ISSUE 7

Health Matters Bulletin

BY REBOOT HEALTH CONSULTANCY & ADVISORY SERVICES INC.

WITH FOUNDING PARTNERS: ROCHE AND ORACLE CERNER

The Next Global Crash is Healthcare

Primary Care Renewal in BC

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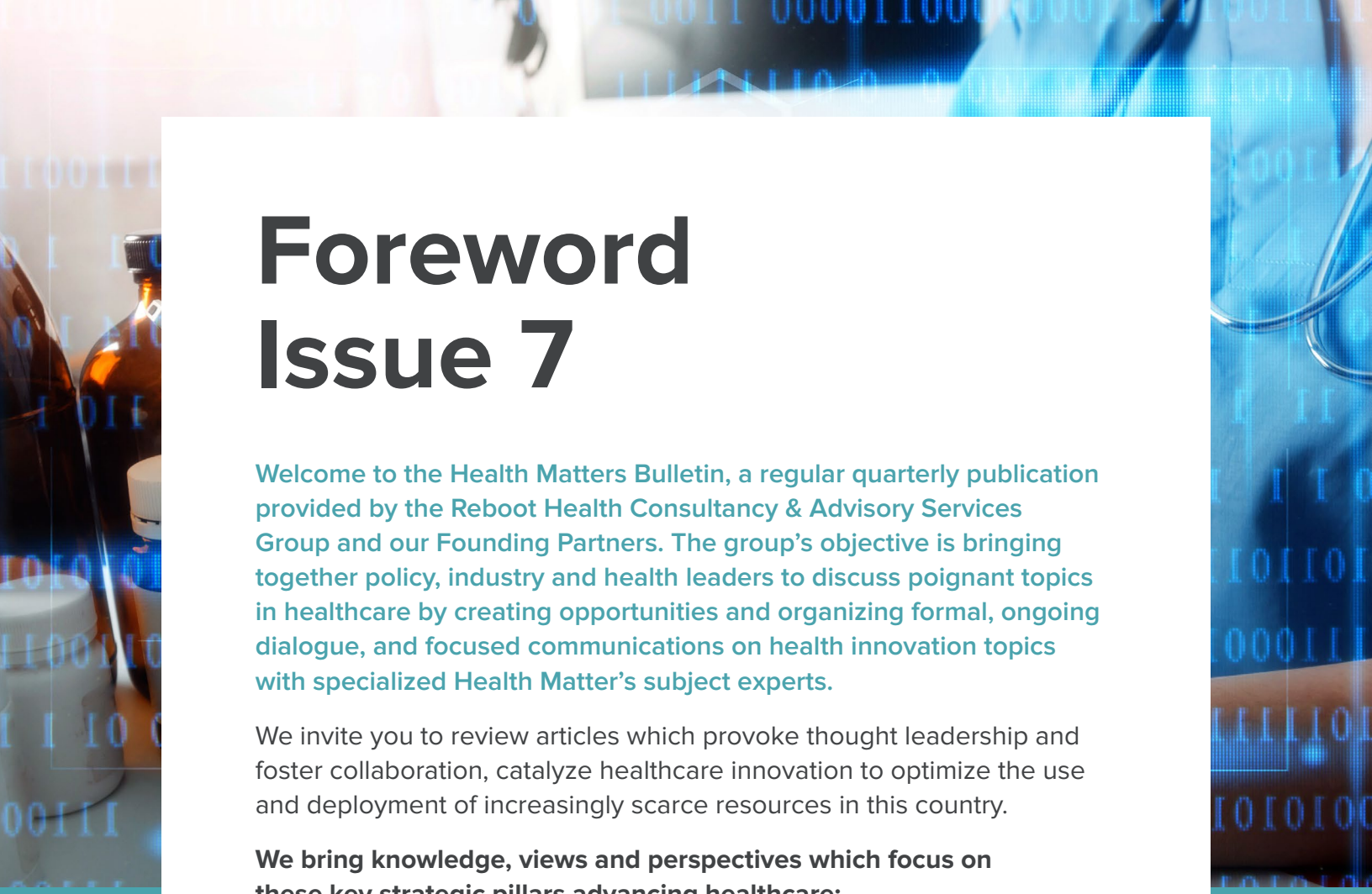

Foreword Issue 7

Welcome to the Health Matters Bulletin, a regular quarterly publication provided by the Reboot Health Consultancy & Advisory Services Group and our Founding Partners. The group's objective is bringing together policy, industry and health leaders to discuss poignant topics in healthcare by creating opportunities and organizing formal, ongoing dialogue, and focused communications on health innovation topics with specialized Health Matter's subject experts.

