Top 10
Best Ideas to Transform Health Care

Improving the quality and efficiency of health care matters to all Canadians. Finding better and less expensive ways of providing care and preventing illness cannot be achieved by sticking to the status quo. Our health care system requires continuous improvement. There are many ideas that have been shown to improve quality and efficiency while preserving or improving equity. Below are the top 10 ideas Canadian Doctors for Medicare believes would improve the quality of care, improve health outcomes, and provide value for money in our health care system.

1) Primary and Community Health Care Reform

The best health care systems are built on a foundation of high-quality primary care. With our aging population, integrating primary care with home- and community-based care makes sense. Shifting non-acute resources from hospitals to the community supports a stronger focus on keeping patients well and supported in the community.¹

Greater integration of community-based primary health care is needed to support a continuum of service provision, including first contact physician care, health promotion and prevention, and the management of chronic disease. An integrated primary health care sector would also better support a system of “shared care” – that is, a system of primary care that is networked, patient-centred, and based on inter-professional teams and rapid access to specialists and non-physician providers.

Primary health care reform was a key feature of the 2003/04 First Ministers’ Accord on Health Care Renewal.² The agreement identified primary care reform as a priority, in order to ensure equitable access to the interrelated factors that affect health, including health promotion, illness prevention, health maintenance, home support, long-term care, community-based rehabilitation and pre-hospital emergency medical services. Since then, the Health Council of Canada has reported some progress on primary care reform, but changes have been somewhat limited to the implementation of inter-professional teams and disease-oriented collaborative practices.

Expanding access to primary care in community-based settings and supporting a smooth continuum of care between the community and institutions are key steps in improving medicare. And there is mounting evidence that it may also contribute to better health outcomes. Patient care delivered within a primary care setting has been found to be more efficient and effective, while countries with “primary care-oriented systems” have fewer disparities in health across the population.³

2) Implement an Electronic Health Record

There is a near consensus among health care providers that electronic health records (EHRs) will improve the practice of medicine, support a more integrated health system and allow different parts of the health care system to communicate more effectively with one another. Electronic prescribing will enable prescribers to better utilize their time, while a prescription drug database can be used by doctors and pharmacists to improve prescribing practices and help to prevent dangerous drug interactions. The use of EHRs can also better support the use of evidence-based guideline by physicians and other providers in the health system.
Yet, in 2009, of an estimated 322 million visits made by Canadians to doctors, 94% resulted in a paper record. Canada is far behind all other industrialized countries except the United States in transferring to EHRs. Almost 80% of health records in Australia are electronic, while in the Netherlands the figure is 98%. Canada has a long way to go to catch up, but achieving an almost universally applied EHR is a reality in other jurisdictions and is a realistic goal for Canada.

3) Widely Implement Successful Wait Times Initiatives

Despite alarming assertions in some quarters, Canada’s public health care system has introduced highly effective measures to dramatically reduce wait lists for specific surgical procedures. A B.C. study published in 2004 concluded that two key changes contributed significantly to better managing wait lists. The first was a transition among doctors from a fragmented array of solo practices to collaborative relationships with other physicians and health care workers in teams, particularly those who work in primary care. In such an environment other providers – such as advanced practice nurses – are better able to work to their full scope of practice. The second change was the transfer of wait list management from individual doctors to regional or local health authorities. This enabled a common wait list to be developed while protecting the right of patients to choose their own surgeon. In some provinces, notably British Columbia, physician wait times are published on the government website to enable patients to choose a surgeon with a shorter wait time if they desire.

Other steps that have been used successfully in Canada and elsewhere include queuing strategies to improve current organizational processes – a process used in other sectors as well. Pre-surgical programs that prepare patients for surgery can also reduce wait times, as well as reduce the stress patients may experience prior to an operation.

Prompt access to care could also be enhanced by the creation of a “wait-time champion,” someone who will point to workable and sustainable ideas being implemented in different parts of the country. For example, Dr. Cy Frank, an orthopedic surgeon and executive director of Alberta’s Bone and Joint Health Institute, led a team that reduced wait times for hip and/or knee surgery from 82 weeks to 11, using innovative approaches to organizing care. Applying similar approaches on a provincial or national scope should produce similar benefits for populations as a whole.

4) Move Toward a National Pharmacare Program

Since 1964, when the Royal Commission on Health Services recommended that prescription drugs be part of medicare, the creation of a national pharmacare program has been part of Canada’s national dialogue. Since then, the idea – and the evidence to support such a proposal – has grown.

