



VOICES INTO ACTION

Report on the National Dialogue on Health Care Transformation



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Health care transformation: Hearing from Canadians

Canada's health care system is a cherished social program and an important contributor to our country's economic success. But with Canadians from coast to coast suffering from unacceptable wait times, crowded hospitals and a lack of physician and other services, it's clear to all that this once proud system is in distress.

Against this backdrop, in August 2010 the Canadian Medical Association launched a discussion on the future of medicare with the release of *Health care transformation in Canada: Change that works. Care that lasts*. Based on extensive research, including a study of health care in five European jurisdictions, this document prescribes ways to bring about a health care system that puts patients first and provides Canadians better value for their money.

To broaden the debate, the CMA then embarked on a national public dialogue — online at www.healthcaretransformation.ca and at a series of six forums held in partnership with *Macleans*, *L'actualité* and CPAC, the Cable Public Affairs Channel. The goal was to engage as many people as possible in an open discussion of what Canadians envision for our health care system and how to achieve this.

The high level of participation online and the crowds attending the public forums testified to the deep concerns Canadians have about the future of medicare. The free-flowing conversation among hundreds of participants reflected frustration with a system that doesn't work as well as it should, but also appreciation for the dedication and commitment of health care workers and a deep longing for patient care that is timely, efficient and compassionate.

Above all, the feedback revealed that many Canadians feel a strong attachment to this vital social service and have faith that, with leadership and will, transformation can take place.

The national dialogue was framed around three questions:

1. It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

Although expressed in a variety of ways, by far the most common response to this question was that good value in health care means getting the care that's needed, when it's needed and in the appropriate location. Timely access to appropriate and needed services was viewed as the critical element in the value equation. The view was also expressed that more transparency and accountability are needed in the system to ensure funding is being used effectively.

"Objectively, I feel it is a sin that there are citizens in our modern nation that cannot find a family physician. How can this have happened?"

The need to reallocate funds from the administrative sector of health care to front-line providers such as family physicians and nurse practitioners was also raised. Also discussed were various models of care delivery and the need to replace the fee-for-service system of paying many physicians. Many participants spoke of the benefits of family health teams, collaborative care and community health centres, where physicians work with other health care professionals to provide a more comprehensive model of care for patients. This was all discussed within the context of bringing more value to the system by strengthening primary care and ensuring everyone has access to a family physician.

The high cost of prescription drugs and a negative perception of large pharmaceutical companies were touched on by a few respondents, as were concerns about inefficiencies in hospitals and the inappropriate use of emergency departments.

Town hall meetings

Halifax January 26
 Toronto March 1
 Edmonton March 29
 Vancouver April 27
 Montréal June 2
 Ottawa June 7

Online consultation process

97,331 Page views
 4,132 Comments posted and ratings
 6,124 Views on YouTube
 2,956 Number of registrants to
www.healthcaretransformation.ca

The need to better utilize technology, especially electronic medical records, was identified by some as a key requirement for providing better value from the health care system.

The majority of respondents felt Canadians are not getting good value from their health care system — especially when compared to some European countries — while a minority expressed the opposite view. Many based this view on their definition of value as timely care and the fact that many Canadians wait unacceptably long times for the care they need.

“The first step is knowing how much we are spending for what we are getting. The federal government collects taxes for health coverage that are apportioned to provinces and in Ontario we receive this insurance via OHIP. We have no idea how much it’s actually costing us ...”

To many, the question about value revolved around whether the current health care system is adequately funded, with a majority of these people believing the system is underfunded to meet the needs of Canadians. On the other hand, several people said the system may be adequately funded but is not operating efficiently.

Still others used the question about value as an opportunity to discuss the merits of public versus private funding for health care. This theme was a thread that emerged in answers to all three of the questions, online and at the town halls, with support for a universally accessible, publicly funded system being by far the most popular option.

“It is the same old story; the rich can afford to look after themselves, the poor are on welfare and everything is paid for, and finally, the middle man is left to take care of it all.”

2. Patients and their families play an important part in their health care. What do you think Canadians’ responsibilities are, now and in the future, in regard to their health?

The vast majority of respondents agreed Canadians need to take some responsibility for their own health and that of their families. However, it was also noted by many that health is also

determined by factors such as education and income that are outside the ability of some people to control directly. As a consequence, it was felt there is a need for “healthy public policy” or an environment that would help and support people in making healthy choices that are both easy to follow and affordable. Education about health was viewed by many as being an important factor. The need to ensure better health for disadvantaged groups was another subtheme that was raised.

“I think it’s important to remember why many (not all) of those people making unhealthy choices do so in the first place. Choice of over consumption of alcohol and tobacco are a reflection of a society not providing effective preventive education.”

There was little agreement on whether taking responsibility for health also means contributing directly to the cost of health services used. However many felt Canadians need to demand more accountability from the health care system and take responsibility for advocating for better health care.

There was also general agreement that people should use the health care system responsibly and not draw on health care resources unnecessarily. Some felt giving people a regular statement of the health care resources they had used and the cost of their care would help encourage them to act more responsibly.

“If nothing else, a user fee must be introduced for those attending emergency room facilities with only minor aches and pains. Our health care system is excellent, but is being abused.”

The use of incentives such as tax breaks to encourage people to make healthy decisions was also suggested.

Another theme raised by several respondents was the need for the system to better respond to people wanting to take more responsibility for their own health. This could be done by making test results and patient health records more easily accessible — ideally in an electronic format.

It was generally agreed that physicians should be doing more to educate patients about healthy living and that the system should put more emphasis on health promotion and disease prevention. Some criticized physicians for not being willing to spend time discussing healthy choices with patients

or for prescribing drugs rather than suggesting other options.

Some felt the Canadian Medical Association itself had a responsibility to continue to advocate for better health care and to hold the federal government accountable.

At another level, the concept of people taking more responsibility for their health by support governments that can improve the health care system and advocating for better health was also raised. The need to demand public accountability from politicians in the delivery of health care services was seen as another responsibility of citizens. Elections were identified as moments when this could be done most effectively.

“Pharmacare and long-term care should absolutely be included in the *Canada Health Act*. Dental and eye care are also important components of health care and should be included. This was the original intent of the Father of Medicare, Tommy Douglas. It is time we got back on track.”

3. The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

The message that came through most strongly from the public was the need to preserve and strengthen the current principles underpinning the *Canada Health Act* to ensure continued support for a universally accessible, publicly funded health care system. A counterpoint made by some respondents was that existing legislation should be changed to permit for the private funding and delivery of health care services.

Secondarily, there was strong support for broadening the scope of the existing legislation.

“Medicare is already swelling out of control. The last thing Canada needs is to make it even bigger. If the health act must be changed, we need to narrow it, not broaden it.”

The need for some sort of national drug or pharmacare plan was mentioned by an overwhelming number of respondents, with examples of the high cost of drugs being detailed by many. Many examples of inequities in the system that were provided related to drugs or other health services being paid for in some jurisdictions but not others.

A long list of other health care services that should be guaranteed by the *Canadian Health Act* was mentioned repeatedly. These included:

- Dental care
- Eye care
- Long-term care
- Home care services
- Care from alternative health care providers (e.g., naturopaths)
- Hospice care

“CMA asks: What do you think Canadians’ responsibilities are, now and in the future, in regards to their health? Assume responsibility at the municipal level to ensure there is an office in the municipal building that responds to ensuring medical and non-medical determinants of health care up to standard. Make it political ... not medical.”

Some more in-depth responses focused on the sustainability of the existing system and the challenges of expanding the publicly funded system without addressing ways to ensure ongoing funding. They pointed out that, as Canada does not have unlimited resources to spend on health care, any decisions about expanding the existing legislation would have to be made within that context.

“As expensive as it is, I agree that it would be the ideal to have public insurance coverage that includes prescription costs as well as doctor visits. However, I think it’s also important that the public has a voice in which drugs are covered or in determining the criteria that enables drugs to be reimbursed. And it should be governed at the federal level, not province by province.”

What Canadians said: A synopsis

In the online comments and at the public town halls, several themes emerged over and over again. In particular, CMA President Dr. Jeff Turnbull noted that:

- Canadians cherish medicare and support a strong, publicly funded health care system.
- Our current health care system is failing Canadians, particularly vulnerable groups such as children, the elderly, Aboriginal Peoples, people in rural settings and those with mental illness. The system is challenged in delivering services to these populations.
- The health care system is fractured to such a degree that it is, in some ways, a system in name only. From the perspective of the patient as a consumer of health care, it does a poor job of transitioning patients from one level of care to another. It does not provide patient-centred care — the care people need when they need it.
- The patient should be primary. Patients should have a say in decisions affecting their health, and health care providers and governments need to listen to the patient's voice.
- The health care system is very good at providing acute care — short-term care for illness or injury — or what one participant aptly called “Humpty Dumpty medicine.” But for the elderly and others with long-term, or chronic, illness our system is much less effective. With the population aging, there is an urgent need to build a system of home-based care to provide families with the support they need to allow patients to get the best care they can at home. We need to build on the acute care paradigm at which we excel to create an equally effective long-term, chronic care paradigm.
- We also need to better support primary care services in the community with new comprehensive models of team-based care.
- The fact that the health care system itself is only one predictor of a good health is widely appreciated. Other predictors of health such as housing, education and employment lead to health inequities among vulnerable populations and underscore the need for “healthy social policy” and a healthy environment.
- Illustrated by stories of inefficiency and waste, we heard the need for a transparent, accountable system that would allow Canadians to monitor spending, prevent waste and ensure they are getting good value for money. Individuals, too, need to accept some responsibility for their own health as well as for advocating for a better system.
- The debate seems to be less about public versus private funding than about how the public sector could work effectively *with* the private sector to create a better, more efficient health care system.
- An efficient and safe health care system requires good data systems and electronic medical records.
- The federal government has a role to play in facilitating national benchmarks and standards to ensure equity across the country. Regardless of where they live, Canadians must be entitled to the same level and standard of care.
- The five principles of the *Canada Health Act* are good ones, but we aren't living up to them. Beyond that, there is support for expanding the scope of the *Canada Health Act* to include a national pharmacare plan and home care. It is also understood that for fiscal reasons this can be achieved only with more effective use of existing health care resources.
- Without a doubt, concerns about our health care system run deep. We heard that there is a “moral imperative” to fix the system, but that our biggest adversary is apathy. Overall, there is a strong sense that health care providers and the members of the public must join together and demand of decision-makers a better health care system — if not for ourselves, then for the sake of our children.

Halifax town hall — January 26, 2011

Attendance: 190

Introductory remarks

Moderator: Ken MacQueen

***Maclean's* Vancouver Bureau Chief**

“We’re thrilled but not surprised by the crowd here tonight,” MacQueen said.

MacQueen said the title of the session, *Health care in Canada: Time to rebuild medicare*, was framed as a statement and not as a question because the Canadian health care system is in need of “attention and fresh ideas ... We’re in this together.

Dr. Jeff Turnbull,

President, Canadian Medical Association

Turnbull welcomed the audience, inviting them to help the CMA “shape health care for the future.”

He said health care is a foundational pillar of Canada but that “the foundation is eroding below us” as both patients and physicians can attest.

“The CMA believes we can transform the health care system with your help. We’re here to listen.”

Panellist: Dr. Jane Brooks

President, Doctors Nova Scotia

Brooks talked about the unacceptable situation with respect to wait times and access to care in Nova Scotia and the need to start thinking about innovative ways to improve access. As a member of a collaborative care practice, Brooks talked about the need for a more integrated approach to patient care involving all health care providers and governments.

