Commentary: Improving the Sustainability of Healthcare in Canada through Physician-Engaged Delivery System Reforms

Commentaire : Favoriser la durabilité des soins de santé au Canada grâce à l'engagement des médecins dans la mise en œuvre des réformes du système

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Abstract

Increasing private healthcare financing has been suggested as a solution toward improving healthcare quality and access within the Canadian healthcare system. However, Lee et al. (2021) find no evidence that increasing private financing would address the challenges faced by Canadian healthcare. We suggest turning our focus away from reforms that solely increase private healthcare financing and toward evidence-based delivery-system reforms to address both quality and sustainability. We present examples and supporting evidence of the effectiveness of patient-, physician-, organization- and system-level strategies. Changes should engage physicians and be implemented across Canada to facilitate a cultural shift toward experimentation and high-value care delivery.

Résumé

L'accroissement du financement privé des services de santé est considéré comme une solution pour améliorer la qualité et l'accès aux soins dans le cadre du système de santé canadien. Toutefois, Lee et coll. (2021) n'ont décelé aucune donnée voulant que le financement privé

soit la solution pour répondre aux défis propres aux services de santé au Canada. Nous proposons de déplacer l'attention des réformes qui visent uniquement l'accroissement du financement privé, pour se tourner vers des réformes fondées sur les données probantes et qui visent la qualité et la durabilité des services de santé. Nous présentons des exemples ainsi que des données venant appuyer l'efficacité de stratégies axées sur les patients, les médecins, les organisations et le système. Les changements devraient mobiliser les médecins et être mis en œuvre partout au Canada pour favoriser un changement de culture qui vise la prestation et l'expérience de soins de haute qualité.

Realities of the Canadian Healthcare System

Canadian healthcare currently faces daunting challenges across the healthcare system. These include the availability of ICU and hospital beds for people with COVID-19; waiting times for surgeries and specialist visits; the affordability of pharmaceutical drugs; escalating costs of physician care accompanied by lack of physician accountability; concerns about the quality of care in some long-term care residences; health disparities resulting from social, political, and economic inequities; and the rising prevalence of chronic diseases. The growth in healthcare spending looms large. Solutions to these problems must take into account the principles of medicare (universality, portability, comprehensiveness, public administration and accessibility) and the reality of operating in a system with limited resources.

Expanding private healthcare has been proposed repeatedly as a potential solution to the problems identified in publicly funded care, including changes to private healthcare financing (i.e., payments from individuals and/or third-party non-government insurers) and private healthcare-service delivery (e.g., private radiology or surgical services). Proposals to expand private duplicative insurance (e.g., *Chauolli v Quebec* 2005) and overturn restrictions on patient fees within medicare and on physicians working in both publicly and privately funded systems (e.g., *Cambie Surgeries Corporation v British Columbia* 2020) have been hashed out in courts, while suggestions to deliver surgical procedures with long wait times in privately owned facilities (Babych 2019) have been debated in the court of public opinion. And the discussion continues. For instance, the United Conservative Party of Alberta recently passed a platform policy at its annual general meeting, recommending the establishment of private insurance and overturning of restrictions on patient fees and physician dual practice (Bench 2020).

More Private Financing Is Not a Solution, So What Is?

Could *more* privatization be a solution to medicare's problems? Lee et al. (2021) examine this question in their article "Increased Private Healthcare for Canada: Is That the Right Solution?" Using data from published health indices, they estimated the association between private financing – defined as private for-profit insurance and private out-of-pocket *financing* – and a series of outcomes that reflect universality, accessibility, equity, quality, overall

system performance, health outcomes and health spending growth. They found that health systems with more private financing were associated with significantly higher markers of lower universal coverage and poorer equity, accessibility, quality and overall performance. There was no association between countries with more private financing and improved health outcomes or healthcare spending growth.

After finding no signal suggesting that increasing private healthcare financing would help address the challenges faced by the Canadian healthcare system, Lee et al. (2021) raise a number of thoughtful questions to consider as we face these challenges: How can we make public healthcare in Canada more comprehensive? If we expand public financing, how can we control the demand for covered public health services in a way that does not reduce access to medically necessary services? If we expand private financing, how do we design and regulate that system to prevent insurance companies from not accepting sick patients, not offering comprehensive services, charging high copays and putting restrictive treatment limits in place?

Canadian healthcare reform does not have to focus on just one of the questions Lee et al. (2021) raise, and perhaps financing reform is not where we should focus at all. The *Patient Protection and Affordable Care Act* (Office of the Legislative Counsel 2010) in the US (also known as Obamacare) provides an example of a healthcare policy that simultaneously attempted to address many components of healthcare financing and delivery. Because of the fractured nature of healthcare financing in the US, Obamacare included changes to both public and private insurance, including the expansion of public insurance coverage and covered services, regulation of private insurance, subsidies to buy private insurance and elimination of patient copays for important services such as primary care visits and essential medications. While less publicized, Obamacare also launched delivery system reforms (Emanuel et al. 2020). These reforms focused on improving care coordination and reducing inefficiencies by changing the way physicians and hospitals are organized, paid and evaluated. Most importantly, these reforms fostered a culture of experimentation and instilled feelings of anticipation and acceptance for a shift away from fee-for-service payments.

