
Special Report



The Canadian Health Care System: Cost and Quality¹

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Canada is the second largest country in the world, covering some 10 million km², but ranks 31st in the world in terms of total population, having only 27.5 million inhabitants. Population density ranges from over 5 000 people per km² in the cities to less than one person per km² in remote areas, a circumstance that presents major challenges for our health care system. Overall, more than half the population is concentrated in large urban industrialized areas in the southernmost part of the country near the Canadian–United States border (1, 2).

The country is divided politically into 10 provinces and two territories. The largest province, Ontario, has a population exceeding 10 million people, while

the smallest, Prince Edward Island, has only 130 000. The two territories, the Yukon and the North West, are located in the northernmost part of the country. Though vast, they have a combined population of only about 80 000 inhabitants.

Canada is also a multicultural, multilingual nation. Approximately 63% of the population claims English as a mother tongue while 25% claims French. Other major cultural groups within the country speak primarily Italian, Chinese, and German. About 1% of the people claim an aboriginal language as their mother tongue. Another significant demographic point is that over the course of this century birth rates have diminished, the percentage of elderly people has increased, and the percentage of younger people in the population has exhibited a corresponding decline.

THE CANADIAN HEALTH CARE SYSTEM (3, 4)

A 1990 survey by Statistics Canada, the Federal Government's official gatherer of statistics, indicated that Canadians felt good about their health (26% rated their

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health excellent, 36% very good, and 26% good). Canadians have an unusually long average life expectancy (73.0 years for males, 79.7 for females), as well as an unusually large number of healthy and productive years. Dramatic changes occurring over the past 20 years have contributed to this. For example, deaths caused by heart disease have dropped 40% among men and 30% among women, and death from stroke has declined 50% in both sexes.

Besides feeling good about their health, Canadians also feel good about their health care system. In a recent national poll (by Environics) 85% said they were satisfied with the quality of health care. Two-thirds of those surveyed were also optimistic that Canada would be able to maintain its health care system over the next decade despite rising costs. However, 82% believed that individual Canadians should be taking more responsibility for their own health, thus lending support to an increasing emphasis on individual responsibility and health promotion.

Canada's health care system is financed through the country's tax system. All Canadians, regardless of their ability to pay, have access to well-trained doctors and well-equipped hospitals, as well as to other health care services. Under Canada's constitution, the provinces are responsible for delivery of health care within their own jurisdictions. All provinces are currently guided by a federal Act of Parliament, the Canada Health Act, which sets forth the basic terms of health delivery for all Canadians. The Canada Health Act articulates five principles: universality, accessibility, comprehensiveness, portability of coverage from one province to another, and nonprofit public administration. Canada's national health system is thus based on a set of federal guidelines which are enacted by each province individually.

ECONOMICS AND THE HEALTH CARE SYSTEM (5)³

It is difficult to look at health economics without placing it within the broader context of national economics. Simply put, Canada has been hit hard in recent years by a major recession. While statistics and perhaps optimistic economists tell us the country is beginning to recover, common folk find this hard to believe—there being many unemployed with no apparent employment prospects in sight.

In addition, Canada's national debt has reached staggering proportions, and interest on that debt is consuming an ever-increasing portion of available tax revenues. The current national debt (federal, provincial, and municipal combined) is approaching Can\$ 620 billion (90% of the gross domestic product, or roughly Can\$ 23 000 for every inhabitant), and the yearly cost of financing this debt is Can\$ 55 billion.

One of the most serious results of the recession and the national debt has been a dramatic (some would say drastic) decrease in tax revenues available to all levels of government; and of course, health care as well as other social programs in Canada are currently financed from tax revenues. So there is now, inevitably, increased competition for these limited tax dollars.

Each of Canada's provinces currently spends about one-third of its yearly budget on health care; and, as a country, Canada spends approximately \$68 billion per year (about 9.2% of the gross national product, GNP) on health care. This percentage of GNP devoted to health care has risen dramatically in recent times, from

³Also based on current statistics from Canada's Federal Ministry of Finance and on statistics from the Health Information Division, Policy, Planning, and Information Branch, Department of National Health and Welfare, March 1993.

5.5% in 1960 and 7.4% in 1971). Although the percentage of GNP currently spent by Canada for health care is about the same as that spent by other wealthier nations (France and Sweden spend close to 9%, Germany and the Netherlands a little over 8%), considerable concern is now being expressed about continuously and rapidly rising costs matched against decreasing tax revenues available to fund these costs. In short, decreasing tax revenues plus increasing health costs are beginning to result in insufficient funds for health care.

