Building a sustainable health care system: Obstacles and options

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The previous government of Ontario had the unhappy task of putting the brakes on an accelerating, 17 billion-dollar-a-year health care locomotive. The current government and its successors have the equally unenviable task of trying to retool the train while it rolls down the track carrying an ever-larger load of older and sicker passengers...

In this afternoon's talk, I shall start with some reflections on health care expenditures. I shall then touch on some aspects of how we currently fund and organize care in Ontario, highlighting potential obstacles to the creation of a more sustainable health care system. I shall briefly touch on short-term restructuring and budgetary issues; and then turn finally to some ideas for the longer-term reconfiguration of health care.

The aim of our health care system remains the provision of effective care to all those in need, at a cost and in a manner that is acceptable to the individual patient, those who work in the system, and to society at large. This is no easy matter.

The "impossible triad" in industry is said to be: good, fast, and cheap. The smart CEO tells her customers that they can have any two without compromise. In health care our "impossible triad" is accessibility, quality, and affordability. Affordability is obviously constrained in Ontario as elsewhere in Canada. Thus, erosion of quality or access is the logical concern.

Given that concern, I am sometimes asked whether we should be spending more on health care. Some advocate more private money. However, we already raise and spend about 28 cents of every dollar oustide the public system in Ontario, more than most European nations, and double the level in the United Kingdom which actually has a parallel private system. It's accordingly hard for me to imagine how more private spending would be anything other than a tax on the sick, or a prescription for social divisiveness, or a major additional burden on the payrolls of Canadian businesses.

And so the real question becomes: What will the marginal returns of extra *public* expenditure be?

As a physician practising in a teaching hospital, I do see individuals for whom health services provide dramatic benefits. I share my colleagues' frustration with waiting lists and bed pressures. And the research literature certainly supports the notion that medical progress has a lot to offer today's patient.

But let us also be realistic about modern medicine. Despite some wonderful advances, and despite the promise of molecular and genetic engineering, there are still no magic bullets to eliminate coronary heart disease, most cancers, osteoarthritis, Alzheimer dementia, and a host of other disorders.

Thus, extra public expenditures on health care may draw resources away from other programs that could effect greater improvements in health and well-being across the whole of society.

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I think here specifically of the effects of social deprivation on children, or the need for vibrant and well-funded schools and universities, or the growing problem of labour market adjustment and retraining in an era when transient joblessness seems likely to afflict more and more Canadians. These areas arguably need more support than they have been getting, and they are very legitimate competitors with the public health care budget.

In sum, it may make sense to peg growth in public health care expenditures to population growth and aging, as well as to general inflation. By those measures we *are* a little behind where we should be in Ontario. Beyond that, I cannot in good conscience tell you that we should have a spending spree on health care.

Let's accordingly look at some elements of the current Ontario health care system.

About 7.5 billion dollars per year goes into our 189 acute care hospitals. As you know, Ontario's general hospitals are structured as private, voluntary non-profit corporations. Each hospital receives an annual allocation of funds from the province, adjusted according to the fiscal situation of the government and informal measures of the adequacy of hospital services. Let me emphasize that point: informal measures of adequacy of service --- not a systematic appraisal of population needs. Apart from a few high-profile and high-cost items, inter-institutional coordination has been grossly underdeveloped.

Add in physician maldistribution, and it's hardly surprising that there is a lot of random variation in service levels. For example, Toronto residents are underserved from the standpoint of knee replacements --- about half as many procedures per capita as Huron/Perth residents. Ottawa residents are twice as likely to get cataract extractions as Hamilton residents. Perhaps residents of our nation's capital require greater clarity of vision. Residents of Sudbury are twice as likely to get bypass surgery as residents of London. And while trends are positive, women living in northeastern Ontario, including the Premier's riding, are still subject to almost three times as many hysterectomies per capita as those living in Toronto.

These concerns about lack of sectoral co-ordination should not detract from the real achievements of individual institutions, and the women and men who work in them. Long before the Restructuring Commission started its work, Ontario's hospitals were undergoing their own transformation. Over the past decade there has been a 25% reduction in length of stay in Ontario hospitals. The use of day surgery has increased sharply --- 25% in the last 4 years alone. Indeed, many in-patient surgical procedures have shifted completely to day surgery.

One result is that Ontario's hospitals have put about 8,000 beds out of service since 1990. And the same thing has been happening right across Canada. Nationally, more than 50,000 acute care beds were closed between 1986 and 1994.

