Is Canadian Medicare dying?

Transforming Healthcare through digital platforms

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Syilx/Okanagan People

MISSION STATEMENT
Reclaiming and restoring Syilx way of being and knowing (worldview) through development of wholistic Wellness programs and services grounded in a Syilx – centered framework.

Okanagan Nation Alliance Wellness Department Health

Youth
Mental Health
Children & Families

I declare no conflicts in this presentation

International rating of Canadian Health Care

Efficiency and Quality

1. United Kingdom
2. Australia
3. Netherlands
4. New Zealand & Norway
6. Switzerland & Sweden
8. Germany
9. CANADA
10. France
11. USA

Source: Commonwealth Fund, 2017

Health Care System Performance Scores

Source: Commonwealth Fund analysis 2017.

E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror: How the U.S. Health Care System Compares Internationally at a Time of Radical Change,* The Commonwealth Fund, July 2017.

Health Care System Performance Rankings

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	**2**	**9**	**10**	**8**	**3**	**4**	**4**	**6**	**6**	**1**	**11**
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

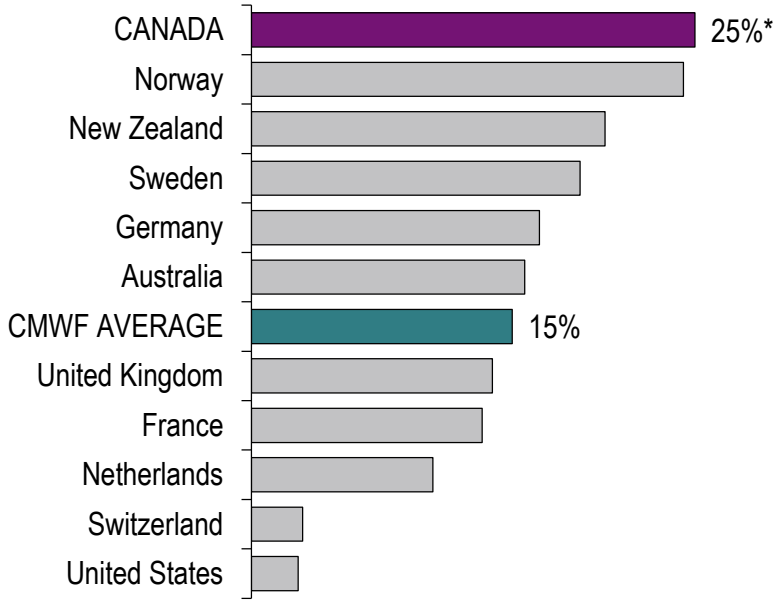
Source: Commonwealth Fund analysis.

E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror: How the U.S. Health Care System Compares Internationally at a Time of Radical Change,* The Commonwealth Fund, July 2017.

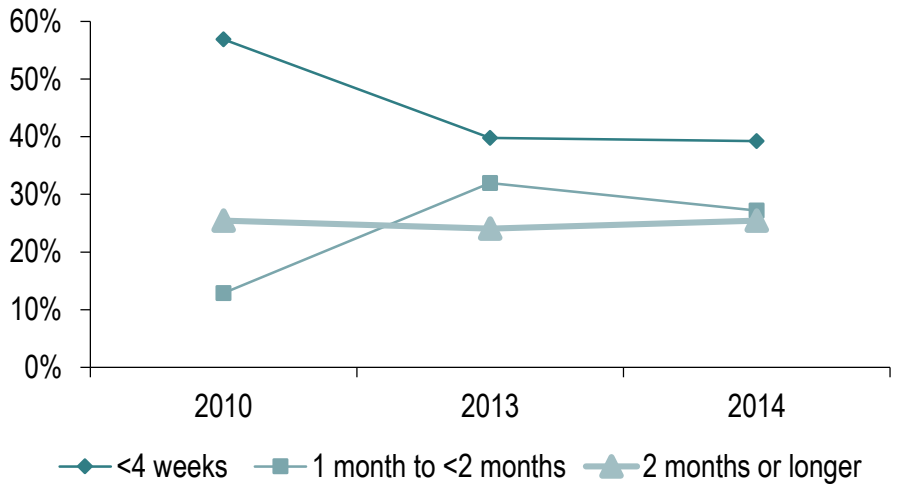
Canadians wait longest for specialist care

25% **of older Canadians waited for at least 2 months to see a specialist; these waits had not improved over time.**

How does Canada compare (2014)?



Specialist wait times, by year



Sources: The Commonwealth Fund, 2010 and 2013 Commonwealth Fund International Health Policy Survey.

International rating of Canadian Health Care

Canada's Relative Performance

- **Care in the Community** Good
- **Patient Experience** Poor
- **Cancer Care** Good
- **Patient Safety** Poor
- **Acute Care Outcomes** Mixed

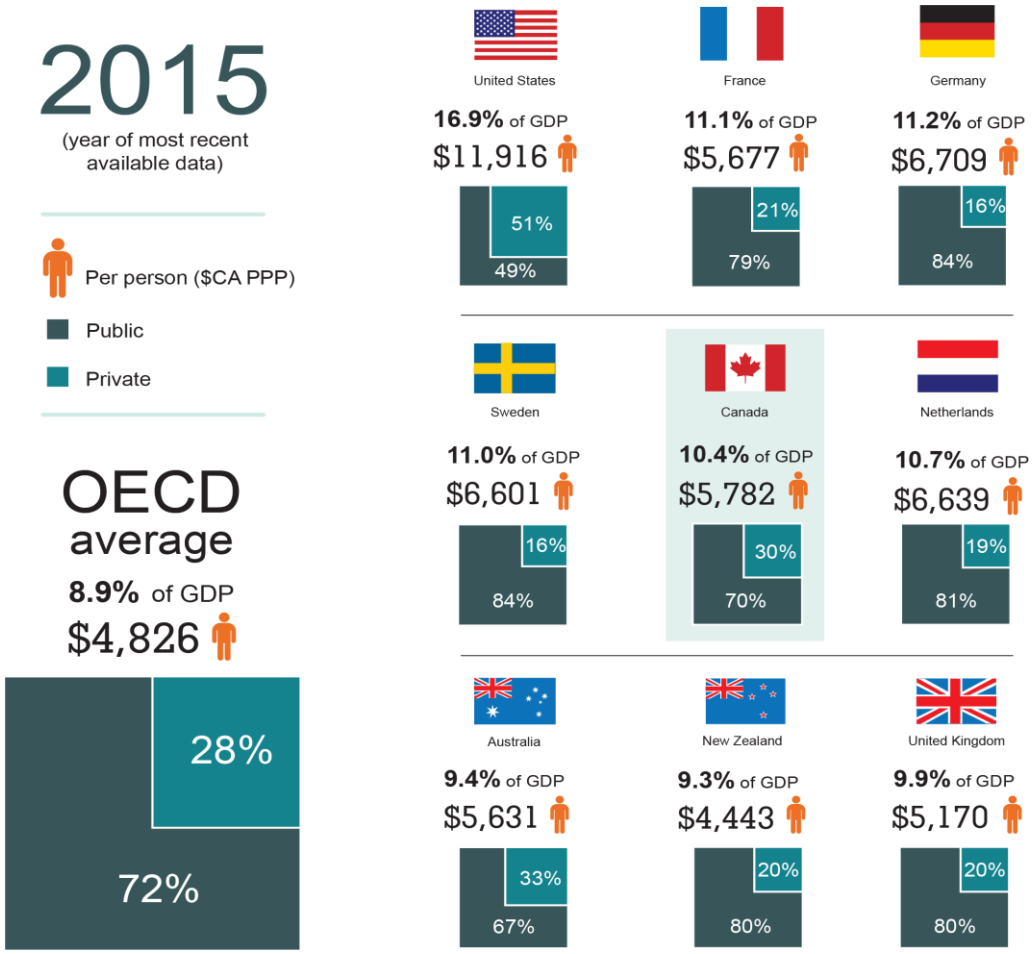
Source: Canadian Institute for Health Information Jan 2014

