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Speech

Sustainable Health Care for Canada: Lessons for Ontario

Speech to the Ontario Hospital Association Convention and Exhibition

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I want to thank the OHA for their kind invitation to participate in this conference today and to speak to you about the challenge of creating a Sustainable Health Care System in Canada.

As you know, I supervised a major project on the Cost-Effectiveness of the Canadian Health Care System which culminated in the synthesis report called Sustainable Health Care for Canada, which was released last January.

Since that time, I have launched Canadian Policy Research Networks, a virtual research institution with a mission to do excellent research and to lead public debate on social and economic issues important to the well-being of Canadians. One of our Networks is the Health Network, directed by Marcus Hollander. And we will specialize in studies that explore the effectiveness, the affordability, and the responsiveness of the health system.

Today, I would like to connect the social, economic, and political context shaping health care decisions these days to some of the major findings from the Sustainable Health Care report. I will show you some of the analytical findings, and then close with some comments on the very difficult transitions the Ontario health system faces in the next few years.

The key message is that there are powerful health-driven reasons why the system has to change in fundamental ways. But ironically, it takes a fiscal crisis to overcome the natural resistance to radical change.

Socio-economic context

Let me begin with the social and economic context for the health system, focusing on three key points – fiscal restraint, economic insecurity, and technological change.

Fiscal Restraint

First, we need to discuss the unsustainable fiscal situation afflicting the federal and provincial governments. The federal government is cutting transfers for block funding of health care and post-secondary education beginning next April l. The revenue loss for Ontario is substantial – about $2 billion, according to Michael Mendelson.

At the same time, the provincial government is preparing a program of radical expenditure reduction in order to bring the provincial finances into balance. Even without the promised tax reductions, this retrenchment requires additional expenditure reductions of $ 9 billion out of a total budget of $54 billion.

This retrenchment on the fiscal side presents difficult tradeoffs between old and young:

- Do we invest in treating illness? Or, do we try to protect people from the circumstances that create ill-health?
- Do we invest more resources in the elderly (the dominant users of health care) or in young people (the dominant users of social assistance and education)?

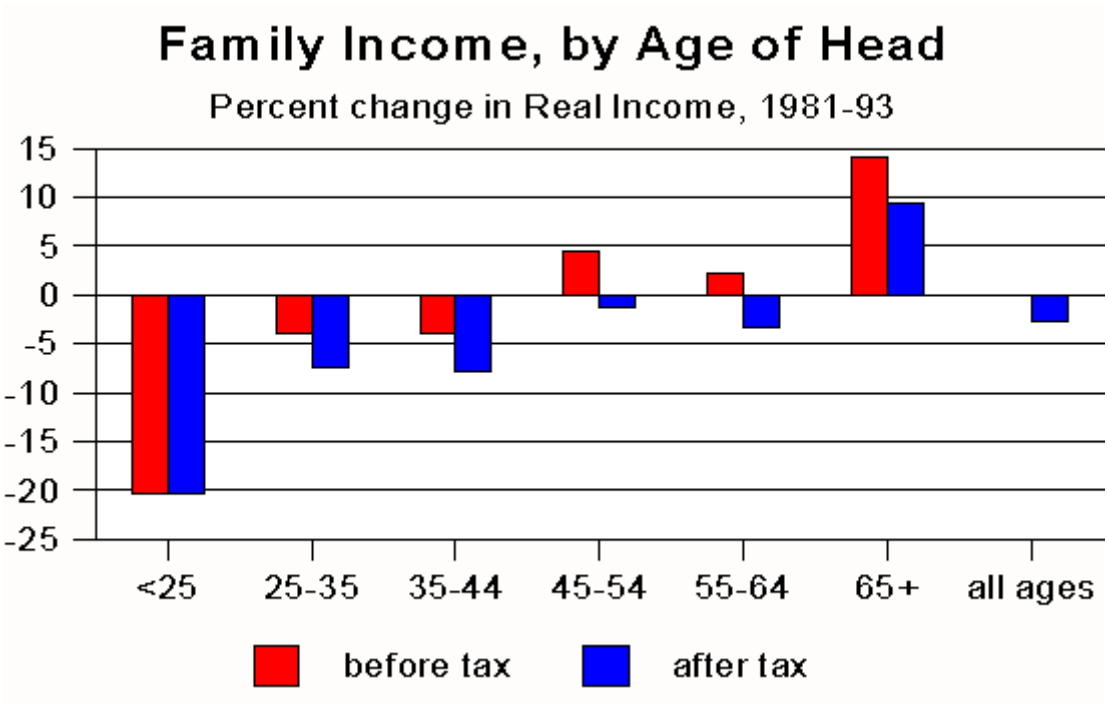
Each province is going to have to struggle with these tradeoffs. The sum total of all their decisions will determine what kind of country we are – what kind of "social contract" we have between citizen and state.

