Is the Doctor in?

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ABSTRACT

The publicly funded Canadian health care system is at risk. The burden of chronic disease has resulted in emergency department wait times and extended hospital admissions. Insufficient community resources have led to late diagnosis and treatment, and in turn, a sicker patient population in acute care facilities. Statistics Canada has determined that Canada's aging population will increase by about eight percent by 2030, placing an even greater demand on medical services. According to the Fraser Institute, health care costs already consume more than 50% of revenues in Ontario and other provinces. As a result, this therapeutic shortfall cannot be simply resolved through more spending. The World Health Organization has proposed a model of Collaborative Practice and suggested the establishment of a robust linkage between primary, secondary and tertiary resources. For example, health professionals who provide the first point of contact with the health care system, specialists who often provide acute care, and even more highly specialized professionals who provide care over an extended period of time. A patient-centered format comprised of increased screening and a digitally-connected, multispecialty outpatient network can expedite the shift in focus from acute to chronic universal healthcare in a cost-effective manner.

Policymakers in Canada are confronted with the challenge of accommodating a growing number of individuals with chronic health care needs. Chronic health conditions, including diabetes mellitus, mood disorders, substance use disorders, and cancer, require continuous management of symptoms over a period of years.[1] The Health Council of Canada found that chronic pathologies affect at least one in three Canadians.[2] In Ontario, 43% of adults over the age of 65 suffer from two or more chronic health conditions, and the risk factors for further morbidity grow progressively with age.[2,3] Chronic relapsing negatively impacts quality of life and ability to maintain employment, and increases the chance of premature death.

Patients suffering from chronic disease often do not receive the right care at the right time and find themselves in hospital emergency departments. The domino effect that connects inappropriately managed hypertension to cerebrovascular disease and advanced cardiac disease is a case in point. When a health disaster strikes, it triggers an obligate chain of events that includes an ambulance ride to the emergency department,

possible hospital admission, and protracted rehabilitation. This process adds a great cost from both an economic and patient perspective.[4]

Patients face increased wait times for emergent care and then continue waiting to access hospital beds and elective surgical procedures.[5] In Canada, one in ten patients requesting emergency care will wait eight hours or more, while the average length of an emergency room visit is more than four hours.[6] Policy reports by the Ontario Hospital Association have identified ongoing system malfunctions, including the excessive number of alternate-level-of-care (ALC) beds in hospitals.[7] ALC beds are defined as those a patient might occupy in a hospital once acute care is no longer required. The lack of suitable community-based care facilities results in an insufficient number of acute care beds available for patients. The problem is exacerbated by Canada's already has a limited acute care capacity, with only 1.7 acute care care beds available per 1,000 residents.[8] It costs approximately $842 a day to care for a patient in hospital, compared to $126 a day for long-term care (LTC) and $42 for home care.[9] It is estimated that relocating ALC patients from hospital to LTC would save $1.4 billion annually.[9]

Canadian health care spending in some provinces, including Ontario, currently amounts to more than 50% of total provincial revenues and these costs are set to accelerate in tandem with the aging population.[10] The baby boomers – those born between 1945 and 1965 – will raise the population of seniors to 23.6% of the total population by the year 2030, compared to 15.3% in 2013.[11] To meet this demand, and to bypass a stenotic health care system, a national strategy focused on extending hospital resources into the community should be considered. This concept is not foreign to Canadians, particularly those in communities with limited infrastructure who require health care to be brought to them.[12] An online system facilitating cross-referral between specialized tertiary and long-term, residential options such as such as home care, hospice, and palliative care can can optimize the allocation of primary and secondary resources.[13]

It is from this perspective that having "multiple health workers in different professional backgrounds working together with patients, families, caregivers and communities" was formally recognized as a strategic goal. This vision was articulated by the Interprofessional Education and Collaborative Practice in 2010 based on the definition of primary care set forth by the World Health Organization in 1978.[14] The push to remediate individual and system level barriers has already started in Brazil, India, South Africa, the United States, and in Canada, where legislation requiring interprofessional training reinforces the goal of providing continuity in patient-centered care.[14,15]

Therefore, the objective of Canada's health care evolution should be threefold: increased screening to enable earlier diagnosis and treatment, improved outpatient management of chronic disease, and access to primary and secondary care resources with the support of tertiary care facilities.[4]

Patients suffering from chronic diseases may benefit from having a care coordinator so they do not fall between systemic cracks. Care coordinators tend to be non-clinicians that provide a central point of contact between the various stakeholders in the therapeutic process.[13,16] These care coordinators, much like the conductor of an orchestra, can monitor compliance and improve the overall health outcomes of the patients.

Well-targeted investment by the Canadian federal government in the integration of hospital-based and outpatient services has the potential to repurpose scarce economic and human resources. If Canadians continue to put their faith and pride in an accessible model of universal health care and the socio-economic burdens accompanying privatization of medical services are to be avoided, these changes need to be implemented. We do not want to compromise the integrity of a system that has been so crucial to our population's well-being. ■

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