Cost per capita. (2015 in USD)

1.	USA	$9,507
2.	Switzerland	$7,535
3.	Norway	$6,190
4.	Germany	$5,352
5.	Netherlands	$5,296
6.	Sweden	$5,266
7.	CANADA	$4,616
8.	France	$4,529
9.	Australia	$4,492
10.	United Kingdom	$4,125
11.	New Zealand	$3,544

Source: OECD 2018

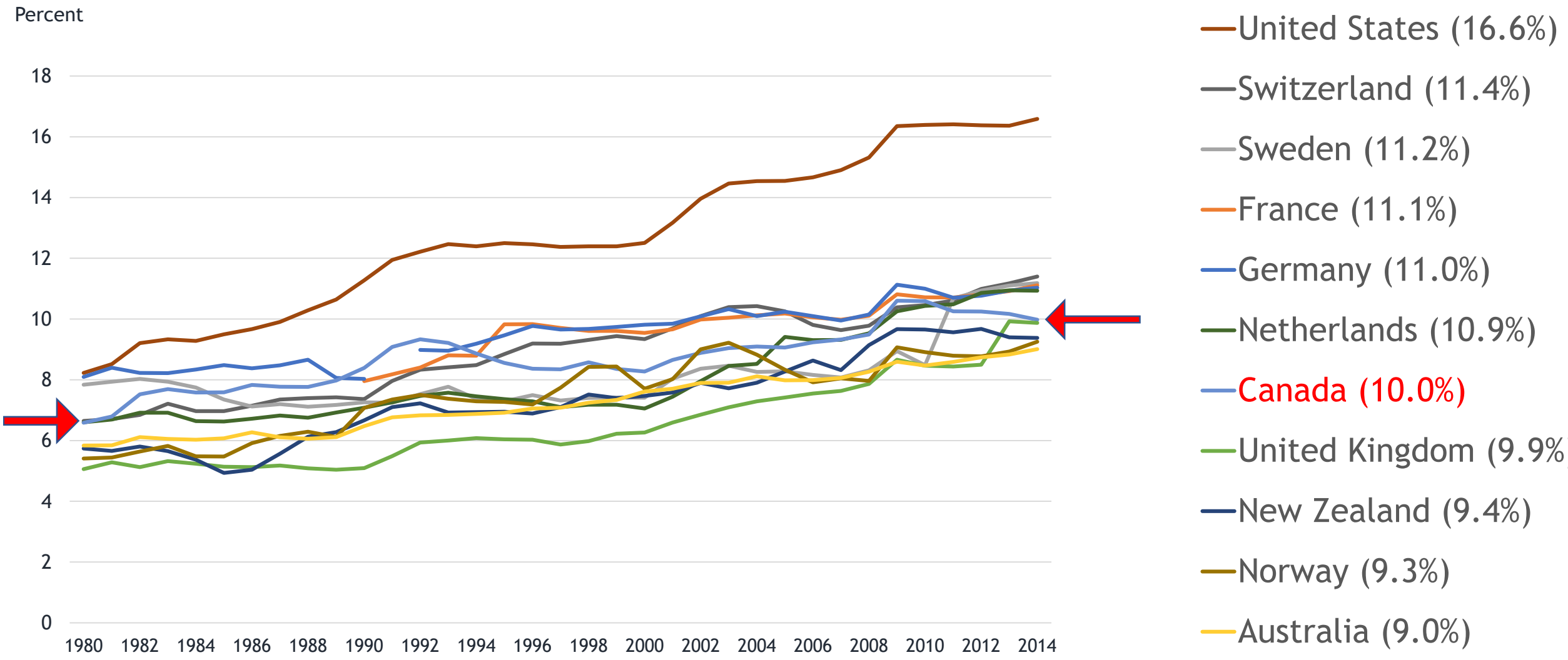
Public/Private Healthcare Expenditures - International comparisons



Notes
$CA PPP: Purchasing power parity in Canadian currency.
Total current expenditure (capital excluded).

Source
Organisation for Economic Co-operation and Development. OECD Health Statistics 2017.

Health Care Spending as a Percentage of GDP, 1980–2014

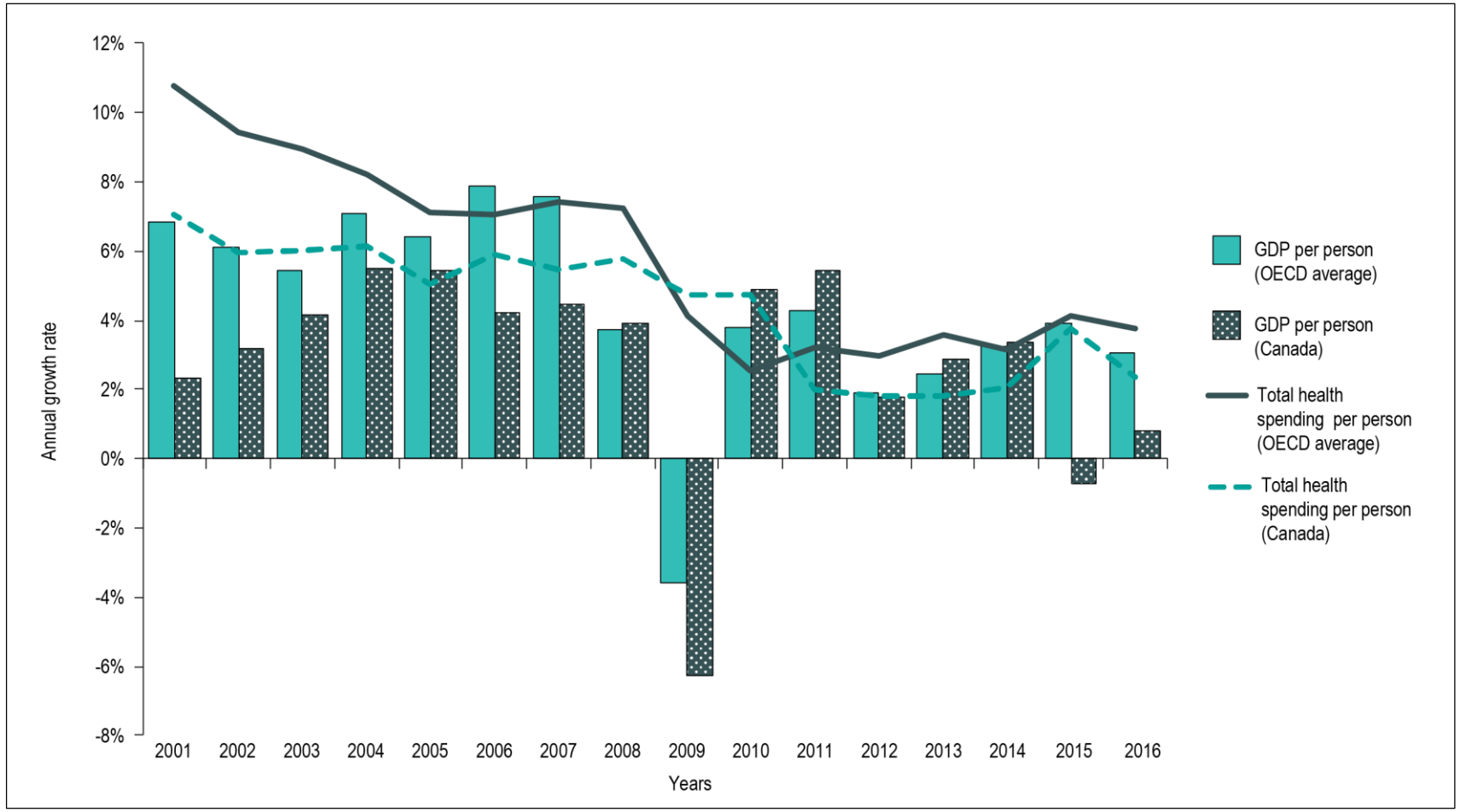


Source: OECD Health Data 2016. Data are for current spending only, and exclude spending on capital formation of health care providers.

