POLICY Brief

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Increasing Capacity: How to meet the Challenge of Health Care Reform

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Introduction

Everywhere you look in Canada the health care system seems overwhelmed and barely able to cope with demand. We've all either heard the grim litany, witnessed it, or experienced it personally: excessive and often punishing wait times, shortage of skilled professions, burnout of health care professionals and support staff, inexorably rising costs that are putting pressure on government budgets. Add to that a rapidly aging population and there seems to be little reprieve in sight. But the core policy question is clear. How do we reform the system so it has the capacity to improve universal accessibility and meet the health care needs of all Canadians?

Let me preface this by stating I do not work in the health care field. I do not profess to be an expert, but like many citizens I am concerned with the state of health care in Canada. As the CEO of Group Medical Services (GMS), my experience is primarily limited to health care in a single province, with some understanding of the medical insurance industry across the country.

I have witnessed acute care in Saskatchewan with my wife's recent passing from cancer. As unfortunate as it was for her (and me) to go through it, her care was, for the most part, very good once she got into "the system". The only real challenge were the many hours spent in Emergency waiting for a bed. Once she was in however, it would be difficult to be critical of her care.

The state of the health care debate in both Saskatchewan and Canada feels circular and nonconstructive. We seem to be at a standstill --- a gridlock where there is consensus that the current reality is unacceptable, but little agreement on the reform necessary.

Governments like to expound the commitments they've made to health, usually in the form of tax dollars committed, but less often in terms of the outcomes that have been achieved. On occasion we have heard of successes in reducing wait times for routine surgeries, but at the same time overall issues of access to both primary and acute care have worsened.

There is no question the COVID-19 pandemic has contributed to today's situation. It forced the cancellation of surgeries that created a huge backlog that still exists today. For example, in the March-June period in 2019, 776,725 surgeries were completed in Canada. In the same period for 2020 the number was 408,971.[1]

But progress is being made in reducing the surgical backlog. Saskatchewan, for example, reported that from April 1, 2022, to March 31, 2023, surgical volume was the highest ever recorded in Saskatchewan for a one-year period. However, a longer-term view presents a less encouraging perspective. In March 2010 there were 3,972 cases waiting more than a year for surgery. In September 2023 the number was 4,294, an increase of more than 8 per cent.[2] According to the Canadian Institute for Health Information, Saskatchewan lags all provinces for some surgeries. For example, the 2022 median wait time for knee replacements in Saskatchewan was 466 days. The national average was 190 days.

The system

Canada's health care system is a collection of plans administered by the 10 provinces and three territories. Each plan differs from the others in some respects but is similarly structured to meet federal funding conditions as outlined in the Canada Health Act, the legislation that guides healthcare service in Canada. The Act sets out the bedrock five principles for provinces to receive federal funding – universality, accessibility, comprehensive, portability, and public administration.

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The concept of publicly funded universal health care, first introduced in Saskatchewan in 1962 and enacted nationally in 1968 under the Medical Care Act (accepted by all provinces by 1972) only focused on in-hospital care and physician services delivered at a doctor's office. It was replaced by the Canada Health Act in 1984 which still serves as the legislation guiding healthcare in Canada.[3]

My intent is not to dissect nor criticize the current health care system. It is intended to contemplate what we might do to enhance, or at least provide some relief to the current system while respecting the tenets that are the foundation of universal health care in Canada.

The system has been built over the last half century and delivered using a cost based or a rationing care approach. Given that demand in a publicly funded, universally accessible system can be greater than supply, the only way governments can control healthcare costs is by rationing care. There are only two ways to get into a hospital -- either through Admitting (which comes from a doctor or specialist referral) or Emergency. You can only access "the system" when there is sufficient capacity within it to permit your entry. So, while many think that "all we need is more family doctors", that doesn't increase the capacity of the system, it merely increases the size of the access point (Admitting) or reduces some pressure on the choke point (Emergency).

Even if we had more family doctors, there remains a constraint downstream in which there are not sufficient beds, equipment, surgeons, radiologists, anesthesiologists, nurses, etc. to serve those who truly need more advanced services. Add the challenge of mental health and addictions, and the pressures on the system keep growing with no end in sight. Therefore, if we can expand the overall capacity of the system itself, then presumably there will be more throughput and hopefully improved outcomes.

Competing interests

Expansion of capacity, however, is inhibited by self interests, deeply felt opinions and ideologies which, unto themselves, are not necessarily wrong, but provide little agreement or constructive debate around defining what would be "better". Each argue from their position, expounding the positives, or highlighting the negatives of other positions, without a holistic view on "would things be better". So in that reality, how do we break the logjam while preserving universality and improving access?

Public opinion and political platforms reflect a consensus that we need to improve access to health care. The challenge is how we do it? The same dilemma exists in different public policy forums (for example the housing crisis in Canada, the Indigenous challenges, growing income inequality, crime, addictions, etc.). It's what public policy practitioners refer to as a wicked problem. In planning and policy, a wicked problem is a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often hard to recognize.[4] Health care reform has many of those traits.

