What Brazil can learn from Canada’s primary health care

Michael M. Rachlis MD MSc FRCPC LLD

www.michaelrachlis.com

Brasilia Brazil CONASS April 24, 2012
Outline

• Introduction to Canada, its health care system, and primary health care
• Canada’s primary health care system’s problems, diagnosis, and attempted solutions
• What can Brazil learn from Canada?
Tommy Douglas Father of Canadian Medicare
<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Population</strong></td>
<td>34 million</td>
<td>314 million</td>
<td>81 million</td>
<td>206 million</td>
</tr>
<tr>
<td><strong>Area (km²)</strong></td>
<td>9,984,670</td>
<td>9,826,675</td>
<td>357,022</td>
<td>8,514,877</td>
</tr>
<tr>
<td><strong>GDP ($US PPP)</strong></td>
<td>$40,300</td>
<td>$48,100</td>
<td>$37,900</td>
<td>$11,600</td>
</tr>
<tr>
<td><strong>Public Debt as % of GDP</strong></td>
<td>84%</td>
<td>69%</td>
<td>82%</td>
<td>54%</td>
</tr>
<tr>
<td><strong>Gini coefficient</strong> (higher is more unequal)</td>
<td>32</td>
<td>45</td>
<td>27</td>
<td>52</td>
</tr>
</tbody>
</table>
Canada is increasingly a low tax country
Government outlays as % of GDP

Canadian and US Govt Outlays as % of GDP

<table>
<thead>
<tr>
<th></th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality/10³</td>
<td>4.9</td>
<td>6.0</td>
<td>3.5</td>
<td>20.5</td>
</tr>
<tr>
<td>Life Expectancy</td>
<td>F 84.2</td>
<td>F 81.1</td>
<td>F 82.6</td>
<td>F 76.5</td>
</tr>
<tr>
<td></td>
<td>M 78.9</td>
<td>M 76.1</td>
<td>M 77.9</td>
<td>M 69.2</td>
</tr>
<tr>
<td>&gt; 65 years</td>
<td>15.9 %</td>
<td>13.1%</td>
<td>20.6%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Migrants/1000</td>
<td>5.7</td>
<td>3.6</td>
<td>0.7</td>
<td>- 0.1</td>
</tr>
<tr>
<td>Birth rate/10⁰₀₀</td>
<td>10.3</td>
<td>13.7</td>
<td>8.3</td>
<td>17.5</td>
</tr>
</tbody>
</table>
Canada: Political Organization

- British parliamentary government
- An American style Charter of Rights and Freedoms
- Ten provinces and three territories
- The 1982 Constitution enshrines equality between provinces
- The world’s most decentralized federation – The federal government is only about 40% of the public sector
- The federal government is responsible for foreign affairs, defense, and criminal law
- The provinces are responsible for health care, education, and social services
- Quebec has special status
Canada: Political Organization

• The federal government and the provinces *share authority* over public health, the environment, and other key policy areas

• Canadian governments fight constantly
  – Have you seen us play hockey?
Canada’s Health Insurance history

• **1947** Saskatchewan legislates hospital insurance
• **1957** Federal hospital insurance legislation
• **1962** Saskatchewan legislates medical insurance
• **1968** Federal medical insurance legislation
• **Late 1970s and early 1980s** doctors and hospitals in several provinces begin to extra-bill patients beyond the public insurance fees
• **1984** Federal government legislates the Canada Health Act banning extra-billing
  – Only covers doctors and hospital care
Canada Health Act principles

• **Universality**  
  – All Canadian residents must be covered

• **Comprehensiveness**  
  – All “medically necessary” physicians and hospital services must be covered

• **Accessibility**  
  – No user charges for insured services

• **Public Administration**

• **Portability**
Canada’s Health Insurance

• Universal coverage for medical and hospital care – No user charges at point of service
• Mainly private coverage for dental and optical
• Mixed public private coverage for pharmaceuticals, long-term care, home care, and durable medical equipment
• Except for hospitals and doctors, coverage varies substantially from province to province
  – The wealthier provinces – Ontario and the west – have much better coverage for non Canada Health Act Services
Canada’s Health Care System