The Commonwealth Fund

E. C. Schneider, D. O. Sarnak, D. Squires, A. Shah, and M. M. Doty, *Mirror, Mirror: How the U.S. Health Care System Compares Internationally at a Time of Radical Change,* The Commonwealth Fund, July 2017.

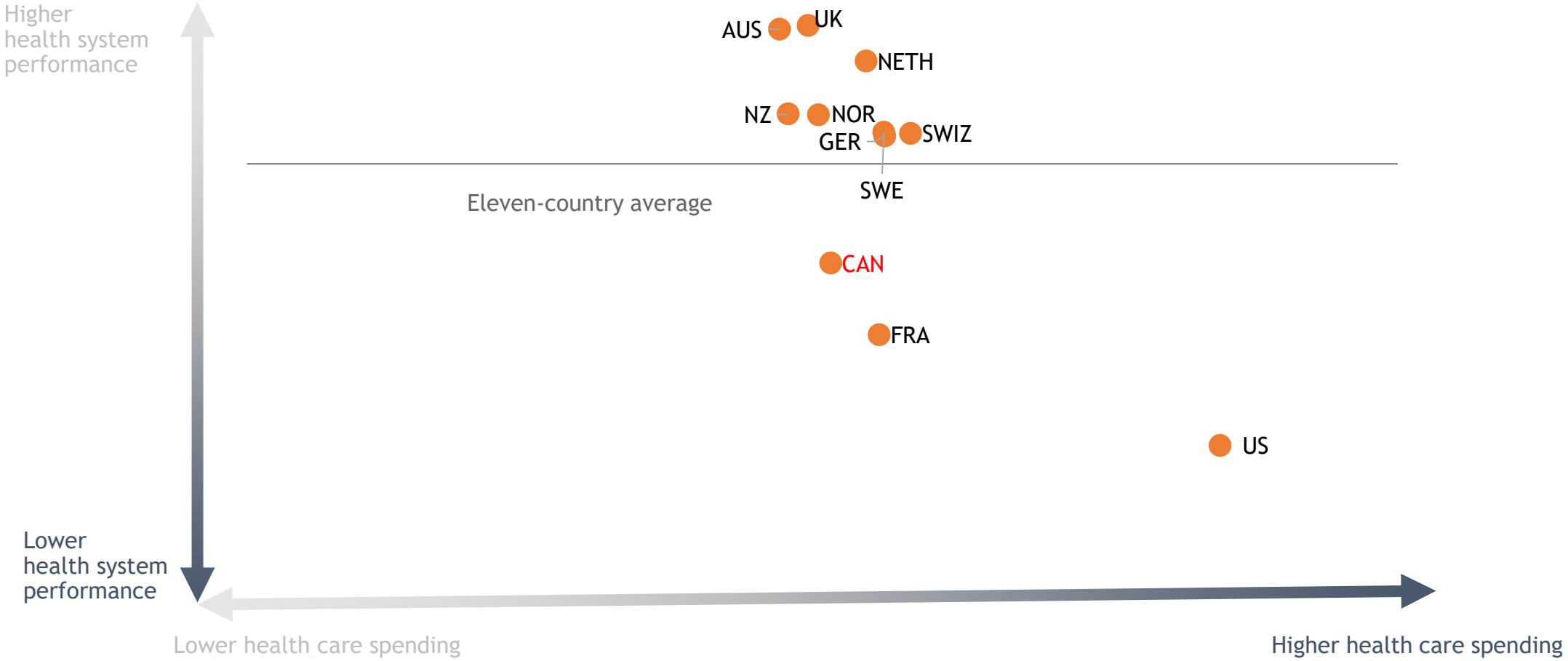
Lower growth in health spending and GDP



Notes
Current price used in the calculation of growth rates of GDP and health spending per person.
Total current expenditure (capital excluded).

Source
Organisation for Economic Co-operation and Development. OECD Health Statistics 2017.

Health Care System Performance Compared to Spending



Note: Health care spending as a percent of GDP.
Source: Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers.

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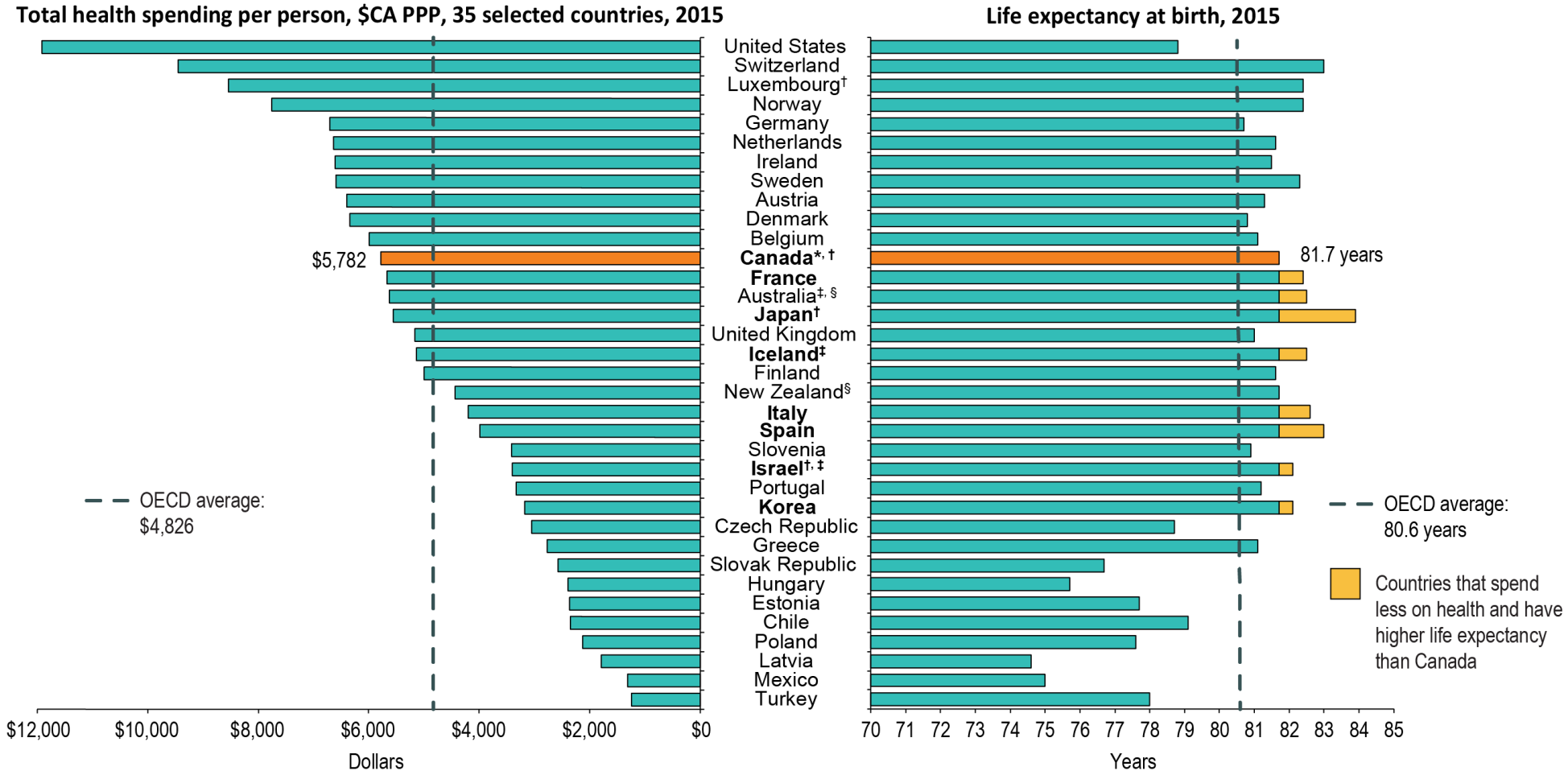
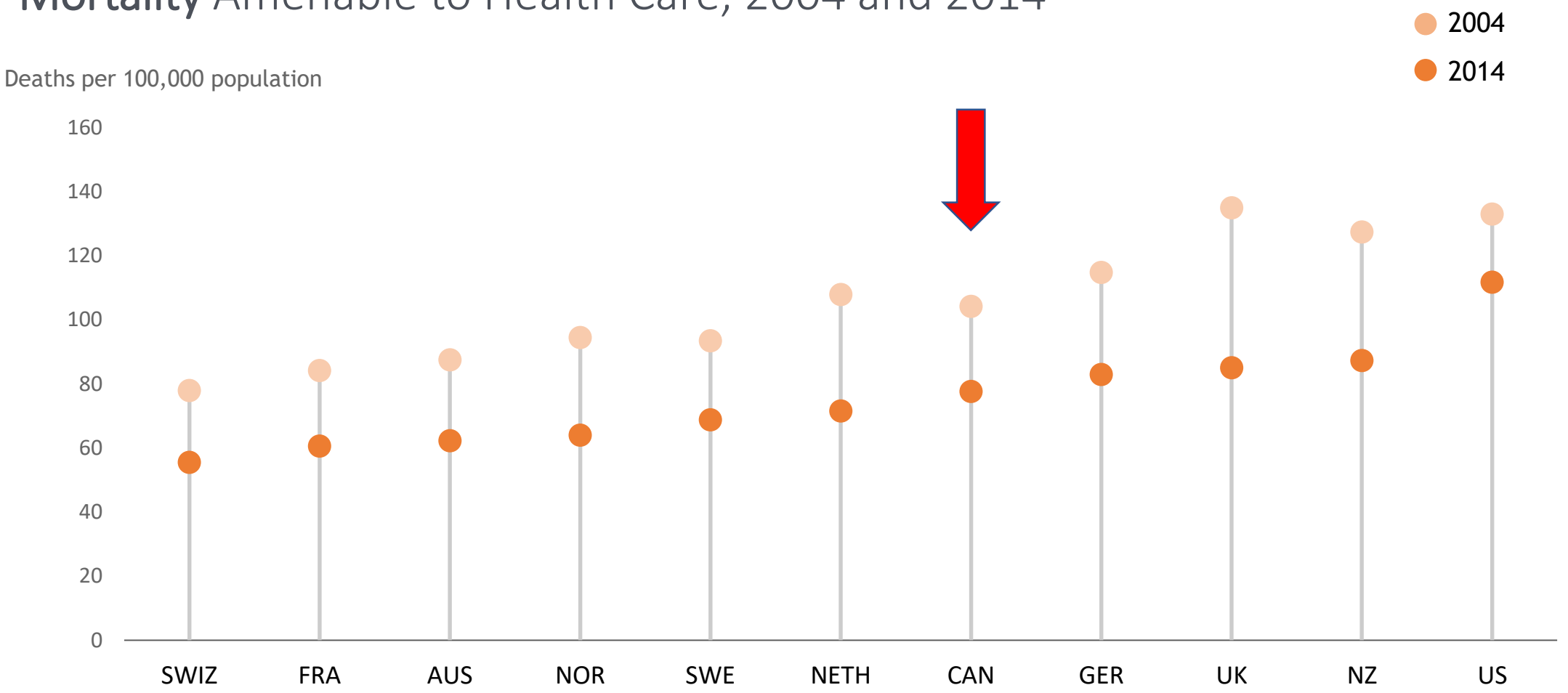
Some OECD countries spend less on health and have higher life expectancy than Canada