Saskatchewan's health care spending has essentially doubled since Brad Wall took over as Premier in 2007 ($3.45B to $7.05B) and has remained relatively steady at around 40% of the provincial budget. Despite this increase in spending, citizens are being asked to wait months (even years) for services. The thought of waiting weeks, months, or even years for a medical service could not have been what our forefathers were contemplating when Medicare was first conceptualized.

While assisting a friend who was developing his thesis on an unrelated topic, he interviewed a psychiatrist in France. He asked the psychiatrist, "what is an acceptable wait time for someone with mental health issues?", and the psychiatrist responded by "Wait list? What the heck is a wait list? If someone needs mental health assistance, they don't need it in six weeks, they need it now."

When I mention this to others they agree with the psychiatrist's assessment, which is an admission that our system is failing us and better access to healthcare is what we need to address.

As a systemic and highly volatile political issue, health care reform defies a political solution. The four-year election cycle inhibits the long-term policy thinking and commitment the issue demands. Moreover, the fact that healthcare is such a dominant and crucial issue in the public mind, and that universal accessibility regardless of ability to pay is the moral foundation of the system, talk of reform has become the third rail of politics.

But there must be opportunities to break the logjam and find some common ground to improving access.

In a Policy Brief last year for the Johnson-Shoyama Graduate School of Public Policy entitled '*Repairing Health Care in Canada: Time to Take the First Step*', Peter Nicholson argued that replacing the Canada Health Transfer Program by creating tax room for the provinces would clarify accountabilities in the delivery of healthcare. This could represent a good start in focusing responsibilities and outcomes where they should be – at the provincial level.

In the face of pressures on the system, governments have been quietly allowing "stealth privatization" – the slow and arguably surreptitious "leakage" of formerly public delivered services to those who can afford to pay for private delivery. In other words, the expansion of a two-tiered healthcare system. This is particularly true for diagnostic services such as MRI's and some orthopedic surgeries.

Then there is the "for profit" delivery of healthcare, which exists in every step of the supply chain. The seller of the drugs, hospital beds, instruments, diagnostic devices, bandages, etc. are all sold to the public system at a profit. In fact, 30% of all public healthcare dollars are delivered privately --- presumably at a profit.

A 2021 survey of the health care systems in 11 nations by the Commonwealth Fund ranked nations based on access to care, care process, administrative efficiency, equity, and health outcomes. It found that Canada ranked 10th overall, or second last, ahead only of the US. The other nations in the analysis included the UK, France, Germany, The Netherlands, Australia, Norway, Sweden, Switzerland, New Zealand. [5]

Canada came in 10th, again ahead of only the US, in terms of health care performance compared to spending. On affordability Canada was eighth. When it comes to equity, Canada was 10th. To reach the equity rankings, the study compared performance for higher- and lower-income individuals within each country, using 11 selected survey measures including care process and access to care. A major factor in Canada's low equity ranking was the lack of a national dental care program. When it comes to access to care for lower income people, Canada ranked seventh.

In its conclusion, the report urged nations to learn from each other. "International comparisons allow the public, policymakers, and health care leaders to see alternative approaches to delivering health care, ones that might be borrowed to build better health systems that yield better health outcomes. Lessons from the three top performers we highlight in this report — Norway, the Netherlands, and Australia — can inform the United States and other countries seeking to improve," the report stated.[6] It goes on to say that improving health care goes far beyond acute care to expanding access to primary care and community support for the more marginalized.

Clearly there are lessons to be learned from how other countries have designed and fund their health care systems. It's time for policymakers to escape from the belief that exploring alternative delivery models, like the ones used successfully in other nations, cannot be applied in Canada while still ensuring universality and improving access to care.

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What is the Prescription?

Arguably the largest constraint that restricts the system's expansion is capital. There is only one taxpayer and increasing taxes to inject in a system with limited ability to demonstrate any value increase does not bode well politically, nor practically. The lack of accountability, demonstrated value for money or agreement on where to put any incremental dollars makes it difficult to do anything but the status quo or adhere to the current "whack a mole" method of decision making/ priorities.

Which is where the private sector can help. Since we already live in a two-tiered system, would it not make sense to selectively embrace private sector delivery for both publicly and privately paid services? The current agreement allowing private MRI's in Saskatchewan requires that for every MRI delivered privately, one must be provided to the public system. It isn't a perfect solution, but most would agree that it's better than not having them at all.

In some respects, it becomes a politically palatable way of taxing the rich. And incidentally, this indirect taxing of the rich (or the increasing capacity of private healthcare services) is already taking place as we speak but being done so somewhat covertly to avoid a public and/or political reaction.

None of this should mean undermining or weakening the core principle of Medicare in Canada that everyone has an equal right to healthcare, regardless of their ability to pay. That is the test our healthcare system must meet. It could be argued in fact, that ignoring the covert privatization could compromise the very tenets of universality that we are trying to protect.

There are best practices and lessons to be learned by the experience of other nations, particularly in Europe, that have blended public and private health care systems and, by almost all measures in terms of accessibility and equity, perform better than we do in Canada.

As a means of improving access and health outcomes for all Canadians, perhaps it's time to focus on best practices in health care that other countries are demonstrating. Canada's current model of a largely publicly funded system simply doesn't measure up with the outcomes of other countries that have parallel public and private health care systems.