We invite you to review articles which provoke thought leadership and foster collaboration, catalyze healthcare innovation to optimize the use and deployment of increasingly scarce resources in this country.

We bring knowledge, views and perspectives which focus on these key strategic pillars advancing healthcare:

OUR KEY STRATEGIC PILLARS

- **Health Data Privacy, Policy and Security**
- **Personalized Medicine and Genomics**
- **Artificial Intelligence in Healthcare**
- **Value Based Healthcare, Operational Efficiency and Health Policy**
- **Health Innovation Development**

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Reboot Health Consultancy and Advisory Services Inc.

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The Next Global Crash is Healthcare – A system on the brink, is frighteningly unsustainable.

GPT SUMMARY: *The global healthcare system is on the brink of a potential crash due to soaring diseases in a younger population, unsustainable healthcare costs, an aging population, a reactive approach to healthcare, fragmented care and inefficiencies, and the fee-for-service payment model. The healthcare system must adapt to the needs of an aging population, shift towards prevention and early detection, streamline healthcare delivery, and prioritize patient wellness over revenue generation to prevent a healthcare crisis with devastating consequences.*

The world has witnessed numerous financial crashes over the years, each teaching us important lessons about the fragile nature of global economies. These crashes have often taken us by surprise, as very few saw the warning signs before it was too late. Today, however, we have another potential crash on the horizon – not in finance, but in healthcare.

The healthcare system itself is ill, following a precarious path with danger lurking in every corner. As mortality rates rise and costs spiral out of control, the system has become a reactive mechanism, waiting for illness before throwing money at the problem. This unsustainable approach is leading us towards a potential healthcare disaster, and it's time to take a closer look at the risks we face.

SOARING DISEASES – IN A YOUNGER POPULATION

The alarming growth of obesity, metabolic syndrome, and heart disease has become a major public health concern worldwide. Driven by factors such as sedentary lifestyles, unhealthy diets, and an over-reliance on processed and calorie-dense foods, obesity rates have surged, contributing to a rise in associated health conditions. Metabolic syndrome, a cluster of conditions including high blood pressure, elevated blood sugar, excess body fat around the waist, and abnormal cholesterol levels, has also seen a significant increase, putting a growing number of individuals at risk for developing chronic illnesses. Consequently, heart disease, already the leading cause of death globally, has continued to gain prevalence, with many cases directly linked to obesity and metabolic syndrome.

SOARING HEALTHCARE COSTS

The cost of healthcare is skyrocketing at an alarming rate. In many countries, healthcare expenditure is consuming an ever-larger share of the GDP, with both public and private spending on the rise. This trend is unsustainable, as it puts a strain on governments, insurers, and individuals, leaving many without access to adequate care.

As technology and treatments advance, the costs associated with them continue to climb–particularly at early stage technology. The development of new drugs and medical devices, while beneficial, often comes with hefty price tags. These costs are then passed on to the consumer, further exacerbating the issue of healthcare affordability.

AN AGING POPULATION

The world's population is aging rapidly, placing increasing pressure on healthcare systems. As people live longer, they require more medical care, particularly for age-related chronic conditions. This leads to a higher demand for healthcare services, stretching resources thin and causing systems to buckle under the weight of this growing burden.

With the number of elderly individuals set to rise significantly in the coming years, healthcare systems must adapt to the needs of an aging population or risk becoming overwhelmed.

REACTIVE APPROACH TO HEALTHCARE

A major issue within the healthcare sector is its reactive nature, focusing primarily on treating illness rather than preventing it. This approach is costly and inefficient, as it results in the overuse of resources and the late detection of preventable conditions.

Preventive care, on the other hand, emphasizes early detection and intervention, reducing the burden on the healthcare system and improving patient outcomes. Shifting the focus towards prevention would help alleviate some of the pressure on the system, making it more sustainable in the long run. Further, the domain of very early detection – a powerful and life-saving tool – is aligned with advances in technology and AI.

