



## The Sustainability of Canada's Healthcare System: A Framework for Advancing the Debate

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### **How sustainable is healthcare spending in Canada?**

The debate over whether Canada's healthcare system is sustainable grows louder. Unfortunately, this debate has become entangled with opposing ideological positions on how our healthcare should be paid for and delivered. The *right* argues that healthcare costs are progressively being pushed to levels that cannot be sustained, and uses this as a premise for proposing reforms that involve more privatized delivery of services and options for people to pay for their own care. The *left* argues that we can pay for the health system we want. They say we need to be careful, lest sustainability concerns undo our long-standing commitment to an equitable healthcare system, one where personal means do not determine access to services. This article explores these points of view and their implications. After weighing the evidence, we conclude that the sustainability concerns are real, but we also offer a framework for addressing those concerns that takes us beyond the ideological standoff that has gripped the discussions to this point. Ultimately, we argue, we must use

this kind of framework to deal ethically with the issue of the sustainability of publicly funded healthcare while there is still time to make the difficult changes that will be required.

### **The debate**

Spending on healthcare in Canada continues to outpace growth in government program spending and economic growth (Canadian Institute for Health Information 2005b). Recent studies by Brett Skinner at the Fraser Institute have looked at trends in the annual growth rates for provincial healthcare expenditures and total provincial government revenue from all sources (Skinner 2005; Skinner and Rovere 2006). He found that if recent trends persist, provincial government spending on healthcare will consume more than half of total revenues from all sources in six of 10 provinces by the year 2020. These projections are corroborated in another report from the Conference Board of Canada. It indicates that on the current course, the Ontario government could be spending 70% of its total revenues on healthcare by 2022 (Conference Board of Canada 2005). A recent report

from British Columbia's minister of finance projected her province is on track to be spending 71% of its revenue on healthcare by 2017. Furthermore, if British Columbia succeeds in holding education spending to its current 27% level, there would by 2017 be virtually nothing left for other areas of provincial responsibility (Taylor 2006).

These trends leave the provinces with three immediate options: increase revenue (most likely through a variety of tax schemes, including premiums or higher marginal rates) to pay for the increasing cost of healthcare; aggressively reduce the costs of healthcare; or reduce spending on other areas of provincial responsibility such as education, social services, income support or roads and other physical infrastructure. To date, the default seems to have been closest to the third of these options (McKinnon 2004). It is not surprising that senior officials in the central agencies of provincial governments make reference to the "healthcare monster," a beast that is progressively harder to reckon with and is making it evermore difficult to maintain other provincial programs. The second

option of reducing healthcare costs may be particularly challenging, given the unrelenting cost escalation pressures, concerns about access and wait times and the high level of support for publicly funded healthcare.

Concerns about the sustainability of healthcare are found not just in projected cost increases emanating from the country's right-of-centre think tanks. Ask any front-line healthcare professional or any chief executive officer of a health region or hospital – they all feel the pressures of having to address healthcare needs with the resources available. The stresses from trying to keep this equation in balance are showing themselves in increasing wait times, access issues and growing concerns about the quality and safety of our healthcare. The *Chaoulli* case is just one illustration of how this is playing out (Low et al. 2005). Recent decisions of the Ontario Health Services Appeal and Review Board also point to growing concerns around timely access (Georgas and Shap 2006). They underline the liabilities governments and providers may face if such obligations are not met.

The forces that lie behind the growth of healthcare costs are well documented (Organization for Economic Co-operation and Development 2006b). They include the aging of the population, new and more expensive treatments (particularly new drugs), new diagnostic procedures, more demanding consumers, new diseases and an increasing prevalence of chronic diseases. One of the challenges in getting a grip on healthcare costs is that the rate of growth has to this point been gradual enough for there to be little incentive for any government to take a long-term view and make the tough decisions that are needed to stem the growth. Most governments seem more inclined to let their preoccupation with the next election override concerns about the sustainability of their healthcare system

for the next 10 or 20 years. Only two provinces have explicitly recognized the necessity of dealing with healthcare sustainability. Alberta was the first province (Aon Consulting 2006; Government of Alberta 2005, 2006). More recently, Premier Campbell of British Columbia initiated a public debate about the healthcare system British Columbians “want, expect and can afford” (MacDiarmid 2006).

