CANADIAN FEDERATION OF NURSES UNIONS

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HEALTH CARE SUSTAINABILITY

CANADIAN FEDERATION OF NURSES UNIONS BACKGROUNDER

Is Canada's health care system sustainable? Critics of medicare point to increases in health spending as the harbinger of financial disaster. And they have a simple, seductive answer ready at hand — *let the market fix health care.*

Both suggestions — that there is a crisis of sustainability, and that the market can fix it — are false. The critics have overstated their case. Canada's health spending is increasing but stable, and in line with other comparable economies. The effect of our aging demographic is minor and slow-moving, while cost drivers with greater impacts, like prescription drugs and the use of technology, can be controlled.

The logic of the market is 'survival of the fittest' where people serve. This logic does not belong in a health care system designed to address needs with compassion and equity. The evidence shows that the path to improving medicare's financial situation is to be found within a publicly funded, publicly administered and publicly delivered system.

Health spending in Canada

In 2011, Canada will spend an estimated 11.6% of GDP on health care. Public spending will account for 70.3% of this, a low portion by OECD standards, at 8.15% of GDP.[1]

The Canadian Institute for Health Information (CIHI) divides the growth of public sector health spending since 1975 into three phases: a growth phase from 1976 to 1991; a short retrenchment from 1992 to 1996 due to fiscal restraint; and a catch-up and growth phase from 1997 to 2008, averaging an inflation-adjusted 3.5% annually.[2]

During this latter period, Canadians, who have repeatedly told pollsters health care was their top priority, pressed for and received commitments from their political leaders to make major investments in physicians, drugs, hospitals and advanced diagnostics.[3]

As CIHI points out, health spending tends to remain relatively constant even when GDP fluctuates up and down. If the GDP takes a turn for the worse, as in the 2008-2009 global recession, health spending will inevitably take up a larger portion of a smaller GDP pie.[4]

Hold the hyperbole

An international perspective

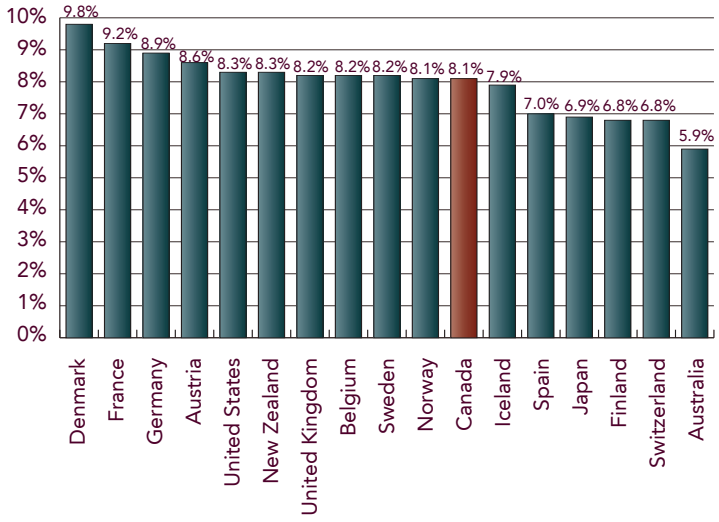
Canada's health spending as a percentage of GDP is in line with other OECD countries. The US is an outlier, spending much more despite huge gaps in coverage. In terms of public spending, Canada ranks eleventh among OECD countries at 8.1% GDP.

As real GDP rose between 1998 and 2008, most OECD countries increased health spending by an even higher percentage. Canada is on or just below the OECD trend line in this respect.[5] The trend itself is not surprising. As revenues increase, it is often best to increase spending on priority areas rather than maintain the same proportion of spending in all categories.

Overstated problems

Although wait times in areas like long-term care and emergency care need attention, the wait times for identified priority areas are often overstated. Eight out of 10 patients across Canada receive priority procedures within benchmarks.

Figure 1: Public-Sector Health Expenditure as a Percentage of GDP. 17 Selected Countries, 2009.



Source: *OECD Health Data 2011 (June Edition),* Organization for Economic Cooperation and Development, June 2011. (Paris, France: OECD, 2011)

CIHI suggests that 90%, not 100%, is a reasonable target.[6] It is not always the case that everyone on a wait list is ready for surgery.[7] A study of joint surgery queues in Alberta revealed that 11% of patients in the queue could not be contacted while another 14% were not really waiting for a procedure.[8]

The apparently large increase in health spending as a proportion of provincial budgets is a result of program cuts in other areas while fiscal room for overall spending has been eroded by tax cuts.[9] Whereas cuts since the mid-1990s amount to 6% of GDP, medicare costs have increased by approximately 1.5% of GDP and total provincial health care costs by 1% of GDP.[10]

CIHI reports that after controlling for inflation and population growth, health care spending per person is forecast to increase by 1.8% in 2011, the lowest annual growth rate in 15 years.[11]

Misguided solutions

Nevertheless, the cost of health care in Canada, as elsewhere, is rising modestly. What effect could we expect from the solutions proposed by medicare's critics?