In the face of this dilemma, what choices do we have? Essentially, we have two: to increase the funds available for health care or to somehow decrease the costs that we are presently experiencing. Let us look briefly at each of these choices in turn.

Three main ways to increase funds for health care have been seriously explored recently. The first of these is to increase taxes. Given the country's current economic condition, it is speculated that a move to increase taxes any further might result in massive tax revolts. Already Canadians pay federal income tax, provincial income tax, provincial sales tax (in most provinces), and a new value-added federal tax of 7% on goods sold and services rendered. Increasing taxes does not seem to be a palatable solution for the Canadian people.

User fees offer a second way to get more funds into the system. However, research seems to indicate that user fees do not improve the appropriateness of care, nor do they reduce the total cost of care. What they do is create new and considerable administrative costs. Research done some time ago by the Canadian Hospital Association showed that in order to recover administrative costs, user fees would have to be so large as to definitely make services prohibitive for the poor. User fees certainly go contrary

to the principles of the Canada Health Act and, therefore, are not generally seen as an acceptable current alternative.

The third alternative, somewhat akin to user fees, involves supplementing current public funding with some sort of private financing. Presumably, our businesses and corporations would be the target groups from which to obtain private financing, especially through benefit packages for employees. We need only look south of our border to the United States to see how private financing of health care works, or does not work, the latter being the opinion of most experts who view the U.S. system.

Private financing, for the most part, directly affects the corporate bottom line of the country. For instance, General Motors, the huge U.S. car producer, now spends more on health benefits for its employees than it does to purchase steel for making cars. Also, the average cost of health care to American businesses rose 21% in 1989 and 1990, and another 13% in 1991. It hardly need be said that in the aftermath of recession, Canadian businesses and corporations do not find private financing of health care to be a viable solution.

Perhaps the most important observation regarding increased funding is that we in Canada seem to have arrived at something of a national consensus, through numerous federal and provincial studies and royal commissions, that we, in fact, do not need to increase funds for health care, that we currently have sufficient funds to provide a good quality system *if only* we can use our funds more appropriately! What we really need to do, therefore, is decrease costs.

Now, how might we decrease our costs so as to live within our present resources? We are currently looking at four major efforts.

The first of these seeks to better control the number of physicians and the method

by which they are now paid. We recognize that physicians are the "gatekeepers" of the health care system and, therefore, a key determinant of health care costs. As of 1992 Canada had a total of 53 836 physicians, or 1 physician for every 510 persons in the country. Of this total, about 53% were general practitioners or family physicians, while the remainder were specialists. The total number of physicians had increased approximately 15–16% since 1986, and this increase had produced a significant impact on the cost of the health care system.

In response, efforts are now being made to decrease and limit the number of physicians being trained in our medical schools. In addition, attempts are under way to move away from paying physicians on a fee-for-service basis, since fee-for-service payments encourage pursuit of increased work volumes as well as high-tech, invasive procedures.

Besides being concerned about controlling the rapidly increasing numbers of physicians and the fees they are paid (which, by the way, have continued to increase at dramatic rates), we are also concerned about the services they prescribe for patients. In a recent article, Dr. Michael Rachlis, one of Canada's most vocal health system critics, suggested that physicians have often failed to be good "purchasing agents" of care on behalf of their patients and that this helps to explain why we have so much inappropriate, often expensive care. Dr. Rachlis went on to say that a service may be deemed "inappropriate" when the best scientific evidence can predict that it will likely be of no benefit to a patient or will be more costly than equally effective alternatives. By this definition, experts have suggested that as much as one-third of all the services provided in our health care system are inappropriate, such services ranging from inappropriate institutional admissions to inappropriate use of

technology to overuse of medications by the elderly.

Examination of service appropriateness goes hand in hand with examination of the least costly services employed. Our tendency has been to use an institutional setting as the focus for health care delivery. What we now recognize is that this setting, while the most expensive, is not necessarily the best, especially in view of what has been made possible by new technologies (e.g., laser surgery). Thus, across our country we are actively decreasing our inpatient beds and dramatically increasing our outpatient or ambulatory services. Often service volume remains the same or increases while costs to deliver the service go down.

We are also beginning to look at more appropriate use of our human resources. For example, nurses are now being used to deliver certain types of care traditionally in the domain of the physician; research indicates that this is producing excellent outcomes as well as reduced cost.