• Not “Socialized Medicine”
• Canadian health care, like other aspects of our social policy, is “mid-Atlantic”
• Canadian Medicare is characterized by “Private Practice: Public Payment” (CD Naylor. 1986)
  – Most doctors are self-employed and bill provincial health plans on a fee-for-service basis and
  – Doctors have little private income
• In most provinces, regional health authorities own and run hospitals, long-term care, home care, mental health, and public health
Quebec

Area: 1,542,056 km²
(Largest Province)

Population: 7,500,000
(Second most populous province)

Montreal
Canada’s 2nd largest city.
Area Population 4 Million
Quebec’s health system

• One Ministry of Health and Social Affairs
  – Other provinces separate these ministries

• 18 regional health authorities (Agence de santé et des services sociaux or ASSS)
  – Regional coordination and evaluation

• 95 local health agencies (Centres de santé et services sociaux or CSSS)
  – Includes all services except private practice doctors
  – CSSSSs employ ~ 15% of doctors
Quebec’s primary health care

• From the 1980s until 2004, the province had a network of 160 Community Health Centres with salaried doctors, other professional staff, and a focus on improving population health

• As part of the 2004 reforms, the Community Health Centres were integrated with smaller hospitals and long-term care facilities to create the 95 local health agencies CSSSs

• About 15% of family doctors are salaried employees of the CSSSs
  – Much higher than in other Canadian provinces
Quebec’s primary health care

• As in most provinces, most Quebec family doctors have their own practices but 99% of their income comes from fee for service payments from provincial health insurance plans
  – Most practices are small (< 3 doctors) and usually do not include nurses or other healthcare providers

• About 20-30% of family doctors are part of 230 Family Medicine Groups which have electronic records and small numbers of nurses – 1 nurse: 5-10 doctors
Purpose of the Family Medicine Groups

• extend the hours of access to family physicians;
• ensure that family physicians are more available through working in groups and sharing activities with nurses within an family medicine group;
• improve patient follow-up and service continuity by strengthening links with other healthcare providers such as the public family medicine clinics run by the CSSSs.
Quebec’s system has done fairly well

• Quebec has integrated health and social services better than other provinces

• Quebec has strong public health
  – All provincial policies are supposed to be reviewed by public health
  – Quebec has excellent health outcomes better than other provinces in the past 50 years.

• Quebec has fairly long waits for care

• Quebec spends more resources on early childhood programs and have an excellent education system.

• Quebec’s social and health policy is more European and less American than other parts of Canada
Ontario
1,076,395 Km² (Second largest Province)
12,400,000 population (Most populous province)

Toronto
Canada’s largest city. Area Population
5 Million
Ontario Health Policy

- **14 Local Health Integration Networks (LHINs)** – Ontario’s version of regional authorities
- Ontario has a system of private BUT not for profit health care services
  - 140+ hospitals
  - 585 seniors homes and community services
  - 80+ community health centres
  - 32 Public Health Boards
Recent major changes in family physician funding models

- 8000+ full time equivalent family doctors
- > 3000 mainly capitation funding
- 450 on salary in 80+ community health centres (CHCs)
- 2000 others with 10-20% capitation payment
- 2000 completely fee for service
- > 10 different funding models of primary health care
- Evaluations indicate Community Health Centres provide superior care but the provincial medical association (union) favours independent practice owned by doctors
Ontario’s community health centres (CHCs)

• Somewhat similar to Brazil’s primary health care centres
• Governed by elected community boards
• Provide high quality personal health care and engage communities on health determinants
  – Teams include physicians, nurses, social workers, community health workers, health promoters, and sometimes dentists, therapists and others
  – Regent Park CHC’s Pathways to Education reduced high school dropout rate from 56% to 14%
In general CHCs deliver better care

• “Last year, we reported community health centres did the best job of providing evidence-based chronic disease management in the province, despite working with the most disadvantaged people. The kind of careful management community health centres routinely give for diabetes and heart disease can keep people out of hospital and help them live longer.”

