



The Future of Healthcare in Canada 2005-2012

Brief Overview

This overview contains a small portion of the total report on the Future of Healthcare in Canada. The most significant omission is a detailed description of the most promising solutions to existing problems, as well as a more in-depth description of the issues.

For information about the complete report including the cost of purchase, please contact:
Dr. Edwin L. Weinstein, 416.585.2414
edwin.weinstein@brondesbury.com

TABLE OF CONTENTS

1.0	INTRODUCTION	2
2.0	HEALTHCARE OBJECTIVES	3
2.1	Patient Experience	4
2.2	System Focus	5
2.3	How objectives changed over the past decade	6
3.0	FORCES AT WORK IN HEALTHCARE	7
4.0	THE FUTURE OF HEALTHCARE	11
4.1	Patient Experience	11
4.2	Operation of the Healthcare System	12
4.3	Improving Population Health	13
4.4	Closing Comments	13

1.0 INTRODUCTION

On behalf of The Brondesbury Group and the sponsors for this study (Royal Bank of Canada and Manulife Financial); we would like to thank our opinion leaders, for their participation in The Future of Healthcare Study.

In recognition of their help, we have the pleasure of providing this overview of our findings. Please note that this Brief Overview is a condensed version of the full study itself. For information on the full report, please direct your inquiries to edwin.weinstein@brondesbury.com.

Overall, the purpose of the study is to identify how healthcare delivery will change over the next 5-7 years. Why these changes will happen and the impact they will have is critical for understanding the changes. Our analysis aims to assess the impact of changing from “in-patient care” to “patient care”.

In addition to this Introduction, the Brief Overview is organized into three sections: Healthcare Objectives; Forces at Work in Healthcare; and The Future of Healthcare.

Our analysis relies on face-to-face structured interviews with ‘opinion leaders’. Simply put, **opinion leaders are the people who make the future happen**. Because of their leadership role, their views of the future are more accurate than others. To ensure that their views are comprehensive, we have carefully built a diverse group from different parts of the healthcare system. Converging views from a well-rounded group like this are far more predictive than those from any single constituency.

We summarize what opinion leaders say as “independents”. We have no vested interest in the outcomes, other than portraying them accurately. We represent no special interest group nor do we represent any single industry sector. The sponsors for the work are also neutral parties. We are simply seeking to identify convergent views of the future and the logic behind them.

Each opinion leader interview took about two hours to complete. The interview structure was designed to help opinion leaders identify **what will happen** in the future. The structure aimed to avoid the trap of seeing the future in terms of what should happen, by leading commentators through a process that helps them build a rationale for what will happen.

2.0 HEALTHCARE OBJECTIVES

While our 55 opinion leaders mentioned nearly 200 objectives, we find it useful to divide the objectives into two groups; those that directly affect the patient experience and those that affect the healthcare system. By 'patient', we mean any person actively seeking or using the services of the healthcare system regardless of when, where or why.

Four objectives directly affect the **patient experience**.

- Improving access to healthcare;
- Improving quality of healthcare;
- Reducing adverse patient events; and
- Delivery of care to patients.

Another four objectives primarily focus on **system operations** rather than the direct patient experience:

- Improving the cost-effectiveness of healthcare;
- Fostering change in healthcare;
- Education of healthcare professionals; and
- Research on healthcare-related issues.

One additional objective straddles the two groups. It is not actively sought out, but affects both the patient experience and the healthcare system itself. That objective is:

- Improving population health.

2.1 The Patient Experience

Exhibit 2.1 shows the objectives that directly affect patient experience and how often each objective is mentioned by each type of opinion leader. Some key points that we want to raise are:

- Improving access to healthcare is the most common patient experience objective.
- Improving quality of care and reducing adverse patient events are both mentioned frequently.
- Hospital corporations had the most diverse objectives having to ensure day-to-day delivery of care as well as improving access to their services.

2.1 Patient Experience Objectives	Improve Access to Healthcare	Improve Quality of Healthcare	Reduce Adverse events	Deliver care to Patients
Academic				
Community Health				
Consultants				
Councils & Associations				
Government				
Hospital Corporations				
Long-Term Care & Rehabilitation				
TOTAL (w/o duplications)				

Almost Always	
Often	
Seldom	
Almost Never	

2.2 System Focus

Exhibit 2.2 shows the objectives that focus on the healthcare system itself and how often each objective is mentioned by each type of opinion leader. Some key points that we want to raise are:

- Fostering change is a particularly prominent objective among opinion leaders in long-term care and rehabilitation.
- Improving the cost-effectiveness of healthcare is the most commonly stated type of objective among government opinion leaders.
- Improving population health is most likely to be a focus of community health groups plus councils & associations.