How is it, in the face of the evidence, that there is still a debate about whether our healthcare system is sustainable? Part of the explanation lies in the concern that the sustainability issue is being used to challenge our long-standing commitment to a universal public healthcare system. Roy Romanow in his 2002 Commission on the Future of Health Care in Canada argues the debate on sustainability is actually “more to do with ‘who pays’ than ‘how much’ we pay” (Commission on the Future of Health Care in Canada 2002). He argues that what Canada spends on healthcare is on a par with other developed countries and is, in fact, much less than the United States spends. Ultimately, he argues, the question of sustainability for individual Canadians boils down to “will medicare be there for me when I need it?”

Politically, it has been difficult to challenge the Romanow line of argument, given the remarkably high level of support for public medicare. The Canadian public's support for their healthcare system is confirmed again and again in opinion surveys. They show that the Canada Health Act and its five principles consistently have the support of between 93 and 98% of adult Canadians (IBM 2005). Few, if any, other public policies enjoy this level of support. This has prompted some commentators to refer to healthcare as the third rail in Canadian politics – “you touch it, you get electrocuted.” Their point is that no politician with any sense of survival is prepared

to challenge the principles underlying medicare in this country.

Those raising concern about the sustainability of healthcare in Canada note that the line of reasoning used by Romanow appears to be deaf to the arguments of “crowding out” in provincial budgets – the argument that any public expenditure comes at the expense of another. In fact, they might say the debate on sustainability really boils down to this: “Will medicare be there for me when I need it – and will the rest of Canada's social safety net stay intact, too?” The Romanow report also misses the question of the country's competitiveness in a global economy. Can we really go on spending an ever-larger share of our resources on healthcare without, at some point, compromising our economic competitiveness? Canada has an understandable tendency to compare itself with its neighbour, the United States, when it comes to health spending. However, this may give rise to an unjustified complacency. The United States is an extreme outlier. It spends 22% more per capita than second-ranked Luxembourg, 49% more than third-ranked Switzerland and 2.4 times the average reported by the Organization for Economic Co-operation and Development (OECD 2006a). The United States aside, there are still only a few other countries that, compared with Canada, spend an equal or larger part of their gross domestic product on healthcare (Organization for Economic Co-operation and Development 2006a). Further, it can be argued many of the OECD economies, not just Canada, are increasingly having to look at their ability to compete with the growing economies of Asia, most notably China and India.

On weighing the evidence, the authors of this article acknowledge that we do not have limitless public resources to spend on healthcare. If health costs continue to increase, governments will have to either increase

taxation or curtail spending on other areas of public responsibility – education, child care, physical infrastructure and more. Either of these courses has the real risk of compromising Canada's ability to compete in global markets. Higher levels of taxation will ultimately increase costs of production and the price of goods and services produced in this country. And if increasing health costs come at the expense of other areas of public expenditure, in the long run, this too will affect Canada's competitiveness. Education and investment in infrastructure are critical to our longer-term economic development. Loss of economic competitiveness can be the beginning of a downward spiral – increasing costs and prices, declining profits and investment, declining production and unemployment, loss of top talent and so on.

### Reframing the debate

With advances in medical technology, we now find that there is an almost infinite amount of resources that can be devoted to many medical problems. It has long been recognized that there are opportunity costs to spending on healthcare and, at some point, some form of restraint has to be exercised to keep spending “in balance.” This is true at both the macro-level (e.g., how much a provincial government spends on healthcare versus other public policy mandates such as education) and the micro level (e.g., how much to spend to extend a seriously ill older person's life, given the alternative benefits that might be derived from using those healthcare resources for prevention or saving the life of a child). The micro-level decisions about how much care to provide to individuals are made every day by physicians and other health professionals as they balance the resources available against their patients' needs and the kind of benefit each patient might obtain from a treatment.

There are examples of governments taking explicit positions on what services are made available through public programs. The Oregon case is well known, in which the utility of different procedures was ranked and a cut-off point established below which the state's plan would not provide coverage. The New Zealand Ministry of Health in the 1990s struggled with a similar issue. Legislation was passed in 1993 that set out to secure “the best health, the best care, and the greatest independence for New Zealanders that is reasonably achievable within the amount of funding available” (Manning and Paterson 2005). This explicitly raised the consideration of opportunity costs. It played out in the area of access to renal dialysis. There were several high-profile cases in which elderly New Zealanders who had other serious health complications were denied access to dialysis. These decisions were the subject of legal challenges but were upheld in the courts. Some of the recent initiatives in Canada to reduce waiting times for selected procedures also recognize that we need to manage resources so that they are directed to meeting highest-priority needs and minimizing any opportunity costs (Postl 2006).

