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Commentary

Steven Lewis

In 1986, I bought my first hard drive: 20 megabytes for $875. In 2005, I bought a 250 gigabyte hard drive for $179. Factoring in inflation, a unit of storage cost 125,000 times less in 2005 than it did in 1986. When humans get good at something, especially where technology is involved, prices fall over time.

Not so in healthcare. From drugs to imaging machines to surgical supplies, prices seem highly resistant to falling at a "normal" rate. Healthcare is more complex than hard drives; one would not expect a similar rate of increase in efficiency. Healthcare is also labour intensive, and most dramatic increases in efficiency eliminate labour. Yet, there is good reason to worry, not the least of which is that current levels of healthcare spending have no discernible impact on population health. International comparisons show that once per capita annual spending surpasses $600–$1,000, there is no relationship between major health indicators such as life expectancy and infant mortality and costs (Leon et al. 2001). Canada is well on its way to $5,000 per capita.

Despite the huge spending, quality is uneven (Katz et al. 2004) and utilization rates vary widely and mysteriously (Fisher et al. 2000). Emergency rooms are backed up, wait times vary and public confidence has dropped precipitously in the past 15 years. Many things go right in healthcare, but the system is demonstrably unsafe (Baker et al. 2004). Compared with any other industry that has enjoyed such huge public support and massive spending increases, in terms of the quality of service and outcomes, healthcare must be termed a colossal failure.

It's not like we don't know how to fix it – there are countless examples in the Canadian experience (Rachlis 2005) and international literature of quality improvement and major reductions in wait times (Wales Audit Office 2006). Yes, expectations rise; yes, there is more technology all the time; and, yes, Canadians are willing to spend a lot of money on healthcare. Given its flaws, the system is indeed unsustainable, but not in the way unsustainability is normally portrayed, as a fiscal crisis.

What's truly unsustainable is doing business the same old way. We cannot continue to consume expensive new drugs when less expensive, older ones are just as effective most of the time. We cannot continue to have specialists do what family doctors ought to do, family doctors do what nurse practitioners ought to do and nurses do what licensed practical nurses ought to do. We cannot persist with a voluntarist, incremental model of quality improvement, where practitioners and institutions are free to embrace or refuse to adopt smarter and cheaper ways of delivering care. We cannot continue to accept the prices of goods and services that have no relationship to what they deliver.

That is why the article by Stuart and Adams is so depressing: it accepts premises it should not accept, and assumes that the best we can do is tinker with eligibility, diminish expectations and allow the deeply flawed beast to roll merrily along. The single biggest problem in Canadian healthcare is the failure to apply ingenuity on a grand scale. The salient feature of most dramatic stories of quality improvement is that the cost actually

goes down while outcomes improve.

If, in 1986, someone had asked, "Is it sustainable to install massive computational capacity and storage on every office worker's desktop and in most people's homes?" the answer would have been a resounding no. Big consulting firms and think tanks would have rolled out straight-line projections that painted a terrifying financial picture. And they would have been right, if people and institutions had continued to pay $20 million for what can now be had for $179, or paid 10 times as much for a new microprocessor that had the same general specifications as the old one. Healthcare doesn't make errors of this magnitude, but it has long passed the point of zero return on investment at the margin.

Although there are encouraging calls for enhanced accountability and financial prudence, by and large Canadian healthcare remains a cottage industry of autonomous clinical and managerial decision-makers, where bad practice costs more than good practice. Unsustainable? Absolutely. But contrary to the conventional account, it is a failure of will, not the inexorable result of ingenuity and expectation.

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