Finally, we are coming to realize that the best way to decrease our health care costs is to keep people healthier. This has led to a vigorously renewed interest in health promotion. What has also become painfully obvious to us is that the real determinants of health—like income, education, employment, and lifestyle—lie outside the traditional concerns of the health care system. I will not pretend that we have yet made great progress in the area of health promotion. But we have made considerable progress in small ways such as in reducing smoking; and keeping the population as healthy as possible seems to be increasingly recognized as a goal parallel to providing a quality health care system to care for the population when illness occurs.

To summarize, regarding the choice to either increase funds for health care or decrease costs, Canada seems willing to concentrate on the latter. As noted, we

are investigating a number of ways to accomplish this. Essentially, we are looking for a quality health care system based on *demonstrated* need for service, *efficient* delivery of service once need has been established, and *effective* service—that is, service that has a *demonstrable positive outcome*.

As you can see, in the midst of our concerns with cost we inevitably direct our attentions with new vigor to the pursuit of health care quality. In considering that subject, this brief account seeks only to highlight a few of the major activities related to quality that are currently taking place in Canada. These developments arise from a long tradition of emphasizing quality and from a belief that quality must be at the heart of all we do.

A NATIONAL AGENDA FOR QUALITY

A significant national effort to improve health care quality began in 1992. At that time the federal, provincial, and territorial deputy ministers of health (our senior health bureaucrats) met to review and share information about developments in health care quality and effectiveness across Canada. They collectively agreed to adopt a specific strategy to further promote health care quality. This strategy had three initial parts:

- Prepare a *vision* of quality which would provide a common base for pursuing quality health care throughout the country.
- Prepare an *inventory* of all major quality-related activity taking place in key national and provincial organizations.
- *Catalog* success stories of innovative thrusts that were bettering care delivery quality across the country and

that could serve as models or reference points for others.

These three steps have now been completed and have provided a frame of reference for other national and provincial activities. This strategy of the deputy ministers represents a far-reaching commitment by Canada's top health authorities to the concerted and collaborative pursuit of quality. This commitment is essential for success; but success will also depend on the rest of the people in the system. Our vision of quality is evolving and must continue to evolve, but it will only do so through the cooperative efforts of us all.

National Health Organizations

Canada has many national health organizations whose attentions are directed strongly toward the pursuit of quality. Four of these are the following:

Canadian Council on Health Facilities Accreditation (CCHFA)

This is the national accrediting body for health care organizations. Under its mandate, national standards for health facilities and agencies are established and periodic visits are made by teams of external experts to verify compliance with these standards. Accreditation programs exist for acute care, long-term care, mental health, rehabilitation, and cancer treatment centers. Work is currently under way to develop programs for community health services and centers and for home care services.

The Council is starting to apply continuous quality improvement principles to both the standards and the accreditation process. This is designed to refocus the standards on the patient care process and care outcomes, both of which relate directly to care quality. Implementation

of this measure in the acute care sector is scheduled for completion by the end of 1994, with implementation in other sectors to follow.

Canadian Hospital Association (CHA)

This body is approaching the quality question from the perspective of the health reform needed to maintain a quality health care system. The Association recently completed a two-year undertaking called the Vision Project (6), involving extensive national participation, to formulate a "vision" or goals for health reform. The project studied four major areas:

- economy, funding, and cost;
- management, evaluation, and technology;
- human resources; and
- alternative delivery systems.

A major accomplishment, the Vision Project has provided us with a framework for defining and evaluating health policy at all levels of the health care system.

Canadian Medical Association (CMA)

Several years ago the CMA began a major effort called the Quality of Care Program (7) to meet its members' needs. Four strategic areas were singled out to receive priority attention in 1992 and 1993. These were:

- coordination and communication with other organizations in the development and promotion of quality of care initiatives;
- practice guidelines;
- education;
- research and information.

This project has made significant progress in addressing all four priority areas.

Coordination and communication with CMA members, as well as with other key organizations, in promoting improved quality has become well established. A partnership has been created with national medical organizations to facilitate and coordinate quality initiatives in the medical community. A computerized database serving as an inventory of all Canadian clinical practice guidelines, guideline developers, and developing agencies was completed in 1993 and a directory of guidelines was published and distributed.

Canadian Association for Quality Health Care (CAQHC)

The CAQHC provides a forum where national quality issues in the health care system can be discussed and national goals for quality can be promoted. The Association, which sponsors educational workshops, has recently targeted total quality management and utilization management as key areas for its educational efforts. In addition, the Association publishes a journal, the *Canadian Journal of Quality in Health Care*, that provides a vehicle for centralized communication about health quality issues and for sharing information about monitoring quality.