Lee et al. (2021) also discuss another key question: regardless of who pays for it, how do we create a sustainable healthcare system that reflects our values? Spending on physicians is a substantial area of healthcare spending (15.1%) and is growing at a higher rate (3.5%) than spending on hospitals and drugs (CIHI 2019). Improving the value of physician services by improving the outcomes achieved relative to the dollars and resources invested is a key area to focus our efforts on so as to address healthcare sustainability. Reforming how Canadian physicians are organized, paid and evaluated could – as it did in the US – generate a cultural shift toward experimentation and away from fee-for-service payments. As physicians are powerful players in the Canadian healthcare system (Flood et al. 2018), implementing physician-focused reforms would require physician engagement and synchronous changes in governance, payment and accountability for such reforms to be successful (Marchildon and Sherar 2018).

Physician-Engaged Delivery System Reforms: Examples and Evidence

Before implementing any healthcare reform, it is important to examine the effectiveness of the strategies that might improve the value of the healthcare system (many of which require the engagement and partnership of physicians or would impact physicians). Such reforms to increase the use of high-value care and reduce the use of low-value care may be implemented at different levels of the healthcare system: patient- and clinician-level, organization-level and system-level. The evidence supporting these strategies is taken from a recent working paper that sought systematic reviews on each of these strategies (Table 1) (Farkas et al. 2020). Selected examples are highlighted in the following sections.

An example of reform at the patient level is shared care, meaning patients and physicians are partners in clinical decision making. Shared care is considered a key element of patient-centred care in several health systems. However, a recent systematic review identified 83 randomized controlled trials evaluating shared care (many with a high risk of bias) and found an uncertain effect of shared care on healthcare costs (Légaré et al. 2018). At the physician level, one of the central tools to support practice change is audit and feedback, which can facilitate performance measurement and improvement. A Cochrane review evaluating audit and feedback noted an overall improvement in outcome attainment of 4% (range: 0.5–16%) (Ivers et al. 2012). The range reflected the extent to which the intervention included the best practices known around audit and feedback. At the organization level, policies or interventions include prompts in electronic health records that encourage the use of high-value interventions or tests and discourage the use of low-value interventions and tests. A Cochrane review of electronic prompts and decision aids concluded that these interventions are effective in reducing costs (Stacey et al. 2017).

System-level reforms include changes to payment models, with the aim of moving away from fee-for-service models in areas where high-volume care is not warranted. Fee-for-service payment remains the dominant model of physician remuneration in Canada, despite concerns that it incentivises volume over value. Fee-for-service is associated with higher utilization (particularly for elective procedures) when compared to other payment models, but evidence of the impact on outcomes such as quality and cost is mixed (Gosden et al. 2000; Quinn et al. 2020). Accountable care organizations (ACOs) have been introduced in the US as a mechanism to improve care integration and the use of high-value care. There is limited evidence that ACOs have led to financial savings; however, evaluation has been challenging due to the widespread delivery-system changes occurring at the same time in the US. It remains to be seen whether the introduction of ACOs could benefit healthcare in Canada (and what their impact might be), though improving care integration is a laudable goal because it is associated with high-performing healthcare systems (Canadian Nurses Association et al. 2013; Curry and Ham 2010; Suter et al. 2009).

TABLE 1. Strategies for incentivising value in healthcare system delivery, by level of implementation

Healthcare system level	Strategy	Description	Evidence
System	Encourage/enforce use of evidence-based data	Clinical guideline development and health technology assessment; computerized care pathways (e.g., the "do-not-do" recommendations featured in "Choosing Wisely" campaigns)	Evidence suggests that these strategies can change practice behaviour and reduce costs (Goetz et al. 2015; Rotter et al. 2010)
	Medical staff by-laws or other regulations aimed at regulating physician practice	Ministerial directives; clinical rules	No systematic review evidence was identified for this strategy
	Compensation reform	Reimbursement for care coordination; implementation of payment models other than fee-for-service; monetary and non-monetary incentives	Evidence of effectiveness in changing utilization and compliance with desired practice for some non-fee-for-service payment models (Chaix-Couturier et al. 2000; Mendelson et al. 2017; Quinn et al. 2020; Witter et al. 2012)
	Constrain resources through regulation	Restrict use of certain tests and treatments	Inconclusive evidence (Flodgren et al. 2011a)
Organization	Leadership inclusion, endorsement and support	Promotion of cost-conscious care by clinical champions and senior leaders	Inconclusive evidence of improving compliance with desired practice (Flodgren et al. 2011b)
	Decision-support tools and electronic prompts	Point-of-care access to effectiveness, cost and quality information	Evidence on effectiveness in reducing costs (Stacey et al. 2017)
Physician	Education	Creating and facilitating easy access to education about care quality, value, and decision making	Evidence of effectiveness in improving compliance with desired practice (Forsetlund et al. 2009)
	Mentorship	Encouraging reflective practice and co-learning	Evidence of effectiveness in improving compliance with desired practice, delivering appropriate care and reducing costs, volume or unnecessary procedures (O'Brien et al. 2007; Stammen et al. 2015)
	Audit and feedback	Individual and group performance measurement and management, including clear accountabilities in response to information	Evidence of effectiveness in improving compliance with desired practice (Ivers et al. 2012)
Patient	Shared decision making	Involving patients as partners in clinical decision making; discussing options for treatment, including prices and value of treatment options	Uncertain effect on costs (Légaré et al. 2018)

Adapted from Farkas et al. 2020

Conclusion

At its core, healthcare is about a caring relationship between a patient and a provider. We agree with Lee et al. (2021) that increasing private financing as a solution toward improving universality, accessibility, equity, quality, overall system performance, health outcomes and health spending growth is not supported by the evidence. We suggest turning our focus away from financing reforms and toward evidence-based delivery-system reforms. Engaging physicians in these reforms and implementing structures to foster sustained physician engagement will be critical in order to successfully improve the quality and sustainability of the healthcare system.

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