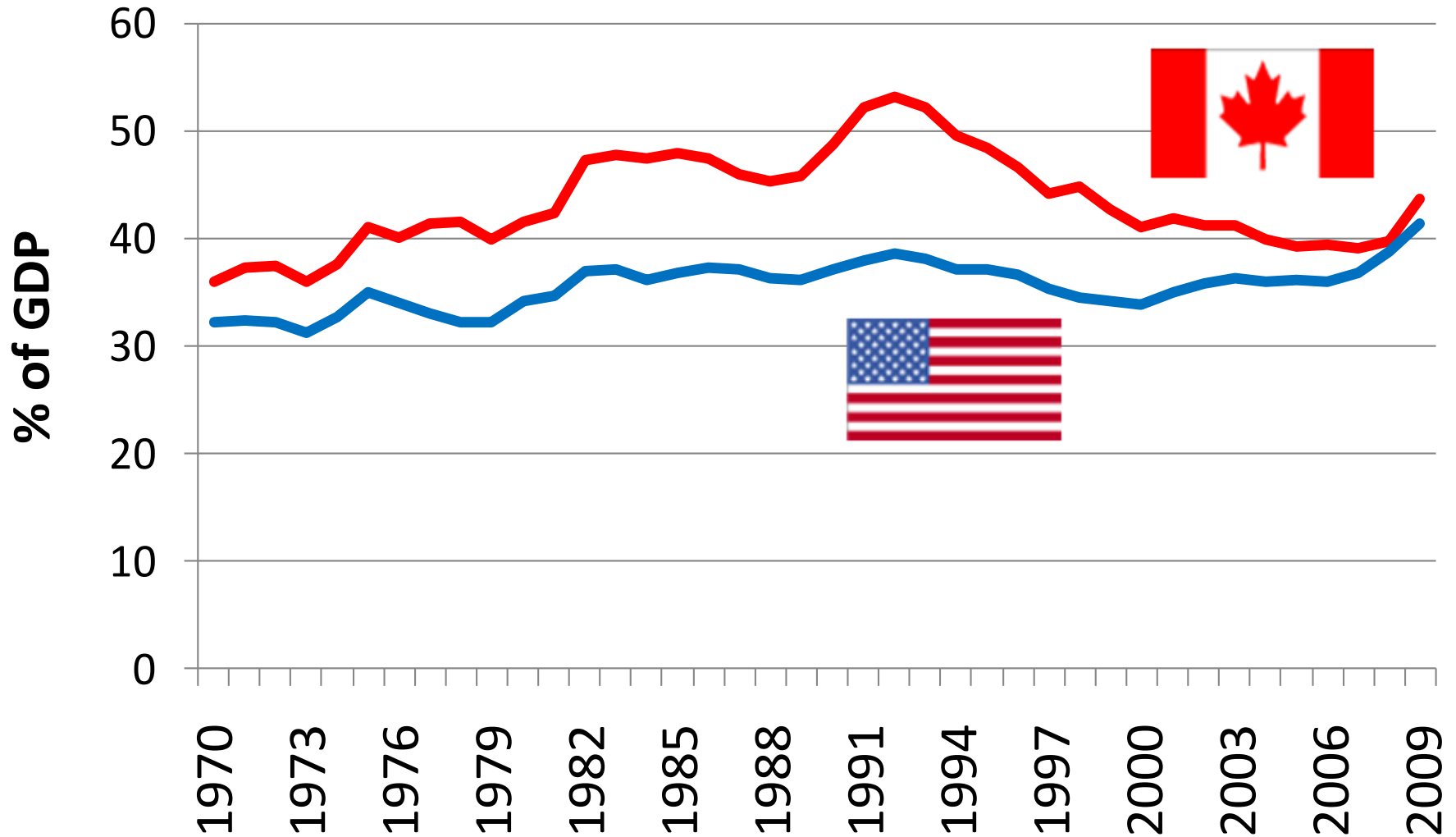
# The shrinking Canadian public sector

- Overall Canadian government spending as a share of GDP has fallen since the mid-1990s
- Nationally, government revenues have fallen by 5.4% of GDP since 2000, the equivalent of \$90 Billion in lost government revenue
  - Just half of this could fund first dollar universal pharmacare, long term care and home care AND regulated child care for all who parents who want it AND new fighter jets
- Canada's public sector used to be 35% bigger than the US public sector but now they are almost the same size