The Canada Health Act recognizes publicly provided healthcare does not include all possible healthcare. It establishes “*medically necessary*” hospital and physician services as publicly insured services. However, the Act does not define the term medically necessary. Over the past 10 or more years, as provinces struggled to contain rising healthcare costs, there has been much discussion as to how medical necessity should be defined and what services could appropriately be delisted from provincial health plans. Several provincial governments sought the input of their provincial medical associations to clarify what services were medically necessary. The net result of these

initiatives was the delisting of a few procedures that were argued to not be medically necessary. In many cases, the services that were delisted were ones provided by non-physicians, reinforcing further the bias of publicly funded healthcare to services provided by physicians. Some academics and health policy analysts argue that any formalized initiative to determine what is medically necessary is too fraught with ethical issues and the matter is best left in the hands of front-line service providers (Charles et al. 1997; Rachlis 1995).

Many health services are not covered by provincial healthcare programs and what is and is not covered varies greatly from one province to another (Canadian Institute for Health Information 2005a). Most provincial plans provide little or no coverage, for example, for general dental care, physiotherapy, speech therapy, vision care, chiropractic care and antenatal genetic testing. How do we decide what is publicly covered and what is not? Canada's focus of public funding mainly on hospital and physician services is largely an artifact of history. When federal cost sharing for provincial health plans was introduced in the 1960s, hospital care and physician care comprised most of what was thought of as healthcare. Since then, home care, drugs, long-term care and the role of other health professions have assumed an importance that was never foreseen. Clearly, a degree of control over the costs of publicly funded healthcare has been achieved through decisions about what kinds of care are covered and what kinds are left to be paid for through private spending. However, we seem to have arrived at this approach by default. It lacks a clear rationale. We have defined what is included in the publicly funded basket largely on the basis of who provides the service (i.e., physicians versus other health professions) and where the service is provided (i.e., hospitals

versus other settings). The Commission on the Future of Health Care in Canada (2002) argued for expansion of public coverage to drugs and home care, but again there was not a cohesive rationale. And, ultimately, concerns about what public treasuries could afford stalled any such extension – an irony given Romanow's deafness to the crowding-out arguments.

The authors of the current article suggest that it is time to reframe how decisions are made on which health services are publicly funded. We need a more appropriate rationale for public funding of health services, one that reflects both the opportunity costs and the nature of the health need being addressed. It no longer makes sense to simply base public funding on who provides the services or where the services are provided. To help advance this discussion, we draw on a recent report from IBM that offers a framework for categorizing health needs (IBM Institute for Business Value 2006). This framework allows us to consider the contribution of different types of health service according to the needs being met. If we accept that there are limits to how much governments should spend on healthcare, the framework also gives us a new, more ethical and consistent way of establishing what should be publicly funded and what should be left to private spending. We believe that this framework will allow us to break out of the ideological stalemate that has come to characterize recent discussions on healthcare sustainability.

### **A healthcare hierarchy of needs**

The Canada Health Act is premised on a binary concept of health needs. Services are medically necessary or not. This conceptualization of needs may have served us well 25 years ago. However, healthcare has become more complex. On the supply side, we have seen the emergence of home care, new health professions, more team-

based approaches to care, a plethora of complementary and alternative therapies, increasingly sophisticated sports medicine and a much greater use of drug therapies. And as we look to the future, we see new possibilities including those enabled by e-health and genomics. On the demand side, the nature of consumer demand has also changed. People are increasingly looking to healthcare not just to sustain life and restore basic human function but as a way of maintaining lifestyles and increasing their individual performance.