Source OECD Health Statistics 2017.

Mortality Amenable to Health Care, 2004 and 2014



Source: European Observatory on Health Systems and Policies (2017). Trends in amenable mortality for selected countries, 2004 and 2014. Data for 2014 in all countries except Canada (2011), France (2013), the Netherlands (2013), New Zealand (2012), Switzerland (2013), and the U.K. (2013). Amenable mortality causes based on Nolte and McKee (2004). Mortality and population data derived from WHO mortality files (Sept. 2016); population data for Canada and the U.S. derived from the Human Mortality Database. Age-specific rates standardized to the European Standard Population (2013).

Indigenous Health: A problem within a problem

- Indigenous peoples comprise about 4% of the Canadian population
- Health status and longevity are markedly worse
- Suicide rates up to ten times higher
- Federal incarceration rates (Feb 2013)
  - 4% of the Canadian population,
  - 23.2% Aboriginal

UN Human Development Index

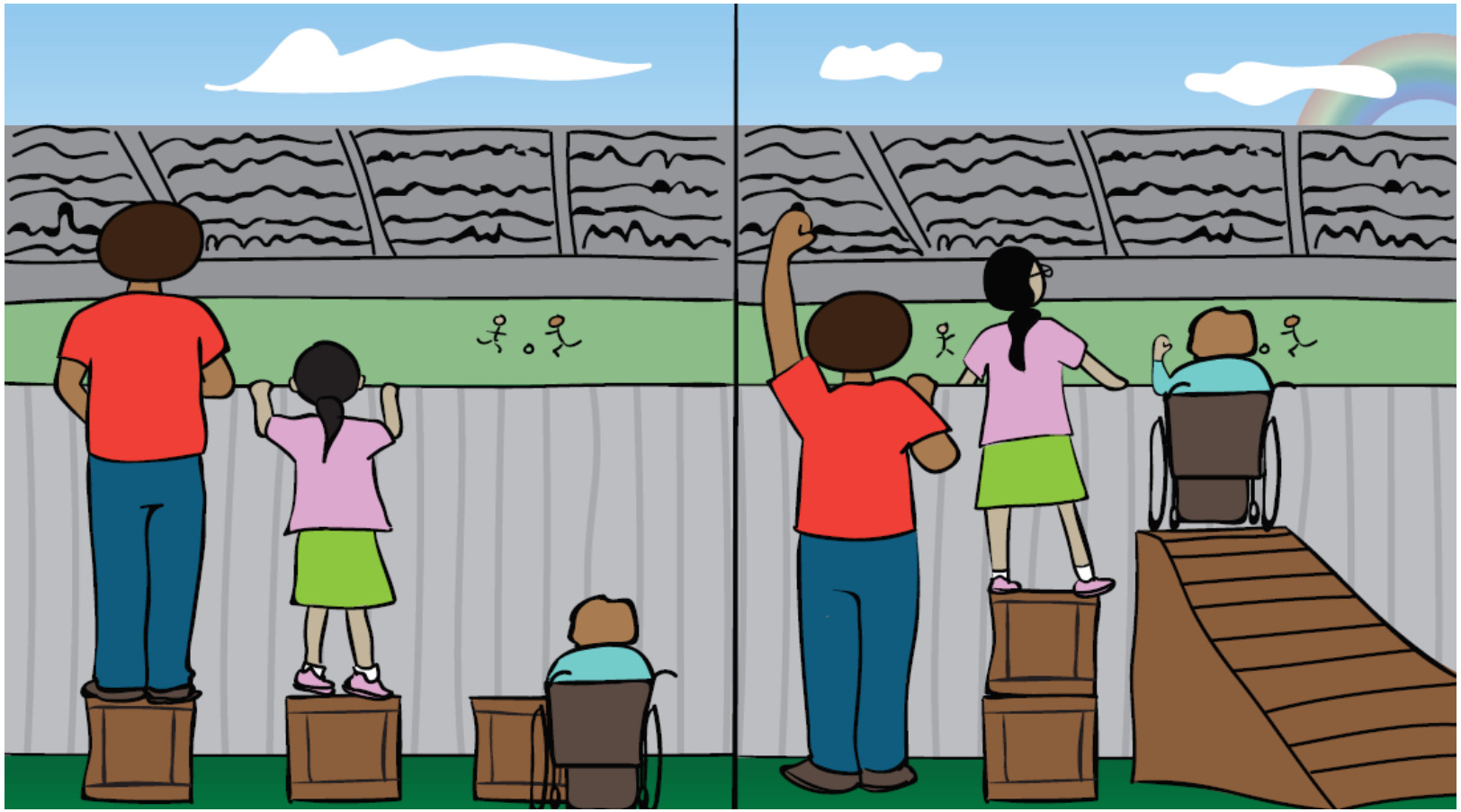
Measures:

- Long & Healthy Life
- Knowledge
- Standard of Living

Canada ranks 10th / 188 countries

First Nations within Canada – if measured separately as though a country – would rank 63rd

Equality is not equity



Summary:

Poor Canadian Health Care performance but mid-level costs.