Canada pays more for prescription drugs than any country within the Organization for Economic Cooperation and Development (OECD) except the United States. We pay 30% more than the OECD average. Despite this, we have one of the lowest rates of public drug coverage, and about 8% of Canadians are unable to fill a doctor’s prescription because of cost. This has resulted in one of the most inequitable systems within the OECD in regard to access to medicines. A universal national pharmacare program would bring Canada in line with most high-income countries around the world.

A national pharmacare program would also allow Canadians to effectively manage costs in a variety of ways. For example, a single national formulary of essential drugs based on independent, evidence-based drug evaluation could reduce costs by 8%. Additional savings from competitive bulk purchasing could also reduce expenditures substantially. One study estimated that a combination of strategies could reduce our prescription drug costs by as much as $10.7 billion per year, or an estimated 43% of Canada’s $25.1 billion drug bill.
5) **Place Greater Emphasis on Health Promotion and Illness Prevention**

Evidence is mounting that the social determinants of health are as important – if not more important – than the health care system. Poverty, for example, is probably the greatest cardiovascular risk factor of all. Similarly, physical inactivity has been linked to many chronic conditions and cancers.\(^{\text{iii}}\) The promotion of exercise and healthy eating, along with progressive policies that reduce poverty, may prevent illness, reduce its severity, and generally enhance the quality of life.

Vaccination programs are also an important aspect of public health policy in Canada, and their increasingly uneven application causes concern. Widespread application of effective vaccines should be the norm in Canada, but recent high-cost vaccination programs, and direct-to-consumer advertising have affected public confidence and cost more than is perhaps necessary. Vaccination programs should be based on solid evidence and transparent arrangements with manufacturers, and should be delivered in the most broadly accessible ways.

6) **Focus on Quality Care Based on Sound Evidence**

The development and implementation of evidence-based guidelines can help improve the quality of medical care. Since the introduction of the term “evidence-based medicine” in the early 1990s, the principle of a “hierarchy of evidence” has been increasingly central to good medicine. In 2001, the US Institute of Medicine formally embraced evidence-based medicine, describing it as a key feature of patient-centred, high-quality medical care. In 2008 the IOM further called for “a stronger focus on evidence to ensure … the right care for the right patient at the right time.”\(^{\text{ix}}\)

Access to evidence has improved with the development of the internet and the introduction of the Medline database and other search engines. But Canada lacks a coherent strategy to put evidence into practice. A national body tasked with continuously reviewing the evidence and issuing guidance to health care providers, similar to the National Institute for Health and Clinical Excellence in the United Kingdom, would likely improve the quality of Canadian health care and save money. For example, such an organization could issue recommendations regarding when expensive diagnostic tests such as MRI scans and echocardiography are truly needed, thus reducing unnecessary spending.

7) **Use Health Resources According to Best Practices**

Victoria-based researcher Alan Cassels has written extensively about the misuse of technology within the health system. A 2009 paper he co-authored on screening technology (PET and CT Scans) found that while a growing number of medical imaging companies in Canada were promoting health screening services to patients, very little was known about the benefits and harms that associated with the use of this expensive technology, especially among asymptomatic people. “Screening tests being promoted to Canadian consumers are often marketed under the pretence that such screening can ‘save your life,’” the paper found, “despite the fact that neither the scientific literature nor professional or regulatory bodies condone such practices.” The use of medical imaging equipment in Canada is growing at a rate of between 5% and 10% amidst controversies within the medical profession about the appropriateness of screening asymptomatic patients.\(^{x}\)

In a similar vein, the Health Council of Canada cautioned Canadians in a 2010 report about the inappropriate prescribing of drugs and over-use of diagnostic imaging which not only can harm patients, but also adds unnecessary costs to the health care system.\(^{\text{xii}}\) According to the Canadian Association of Radiologists, as many as 30% of CT scans and other imaging procedures are inappropriate or contribute no useful information.\(^{\text{xii}}\) The use of health technology standards and tools to support clinical decision-making need to be made more commonplace, the report said, with “providers and payers held accountable for their decisions in the interest of good medicine and cost effectiveness.”
In health care, more is not necessarily better and, in fact, can result in greater harm than good. Resources within the health care system should be used appropriately and when required to ensure that patients are not exposed to unnecessary risk and that health practitioners are using the best tools to achieve the best outcomes.

8) Increase Access to Affordable Dental Health Care

In 2009, Health Canada estimated that 62% of Canadians were covered by private dental insurance, while another 6% received public dental care. This leaves many Canadians without access to affordable dental care.