Brooks was the first to mention both mental health — or “mental unwellness” as she termed it — and health promotion as issues needing attention.

Panellist: Andrew Coyne

National Editor, *Maclean's*

“Our system is in an advanced state of disrepair and in urgent need of reform,” said Coyne, remarking that health care spending is approaching 50% of many provincial budgets “even before the first baby boomer retires.”

Despite improvements in the health care system in



recent years, he said the system is still “a black box” with people unaware of the true costs of delivering health care services.

Coyne stressed two key issues:

1. The need to “get prices into the system somewhere” to help provide signals on how the system can be used more efficiently
2. The need to localize health care budgets to make responsibility for health care spending the responsibility of regional authorities, autonomous provider groups and health care consumers

He said there is “a moral imperative” to make the existing system work more efficiently so key principles such as universal access can be maintained.

Panellist: Dr. John Ross

Nova Scotia Provincial Advisor on Emergency Care

Ross described the existing situation as a “disease care, non-system — not true health care” and described emergency care as “a reactive system where I am busy fending off diseases as they arrive.”

He referenced the seminal work done by former federal politician Marc Lalonde in defining determinants of health of which the health care system itself is not the most important factor and said “good health is the bedrock upon which good social systems are built.”

Panellist: Maureen Summers

CEO, Canadian Cancer Society — Nova Scotia division

Summers said the Canadian Cancer Society believes that within Canada there are currently gross inequities in the provision of health care services and significant financial burdens depending on where the patient lives.

She noted Nova Scotia has the highest rates of cancer in the country and the second highest cancer-related mortality rate as well as a higher than average percentage of the population over age 65.

While cancer patients value the care they receive, she said, there are still many specific instances where patients face hardships due to unacceptable wait times to see an oncologist and undue financial hardship because of the cost of medications that they must bear personally. “We hear these stories daily.”

“Universal care should not be health care by postal code or pocketbook,” Summers said.

Regional issues

Asked to identify the biggest challenge facing health care in Nova Scotia, panellists responded as follows:

Brooks said it was difficult to identify one main challenge but referenced the recent report done by Ross in Nova Scotia on emergency care services and the challenge of implementing the recommendations contained in that report while remaining fiscally responsible.

Summers said a major challenge was how to create a seamless, equitable and affordable health care system while also investing in disease prevention and putting a greater focus on “creating healthier Nova Scotians.”

Ross answered the question by taking to task those who suggested Nova Scotia was a “have-not” province. Relative to much of the rest of the world, he said “We’re not a have-not province. Get over it.”

He said there was a need for more innovation within the system and the application of a business model to health care.

Coyne said the major issue that is not unique to Nova Scotia alone is the aging population and the increased burden this will place on health care services.

Again talking about the system as a whole rather than just Nova Scotia, Turnbull said six months ago he would have identified access as the major challenge facing the system. Now, he said, he feels the main issue is apathy.

“We accept a system that is not delivering value for money,” he said. “It’s your system, make it your own.”



Audience interaction

Brooks was complimented for establishing a collaborative care practice and it was suggested other physicians in practice should be asked about the innovative measures they are taking to improve care.

Another audience member noted the health care system in Nova Scotia is “tremendously opaque,” and the public has little knowledge of how health care spending is allocated. “The public does not have the information to make decisions,” he said and this means they are not in a position to suggest innovative solutions.

Ross noted that funding the system is a critical issue and he referenced a US study showing that a minority of patients consume a disproportionately high share of health care resources. He said it was time to ask difficult questions about whether spending on health care interventions for dementia patients, for example, could maybe be better put toward palliative care.

Coyne returned to his argument about the need to decentralize health care spending by linking decision-making and budgetary responsibility at the regional level.

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

“Good value is access to a family physician and the opportunity to have access to the care you need when you need it,” said Brooks.

Coyne said the question was a difficult one to answer and it was necessary to take into account a calculation of health outcomes in relation to dollars spent. He said he was confident that building incentives into the system would improve this ratio.

Summers said she agreed with Brooks and that good value for patients was getting needed treatment in a timely manner without financial impediment.

Ross said while from the patient perspective good value was indeed access to needed care, it is impossible to gauge value at the system level because of the block funding approach for hospital services.

An audience member again raised the need to improve the system by dedicating more resources to health promotion and preventing people from getting sick and having to enter the health care system.

Summers responded to this at some length, stressing the need to have a healthier population. However, she said blaming people for being unhealthy was not fair unless environments are created that encourage healthy lifestyles. “Making health choices the easy choices is not going to happen” until the other determinants of health are addressed.

A representative from Access for Care of the Elderly (ACE) told the panel about the deficiencies he had noticed in supporting his mother in long-term care. He mentioned the reduced percentage of federal funding in support of health care and questioned how “the regular guy” was going to be able to get expensive and scarce services if those with money could jump to the head of the queue.

In response to the comment about the need for increased participation of the federal government in health care funding, Coyne said the opposite is true and that the federal government should seriously consider getting out of all health care funding arrangements and transfer the tax points to the provinces. He said the experience following the release of the Romanow report and an influx of federal funding was that “everyone went back to sleep” and innovation did not take place.

An audience member who has a home care agency commented on the political nature of decisions that allow hospital beds to stay open even though care can be delivered more efficiently in the home or a hospice.

“The people we should be talking with are our patients,” a Nova Scotia family doctor told the meeting, stating that innovation in health care is more likely to come by getting meaningful input from the public.

Patients and their families play an important part in their health care. What do you think Canadians’ responsibilities are, now and in the future, with regard to their health care?

Brooks said everybody has an important role to play in maintaining their own health.

However Coyne said more than exhortations are needed to do this and incentives need to be built into the system to encourage both patients and physicians to adopt healthier lifestyles and habits. He said moving physicians to a more capitated form of remuneration would make them apply preventive measures more aggressively.

Summers said that in addition to individual responsibility for health, patients also need to become educated advocates for better health care. It is all too easy, she said, to accept the status quo and not ask questions.

Ross referenced a free skating oval in Halifax created and maintained for free by the community as an example of responsibility for health in action.

He also said patients need to question decisions about health care funding and the delivery of services.

A Halifax cardiac surgeon said “Canadians’ most important responsibility is to speak up about what they want to fund (in health care).” She said it was important to get an accurate accounting of health care costs and for the public to weigh in on which services should continue to be funded. “We can’t afford to keep every emergency department in Nova Scotia open,” she said.

A representative of a community health centre in Halifax said the debate had been lacking a discussion about population health. She said while community-based care for disadvantaged individuals can be very productive, it is also “messy and time-consuming.”

Coyne responded to the comments by reiterating that there is a moral imperative to reduce inefficiencies.

An audience member who was caring for someone dying from pancreatic cancer spoke vehemently about the frustrations involved in trying to do that effectively in the existing system.

“I want to be accountable, I want you to let me,” she said, but she voiced frustrations about the amount of paperwork still involved in care and also the “insane amounts of time” required to wait to meet with health care providers. “I want you to send me an email,” she said.

The woman also talked about the mismanagement within hospitals and the need to hire trained managers to manage the system rather than putting nurses or physicians in management roles. “Stick to your knitting,” she said.

Turnbull said the comments reflect exactly what the CMA intends, which is to put the focus of the health care system on the patient rather than the provider. “We need to listen to patients and stop telling them what to do,” he said.

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

All panellists except Coyne agreed the *Canada Health Act* needs to be reviewed and revised to include areas such as coverage for pharmaceuticals and the work of other health care providers.

One audience member cautioned that opening up the *Canada Health Act* would become a highly politicized event subject to pressures from various professional groups.

“Until we have a genuine and authentic paradigm shift in our illness system to be patient-centred and outcome driven, how can we have a conversation about accountability in care?” he asked.

Speaking more generally, another audience member said: “Yes, we do have a good health care system and I do

experience it regularly. The question is how do we make it better? He pointed to European systems as good examples of what Canada should be trying to achieve.

Concluding statements

Asked how they would make change happen, panel members talked about the need for a vision for the future and experimentation to discover what really works.

In his concluding comments, Turnbull identified six big themes that he had heard expressed during the meeting:

- Inequities in health.
- Accountability and the need to make the system more accessible.
- Patient-centred care.
- A new system of health care management and governance that delivers on expectations, especially at the community level.
- Making health care a truly integrated system.
- Innovation.

He said it was clear from the comments that there is “a moral imperative to fix the health care system.”

Toronto town hall — March 1, 2011

Attendance: 500

Introductory remarks

Moderator: Ken MacQueen

Maclean's Vancouver Bureau Chief

MacQueen talked about the fact that in 2014 the federal government and provincial–territorial governments would be signing a new health accord.

“We won’t be at that table but we can help set the agenda,” he told the audience.

Dr. Jeff Turnbull

President, Canadian Medical Association

Turnbull told the audience it was “fantastic” that they were present to help participate in the discussion. He noted that in addition to the capacity crowd of 500 attendees, 150 people had been on a waiting list and he encouraged them to use the health care transformation website (www.healthcaretransformation.ca) to continue the discussion.

Turnbull said the aim of the town hall meeting was to give Canadians a voice in their health care system. Physicians and other health care professionals have ideas about what is needed for health care reform “but tonight is an opportunity to hear from Canadians who experience the health care system directly,” he said.

He said Canadians need to first figure out what the health care system should look like in the future and then look at how to resource or fund it.

“Sustainability is not just about money. It’s about providing universal access to high quality health care, delivered in a timely and cost-effective manner and that emphasizes evidence and outcomes.”

Panellist: Dr. Mark MacLeod

President, Ontario Medical Association

MacLeod noted that 46 cents of every tax dollar in Ontario is already going to fund health care and that the public has clear expectations about what the health care system should look like. He added that physicians are part of the problem but are talking about the need to improve the system so that their patients receive better care.



He said the OMA has developed a series of policy recommendations dealing with issues such as improving mental health services, using hospital services more effectively, and the need for province-wide electronic medical records to make the system better both for those working in it and those being treated in it.

“This is a complicated discussion,” he said.

Panellist: Durhane Wong-Rieger

President and CEO, Institute for Optimizing Health Outcomes

Wong-Rieger stressed that patients must play an active role in planning how the health care system will be improved so that it focuses on patient-centred care.

She cited three areas where patients must be more involved:

1. Management of chronic disease.
2. Expanding medicare to include a national pharmacare plan and access to home care.
3. Ensuring all Canadians, including the one in 12 with rare disorders, have equitable access to services.

Panellist: Mary Jo Haddad

President & CEO, The Hospital for Sick Children

Haddad said she was basing her comments on her experience of more than 35 years in the health care system as a nurse and hospital administrator, 10 of those years in the US.

She supported the call for patient-centred care and said improvements to the system must be based on “innovation and evidence.” She noted that Ontario has an “incredible engine” for encouraging innovation in medical science in its teaching hospitals and individuals and has a system supported by “incredibly passionate professionals.”

She added that to reduce demands on the health care system, the health of Canadians must be improved and this involves addressing the social determinants of health — poverty, housing and nutrition.

Haddad also discussed “some very disturbing trends in children’s health” such as the increase in childhood obesity and the fact that 70% of mental health issues have their onset in childhood.

**Panellist: Andrew Coyne
National Editor, *Maclean’s***

Coyne said the cost of funding health care “is eating us alive,” and that the aging demographic will be biggest challenge to sustainability of the system in the future. “It is going to be the challenge of our times.”

He described Canadian health care as a “radically inefficient system,” in which 30% efficiency gains could be achieved. “Inefficiency kills people,” he said, and there is a moral imperative to address it.

He argued that the solution is to decentralize funding of medicare and make local funding agencies responsible for budgetary constraints while allowing pricing and competition.