Of 11 OECD countries, Canada's health care rank:

#4 2004 > #9 2018

Source: Commonwealth Fund 2018

National change reports for Canadian Healthcare

1964 Hall Report

1991 Barer Stoddart Report

2002 Kirby Report

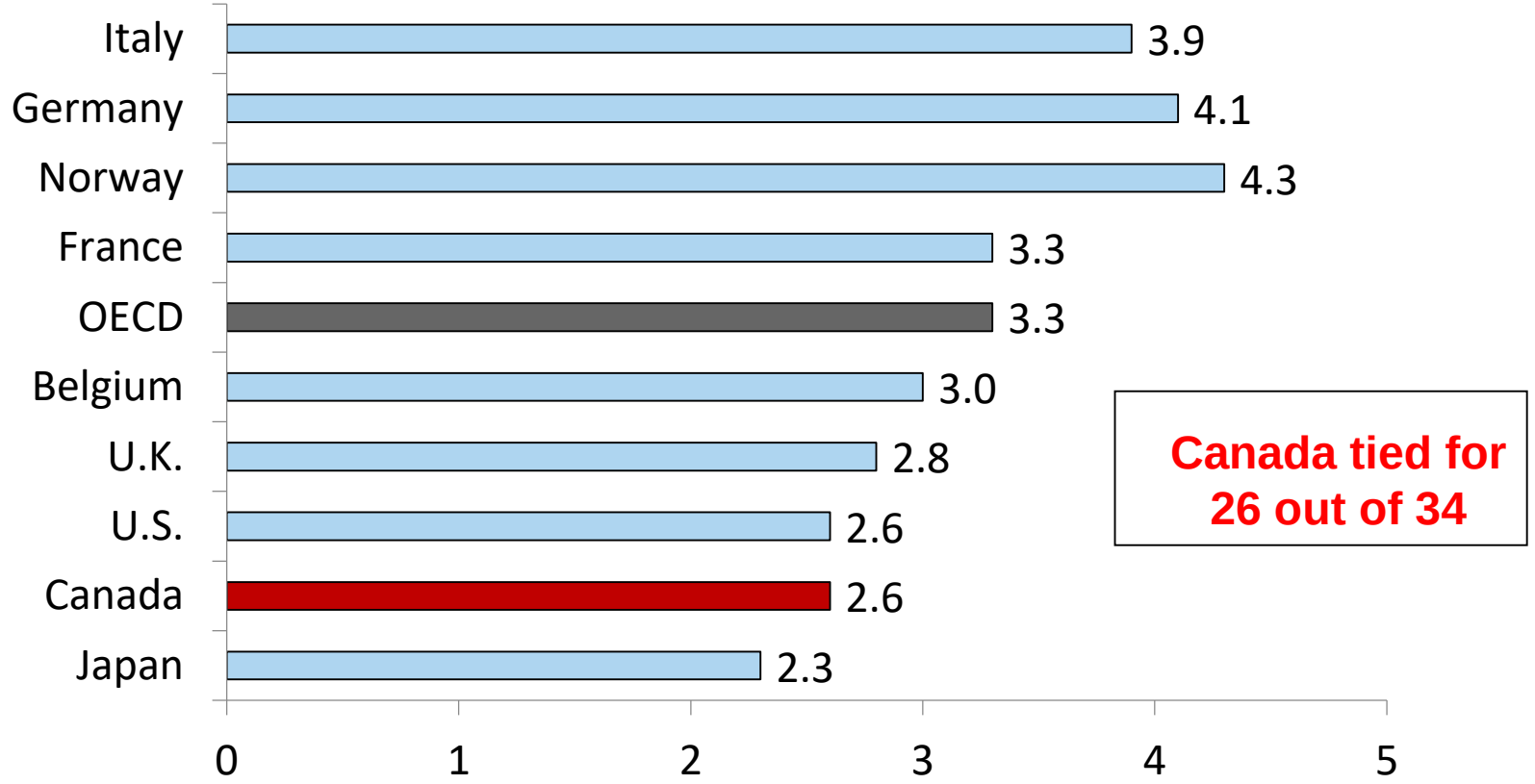
2002 Romanow Commission

2011 CMA Health Care Transformation

2015 Naylor Report

Why is Canada doing (relatively) poorly,
compared to other similar, rich countries?

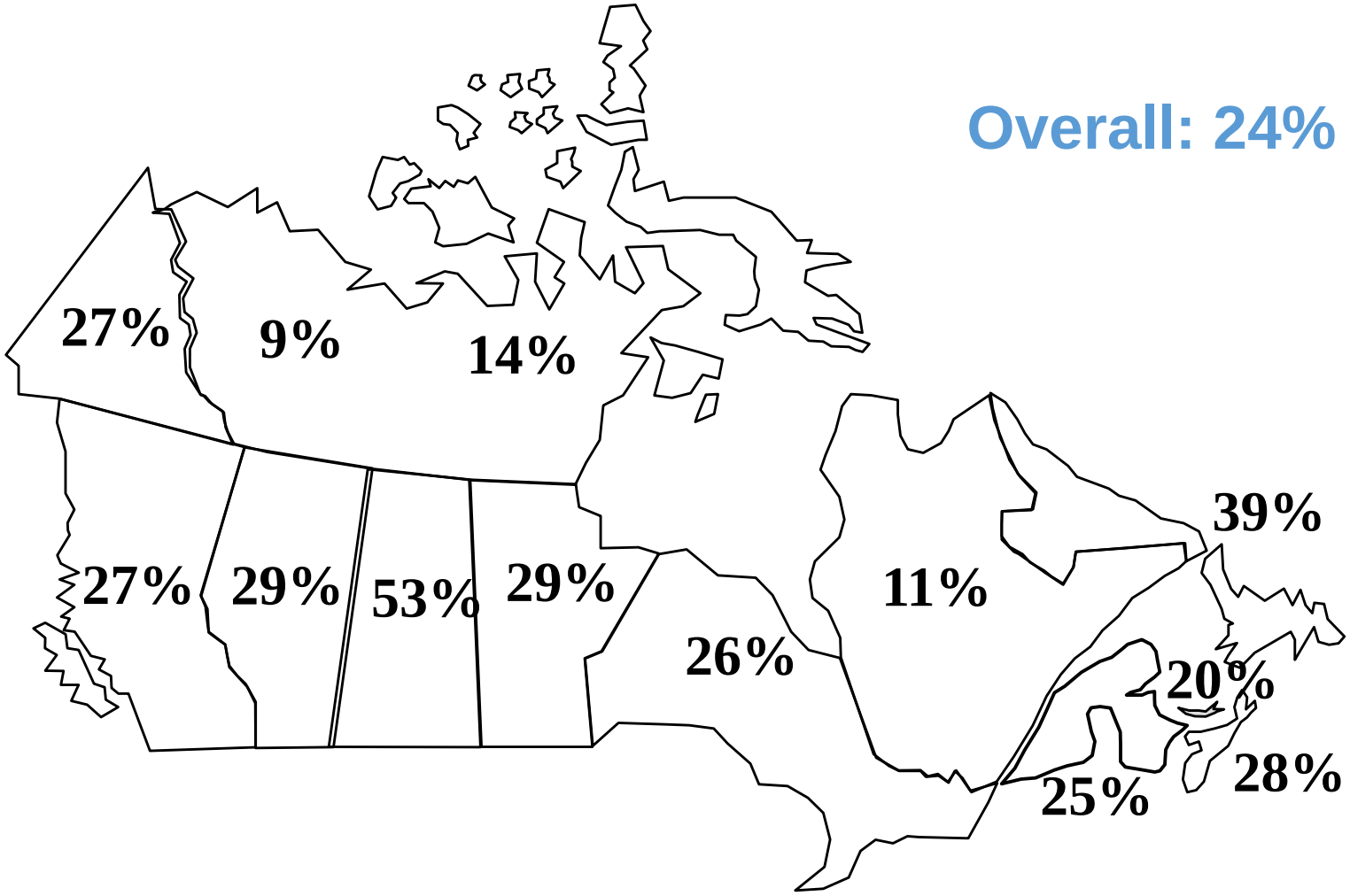
Practising Physicians (including residents) per 1000 pop, 2013