Based on media anecdotes, you might well believe that quicker discharges are leading to reams of sicker readmissions. The Institute for Clinical Evaluative Sciences took a look at this issue in 1996. We found only a very modest relationship between levels of day surgery or short

lengths of stay on the one hand, and readmission rates on the other. The handful of patients who will fare poorly and require readmission are hard to identify ahead of time. So, hundreds of extra days in hospital would be required for many patients in hopes of preventing one avoidable readmission.

I am personally more concerned about cost-shifting. We must beware of a situation where breadwinners are forced to take time off work to care for rapidly-discharged relatives, or where elderly persons are overloaded in caring for significant others. Women, in particular, are frequently the losers in this game of informal caregiving.

How much manoeuvering room remains for our acute care hospitals?

Recently, the Institute collaborated with the Ontario Hospital Association and 98 hospitals to audit over 13,000 admissions for some common reasons that took place in late 1995. Misplaced long-term care patients were excluded. And yet about one-third of the days in hospital were committed to patients who didn't require full acute care, and for another third, it was a little hard to explain why the patient actually was in a general hospital. Some hospitals performed better than others. But the overall message is simple. We can make better use of our resources. For starters, why not concentrate skilled nurses in acute care wards, and designate subacute areas within hospitals where the focus is on convalescence, rehabilitation and discharge planning? One has to believe that patient care would be enhanced by better matching teams of caregivers to the stage of a patient's illness.

The reasons why some hospitals are more efficient than others are complex. Some of it is organizational culture and staff commitment. Some of it is the use or availability of services such as community and long-term care.

However, that latter *caveat* shows a fundamental deficiency in the Ontario health system. Acute care hospital services must be seamlessly integrated with ambulatory and home care, as well as a variety of longer-term institutional services. This has been happening too slowly in the current system.

In contrast, American organizations that have integrated across levels of care are able to achieve lower utilization of expensive acute hospital beds. We must be wary of emulating the reckless profiteering and care-skimping that characterizes some American managed care chains. However, there are credible operations south of the border that report acute hospital bed utilization that is about 50% lower than the average in Ontario today. The most successful systems do more than integrate acute and chronic institutional care with home care programs. They also bring both primary care and specialist physicians into their organizations.

So, let me turn now to the OHIP sector where about 80% of the $5 billion dollars is spent on payments to physicians.

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Ontario's 20,000 physicians are among the best-trained in the world. They are perhaps the key resource allocators in the system. Many have risen brilliantly to the challenges of helping hospitals cope with unprecedented budget pressures. However, Ontario's physicians continue to practice overwhelmingly on a fee-per item-of-service basis that primarily rewards volume of services.

Our fee schedule is a rather bizarre document. The level of specific fees seems to be driven more by remote history or recent political infighting, than any element of rational and relative valuation of the services delivered.

As well, starting in the early 1990s, there have been caps on the overall level of funding available for physician services. Coupled with fee-for-service payment, this has created a situation where Pauline's productivity threatens Peter's income. It combines two irreconciliable principles: a volume incentive for individual billings and a fixed pot of funds. This is a prescription for conflict and frustration. And it can only magnify any inequities or perverse incentives in the fee-for-service system.

Regional disparities in physician expenditures are dramatic. Per capita expenditures on specialists in the north are only about half the levels seen in southern regions. Analyses of billing data also show some odd service patterns. Why is it that some radiologists routinely bill for three views of the elbow or knee or spine, while others seem to need four or five or six X-rays to make the same diagnosis? Why has there been such a proliferation of diagnostic devices in some family physicians' offices? When scientists from the Institute examined billing data for lung function tests in family doctors' offices, we found that one of the commonest tests was also one that is largely useless. And there are many more examples in this vein.

The majority of physicians are competent, hard-working, and as honest as the day is long. It is ultimately in their professional interests to have much stronger audit mechanisms as long as fee-for-service payment continues.

Let us hope, however, that we can soon improve that mode of payment. In a sustainable health care system, there must be alignment of incentives so that physicians are rewarded not only for the volume of procedures performed or services provided, but also for the quality of their work and for the prudent use of health care resources in general.

I turn next to long-term and home care: Over $2 billion dollars goes here, and it's been one of the few ongoing growth areas. Just as the OHIP budget sits in a separate envelope, so also are the budgets for long-term care and home care separated from other sectors.

