The Facts

The costs and performance of Canada’s health system

What we are spending and how

The Commission carried out its work against a very specific historical backdrop. Our health-care system has been largely built upon a reactive, sickness model, where treatment services dominate and care is focused in clinics, hospitals and other institutions. Physicians are typically the access point for this acute care system.

Some $200 billion, closing in on 50 per cent of some provincial budgets, are now spent to keep this system operating each year — based on GDP, the world’s sixth most expensive health-care system per capita. Of this amount, more than three quarters (about 76 per cent) is spent for hospitals and other institutions, physicians’ fees and drugs. Hospital costs include expenditures such as nurses’ salaries.

The public/private health-care spending split in Canada is about 70:30, with the public portion at 70.6 per cent, down from 74.5 per cent in 1990 and slightly less than the 2009 OECD average of 71.7 per cent.

Insured publicly funded services in Canada include:

- medically-required physician services rendered by medical practitioners; and
- in- or out-patient hospital services, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.

As noted by Health Canada (2011), “provinces and territories may also offer ‘additional benefits’ under their respective health insurance plans, funded and delivered on their own terms and conditions.” Such services, often targeted to specific population groups (e.g. children, people living in poverty) or those with certain health needs, could include the following:

- prescription drugs
- dental care
- optometric services
- chiropractic services
- ambulance services

Our ability to deliver medically necessary care has changed dramatically and encompasses a wide variety of settings including complex acute care in the homes of Canadians. Today, hospital admission is sometimes not even offered as an option for procedures that would once have required a stay of several days. But funding has not followed the advances in health sciences that have made those policies possible. Once care moves beyond a physician’s office, specialty clinic or the confines of a hospital, the funding and availability of services can become
much less clear. As a result, expenses for services deemed medically necessary, and for which the public medicare system was created, can now fall directly to patients (and/or their private insurers), who are at home because the care is no longer provided in a hospital.

The acuity and need may not have changed, but the expense to individual Canadians surely has. With all the advances we have to strengthen population health, and a decade of talk about patient-centered care, we cling to a model where Canadians must follow insured funding rather than the reverse. And that story is an interesting one: despite the policy rhetoric, and indeed the large-scale move toward more services delivered outside the walls of traditional institutions, the reality is that public spending on health care has not changed much. The numbers move up and down a little over time — a little. But within the 70 per cent of overall spending on health care from public dollars, the portion spent on hospitals and other institutions, doctors and drugs has hovered pretty steadily around the 70 per cent mark for the past decade.¹⁶

We know that many procedures have moved away from hospitals, and length of stay certainly has decreased over a generation. And with just half the number of hospital beds as the OECD average,⁷ we know too that somebody surely is picking up the costs of these changes in health care, both fiscal and otherwise.

This funding pattern poses a significant, looming problem in a society where the most rapidly growing population group is older, especially since such people are likely to live long lives with one or more chronic conditions while on fixed incomes and modest pensions. Already, we know that cost alone significantly increases the number of Canadians who do not follow the medically necessary treatments prescribed to improve their health.⁸ Anecdotally, we even heard about cancer patients choosing to seek admission in emergency departments, because the costs of their necessary treatments, including expensive drugs, would be fully covered once they were admitted.

Summarizing what is needed at a March 2012 forum on continuing care, hosted by the Canadian Federation of Nurses Unions, John G. Abbott, chief executive officer of the Health Council of Canada said that “An integrated system of continuing care is a cornerstone of high-performing health care systems.”⁹ He went on to assert that “Canada’s challenge ahead is to adjust priorities appropriately, ensuring our funding follows the needs of those who require care at home and within the community.”¹⁰

Health outcomes and system performance

In an analysis of current health-care system funding and financing models undertaken for the Commission, Soroka and Mahon noted the “striking increase in public spending on health care” since the mid-1990s.¹¹ Controlling for inflation, “per capita spending as of 2010 … on health

Cost-related non-adherence was reported more often among Canadians who are in poor health, have a lower income and are without drug insurance.

“About 1 in 10 Canadians who receive a prescription report cost-related nonadherence.”

_Law, Cheng, Dhallia, Heard & Morgan, 2012_
care in Canada was more than 50% higher than in 1996.\textsuperscript{12} And they note that those increased health-care expenditures coincided with improved assessments of the system by Canadians. Investments in drugs, hospitals and public health stand out as particularly valuable according to changing public assessments of health care quality.

