THE SINCLAIR LECTURE
MEDICARE IN CANADA
WHAT IS WRONG & CAN IT BE FIXED?

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Honourable Elinor Caplan PC
Health is in Provincial Jurisdiction. Canadian Constitution

Provincial Governments:
  are the Insurance Companies

Federal Government: Is a Funding partner

Government is a dominant but passive payer.

*Governments Just Pay & Trust*

“We do not have a system!”
A Vision for the Health/Healthcare

- Integrated & Coordinated
- Evidence-based
- Appropriate, High Quality & Safe
- Patient-centred & Outcome-focused

A Health System that will help Canadians be the Healthiest in the world!
What do the owners the taxpayers want & expect?

*Good value for their taxes.*

What else do the owners have a right to want & expect?

*Timely access to appropriate, safe, high quality care & services.*
Canadian Medicare

- 2009 Health is almost 50% of provincial budgets
- 93% of ministry budget is transfer payment
  - Doctors (OHIP)
  - Drugs
  - Hospitals with Independent Boards of Directors

Who is held accountable?

The Governments
How Does Canada Compare

Health expenditure as a share of GDP, OECD countries, 2007

- Canada: 11.0%
- OECD Average: 8.9%
- United States: 16.0%

Source: OECD Health Data 2009, June 09.
Total health spending accounted for 10.1% of GDP in Canada in 2007, more than one percentage point higher than the average of 8.9% in OECD countries.
Health spending as a share of GDP is lower in Canada than in the United States which spent 16.0% of its GDP on health in 2007.

This explains our competitive trade advantage. Kill Medicare & kill jobs.
Canada also ranks above the OECD average in terms of total health spending per capita, with spending of $3895 USD in 2007 (adjusted for purchasing power parity), compared with an OECD average of $2964 USD.

Health spending per capita in Canada remains nonetheless much lower than in the United States which $7290 USD per capita in 2007.
How Does Canada Compare

Health expenditure per capita, public and private expenditure, OECD countries, 2007

- Public expenditure on health
- Private expenditure on health

Canadian Medicare

Studies, Literature & Evidence

- GDP “Spending Enough”
- GDP - Funds From All Payment Sources
- Government is a Dominant not a single Payer
- At least 25% Inefficiency (overfunding?)
- More Money may make the ‘Value’ Worse

In Ontario the last $10 billion = lower productivity

Today we Pay More & Get Less!
Change in productivity performance indicator scores
- Productivity scores declined by over 11% over the 6 years under review.
Percentages of clinical cases being treated per evidence-based guidelines
- This performance indicator declined by 6% in the period under analysis.

Percentage of clinical cases being treated per evidence-based guidelines: Breast, colorectal cancer, diabetes, congestive heart failure management

Percentage: 1.1, 1.08, 1.06, 1.04, 1.02, 1.0, 0.98, 0.96, 0.94, 0.92, 0.9, 0.88
“Quality of care or service is meeting or exceeding your customer/client/patient expectation.”  

Peter Drucker

“You can not improve what you don’t measure. Qualitative & narrative measurement is also needed.”

W. Edward Deming from “Out of the Crisis”

“You can not meet or exceed expectations… if you don’t know what is expected.”

Elinor Caplan
A reasonable quality expectation:

DO NO HARM

It is also reasonable to expect that health professional care will do some GOOD!
How many preventable errors are OK?

- Preventable deaths
- Preventable infections
- Preventable adverse drug reactions
- Preventable injury (falls) etc

NONE
Preventable errors **harm** 1 out of 13 who use our hospitals.

Preventable errors **kill** about 28,000 in our hospitals in Canada (40% in Ontario).

Baker & Norton
With a Focus on Quality, Evidence, & Outcomes the results will be efficiency & cost effectiveness.

Quality Care will Cost Less!
Can we create a Culture of Patient Safety & Continuous Quality Improvement in Canadian Healthcare?

If we can… why haven’t we?
If we can’t… why can’t we?
Every Incentive is Perverse to the Outcomes Canadians (the Owners & Taxpayers) want & need.
Reality & Problem

- Pharmacare Drug Programs
  - eg Ontario Drug Benefit (ODB)

Governments Just Pay & Trust

Results = Many prescribing errors
  = Many drug related hospital admissions
  = Rising Expenditure is making many of our elderly sick

Poor Accountability = Poor Safety & Quality
Reality & Problem

- No Governance Best Practice?
- Ontario’s Public Hospitals Act requires a Board of Directors - Section 13 (no liability)
- PHA Legislates responsibility for Quality & Management to the Hospital Board
- Board Appoints CEO & Medical COS
- Board Composition requires CEO, COS, & Staff Association Representative (Union Steward)
Role of The Provider

“Our number one priority is safety & the quality of care & services.”