Home care is a special concern. It is obviously a crucial component of a sustainable health care system, and it must be strengthened. Home care can help cushion the cost-shifting that I warned about earlier. It can help those recently discharged from hospital; others who require support to prevent an admission to a long-term care facility; and still others who require care to avoid an acute hospital admission.

However, expenditures on home care in Ontario rose 16% per annum between fiscal 1984 and fiscal 1993. Home care has gone from a cottage industry to a major element of the system almost overnight. Today, it's an $850 million-dollar-a-year jigsaw puzzle of agencies and providers, not a coordinated system.

Regrettably, the evidence to support the effectiveness and efficiency of some home care services is much weaker than it should be. The amounts paid for specific home care services vary sharply across regional home care programs.

And not surprisingly, uptake of acute home care is highly inconsistent. For example, after cataract day surgery, 78% of Peterborough patients get home care, and 2% of patients in Peel region get home care. After hospitalization for musculoskeletal conditions, only 15% of Metro Toronto residents received home care, as opposed to 43% in the Kingston area. No one knows which rate of service is the right one.

About $300 million of the home care budget now goes for post-discharge services, or so-called acute home care. I believe there should be a general reassignment of existing budgets and future investments in acute home care. In my opinion, these budgets should be held in our acute care hospitals. This policy step would catalyze more partnerships between institutional and community caregivers, foster integration, and allow resource allocation to be made by an existing infrastructure of experienced managers.

Time is too short for me to cover some of the other sectors, and so let's come back to the thorny short-term problem of hospital restructuring.

I earlier outlined how thousands of beds had been taken out of service in this province. Yet, up to mid-1996, not a single institution had shut its doors, and mergers were few and far between.

Our populations have grown and shifted. Hospitals developed decades ago in thriving neighbourhoods now sit among office towers that are empty at night. It is hardly surprising that various District Health Councils accepted the idea of consolidating services in a smaller number of upgraded physical sites.

A simple example: It is largely historical happenstance and academic expediency that has seen a huge cluster of hospital beds in the core of downtown Toronto.

Certainly, the core area requires ambulatory services for those who commute in, and work downtown. It requires some inpatient capacity geared to the special needs of our inner city communities and various of our downtown neighbourhoods. But if we were starting over with a clean slate, looking at the greater Toronto region in 1997, does anyone really believe that we would create the concentration of hospital capacity that currently exists on and near University Avenue? And when it comes to restructuring that capacity, does it make sense to pour hundreds of millions of dollars into upgrading some of the decaying physical plants in that part of the city? I doubt it.

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So by all means, let us carry on a vigorous debate about how the acute hospital system should be reconfigured. But most folks who work in hospitals agree that something had to be done, and that Dr Duncan Sinclair, Mr Mark Rochon, and the Commission have tackled issues that would otherwise have taken years of posturing and politicking in the Legislature before an agenda was even decided.

It is also noteworthy that despite 25 years of universal health care prepayment, and a decade of unprecedented change in the hospital sector, there had been no systematic review of the siting, capacity, and infrastructure of our acute care institutions. The Health Services Restructuring Commission has begun that process, and has already successfully pressed the Government for major capital outlays.

As an advisor to the Commission, I support the idea that some operational savings can still be achieved in our hospitals. However, I have also expressed some ongoing concerns about the level of the operational savings forecast by the Commission's staff. We should be wary of sharply reducing hospital budgets, and potentially compromising a comparatively efficient sector, only to generate savings for reinvestment in other sectors that are not as closely managed and may not produce the same health gains.

In that respect, I am deeply concerned that the Commission finds itself working against a backdrop of overall hospital cuts that are being applied with minor variations to all acute care institutions. 5% was cut in fiscal 1996, 6% is being cut this year, and up to 8% will be cut in fiscal 1998. Before the Commission began, I suppose there was some rationale for this across-the-board approach. Now, there is none.

Consider the likely consequences. If you are CEO of an institution that has already been a leader in efficiency, you will have limited manoeuvering room. Budget cuts will lead to staff cuts and program cuts. And there is no mandatory review of those program cuts by any agency or group --- no coordination with other centres to ensure access or uninterrupted delivery of particular services.

I would like to take this chance to call publicly on Minister Wilson and Premier Harris to take two key steps that will help stabilize our hospital sector in this period of unprecedented restructuring:

First, cancel the across-the-board cut planned for fiscal 1998. With a growing, aging population, with the pressures of new technologies, and above all, with the Commission moving quickly, I don't see any common sense in this policy.