(Ontario Health Quality Council 2009)
In general CHCs deliver better care

“Compared with the Ontario population, CHCs served populations that were from lower income neighbourhoods, had higher proportions of newcomers and those on social assistance, had more severe mental illness and chronic health conditions, and had higher morbidity and comorbidity. In both urban and rural areas, CHCs had Emergency Room visit rates that were considerably lower than expected. “

http://www.ices.on.ca/file/ICES_Primary%20Care%20Models%20English.pdf
How does Canada’s health system perform?
<table>
<thead>
<tr>
<th>Health Expenditures (GDP %)</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.9%</td>
<td>16.2%</td>
<td>11.4%</td>
<td>9.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Public % of Health Expenditures</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>68.7%</td>
<td>48.6%</td>
<td>78.8%</td>
<td>45.7%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Expenditures (US $/capita)</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>$4380</td>
<td>$7410</td>
<td>$4629</td>
<td>$734</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MDs/10³</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.0</td>
<td>2.4</td>
<td>3.6</td>
<td>1.8</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurses &amp; midwives/10³</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.4</td>
<td>9.8</td>
<td>11.1</td>
<td>6.4</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital beds/10³</th>
<th>Canada</th>
<th>USA</th>
<th>Germany</th>
<th>Brazil</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4</td>
<td>3.1</td>
<td>8.2</td>
<td>2.4</td>
<td></td>
</tr>
</tbody>
</table>
Canada vs. the US: No contest!

- All Canadians are covered but 47 million Americans are uninsured, and tens of millions more are under-insured
- Canada spends much less than the US
- Canadians get only slightly fewer services overall
- Canadian outcomes are as good or better
- Canadians live 3 years longer than Americans and our infant mortality rate is 20% lower.
- Public insurance boosts Canadian business
  - Health care costs are 1.5% of Canadian manufacturers’ payrolls vs. 9% in the US
Health Spending as share of GDP

From: http://www.oecd.org/document/30/0,3343,en_2649_34631_12968734_1_1_1_1,00.html
Canadian health care outcomes on average are as good, or better than those in the US

- Guyatt et al 2007 published an overview of individual studies comparing US and Canadian health care. They concluded that overall Canadian care was as good or superior to US care.

- See: [http://www.openmedicine.ca/article/view/8/1](http://www.openmedicine.ca/article/view/8/1)
However, Canada doesn’t do so well compared with the rest of the world
After-Hours Care and Emergency Room Use

Difficulty getting after-hours care without going to the emergency room

Used emergency room in past two years

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.
Patients with a Regular Doctor versus a Medical Home

<table>
<thead>
<tr>
<th>Country</th>
<th>Has a regular doctor or place of care</th>
<th>Has a medical home</th>
</tr>
</thead>
<tbody>
<tr>
<td>UK</td>
<td>99%</td>
<td>74%</td>
</tr>
<tr>
<td>SWIZ</td>
<td>99%</td>
<td>70%</td>
</tr>
<tr>
<td>NZ</td>
<td>99%</td>
<td>65%</td>
</tr>
<tr>
<td>US</td>
<td>91%</td>
<td>56%</td>
</tr>
<tr>
<td>NOR</td>
<td>99%</td>
<td>53%</td>
</tr>
<tr>
<td>FR</td>
<td>99%</td>
<td>52%</td>
</tr>
<tr>
<td>AUS</td>
<td>97%</td>
<td>51%</td>
</tr>
<tr>
<td>CAN</td>
<td>96%</td>
<td>49%</td>
</tr>
<tr>
<td>GER</td>
<td>97%</td>
<td>48%</td>
</tr>
<tr>
<td>NETH</td>
<td>100%</td>
<td>48%</td>
</tr>
<tr>
<td>SWE</td>
<td>95%</td>
<td>33%</td>
</tr>
</tbody>
</table>

Patients with a medical home have a regular practice which is accessible, knows them, and helps coordinate their care.