He also called for better accounting to gain a true sense of the real costs of delivering health care services. He stressed this does not mean charging patients directly for health care because they do not have the information to make informed choices.

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

“At the end of the day ... what is good value for the patient is that the patient gets the most appropriate care possible. And that’s the only thing that counts,” said Wong-Rieger. She added this involves investing in services that will allow patients to be responsible and look after their own health.

Haddad agreed that good value “is getting the health care you need when you need it.”

Coyne said that to measure whether the system is offering good value there need to be benchmarks to ensure the best use is being made of existing resources and that systemic incentives are needed to make sure this happens.

“Patients and the public should demand value,” said MacLeod.

He reiterated the need to develop better information technology (IT) systems in health care to bring more value to the system. “We still function in a paper world,” he said, and this makes it important to make cost comparisons and share information.

Audience member Michael McBane, national coordinator of the Canadian Health Coalition, applauded the CMA for calling for federal leadership in health care.

“The system is splintering because there is no guardianship and there is no building for the future without federal leadership,” he said. “We’re not getting value for money.”

McBane focused on the pharmaceutical industry as being primarily responsible for driving up health care costs and said Canadians are paying 30% more than the international average for new drugs, adding that these are being over-prescribed based on marketing campaigns and not evidence.

“I think the solution is a universal public pharmacare plan,” he said, noting that the current system in Quebec should not be used as a model because it is unable to control costs.

Another audience member made the case for addressing determinants of health. “Good value (involves) not treating things through the health care system that are better addressed elsewhere. This is to go to the importance of the social determinants of health. The importance of including that is that in many cases the health care system has become the end point for all kinds of social problems, be that lack of affordable housing (or) lack of good quality, nutritious food. These kinds of things are ultimately dealt with in the health care system.

“I’ll use the example of someone who I will refer to as Betty, who came into the TGH (Toronto General Hospital) with abdominal pains. She was on welfare, all she could afford to eat was white rice and she came in with an abdominal blockage so severe it needed to be dealt with through quite radical surgery. It cost more to perform that operation than it would have cost to feed Betty good nutritious vegetables for 20 years.”

Haddad said that, as someone who runs a hospital, she often sees patients admitted who really should not be there.

“Why isn’t home care part of the *Canada Health Act*,” asked Dr. Mark Nowaczynski, a Toronto physician. He said home care had huge potential for providing better care especially to the frail elderly who cannot easily access the ambulatory care system.

“Too many frail seniors are falling through the cracks and not receiving the care they need,” he said, arguing that a greater use of home care would save the system money.

MacLeod said “the simple reality” is that up to 20% of hospital beds are occupied by people who theoretically could be better cared for at home or in another setting. But he also noted that community care needs are potentially so great that the system needs to use team-based collaborative care models to provide the necessary services.

Dr. Irfan Dhalla, another Toronto physician, said high-performing health care systems such as the Veterans Affairs system in the US provide good models to follow. He said good value would be an integrated health care system centred on the patient.

Patients and their families play an important part in their health care. What do you think Canadians’ responsibilities are, now and in the future, with regard to their health care?

Coyne said people will choose to be healthy rather than not healthy and will respond to incentives to do so. But he said the incentives will have to be adjusted for physicians to ensure they provide care appropriately rather than overloading patients with care and this means moving to a capitation model rather than fee-for-service.

Haddad stated that when people take responsibility for their own health, the outcomes are better. She said the provision of health care should be a partnership between health care providers and patients.

MacLeod said that one of the best thing people can do is to participate in discussions about health care such as the town halls. He also noted that in discussions about responsibility for health it is easy to fall into the “blame game. ... Looking after health is not easy.”

Turnbull added: “Education is really important. Incentives are important. But I must also tell you that I deal with a population of people who can’t afford food. They can’t afford to go to a sports club. They can’t afford to exercise. They have disabilities, they’re vulnerable. They have psychiatric disease and drug and alcohol addictions. They’re struggling every day

to get their head out of water. Those individuals, as much as you might like to inform them and educate them about better and higher quality lifestyles, are just trying to get through to the end of the day. Until we address those circumstances that put them in that setting, they’re not going to join a sports club.”

“One of the things that has emerged from the discussions so far is that we are really thinking about our system back to the 1940s and 1950s, but we should really think about our system as when it started, which is in the 1880s when Koch and Pasteur proved that the germ theory was right and discovered that there were microorganisms that caused acute infections in people and found the cures for them and found ways to prevent them. That’s when our health care system started to be built.

“Our health care system is built on and based on acute infectious diseases. These are the diseases that it treats very well. It treats the acute episodes of diseases very well because that’s how it’s built. And it was built that way for a reason. So we have hospitals where people come in who have chronic conditions and what happens is they come in when they have an acute episode of the chronic conditions. Very often that’s one of the reasons why, when they leave the hospital, the chronic condition persists and very often the acute treatment doesn’t really deal with the long-term nature of that chronic condition.

“One of the things that happened between 1920 and 1970 is that there was a huge mortality shift. In 1920 the vast majority of people died of acute, infectious diseases — they died of the flu, they died of smallpox, they died of diseases that happened because of microorganisms. By 1970 that had changed completely. Now most people die of the effects of chronic disease and our system is still based around the acute. An enormous difference between acute disease and chronic disease is that to treat an acute episode you really don’t need patient advice; the system kicks in, doctors know what to

do, they have protocols, you can actually cost the particular service.

“But for chronic diseases it doesn’t work like that. Chronic diseases are complex and complex diseases don’t get treated in the same way as acute ones and we have to figure out how to treat them. So we have a system that’s mired in the acute when, in fact, most people suffer from chronic diseases and our system only kicks in when those diseases become acute. One of the other things about chronic conditions is ... that the patient must play a part because how a patient responds to a drug and how a disease progresses really depends upon the patient’s input and what the patient says and what the patient wants.”

— Sholom Glouberman, president of the Patients’ Association of Canada

An audience member raised the issue of maintaining quality in the system and preventing medical errors and called for external oversight to ensure patient safety is assured. Haddad noted the *Care for All Act* in Ontario is a bold step in this direction.

Claudine Bennett, a public health nurse and board member of the Registered Nurses Association of Ontario, said it was important to remind the audience of the value of prevention and especially the importance of considering the health of the mother at the time of conception.

“There is a ton of new evidence to support early child development,” she said.

A medical student from the University of Toronto talked of the importance of removing barriers so that people could get accurate health information. He referred to the biased nature of much of the information in direct-to-consumer advertising of pharmaceuticals to an often uninformed audience.

“When you’re spending your own money you tend to be more invested in your own medical care,” a representative of a company that helps Canadians receive care outside of Canada at their own expense commented. This prompted Coyne to say that if people want to spend money on their own health care that should be permitted. He said the problem comes when private and public spending on health care is mixed and people are allowed to pay to get first access to publicly funded services.

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

Dr. Danielle Martin, founding chair of Canadian Doctors for Medicare said the health act should be expanded to cover pharmacare and long-term care and that a “public, single payer system” is the best way to control health care costs. She noted funding of physician and hospital services included in medicare has been remarkably stable, but described rising pharmaceutical costs as “the Pac-Man” in the health care system “eating its way through provincial budgets across the country.”

Another audience member said that much of the discussion to that point had been about medical care rather than health care and that the health act should be expanded beyond medical and hospital services to include the services of a broad range of health care professionals. He also said the more that could be done help people avoid having to use the health care system, the better it would be.

Coyne said that while he was in favour of expanding the *Canada Health Act* “in theory and in principle” to include pharmacare and home care, “I’m really, really worried that we’ll screw it up.”

Wong-Rieger said patients are not looking for more “goodies” by expanding the scope of the *Canada Health Act*. While she said while there is a case for including pharmacare in the *Canada Health Act*, many issues impede the most effective use of drugs, such as poor patient compliance.

“It’s a zero sum game. We can’t talk about an ever-expanding basket (of health care services).”

She described health care as a “huge, shared responsibility” and said patients need to use the system as if the money they were spending were their own.

Haddad said if demand for health care services could be reduced by making the population healthier then funds could be reallocated within the system to services that may be considered essential, such as home care. However, she said, tradeoffs are required as it is not possible to just keep adding services to the publicly funded system.

MacLeod agreed, noting that more needs to be done to make the current system as efficient as possible before expanding the scope of the *Canada Health Act*.

“I want to thank Andrew Coyne for speaking about the aging population because I think it’s something we really need to seriously consider. Take, for example, that currently 13.7% of the Canadian population is 65 and older and that population is going to double in the next 20 years. That population accounts for nearly half of every health care dollar spent in the country currently and that cost will continue to increase. I’m not telling this to try and scare everybody ...

— Dr. Samir Sinha, Chief of Geriatrics
Mount Sinai Hospital

“I think this represents an opportunity to understand that when our health care system was created, when we founded medicare back in the early 60s, patients on average only lived to their late 60s. Now people in Canada are going to be living into their 80s. So we have a large geriatric population that has issues of chronic disease that needs to have their issues better addressed. The system has not changed but the patients have. They’re an older population that needs to be more involved in their care. We need to start looking at how we can actually have other health practitioners involved in their care. In Canada right now there are 68,000 physicians but there are only 200 geriatricians in the whole country. We need to have about 800 geriatricians to deal with the current needs that exist.”

MacLeod agreed there is a need to train more health care providers to provide geriatric care, which is a relatively new specialty. He also said the system has failed to align incentives to encourage provision of more care for the elderly in their homes.

Connie O’Connor, a nurse practitioner and representative for Alpha-1 Antitrypsin Deficiency Canada, said that patients with rare disorders often get differential treatment across Canada because their care is a provincial responsibility. She said there must be a return to the basic principle of universal access for these patients, regardless of where they live.

Wong-Rieger said that from the patient perspective, the most troubling aspect of medicare is the variable drug coverage based on jurisdiction.

“I’ve heard people say ‘I’m a prisoner of my province’,” she said, because if that province covers the costs of their medications and others do not, they are not able to move.

Another audience member added: “If 2014 is going to be the accord that changes Canada, it happens this year (because of the Ontario election and a possible federal election that will determine who will be negotiating the accord).”

Audience member Jeff Hanks, a nurse from the London Health Sciences Centre, agreed and talked of making the provincial and federal elections referendums on health care. He said politicians who use private health care have no incentive to improve medicare. Hanks was also critical of the move toward “payment by results” because extensive experience with this in the United Kingdom has found that it is not effective.

A licensed pharmacist and graduating medical student said she agreed with including pharmacare and long-term care in the *Canada Health Act*. She said it was strange that people can get their drugs paid for while in hospital but not necessarily when they are discharged into the community.

Derek Chadwick, a representative of the Ontario Health Coalition, said it was a fallacy that the aging population is adding significantly to health care costs as it has been estimated this is only adding 1% per annum.

Chadwick said including pharmacare in the *Canada Health Act* would significantly decrease health care costs.

Regional issues

The panel and audience were asked what was the single, biggest action the federal government could take to improve health care in Ontario.

MacLeod identified two key actions the federal government could take — stabilizing funding for health care to allow for proper planning and addressing the social determinants of health.

Haddad said she agreed with these two items and would add ensuring that the health care system is connected electronically across the country.

Wong-Rieger said the successful experience of Australia shows that a national strategy for chronic disease management is necessary to ensure national guidelines and infrastructure are in place.

“Stop funding it,” was Coyne’s response. He argued that the only reason for the federal government to make transfer payments to the provinces is so that conditions could be attached to these funds and there is now no political will to enforce the conditions. He proposed converting the current system of cash transfers to one of tax points.