FRAGMENTED CARE AND INEFFICIENCIES

Healthcare systems worldwide are often plagued by fragmentation and inefficiencies. With multiple providers and payers involved, care can be disjointed, leading to a lack of communication, misdiagnoses, and unnecessary treatments. These inefficiencies drive up costs and negatively impact patient outcomes. Addressing these issues and streamlining healthcare delivery would not only save resources but also improve the overall quality of care.

FEE FOR ... WHAT?

The fee-for-service payment model, which has long been the foundation of the healthcare system, has inadvertently locked many clinicians into a system that prioritizes revenue generation over patient wellness. Under this model, healthcare providers are compensated for each test, procedure, or consultation they perform, incentivizing a higher volume of services rather than focusing on the quality and effectiveness of care. This approach can lead to unnecessary treatments and tests, as well as the over-treatment of patients, all of which drive up healthcare costs without necessarily improving patient outcomes.

THE SYSTEM IS IN THE ICU

As the warning signs become more apparent, it's clear that the healthcare system is on an unsustainable path. Addressing the challenges of soaring costs, an aging population, a reactive approach, and fragmented care is critical in preventing the collapse of the system. By making necessary changes and focusing on prevention, efficiency, and adaptability, we can create a more sustainable and effective healthcare system that is better prepared to face the challenges of the future. Failure to do so could result in a healthcare crisis with devastating consequences, impacting millions of lives worldwide.

By: John Nosta | *Founder and Technology Theorist, Nostalab*

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First and foremost, John is a thinker. A thinker entrenched in the world of technology, science, medicine and innovation. John is the founder of NOSTALAB – a innovation think tank recognized globally for an inspired vision of transformation. He's currently ranked as one of the leading global influencers in innovation and technology and well established as one of the top global strategic and creative thinkers. He is also one the most popular speakers around the globe presenting his vibrant and insightful perspective on the future on innovation. His focus is on guiding companies, NGOs, and governments through the dynamics of exponential change and the diffusion of innovation into complex systems, particularly in technology, AI and GPT. **www.nostalab.com**

Join us October 2 - 4, 2023 for **The 23rd Annual Healthcare Summit** where John Nosta will provide an opening keynote address. The Summit will embrace change, turn problems into potential, and chart the future in healthcare. If you care deeply about the current and future state of healthcare, this is the event to attend. Follow **@HlthcareSumm** on Twitter to learn more and for event news and announcements. You can register now for the summit at **www.healthcaresummit.ca**.

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Primary Care Renewal in BC

The primary care health system in BC, and in fact all of Canada, is in a state of crisis. The reasons for this are complex and multi-dimensional, however, the fundamental issue to be resolved is the fact that the current “Fee for Service” model for compensating family doctors is not working. It’s not working for patients, or for doctors. A recent survey indicates that 6 million Canadians do not have a family doctor, and one third of those have been searching for more than a year.

While the recent BC Government increase in fee for service billing is welcomed, it does not address many of the other issues and barriers faced by current General Practitioners (GP’s) and those considering family medicine as a career choice. Without a major change in the way governments fund and operate our primary care system, the problems will remain.

When the time comes in a medical student's training for them to choose a specialty area – as part of the national Canadian Resident Matching System (CARMS) matching process – medical students are aware that most hospital based specialty practice career pathways offer higher levels of income potential. In addition specialty practice functions in a team environment, involves less administrative burden and overhead costs, and may provide a better work-life balance than family medicine. Until the system issues discussed in this paper are addressed, we believe that we will continue to see training placements in Family Medicine remain unfilled. We understand that as part of the 2023 national CARMS matching process, over 250 Family Medicine places went unfilled in Canada. There has likely never been a more appropriate time for Governments, at both a National and Provincial level, to critically review our current registration and licensing processes – with the aim of simplifying and reducing many of the barriers to entry.

Primary care is the heart of a well-functioning health system. This is where preventive care happens, emerging health issues are detected early, people are kept out of emergency rooms, and cared for in their homes, reducing pressure on our hospitals. It coordinates specialist care for people with multiple chronic conditions, and supports peoples' heaviest care demands at the end of life.

