

Synthesis Report

Sustainable Health Care for Canada

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Members of the Advisory Committee

Funding Partners

Project Team

Executive Summary

Health care in Canada is under stress from four interconnected areas: the fiscal pressures on governments; lack of knowledge about the links between health care and health; the ethical dilemmas involved in rationing health care services; and the contradictory incentives built into the rules and regulations governing health care delivery.

These tensions are not new. What is new, however, is that no new money can be added to the system. To make the health care system sustainable, Canada must find new and innovative ways of delivering health care.

To meet this challenge, better information is needed – information that shows how health care affects health and how much it costs to achieve this health. It was precisely this lack of information that gave rise to the project on Cost-Effectiveness of the Canadian Health Care System. By examining the health care sector through a system-wide lens, we are able to explore the links between health care and health, and reach some conclusions about making health care sustainable.

We learned that much can be done to make the health care system more efficient without adversely affecting the public's health. The secret is to substitute less costly types of delivery and forms of treatment in more appropriate care settings.

The project developed a Resource Allocation Framework so that a few scenarios could be tested for their feasibility and their impact on health outcomes. In general, these scenarios reflect the direction of change in provincial health policy in recent years. They are:

- reducing acute-care beds and length of stay in hospitals;

- substituting continuing care for acute care;

- reducing the rate of unnecessary surgery and substituting same-day for inpatient surgery; and

- reducing institutionalization of the elderly by substituting home and continuing care for institutional care.

The project also identified successful modes of delivery in some provinces that could be used as benchmarks for “better practice” to generate savings in other jurisdictions.

The overall reduction in the cost of the Canadian health care system is estimated (conservatively) to be about 15 percent of public health care costs, after taking into account the necessary investments in new, less costly, facilities and services. Based on 1990 health care expenditures data, this translates into savings of about \$7 billion.

The overriding goal of doing the appropriate things to the appropriate people at the appropriate time can be achieved. However, in reducing overall costs and becoming more efficient, there are notable implications to consider.

First, significant cost savings are feasible, but they do require a major reconfiguration of health care facilities – replacing high-cost acute care treatment with continuing care. As long as appropriate continuing care services are available and working well, these alternatives are viable over a wide range of problems.

Second, as hospital capacity is reduced, the need for effective continuing care in the community will increase. Policy will have to focus on developing cost-effective continuing care as well as support services for families, friends and other informal caregivers who represent important elements of such care.

- Third, part of the savings to be realized by this reconfiguration will have to be set aside to cover the real human costs of such transitions, through strategies like training programs and worker assistance programs, outplacement programs and, where unavoidable, severance packages.

Finally, as provinces regionalize their health care system, they must retain the strong central control of health care financing and overall health care costs. At the same time, regional authorities must be given authority to reconfigure health services to meet the needs of the population. To do this, new kinds of information will be required on health needs, on the costs of alternative treatments, and on the outcomes flowing from those interventions.

Analysis of the cost drivers in the health care system in the 1980s shows that Canadians are taking more pills, receiving more intensive hospital services, and visiting the doctor more frequently than they did in earlier times. The state cannot regulate use of the system, but it can create a new set of incentives that will realistically encourage both providers and patients to choose less costly – but equally effective – health alternatives. That is the essence of sustainable health care.

Foreword

This project was launched in late 1991 by the Economic Council of Canada. The Council was responding to the fact that nearly all the provincial Royal Commissions and Task Forces of the 1980s had recommended work on cost-effectiveness, but that none of them had been in a position to commit the time or the resources to the pioneering work in data development or modelling required. We knew from the start that the project was too big to be funded solely from Council sources and wish to acknowledge the funding support from the partners listed at the end of the report.

The team faced a daunting task of finding measures of the outcomes from health care and of creating a statistical and institutional portrait of the health care system from stem to stern – that is from hospitals to continuing care. They then had to contend with the shutdown of the Council and the transition to the University of Ottawa, where a new home was created that offered valuable linkages to the Department of Medicine, the Faculty of Health Sciences and the Faculty of Administration. Their contributions have enriched the project.

Over a three-year period, the team has covered an extraordinary amount of ground in gathering data from every corner of the health care system and integrating it into a system-wide view. They have commissioned a large number of studies by respected Canadian researchers. Some of these studies have focused on the institutional and regulatory issues that have an important influence on the performance of the health care system; others have developed new analytical insights with respect to the continuing care sector, the use of new technologies, drug utilization patterns, and the shift from inpatient to outpatient care. These studies have been reported in Working Papers and in a research report, aimed at a more technical audience, which will be published in early 1995.

This synthesis report condenses a vast array of technical documents into a readable and highly relevant review of the current challenges we face in updating health care in Canada. It demonstrates the new ground that the project has opened for health care research, and the immense amount of work that remains to be done if we are to create a solid foundation for the efficient allocation of health care resources in Canada.

The past three years have been turbulent ones for the Canadian health care system, as the inexorable pressures of budgetary restraint have forced important

changes in the configuration of health services and in the governance of many provincial systems. This report offers support for many of the trends in health care reform, and it sets out criteria for success in a number of areas where provinces are breaking new ground – specifically in the development of comprehensive continuing care and in the regionalization of their systems.

The research has been guided by a hard-working and demanding Advisory Committee whose members are listed at the end of the report. The Committee was chaired by Mary Mogford, a former member of the Economic Council and an independent consultant based in Toronto. I would like to thank all of them for their diligence, their encouragement, and their good advice.

As we close the project, we are committed to developing the data and the models further so that the tools for analyzing cost-effectiveness will become a continuing aid to the complex process of allocating scarce health services. In the end, we all share the same objective, which is to ensure that the health system is sustainable so that it can make, on an ongoing basis, the maximum contribution to the health status of Canadians.

Judith Maxwell

Acknowledgments

We would like to thank the Advisory Committee members (listed at the end of the report) for their guidance and advice throughout the course of this project. Although not listed as authors of this report, the contribution of those team members involved in the project at various stages along the way certainly made our work easier than it otherwise would have been – they, too, are identified at the end of the report. The initial work and effort from Caroline Pestieau – who is now Director General, Social Sciences, at the International Research Development Centre – to successfully launch this project is particularly appreciated.

Without solid administrative support, projects such as these labour under great difficulty. That our undertaking – all of the Advisory Committee meetings, research workshops, our major colloquium, and the numerous draft versions of our major reports – went so smoothly is due to the professional and meticulous work of Gisèle Lacelle. Also, through Lynn Landriau's desktop publishing skills, many excellent charts, figures and tables were prepared. A picture truly is worth a thousand words.

Finally, the unconditional commitment, encouragement, insight, feedback, advice and friendship from Judith Maxwell – from beginning to end – helped lead us successfully to the other side of the policy research bridge. All of us are much richer for the experience.

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