Provincial Quality Monitoring Efforts

Six of Canada's 10 provinces, as well as one of its two territories, recently completed major health system studies, all of which provide individual blueprints for improving the provincial health system. Each of these studies makes reference to the need for quality improvement strategies, underlining the fact that concern for quality exists not only at the national level, but also at the provincial level responsible for health care delivery.

In 1992 the Province of Manitoba (8) released a provincial plan entitled *Quality Health for Manitobans: the Action Plan*. This plan calls for the Manitoba health system to be driven by health status needs and health outcomes. It also states that all major health services, interventions, and procedures will be monitored and evaluated in terms of health outcomes.

The Province of Newfoundland (8) has a well-developed and active Provincial Quality Assurance Committee that has been in existence since 1991. It focuses on maintenance and improvement of the population's health while fostering equal access to services—competent and efficient services providing patient satisfaction. The most striking thing about the committee is the extent to which its efforts are supported by all the major constituents involved in health care in the province—including the provincial health department, the Newfoundland Hospital and Nursing Home Association, the medical and nursing professional associations, the provincial medical school, and consumers. All collectively and actively participate in the committee's work and in establishing the directions to be pursued. Specific committee activities focus on health status surveys of the population, health outcomes of interventions, and practice standards—for the purpose of improving health and integrating quality assurance activities into daily care delivery as a means of striving for continuous improvement.

In 1992 Quebec Province's Ministère de la Santé et des Services Sociaux issued a policy paper on health and well-being (8) that set forth 19 specific objectives intended to reduce the most widespread health and social problems affecting the people of that province. This statement of specific objectives is overlain by monitoring and evaluation requirements. Specifically, reliable indicators of the public's state of health and well-being are

to be developed; the quality and effectiveness of interventions, new technologies, and new services are to be systematically evaluated; and the range of services offered is to be reviewed periodically in terms of need, effectiveness, and results.

Work on improving health service utilization and creating clinical practice guidelines is taking place in several of the provinces. Two examples will serve to illustrate the nature of this work.

The Province of Saskatchewan has recently established a Health Services Utilization and Research Commission.⁴ This independent, permanent crown corporation has a mandate to analyze various aspects of the health system with a view toward effecting change where appropriate. The Commission undertakes both long-range and short-range projects. Two long-range projects in the initial planning stages are (1) examination of the social determinants of health status and utilization of services and (2) examination of factors influencing service patterns for the elderly and our perception of them. Short-term projects currently being pursued by the Commission deal with routine testing in hospitals and ambulatory care settings (including urinalysis and urine culture testing); guidelines for thyroid testing; interventions to prevent or delay admission to long-term care facilities; the level of acuity observed in Saskatchewan hospitals; the use of chest X-rays and obstetric ultrasound services; and EKG testing in hospitals and ambulatory care settings.

In the Province of Ontario, the Institute for Clinical Evaluative Sciences (ICES) was launched in 1992.⁵ The institute is

⁴Letter from Steven Lewis, Chief Executive Officer, Saskatchewan Health Services Utilization and Research Commission, 9 November 1992.

⁵*Information Bulletin*, Institute for Clinical Evaluative Sciences.

an academic center where researchers examine how Ontario's health care system works and how health care services can be delivered more effectively. Sponsored by the Ontario Ministry of Health and the Ontario Medical Association, the institute reports to a joint management committee of the two organizations from which it receives many of its research directives.

Approximately 15 scientists and 20 affiliated clinicians carry out research at the institute. Some of the current research projects deal with rates of variations in surgery across Ontario; use of ankle X-rays for potential fractures; medication for heart attacks; examination and improvement of hospital efficiency; and patients' expectations of lowered risk with drugs for high blood pressure or high cholesterol.

CONCLUDING REMARKS

To sum up, we currently have an excellent health care system of which Canadians are both proud and protective. However, our system appears to be "getting out of hand." Funding available for health care cannot keep up with the current rate of rising costs. Quality is beginning to be questioned. So, if we are to maintain our system we must act now, collectively, and in concert as consumers, providers, and funders. We must make sacrifices; we must act on common goals and pursue common paths; we must be easily self-critical; and our actions must have two aims: to control costs and to maintain quality.

Accordingly, as the foregoing has tried to point out, we have sought to create a

national vision of quality and a framework for creating and assessing policy that will make that vision real; to establish and monitor national standards for health care organizations; to define and implement clinical practice guidelines; and to assess the outcomes or results of care, especially in terms of improved health for our people.

We certainly do not have all the answers, nor are we doing everything right. But we seem to know what we have to do; we have a vision. Our major problem at the moment, one that is common not only among ourselves, is that we must find the collective will and energy to do what must be done.

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