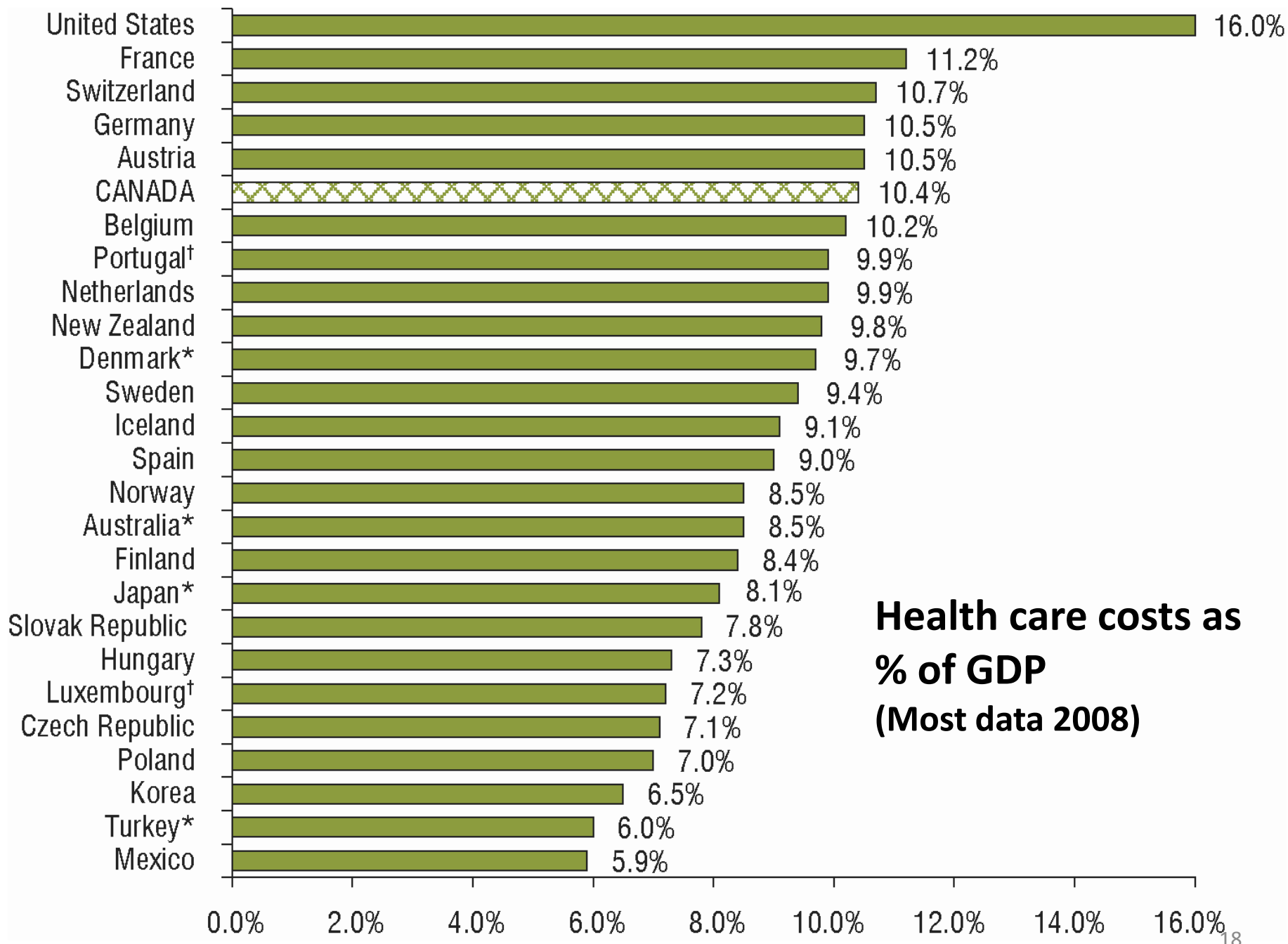
# Canadian Government Outlays and Provincial HC spending as % of GDP



# Government Outlays as a share of GDP



**Canada's health care costs are much lower than the US and pretty much the same as other wealthy countries**



Notes \* Data for 2007. † Data for 2006. Source Organisation for Economic Co-operation and Development, *OECD Health Data 2010 (June edition)* (Paris, France: OECD, 2010).