Economic Insecurity

It is now widely accepted that social and economic circumstances have a marked influence on health. People who live in poverty have a shorter life expectancy and a much higher incidence of poor health.

Since the recession hit in 1990, unemployment and underemployment have increased dramatically. And layoffs have become a common occurrence. At the same time, marriage breakdown occurs more often, and when it does occur, there is a high probability that the mother and children will fall into poverty. The net effect, is to increase insecurity and hardship for almost all Canadians – especially families under the age of 25. You can see from this chart that the decline in living standards in the past decade or more has been concentrated among young families.

Chart 1: Real Family Income by Age of Head



Source: Statistics Canada

As a result, the number of children living in poverty has increased from less than one million in 1989 to 1.4 million in 1993. Thus, in all our budgeting decisions, we must not lose sight of the urgent needs of children and youth – needs that show up in education, social services, and in health budgets. We must also bear in mind that Ontario has an ineffective and underfunded children's services system (Liz Verlaan).

As we go forward with reforms in the health system, we must bear in mind that the most vulnerable people in society continue to require support from the state. Some of that support comes from the health system, but much of it comes from other public services such as education and social services.

Thus, we cannot allow expenditures on health to crowd out the other programs that are essential to the well-being of citizens. It is comforting to you perhaps to hear the Minister of Health say that he is sealing the health care envelope, but the government will find before too long that it not possible to reach the deficit targets while exempting the health care budget.

Technological Change

Technology will have a profound influence on the way the health system responds to these fiscal challenges.

In most sectors of the economy, technology is cost-reducing. Only recently have we begun to see the reorganization of work in the health system that produces cost-reductions – the shift to day surgery, for example.

The experience of other sectors tells us that cost-reduction can only be achieved through broadly-based institutional change in other words through changes in the way work is organized and in the way power is distributed in an organization.

In summary, the fiscal pressures are about to hit the Ontario health system in ways that will force radical changes in the way health services are delivered. This transformation will be assisted by the scope for cost reduction through technological change – so that the system can deliver more with less. And, finally, it is important to recognize that health is not the only, and probably not the most important, contributor to the well-being of citizens. This means that health spending should not be permitted to crowd out other important public services.

The major challenge is to choose options which lead in the direction of a sustainable health system for the long-term. By sustainable, I mean, a system that meets the needs of citizens at a cost that society can afford.