Positive public perception might indeed reflect actual improvements in care; but our population health outcomes and international performance rankings suggest otherwise. So, beyond public perception, what are we buying with all those dollars? Surely, initiatives such as strategies to reduce wait times for certain surgical procedures — taken on in the 2004-2014 Health Accord — have contributed to improved public perceptions. However, the fact that the public continues to cling to costly hospitals, doctors and drugs may really reflect uncertainty about what other services they believe (or trust) could really be put in place to improve health and treat illness in more affordable ways. In other words, "If you take away my hospital or my emergency room, where do I go for care? And what will it be like?"

Cause and effect cannot be assumed here, of course, but we note Soroka and Mahon’s finding that "spending in other healthcare domains is not clearly associated with improved public assessments."\textsuperscript{13} Does this discrepancy exist because the public does not value other kinds of services? Do they understand them, know them or even have any experience with them? Indeed, the constant focus on acute care is one of the difficulties we have in moving the system beyond hospital walls. The Conference Board of Canada noted that "Funding for health promotion and disease prevention invariably competes with the financial demands of the [acute] health-care system" and that, "It is often politically difficult to deny urgent needs in the present to invest in the future."\textsuperscript{14}

Even our interest in broad public and population health has taken on a sporadic, episodic tone, ramping up in response to acute communicable disease crises, such as sudden acute respiratory syndrome (SARS), the Walkerton (Ontario) water crisis, and H1-N1 influenza, and then fading into the background. The current crisis — obesity — is not communicable, although its spread across society might suggest otherwise. The sudden realization of the staggering burden of disease (and associated fiscal costs) set to befall the next generation has once again prompted worried attention towards wellness, public health, health promotion and disease prevention.

A number of domestic and international organizations have attempted to assess exactly what health and system outcomes Canadians are buying with the dollars we invest. The results are predictably mixed, and the Canadian Institute for Health Information cautions us that "rankings of health and health care are not yet standardized nor well understood."\textsuperscript{15} As in all such analyses, the emphasis can be shifted to favour different views of the "truth." Hence we find Canada ranked 23rd (even 30th) among 30 OECD nations in some analyses of system performance indicators — and yet, in the top position in others.\textsuperscript{10} Perhaps the message for Canada is the overarching sense among these analyses that we are spending a lot (and it keeps growing), and that we can and must do better to achieve better health, better care and better value.
Among seven wealthy OECD nations (Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States) studied by the Commonwealth Fund in 2010, Canada’s health system placed second-highest in cost and second-last on performance indicators, book-ended in both cases by the United States. 17 While we scored well on life expectancy, Canada ranked poorly in areas like equity and efficiency. 18 The study noted, for example, that, based on cost, poorer Canadians have less access to necessary services like dental care and pharmaceuticals. 19 That result may reflect the OECD observation of the rising income inequality problem in Canada. 20 — and it perhaps relates to its September 2010 recommendation that pharmaceuticals, home care and therapeutic care should be integrated into the bundle of Canada’s publicly funded services. 21

Of great concern to this Commission is Canada’s overall last-place position in quality of care in the Commonwealth Fund study — including the lowest scores for effectiveness and timeliness of care, and a fifth-place ranking (of seven) for safe, coordinated, patient-centered care. 22 We were ranked fifth on access measures and sixth on efficiency. 23

Commenting on the study, health policy journalist André Picard bluntly encapsulated the kinds of concerns voiced during many of our consultations across Canada by noting that “Canada does not have a patient-centred health care system.” Picard believes that “communication with patients is abysmal, customer care is virtually non-existent and the opportunities for feedback are minimal.” 24

Yet, Canada’s low efficiency scores in the Mirror, Mirror study reflect fixable problems such as over-use of emergency departments and high re-admission rates after discharge from hospital. In part, emergency room crowding reflects the low ranking given to Canada on access to care (compared to 12 OECD nations) in the Commonwealth Fund’s International Profiles. That ranking was earned because of poor performance on access to after-hours care. The study found further that we have the longest wait times for specialist care and the second longest wait times for elective surgery. 25 Those sorts of findings reinforce the outcomes so many Canadians have experienced: no access to a regular primary care provider (or no timely access), long waits in emergency rooms, long waits for surgery and inconsistent access to necessary post-hospital care.