2.2 System Objectives	Improve Population Health	Cost-Effective Healthcare	Foster change	Education & Research
Academic				
Community Health				
Consultants				
Councils & Associations				
Government				
Hospital Corporations				
Long-Term Care & Rehabilitation				
TOTAL (w/o duplications)				

Almost Always	
Often	
Seldom	
Almost Never	

2.3 How Objectives Changed Over the Past Decade

When this study was first done in 1996, the focus of change was ‘hospital care’ rather than ‘healthcare’. Only three major objectives were needed to describe the aims of opinion leaders:

- Deliver cost-effective healthcare.
- Improve health.
- Provide leadership in healthcare.

Ten years ago, cost-effective delivery was solely a hospital issue. Cost-effective delivery is now more of a system issue and care providers are more focused on the patient experience than on delivery cost. Increasingly the patient experience is viewed as an ongoing set of events that requires coordination between multidisciplinary primary care teams and the many other facets of the healthcare system. Access and quality of care involve a far more diverse group of professionals than the hospital-centric model of 1996. And in fact, coordination of care among diverse healthcare providers is seen as a core part of efforts to reduce adverse patient events.

Leadership now means “fostering change” at a system level, not just within a hospital. It involves large scale structural changes in health care including IT infrastructure, planning for pandemics, developing strategies for critical shortages of health professionals and a host of other systemic issues.

In 1996, most of the opinion leaders we interviewed were pessimistic about the future. **Despite the negativity of the press, we find the opinion leaders of today are far more optimistic about the future.** There is a sense that many of the solutions to our problems are known, and while it will be difficult to implement these solutions, there is good reason to believe our healthcare system will improve over the next decade.

3.0 FORCES AT WORK IN HEALTHCARE

After weighing the many comments on this topic, we find that opinion leader comments focus on some 17 forces that are shaping the future. The list is longer than our 1996 list of forces, reflecting the increased complexity of healthcare today and the broader scope of this study.

We now identify the forces at work that are affecting the achievement of objectives. Our discussion focuses on the forces that opinion leaders cited as having the greatest impact on the achievement of their objectives. The politicized nature of healthcare is reflected by the fact that **social-demographic and political forces are seen to have a bigger impact on outcomes than economics or technology.**

Political-Regulatory Forces

There were nearly 200 comments about political-regulatory forces affecting healthcare. The comments point to four forces shaping the future. The impact of these forces may vary by region and organization, but none of these forces can be overlooked.

1. Public pressure is forcing political action.
2. Governments are not providing **coordinated** leadership.
3. The election cycle affects the initiatives that get funded.
4. Jobs are a political issue.

Public pressure for political action is a positive force for change in health. It is moderately positive now and is expected to have more impact about 2009-10.

The other three political forces are all negative. **Lack of coordinated government leadership is seen as the biggest obstacle** to success among forces of all kinds, but coordination will improve steadily over the next seven years. By contrast, the impact of the election cycle on what gets funded is also an obstacle, but this is not expected to change. The political nature of healthcare jobs is less of an obstacle than the other two negative political forces and it will move towards the neutral point as issues are resolved over our seven-year time horizon.

Economic Forces

The three most critical economic forces shaping the future of healthcare are widely agreed upon. They are also inextricably related to one another.

1. Costs are rising faster than inflation or GDP.
2. Drive to increase cost-effective use of limited resources.
3. Lack of information on supply, demand, capacity and output allows inefficiencies.

A fourth economic force is often mentioned, but necessarily more political in nature, namely:

4. Traditional methods of compensation are increasingly dysfunctional.

Rising costs are the most cited economic force and also the economic force with the most negative impact. Costs are certainly a barrier to achieving objectives and the problem will only start improving some 5 years from now. The drive to increase cost-effectiveness is seen as a barrier to achieving some objectives now, but it will move toward a neutral impact over time.

Lack of information about supply, demand, capacity and output are recognized as creating the potential for inefficiencies. This recognition is helping foster change in healthcare, and the pressure to get this information to improve efficiency is expected to increase over the next 5 to 7 years.

Traditional methods of compensation are recognized as an issue and governments are trying a variety of funding schemes to make compensation more tightly related to objectives, both at the level of the healthcare professional and at the organizational level.