“I think there is a strong need for national standards,” said Turnbull “Canadians expect a comparable level of care when they go from one region to another,” he said, noting that diseases don’t stop at provincial borders.

Dr. Sandy Buchman, who provides palliative home care services and is president-elect of the College of Family Physicians of Canada, said the federal government should enhance and support primary care. “We need a strong primary care system. The evidence supports it.”

Buchman also repeated the call for better IT support in health care to ensure continuity of care when patients are discharged from hospital. Too often at the moment, he said, physicians must rely on patients and their families to provide the information needed for their care because the hospital does not provide it.

Another speaker called on the federal government to embed in the *Canada Health Act* rights for patients that mirror those people have as citizens.

Donna Dill, a nurse providing continuing care in Nova Scotia, said the federal government must do more to change the culture and place more emphasis on preventing illness in the community.

A public health physician working with the provincial NDP health critic said that for ideological reasons the federal government is not interested in enforcing the *Canada Health Act*. Coyne commented that if people wanted the *Canada Health Act* enforced they should vote NDP because neither the Conservatives nor the Liberals would do so.

Dr. Doug Crawford, a retired anesthesiologist from Barrie, Ont., said the biggest thing the federal government could do is provide IT infrastructure for the health care system that will talk across different platforms. He commented that the

\$11 billion already spent in this area has “disappeared down a black hole.”

Gina Konjarski said what the system really needs is “transparency and accountability” and she made a plea for support of an NDP bill in the Ontario legislature to expand the powers of the provincial ombudsman.

Concluding statement

Turnbull said the main issue he heard during the discussion was the need to change the paradigm of health care so the focus of the system is not just on acute care and an illness-based system focused on care but one that also acknowledges new health care realities and the need for illness prevention and health promotion and home-based, integrated care for chronic diseases.

Other themes addressed at this meeting, Turnbull said, included:

- Accountability and the need for everybody involved in the health care system, including communities and the public, to accept some responsibility.
- The need for good data systems and electronic medical records to allow for the provision of safe and effective care.
- Support for expanding the scope of the *Canada Health Act* but only in a way that would make better use of existing health care resources.

“The future looks very bright as we take in all of these good ideas,” he concluded.

Edmonton town hall — March 29, 2011

Attendance: 200

Introductory remarks

Moderator: Ken MacQueen

Maclean's Vancouver Bureau Chief

MacQueen welcomed the audience and noted that the timing for the meeting was ideal as it coincided with the start of the federal election campaign. He said the topic of rebuilding medicare “deserves a place on the platform of every national party” and “deserves the attention of our politicians at every level.”

Dr. Jeff Turnbull

President, Canadian Medical Association

Turnbull reiterated that the purpose of the town hall meetings was to hear from Canadians — patients, their families and other health care stakeholders — and get their perspectives on the future of health care. He said all of the comments received at the town hall meetings and on the CMA’s www.healthcaretransformation.ca website would be collated into a report “that takes your voice back to governments.”

“The CMA believes strongly that your voice is important. We need your input,” he said.

Panellist: Dr. Patrick White

President, Alberta Medical Association

White noted it would be an “understatement” to describe health care as being a big issue in Alberta at this time as the AMA is hearing from everyone about general concerns with the provincial system. “The system, once you get into it, is excellent,” he went on. “The issue is how do you get into the system?”

White said one of the successes of the recently expired eight-year agreement between doctors and the provincial government was the development of primary care networks providing 24-hour care to defined groups of patients at a cost of \$50 per patient per year. “What we are looking for in the future is a significant development of primary care so that we have doctors working not just on their own but in teams, working with other disciplines.”

“Wouldn’t it be nice to say in five years that every Albertan has a family doctor? That’s not the case today. We should be frontloading the system into primary care.”



Panellist: Dan MacLennan

Member, Alberta Health Advisory Committee

MacLennan referenced the controversy in Alberta around allegations that some physicians had been persuaded not to speak out about patients dying while on waiting lists. He said there is a need for strong whistleblower legislation in the province.

Panellist: Cathy Gulli

Associate Editor, *Maclean's*

For most Canadians, Gulli said, the issue of how good or bad the Canadian health care is only becomes important when they go in for a medical test or to receive a medical service. With the growth of the aging population and increased prevalence of chronic diseases, she said many people are going to face the issue “in a very personal way.”

Panellist: Rachel Bard

Chief Executive Officer, Canadian Nurses Association

Bard said doctors and nurses know that the current health care system is not as efficient in meeting the health needs of Canadians as it could be. She cited a number of statistics such as the five million Canadians who do not have access to a family doctor or nurse practitioner and the fact that one-third of the population has a chronic health condition.

Bard said there is a need to transform the system so that it becomes more patient-centred, efficient, inclusive and

responsive to the needs of patients. This transformation must include focusing on illness prevention and health promotion as well as acute care and on allowing people to be more responsible for their own health, she said.

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

White said that with the current access problems facing many patients in Alberta, good value means getting timely access to a physician or needed health care service. “We’ve been throwing money at the system for so long and yet the system doesn’t change. ... To me, a measure of value is shorter wait times,” he said.

Gulli said Canadians want to know they are getting a good deal with the money spent on health care and that the money is not being wasted. What constitutes good value in health care seems logical but is also very difficult to achieve, she said; namely timely, empathetic and appropriate access to care.

Bard defined value as getting the right service, at the right time, in the right place and from the right provider. She repeated concerns about too many people being kept inappropriately in hospitals when they could be treated in the community. And she reiterated White’s point that most Canadians would define it as having easy access to care.

Audience response

Diane Dyer, president-elect of the College and Association of Registered Nurses of Alberta, referenced the aging population and growing burden of chronic illness and asked whether, with more care being delivered in the community, these people are receiving the care they need when they need it.

Better use of interdisciplinary health care teams in the community can help people “avoid expensive care in hospitals,” she said. But for team-based care to be effective, Dyer said, barriers must be removed and patients must have access to all members of the interdisciplinary teams.

Dyer also talked about the need for a national pharmaceutical plan to control “soaring” drug costs and for more emphasis on illness prevention to minimize the severity and impact of chronic disease the future.

Another nurse said that having worked in Canada and

the US she strongly supported a publicly funded health care system because “it has defined Canada.”

She noted that fewer than 2% of Albertans access home care and that it is easier to get into a hospital and receive expensive care than to receive home care. She talked about improving value for money by shifting funding from the acute care sector to home care and long-term care services.

In agreeing with these comments, White commented that “we have a complete lack of vision about the overall health care system and (instead) are focusing on crisis after crisis.” Such a vision would incorporate long-term care in the community and primary care, he said.

“My name is Helen Demsey-Simmons and I don’t mind saying to everybody here that I have been in nursing probably before some of you were born. I have been a nurse for almost 50 years ... I think we desperately need to keep our health care system but it needs a lot more than just a Band-Aid. I think we need to look at people as human beings. My husband died 18 months ago and he did not die a death with dignity. I do not fault the nurses but I will say that I will probably be sorry for the rest of my days that I did not keep him at home with me. I couldn’t take him home when he begged me to take him home because I could not look after him at home, alone. And the care at home is the pits. Trust me on that. My dad died on the East Coast six months before my husband died. He went into that hospital for surgery like a lot of seniors do. He survived that surgery very well but he did not survive the hospital-acquired infections.”

Another audience member said that governments are not very good at running businesses, especially businesses as complicated as health care. MacLennan responded that governments are more likely to be forthcoming with information than privately run companies and that from a labour-relations perspective it is far better to have health care being run by the government.

Carol Wodak said she had been researching elder care in Alberta for some time and that, in 1985, the provincial government started planning to dismantle the long-term care system. She said this was the same year that Denmark introduced an alternative to institutional care by moving care

into the community and having the public system pay for all costs including those for social programs, income security, security, housing and transportation. Wodak also noted that, in 1988, coverage for rehabilitation and convalescent care was removed from the publicly funded system by the provincial government even though they are the backbone of long-term care.

“We need to remove the profit motive from all of our health care system,” Wodak said.

She asked what doctors could do now “to fix the system they were complicit in establishing,” to which White responded that everyone has a responsibility to advocate with politicians for a better system.

“I do think all the health care providers of Canada (and) all of you (in the audience), can actually effect that change. It requires courage and leadership and I don’t think we will be successful unless we all do that together — getting beyond this apathy that we have that the system is broken and we can’t fix it. We can fix it. It can be done, together, when we stand up, especially at the time of an election and say, ‘this is so important for our futures you must listen. You must effect meaningful change’.”

— Jeff Turnbull

Patients and their families play an important part in their health care. What do you think Canadians’ responsibilities are, now and in the future, with regard to their health care?

Bard echoed earlier comments that everyone has a role to play in promoting good health and preventing illness. She noted the current generation is more knowledgeable about health and the importance of staying healthy. People need to take ownership of their own health, she said, and see what they and their families can do take change behaviours in a way that will make the health care system more sustainable.

Gulli said she thought personal responsibility was a “really sticky” issue for doctors and patients because it can easily move into the area of blaming people for not looking after their own health. She said many people do not make the right choices when it comes to their own health for a wide variety of reasons. When a health problem is identified, she said,



people have a responsibility to follow treatment plans or be compliant with medication, which is often not the case now.

With respect to the current situation in Alberta, she said, people need to hold political leaders accountable when injustices within the health care system are identified.

White said people have a responsibility to talk directly to their provincial and federal politicians and demand change to create a better system. “With some of us, when we leave here the passion will disappear, and really what we need to do is to get angry and we need to say, this is not good enough. That anger has to translate into action. There needs to be a social movement as a request for change and that needs to come from the population.”

Audience response

Heather MacKay, a registered psychiatric nurse, said people should be advocates and supporters of programs that do offer patient-centred care. She said people should not sit back and accept unnecessary wait times and barriers to care.

In response to a query from MacLennan, Turnbull described the work he does with the homeless and the huge burden of illness they face. He said their challenges speak to the need to address the social determinants of health such as poverty, housing and early childhood development.

Richard Perry, a representative of the Canadian Association of Retired Persons (CARP) Edmonton, discussed sustainability in health care and the fact that everyone seems to talk about costs and inputs but not outputs. He said there is a need to measure outputs from the health care system to determine if any difference is being made.

Bard said there is enough money in the health care

system now to sustain it but the funding needs to be reallocated to reflect the whole continuum of care and better manage chronic conditions. The federal government, she said, has a role in setting benchmarks and measuring health outcomes.

Elisabeth Ballermann, head of the Health Sciences Association of Alberta representing 21,000 allied health care professionals, also spoke of the critical importance of addressing the socioeconomic determinants of health. Root causes of poor health such as lack of health literacy need to be addressed before dealing with issues of personal responsibility for health care, Ballermann argued.

“Our responsibility collectively has to be to our public health care system,” she said. “We as Canadians have a personal responsibility to hold our governments accountable at all levels — to demand that they respect what we’re hearing here that we want strong public health care system.”

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

Bard said the scope of the *Canada Health Act* needs to be expanded. In addition, she said, because the act is based on an illness-care model there needs to be consideration of other components of the health system such as community care, home care and pharmacare.

Gulli agreed that the consideration needs to be given to expanding the health act to include all the items that Bard mentioned.

Audience response

Don Mayne, an audience member who described himself as having been retired for 18 years, said his interest in expanding the scope of the health act to include coverage of services such as pharmacare and long-term care is growing now that he is older.

The past-president of the 1,200-member Professional Association of Residents of Alberta echoed need for patients to hold politicians accountable by voting to ensure government hears the message about their health care concerns.