# The aging population won't kill Medicare

- The aging of the population per se has had and will have only a moderate impact on health expenditures
- Aging of the population has increased health care costs by 0.8% per year over the past ten years and will increase costs by about 1.0% per year for the next 25 years
- Aging is like a glacier not a tsunami. We have lots of time to prepare and adapt our health system before we get swamped!

# **High performing health systems can hold costs and enhance quality**

“Many attribute the quality problems to a lack of money. Evidence and analysis have convincingly refuted this claim. In health care, good quality often costs considerably less than poor quality.”

Fyke Report 2001 (Saskatchewan)

**There are affordable, non-profit solutions to all of Medicare's apparently intractable problems. With current resources we could:**

- Have same day access to our regular family doctor or someone on the doctor's team
- Have elective specialty input within one week
- Have elective surgery within two months
- We could prevent illness and promote health

# Queue management

## Advanced Access

### Relationships to specialty services



# What causes queues for care?

- Often there is enough overall capacity
- Queues usually develop because of temporary mismatches between capacity demand

- See:

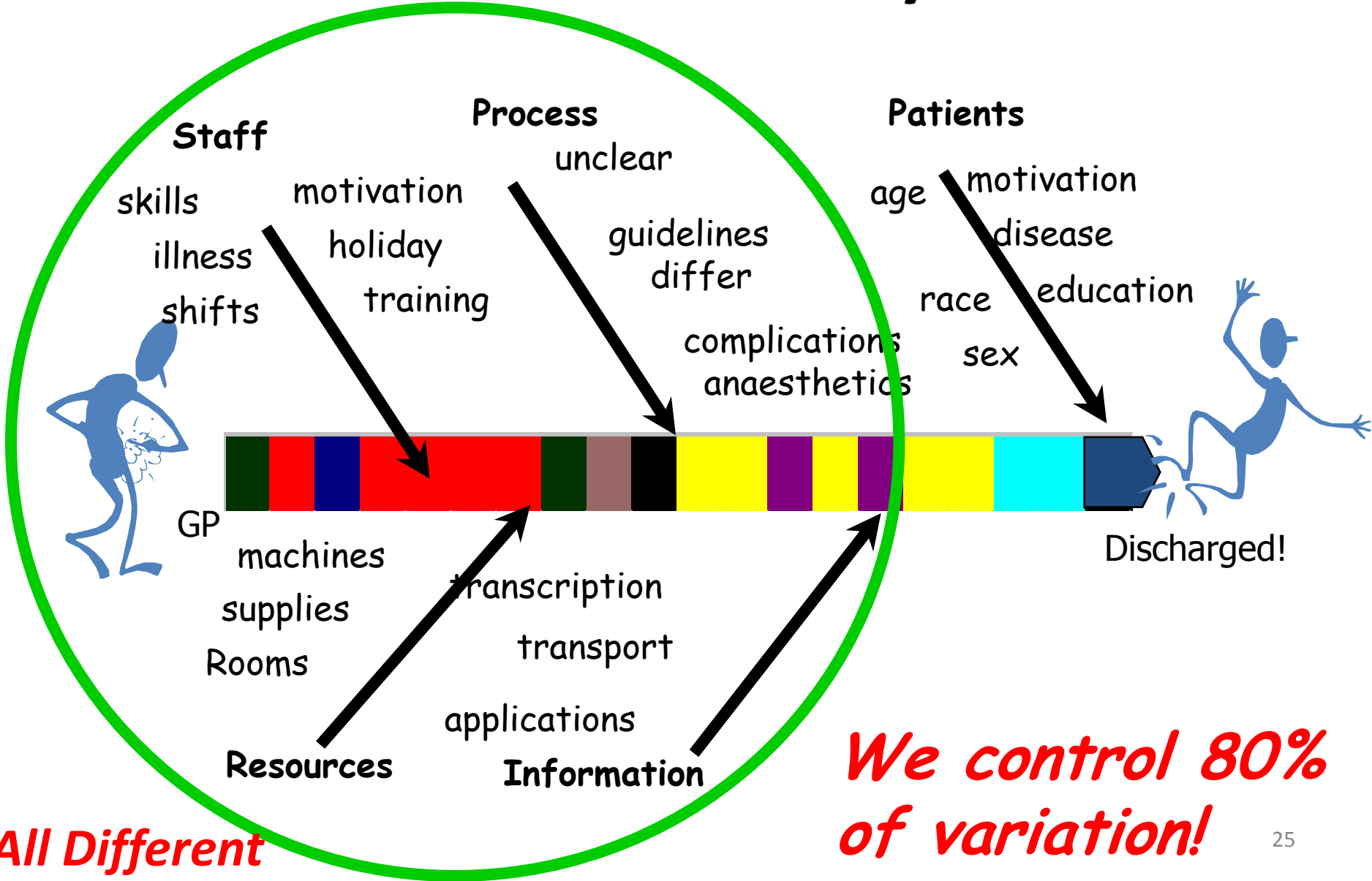
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# Imagine an endoscopy clinic with an average capacity of 10 patients and an average demand of 10 patients