Main Conclusions of the Report

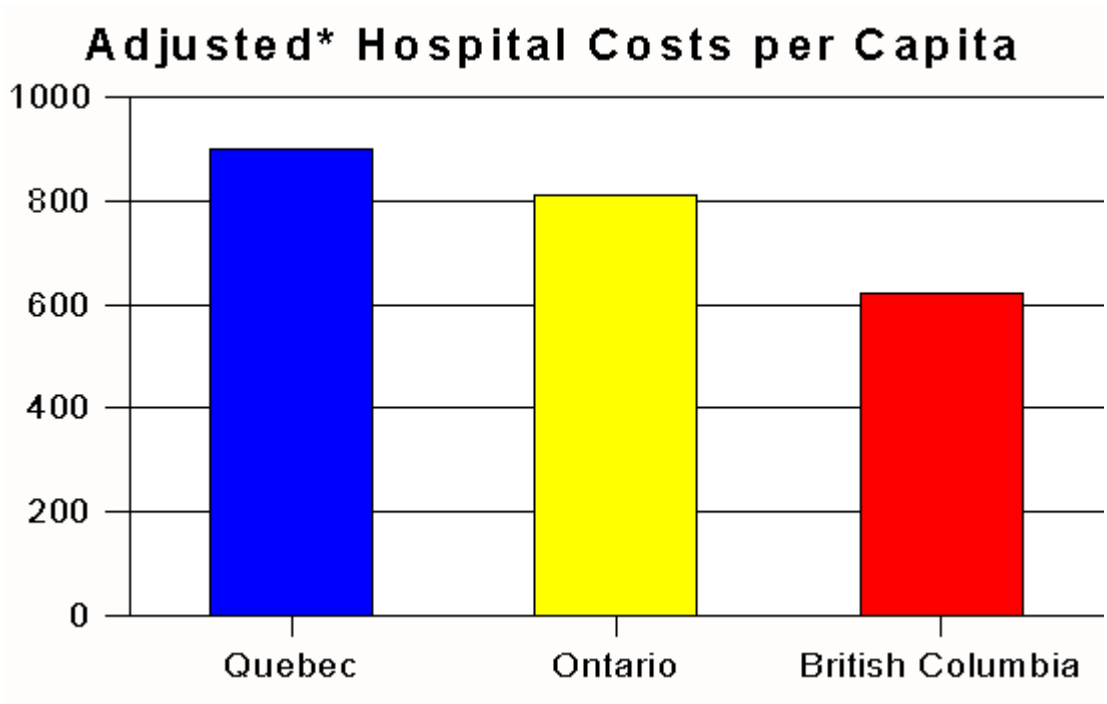
Sustainable Health Care is one of the few Canadian studies that has looked at health care as a comprehensive system embracing hospitals and the whole spectrum of continuing care. The three main conclusions of the study are:

1. Global provincial budget controls and the single payer system are essential to cost-effective health care. In that sense, the overall architecture of the Canadian health system is solid.
2. However, Canada does not have the ingredients required to ensure cost-effective choices are made by providers and managers of health care. We do not know nearly enough about the costs and the outcomes from specific interventions or health services. Neither the physician, the patient, or the health care manager has the information required to make cost-effective choices. Creating this information has to become a top priority for health research.
3. The main driver for the growth in health care costs over the decade of the 1980s was more intensive use of the system. People were taking more pills, seeing the doctor more often, and, if they were in hospital, they were receiving more services. However, there is no evidence to indicate whether this more intensive use of the system produced more health. Indeed, the decline in Potential Years of Life Lost in the 1980s averaged out to five days per capita.

In analytic terms, the two main contributions of the project were:

1. Creation of a Resource Allocation Framework which permitted us to measure the system-wide effects of changes in the configuration of health services. These effects were measured in terms of total cost and in terms of the outcomes for patients (QALYs). We are trying to find an opportunity to pilot the RAF model in one of the Ontario reconfiguration projects. Because the model can add up the consequences for total costs and for outcomes under different scenarios, it can be an extremely useful aid to difficult decisions.
2. A detailed analysis of the cost drivers in the health system, including rigorous interprovincial comparisons of costs in the three largest provinces. I would like to show you these results, and talk a bit about where I think they are pushing us in future research.

Chart 2: Hospital Costs per Capita in Three Provinces



*Adjusted for economy-wide factors which influence costs, such as demographics and wage

Source: L. Auer, et al., Research Report, "Cost-Effectiveness of Canadian Health Care", Queen's University of Otawa Economic Projects,1995.

The chart compares the total cost per capita of hospital services in British Columbia, Ontario, and Quebec. Note that the cost per capita is much lower in BC than in Ontario, even when we adjust for the differences in wage levels and in the age structure of the population in the two provinces.