Another audience member said he was “appalled” by the scientific illiteracy of politicians when it comes to the biological and environmental sciences. He said there is a need for elected

officials who truly understand what health care professionals are trying to tell them.

Sheila Cousineau, who is with the St. Albert and Sturgeon primary care network, talked of the need to develop a more multidisciplinary approach to health care delivery. She blamed ongoing emphasis on fee-for-service as a means of paying physicians as one of the barriers to this.

Cousineau also referred to the need for patients to take more responsibility by showing up for medical appointments on time so the system will function more efficiently.

Noel Summerville, who chairs a seniors’ task force in Alberta, argued for a vast expansion of the *Canada Health Act*. He said that many of the health services needed by seniors are not covered by the existing act and that many are probably not aware of the limitations of the legislation.

He also said it is ridiculous to say Alberta cannot support a sustainable health care system as the issue is not expenditures but the fact that provincial revenues are being squandered.

Doug Maggison, a policy analyst for the Alberta health care unions, urged the federal government to follow through and implement the recommendations of the 2004 Romanow Commission report.

Former provincial MLA Mary O’Neill said the *Canada Health Act* should be a “living document” that should be expanded to meet current needs.

“I feel very good about the health care system. And I want to be part of that which moves it along,” she said.

What is the biggest challenge of the health care system in Alberta?

Bard referenced the recent health care system reorganization and realignment in Alberta and the need to integrate primary care and team-based delivery models into the new system.

“We need to improve upon what we’re doing well,” said MacLennan, noting examples of new health services that are working well in the province.

“What we’ve got is very good. The problem is a lot of us can’t access it quickly enough. We’ve had a huge administrative change in this province. Let’s have no more changes, let’s have some consolidation because it took two years of planning when they went from all those health regions to one. Let’s leave it alone. I think

we can't keep throwing more money at the system. It's just not sustainable. And I think we need to look at how can we reorganize the system to make it better. The pillars are access and waiting lists, referrals to specialist care and primary care ...

"How can we move resources from the acute care into those areas? That's the challenge. Right now our ERs are full. We have patients who need hospital care who can't get it. When they get in they get fantastic care. It gets back to where we want to go. We've heard numerous people talk about the lack of resources for home care, continuing care, nursing care, etc. We've talked about elderly patients in acute care beds probably getting poorer care than if they were in a nursing home with appropriate support. I think we have the money — this is a rich province comparatively speaking. The issue is how do we treat it. You're not going to get a huge change immediately. Suddenly the system is not going to be better overnight. It's going to take five years or 10 years."

— Patrick White

Gulli said that as an outsider she was struck by how such a "rich, rich province" like Alberta could have a health care system that was faltering so badly. She said this made it clear to her that the issue was not just funding but how the system is managed.

A second-year medical student from the University of Calgary asked how the federal government was going to police the health care system if they are contributing less than 25% of the dollars to support it.

Wendy Armstrong, a consumer advocate and independent policy researcher, said much of health care today has been shifted to private payment and private responsibility. Far too many politicians bought into the business model for health care, she said, and fuelled more private markets for doctors in areas such as cosmetic surgery.

"How can we expect to ensure safety, quality and access in the public system or even in any privately funded system when we have allowed private companies to market full body CT scans under very misleading circumstances," Armstrong asked.



What issue should politicians be debating in the federal election?

Turnbull said the contributions from the federal government for health care remain significant and as such we should "expect a lot." He said the federal government needs to set national standards in areas of health where it has direct responsibility such care for Aboriginal people, the military and the RCMP. "They are custodians of the *Canada Health Act* and they should be protecting it."

Audience response

Donna Hutton, a nurse, said she has seen examples of how health care systems in other countries can accommodate access and ongoing care in a coordinated and integrated fashion. "Why is it that we cannot learn from other countries and systems that are obviously effective?" she asked. Many of these nations do not cap home care, she noted. They also use nurse practitioners extensively and integrate health care providers across the continuum of care.

A second-year medical student from the University of Calgary said many people still put a lot of trust in their physician, implying that doctors thus have a responsibility to practise the highest standards of care. "Some doctors are willing to write a prescription just to get me out of the room," and to maximize the number of patients they see, he said.

"You might think we've a good system but it's not good enough. We're bright, we're capable and we're wealthy,

so we could do a heck of a lot better. As for our federal government, why don't they engage in looking at national program standards? ... They should be able to guarantee to every Canadian certain minimum services and standards and there should be penalties. The one thing that's missing out of the *Canada Health Act* is accountability, your accountability, my accountability, political accountability ... But before people leave here tonight feeling doom and gloom, there are lots of examples across Canada of great things. I worked in the Edmonton-Oliver primary care network (with about 62,000 people). Those 62,000 people can count on nurses, nurse practitioners, family doctors and teamwork like you wouldn't believe."

— David Moores, professor of family medicine,
University of Alberta

Concluding summary

Turnbull summed up the meeting by listing the key points he heard during the evening:

- The challenges of access.
- The need to build a home-based care sector, long-term care sector, chronic disease sector around the acute-care sector.
- Extending the scope of the *Canada Health Act* to include long-term care, home care, pharmacare and rehabilitation services while enforcing the existing principles.
- The importance of the social determinants of health, health promotion and a focus on vulnerable populations such as Aboriginal peoples and the homeless.
- A renewed sense of vision for a publicly funded universal health care system
- A glaring failure of management of the system.
- A call for action to advocate for a better health care system.

La Prairie town hall – June 2, 2011

Attendance: 200

As part of the annual meeting of Réseau FADOQ (La Fédération de l'Âge d'Or du Québec) Rive-Sud Suroît.

Introductory remarks

Moderator Claude Thibodeau

The moderator welcomed participants and explained that this meeting was part of a series of town hall meetings taking place across the country organized in partnership with *L'Actualité* and *Maclean's* magazines and CPAC. The theme of the national dialogue was Health Care in Canada: The time has come to transform our system.

The moderator thanked the Réseau FADOQ-Rive-Sud Suroît for allowing the CMA to hold this meeting and stated the objective of the public consultation, which is to give Canadians the opportunity to express their vision of the health system from the client's perspective.

The moderator acknowledged the presence of CMA President Dr. Jeff Turnbull, adding that Dr. Turnbull was taking part in all town hall meetings in order to hear comments and get input from the public.

Introductory remarks Dr. Ruth Vander Stelt President of the Quebec Medical Association

Dr. Vander Stelt described the current context in which the consultation was being held. She said that the health care system had failed to live up to expectations and that there was a great deal of work to be done to adequately meet patients' needs. She explained that the CMA launched the discussion on this nation-wide problem with the release in August 2010 of the *Health Care Transformation in Canada: Change That Works. Care That Lasts* document. She pointed out that the CMA now wanted to hear what citizens had to say and what they thought about their health care system.

Dr. Vander Stelt then laid out the three questions to be discussed.

Panellist Dr. Pierre Audet-Lapointe
President of the Coalition Priorité Cancer au Québec
Dr. Audet-Lapointe explained the rationale behind the



Coalition, which is to defend cancer patients in Quebec and to give them a voice.

Panellist: Dr. Ruth Vander Stelt President of the Quebec Medical Association

Dr. Vander Stelt, a family doctor in rural practice, pointed out that the main challenges facing the system were organizational. Patients are not always being seen at the right place and the right time. The current system is also centred more on the caregivers, institutions and structures than on the patients. She stated that the system was not set up properly and that it needed to be re-centred on the patient to improve efficiency and quality. She added that doing this would not necessarily cost more. "We need to work better to achieve our true goals of prevention, universal health care delivery and the introduction of a health system that is built on a solid basis, our patients."

Panellist: Danis Prud'homme Executive director of Réseau FADOQ

The Réseau FADOQ has 265,000 members and a mission to represent the interests of persons 50 years of age and over. Its members are among the few individuals who have lived under the private health system and are able to differentiate between the previous situation and universal health care. Prud'homme presented the results of a survey of members that showed 88% were satisfied with the health care system while only

62% considered that services were acceptable, particularly concerning access to care. Once a person is in the system, the care provided is good but accessing the system is the problem, he said. “Operationally speaking, the reputation and efficiency of the system are what takes the hit,” he added. In terms of specific areas in need of attention, much work remains to be done on electronic patient files and system accountability. He added that people want to be more involved in their care, to be listened to more and to be informed about all proposed treatment choices. In the survey, members indicated that they would like pharmacists to be able to make minor adjustments to prescriptions, thus avoiding the need for visits to the doctor. They would like nurses to be involved in medical duties and be able to show patients how to care for themselves.

Prud’homme claimed that “home care was the poor relative of the health system.” He said that only two percent of the budget of the Ministère de la Santé du Québec was set aside for home care and that this care was not being provided equitably in all parts of the province. He also highlighted palliative care as an area of concern. People are afraid of being isolated at the end of life because of a critical lack of resources. While seniors recognize the advances made in medicine, they feel that physical and legal resources needed to be upgraded.

Panellist Paul G. Brunet

Chair of the Conseil pour la protection des malades

Paul Brunet began by citing Article 5 of the *Act Respecting Health Services and Social Services* in Quebec: “Every person is entitled to receive, with continuity and in a personalized and safe manner, health services and social services which are scientifically, humanely and socially appropriate.” His impression was that the Act was not being respected, especially when it came to the services citizens receive compared with the taxes they paid. He maintained that once individuals make it in to the system, they are well cared for, especially when it comes to short-term care. But once released from the hospital, there is little follow-up care and what is provided is uncoordinated and disrespectful of the individual. There is confusion about what is and is not covered by public and private health services. Brunet railed against doctors who work in the public and private systems because doing so raised a serious conflict of interest. “Might we appeal to them to comply with their code of ethics?” he asked. He cited examples of doctors who suggest that their patients opt for a speedy operation in their private clinic — for a fee of

several thousand dollars — rather than wait years in the public system. He added that, at a time of shortage, we cannot permit doctors to straddle both sides of the fence (public and private), thereby exposing themselves to serious conflicts of interest.

He noted “corporatist” interests that prevail in how the health care system is managed, pointing out that the interests of professional groups override the rationale of the health system. He reminded everyone (from the physician to the floor sweeper) that health professionals are just one of the elements in patient care and not an end in themselves.

He noted that there are many problems related to long-term care: finding a place, being treated with dignity, and receiving services, quality care and meals in a respectful setting. “We are not second-class citizens just because we are in a nursing home.” He noted that patients are reticent to lodge a complaint for fear of reprisals.

He ended on the issue of the right to die with dignity: “No one should die without having decided how that death will occur (keeping in mind clinical considerations.)”

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

Dr. Audet-Lapointe suggested that the problem was with the management of the system and not with the financial resources available. By way of example he pointed out that 80% of cancer patients want to die at home but that only 10% actually do so. Many who could be treated elsewhere are taking up hospital beds intended for acute care patients. He believed resources should be transferred to palliative care, thereby freeing up emergency departments.

According to Brunet, medicare is failing to live up to the promises made when it was first brought in — taxes continue to rise while care remains inadequate. “I would like to say, with all due respect, that we are being conned because, in addition to paying for the initial promises, we have had to inject more money to continue receiving the care promised by the 1990s act.”

While readily acknowledging the dedication of health professionals, Prud’homme insisted on the establishment of performance, productivity and satisfaction indicators. Putting more money into the system will not necessarily bring about

change: the goal instead should be responsible and transparent management of the system.

Audience response

The first participant to speak said she felt the health care system devotes more time to bureaucracy than to patient care. She added that there is not enough investment in prevention, which could represent savings in the long term.