- Monday, Tuesday, Wednesday: 10 patients show up, 10 patients get service, no waiting list, no waste
- Thursday: 9 patients show up, 11 patients get service, no waiting list, 2 wasted units of capacity – ***lost forever***
- Friday: 11 patients show up, 9 patients get service, ***2 patients get put on the waiting list***
- ***After one year 104 people are waiting and there's moral panic. BUT average capacity equals average demand***

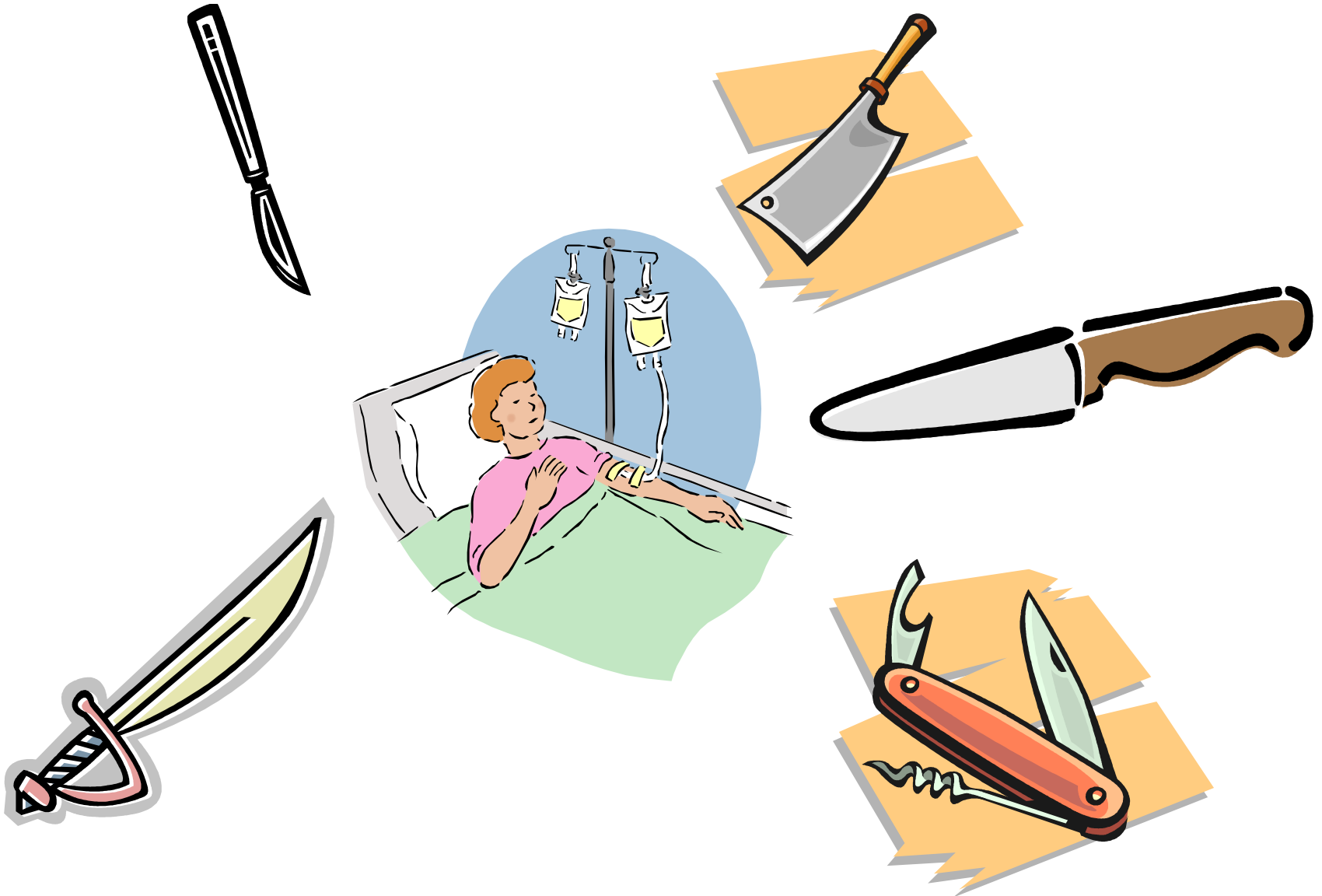
# Variation in clinical systems



*All Different*

*We control 80% of variation!*

# Variation kills quality AND patients



# Six Steps to reduced waiting

1. Map the process
2. Eyeball the map
3. Eliminate redundant stages
4. At each stage measure demand and Capacity
5. If Capacity is greater than demand...
6. If Capacity less than demand...

# 1. Map the process

- Follow the patients through the process using their eyes
- Don't miss the informal stages
- Measure time at each stage



## 2. Eyeball the map

- Use a patient-centred view
- Are there redundant stages?
- This is the time for creativity
- Small changes may have big consequences AND vice versa