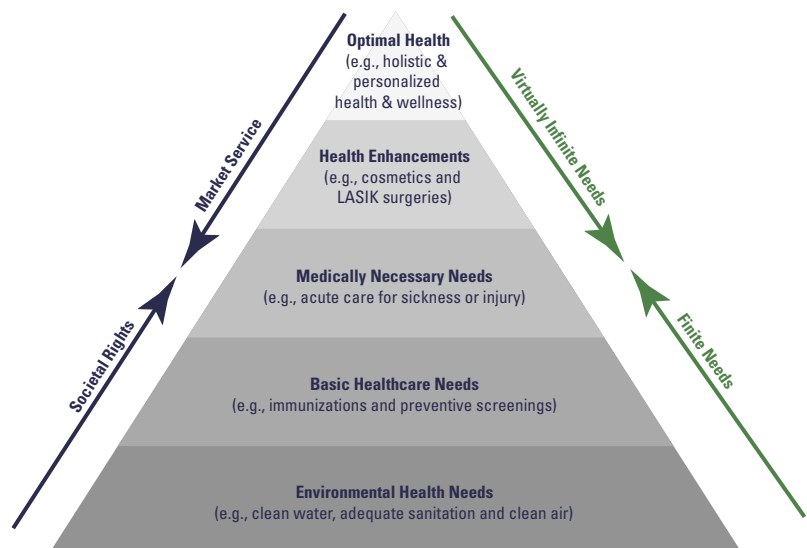
Psychologist Abraham Maslow developed a hierarchy of needs to explain why people are driven by a particular need at a given time (Maslow 1943). Jim Adams has proposed a similar construct to understand needs for healthcare – a “health care hierarchy of needs” (IBM Institute for Business Value 2006). This hierarchy of healthcare needs helps us move beyond the simplistic binary view of healthcare needs. It provides a framework we can use to consider the appropriateness

of public programming in relation to different levels of need (Figure 1). The authors believe this hierarchy can also help guide deliberations on where we should be looking if we are seeking to ensure the sustainability of our public healthcare system.

As with Maslow's hierarchy, the healthcare hierarchy has five levels. Starting at the bottom of the hierarchy, they are as follows:

- **Environmental health needs.** Rudimentary healthcare needs, such as clean water, adequate food, clean air and adequate sanitation, form the base of the hierarchy.
- **Basic healthcare needs.** The next level up includes basic medical care, such as immunizations and preventive screenings, which substantially eliminate premature death.
- **Medically necessary needs.** The third level includes the medical treatment of acute, episodic illness, injury and chronic disease. Conceptually, this level includes affordable treatments (as deter-

**Figure 1. Jim Adams's hierarchy of healthcare needs**



mined by societal opportunity costs) that enable someone to perform the activities of daily living. Most of what is currently covered by provincial healthcare programs in Canada falls into this level. This level of need also includes most of the health conditions associated with “catastrophic costs” (e.g., cancers and neurodegenerative disease).

- **Health enhancements.** The fourth level encompasses treatments that are not strictly medically necessary but improve overall health and the quality of life, such as lifestyle drugs and corrective surgeries that address problems that are not seriously health threatening (e.g., arthroscopic surgery to improve mobility or the strength of a joint so an individual can resume his or her desired level of activity beyond normal activities of daily living).
- **Optimal health.** The peak of the hierarchy encompasses a higher and more holistic understanding of health in which individuals attain optimal physical and mental health, which is more than just an absence of symptoms or disease. Treatments at this level include genetic testing, therapies to mitigate future genetic risk, personalized wellness plans and sports medicine programs.

In both Maslow's and Adams's hierarchies, there is a precedence of needs, with the lower levels generally taking priority over the higher levels. This can apply both to individuals and to societies at different points in their economic development. For individuals, most people are not going to be focused on meeting optimal health needs if they do not have adequate nutrition or if they are suffering from a severe case of the flu. Also, at a given point in time, only a small percentage of the population may focus on the optimal health level. From a societal perspective, this precedence applies in a general manner too.

In Canada, in the 1960s, there was broad public concern about ensuring that all Canadians had access to healthcare for the third level of basically necessary medical needs. That was the most important need at a collective or societal level at the time. Today that need has largely been satisfied and many Canadians are increasingly preoccupied with the higher enhancement or optimization levels. This reflects the advances in our economic development. Middle-class individuals have much more disposable income and a higher standard of living, and they place a higher premium on enjoyment of life. This is a positive trend when it means that consumers are taking more responsibility for their health and healthcare as they pursue optimal health. However, since our public system of coverage has been structured around who provides the services and where they are provided, the pressure for health enhancement and optimization is meeting an ambivalent response. People can get hip replacements through public programs but not as soon as they would like, and sometimes they are not able to obtain the high-performing prosthesis they want. And, they are not allowed to pay the difference to get the higher-level prosthesis (Glover 2005). In some provinces, they have not been permitted to buy insurance for these services. Our publicly funded healthcare tends to be “one size fits all.” The healthcare hierarchy would allow us to identify the different levels of need and develop more appropriate responses.