Canada and France include those in administration and research

Source: OECD Health Data, 2015

IMGs as a percentage of all physicians, 2016



Source: 2012 CMA Masterfile

Rural physicians in Canada

Less than **10%** of physicians practise in rural areas whereas about **19%** of Canadians live in rural areas

- **14%** of Canada's family physicians live and work in rural Canada
- **2%** of specialists live in rural areas

Rural physicians, and other HCPs, in Canada

- Lack of professional back-up
- Extra demands on physicians' time
- Inadequate facilities
- Limited specialist services
- Lack of access to continuing education
- Social difficulties may arise in small communities

Rural Advantages

- ✓ Proximity to our patients demands relationships and social accountability
- ✓ Service problems demand innovation and flexibility
- ✓ Transport issues become collaboration tasks
- ✓ HHR problems become shared care organization
- ✓ Happiness; addressing our patients' fundamental questions; personal satisfaction and professional fulfilment take on importance - in addition to scientific medical accuracy.

Land of 100,000 Health Care Silos

System review:

Why is Canada doing relatively poorly?

- Efficacy of work?
- Professional and personal satisfaction of our Health Care Professionals?

Physician burnout

"The Canadian Medical Association will strike a Task Force to review the role of the system in physician anger; their responses; & the effect on professionalism and to provide recommendations to the Board on what, how and if CMA should provide leadership."

CMA Board Motion passed December 2016.

Physician burnout

What are the most common/important **problems**

Which problems are due to the **system** failure, and which indicate the need for more **resiliency** supports?

How physicians **feel**?

What we **do** when we feel like this?

How does this **Affect** patient care and system efficacy?

What to do about it?

Physician burnout

- Conferences in Canada, UK, US and Australia.
- Many Provincial and Territorial meetings.
- Meetings with medical students and with resident groups.
- Surveys from Canadian medical students and residents.
- Focus groups convened in Fredericton, Winnipeg, Quebec City, Vancouver & Ottawa.
- CMA Member Survey - 34,517 physicians, residents and students
- Many National & International papers

Physician burnout

In this qualitative and quantitative, wide-ranging exercise have heard from a broad swath of our profession, in many different venues:

- Canadian medical students from all years
- Residents from a variety of specialties
- Early-in-practice physicians
- Mid-career physicians
- Experienced physicians
- Retired physicians
- International Medical Graduates
- Rural and urban physicians
- Academic physicians
- Trainees and practicing physicians from other countries
- Both women and men in each case.

Physician burnout

7 point range scale for 22 items, measuring:

1) Emotional Exhaustion
2) Depersonalization
3) Low sense of personal accomplishment

C. Maslach

Physician burnout:

"An erosion of the soul caused by a deterioration of one's values, dignity, spirit and will"

C. Maslach

Physician burnout

Concurrent investigation showed:

Students: The unacceptably high rates of Canadian student stress, burnout (**37 > 45%**), depression, & suicidal ideation (**14%**).

Residents: In an independent study, similarly **unacceptably high rates** were found.

Practicing doctors: **60%** find excessive work disrupts personal and family life.

Rate of physician burnout estimated around **50%** (in one Canadian province **90% burnout** was recently reported).

19.5% suffer from depression.

Health and wellness challenges for Canadian physicians

- **60**% find excessive work disrupts personal and family life
- Physicians experiencing burnout approaching, if not exceeding, **50%**
- **34.5%** of practicing physicians screened positive for depression
- **18.6**% had suicidal thoughts (**26.8**% of Residents)

Most common problems for most physicians

- ”PAPER WORK” 80%!
- Loss of control over work and time
- Inability to get what my patient needs
- Increasing patient complexity without increased pay or time
- Increasing patient demand
- Income expectations unmet
- An environment of “hypercontrol”

- Requesting leadership (again & again!)

What are the most common/important **problems**

Which are due to the **system**, and which to need for more resiliency supports?

How physicians **feel**?

What we **do** when we feel like this?

Effects on patient care and system efficacy?

What to do about it?

How do we Feel?

Helpless
Angry
Loose pride in our profession
Consequent loss of professionalism
A wish to retreat from doctoring
Focus on ourselves
Look for someone else to blame

Contributing factors

- Strain felt even prior to medical school, during training, & in practice.
- High expectations
- Financial strain
- Disruptive work environments
- Restricted autonomy, but “Requirement” for perfection
- Heavy workloads, long hours and fatigue
- Reduced work-life balance
- Stigma
- Influences within medical culture

What are the most common/important **problems**

Which are due to the **system**, and which to need for more resiliency supports?

How physicians **feel**?

What we **do** when we feel like this?

Effects on patient care and system efficacy?

What to do about it?

Frequent physician responses

- Overwhelmed by “Paperwork” …. Take it home X
- Inability to control one’s life …. Try harder X
  …. Restrict & narrow scope of practice X
  …. Retire X

What else do we do?

- Choose specialties that appear less demanding, or better remunerated.
- Work longer
- Retreat from doctoring:
  - reduce hours,
  - reduce scope of practice,
  - change practice
  - leave medicine
- Focus on finances
- Look for someone else to blame
- Loose relationships
- Loose ourselves

Effect on Patient Care of Physician burnout:

- impacts empathy and compassion towards patients
- Impedes building appropriate Patient-Physician Relationship
- Impairs care delivery
- Contributes to declining trust in physicians

Recommendations

Stress reduction responsibilities for the System:

- "Need for administrative assistance". √
- "More time to select specialty". √
- "Teamwork is good stress management". √
- "Department chiefs need to understand some behaviours as symptoms of burnout". √
- "Good communicating leadership in hospital & health authority". √
- "Need for physician and association leadership". √

Assessment:

- All medical education, clinical interventions, system improvements, advances in care, regulatory changes must make it easier for physicians and other HCPs to do their work.
- The System bears as much - or more – responsibility as individuals.
- We have all the ingredients for change.
- BC is the best positioned in Canada to make these changes.