In response to the moderator's question about whether there was a key moment in the history of the province when everything was turned on its head, Dr. Audet-Lapointe answered that the Quiet Revolution in Quebec had had a detrimental effect on decision-making within the health care system. "Cumbersome bureaucracies were set up. A class of managers was created, made up of bureaucrats who don't want to change their way of doing things and who are deaf to new ideas, especially when it comes to patient participation. The health system is not open to the participation of patients because they ask questions and don't want the run around."

Brunet reminded the audience that Dr. Jean Rochon concluded, during his commission of inquiry in 1998, that the public system was being held hostage by professional corporations. By way of example he pointed to the refusal of professional medical associations to acquiesce to the request of pharmacists to extend or adapt prescriptions. This could have saved hours of work for doctors — hours that could have been put into caring for more patients.

Dr. Audet-Lapointe replied that the status of a doctor in a hospital is one of a self-employed worker who has a certain degree of power that is nonetheless largely shared with unions. "Corporatism" is palpable in all health care professions. "The impression is that the patient is no longer at the centre of the health system."

One participant declared that the public was not getting its money's worth. As someone who had worked in the system she observed that, when it came time to making reforms, health care providers were the last to be consulted. She believed that caregivers should set the priorities for the system.

One participant went even further by citing two examples. The first related to long wait times in emergency rooms and the second to the proposal by a doctor to operate immediately in his private clinic or have the patient wait a year to do so in the hospital. The participant ended by asking: "Is it normal to pay \$2,000 to be operated on the following morning? You need money for that."



Patients and their families play an important part in their health care. What do you think Canadians' responsibilities are, now and in the future, with regard to their health care?

Prud'homme stated that his members had clearly indicated in a recent survey that they understood the importance of staying active and maintaining good lifestyle habits and that they were taking the necessary measures to do so. His concern was more with the fate of young people who are generally in poorer shape. He insisted that the myth that seniors are a financial burden on the system should be debunked.

Audience response

One participant pointed to the example of a health promotion program in Montréal. She said that, while it was important for people to take care of themselves, they needed information to help them do so.

Another participant stated that, in effect, people have a personal responsibility for their health. On the other hand, she was critical of crowded emergency rooms and the way that money was being spent — on refurbishing managers' offices instead of on patient care. She also demanded that the government properly monitor the contents of drugs.

Dr. Vander Stelt made the following appeal to participants: "Unless Canadians stand up and demand a better performing, accountable and efficient health care system, you won't have one." She added that one of the CMA's goals is to transform the system, but the public also needs to demand that this happen.

Brunet went further by pointing out that patients have not had the political clout or authority necessary to help bring about change. Quebec's health ministers are well inten-

tioned but have little power to make major changes. On the other hand, he asked that, if patients are truly responsible for their health, why do they have to fight to have access to their medical file? That file should belong to the patient.

He delivered a message about the value of patient care and the importance of visiting patients in long-term facilities to prevent negligence and abuse.

Dr. Audet-Lapointe added that, apart from individual responsibility, society itself must play a role and show its discontent. He bemoaned the fact that people are ready to demonstrate in the streets for a hockey game or arena but not for health care. “I don’t understand why people aren’t up in arms about it!”

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

Dr. Audet-Lapointe maintained that the *Canada Health Act* does not reflect the new reality and doubted that it was possible for the Act to cover everything for everyone. “We can’t continue to have an open bar where some people have Perrier water while others have 40 oz. of scotch.” People should be consulted and decide on what they want in the way of coverage.

Audience response

One participant stated that the *Canada Health Act* should be modernized. She added that alternatives to private health care should be explored to improve access and avoid the need for long-term care. “I think it’s terrible that people have to wait months for an operation. Our health is our most precious possession.”

Another participant pointed out that, in addition to better access to drugs and long-term care, provisions should be made in the Act for scientific research. As an example she cited hypertension — a leading source of costs to the health system; yet very little money is committed to research.

One member of the audience recounted her experience as an informal caregiver and deplored that fact that she had not received any assistance to help her mother live out her final days at home. She pointed out that, had she received assistance, her mother would undoubtedly have died at home instead of in the hospital and there would have been no cost to the system.

Prud’homme expressed the wish that additions be made to the Act to encourage people to continue living in the community as they age and to ensure that the elderly are less vulnerable and subject to budget fluctuations. “We need to shore up integrated health care services, provide more efficient home care and ensure access to drugs regardless of income.”

He added that the provinces and the federal government should remind themselves that the patient is at the centre of the system and that bickering over transfer payments between levels of government is harmful to patients. Guaranteed income supplement scales should be reviewed. He noted that the recent health contribution requirement brought in by the Quebec government is unfair. “If we stopped arguing and put power back into the hands of patients, we would have a more viable system.”

A participant gave the example of a pharmaceutical company that agreed to administer a very expensive drug to him in his home. He concluded that pressure could be put on other companies to better heed and support patient wishes.

Dr. Vander Stelt told of one health centre in Cleveland where patients can make doctor’s appointments and get test results online. She pointed out that doctors are not trained as business managers and administrators are not versed in the realities of medical practice. Both parties need to be better trained.

Dr. Vander Stelt ended the meeting by issuing a heartfelt appeal to users to get involved by communicating their concerns to their elected representatives and by encouraging family members and friends to take part in redesigning the Canadian health care system by going to www.transformation.sante.ca. “You are the users of this system. If you really want the system to meet your expectations, it’s up to you to make yourselves heard.”

Concluding summary

The moderator summed up the discussions by reiterating the main themes that were raised. Lack of money is not the issue. There is a certain corporatist resistance to efficiency. People recognize the important of good lifestyle habits. More should be done to encourage research. The system’s problems have a real impact on informal caregivers. Long-term care and end-of-life options should be explored.

Vancouver town hall — April 27, 2011

Attendance: 150

Introductory remarks

Moderator: Ken MacQueen

***Maclean's* Vancouver Bureau Chief**

“When we started these town halls meetings in late January it was clear that health reform was an issue of concern to the public,” MacQueen said after welcoming the audience. “But it seemed to merit little attention from our political leaders. It became a political priority only in the dying days of this federal election campaign. Now all parties talk of the need to save the health care system in some way, somehow.”

Dr. Jeff Turnbull,

President, Canadian Medical Association

Turnbull once again stressed that the purpose of this and all the town hall meetings was to get the unique perspective of Canadians on the future of their health and the health care system. He touched on the major theme of the sustainability of the system and said the issue was not just about money but rather the need to provide “universal access to high-quality, patient-centred care delivered in a timely fashion across the whole continuum of health and which is cost effective.”

Panellist: Kelly McQuillen

Director of Patients as Partners, Primary Health Care Branch, BC Ministry of Health Services

McQuillen said British Columbia is “definitely” recognized as having one of the best health care systems in the country, but there was a need to ensure that it continued to be improved. One innovation, she said, was the move toward a community-based system delivered in a collaborative fashion by a team of health care professionals. She said there is also an emphasis on engaging patients and their families in decisions about their health. What is unique in BC, she said, is the attempt to look at the “experience of care” for patients.

Panellist: Dr. Ian Gillespie

President, British Columbia Medical Association

Gillespie said that with 45% of tax revenues going to fund health care in British Columbia, reforming the system could not just be about injecting more money into the system.

Another challenge Gillespie noted was the aging physician population in the province with 46% of physicians older than 55 years of age. While medical school classes are being increased to fill the void left by those who will be retiring soon, he said, the challenge is to find enough clinical teachers to train these students. On the positive side, Gillespie pointed to the work done by the General Practice Services Committee to save money, provide better care and provide more satisfaction for physicians under the current agreement between the BCMA and provincial government.

Panellist: Michelle Degroot

V-P, Health Policy and Advocacy, First Nations Health Council

First Nations individuals are part of a very complicated health system, Degroot said, involving federal and provincial–territorial governments and First Nations jurisdictions. She said that this complex system has developed “around us and not with us. We have not had much input into our health services or participation in the development of the policies and programs that affect our lives.”

Degroot noted that First Nations people have the poorest health of any group in the province and specifically noted the high rates of diabetes and suicide. “For us it’s not about illness, it’s about wellness and we want to be well.” She noted that the creation of a First Nations health organization is in the works to give First Nations peoples more control at the local level.

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

Gillespie said value refers to a formula comparing the cost of health care versus the available resources and that there is a “tug of war” between the two because governments want to balance budgets but physicians want care available to patients in a timely fashion.

He said Canadians want value in health care by having a

system that delivers timely, effective, compassionate and integrated care. When it comes to planning, he said, collaborative effort early pays off.

McQuillen said many patients have told her department that good value means receiving the right treatment in a timely fashion and in the right place. People want continuity in their care and relationship-based care, she said. They also want independence and the ability to manage their own care closer to home.

Degroot said more value could be brought to the system through greater emphasis on health promotion and disease prevention rather than on spending on treating illness. She said many First Nations communities are doing good work developing care models emphasizing physical fitness, nutrition and spiritual practices.

Audience response

The first audience member to speak said access is the glaring problem facing the system and that the Canadian Medical Association should do more to ensure more international medical graduates (IMG) are licensed to practice in Canada and to allow retired physicians to re-enter the system to help deal with millions of people who do not have a family doctor or who are on a waiting list for services.

Turnbull responded by agreeing “access is one of the key issues that we face today.” While there is a need to provide access to primary care services to everyone, Turnbull also noted that First Nations peoples, the poor and other disadvantaged groups face specific access problems. He agreed that IMGs need to be part of the system and that the CMA supports ensuring they have the necessary supervision to get the training they need.

Another audience member raised the issue about the need for long-term care for seniors and noted that no new long-term care facilities have been built in the last decade. As a result, she said, seniors are using hospital beds when they should be cared for in long-term care facilities. She also said those working in existing facilities are overworked and underpaid.

An audience member expressed his concerns about “campaigns” by organized medicine in British Columbia and elsewhere to deny patients access to chiropractic services and massage therapists. He also noted it was difficult to have collaboration when there were no alternative health care practitioners on the panel at the meeting.

A speaker praised the provincial government for starting the patient voice network. He expressed concern about silos



of care in the existing system rather than unifying programs in areas such as chronic disease. He talked about the need to emphasize self-help.

A community nurse emphasized the importance of nurses in providing good value in the health care system. She talked about the underutilization of nurse practitioners and the fact patients have to pay more for a reduced slate of community services. She was especially critical of cuts to healthy baby programs and their ability to identify problems early that may impact mothers and children, such as postpartum depression.

“I’ve had some personal experience with the value of community care services. My youngest son — who is now six years old — was born by C-section. After two days in hospital he came home and the community care nurse came by the first day after his being home and found out he had a heart rate of 200. Were it not for that visit, the first time we would have recognized he had a problem would have been when he had heart failure.”

— Dr. Ian Gillespie

Patients and their families play an important part in their health care. What do you think Canadians’ responsibilities are, now and in the future, with regard to their health care?

Degroot said that from the First Nations perspective, people think of their health not only as individuals but as families and communities. This makes the social determinants of health

very important, she said, especially in communities where, for example, healthy eating can be difficult because a bag of potato chips is cheaper than a small bag of carrots. In many First Nations communities, she said, access to health services may not be an option and even when health services do exist, people may be reluctant to use them because of negative earlier experiences. For instance, she noted that in one First Nations language the word for hospital is “container for illness.”

Audience response

Heather Chapman, a representative from the www.thepatientfactor.com website said it was time to acknowledge that governments cannot meet the health care needs of all of the people all of the time. She said there needs to be a new system that puts patients and doctors in charge of making health care decisions rather than bureaucrats and politicians. She said this system would allow patients to spend their own money on their own health care in Canada if they chose to do so.

