Five drivers, some implications, one vision and an invitation: Thinking about the future of health care in Canada

Presentation to the Catholic Health Association of Canada

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Good morning.

I am delighted to be here today and there are several reasons for this.

First, as I hope you will discover I have a real passion for health policy issues having worked in the area for about a decade now.

Second, I have recently returned to full-time academic work and some of the work that I have done at the Canadian Policy Research Networks can be recast in a more scholarly setting. I agreed to give this talk this morning in part to force me to put some structure on a series of ideas I have worked on – I will let you be the judge of whether the structure makes my ideas intelligible.

Finally, I want to hear from you. You are, as I understand it, people who work in the actual delivery of health services. I firmly believe that there must be a continual dialogue between policy people and program people – in fact I am not sure that distinction in fact makes any sense. To put it another way, I believe in the importance of what some have called knowledge mobilization. The idea here is that some of the best knowledge we can produce is not about me telling you about what I know but rather we produce knowledge in partnership – I may provide an initial framework and some background research but what is most interesting is what we come up with together.

Let me take a minute to sketch what it is that I want to cover this morning. In broad terms, I have been asked to comment on some of the drivers or forces that will shape the nature of health and health care over the next 15 years or so. I have also been asked to speak about the implications of theses drivers and finally offer my own vision of what health care will look like in say, 2020.

To tackle this vast and complex undertaking I would like to begin by sharing with you both the paper that the Ontario Medical Association has drafted as part of its Campaign for Healthier Care and some of the thinking that went into it.

The discussion paper identifies a series of drivers that will shape health care over the next 15 years or so and I will sketch some of these here.

I then want to tackle an issue the discussion paper aggressively avoids – the roles of "public" and "private" in both the delivery of health care services and in how we individually and collectively pay for health care services. I recently wrote a short essay for the Newsletter of the Saskatchewan Institute of Public Policy and, as those of you who have read it will know, I am dubious about the utility of trying to distinguish between public and private in the delivery of health care and I think this is particularly important for Catholic health care as you will I hope see in a few minutes.

Mixed in with what I have to say about some of the drivers of health care are some thoughts on the implications of these drivers. This is where I move from being analyst to crystal ball gazer. I am not convinced that my reading of the implications of some of the more important trends is any better than yours. Rather, my goal is to get you thinking about the future in perhaps new ways and I look forward to your own thoughts on the implications of the at least some of the powerful forces that shape health care in Canada and beyond.

Finally, and again with some reluctance, I will sketch my vision of health care in 2020. Again, my goal here is not to convince you of the accuracy of my vision or visions but rather to get us all thinking about the future.

Before I move to a discussion of some of the drivers, I would like to say a word about "the future." My first take away message is that ***the future is now***! While it is important and useful to talk about the future it is critical to grapple with the fact that the distance between 2007 and 2020 is actually quite short indeed. Consider how long it takes to dream about, plan, design, build and move into a new building. The two so-called super-hospitals in Montreal are a telling example of the lead time between deciding that a new building is needed and making it happen. Or consider the time it takes to train some of the more sophisticated specialists that work in hospitals. I am told it can take upwards of 15 years to train a specialist. Decisions that young people are taking today will shape the supply of these specialists in 2020. Or consider the fact that we now have the technical ability, thanks to the mapping of the human genome, to routinely diagnose people today for a disease that might not manifest itself for 15, 20 or even 30 years. But I am getting ahead of myself – more on this later.

Some phenomena that will drive health care to 2020

I would like to spend a few minutes discussing … phenomena that I think will drive health care over the next 15 to 20 years. This is not an exclusive list, and you will want to add some more. But I would like us to think about in turn:

- Technological change
- Demographic change
- What the OMA has called Health Consumerism or I would like to describe as "the boomers meet health care"
- Environmental degradation, and finally,
- Changing conceptions of public and private.

Again, I want to emphasize that this is by no means an exclusive list but rather a starting point to describing some of the broader forces that will shape demand and supply of health care over the next two decades.

Technology (and the New Biology)

We are getting used to technological change and the increasing pace of change. But based on the technological and scientific innovation that is coming down the pipe there are those who would shout "hold on to your hat."

Every day it would seem that there are new diagnostic tools, new machines to monitor chronic illness, new drugs to treat old diseases. And the mapping of the human genome is being married to the pharmaceutical industry and the result will be a dizzying avalanche of new products, some tailored to ever smaller slices of the population but at an every higher cost. Moreover, if we adopt an innovation widely without sufficient evaluation, we risk serious misadventure. If we delay until the innovation is fully proven, many who could benefit from it will not have the chance. How will we know the right moment to adopt the new and move out the old? Who gets to decide, on what grounds, with what input, from whom?

Developments in cell biology, the human genome and nanotechnology are now informing our understanding of the subtle regulation and balance of the human body. As a result, cancer is no longer studied as simply an anatomic lump that arises somewhere, but rather as the result of changes that start long before the lump develops. Stomach ulcers, once visualized as an anatomic hole, are now understood to be the result of bacteria that alter the local resistance to stomach acid. This fundamental reframing of human biology is causing our classification of diseases to change, tests to be reinvented and entire therapeutic strategies to be revamped. The very definition of "disease" and "patient" is changing, in part

because illnesses we used to start thinking about at age 50, are now predictable as early as birth.