User fees

User fees may seem like an intuitive solution. Unless there is a price associated with a doctor's visit or a prescription, the logic goes, the system is open to abuse.

But user fees hit hardest those most likely to need care — the poor. When Saskatchewan introduced user fees in the 1970s, physician visits by low-income people decreased by 18%, and no cost savings were documented.[12]

User fees are wrongheaded in that they attempt to address a problem that does not exist. Let's remember, the bulk of health spending is controlled by providers, not users: hospital care, surgery, prescription drugs and so on.[13]

A recent review in the *British Medical Journal* argues that the introduction of user fees has the effect of reducing both ineffective and effective care to almost the same degree. User fees also cause unforeseen cost increases in other services, such as community health, long-term care, and emergency care.[14]

Private care: less efficient, more costly

The claim that privatizing health care delivery will save money is flat-out wrong. As former Saskatchewan Premier Roy Romanow has said to privatizers, "Show me the evidence. Table it now."[15]

Health spending per capita is 85% higher in the US private system,[16] yet Canada ranks equal or better on health outcomes.[17]

Cataract surgery wait times in Calgary's private clinics were typically more than double those in Edmonton and Lethbridge, cities where a great majority of procedures are done publicly.[18]

Privatization harms the public system

It is easy to believe that allowing the wealthy to pay for private care will free up resources for the rest of us, but this too is false. Private care for the wealthy comes at the expense of quality care for the rest.

For-profit care providers focus on patients in good overall health, who are well-insured. When complications arise, patients are off-loaded onto the public system which is forced to absorb these difficult cases and expensive procedures. Low-risk, low-cost and high-reimbursement patients are referred back to their own clinics.[19]

Private health care would poach resources that are already in short supply, like doctors and nurses, and use them less efficiently while catering to the tastes of the wealthy. It is estimated that if 10% of specialist capacity in hip and knee surgery were diverted to the private sphere, average wait times for both procedures would increase by at least 20 days in the public system.[20]

When the Winnipeg Maples Surgical Clinic bought an MRI and lured two technicians away from the public sector, a 20-hour per week reduction in services at the Health Sciences Centre ensued.[21]

A 2008 report by the Ontario Health Coalition found that wait times were highest where privatization was most advanced due to the diversion of financial and human resources from the public sector to private providers.[22]

Health care's cost drivers — Are they fatal?

Measuring the sustainability of medicare depends upon understanding which factors are driving increases in health spending.

Pharmaceuticals

Pharmaceuticals alone have been responsible for 25% of the increases in medicare costs as a share of GDP since 1975. Between 1998 and 2007, prescription drug expenditures grew at an annual average of 10.1%,[23] and between 1975 and 2009, prescribed drugs went from 2% to 9% of total costs.[24]

Between 1998 and 2007, for example, retail spending on cholesterol-lowering drugs grew from $500 million to $1.9 billion. Nearly 90% of this increase came from a rise in volume of sales.[25]

Response: A Pharmacare strategy

Canada has the highest generic drug prices and, with Germany, the second-highest patented drug prices among comparator countries.[26]

In 2009, drugs with patents expiring between 2010 and 2014 accounted for 38.2% of wholesale spending (almost $8.7 billion) that year. The average generic in Canada sells for 60% of the price of the patented drug.[27]

France has implemented a strategy of generic drugs substitution, which saved an estimated US$1.94 billion in 2008 alone.[28]

The public sector funded 38.4% of total drug expenditure in Canada, the fourth lowest of 25 OECD comparator countries. If Canada modeled its Pharmacare program after New Zealand's it could shave over $10 billion annually from its current drug expenses, without raising taxes.[29]

Aging demographic

In the popular media, Canada's aging demographic is characterized as the force that will sunder medicare. Health spending is weighted heavily towards seniors. The 14% of Canadians over 65 consume 44% of provincial/territorial health spending.[30]

Response: Aging in context

But spending on seniors has gone from 43.6% in 1998 to only 43.8% in 2008.[31] CIHI estimates that the aging population accounts for only 0.8% in annual increases in spending over the past decade.[32]

The Office of the Parliamentary Budget Officer forecasts that increases due to aging will reach 1.2% per year by 2032 and then decline towards zero.[33]

Health services enrichment

'Enrichment', the expansion of health services, is another important cost driver. It covers a range of enhancements, including the introduction of new drugs and surgical techniques. Health economist Marc Lee estimates that the average Canadian received 61% more health care services in 2005 compared to 30 years earlier.[34]

Enrichment also includes increases in the use of health services. From 1996-1997 to 2006-2007, for example, there was a 101% increase in the number of hospitalizations for hip and knee replacements. And between 2003-4 and 2009-10, the annual number of MRI and CT exams nearly doubled.[36]