The vice-president of the Association of International Medical Doctors of British Columbia once again raised the issue of IMGs and asked what they could do to help. Gillespie noted that the issue of licensure must be addressed by the College of Physicians and Surgeons of BC and not the BCMA. He said while the role of IMGs is valued, having more doctors in the system is not the whole solution.

Dr. Yolanda Cutanda-Dela Cruz said health care should be adjusted to meet the needs of the user. She referenced the incident at a BC hospital in which patients awaiting care in the emergency room were treated in the Tim Horton’s outlet in the hospital. “We don’t want to forget that,” she said.

“I’m desperately concerned about the future for my grandchildren and everybody else’s,” said another audience member focused on environmental concerns who urged physicians to become educated and speak in the community on these issues. Gillespie said BCMA divisions of family practice are working more closely with many communities in BC to customize services to community needs.

McQuillen built on this theme of community-based care and said patients, families and communities are not just the recipients of health services but are also the co-producers of health and need to be at the table.

Turnbull said the discussion demonstrates the need to build on the good acute care health sector that exists with another system to support a chronic disease model that is

patient-centred and home-based. He said this new reality needs to be reflected in the health accord that will be signed in 2014.

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

McQuillen said the answer to this question “lies in the deliberative dialogue with the public as the stewards of the health care system.” She said the public needs to speak up on where tax dollars should be spent.

Audience response

A family physician said collaboration between doctors and other health care providers and integration across the continuum of care are “really, really important components” of value to health care. But she said physicians still tend to be organized as small businesses and this discourages collaboration and integration. Gillespie admitted this assessment was true and said it will require a change in the mindset of the medical profession to work in interdisciplinary teams.

A medical student talked about the value of multidisciplinary teams and lauded the health care system in Cuba with its emphasis on preventive health and collaborative primary care. She said this focus on the social determinants on health will end up saving money. She said the medical education system in Canada emphasizes pathophysiology rather than focusing first on preventive measures. Degroot supported this approach. “We (First Nations) are tired of being told we’re sick and want to be told how to be well,” she said.

Rachel Tutte, a physiotherapist, argued for an expansion of the *Canada Health Act* to include rehabilitation services in the community and home care. In the rehabilitation hospital for older patients that she works in, she said, the pressure is to get patients out of hospital faster. However, she said, the rehabilitation system isn’t able to provide the care in the community these patients continue to need. She also said the principles underlying the *Canada Health Act* such as universality and public funding need to also apply to any new areas covered by the legislation.

An audience member said it was the responsibility of patients and their families to demand that the *Canada Health Act* be retained and expanded to include a number of other services such as pharmacare, home care and complementary

medicine. She also said people are being denied access to acute care because elderly patients are occupying hospital beds rather than being cared for more appropriately in the community.

“My mother has been in care now for 18 months because she hasn’t been able to get the amount of rehabilitation services that she needed,” another audience member said, noting that if such services could have been expanded beyond the six to eight weeks allowed then that may not have been the case.

Turnbull responded by saying that the challenge in enhancing home care and community care services was not related to cost. He said his own hospital has an occupancy rate of 104% and 144 patients waiting to get into long-term care at a cost of \$150,000 a day for care that is not as good as they could get in the home. “I don’t think this is an issue of money. It’s an issue of bridging silos, redistribution of funds, breaking down barriers, leadership and courage.”

What is the biggest challenge of the health care system in British Columbia?

Gillespie said timely access to care is certainly part of the challenge facing BC as demonstrated by the “Tim Horton’s incident” referenced earlier in the meeting. He said another important issue is better integration of services and involving patients more extensively. “Too often the patient voice comes in last. It needs to be part of the strategic planning process and not an afterthought.”

Degroot identified silos within the system as being a major challenge for First Nations people. Some patients “get lost in the system” and fail to get access the care they need, she said.

McQuillen said the provincial system faces many challenges including the growing number of people living with chronic diseases, the frail elderly, and those with mental health issues or addiction. She reiterated the challenge of getting the patient voice heard within the system. “One of the biggest challenges is reminding the leaders about what it is we need. We need your voice to help shift the system and its going to take a loud voice,” she said.

Audience response

An audience member identified shortages of publicly funded counseling services for depression and dental services as major gaps in the system.

Another audience member noted that other variables

contribute to health beyond the system itself. She called for pharmacare to be included in the *Canada Health Act* as well as community-based mental health care.

Bottlenecks in the system were identified by another audience member as the main challenge facing the system, especially with respect to hospital care and chronic disease management. This speaker also talked about his experience working with electronic medical records (EMR) in Alberta and the ability of EMRs to give patients more control with the doctor in managing their own chronic disease

To much applause, a representative of the Council for Canadians talked about the need to stop eroding the public health care system in favor of private care. She said the *Canada Health Act* needs to be expanded and enforced. She made specific reference to pharmacare and the need for a national program.

A nurse who cares for newborns talked about ability to prevent hospital readmissions with proper follow-up of these babies. She said she was speaking as an advocate for publicly funded health care.

A woman whose husband has advanced prostate cancer said the most important thing to do was to “slam the door on private, for-profit health care.” She said care within the public system is excellent and that they had received proper instruction on navigating the system. She also advocated making pharmacare part of the *Canada Health Act*.

What issue should politicians be debating in the federal election?

Dr. Randall White, a Vancouver psychiatrist, talked about the problems in finding appropriate housing for his patients, which make it difficult to discharge them from hospital. He also advocated for more community-based, evidence-based mental health services that are currently not available. White called for the federal government to drop its court challenge of the Insite safe-injection site in Vancouver’s Eastside.

Gillespie noted that the Canada Health Care Accord stigmatizes mental illness by only paying 50 cents on the dollar compared to other needed health care services. He likened mental health care and addictions as the “canary in the coalmine” for measuring the health of the health care system. He said the responsibility for funding mental health care services adequately clearly rests with the federal government.

Janice Buchanan, vice-president of the BC Nurses Union, also spoke in favor of the Insite clinic noting that it saves lives

and should be expanded across the country. Turnbull indicated the CMA has intervenor status in the case, which is currently before the Supreme Court of Canada, and will be speaking in favour of the clinic.

Another audience member said maintaining and expanding the *Canada Health Act* in a public, non-profit direction was the most important issue politicians should be addressing. She said private, for-profit clinics are operating in defiance of the act across the country. Gillespie said the BCMA was interested in managing waiting lists in a manner that was best for patients without focusing on the public–private issue.

A physician referred to the “created crisis” of sustainability of the health care system and said she would like to see more opportunities for primary care physicians to provide care in innovative ways under alternate payment mechanisms.

Concluding summary

“I’ve heard a fantastic conversation,” said Turnbull in summarizing the discussion.

He listed the following as themes raised during the meeting:

- Supporting primary care services in the community with new comprehensive models of team-based care.
- The primacy of the patient and their decision-making power and the need to listen to their voice.
- Issues around the social determinants of health, especially the environment and moving to a wellness model — not just health promotion services.
- Support for a strong, publicly funded health care system with elected politicians needing to be stewards of the *Canada Health Act*.
- The need to bring innovation into the system.
- The need for everyone to have responsibility for the health care system.

Ottawa town hall — June 7, 2011

Attendance: 200

Introductory remarks

Moderator: Ken MacQueen

***Maclean's* Vancouver Bureau Chief**

MacQueen welcomed the audience to the “splendid National Gallery” where the final town hall meeting co-sponsored by the CMA and *Maclean's* was being held. He said the consultations have proved that the health care system is both a source of national pride and of concern. To date, he said, few have taken issue with the contention that “much can be done to improve and expand the health care system while keeping it sustainable.”

Dr. Jeff Turnbull,

President, Canadian Medical Association

Introduced by MacQueen as the “driving force” behind the CMA’s initiative to engage the public in a discussion about health care, Turnbull stressed the aim of the town halls was to hear what the “unique perspective” of what the public has to say on the issue. He said the discussion was being framed around three key questions to help determine what health care will look like in the future.

“For us sustainability is the access to universal health care that is patient-centred, timely and delivered across the continuum in a cost-effective fashion.”

Panellist: Nadine Henningsen

Executive Director, Canadian Home Care Association and President, Canadian Caregiver Coalition

Henningsen said that as the representative for home and community care she wanted to share three concepts that could have a huge impact on the future of the health care system:

1. The need to shift from a reactive, acute care, episodic model of health care to proactive, long-term, chronic care approach. She said this would be supported by building a strong partnership between home care and primary care.
2. Leveraging what technology can do to improve health care— whether it be m-health, e-health, telehealth or the electronic health record. She said it has been proven that technology can improve the quality of care and reduce administrative costs.



3. The need for a national caregiver strategy to support the vital role of family caregivers. Such caregivers should be able to fill this role without suffering financially or with their own health.

Panellist: Irwin Elman

Ontario Advocate for Children and Youth

Elman talked about how Canadians’ identity is tied to the health care system and the expectation that health care services will be available to all when we need them. He noted that the health care system can be changed without giving up the values that Canadians cherish.

Panellist: Scott Dudgeon

Founding Member, Neurological Health Charities Canada

Dudgeon talked about how his organization is taking a leadership role in engaging governments in improving brain health and better understanding brain disease and neurological issues.

He echoed Henningsen’s call for a caregiver strategy to help support those who care for those with brain injuries or neurological disease. He also referenced the need for a better coordinated health care system.

Dudgeon talked about a “person-focused” approach to care rather than a “patient-focused approach” because people are only patients for a small part of the time.

Panellist: John Geddes***Maclean's* Ottawa Bureau Chief**

Geddes discussed the role Tommy Douglas played as the “patron saint” of medicare and how his stock has risen in recent years. His stature is indicative of the fact that the Canadian health care system has become “sacrosanct,” said Geddes. As such, he said, it is no longer feasible for politicians to question the foundations of medicare and this means the challenge has become how to change the system without doing that.

CMA questions

It is important for Canadians to feel they are receiving good value for their health care. What would you consider good value?

Elman answered the question by describing a case involving a two-and-a-half year old child in a Hamilton hospital who had been brought there from another city because he required a tracheotomy. He said the child had been hospitalized for more than a year and he had been called by the doctors involved because the child was not sick and no longer needed to be in hospital but could not be discharged because of concerns that the parents were not able to provide the necessary care. However, he said it was not possible to find the necessary community services to help care for the child. “Is he getting good value for health? No he isn’t,” Elman said.

Elman said the solution was not just to provide more money to ensure that necessary care in the community is available, but also to have greater cooperation between government departments and hospitals to break down silos that are creating an “incredible waste of energy and resources.” He said the system needed to be streamlined so parents can receive the assistance they need to care for children such as the one he described.

Henningesen said that as a taxpayer she felt getting good value for health care means getting needs met with exceptional customer service, and it is this latter element that is currently missing from the system. “Exceptional customer service is a health care system that engages you and gets your involvement and navigates your way through the system so you can get your needs met.”

Audience response

An audience member proposed six points to create more value in the system.



1. With relatively too much money being spent on hospitals, provincial governments should be required to fund an amount equal to the number of “alternative” hospital beds currently occupied by seniors who cannot be placed in long-term facilities— plus 10% — to build long-term care homes to meet this need. By doing this, she maintained, in two years it would be possible to phase out the alternative beds and allow seniors to receive better care for less money. The funding could then be redirected to help support home care programs.
2. Physician offices should be required to be open from 7 am to 10 pm, Monday through Sunday, and be more patient-centred to take pressure off emergency departments. These offices should offer better integrated care by involving more allied health professionals, she said.
3. “Make school fun” and encourage cooking classes to merge the theory and practice of good nutrition. The same should be done with exercise classes, she said.
4. Have provincial governments institute bulk buying of generic drugs to reduce costs.
5. Have the federal government extend the guaranteed income supplement for 10 or 15 years so poverty can be eliminated.
6. Institute a portable health card to “knit” the system together so the patient record would be available wherever care was provided.

