



ACCESSIBILITY: THE SOLUTION LIES IN COOPERATION

Joint Brief of

The Quebec Medical Association

and

the Canadian Medical Association

BILL no. 20:

*An Act to enact the Act to promote access to family
medicine and specialized medicine services and to amend
various legislative provisions relating to assisted
procreation*

March 25, 2015

Preamble

We would like to thank the members of the Committee on Health and Social Services for giving the Quebec Medical Association (QMA) and the Canadian Medical Association (CMA) the opportunity to express their preliminary views on Bill 20. We use the word “preliminary” deliberately because the bill in its current form sets out broad principles but is lacking in specifics. We would have liked to see more transparency on the government’s part early in the process, whereas the regulatory guidelines were only made public on March 19. This shows a lack of respect or courtesy, or is a deliberate expression of the government’s determination to ignore the opinion of the professionals concerned, that is to say, physicians.

We have chosen not to critique the bill clause by clause, so we will not go that route for the regulatory guidelines either. We will instead limit ourselves to a few general comments.

For example, how was it determined that an HIV-positive patient is “worth” two vulnerable patients, or that a patient receiving end-of-life care at home is worth 25? Why not 22, 26, or 30? Only ministry insiders know for sure, since neither of our organizations was consulted. And how many civil servants will it take to measure and monitor this new form of “mathematical” medical practice?

The QMA is the only Quebec association whose members include general practitioners, specialists, residents and medical students. It calls on its vast network of members to consider the issues the medical profession faces, propose solutions and innovate in order to rethink the role doctors play in society and continually improve medical practice.

The CMA is the largest national association of Canadian physicians and advocates on their behalf at the national level. The association’s mission is to help physicians care for patients. The CMA is a leader in engaging and serving physicians and the national voice for the highest standards for health and health care.

This brief is a historic first for both organizations. This is the first time that the CMA has submitted a brief in Quebec’s National Assembly as well as the first time that the QMA and CMA have submitted a joint brief.

This joint initiative says a lot about how concerned the country’s physicians are about Bill 20. This attack on the professional autonomy of physicians is unprecedented in the history of Canadian organized medicine. Undoubtedly, the issues speak to the entire medical profession because of the consequences the bill could have on the profession itself.

Our input is intended to be realistic, constructive and reflective of our member’s opinions and legitimate concerns.

Our two organizations—which, we note, are not negotiating bodies—have a profound understanding of the health community in Quebec, Canada and internationally.

In keeping with the tradition of our two organizations, we are constantly seeking ways to improve the health care system in order to bring about patient-centred care. That said, we are also well aware of the budget constraints Quebec is currently facing.

Our comments will mainly address the following points:

- Access to family physicians and specialists;
- The “productivity” of Quebec physicians;
- Examples elsewhere in Canada;
- Success factors.

Physician access

Obviously, access to health care and services in Quebec is a problem, particularly with regard to family physicians.

Statistics Canada reported that, in 2013, an average 15.5% of Canadians did not have a regular medical doctor¹. Quebec, with 25.1% of residents lacking a family physician, was

¹ <http://www.statcan.gc.ca/pub/82-625-x/2014001/article/14013-eng.htm>

well above the national average. All four of the Atlantic Provinces as well as Ontario provided better access than Quebec while Manitoba and British Columbia reported rates that were about the same as the national average.

Despite considerable investment in recent years, plainly many Quebecers still do not have access to a family physician and other specialists. We do not believe the status quo is an option. Something must be done.

Unlike as provided in Bill 20, however, we do not believe that imposing patient quotas on physicians is the solution. Quotas could have the adverse effect of leading physicians to choose quantity of care over quality, which could result in incomplete examinations, increased use of diagnostic tests and, ultimately, overdiagnosis.

This is the sort of practice that the QMA and CMA have been trying to eliminate for 18 months with their “Choosing Wisely Canada”² awareness campaign, which advocates for better medicine and fewer tests and procedures of no added value. Overdiagnosis has significant impacts on cost, quality, effectiveness, efficacy and patient access to health care and, as a result, on the efficiency of the entire health care network. In short, doing more is not always better. The campaign has been embraced both by physicians and patients, but Bill 20 risks not only undermining considerable effort but also sending the public a contradictory message.

The “productivity” of Quebec physicians

The services provided by Quebec physicians have been the subject of much debate in recent months. The government’s claim that Quebec physicians are less “productive” than their colleagues in other provinces is based on a false premise. The reality is that billing methods are different and cannot be meaningfully compared.