“Excellence in our financial management of public funds.”

“Innovation begins with a commitment to a Balance Budget.”

“We are partners in strategic planning & implementation of a Health System.”

“We will be transparent.”
Organized Medicine & Physician Unions

The OMA are Modern Day Luddites. They encourage their members to throw their stethoscopes into the technology of Transparency, Accountability, Measurement, Decision Support & Quality Improvement.

Hon Elinor Caplan PC
History of Cooperation

- Larry Grossman 40 years ago
- Don Orchard in Manitoba 23 years ago
- Ray Frenette in New Brunswick 22 years ago
- Every Provincial Government has tried
- 1987-90 Ontario Offered Partnership
- 1990-1995 Ontario legislated Rand
- 1995-2000 Policy Veto to protect incomes
- 2000-2004 Utilization Cap removed
Evidence of a Problem

Results OMA is militant powerful Union

- Alternate funding plans were stopped (little reallocation from OHIP & FFS still dominates)

- Guiding Principle = No accountability or performance monitoring is permitted

- Queen’s & Sick Kids is the only models 20 year later

- 2004 OMAMD e-health $150 (18 vendors)

  It took 5 years (2009) for interoperability.
Evidence of a Problem

- No Transparency (gaming)
- No Accountability (now service agreements)
- No ability to compare results
- Hospitals allocate resources to equalize physician income. It’s not about community needs.
- Most hospitals do NOT know their costs
- 2006 OMA/ONT PCP $80,000 stipend with no agreement
  - Result Primary Care Physicians (PCP) work less
Evidence of a Problem

- No CHO & few integrated models attempted
- Rapid Primary Care Reform is not supported
- Wait time Strategy angered physicians
  - Competition was on quality & price
  - Additional resources only for some not all
- Government must now pay more for every change ie: most recent OMA negotiations
  - Changes to fee schedule were rejected (strike threat) so result = hospitalists (more $$$)
I have enormous regard & respect for so many of the dedicated physician that I have known over the years.

Many didn’t want to be conscripted into a union & forced to pay union dues. (RAND)

Many doctors are embarrassed by the antics, the negotiating tactics, & obstruction of organized Medicine.
Why has there been no progress developing a system in Ontario?

OMA Policy veto & resistance to reallocate $$$ from OHIP, has hindered real change in payment models from Fee-for-Service.
Lessons Learned

- In the Fee-for-Service Funding Model when the focus is on Quality Improvement, incomes that depend on Quantity will decline.

- Transparency, Accountability & focus on appropriate care, adherence to guidelines, measurement for continuous improvement will eliminate ‘churning’ & volume generated income… will drop.
So many wonderful doctors are unhappy & frustrated. Who should they blame? The Government?

The truth is that over the years every Provincial government has asked for cooperation, collaboration & even partnership.

I want our doctors to be amongst the highest paid in the world but... only if we get Value & Quality
Evidence of a Problem

• Recertification in the USA (for 15> years) UK & Europe, but NOT in Canada (Eh?)

• Proposed by CPSO & Rejected by OMA

• Are Canadians getting continuous practice improvement & best practices implemented?

• Are Canadians receiving person/patient/client centred care?
Lessons Learned

To improve quality, safety & efficiency a Continuous improvement, blame-free environment, produces the best results. Learn from your best mistakes & near-misses.

To Create a Learning Culture use Story Telling & Appreciative Inquiry.
93% of the Time a Quality Problem is the Result of Lack of a Process, Structure or System to Support Decisions.

7% of the Time the Problem is a Competency Issue or Negligence
Lessons Learned

- Fee-for-Service rewards & incentives **quantity** not **quality**
- Fee-for-services does not reward care that especially takes time. (ie Primary Care, Pediatrics, Geriatrics, Chronic Disease Management, Emergency & Trauma, Pathology etc)
- Fee-for-Service with Service Accountability Agreements (contracts) may be appropriate for specialists
Governments: on behalf of the owners

Just pay & trust

Public Pay & Private Delivery

- Hospitals are private corporations with Boards
- Doctors, midwives, pharmacists, dentists, etc. are independent & self regulating.