“I have a good doctor and we’re good friends. And we both laugh when we look at the system. He sends me off to see somebody to get some tests at the other end of town. I go over there and then come back, and they send the reports to him and he looks at them and sends me off some place else for some tests and they come back. Then he says that I had better see a specialist. And before I’m finished I’ve spent within a month, six days going to six different people and another six days going to have six different kinds of tests, all of which I could have had in a single clinic.”

Tommy Douglas

BIZARRO

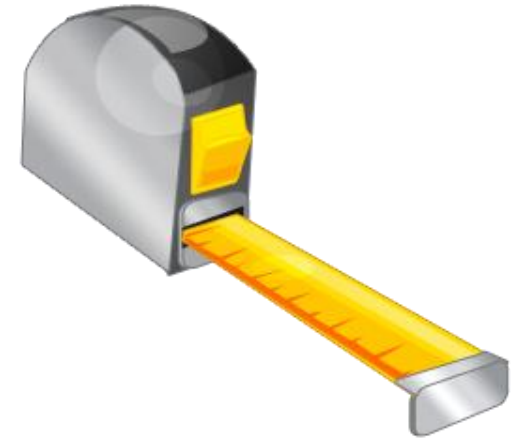


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### **3. Eliminate redundant stages**

- Edmonton Alberta decreased delays for diabetic education from 8 months to 2 weeks by not insisting patients see an endocrinologist on the first visit
- Sault Ste. Marie decreased delays from mammogram to definitive diagnosis by 75% collapsing visits for mammogram, ultrasound, and biopsy

## 4. At each stage measure demand and capacity



- Demand should be measured prospectively
- Patients shouldn't wait for care they don't need!
- Capacity should be measured according to the actual length of time to provide services
  - Don't forget no shows and cancellations
- Measure variation

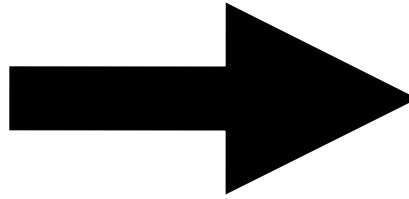
## 5. If Capacity is greater than demand...