² <http://www.choosingwiselycanada.org/>

The national data shows that 8.5% of Canadian physicians are salaried, while 41.9% are paid a fee per service and 41.4% are paid lump sums or through capitation, or a combination of the two.

Longitudinal analysis of the 2014 National Physician Survey—a partnership between the College of Family Physicians of Canada, the Canadian Medical Association and the Royal College of Physicians and Surgeons of Canada—offers a way to relativize the “productivity” of Quebec physicians compared to that of their colleagues in other provinces. For more than a decade, the survey has been a point of reference for researchers, governments and stakeholders interested in analyzing and improving health care in Canada.

The Canadian database for this study clearly shows that the gap between the hours devoted per week to direct patient services by Quebec and other Canadian physicians is shrinking. Even though physicians in the rest of Canada still report working more than their Quebec colleagues, the difference decreased 44% between 2010 and 2014 to 1.37 hours per week. For family physicians, the gap decreased 23% to 2.41 hours in 2014. Plainly, we are far from the alarming situation that has been decried in recent weeks.

Furthermore, the results show that, on average, Quebec physicians perform more than 20% more research-related activities per week than their Canadian counterparts, confirming a trend over the past 10 years.

On-call work for health care establishments should also be considered in the productivity debate as family physicians who perform such work spend on average more than eight hours per week on related tasks compared to approximately six hours in the rest of Canada. Counting specialists, the figure rises to more than 11 hours per week, compared to a bit less than eight hours per week by family physicians and specialists in the rest of the country.

In 2014 Quebec family physicians reported having to spend 23% more time each week on administrative tasks than their Canadian colleagues (2.8 hours versus 2.27 hours). This trend has become more pronounced over the past 10 years.

In short, Quebec physicians work almost as much as their colleagues in the rest of Canada. Yet they appear to be less efficient. Why? Because of the shortcomings in the way our system is organized, physicians are busy doing administrative work, seeking out clinical information that should be at their fingertips, and performing tasks that could be left to other health care professionals.

These figures, which show that the number of hours worked by physicians in direct patient care declined an average of 10% in the other provinces between 2004 and 2014, raise a question. How is it that, despite this decrease in hours worked, there is better accessibility to health care services? Because in collaboration with physicians, Alberta, Ontario and British Columbia have each successfully introduced measures in recent years to improve their services, particularly on the front line. Quebec would do well to examine those initiatives.

Elsewhere in Canada

A GP for Me

A GP for Me is an initiative in British Columbia jointly funded by the provincial government and Doctors of BC to:

- Enable patients who want a family doctor to find one;
- Increase the capacity of the primary health care;
- Confirm and strengthen the continuous doctor-patient relationship; including better support for the needs of vulnerable patients.

The mission of Doctors of BC³ is to make a meaningful difference in improving the health care for British Columbians by working to achieve quality patient care through engagement, collaboration and physician leadership. Its goal is to promote a social, economic and political climate in which members can provide the citizens of BC with the

³ <https://www.doctorsofbc.ca/sites/default/files/strategicplan-doctorsofbc-web.pdf>

highest standard of health care, while achieving maximum professional satisfaction and fair economic reward.

Ontario

Ontario chose to tackle the access problem by obtaining the support and cooperation of faculties of medicine, health organizations and the College of Physicians and Surgeons of Ontario. Two hundred family health teams (the equivalent of Quebec's family medicine groups) were created. The groups promote access to care by bringing different health care providers together under the same roof. Ontario also has more specialized nurse practitioners than Quebec does. The result of all these efforts is that two million more Ontarians can now call on a family physician.

The inspiring example of Taber, Alberta

The Taber Integrated Primary Healthcare Project⁴ is an initiative launched in the early 2000s in the town of Taber, in rural Alberta. The goal of the project was to improve health care services delivery through integration of the services provided by a physician group and the Chinook Health Region. In light of the project's success, it was expanded to the entire region five years later.

According to Dr. Robert Wedel, one of the people behind the project, four factors explain the initiative's success: a community assessment and shared planning; evidence-based, interdisciplinary care; an integrated electronic information system; and investment in processes and structures that support change.

Community evaluation and shared planning: First, successful integration of primary health care depends on gaining an understanding of individual, family and community health care needs. Health services providers and users must also have a shared vision of optimal health care delivery.