Social-Demographic Forces

There are four major demographic forces cited as shaping the future of healthcare:

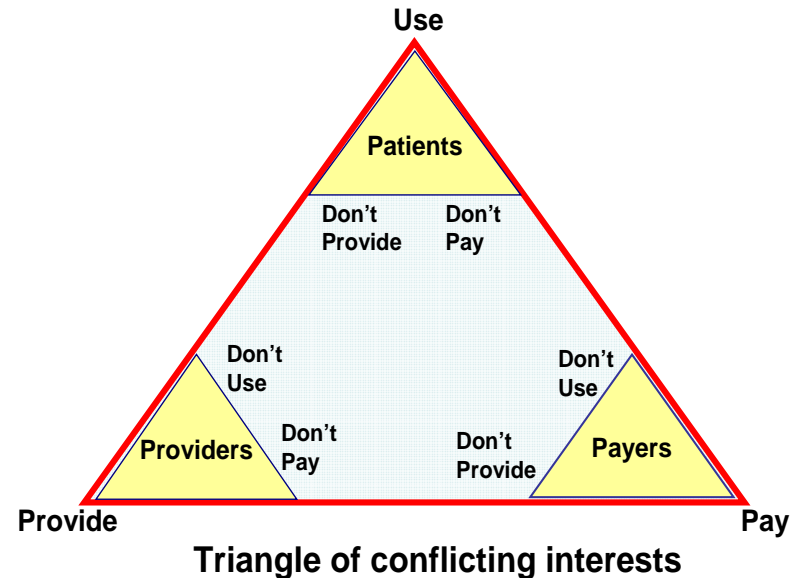
1. The aging of the Canadian population
2. More chronic illness in the population
3. Shortage of skilled healthcare personnel
4. Consumers expect a “patient-centric” system

Surprisingly, the one single force that was deemed high impact by the largest number of people is the shortage of skilled healthcare personnel. This is not the largest negative force at work, but rather it is the negative force that interferes with the achievement of the largest number of objectives.

Offsetting this belief is a visible increase in training and retraining of healthcare professionals in some jurisdictions. The net result is a problem that will remain across our seven-year time horizon.

The aging of the Canadian population also impacts healthcare, imposing an extra burden that makes it more difficult to positively change the system. **Consumer demands for patient-centered service will be the leading social force for change by 2010.**

One of the major problems in creating a cost-effective patient-centered system is reconciling the conflicting interests of the various parties to the health system including patients, care providers, and those who pay for the care of others (i.e., government and employers).



Technological Forces

Opinion leaders believe that five forces characterize technological change today.

1. Changes in drug care are significant.
2. Diagnostic imaging is high demand.
3. New technologies raise ethical questions.
4. IT infrastructure is essential to improved costs and outcomes.
5. Willingness to adopt new technology is uneven.

Technology offers a set of tools that mitigate the impact of negative economic forces like inefficient care.

Technology does come with a cost, but overall technology is seen as a positive force for change in healthcare.

IT infrastructure is the single most positive force that we encountered. In tandem with IT infrastructure is the willingness to adopt technology, whether that is IT or treatment technology.

The impact of drug care is much more ambivalent. While there is great promise to some of the drugs on the horizon, their cost mitigates their benefit. Some 5 years from now the cost-impact of drug care is expected to stabilize.

4.0 THE FUTURE OF HEALTHCARE

As we stated earlier, despite the negativity of the press, the opinion leaders are far more optimistic about the future than in 1996. The problems are known and their solutions, though difficult to implement, have been identified.

The strategies that opinion leaders are implementing and the changes they envisage point to the key theme for the next decade being “Integration”. This reflects three essential trends: coordination, participation and shared responsibility.

In turn, our view of the future, according to our opinion leaders’ objectives was organized into three groups:

1. Improving the Patient Experience;
2. Improving the Operation of the Healthcare System;
3. Improving Population Health.

4.1 Patient Experience

Here the focus is on improving the quality of care, providing timely access and reducing adverse patient events. The pursuit of these objectives will be through a number of fundamental changes:

- ❖ Costs will be shifted away from the public healthcare system and a larger burden of care will be shifted to the patient;
- ❖ Better management of demand, supply, capacity and delivery; and
- ❖ Better coordination of healthcare professionals in delivery of patient care.

The Primary Healthcare Team (PHT) is the foundation of integrating healthcare. The numbers of PHTs are expected to increase after 2008 while their role will expand as in-patient care moves to day surgery and ambulatory care. By 2008 it is anticipated that PHTs will be the focus for coordinating assessment and treatment.