Again, like Maslow's hierarchy, the needs at some levels of the healthcare hierarchy are essentially finite, while the needs at other levels have the potential to be virtually limitless. The bottom two levels are basically finite needs, as are some of the needs at the medically necessary level. In simple terms, giving an individual multiple screenings or several immunizations for the same

disease does not improve and may even harm the person's health. Similarly, treatment of many acute episodes of illness or injury requires finite healthcare resources. In sharp contrast, some other needs or wants at even the medically necessary levels and certainly at the health enhancement levels could potentially require almost infinite resources. Examples include treating end-stage diseases (e.g., certain types of cancer and heart disease), keeping people on life support over many years and performing continuous cosmetic surgeries on a client. In this way, the healthcare hierarchy of needs helps us to understand the open-ended nature of healthcare needs and how these needs have become so overwhelming. We have moved beyond satisfying basic needs toward optimizing health status, and in so doing are finding an unyielding demand to improve health and the enjoyment of life. Healthcare administrators today often remark that they see little incentive to improve system throughput or to free up capacity to take on additional cases. They note that any capacity that can be freed up will almost immediately be consumed, given the overwhelming unmet demand (or need) for health services.

### Putting the healthcare hierarchy of needs to work: a scenario

If Canadians were to take the healthcare hierarchy of needs as a framework for organizing healthcare responsibilities, it would represent a profound change. It would have implications for how we think of healthcare, organize it, pay for it and use it.

There would have to be public debate and ultimately acceptance that today's approach to determining what is covered under publicly funded healthcare is no longer working and that it is threatening the sustainability of our public healthcare system. We might even question whether it is time to revisit the Canada Health Act.



If there were acceptance of a needs-based approach (along the lines of the Jim Adams's hierarchy) to determining the scope of publicly funded healthcare programs, implementing it would require new ways of making decisions and new policy processes. It would be important to develop principles that could be used to guide decisions about what is medically necessary. To what extent would *medical necessity* be defined in terms of the underlying condition (e.g., pregnancy, diabetes, heart failure, cancers and arthritic joints) and to what extent would it be defined in relation to the expected benefit (e.g., warding off immediate death versus extending life versus improving daily living versus improving life prospects [particularly for the disadvantaged] versus enabling greater enjoyment of life)? There are also questions related to the timing of benefits from treatment (e.g., short term versus long term) and whether treating young people is of more value than treating the elderly. Benefits might be considered in terms of an outcome-related metric such as disability-adjusted life years (DALYs). And, finally, there is the question of whether there should be consideration of the cause of the conditions being treated and whether they are influenced by lifestyles – smoking and obesity, for example.

New information on health needs would need to be identified and compiled to help support planning and management decision-making under such a framework.

There would have to be a shift in how Canadians think about responsibility for healthcare. Today, most Canadians view healthcare as a social right that they have an almost unlimited ability to draw on. Canadians would need to develop a new understanding of their responsibilities for their health and healthcare and an appreciation of the opportunities that this gives them to take control of their health, particularly

in relation to the higher-level healthcare needs. It would allow them to get away from “one size fits all” healthcare.

Health service providers (institutions, community service organizations, professionals in clinical practice, private, sector service organizations, etc.) would have to adapt to a new set of accountabilities in which they provide a mix of publicly funded services addressing basic medical needs and other services addressing higher-level needs that are paid for by the individual consumers (or their private insurance). This would be a significant departure from the current state, where the funding source is largely determined by who the provider is. The current health policy framework in Canada has divided providers into two distinct worlds. Some providers such as hospitals and physicians exist in a predominantly public-pay environment and most others in a largely private-pay environment.

We could expect new business models for the delivery of health services to proliferate. The health service system would no longer be constrained by a framework that drives users to particular settings and professionals because that is where the funding is. There would be the potential for more innovative and efficient approaches to meeting consumers' growing expectations, particularly around health enhancement and optimization.