Second, make a public announcement confirming that contingency funds are available this year. If an institution feels that major program cuts are necessary to balance its budget, a rapid review process should be put in place, with the option of bridge financing to ensure that essential patient care programs are not lost.

Speaking of losses, we must look carefully for hidden victims as restructuring proceeds. The wealthy and well-educated will always navigate the system, or go elsewhere. Those potentially vulnerable will be the low-income elderly, the poor of all ages, visible minorities, and the chronically ill. For the next several years, there must be special surveillance to ensure that quality and accessability of care is maintained or improved for these groups

As we look downstream, what are the possibilities? Let's consider what policies are desirable and imagine where they might take us.

Let's imagine that the provincial government catalyzes the creation of integrated delivery systems that cut across levels of care, including acute and long-term institutional care, and home care. Health professionals, including physicians, are drawn into these integrated systems, compensated fairly, and rewarded for both quality and efficiency of care. Because these integrated delivery systems cover the entire spectrum of services, they facilitate redeployment of health care workers from acute care to the other components of the system, and mitigate some of the wrenching job loss that is occurring now.

Let's imagine that many of these delivery systems are regional, and that they have local governance. At this point, you may interject and remind me that the previous and current governments have both rejected regionalization and devolution of health budgets. I think it's time to change that policy. Every other province has taken steps toward regionalization and devolution of budgets, and we can capitalize on their experience. Personally, I don't understand how consolidation of municipal services for Greater Toronto is deemed sensible, and yet it's somehow deemed impractical to create a single health services budget for Thunder Bay or Sudbury or London or Hamilton.

Let's imagine that funding finally reflects population needs. Block funding flows to regional health authorities based on the special characteristics of the populations they serve. And in some urban areas, we opt for multiple competing systems, where hospitals, physicians, and other providers form alliances to attract and retain patients. In those areas, funding is tied to individual patients who choose which organization will best meet their health care needs.

Let's imagine that we finally have information systems that provide access to some key elements of the medical record no matter where the patient receives care. The same system offers decision-support and guidance to clinicians. Because the information is integrated and clinically based, it permits careful scrutiny of the quality and accessability of care. Those indicators are reported regularly, so that public debate and patient choice are informed by real information, not poor data or the latest one-off horror story.

Finally, let us look beyond Ontario, and recognize that all the provincial health care systems have been undergoing major changes. Now, more than ever, we have ten separate experiments in public administration. I suggest that this country is at risk partly because of the new Canadian administrative disease --- a reasonable desire for a highly decentralized federation, coupled with an unreasonable refusal to believe that any other province's experiences are relevant.

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We cannot embrace decentralization, pluralism, and innovation without also seizing every opportunity to learn from each other. Let us therefore imagine that Ottawa and the provinces collaborate on a national health and health care report card, and that they also create a national clearing house for research findings, practice guidelines, policy analyses, and program evaluations.

My time is up, so I shall close with a little story. Justice Emmett Hall died in November 1995 at the age of 97. Mr Hall chaired many public commissions, most notably the Royal Commission on Health Services that set the framework for a national Medicare program 30 years ago; and he continued to advise governments on health care into the 1980s. Mr Hall's ideas about educational reform have lost their lustre, but his basic vision of public health care endures.

Some time ago, I had the honour of sharing a platform with Mr Hall at Queen's University. He was then 91. He looked old and tired, and at first spoke poorly, with stuporously long quotes from his various reports. Eventually, after fumbling with his text, he realized that the pages were hopelessly out of order. He began extemporizing, and one could almost see the years fall away as he spoke about his life and his beliefs. Mr Hall closed by paraphrasing a motto from Robert Kennedy, and said: "Some look at things the way they are and ask, 'Why?'. Let us instead imagine how things might become, and ask, 'Why not?'. "

Ladies and gentlemen, this is a difficult time for all those who work in and around Ontario's health care system. Public concern is palpable, political anxieties are high. But if we are to have a sustainable health care system, we cannot turn back. We need to do more than restructure acute care hospitals; we need to rethink the way the system is organized and funded. And if that task seems too daunting, let us remember Mr Hall, not only for his commitment to publicly-funded universal health care, but above all for his unceasing belief that the future can be made brighter whenever vision and the courage to embrace change are joined together.

Thank you.