A practical solution is needed now – with a new approach, which will accomplish the following objectives:

1. Ensure all citizens have access to a family doctor supported by an interdisciplinary primary healthcare team and alongside other health professionals such as pharmacists working to their full scope of practice.
2. Enable family physicians to earn a net income comparable with other hospital based physicians, and sufficient to both retain our existing complement of general practitioners and to make general practice a more desirable choice for medical students in training going forward.
3. Reduce the administrative and bureaucratic burden placed on family doctors in the current "fee for service" billing systems.
4. Preserve and protect Canada's publicly funded healthcare system.

“FEE FOR SERVICE” VS “VOLUME-BASED SALARIES AND CONTRACTS” FOR FAMILY DOCTORS

There has been an ongoing debate for many years about whether the health system is best served if family doctors are compensated through “fee for service” or salary. We believe that Governments need to develop a range of salary alternatives that include both salary arrangements and service contracts, given the reality that many family doctors who are already incorporated may prefer to continue to work under this fee for service model. We hear from many younger doctors that they would prefer a salaried arrangement to allow them to focus on providing care to patients without the need to operate as a “business”. Both fee for service and salary/contract approaches have pros and cons. Fee for service drives higher productivity, but has unintended consequences that can disincent care for patients with time consuming health problems. When doctors receive a “flat-fee” for a patient visit, it begins to explain why many doctors are incented to increase revenue by limiting the number of health issues they will deal with at one appointment (one issue at a time). A high level of administrative effort is also involved in order to track each visit, to correctly code the service provided, to file claims with the Medical Service Commission, and deal with questions and audits. The result is relatively high productivity, but with heavy administrative demands and lower quality of care.

Salaried and contracted physicians are able to spend more time with each patient, but often support a lower number of patients. This model enables better preventive care, and is better for people with time consuming health issues such as mental health or multiple chronic conditions. The result can be lower overall productivity, better healthcare for individual patients, but with fewer patients served per physician.

It’s fair to say that neither system works well. Fee for service has fallen down primarily because the administrative demands and the overhead costs that this model demands leaves physicians with too little net income at the end of the year. As a result, the question becomes – is there a model that can achieve the benefits and avoid the shortcomings of each approach, without blowing up the publicly funded health system Canadians value? We believe there is.

VOLUME BASED SALARIES OR CONTRACTS FOR FAMILY DOCTORS

One alternative is to provide physicians with a satisfactory level of compensation through salary or contract without losing the productivity benefits of fee for service. There are approximately 6,000 family medicine physicians registered and reported by the BC Medical Services Commission. However, not all of these are actually working, and others may only be working part-time.

With a comparable population to BC, and facing the common issues of aging populations and increased life expectancy and associated chronic conditions – both Scotland[1] and Denmark[2] report rosters of around 1,600 - 1,700 patients per full-time family doctor working in a primary healthcare team. Some family doctors in BC already have rosters of this number or more. If 60% of all family doctors currently registered in BC worked full-time in a primary care team arrangement – (say 3,600 GP's), each with a roster of around 1,600 patients, there should be enough capacity in BC for each of our 5 Million residents to have a doctor. If this is true, why are so many people unable to find a family physician?

One reason may be because so much of our family doctor capacity is employed in walk-in clinics, as hospitalists and other roles in our hospitals or working outside the public system. Walk-in practices are reportedly more lucrative for family doctors, as they can bill for more patients per unit of time, have less overhead and have no ongoing relationship with patients they see in this environment. Walk-ins provide episodic care at best, and are not ideal for patients with chronic conditions or multiple illnesses. The goal must always be to provide "joined up care" which is consistent over a patient's lifetime. While there is undoubtedly a place for some walk-in clinic services, they should enhance and not replace the desired model of longitudinal "joined-up" interdisciplinary team based care.

In a volume-based compensation arrangement, each physician earning full-time remuneration would be expected to carry a full patient load, with patients across the health spectrum. Physicians who wish to work less than full-time should carry a percentage of a full patient load and earn an equivalent percentage of full remuneration.

In this model Physicians on salary or contract would not need to bill for every visit or interaction with a patient and the proposed change would allow a huge reduction in administrative time demands and associated costs.

Doctors on salary or contract would have more freedom to focus on preventive care, much of which is not presently compensated. They could decide whether and when to use telehealth tools instead of in-office visits. In short, doctors would be much more trusted and empowered to manage their practice, and to decide how to best serve the health needs of their patients.

We believe that with a prioritized approach, with a thoughtful redistribution and reallocation of resources the goal of a family doctor for every resident should be achievable.