Source: 2011 Commonwealth Fund International Health Policy Survey of Sicker Adults in Eleven Countries.
Practices with Advanced Electronic Health Information Capacity

Source: 2009 Commonwealth Fund International Health Policy Survey of Primary Care Physicians.
Canada’s health system’s problems, diagnosis, and solutions
Canadian Medicare was designed for another time

1. It was designed for acute illness and Canada’s acute care system compares well internationally
2. But now the main problems are chronic diseases and Canada does poorly with these and with equity and waits and delays.
We could prevent most chronic diseases

• > 80% of ischemic heart disease, lung cancer, chronic lung disease, and diabetes cases could theoretically be prevented with what we know now

• This would free up over 6000 hospital beds across Canada
Canadian disparities in health between different groups are responsible for 20% of health care costs

Toronto Diabetes Prevalence Rates by Neighbourhood 2001

From: R Glazier. Neighbourhood environments and resources for healthy living http://www.ices.on.ca/file/TDA_Chp2.pdf

Age and sex adjusted Diabetes prevalence rates

- 2.8 – 4.0
- 4.1 – 5.0
- 5.1 – 6.0
- 6.1 – 6.5
- 6.5 – 7.6
Why are there different rates of diabetes and diabetes complications by neighbourhood?

• Almost all related to socio economic, genetic, and neighbourhood differences.
  – Canadian Aboriginals and South Asians have higher rates
  – City planning and public transportation are important factors
  – In some neighbourhoods it is hard to find affordable healthy food
What are the barriers to more effective primary health care?

- Definitions do matter. They reflect different visions and values for health care delivery.
  - Is health care largely a public good or is it largely a private commodity?
  - Is health care primarily focussed on individual needs or on populations
  - Is health care primarily owned by doctors or Canadians and their communities?
“PHC is essential health care made universally accessible to the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford....it is the first level of contact of individuals, the family and community within the national health system ... and constitutes the first element of a continuing health care process...**PHC addresses the main health problems in the community, providing promotive, preventive, curative, supportive and rehabilitative services accordingly.**“

(World Health Organization 1978)
“Primary health care represents the first point of contact for individuals with the health care system, and is the key to efficient, timely, quality family and community care based on continuity and coordination, early detection and action, and better information on needs and outcomes.”

First Ministers’ Accords; 2000, 2003, 2004
• Approved by all countries in Pan American Health Organization
• PHC should be integrated into health systems
  – Not implemented as a separate program
• Commitment to social inclusion and equity
• Recommendations to strengthen community participation and oversight of PHC
Canada’s implementation of a narrow vision of primary health care is mainly related to continued medical dominance in health policy decisions.
Provincial medical associations and governments regard public medical insurance money as belonging to doctors and to be divided up by the Association
In Canada, the medical associations (doctors’ unions) mainly control primary health care planning by negotiating models of care with the provincial governments – to the exclusion of most evidence.
“There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention. The panel notes with concern that well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action.”

Ontario Health Review panel 1987
“However, as outlined in the reports of the five working groups, and according to a number of recent reports, policy papers, and conference proceedings, there are missed opportunities in reaping the benefits of Ontario’s investments, effecting quality and costs both within the primary care sector as well as at the system level. There was general consensus amongst all working group reports that it is timely to: mobilize the resources of the primary care sector in order to improve the quality of care offered to Ontarians; and enhance value for the system.”

The ideal health system would emphasize the *prevention* of poor health. It would be *patientcentric* and would feature co-ordination along the complete continuum of care that a patient might need. *Primary care* would be the main point of contact, but there would be much less emphasis on treating patients in hospitals. *All professionals would exercise the full scope of their skills* in their work; nurses, for example, would administer vaccines, and nurse practitioners would manage chronic illnesses such as diabetes and high blood pressure. Payment schemes and information gathering would support the patient-centric notion.

Commission on the Reform of Ontario’s Public Services. 2012. p 18
Many individual physicians DO want real reform. But the current decision-making process offers them little support.
We need to change the way we deliver services

“Removing the financial barriers between the provider of health care and the recipient is a minor matter, a matter of law, a matter of taxation. The real problem is how do we reorganize the health delivery system. We have a health delivery system that is lamentably out of date.”