The fact that by something of an historical accident pharmaceuticals are not a core part of the Medicare basket also becomes critically important here. As acute care moves from hospital to home, from surgery to tailored drug and outpatient therapies, the fact that we did not include drugs in our definition of a publicly-funded health care system becomes a real problem. So one prediction that I am comfortable making is that technological change will result in a blurring of the lines between sickness and health, between patient and non-patient, and between hospital and home. And pharmaceuticals, how we evaluate them, how we pay for them, and indeed how we define them will be on the cutting edge of this debate.

In the OMA discussion paper we are invited to consider the case of Arish is an active seven-year-old boy who appears completely healthy. Because his family history suggests the possibility of early degenerative bone disease, however, he underwent genetic testing . The results of that test showed that Arish carries a genetic defect that alters a metabolic pathway. The metabolic abnormality indicates an estimated 60 percent risk that he will be seriously affected by the age of 55. A drug has been developed that is best administered starting now;

however, only about seven years' clinical experience with the drug has occurred. So far, few side effects are apparent. The drug is costly. At the age of seven, is Arish a patient in the health care system? Should he be asked to bear the costs of a drug therapy that will run the course of his life? What if he chooses not to take the drugs or cannot afford to and he becomes ill earlier than he might have and then becomes a patient in the traditional sense? Should we not try to avoid this scenario?

Demographics

The second reality is demographics. Consider what is coming: in the next two decades, Ontario's population will grow by 20 percent, or another 2.5 million people. It is reasonable to expect that the population of Canada overall will grow at a similar pace but increasingly unevenly – with significant growth in places like Alberta and the lower mainland and significantly lower growth in rural and small town Canada. This will have major implications for how and where we deliver services. More small hospitals will be forced to close while at the same time we will need to increase the number, depth and range of services in large cities.

A large part of this growth will result from immigration, which will introduce new or unfamiliar health conditions and pose new challenges for diagnosis and treatment. Moreover, to some extent immigrants arriving in Canada bring with them more traditional value systems. I am reasonably confident in predicting that one of the implications for health care is that the ethical debates will intensify and that Catholic health care professionals will be joined by professionals from other faith traditions asking hard questions about the wisdom of the dizzying array of new technologies.

The proportion of the population over the age of 65 will double; the health care needs of older Canadians will be many and complex. At the same time, the development of new therapies that can stem and even reverse the effects of aging (such as joint replacement) will drive more demand among older people for treatments and services. Canadians will enter the "health care system" at an earlier stage and stay in the system longer as they age. And to anticipate what I will say later about how we pay for health care, I think it would be ironic if the ageing boomers were to use their numbers to recast the Medicare bargain and shrink the size of the public basket of services just as their children and grandchildren becomes more intensive users of the system. There are real issues of intergenerational justice that I do not have time to tackle but should be of real concern.

The demographic picture has another challenging dimension: diversity and mobility. SARS and other less infamous diseases that originate far away have taught us that people and diseases are increasingly mobile and that the health care system must be able to respond quickly to infections diseases that originate far away but can move quickly to affect Canadians.

Moreover, the people that require health care are every day more diverse. Health care in general and medicine in particular work best when we have experience that we gain experience from many similar individuals to shape treatment. But when we observe the dizzying cultural diversity of large cities in Canada and link this to the genetic reality that disease affects each person a bit differently, we encounter highly individualized biology that leads to highly individualized health care needs. What we need to know to provide acute care or long term care or home care services to a Canadian who was born in Kashmir or Kurdistan or Katmandu may well be in Asia and Africa not in the local hospital or long term care home.

Health Consumerism (or the baby boomers discover health care)

In 2005 the front edge of what has been called the baby boomer generation turned 50. As the health care needs of the boomers increase, the way that citizens

interact with the health care system will change dramatically. As a population, Canadians are now more educated than ever before and more inclined and able to do our own research and participate in decision making about our health and well-being. Boomers are much less deferential to authority as compared to their parents and, having grown up in complex systems that can be made to work, impatient with a health care system that all too often does not work or at least does not work as well as it could or perhaps should.

The result is a health care system where patients, clients, users and observers will be, among many other things:

- More individualistic in their decision making (more "me" and less "we");
- Demand greater timeliness, quality and choice.
- More open-minded about alternative approaches to health care, and willing to explore complementary and non-Western medical treatments.

But changing demographics also has a major impact on the supply, nature and career paths of health professionals. The health care workforce of 2020 will be quite different from that of today as a result of population ageing, immigration, and changing ideas of what constitutes a good job. Once again, it is important to emphasize that the lead time required to train health care workers means that we cannot start soon enough to work out what the health care workforce of 2015 and 2020 will look like.