Henninger responded said “it’s a crime” that alternative care beds exist. She noted that Ontario recently invested resources into community support services to try to reduce this problem, but after one year no progress had been made because of the way hospitals operated. She said discharge

planners were placing people into long-term care facilities rather than sending them home and only then considering long-term care placement. This is because admission to a long-term care facility is a social decision rather than a medical one and should not be done from a hospital.

A father with an autistic son said that the *Canada Health Act* does not constitute value for autistic patients because it does not ensure they receive the care they need. He talked about the fractured nature of services provided for autistic care across the country. “I’ve watched people lose their homes and sell everything they own to provide for their children,” he said, reiterating that the range of autistic care services across the country is “abysmal.” At the very least, he said, the need to agree on at least a diagnosis for children such as his son should be recognized.

He noted that care is not available for autistic children in Inuit families “and you can forget getting help. It does not exist for you. ... Our system must meet the basic needs of our most vulnerable and disadvantaged people.” He said there is a two-tiered system for care for autistic patients in Canada, with those in British Columbia, Alberta or Ontario having access to good programs that do not exist elsewhere in the country or in rural areas. “That’s just not right,” he said, adding that the federal government must provide some direction to resolve this issue.

Dudgeon said good value in the health care system has to be in meeting the needs of patients and families. He said unlike what happens in other sectors, people who access the health care system are not asked whether their needs were met and if they are better off as a result of the care they received. He said better outcomes can be achieved by marrying medical expertise with feedback from the person actually receiving care, or their family. He said the federal government needs to take an active role in ensuring people have a similar experience when they access the health care system in different jurisdictions.

A recently retired neurologist noted that one thing missing was a patient on the panel and said the discussion would be better if there was a patient with a chronic condition to offer his or her perspective. He talked about the shortage of physicians and referenced “26,000 missing physicians” while at the same time there were 8,000 qualified foreign medical graduates in the province willing to work. He said there was a need to accelerate the process so they had the ability to work in the province. He also talked about the significant cost savings that could be had by eliminating unnecessary medical

tests and investigations and by spending more on preventive care services.

He said that as president of the CMA Turnbull should stand up and tell the government “we need pharmacare and we need more physicians and we need more MRIs and we need those a lot more than we need F-35 fighter jets,” he said.

Turnbull responded that pharmcare, long-term care and health promotion strategies are very much part of the necessary requirements for moving ahead.

A nurse who said she had been harmed by the care she received from a physician was critical of the College of Physicians and Surgeons of Ontario as she said they use experts who do not provide unbiased opinions. She also noted that it was impossible to take a major catastrophic health care issue to the courts for attention.

I have to tell you that I had a very recent experience where the health care system did work well and sometimes we forget to recognize those. My daughter was sent to Sick Kids for a battery of tests. My daughter is 12 years old and after going through an entire day of tests and quite elaborate procedures on the way out she looked at me and said to me “Mommy, how are we ever going to pay for all of this?” I had an opportunity to explain to her about one of the wonderful things about living in Canada and if you lived in other places that would be a major, major problem. So I think we need to focus on what works and hold on to what works and we need to find innovative solutions to what’s not.”

— Shannon MacDonald, Neurological
Health Charities Canada

MacDonald noted that in Ontario, 50% of the provincial budget is now spent on health care and that we need to hone in on opportunities to add value to the system. “Living well is much more than a health issue,” she said, and the focus needs to be put on other government departments such as transportation that impact on how effectively health care is delivered. “The federal government has shown leadership by starting to talk about a prosperity agenda and how to keep people well ... and how to ensure people can access the programs they need. We are a better society if we keep each other well.”

Patients and their families play an important part in their health care. What do you think Canadians' responsibilities are, now and in the future, with regard to their health?

Geddes said it seems obvious that people should be expected to take a high degree of responsibility for their own health. But he noted barriers exist to achieving this, such as the lack of progress on electronic health records so people can track their own health care, as well as the lack of resources in Canada that would make it possible to compare the quality of services available at different hospitals and other settings. The United Kingdom does a good job of this, he said, by making websites available to make these comparisons. In contrast, he noted, it is even hard to find data comparing hospital care in different provinces, although he added some progress is being made, such as a project involving the academic health centres.

Dudgeon said guidelines do exist to help Canadians keep their brains healthier. He said there is evidence suggesting that a healthy diet and appropriate exercise will reduce the risk of dementia. However, he was critical of those disseminating the guidelines for holding off on urging family doctors to recommend these steps to their patients because they feel the evidence base is not strong enough in neurology— even though the same steps are recommended for reducing the risk of heart disease.

In addition to taking responsibility for their own health, he said, people also need to ensure public policy encourages healthy living by such means as health literacy instruction in schools.

Audience response

Dr. Merrilee Fullerton, a family physician, was critical of the approach that sees patients as people who have things done to them rather than as participants in their own care. She also talked about health literacy and said while some people may not be capable of being involved in their own care a large percentage are. She said the vast majority of patients do want to be empowered to participate in their own care and be involved in the decision-making process. However, she said, continuing to stress the need to change the health care system fails to address what people can and should be doing in their own lives to improve their own health.

Elman talked about the need to start talking about health when people are children. However, he noted, that for certain groups such as native peoples the environment makes it very

difficult to take responsibility for their own health. For example, he said, it is not realistic to ask people to take responsibility for proper nutrition in some northern communities where, for example, a banana can cost \$4. Only when the playing field is leveled in terms of other determinants of health is it fair to talk about personal responsibility of health, he said.

Elman also suggested having a town hall meeting with young people to ask them what could be done to help them take responsibility for their own health.

Henningesen said health literacy has suffered from the policy in some jurisdictions of evaluating home visits to assist those living in the community based on the number of such visits rather than the quality of the outcomes. In making changes to the system, she said, it is important to ensure time is being built in to communicate properly with patients and their families and to listen to their concerns.

A physiotherapist talked about firing patients who would do not take responsibility and participate properly in their own care. She was critical of the change in Ontario policy in 2005 that removed many physiotherapy services from the publicly funded system. She also talked about the inefficiency of the system that now requires those receiving publicly funded care to receive a referral from a family physician before being able to see a physiotherapist even though physiotherapy is clearly required. “Health care is not free,” she said. “Please don’t have that perception.”

A physician and medical researcher talked about the need for a more “upstream” approach to improving the health care system by investing more in preventive services. He said he feared the current system was moving more toward quick fixes that rely too much on prescription drugs.

Dudgeon said one way people can take responsibility for their own health and improve health literacy is by making sure primary care is provided by teams. He said rather than just seeing a physician and receiving a prescription to manage high cholesterol, team-based care encourages allied health professionals to use other approaches such as improved nutrition or lifestyle changes to manage the problem.

A physician was critical of the perception that the funding model for our health care system is sacrosanct and he said such “sacred cows” must be eliminated to find ways to improve the system. For example, he said, there is no recourse or punishment if a patient is irresponsible and does not look after their own health. “I think that’s something we need to think about.”

“It is a well known fact that anything that is desirable and free (such as health care in Canada) has to be rationed. That’s just a fact,” he added. He said since becoming a physician in 1968, the quality of health care — while still exceedingly good in Canada — has gradually deteriorated and improvements will not be made until there are discussions about how the system is funded.

Geddes said no one “is going to get very far” by challenging the basic precepts of the Canadian health care system, so other options need to be found to bring competitive elements into the system and improve efficiency. He said the key to this is providing transparent, publicly accessible benchmarks and measures to give people choice.

An audience member noted the quality of health care in Canada is actually “pretty terrible” and surpassed by most Western countries except the US. He asked how busy people could be expected to do more to take responsibility for their own health. “There’s a limit to what we can do,” he said, especially as many people refuse to believe what they are being told about health. He used the recent measles outbreak in Europe and the failure of people to get vaccinated, as an example.

The law underpinning our system — the *Canada Health Act* — dates back to the 1980s. It covers only doctor and hospital care. Do you think it should be broadened to include things like pharmacare and long-term care?

Elman talked about deficiencies in the provision of mental health services, noting that 25% of children will have a diagnosis of mental illness but only one in six will receive treatment. He said the system does not invest sufficiently in either children or in mental health services for children and adolescents.

He said the fact that many adolescents lose access to prescription drug coverage when they turn 18 or 21 points to the need to develop a national pharmacare program to ensure they can continue to receive the drugs they require.

Henningsen said a very robust home care system backed by supporting legislation already exists in nine provinces. She said the question needs to be asked about what adding home care to the *Canada Health Act* is designed to achieve.

Audience response

University of Ottawa health economist Doug Angus said he was “amazed” at the variety of comments and the depth of the insights heard during the evening. He agreed that medi-

care is probably sacrosanct and suggested it should be changed by revising and amending it rather than rewriting it. He said there are many dedicated people on both sides of the political fence who could bring thoughtful discussion to the issue of what is needed to improve the system.

The issue of differential access to services across the country was raised by another speaker. He said there needs to be a mechanism to allow people to come together to discuss what is important to address in health care such as happened a few years ago with primary care.

An audience member who works for the Council of the Federation said the question should be what the provinces and federal government can do to improve individual health.

A family physician said he wanted to see development of a sustainable health care system that would look after him even when he does all the right things to maintain his own health. He said he hoped the outcome of the consultation exercise being conducted by the CMA would result in subject matter that could be used with focus groups of consumers to evaluate various options. He stressed the need to consider the importance of the other determinants of health, noting that the health care system itself is the “icing on the cake” when it comes to health.

A nurse working with prenatal and postpartum programs in rural communities talked about the importance of ensuring health care services are maintained in smaller communities. She referenced how having to travel long distances for care can lead to poorer outcomes.

Caitlin Schulz, a student in the school for public policy at the University of Toronto, said the issue of rationing has to be considered because more services cannot be added to the publicly funded system indefinitely without increasing taxes. She said there is a place in the conversation for looking at the private provision of health insurance without seeing it as an attack on the publicly funded system.

She expressed concern about earlier comments about firing patients or punishing people who do not take responsibility for their own health for abusing the system.

Geddes said that from his perspective the current federal government has no interest in expanding the scope of the *Canada Health Act* and the challenge will be to maintain the existing scope of services funded by the public system. However, he did, say there was some potential to explore a national pharmacare system, especially for drugs to deal with catastrophic illness.

Another speaker reiterated Elman’s comments about the

need to address the shortage of mental health services for children and adolescents. He said amending the *Canada Health Act* to put a focus on this would be useful. He also noted the challenges of having silos of care and problems that they bring.

A medical student at the University of Ottawa expressed disappointment with the current status of the *Canada Health Act*, describing it as a “Gordian knot” rather than as a “lighthouse” for health policy.

Another audience member talked about “Humpty Dumpty medicine” and the tendency of the system to focus on acute care issues and doctor and hospital care. “What if I’m not broken but just a bit cracked?” he asked. He said the system has evolved to deal with crises rather than society as a whole. He said ranting at politicians is not going to fix things.

Concluding summary

Turnbull summarized the key themes he heard during the evening:

- The system is failing Canadians, especially vulnerable populations.
- The system is fractured and transitions are not well-managed and people cannot get care where and when they need it.
- The sense we have moved from an acute-care paradigm but we have not developed a system to manage chronic conditions or home and community care services.
- The importance of the social determinants of health.
- The need for transparency and accountable systems to develop national standards and benchmarks.
- The need to modernize the *Canada Health Act*.