The public sector could and should be playing a larger role. Canada has one of the lowest levels of public funding for dental care in the industrialized world, falling behind even the United States. In 2009 only 5% of dental care costs came out of the public purse, a figure that compares with 75% in Japan and Norway. That has an impact on patients but also on our universal health care system because poor oral health is linked to a variety of chronic diseases. The link between periodontal disease and an increased risk of coronary heart disease, for example, has been known for many years. The outright loss of teeth, on the other hand, has been linked to malnutrition. These chronic ailments are routinely much more expensive to treat and manage than tooth decay.

Several provinces are exploring the idea of increased public funding for dental care, especially for targeted populations such as school-age children. But all Canadians need adequate dental care.

9) Optimal Use of Health Human Resources

Effective health human resource (HHR) planning is needed to ensure that patients are getting the right service, at the right time and in the right place. Approximately 800,000 people work in Canada’s health care system, and between 60% and 80% of every health care dollar goes to human resources. A broad range of complex issues, from equitable access and wait times to health outcomes and patient safety, depend on a number of factors, including an adequate supply of health care personnel. An appropriate allocation of human resources is essential to achieve desired health outcomes, greater efficiencies and improved recruitment and retention.

Despite the significance of HR planning, Canadian and international studies show HHR planning is often “poorly conceptualized, intermittent, varying in quality, profession-specific in nature and without adequate vision or data upon which to base sound decisions.” Although federal, provincial and territorial governments adopted a framework for pan-Canadian HHR planning in 2005, progress towards a coordinated approach that crosses jurisdictions and professions has not yet materialized. Canadian Policy Research Networks found a genuine desire to move beyond the more traditional “supply-demand” models based on past utilization patterns towards “models firmly rooted in the health needs of populations served.” But there are equally genuine challenges to effective HHR planning, including the fact that many of the services provided by health professionals are offered in increasingly fragmented ways, including private clinics. “How and whether those services are accessed by Canadians,” the CPRN paper said, “poses real HHR planning challenges.”

New studies suggest that an effective HHR strategy should match HHR inputs (time, effort, skills and knowledge) to improved individual and population health outcomes. Much of our focus to date, however, has been on outputs (productivity) rather than outcomes. Canada needs to further explore the relationship between HHR planning and productivity, on the one hand, and health outcomes and patient needs on the other hand.
Governments, health professionals and institutions should pursue a more coordinated, comprehensive, pro-active and cross-jurisdictional effort to develop a pan-Canadian collaboration on health human resources planning. Such a plan should also include education and training of the workforce, increased training of generalists, “shared care” arrangements, recruitment and retention strategies for health professionals, and a rational distribution of providers across jurisdictions. A broadened scope of practice among physicians and greater utilization of team-based care that enables nurses to assume broader clinical tasks is needed.

Proactive HHR planning across a coordinated system of health services would benefit patients and taxpayers considerably.

10) Appreciating the Role of Relationships

Study after study points medical professionals toward a greater appreciation of the role of relationships in health care. Whether it is the impact of cross-cultural and inter-racial relationships on doctor-patient interaction \(^{xx}\) or the benefit of peer reinforcement in the management of chronic disease, \(^{xxi, xxii}\) studies of patient experience and outcomes show that stronger relationships between health care workers and patients yield better outcomes for patients. As Dr. Mike Evans says, stories trump evidence, but relationships trump stories.

A 2010 review of the Canadian and international literature found that patients treated by interdisciplinary health care teams enjoy better health outcomes, shorter wait times, and a greater degree of patient empowerment, as well as higher rates of patient satisfaction and greater cost savings to the health care system. \(^{xxiii}\) Other studies have concluded that patients who obtain primary care in community health centres are healthier than those from similar socio-economic backgrounds whose care is delivered in other settings \(^{xxiv}\).

While it may strike many as obvious that a profession that relies on accurate disclosures, confidence in professionals and post-treatment compliance by patients would be heavily dependent on the quality of relationships between providers and patients. But it has not been a focal point in much of the planning around enhancing health care. The promotion of more fragmented, competitive, commercial relationships has been a common refrain, with little emphasis on the benefits of collaboration, stronger relationships and cooperation. Health care reform needs to focus on the relationships between patients and their health care providers, and also on relationships between providers.

---


\(^{vii}\) Ibid. Based on 2008 expenditures of $25.1 billion, an estimated saving of 43% would apply to the $24,995,800 spent in 2009.


x Cassels A, van Wiltenburg J, Armstrong W. What's in a scan? How well are consumers informed about the benefits and harms related to screening technology (CT and PET scans) in Canada? Ottawa: Canadian Centre for Policy Alternatives; 2009


xii Canadian Association of Radiologists. (2009). Do you need that scan? Ottawa: CAR.


xvi ibid.