The acute hospital bed situation is a mirror of that quagmire. Every day, an average of 14 per cent of all acute hospital beds in the country — 5,200 every day — are occupied by “alternate level of care” patients who do not require acute care and who could be provided care in some other setting (e.g., home care, palliative care, long-term care) if it was available. 26 “From a clinical perspective, these patients no longer require the intensity or specialization of medical care provided by acute

Each 10% shift of ALC patients from acute care (who are waiting for long term care) to home care in Ontario results in a $35 million savings.

hospitals, and can be safely discharged to a post-acute provider, or to the community (with home community or family supports). In some provinces this average is even higher, and in some hospitals on some days the figure rises to one third of the beds.

That enormous expense is a testament to our focus (and reliance) on acute hospitals and our corresponding failure to invest in the home- and community-based care, long-term care and palliative and end-of-life services required to address our actual population health needs. Another solution would be to imagine that the beds beyond acute hospital walls might themselves have to be flexible — re-cast in a newly designed system as “alternate level of care” or “sub-acute” care that could encompass some mix of long-term care, short-term respite care, rehabilitation care, and/or palliative care, as needed. As noted by the Registered Nurses’ Association of Ontario’s (2011) submission to the Commission, continuing to pour money into acute care simply perpetuates “ineffective, inefficient and costly care.”

Our performance (and sometimes waste) in other areas was similarly disconcerting. For example, despite the billions of dollars spent over the past 20 years, Canada placed dead last in the Commonwealth Fund Profiles for physicians using electronic records in their practices. Although those rates are approaching the 50 per cent mark in some jurisdictions, they already exceed 90 per cent in seven of the Commonwealth Fund’s comparator countries. Of course, this issue is much broader than physicians — but that was the common measure in the Commonwealth Fund analysis.

*Health Overview, Conference Board of Canada, 2012*

Looking at health outcomes rather than system performance, the Conference Board of Canada gives Canada a “B” grade overall, ranking us tenth out of 17 OECD peer nations (behind Japan, Switzerland, Italy, Norway, Finland, Sweden, France, Australia and Germany.) The study notes that, though we have had “B” grades for five decades, we are making some progress, with mortality rates dropping for some diseases. The reason we have merely maintained our grade, despite this improvement, is that our comparator, peer nations have also improved significantly. So, our relative overall score has stayed the same.

The study concludes that mortality due to cancer, diabetes and musculoskeletal diseases, as well as infant mortality, are at a “C” grade level and warrant action to improve overall societal health. The Conference Board notes with concern that “Canada has the third highest mortality rate due to diabetes among the peer countries, and diabetes prevalence continues to increase. This should be raising alarm bells, not only among Canadian policy-makers but also among the public.” Each of these areas is linked to broad determinants of health and could be responsive to intervention through broader primary health care services, including health-promoting and chronic disease management services delivered by nurses.
Controlling costs, improving health: there are solutions

Moving beyond health-care spending and thinking differently about buying health

On the issue of what we are buying with our Canadian health-care dollars, it is clear that we have significant issues to tackle within the existing roster of primary, secondary and tertiary care services. But looking at the broader drivers of health, Browne, Birch and Thabane are very direct — concluding that our system “has been driven principally by insured physicians and hospitals providing acute and episodic care that is a poor match to the changing demographics of persons with chronic disease living longer.”34 Based on year-2005 OECD empirical data, they note that, “after adjusting for overall gross domestic product per capita, it is the ratio of social service expenditures to health service expenditures that is better associated with improved outcomes in key health indicators and not the amount spent on health services.”35 As a result, they conclude:

These findings suggest that, given the paradox of high health spending without improved health outcomes, perhaps differences within OECD countries on expenditures for social services and benefits are associated with better health outcomes, such as improvements in infant mortality, life expectancy and potential years of life lost.36

When we turn to ask what we should do to boost our performance while reining in costs, we are inevitably driven back to evidence that is remarkably consistent across the related, published literature: that health is a product of many factors beyond health care. In 2009, the Subcommittee on Population Health of Canada’s Standing Senate Committee on Social Affairs, Science and Technology concluded that health care system accounts for only 25 per cent of health outcomes.37 That leaves 75 per cent somewhere else. They argued that “fully 50% of the health of the population can be explained by socio-economic factors” including early childhood development, income, education, housing and social support.38 Put succinctly by the Conference Board of Canada,

Most top-performing countries have achieved better health outcomes through actions on the broader determinants of health such as environmental stewardship and health promotion programs focusing on changes in lifestyle, including smoking cessation, increased activity, healthier diets, and safer driving habits. Leading countries also focus on other determinants of health — such as education, early childhood development, income, and social status — to improve health outcomes.39