The difference in the annual per capita cost of hospital services is significant. Ontario is about $163 per capita higher than BC, with no apparent difference in the quality of care. When you consider that there are 10.7 million people living in Ontario, this represents a substantial sum of money – about $1.7 billion per year, or about 10 percent of the province's annual health care expenditure.

The two factors which appear to explain the control of costs in BC are:

1. Lower service intensity in the hospital (that is, fewer tests, fewer nursing hours etc). More research is needed to understand how this works in B.C.
2. Much more effective organization of the continuing care system. Let me describe that system briefly.

What British Columbia has created is an integrated continuing care system based on one-stop shopping, with a coordinated system of assessment and placement. It uses a standard classification system, based on severity of illness, for better case management and planning. And the funding is allocated by a single administration to permit the transfer of funds between program components. (Manitoba operates a similar system.)

This integrated system permits the acute-care and long-term care hospitals to concentrate their effort on people who are more seriously ill. But B.C. has been able to reduce the number of residential care beds per thousand elderly people by 21 percent, while increasing the proportion of elderly cared for in the community by 28 percent.

In effect, BC has created a benchmark for other provinces to emulate. In my view, health research in the coming years must focus on creating and interpreting benchmarks on costs and methods of delivery across the country. That information is essential so that provinces and regional health authorities can make informed decisions about resource allocation. That is a key task for CPRN's Health Network.

This evidence from British Columbia, combined with other projects commissioned for our report [Jacobs, the Resource Allocation Framework], convinced us that one of the secrets to creating a sustainable health care system is to focus on the continuum of care. This is not a new conclusion, but the fact remains that in Ontario (and many other provinces) the system is not designed to create a seamless continuum. The virtue of a seamless system is that it enables patients to be treated in the most cost-effective setting, using the most cost-effective treatments.

The big challenge is to figure out how to get there from here?

For the most part, here is composed of a large number of autonomous health care institutions struggling to maximize efficiency within a specific domain. In effect, most of the resources in the health care system are managed in separate compartments, and the end result is inefficiency. As budgets are reduced, there is considerable stress on the managers, professionals, and staff in those compartments and growing concern on the part of citizens, that the quality of care is deteriorating. What is worse, the compression in operating budgets often means that the unit cost of service is going up. Institutions are become more inefficient.

This challenge of creating a seamless system can be broken down into three questions:

1. What will be the most efficient configuration of health services in a particular region or city to meet health care needs in the future?
2. How do we ensure that the transition costs are minimized for professionals and staff whose careers are closely tied to the future of a particular institution?
3. How can we demonstrate to the patients associated with each institution or service, that their needs will still be met in that new configuration?

I would be misleading you if I pretended to have full and complete answers to these three questions. But I would like to offer a few ideas and insights that flow from our research.

1. **The Most Efficient Configuration of Services**

   A number of regional reconfiguration projects are underway in Ontario this year. They require a lot of painstaking work, followed by difficult choices, based on both qualitative and quantitative information. The first key objective is to eliminate duplication, while fostering excellence and specialization. Many of the shorter range savings will be achieved through this route.

A second objective is to begin to view health care in the region as a system of interconnected services – a continuum of care. Are all the elements of the continuum able to carry their share of the job? In Ontario, we know that the continuing care system is highly fragmented and quite uneven from one service and one region to another. It will be difficult to generate the very significant potential savings from this source until a more robust system is in place. That cannot be done overnight. It certainly deserves a high priority, if we are to create a sustainable system.

How do we test the plans that are put forward for their internal consistency? Have they ensured that all patients will be cared for? Have they captured all the spillover effects that occur when a service is eliminated or a new one is created? To do this consistency check, a decision-support tool like the Resource Allocation Framework would be ideal. It prevents things from falling through the cracks, and provides a rare opportunity to document the impact on health outcomes. More on that in a moment.