Two-in-five (39%) Canadians are Public Health Purists: they see little to no place for privatization and say any movement in this direction only exacerbates current challenges within the system.

On the other end of the spectrum, approximately three-in-ten (28%) are Private Care Proponents: they say increasing privatization is a necessary evolution in Canadian health care and are supportive of seeing a host of hybrid care options from other countries such as Australia, Germany, and Britain brought to their own provinces.

In the middle are the Curious but Hesitant (33%), who are sympathetic to elements of both sides of the debate. This group finds potential value in concepts such as contracting for-profit doctors to work in public facilities and paying for operations to be done in the private network through Medicare. They express deep concern, however, about just how far to go, citing concerns about the access of low-income Canadians, and the potential exacerbating of staffing shortages.[7]

If one was to engage in the capacity discussion and agree that adding capital (say an MRI that has a 3:1 "give back/paid" ratio), how might we handle the "jump the queue" matter whereby the person who has just paid for their MRI can now access the system ahead of those who remain in the queue (even if there are 4 less people in said queue)? Are the benefits of removing 4 people from the queue greater than the downstream challenge of those people potentially accessing healthcare services, even if their issue is of less severity than someone in the queue?

A common tangential discussion is the issue of staffing. This highly charged topic questions whether the growth of private sector participation will lure professionals from the public system to potentially better paying or simply "better" jobs in the private world.

In general, competition is good for consumers - in this case, the professionals. It is less clear whether there is a benefit for the users of the service. Competition for professional staff exists between countries and even provinces. In 2008, Saskatchewan nurses received a 35% increase in pay to stem the exodus of nurses to Alberta. Doctors are frequently lured to university hospitals with the highest research budgets to further develop their specialties. So, whenever staff shortages exist, putting additional pressure on those already strained resources is bound to dilute the resource pool. Whether or not the benefits of additional capital outweigh the potential dilution of staffing is likely a conversation to be had.

Even if we could find our way through this discourse of positive and negative consequences of any choice, perhaps the biggest challenge we face is how to effectively engage the public in this discussion. As mentioned, democracy seems to have broken down such that substantive issues (such as the state of healthcare) have become simplistic sound bites that do little to deal with root cause or creative solutions, let alone provide a forum for constructive debate.

Social media, special interest, disruptors for a cause, vanilla (non-accountable) statements, or simple "yelling" have not provided a forum for stakeholders to determine if a solution would leave us (generally) in a better position. Perhaps if Government or some other stakeholder organized (or utilized) a neutral method of engagement involving healthcare workers, first responders, educators, citizens, unions, and/or whomever else should be in the debate and used it to inform how to increase capacity in the healthcare system, maybe that's a start. The goal would be to constructively debate the positive and negative consequences and determine what might constitute "better". While difficult, stakeholders would be asked to check their ego (or their group's interest) at the door and focus on those proposals that might be better for the system on the whole.

I have been told this is an idealistic way to approach things with little chance of success. And that might be so. However, the current system is clearly not working and people are dying while solutions are potentially available to us if we could just stop the rhetoric and get down to meaningful engagement. I know in my small sample size of significantly less complicated issues; I have found success in gaining agreement on what might be better for all (all things considered).

The Canadian Medical Association (CMA) has been conducting a series of discussion sessions (hosted by the Globe and Mail) to solicit input from Canadians on their opinions of balancing private and public health care. Their goal is to educate and engage Canadians, and what they hear will help shape CMA policy and advocacy at a national level.[8] This exercise is intended to inform a national agenda, but will have difficulty providing real insight for smaller population provinces like Saskatchewan.

There are solutions out there. We need to find a way to organize ourselves for the constructive debate on the future of health care -- a public dialogue that brings together passionate people in a manner that might encourage political action or a more concerted dialogue. Being able to do so might save lives while injecting much needed capital into an already starved system.

Mark MacLeod is the CEO of Group Medical Services, a Saskatchewan-based non-profit organization that helps people pay their medical bills through health, dental, and travel insurance. With its roots in rural Saskatchewan of the 1930s, GMS became a forerunner in the creation of public health insurance, pooling resources of its members to cover their health costs. Its profits are donated to health-focused community initiatives. Mark has more than 30 years experience leading traditional and knowledge-based organizations, including as President & CEO of ISM Canada, where he led the company's evolution into a pioneering force in big data analytics within the public sector.

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People who are passionate about public policy know that the Province of Saskatchewan has pioneered some of Canada's major policy innovations. The two distinguished public servants after whom the school is named, Albert W. Johnson and Thomas K. Shoyama, used their practical and theoretical knowledge to challenge existing policies and practices, as well as to explore new policies and organizational forms. Earning the label, "the Greatest Generation," they and their colleagues became part of a group of modernizers who saw government as a positive catalyst of change in post-war Canada. They created a legacy of achievement in public administration and professionalism in public service that remains a continuing inspiration for public servants in Saskatchewan and across the country. The Johnson Shoyama Graduate School of Public Policy is proud to carry on the tradition by educating students interested in and devoted to advancing public value.

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