Governments would have to take a long view of health needs. They might consider arm's-length organizational structures to oversee new policies, structures that have some insulation from political decision-making. They would also have to guard against situations where parties with vested interests were making or shaping decisions that maintain the status quo.

Governments would have to be prepared to take a “tough love” stance. They would have to understand that they could no longer go on

promising everything to healthcare consumers. Governments would need to signal clearly what has to be done if we are to maintain a thriving healthcare system that is focused on the health of Canadians, one that does not crowd out other public policy mandates or compromise economic competitiveness.

Some might fear that this proposal for an ethical needs-based approach to deciding what kinds of care should be covered by public programs will open the door for a massive unloading of public responsibility for healthcare. The authors argue that, on the contrary, it represents a vehicle for ensuring that we can continue to provide public programming for those services that are deemed to be an appropriate social responsibility. Under our current policy framework, there is no room to consider new services as healthcare delivery evolves. The current framework could not accommodate Romanow's proposals regarding public coverage for home care and drugs. The reality is that there are a growing number of procedures and services that should almost certainly be considered medically necessary, but people have to pay for them out of pocket. In some cases, we are even seeing an erosion of coverage for services that many would deem appropriate for public programming. This is illustrated in Ontario where public coverage of vision tests with optometrists has been progressively reduced as a way of managing health spending. Five years ago it changed from a service that was covered once a year to one that would be covered only once every two years. Then two years ago, coverage under the provincial plan was terminated (Ontario Ministry of Health and Long-Term Care 2004). Perversely, public coverage for seeing an ophthalmologist (a much more expensive physician specialist) is still covered, but for most residents of Ontario it is difficult to get a timely appointment to see one. If we were to apply the hierar-

chy of healthcare needs, it might be determined that vision tests address the second level of need, a preventive screening that enables early detection of glaucoma, cataracts, macular degeneration and more – all conditions amenable to treatment that, if left unattended, have irreversible consequences and lead to much higher costs. Do we really want a financial barrier to people obtaining such tests? The hierarchy of needs provides a framework for making sure that no segment of society is left behind in terms of basic healthcare needs.

### Moving forward

Canadians have reached a stalemate on the issue of ensuring the sustainability of our healthcare system. The federal government and most provincial governments have shown great reluctance to explicitly address this issue. And, unfortunately, despite its mandate to recommend on the future of healthcare in this country, the Commission on the Future of Health Care in Canada chose to sidestep this issue. The authors of the current article firmly believe that the time has come for a full-policy discussion on the sustainability of our healthcare system. Once we have such a debate, we must translate the conclusions into meaningful policies that can be implemented. We need to find ways to make governments take the long view of health. Failure to come to terms with the sustainability issue would put in jeopardy many of the great advances in the provision of healthcare that have been achieved in the past 40 years.

We believe that, in the long view, there are valid concerns about the sustainability of Canada's healthcare system. Our public medicare system as we know it is threatened. In the worst-case scenario, if we fail to come to terms with the sustainability question, we will see an exacerbation of issues regarding the quality of services and timely access. The introduction of new

diagnostic modalities and new more effective treatments will increasingly lag behind that in other developed countries. Professionals and workers in the public system will be further overburdened and find it evermore difficult to provide the attention that their patients seek. In this worst-case scenario, middle-class individuals will eventually become convinced that their healthcare is second rate, and their long-standing support for a universal, public system will come undone. Significant numbers of consumers will purchase health services outside the public system, and publicly funded healthcare will become the care of last resort, care that users turn to when they cannot afford to pay for it themselves or when any private insurance coverage they might have is depleted. Many disillusioned and overburdened healthcare providers in the publicly funded system will move over to privately funded care, thus adding to a self-reinforcing dynamic of the decline of publicly funded healthcare.

To deny that sustainability is a real issue puts our remarkable medicare system at risk. The stakes are high. The consequences of failing to come to terms with this issue are daunting. But on the positive side, if we do deal with the issue, we have the opportunity to maintain a universal healthcare system that will make Canadians among the healthiest people anywhere and that will continue to be the pride of the country. Canadians will have the opportunity to reap the benefits offered by new and evolving medical technologies and new ways of delivering healthcare. By taking measures to ensure sustainability, we will prevent healthcare from crowding out other important government programs, and we will make sure that our healthcare system is an economic asset.

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