- Work down the backlog
- Identify temporary mismatches between capacity and demand
- Reduce variation
  - *Re-shape demand*
  - *Smooth capacity*

## 6. If Capacity is less than demand...

- Identify temporary capacity/demand mismatches
- Reduce variation to eliminate or decrease capacity/demand mismatches
  - *Re-shape demand*
  - *Smooth capacity*

# Reducing and reshaping demand



# Reducing demand

- Reducing demand for services by improving health
  - More effective primary health care can reduce demand for acute and long term care by reducing acute episodes of chronic conditions and consequent loss of function
  - More effective PHC, public health, and healthy public policies can reduce chronic conditions and the demand for PHC services

# Re-shaping demand

- Improve the specialist referral process
- Do you have to respond to the demand for care of a middle aged man with COPD (chronic lung disease) with monthly 10 minute doctors visits and two hospital admissions per year?
- Can you provide care in groups, on the telephone, through the internet?
- What is the appropriate mix of providers?
  - No one knows!

# Spine surgery in Ontario

- Only 10% of patients referred to a spine surgeon need surgery
- \$24 million in unnecessary MRI scans in Ontario alone
- The simple solution? Integrate specialists into primary health care practice.

# A randomized trial of group visits in Colorado

## Kaiser found:

- 30% decrease in emergency department use
- 20% decrease in hospital use / re-admissions
- Delayed entry into nursing facilities
- Decreased visits to sub-specialists
- Increased total visits to primary care
- Decreased same day visits to primary care
- Increased calls to nurses, fewer calls to physicians
- Increased patient and physician satisfaction

# Re-shaping demand

- Can we empower patients and their families to be more effective in their own care?
- Can we empower non-physician providers to play more effective roles?
- Can we empower family physicians and specialists to be more effective in their roles?
- How can electronic systems help us?

## **6A. If your Capacity is now greater than demand...**

- Go to Step 5

## **6B. If your Capacity is still less than demand...**

- Which resources are the constraint?
  - Capital? Personnel? Others?
- Add appropriate new resources
- Find the new bottleneck
  - There will always be one part of the process which runs slower than others
- Continue to “chase the bottleneck”

# Good News! We could access primary health care within 24 hrs

“Even if we did nothing else, and we should implement other reforms, if every family physician implemented ***Advanced Access***, every Canadian could have a family doctor.”

Penticton British Columbia’s Dr. Jeff Harries to the CMA meeting, “Taming the Queue”. Ottawa. March 31, 2006



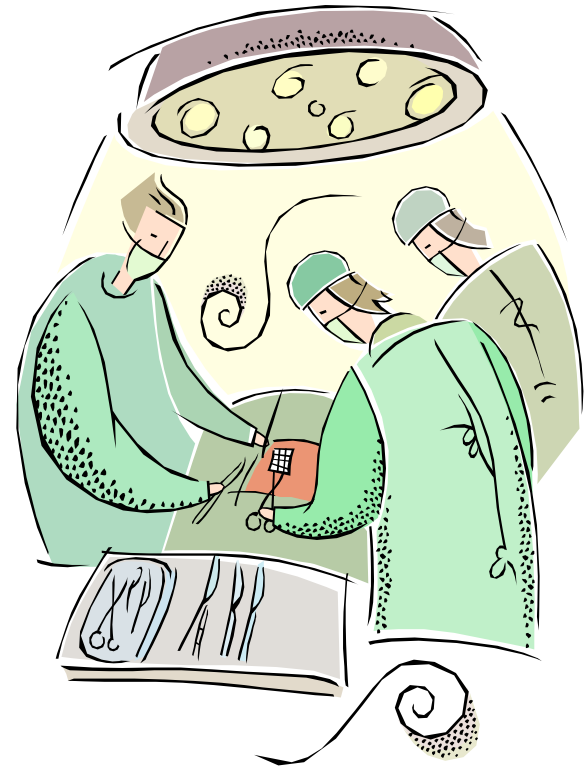
# Good News! We could have elective specialty consultations within one week