PENSIONS AND BENEFITS

Moving to a volume-based compensation model also opens the door to providing family doctors with access to a contributory and voluntary pension scheme, vacations, training allowances and other benefits. The availability of these benefits would make BC a unique and highly attractive jurisdiction to practice family medicine. Retention of our current doctors, attracting doctors from other jurisdictions and encouraging medical students to choose family medicine would give BC a huge advantage in supporting our primary care health system into the future.

ADMINISTRATION ALLOWANCE

A goal of this model is to see family doctors receiving an attractive net income. Presently, family doctors pay both their overhead and administrative costs out of their fee for service revenues, often in the order of 30% or more of total revenue. Moving away from fee for service would reduce total administrative costs. To sustain the target net income, if they continue to own and operate their own doctor's office – each family doctor would require an administrative allowance, sufficient to support the cost of their premises, a receptionist, and costs for insurance, professional fees, technology, and other expenses. If the goal is to see doctors working in shared facilities, the allowances could be set at a level to encourage the creation of shared and interdisciplinary team practices, or in a salaried model, the health system would provide the physical space and necessary supports to provide interdisciplinary healthcare team based practice.

INTERDISCIPLINARY PRACTICE

Team based healthcare is an internationally accepted, and evidence based best practice approach which has been proving to have considerable benefits to the health system and quality of care being provided to patients. A volume-based or contract model for doctors would work well in interdisciplinary team based care. Each family doctor in a team situation would need to serve a roster of patients as described above and be remunerated on a full-time or part-time basis. Team based care also contemplates the involvement of additional health professionals such as nurse practitioners, pharmacists, physiotherapists, nutritionists and so on. Compensation for these additional health professionals could also be salaried, and this approach increases the number of patients a practice can support by an estimated 30% while reducing overall unit costs per patient served. This approach may need to be a condition of moving to volume-based salaries or contracts.

FAMILY MEDICINE SERVICES FUNDING ENVELOPE

Historically, funding for all physicians in BC has been provided by Government in the form of a lump sum allocation to the Doctors of BC, who in turn decide how much of the total pot is allocated to each medical specialty. To date, family practice physicians have not been well served by this approach, to the benefit of more influential specialties. Funding for family physicians needs to continue to be a top government priority, with an appropriate amount removed or separated from the rest of the pool in order to guarantee sufficient funding to support the number of physicians needed to ensure all citizens have access to a family doctor.

IS IT NECESSARY FOR A NEW COMPENSATION MODEL TO BE MANDATORY?

We believe that the proposed compensation model shouldn't need to be mandatory. Fee for service and volume-based salary or contract arrangements should be able to work in parallel. Ideally it is voluntary, but compelling. Freedom of choice is important when trying to drive change in our health system.

WHY NOW?

The fact remains that hospital based medicine has little or no overhead cost for physicians, and has none of the administrative burdens of running a family practice. GP's report feeling burned out, depressed, frustrated and underappreciated. As a consequence, family doctors are leaving their practices and, too often, medical students are unwilling to consider family practice. When doctors leave, especially in single doctor practices, the practice is often closed, as few newly qualified family doctors want to

buy or continue an established practice. Patients find themselves “stranded” without attachment to a doctor, and their medical records are often lost.

Any kind of change is very difficult in our complex healthcare system. However, the current model for primary care medicine is suffering unprecedented challenges and is at risk of collapsing completely. Primary care is the heart of our health system, and the best hope for a healthy, productive population. There has never been a time when there has been so much awareness of the system’s shortcomings among health professionals, political leaders and the general population. The authors of this paper believe that this is the ideal time to make a major shift in primary care delivery, and to do so without damaging our highly prized publicly funded health system.

By: Gord Macatee | *Former BC Deputy Minister of Health*
and Howard Waldner | *Former CEO of Vancouver Island Health Authority*

References:

[1] *General Practice Workforce Summary, 2019- (published October 26th 2021). Public Health Scotland. From https://publichealthscotland.scot/media/9866/2021-10-26-gpworkforcesurvey2021-report.pdf*

[2] *Primary Health Care in the Nordic countries – Comparative Analysis and Identification of challenges. VIVE-The Danish Centre for Social Science Research. Herluf Trolles Gade 11, DK-1052. From https://www.vive.dk/media/pure/15439/4892199*

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