The Conference Board of Canada has expressed worry that “Canada is not making significant progress in prevention and health promotion.”40 They noted that “Countries with considerably older populations than Canada’s — like Japan and Sweden — do not have more expensive health systems.”41 Having one of the oldest populations in the world, Sweden “has prioritized an integrated approach, tailoring home care, health care, and fitness activities to the needs of older Swedes.”42 They concluded that “Canada has no choice but to adopt a model that focuses on sound primary care practices and population health approaches — particularly preventing...
and managing chronic diseases — and recognizes and rewards high-quality health-care services.”

Those conclusions about impacts on health from inputs beyond health care would seem to find support in the work of Muntaner, Ng and Chung, who urge “wide-ranging policy recommendations...to encourage intersectoral action on health.” Starfield concluded that the literature on the benefits of primary care- oriented health systems is “consistent in showing greater effectiveness, greater efficiency, and greater equity.”

As a result of their research, the Senate’s subcommittee on Population Health made 22 recommendations; among them, that the Prime Minister “take the lead in announcing, developing and implementing a population health policy at the federal level” and that “the Treasury Board of Canada Secretariat pro-actively undertake to enhance the range of models and resources available for the management of horizontal and vertical collaborations.”

And what of Canada’s current health-care model?

While taking on a broader view of health in the future, we must also tackle the models, practices and costs associated with our existing health-care system. Both problems have to be tackled. The Commission received many written submissions and discovered examples of innovations in nursing, health-care delivery and systems models, each of which can inform decisions to transform how, where, by whom and at what cost care is delivered. These examples included: (1) delivering much more care outside hospital walls; (2) through teams of providers, having multiple points of access to care at times and in places that make sense for Canadians; (3) expanding scopes of practice for nurses and doctors; and (4) putting in place the range of services across society that make it feasible for Canadians to move into very old age as healthfully as possible and as much in their homes and communities as possible.

One example: chronic disease

If we did nothing else, managing the care and costs of chronic disease more effectively would be a game changer for Canada, and, along with healthy aging, this should be our “landmark national program.” The Centre on Global Health Security tells us that “Modest investments to prevent and treat NCDs [non-communicable diseases] could bring major economic returns and save tens of millions of lives” — asserting that “every dollar invested in NCDs [realizes] three dollars in return.”

What is more, the care of older Canadians and those with chronic or non-communicable diseases (often the same population) must be of paramount concern to nurses. Much of the health promotion, wellness and treatment needed by these groups could almost entirely fall independently, safely and effectively within the domain of nursing practice (i.e., registered nurses with superb training in these areas, but not all masters-prepared nurse practitioners).
Different outcomes certainly depend on reallocating the funding and mobilizing nurses differently. But the results can be impressive. For example, it has been found that:

Doubling the home care daily maximum to $200 to maximize care for these people at home (to cover the cost of a daily personal support worker and weekly health professional visits) would save $250 per day in hospital costs per patient, or $750,000 per day per 3,000 Ontarians. This would result in a total of $273,750,000 per year in hospital costs that could be reallocated to home care. (Browne, Birch & Thabane, 2012, p.23)\(^4\)

Those returns on investments matter when we consider that:

- experts such as the Public Health Agency of Canada estimate that “Chronic diseases cost Canadians at least $190 billion annually”\(^5\) in direct and indirect costs;
- the World Economic Forum tells us that productivity losses as a result of chronic diseases are as much as 400% more than the direct medical care costs;\(^6\) and
- the 2007 Ontario Chronic Disease Prevention and Management study estimated that every 10 per cent reduction in expenditures for chronic illness would result in $1.2 billion annual savings for Ontario alone.\(^7\)

**Implications going forward**

It is clear to us that we must overhaul our system in some important ways to meet the population needs of this century and to corral costs. Based on a preponderance of evidence, the way toward *better health, better care and better value* seems clear to us:

- We have to vigorously repair, reinvigorate and redesign aspects of our primary and acute care system of services.
- We must build on the transformation efforts already underway, not start over; rather, we need to accelerate action and change in certain areas to make care services nimbler, safer, more effective and accessible to all.
- We must all expand our shared concepts of health and health-care to include the urgent implementation of a broader roster of primary health care services able to respond effectively to the current and looming population health challenges that have been identified through a generation of research.

**References**

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