A priority for the healthcare system between 2008 and 2012 will be the cost-effective management of chronic disease. PHTs with patient education and mutual support groups will attempt to keep patients out of hospital and slow/halt the impact of the disease.

Lastly other initiatives that will improve the patient experience are:

- ❖ Telehealth;
- ❖ Satellite treatment centers for tertiary care facilities; and
- ❖ Integrated practice standards and care guidelines.

4.2 Operation of the Healthcare System

Improving the operation of the system involves fostering change, educating professionals, research on key issues and improving the cost-effectiveness of healthcare. The strategies for change are complements to those for improving the patient experience.

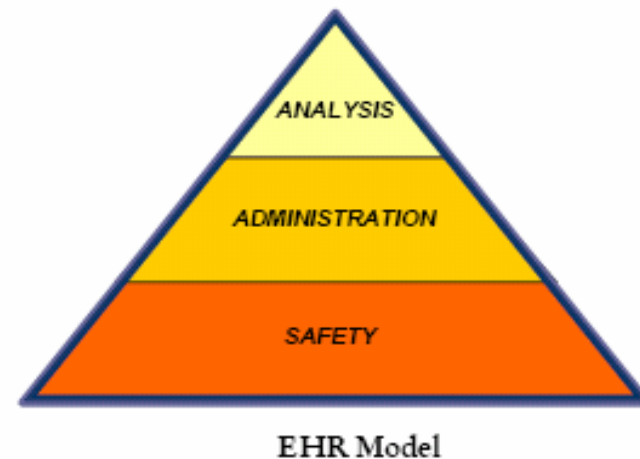
The following are some of the strategies/changes envisaged.

- ❖ Public-private partnerships (P3s) will play a big part in realigning infrastructure costs.
- ❖ There is consensus that by 2008, the provinces will have a good grasp of the supply of services (as long as IT is in place).
- ❖ Over the next four years, it is expected that staffing shortages will be recognized by increases in enrolment.
- ❖ A move to establish a compensation scheme that meets the goals of balancing supply and demand. Opinion leaders expect several compensation methods to be tried with some consensus on “best practice” emerging around 2009-2010. Base pay plus an ‘encounter fee’ is the most common alternative scheme mentioned.
- ❖ There will be interim solutions for compensating large healthcare organizations over the next 3-4 years; outcome based solutions will follow in 2010-2012.
- ❖ Better sharing of vetted information about patients, treatments, outcomes and supply of services.
- ❖ Ending of regionalization of administration and uploading of select functions (like IT) back to the provinces (2007-8).

- ❖ More coordination and outsourcing of non-core management functions (2008-9).
- ❖ More management focus on all types of risks (2010-11).
- ❖ In terms of medical technology integration, we expect to see common review of drugs and new technology (2007), core drug formulary for provinces (2008) and multi-province drug buying (2009-10).

Underwriting virtually all of the above initiatives and changes is the evolution of an IT infrastructure. There are two IT goals that opinion leaders support:

- ❖ Evidence-based decision making systems for resource allocation at the operational level; and
- ❖ A comprehensive electronic health records (EHR) info-structure that allows appropriate health providers across Canada to access authorized patient information.



IT systems are expected to support the development of evidence-based treatment standards around 2008. Most development will not occur until 2011-12. Privacy issues will be dealt with piecemeal and only when there is nationally harmonized privacy legislation will there be national access to EHR.

The general consensus for EHR is that should focus on local information first and then move to strategies that generate new information.

4.3 Improving Population Health

Chronic disease management and personal responsibility for health are the main issues. The following are the opinions voiced.

- ❖ Shift of healthcare to the patient, their family and peers. The push for self-help will be strong in 2009 when shortages in healthcare personnel make it necessary.
- ❖ Patients will be educated about how to prevent further deterioration and how to self-monitor.
- ❖ Better information for chronic disease patients on where they can get treatment quickly.
- ❖ Prevention work is expected to be more targeted by 2009-10.
- ❖ Health promotion efforts will support early identification programs and CDM.

4.4 Closing Comments

As a final note, we offer an editorial comment. Opinion leaders have predicted events they believe will happen over the next 5-7 years, whether that is what they personally desire or not. Based on our 1996 study, we believe it is realistic to assume these events will largely happen as predicted, but they will take 10 years to unfold, rather than the 5-7 years that opinion leaders expect. Nonetheless, if history repeats itself, these opinion leaders will indeed shape the healthcare system into a more sustainable public system over the next decade.

The full study report contains a detailed examination of successful strategies used by healthcare organizations across Canada. For further information about purchasing the full report, please contact edwin.weinstein@brondesbury.com .