2. **Transition Costs**

I said earlier that extracting the benefits of new technologies requires changes in the way work is organized and power is distributed in an organization. When provinces create regional or district health authorities, for example, the hospital CEOs become part of a regional management team. The regional board acquires responsibility for deciding how to eliminate duplication, create new alternatives, and invest in new capacity.

One troublesome issue that all boards face is how to manage transitions that are alarming to patients, professionals, and employees. The Sustainable Health Care report identified five guiding principles to minimize the human and financial costs of transition: (Several of these principles are echoed in the JPPC document entitled Advice to Government which was released in July.)

1. Involve employees and professionals in the decision-making process to give them some ownership in the transition. These people know a lot about the day-to-day detail of health care delivery – they have a lot to offer and they can only make the transition work if they have a solid understanding of the new direction.
2. To preserve the confidence of employees and the comfort of patients, emphasize a commitment to service quality and to improve the health of citizens.
3. Redeploy health professionals and workers within the system, broadly defined. This requires up-front investments in training and career counselling.
4. Ensure that community and alternative services are available before closing existing facilities. This means that the patient will have alternative forms of care and that workers and professionals will have employment opportunities. This too requires time and up- front investment in facilities.
5. Acknowledge from the beginning that the changes are not a one-time response to the budget squeeze, but part of an on-going evolution of the way the community will deliver health services.

By definition, these changes need time and they need investment, if we are to minimize the human and financial costs of transition.

Thus there are two sides to the coin. What we see as turbulence and insecurity on one side shows up as a period of extraordinary innovation and creativity. Somewhat to their own amazement, health service providers are beginning to demonstrate that they can deliver excellent care with fewer dollars. In short, health systems are opening up to new ideas, new perspectives, and new attitudes.

3. **Reassuring Stakeholders**

   Now that governments have run out of money to add to the health care system, they are caught in a bind. Citizens consider the health care system to be a national treasure. They do not like to see governments taking resources away. They are deeply distressed about the possibility of deteriorating quality or access. But they are also adamantly opposed to tax increases and they are determined to maintain the quality of other government services, especially education.

With the lack of data on costs and outcomes, governments and providers have very limited capacity to reassure citizens about the trends in quality and effectiveness. How do we maintain trust in a system that has always been held accountable for inputs rather than outputs? Unless you have system-wide data that show the trend in quality and access, there will always be an anecdote about one patient who did not get the right care. That one anecdote can undermine credibility and leave management and the board tilting with windmills.

Other provinces, including Saskatchewan and New Brunswick have been forced to deal with this sens of loss, and my visits with the health administrators on the firing lines have led me to two conclusions.

First, the change process requires an intensive effort in consultation with citizens along with a hard nosed commitment to get on with the job.

Second, the key to building trust is to demonstrate performance. Once they see the system functioning to meet their needs, citizens are prepared to buy in.

Concluding Comments

In summary, ladies and gentlemen, your task as health care managers is to begin to think in systemic terms. The demand for health services is determined to a considerable degree by the social and economic environment in which citizens are living. A trend toward greater poverty among children, for example, and reduced social services for families, is a trend that leads to more illness in the longer run.

The more you can ensure that health services are linked to, and cooperating with social services, the more you can do to prevent escalating demands on the system in the years ahead.

On the supply side of the system, it is important to differentiate the savings that can be achieved in the relatively short run, by reconfiguring existing services. On this, and many other topics, there are solid lessons to be learned from other provinces – lessons that can prevent mistakes and that can move Ontario well up the learning curve.

But, the biggest savings, and the biggest contribution to sustainability will come from the creation of a well-developed continuum of care – a continuum that recognizes and values the contribution that flows from each component of the system – from self-care and home care at one end of the spectrum to the high acuity care offered in many institutions at the other end.

I admit that there are no short cuts in moving Ontario towards a seamless health services system. The turmoil may be hard to handle, and there are always risks of going off the rails. But you should go forward armed with the confidence that this is not Mission Impossible. There are options which can meet the expectations of citizens and the hopes of the professionals in the system – options that can lead Ontario in the direction of sustainable health care,

I wish you all good luck.

(November 7, 1995)