Evidence-based, interdisciplinary care: Second, the introduction of interdisciplinary teams (physicians, nurses, managers and other health professionals) facilitated the

⁴ Wedel R, Kalischuk RG, Patterson E, et al. Turning Vision into Reality: Successful Integration of Primary Healthcare in Taber, Canada. *Healthcare Policy* 2007; 3(1): 81–95.

transition from a facility-based service delivery approach to a community-based wellness approach.

Electronic information system: Third, the introduction of an integrated information system aided interdisciplinary care and access to patient information in various points of service.

Alternative payment plan: Finally, processes and structures were put in place to support change over the long term. An alternative payment plan was implemented to clarify physician remuneration, define service and productivity expectations and protect organizational autonomy.

The plan was also designed to enable physicians to delegate tasks to other professionals on the team in order to spend additional time with patients with more complex needs. The physicians now receive a fixed salary for specific services (in-clinic ambulatory services, emergencies, minor operations, prenatal care, and so on). However, some services continue to be billed on a fee-for-service basis (births, major operations and anaesthesia). Salaries are reduced when a registered patient receives care outside the physician group. Furthermore, organizational change strategies were put in place to address resistance to the changes. Modifications were made so that a common, integrated care site could eventually be established.

All these changes had significant, positive consequences in Taber but also throughout the Chinook region. This approach enables better monitoring of chronic diseases and more prevention and education services for patients. Also noted was better accessibility to care, even for vulnerable and generally underserved patients. In the early 2000s, patients had to wait about 30 days before the first available appointment, but the wait has been completely eliminated since 2006. Physician services increased about 10% and those by other professionals, 50%. Patients visit their physicians less often (2.1 visits per year rather than 5.6 visits in other regions), and a marked decline in emergency room visits and laboratory tests has been observed.

Quebec could capitalize on the Taber initiative by adapting it to the situation in Quebec and encouraging physicians to participate fully like the committed partners they are of patients and the health system.

Success Factors

Improvements from the Taber project and other initiatives in Alberta, Ontario and British Columbia—all of which provide greater health care access than Quebec—share three common features that are available to Quebec as well:

- **Electronic health records (EHRs)**

Quebec lags behind other provinces in adopting EHRs. A mere 25% of Quebec physicians order diagnostic and laboratory tests electronically.

The 2014 National Physician Survey ranks Quebec almost last in health care system computerization. The Quebec Health Record Project promised for 2011 at a cost of \$543 million has been, according the health minister himself, an abject failure. Recently he said that the Quebec government planned to deliver the project in 2021 at a cost of \$1.6 billion before adding that he was not sure there would be money to pay for it. Physicians have nothing to do with this delay or the squandering of public funds. They're ready and waiting to make use of computerized records to improve health care access and communicate better with patients.

The confusion and delays in switching to EHRs in Quebec are a big part of the reason for Quebec's poor results on the survey. Some of the problems might indeed be caused by the older generation's reluctance to embrace information technology, but that's not the whole story. We need to have a system that is absolutely reliable and accessible.

Primary care organizations in Ontario are using electronic medical records to identify and support patient needs. All Ontario's primary care organizations mentioned using EHRs in descriptions they submitted on their quality improvement plans⁵—an example of how technology can be used to monitor patient needs and support improved delivery of care. Approximately 38% described using EHRs to identify specific diseases.

We cannot overlook the fact that EHRs have been the cornerstone of the productivity improvements elsewhere in Canada.

- **Interdisciplinary work organization**

Quebec also lags behind in providing environments conducive to greater interdisciplinary work and enlisting contributions from other health professionals (nurse practitioners [NPs], nurses, managers and other health professionals). Certain Canadian provinces are far ahead in this area. Team care allows the various professionals to do their regular tasks and delegate when the situation calls for it.

The solutions that have put most Canadian provinces on the road to solving the problem of frontline health care access have generally come through collaboration between the government and the medical profession. With effective information systems and the implementation of interdisciplinary approaches, in a spirit of cooperation and collaboration, such health care systems manage to provide the kind of accessible, high quality care patients and taxpayers are entitled to expect when they need it.

⁵ <http://www.hqontario.ca/portals/0/Documents/qi/qip-analysis-pc-en.pdf>

The bottom line is that interdisciplinary work allows physicians to do what they do best: diagnose and treat.

○ **Remuneration practices for population-based responsibility**

Quebec seems to be the Canadian province where physician remuneration is closest to a fee-for-service model. Quebec Health Insurance Plan data from 2013 shows that close to 80% of Quebec physicians' total compensation is fee-for-service.⁶ Elsewhere in the country, mixed remuneration methods appear to make it easier to foster population-based responsibility, i.e., not just covering a territory, but also incorporating the determinants of population health and well-being, among which are access to high quality services and the full participation of all stakeholders.