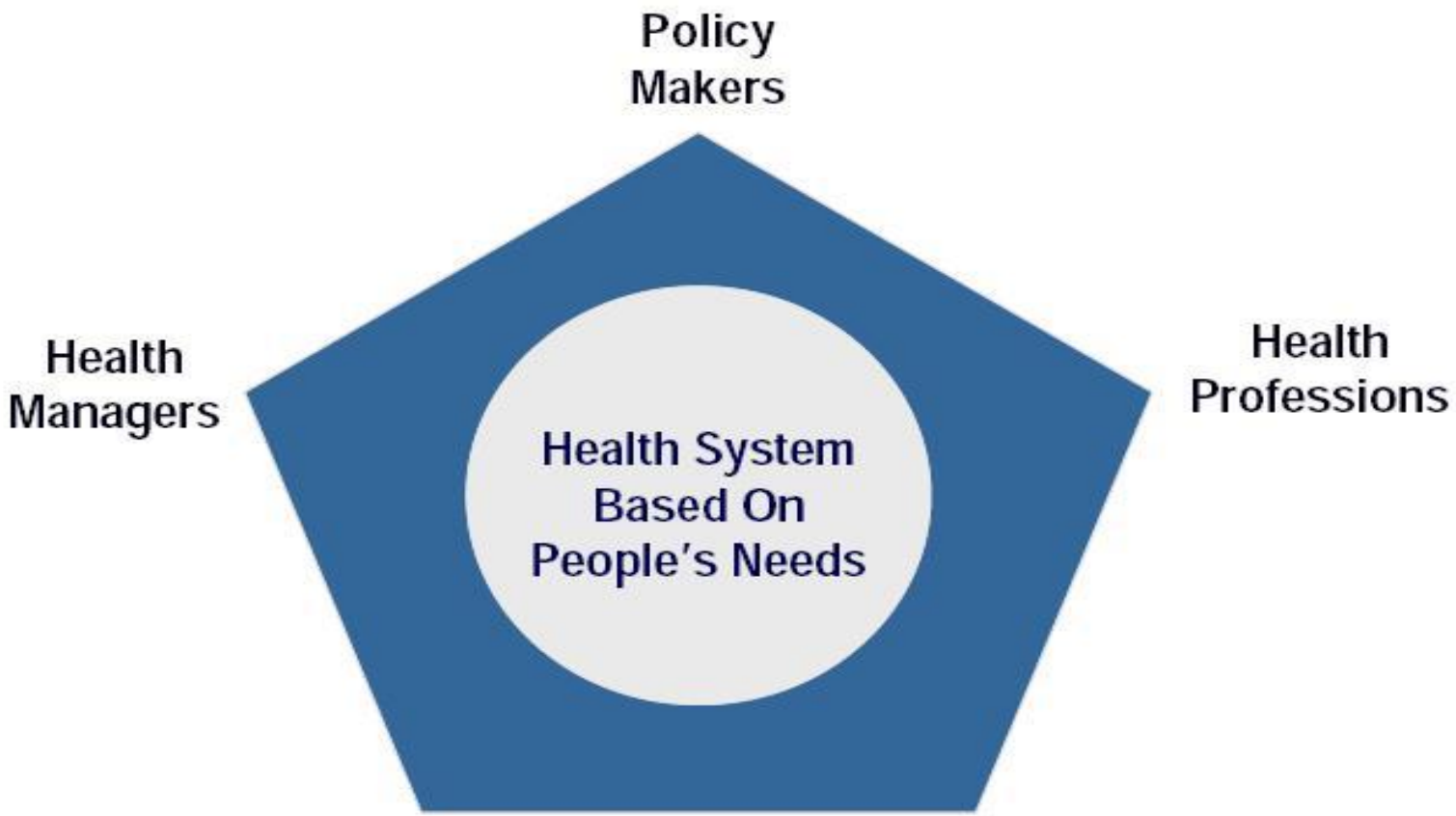
1. Enhanced, collaborative system guidance
2. Look after the workers in the HC system
3. Reformat practice models

1. Enhanced, collaborative system guidance:

Visioning, prioritization and surveillance by the five societal partners that World Health Organization identified in 2000:

- Governments
- Professions
- Citizens
- Universities
- Health Care Administrators

The Partnership Pentagram*



*from "Towards Unity for Health" – a WHO Working Paper, 2000

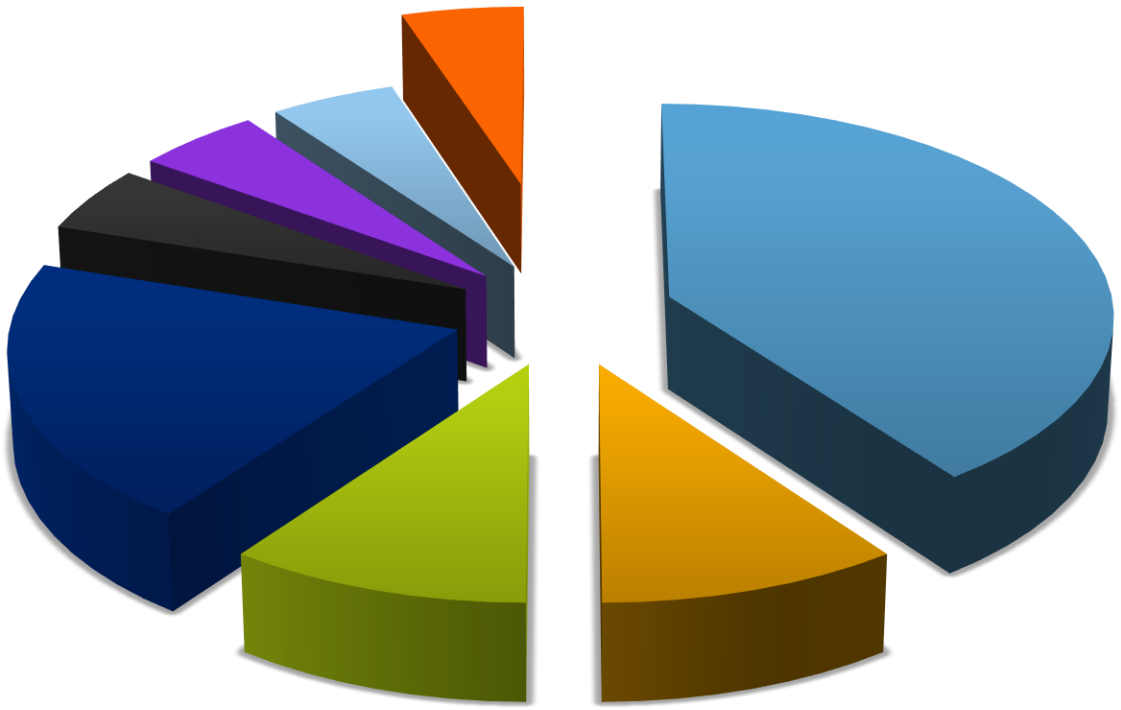
2. Look after the workers in the HC system

Acknowledge and reward respectful and collaborative behaviours in truly patient-centred teams

3. Reformat practice models

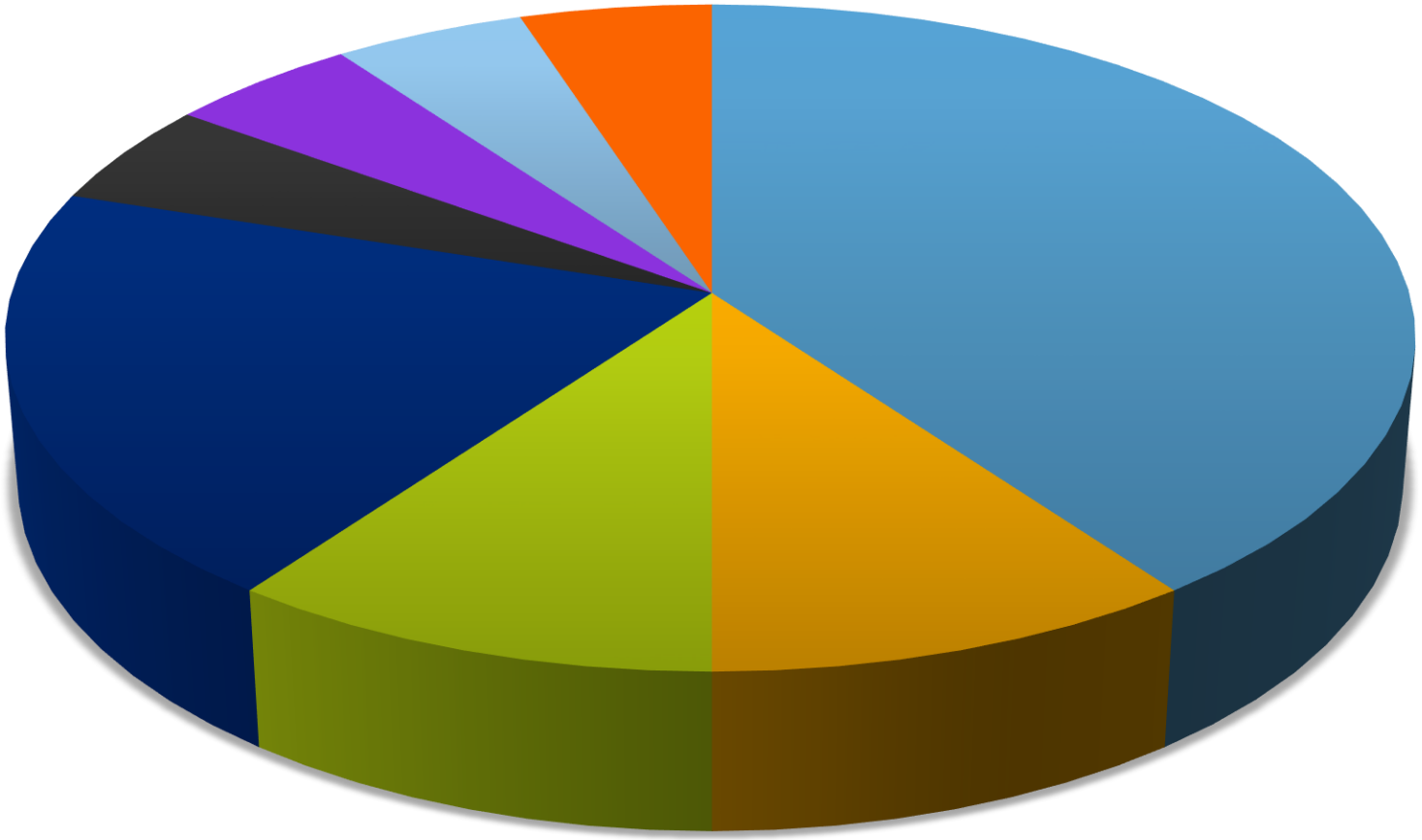
- ✓ Relationship-based HC teams with shared, accurate & contemporary HC data;
- ✓ Community - as well as individual - focused;
- ✓ Working with a full understanding of generalism;
- ✓ each member working to full scope of practice;
- ✓ straddling community, acute care and long term care; and
- ✓ blended funding arrangements allowing ‘up-stream’ work.