- The Hamilton Family Medicine Mental Health Program increased access for mental health patients by **1100%** while *decreasing* psychiatry outpatients' clinic referrals by **70%**.
- The program staff includes 120 family doctors, 80 mental health counsellors, 22 psychiatrists and provides care to 250,000 patients



# Good News! We could have elective surgery within two months

- In many parts of Ontario arthritis patients are assessed within two weeks for joint replacements and have their surgery within two months



# Going for gold: Re-engineering services for immigrants in Toronto



- Toronto's Access Alliance Community Health Centre hires community health workers (CHWs) from immigrant communities
- CHWs are given 3 months of paid training and 3 year contracts
- The CHWs run educational workshops and facilitate well children and well women care
- CHWs have brought services to more than 12,000 women and their children
- 85% of CHWs get jobs in health or social services after their contracts are over

# In summary

- Health Care costs should concern us but they are not out of control
- The aging population won't break the bank
- There are affordable, non-profit solutions to all of Medicare's apparently intractable problems
- The real issue should be how we spread these proven innovations

*Vielen*  
**Dank**

**Gracias**

*Merci*

  
*Grazie*

**THANK YOU**

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**Humboldt**

# A seniors' framework could achieve:

- Outline a vision for the future.
- Act as a 'policy lens' to review current programs and plan future policy.
- Ensure that solutions are developed systemically and not as a series of band-aids.
- Affect and guide the actions and attitudes of everyone in Saskatchewan including government, health organizations, research and education institutions, and voluntary and private sector organizations.

# National Framework on Aging 1998

"Canada, a society for all ages, promotes the well-being and contributions of older people in all aspects of life, and promotes the well-being of seniors, recognizes their valuable contributions and reflects the goals of elimination of ageism in all sectors."

# Principles of the National Framework on Aging

- Dignity
- Independence
- Participation
- Fairness
- Security

# Dignity

Being treated with respect, regardless of the situation, and having a sense of self-esteem e.g., having a sense of self-worth; being accepted as one is, regardless of age, health status, etc.; being appreciated for life accomplishments; being respected for continuing role and contributions to family, friends, community and society; being treated as a worthy human being and a full member of society.

# Independence

Being in control of one's life, being able to do as much for oneself as possible and making one's own choices e.g., decisions on daily matters; being responsible, to the extent possible and practical, for things that affect one; having freedom to make decisions about how one will live one's life; enjoying access to a support system that enables freedom of choice and self-determination.

# Participation

Getting involved, staying active and taking part in the community, being consulted and having one's views considered by government -- e.g., being active in all facets of life (socially, economically, politically); and having a meaningful role in daily affairs; enjoying what life has to offer; participating in available programs and services; and being involved and engaged in activities of daily living (decisions/initiatives in all spheres, not just those specifically oriented to seniors).

# Fairness

Having seniors' real needs, in all diversity, considered equally to those of other Canadians e.g., having equitable access (socially, economically, politically) to available resources and services; not being discriminated against on the basis of age; being treated and dealt with in a way that maximizes inclusion of seniors.

# Security

Having adequate income as one ages and having access to a safe and supportive living environment e.g., financial security to meet daily needs; physical security (including living conditions, sense of protection from crime, etc.); access to family and friends; sense of close personal and social bonds; and support.

**Health Quality Council vision:** Saskatchewan residents have the highest quality of health care for everyone, every time.

We envision a health care system where the response to gaps in quality is a collective desire to match or exceed the best quality achieved anywhere, and where quality is being continuously improved across all of its different dimensions.

# Health Quality Council definition of quality

“Quality health care means doing the right thing at the right time in the right way for the right person and having the best possible outcome.”

# Saskatchewan Health Quality Council

## Dimensions of quality

- Safety
- Effectiveness
- Patient-centredness
- Timeliness
- Efficiency
- Equity
- Access