

No magic pill to health system challenges

The problem is that people are looking for a single quick fix when there are multiple solutions. We know what we need to do. We just need to get on with it.

By: Sharon Sholzberg-Gray

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At the end of December 2007, after ten years, I left my position as President and CEO of the Canadian Healthcare Association (CHA). It was a pleasure and a privilege to be the spokesperson for the publicly-funded health system in this country and to convey the concerns of health system leaders to the federal government.

People have been asking me whether I have seen positive change over the last ten years. Are there solutions to the challenges facing our health system? Everyone is looking for a magic solution. In a world of 30-second sound bites and instant messaging, it is difficult to communicate health system complexities, challenges and solutions. So I'll give you my take on some key issues and suggest some solutions. Regrettably, there will not be one magic pill.

Ten years ago, the major issue facing the health system was insufficient funding. The health story of the 90s was one of deep spending cuts, both federal and provincial, exacerbated by poisonous inter-governmental relations. The health system bore the burden of effort to slay government deficits. Thus the issue of funding and sustainability (together with health system renewal) was always at the top of my list of concerns and the more successful we were at making the case for increased funding, the more challenges we faced from those who argued that health spending was out of control and the system was unsustainable.

Canada's health spending is not out of control. Yet the myth persists that our health spending is one of the highest in the developed world. Canada is ninth among OECD countries in total health spending (public and private combined), expressed as a percentage of GDP or in per capita terms. Canada is thirteenth in public spending only. Yet, how often have we read and heard that Canada is one of the top spenders? The OECD Health Data report 2007 noted that across all OECD countries, a growing share of the economy is devoted to health, many with private options. Those who advocate that we should look to Europe for solutions ignore the fact that most of these countries spend more, not less than we do, so they are not the miracle source of answers. They also spend more than Canada on social programs, which are important determinants of health.

The percentage of GDP expended on health services in Canada has remained between nine and ten percent for over 15 years. This covers the period of spending cuts in the 90s as well as subsequent reinvestments, including the impact of the 2004 Health Accord. So why is there a disconnect between the relatively stable health spending as a percentage of GDP and the ongoing concern about out-of-control health spending in the provinces,

which is claimed to be crowding out other key areas? Tax cuts have resulted in a decline of both federal and provincial revenue as a share of GDP. This has created the appearance of health spending crowding out all other spending when the reality is other spending has declined relative to GDP. Ontario is first in health spending at 39.5 per cent of total provincial spending including interest on the debt, while the Canadian average is 34.6 per cent.

Will privatization solve the issue of rising costs? Increasing costs are a problem in most industrialized countries, including those that have more privatization than Canada. 70 per cent of Canada's health spending is publicly funded and 30 per cent privately funded (out-of-pocket expenditures or private insurance, usually employer provided). Canada Health Act services, medically-necessary services provided in hospitals or by physicians, are almost exclusively publicly funded. Other services are funded in a patch work quilt across Canada. Canadians can buy these other services privately. Yet, there is ongoing pressure to cover more of them in the public system. So if privatization were the magic solution, there would be no pressure to include more services in the publicly-funded basket.

The efficiency of Canada's single payer system has provided a competitive advantage to Canadian business due to reduced health benefit costs. Shifting more health costs to business would extinguish this advantage. Cost shifting is not cost savings. A 2004 OECD policy brief made two important points: 1) Countries with significant private health insurance options tend to be those with the highest spending levels and 2) Private health insurance has not significantly reduced public financing burdens. These are some of the reasons why all federal political parties, including the current government, support a single payer system.

Privatizing costs are not the answer. Nor is more private delivery. There may be cost savings doing routine repetitive procedures in private clinics, but expensive, complicated procedures will always be done in full-service hospitals. Private clinics provide cheap care because they select their patients cream skimming. In a January 2008 letter to the National Post, a physician wrote that private sector medicine in the UK only has the ability to service the wealthy and the insured sick, the latter group receiving low risk, routine surgeries....Private care....is almost completely ineffective at helping the critically ill, who are all farmed out to public hospitals. That is why CHA has always supported an evidence based approach as to when private delivery should occur. Contracting out certain services provided there is quality, accountability, adequate human resources (a problem) and cost savings needs to be on the table and examined with an open mind.

So what about the issue of wait times and access to health services which is the key concern of Canadians? The problem with the current approach is that it is based on the assumption that the measure of a good health system is how many procedures and interventions take place. Focusing on quantity is not enough. A healthy population is the true measure of a successful health system.

The issue of wait times is complex. Resolving it requires integrated lists or centralized intake processes, diversions to appropriate care, access to care based on a standardized assessment of the acuity of a persons condition, case navigators, the efficient use of OR times and appropriate information systems. Examples of these approaches exist throughout the country, and together with an infusion of cash for wait times, they are having a positive impact, but there are still individuals who feel that the solution to wait times is privatization; a December 2007 article in Macleans Magazine noted that a closer study of European systems found no clear evidence that allowing a privately insured option eases wait times in a mainly public system. This has not been the usual opinion expressed in that magazine.

One of the major challenges is the shortage of health human resources, and we need to work more quickly on implementing a multi-faceted pan-Canadian approach. Privatizing more care will not magically create more health workers.

Discussion on the sustainability of the health system and wait times has not sufficiently explored the continuing care/long-term care sector and the interrelatedness between all parts of the continuum of care. The occupancy of hospital beds by patients whose optimal care should be provided in other settings adds to the wait times problem. Wait times cannot be fully addressed or resolved in isolation from continuing care issues. The federal government has supported home care following a hospital stay, but has yet to support a pan-Canadian home care program that keeps people well in their homes, thus preventing the need for more hospitalization.

I am an optimist who firmly believes that there has been much progress in the last ten years and that everywhere in this country there are best practices and points of light that can be emulated. The problem is that people are looking for a single quick fix when there are multiple solutions. We know what we need to do; we just need to get on with it. At the top of my list are: substantial federal funding for a comprehensive electronic health record; a recognition of the link between continuing care services and access to the acute care system; a comprehensive approach to wait times that addresses both quantity and appropriateness; a pan-Canadian pharmacare program; a focus on chronic disease management and keeping people well; more research funding; measurement of health system outputs and outcomes based on comparable data; a focus on quality; and finally, an evidence based approach to everything we do.

The federal government needs to move forward on the unfinished business in health. Health is not a done deal or just a subject that can be ticked off a list. The federal government has an important and continuing role to play in ensuring comparable access to health services for Canadians. We are making progress, but there is much work to be done. In the Ottawa Citizen of January 8, 2008, there was a front page story entitled Canadas health system getting better, study finds. I look forward to more of such headlines in the future.

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