Who advocates for & acts in the public interest?
How government can implement changes?

Reality - The Only Ministry of Health Tools:

- Legislation
- Regulation
- Funding
- Persuasion, Mandatory Reporting & Exposure
- Empowering ‘Public Interest’ Boards
Important Questions

- Is anyone empowering the public with decision support information?

- Are Hospital Boards monitoring the Quality of care & the Safety of their services for Patients, visitors & staff in their facilities?
  - C Diff Defense at JBMH “We didn’t know.”

Is there a Peer Review Culture of Excellence?
There is **fear** of transparency because of the blame & shame & a litigious environment that exists.

**Fear** by both Governments & Providers
What does Media communicate?

- Who is responsible & accountable for delivery of care & services?
- The News is usually sensational, bad or sad anecdotes & is it an accurate portrayal?
- Who do the public believe will tell the truth?

The Government?
Where is the Professional Medical Leadership who can & will offer dedicated doctors (not the Rank & File) the opportunity to act like the profession they want to be?

I see the OMA ‘Union’ Leaders treating doctors like lemmings who are being led to the very edge of the cliff.

Who is thinking about the serious reputational risk?

Where is their pride & professional dedication?
Reality Check

What Minister/Premier/Prime Minister will publically disclose the Safety & Quality evidence if he/she can offer no solutions?

What Minister/Premier/Prime Minister wishes to see our Health Professionals discredited?

What Minister/Premier/Prime Minister wants to shake the public confidence in the Canadian Medicare model?
Lessons Learned

In Any Battle *Truth Is The First Casualty*

- Good information (IT/IM) today is possible.
- UK & US Publish Outcome Information, Canada doesn’t do much & that will change.

But at what price?

An internet savvy public is accessing & demanding information.

I’m sad to say that exposure is inevitable!
What is not Measured, can not be Managed.
What is Measured will Improve!
Do Hospital staff, Doctors & Governments have the decision support tools to measure, monitor & learn how to improve outcomes?
Information Management (IM/IT) can support & will enable System Development. (e-health, connectivity, common definitions, common coding & interoperability standards)
Reality & Problem

- Infoway Focus: Connectivity but Without Common Definitions & Common Coding
- Few Common Indicators Across the Health Sector & none in Ambulatory Care
- (Deliberately) different Hardware & Software
  - With No Common Standards & No Interoperability or Connectivity

*Canadian Outcomes Cannot be Compared*
Reality

- CIHI compares apples & oranges
- Quality Healthcare Councils in provinces
- Saskatchewan is a Quality & Safety leader
- Poor result from F/P/T accountability accord

Provinces fear comparison
Reality

- Other Interests Can/Do/Will Deceive
- Opposition Parties Are Seduced

Good Public Policy Is Only Possible When the Public Understands What Is Really In The Public Interest

If Not….

Good Public Policy Is Bad Politics!
Can we expect Governments to Act in the Public Interest Without Those *Who Know The Truth* Actively Supporting The Required Changes.

Evidence-based Healthy Public Policy & Health System Development policy should be Non-partisan because we all want Quality Improvement & better Health Outcomes & The Healthiest Country in the World.
Questions

- How do We Maintain Public Confidence as the serious Problems are Exposed?

- How do We Hold Independent Boards Accountable to Act in the Public Interest? (scrap Section 13?)

- How do We Encourage Professionals to Act in the Public Interest?
Policy Option: Exposure

- Hospital could publish all wait times
- Hospital could publish program volumes
- Governance (Boards) could set priorities with evidence as partners. (abolish them?)
- Align incentives with outcomes.
- Align incentives with performance.
- Mandate recertification
- Abolish RAND & The OMA Policy VETO
Possible Solutions

- Ensure transparency & accountability by all service providers
- Third party non partisan validation to assure the public.
- Find or fund & implement Canadian evidence & use international evidence.
- Mandate interoperability, connectivity, coding & standards the e-health priority!
Optimal Solutions

- Complete Registration with Green photo/Health Card. Mandate use in all MOHLTC funded Hospital. Use Health Card for all Social Services. Professional a unique provider #.
- Providers & Leaders know how we can Fix it.
- Start before ‘Exposure’ damages reputations.
- Don’t ask for Government Intervention.

Cooperation is the only option & best solution!
One Last Question

• We know HOW to make these changes.
• We know WHY to make these changes.
• We just need to find those WHO will help get it going.

Where are your mirrors?