In its 2011 support strategy for the practice of population-based responsibility⁷, MSSS spelled out the government's approach. However, that strategy was developed around local service networks managed through CSSSs, which were recently done away with by Bill 10, *An Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies*.

The authors of the strategy define population-based responsibility **collectively**, as follows:

- **Using health and social services data** to develop a shared picture of the reality on the ground;
- **Deciding**, in consultation with the public, partners in the health and social services network and other sectors, **on a basket of integrated, quality services** to meet the needs of the local population;

⁶ Régie de l'assurance maladie du Québec. Évolution du coût des services médicaux et du nombre de médecins selon le mode de rémunération. Services médicaux, Québec, 2009-2013.

⁷ <http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2011/11-228-04W.pdf>

- **Strengthening actions on health determinants** in order to improve the health and well-being of the entire local population; and
- **Tracking performance and seeking ongoing improvements**, in the interests of greater accountability

Implementing population-based responsibility clearly requires a **collective** approach. Nothing in Bill 20 appears to indicate that the government might arrive at such an approach.

No discussion of population-based responsibility would be complete without considering the Kaiser Permanente model. Kaiser Permanente is a nonprofit organization whose mission is to provide high quality, affordable health care services and improve the health of its members and the communities it serves. Approximately 9.9 million people receive health care from Kaiser Permanente, which has 17,000 physicians and 174,000 employees (including 48,000 nurses) working in 38 hospitals and medical centres and more than 600 clinics.

The organization lists five keys to its model's success:⁸

1. Accountability for population
2. Transparency
3. Use of electronic health records and the Internet
4. Team care
5. Moving care out of doctor's office

There are no provisions in Bill 20 for developing any of the above.

Clearly, the fee-for-service model does not encourage population-based responsibility. We have seen in the Taber example a broad basket of services covered in the clinic's overall budget, with other things remaining fee-for-service (births, major operations, anaesthesia etc.).

⁸ Molly Porter. *An Overview of Kaiser Permanente: Integration, Innovation, and Information Systems in Health Care*. Presentation for the Canadian Medical Association, Kaiser Permanente International, March 2, 2015.

The way physicians are currently compensated stands in the way of any strategy whereby physician groups would receive fixed budgets to care for a given population. This is where Bill 20 goes off track—by individualizing patient targets instead of grouping them. Under group approaches, a physician who fails to meet commitments and does not see the required number of patients risks repercussions from colleagues and not the government, because the physician is responsible for contributing to the group's objectives. A physician in that same clinic who sees only complex cases will necessarily see fewer patients, but colleagues will be freed up to deal with more.

We sincerely believe that physicians are in favour of a population-based responsibility approach. Yet the inescapable conclusion is that Bill 20, with its fee-per-service and individualized appointment targets, is taking us in a different direction entirely.

We are convinced that physicians are overwhelmingly in favour of mixed compensation methods. The health and welfare commissioner launched a series of studies to assess the impact of remuneration on health system effectiveness and efficiency. As soon as RAMQ data becomes available, researchers will be able to complete their work and show how adjusting remuneration methods would contribute to improving health care access.

Conclusion

It is no coincidence that we have not attempted a clause-by-clause critique of Bill 20. The government's entire approach needs to be changed. It is high time the government understood that physicians are part of the solution to health service access problems, and that a coercive approach is counterproductive and demoralizing.

History is full of examples in which working together in a climate of mutual respect led to impressive results. Both the QMA and CMA fully support the idea and purpose of the bill—to improve access to health care—but we believe Bill 20 is not the answer. We think changes worked out in partnership get the best results. All real improvements to the health care system have always been achieved in an atmosphere of dialogue and collaboration.

To sum up, the QMA and CMA recommend first and foremost that the government work with the medical profession to improve access to health care, as well as the following measures:

- ❖ Speed up the process of switching to electronic health records—an indispensable tool in 2015.
- ❖ Reorganize tasks to accord a greater role to other health professionals (NPs, nurses, administrators and others) by forming care teams that can pool their knowledge and skills to better serve patients.
- ❖ Reconsider Quebec's near-exclusive reliance on fee-for-service and consider bringing in a form of mixed remuneration that leads towards a population-based responsibility model. Elsewhere in Canada, this approach has contributed significantly to improvements in health care access, particularly on the front line.