The work of a Generalist Physician



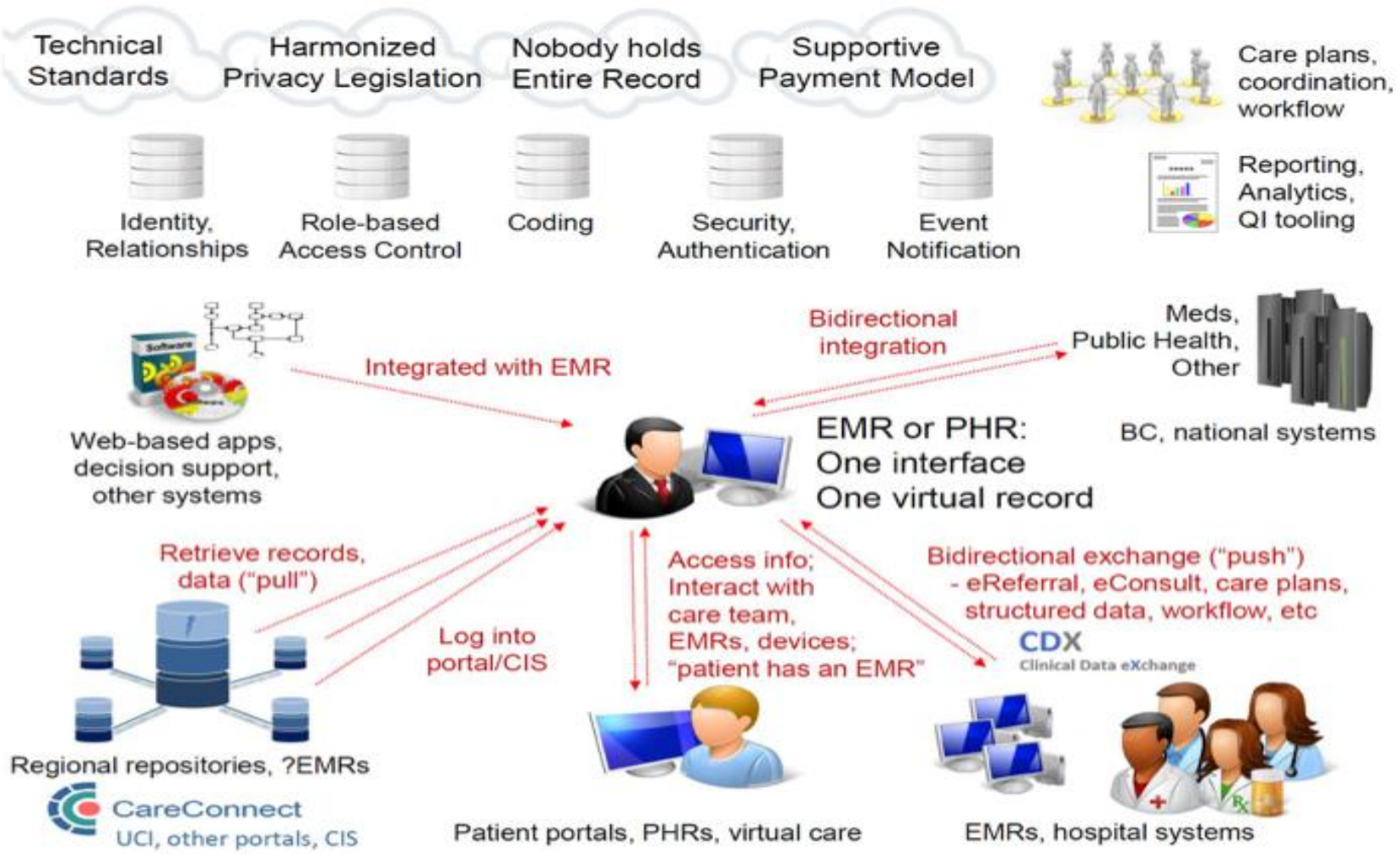
- Clinic/community FFS. CDM/CC 40%
- Comprehensive care in hospital 10%
- EM/Surg/Ob/Anaesthesia 10%
- Unaddressed practice requirements - Addictions/First 5 years/Schools/Obesity 20%
- Research 5%
- Team leadership and Practice surveillance 5%
- CPD 5%
- Teaching 5%

The work of a Generalist Physician



MOA
Physician
Nurse Practitioner
Community Health Worker
Midwives
Community Nurse
Addictions Counsellor
Mental Health worker
Social worker
Pharmacist
Dentist

Developing a System-wide Platform for the Digitization of Healthcare



Dr Douglas Kingsford MBChB FRNZCGP PhD (Engineering) CMIO, Interior Health Authority

Social Accountability

".. the obligation to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have the mandate to serve.

The priority health concerns are to be identified jointly by governments, healthcare organizations, health professionals and the public."

World Health Organization 1995

Social Determinants of Health

1. Income & Income Distribution
2. Education
3. Unemployment & Job Security
4. Employment & Working Conditions
5. Early Childhood Development
6. Food Insecurity
7. Housing
8. Social Exclusion
9. Social Safety Network
10. Health Services
11. Aboriginal Status
12. Gender
13. Race
14. Disability

(Bryant, Raphael & Shrecker, 2011)

BC Medical Quality Initiative: Values

- Health systems should reflect Canadian's ability to care for one another.
- Human relationships are the foundation of any effective health care system.
- Effective teams also promote the individual's need for autonomy, mastery and self- fulfillment.
- Quality is best enabled by supporting health care professionals and teams in doing their highest and best work.
- Sharing successes is foundational to our work.

BC Medical Quality Initiative

Quality Improvement is defined in this context as the ongoing processes and activities that maintain and improve the delivery of appropriate, safe and evidence-informed care at ***the patient, organization and system levels*** *of the health care system. This includes processes that support professional self-reflection* ***and*** *peer review at the individual, team and system levels.*

Surveillance & Formative Evaluation

Rural Practice

Indigenous Health