Environmental Degradation

A fiend of mind, when faced with the news that someone she knows has cancer is of course concerned as we all must be but she also routinely asks, was the cancer patient born in the Great Lakes Basin? Her point is that there is almost certainly a link between the growing incidence in cancer and the fact that the world we live in is dirtier and more toxic than ever before or, less pessimistically, for some of us, the environmental cleanup may have happened too late.

Or consider climate change. The potential health effects of climate change are diverse. The rise in temperatures will mean:

- that certain tropical diseases will move north to populations with no acquired resistance;
- increased air pollution and smog which will mean a rise in lung disease and other ailments;
- more warm days and therefore a rise in the incidence of food-borne infectious disease like Salmonella.

However, the effects of climate change are likely to be even more dramatic in Africa and parts of Asia and the knock-on effect on Canada will be significant as the concerns about Avian Influenza demonstrate.

Changing Conceptions of Public and Private

For CPRN I wrote a paper which I made three linked arguments. First, that when it comes to the **delivery** of health services it makes no sense to try and distinguish between public and private providers much less to try and prove that one is better, safer, more effective than the other. We do not have conclusive evidence one way or the other. More importantly, what mattes is that the care is timely and responsive to patient and family needs – a range of providers can do this.

Second, I argued that when it comes how we pay for health care, public and private do matter a great deal. The Medicare bargain is not only about how we pay for health care it is about taking care of one another. Medicare was conceived and remains as a system that, when combined with progressive taxation, transfers wealth from the relatively healthy and wealthy to the relatively less healthy and less wealthy. Thus, how we pay for health care speaks to the values we hold as Canadians and forces us to reconcile what is best for the individual ("why can't I buy my hip surgery') with what is best for the community ('because it is requires scarce resources and we need to share them fairly"). I want to raise this here as the fifth and final driver of change as we bumble along to 2020 because I do not think the debate about public and private is over, on the contrary.

But I want to focus on health care delivery again for a moment and take something of the long view. Consider that in our lifetimes, at least for some of us in this room, we have moved from a health care delivery system made up a wide range of providers with different financial and service relationships to patients to a system where health care was, or was at least seen to be, public or if you will "run by the government" (even if this was never fully true). And now we are back to a world where there is pressure to allow for a diverse range of providers. But throughout this period, there are a few constants and Catholic Health Care is one. Is a long term care facility run as a Catholic institution a public or private facility? Does the question even make sense? Surely what matters more is the extent to which a Catholic long term care facility or hospital or community mental health program can delivery timely, effective and efficient care that is responsive to the needs of patients, clients and their families. And my casual observation is that Catholic institutions are, all things being equal, better at defining, capturing and delivering holistic care.

Vision of the future

In the few minutes I have left let me sketch the beginning of my vision for the future, of what health care might look like in 2020.

- we take on the tough debates that arise as a result of the new biology and the interventions made possible by advances in genomics, nanotechnology and ever more accurate (and expensive) diagnostic imaging and that Catholics, Muslims and other faith traditions are encouraged to engage in the debate and perhaps point the way even if the majority is unwilling to go as far or as fast as you might want in reversing trends you find troubling.
- We tackle the crisis in health human resource planning and supply, reorganize service delivery make the best use of all skills, and the shortages get worse as the working age population ages and workers in the health care sector retire. I would note I passing that the universities and colleges have a critical role to play here since we have evidence that suggests that health professionals act the way they are trained to act. On this account, the resistance to, say, primary care reform, to take but one example, begins in school.

- we address the issues that arise as a result of technological change and in particular the explosion in the range but also the cost of pharmaceuticals. Unless we come to grips with the fact that drugs are a growing part of overall health expenditures and the costs of individual drug regimes is financially crippling some people, we cannot lay claim to a fair and equitable health care system.
- we do not allow powerful interest to force on us an unproductive debate on the roles of public and private actors in health care when the real issue is how best to organize a range of service providers, public and private, Catholic and lay (and perhaps soon Muslim and Buddhist) to deliver care and a health care system that remains caring and sharing.

I would like to end my presentation with an invitation.

I invite each of you to join with me in a conversation that uses what I have just said as a jumping off point. In particular I invite you to ponder some of the following questions:

- in 2020 what will it mean to be a patient? If therapy can begin at birth even when the person is not ill in the traditional sense, is this health care

as we have come to define it? And who should pay for it – the individual or the state?

- The new biology allows us to target therapy to individual patients based on their genetic makeup. It also allows us to tailor drugs to individuals – who should pay for these drugs, particularly if they are prohibitively expensive?
- Can we afford not to take climate change seriously? Are we ready for the health implications of climate change?
- During the next decade or so to 2020 how will Catholic health service organizations respond to pressure to increase private delivery albeit with continued public payment? What are the implications of the arrival of larger numbers of Canadians from other faith traditions who may share the concerns of Catholic health care professionals about the implications of new technologies? Yet how can we avoid divisive debates that benefit only a few? What role citizens? At CPRN we have extensive experience in engaging citizens to deliberate on complex and divisive policy issues and our experience is that, when given some good basic information and a little structure, Canadians are willing to engage on these tough issues, so allow me to end by repeating my last question – what role citizens?