Tommy Douglas 1982
Catching Medicare’s second stage

“I am concerned about Medicare – not its fundamental principles -- but with the problems we knew would arise. Those of us who talked about Medicare back in the 1940’s, the 1950’s and the 1960’s kept reminding the public there were two phases to Medicare. The first was to remove the financial barrier between those who provide health care services and those who need them. We pointed out repeatedly that this phase was the easiest of the problems we would confront.”

Tommy Douglas 1979
“The phase number two would be the much more difficult one and that was to alter our delivery system to reduce costs and put and emphasis on preventative medicine....

Canadians can be proud of Medicare, but what we have to apply ourselves to now is that we have not yet grappled seriously with the second phase.”

Tommy Douglas 1979
The Second Stage of Medicare is delivering health services differently to keep people well. It’s Population Health Planning and the Institute for Health Care Improvement Triple Aim

1. Safe
2. Effective
3. Patient-Centred
4. Accessible
5. Efficient
6. Equitable
7. Integrated
8. Appropriately resourced
9. Focused on Population Health
Population Health

“The health system should work to prevent sickness and improve the health of the people of Ontario.”

Health Quality Ontario
The Institute for Health Improvement’s Triple Aim

1. Enhance the Care experience for patients
2. Improve the health of the population
3. Control overall health care costs

http://www.ihi.org/IHI/Programs/StrategicInitiatives/TripleAim.htm
Canada could eliminate waits and delays

- We could access primary health care < 24 hours
- We could access specialty consultations < 1 week
- We could access elective surgery < 2 months
Going for gold: Re-engineering services to immigrants in Toronto

- Toronto’s Access Alliance Community Health Centre hires community health workers (CHWs) from immigrant communities
- CHWs are given 3 months of paid training and 3 year contracts
- The CHWs run educational workshops and facilitate well children and well women care
- CHWs have brought services to more than 10,000 women and their children
- 85% of CHWs get jobs in health or social services after their contracts are over
Going for Platinum: Population Health Planning in Saskatoon, Saskatchewan
Saskatoon neighbourhood analysis boundaries, excluding industrial and development areas, 2005

Legend

- Affluent neighbourhoods
- Rest of Saskatoon
- Low income neighbourhoods

Source: Saskatoon Health Region, Public Health Services
What can Brazil learn from Canada’s experience?

• Only public finance can control costs AND provide universal access
• Public finance is business’s best friend
• Public health insurance improves equity and efficiency but does not automatically lead to improved health system performance
• Countries need to dramatically change the architecture of their systems to achieve population health goals
What can Brazil learn from Canada’s experience?

• Population health planning is crucial to ensure the public system is meeting needs not wants

• Primary health care is the most important part of the system
  – Primary health care integrates public health with health care
  – Canada’s poor international performance on access to the system and chronic diseases management is due to inadequate primary health care
  – Primary health care is key for access, equity, and intersectoral action to reduce health inequalities
What can Brazil learn from Canada’s experience?

• The key questions around national health care relate to the ability of the state to achieve:
  – Single-payer public finance
  – Reorganization of the health care system

• Single-payer public finance is usually opposed by the financial services sector, providers of health care services, and sometimes employers

• Re-organization of the health care system to focus on primary health care, disease prevention, and health promotion is usually opposed by the medical profession
What can Brazil learn from Canada’s experience?

- Canada’s system has slowly evolved since the 1960s but now is on the verge of major changes
- However, Canada is still far from Tommy Douglas’s Second Stage of Medicare
- Canada’s health care policy-making is “not for beginners!”
Summary

• Canada is a wealthy, decentralized federation with has 14 health care systems
• Canadian health care outperforms the US
• Brazil can learn from Canada:
  – Single payer systems control costs while providing universal access
  – But you need to re-organize the delivery system to improve quality and population health
  – Focus on population health and primary care
Courage my Friends, it is Not Too Late to Make a Better World!

Tommy Douglas
(paraphrasing Tennyson)