The US Congressional Budget Office cites a number of studies showing that technology-related changes in medical practice have contributed between 38% to 65% or more to the growth of real health care spending per capita in the US.[37]

Response: Managing enrichment

Health care enrichment has generally improved the scope and quality of health.[38] However, we must be sure we are getting value for money. An estimated 80% of increases in drug expenditures come from new drugs that offer no substantial benefit over existing treatments.[39]

The Health Council of Canada warns that costly diagnostic and medical equipment is often overused.[40] They also point out that operations, such as cataract surgeries, are often overused.[41]

The question of sustainability also hinges on how far we want to advance our current suite of services. As CIHI puts it, the biggest cost increases to Canadian health care arise because, "Simply put, more care is being provided."[42]

Improvements

Beyond meeting the challenge of these cost drivers there is a host of other reforms that could strengthen the sustainability of medicare.

Reducing inefficiency

A recent international review of 317 studies found that average hospital efficiency is about 85%, meaning hospitals could reduce costs or increase service.[43] The same study suggested that efficiency levels in public hospitals are likely highest.

In 1999, the US Institute of Medicine reported that 44,000 to 98,000 Americans die annually due to medical errors, with a total annual cost between $17 and $29 billion.[44] A 2004 Canadian study suggests that similar problems exist in this country.[45] Simple initiatives could go a long way here. Michigan, for example, has instituted a checklist to reduce bloodstream infections via

catheter lines. Infections have dropped to less than 20% of the pre-checklist amount, saving an estimated 1,800 lives over four years.[46]

The lack of effective, long-term health human resource planning is a great source of inefficiency. Canada is currently short 11,000 FTE (full-time equivalent) RNs, a shortage which could reach 60,000 FTEs by 2022.[47]

The cost of this shortage in paid overtime alone is $660.3 million annually.[48]

Inadequate staffing and unhealthy work environments increase hospital costs, including length of stay, nurse turnover (averaging $25,000 per nurse) and medical errors.[49,50]

For years, the Canadian Federation of Nurses Unions has been lobbying governments for a far-sighted, pan-Canadian health human resource strategy.

Continuum of care

Better organization of health care services, such that the most effective form of care is delivered at the right time, will enhance the sustainability of medicare. The 2002 Romanow Commission, for example, advocated reform to primary care, claiming "no other initiative holds as much potential for improving health and sustaining our health care system."[51] Unfortunately, little has been done to address this issue.

According to the Public Health Agency of Canada, for every dollar spent on health promotion, an estimated six to eight dollars are saved in health costs. Furthermore, a 20% reduction in falls experienced by older adults would result in 7,500 fewer hospitalizations, 1,800 fewer permanently disabled older adults and savings of $138 million per year.[52]

Ontario Ombudsman André Marin recently reported that 20% of patients in hospital beds actually required community or long-term care (LTC). Care in LTC facilities is much less expensive than hospital care, and expanding this sector offers the potential for immense savings.[53]

Because of a lack of effective community care, 15-20% of older Canadians are readmitted to hospital within one month of discharge. A nurse-led community care initiative in Sault Ste. Marie has reduced readmission for heart failure by nearly 50%.[54] Targeted home care also prevents costly hospitalizations and health complications.[55]

Promising initiatives

Cost-saving initiatives are not pie-in-the-sky scenarios with no hope of being realized. A sampling of current initiatives goes a long way towards showing health care's potential. With support and dissemination of best practices, much can be achieved.

The Health Service Organization (HSO) Mental Health and Nutrition Program in Hamilton integrates 100 family doctors, 17 psychiatrists, 80 counsellors and 20 dietitians. As a result of the program, eleven times more patients are managed in primary health care while referrals to the psychiatry specialty clinic have dropped by 70%.[56]

Innovators have achieved dramatic reductions in wait times in orthopedic surgery in Alberta,[57] joint replacement procedures in North Vancouver, and breast cancer diagnosis in Sault Ste. Marie.[58]

This is a mere sampling of solutions waiting to be extended and reproduced.

Conclusion

The doomsday scenarios of medicare's critics are simply not supported by the evidence. Spending is not out of control, and the solutions they propose would worsen medicare's sustainability. Cost drivers can be managed, and a host of initiatives is possible to bolster medicare's effectiveness. Investments in home care, long-term care, Pharmacare and other initiatives will go a long way to enhancing the sustainability of medicare.

Put in the simplest terms, the most cost-effective and equitable way of distributing health care is publicly funded, publicly administered and publicly delivered. Sustainability, then, is a challenge for a public system, and it is a challenge we can readily meet.

For more information, see CFNU backgrounders on Pharmacare and privatization (http://www.nursesunions.ca/publications/factsheets).

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