Healthy Conversation

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In the aftermath of the US legislation expanding health care coverage for Americans, it is common for Canadian visitors to the USA to hear comments such as: “Well, now we have Canadian style health insurance”. The new American system is so complicated that it is difficult for anyone to understand it, but it is certainly not like anything we have in Canada.

Canadians who have watched the Americans argue about their health insurance have found the debate both before and since legislation was passed to be both vicious and shallow. We have no reason to be smug. Change never comes easily. When Medicare was first introduced in Saskatchewan the doctors went on strike for weeks, largely supported by the public who rejected the government of Tommy Douglas at the next election. In more recent years, any attempt to address problems in the Canadian system is labelled by defenders of the status quo as “two-tier health care” or “American style health care” when the proposals are nothing of the sort. In fact the ideas that are needed to make our system work better cannot be articulated in short sound bites.

Canadians are well served by our health care system—compared to the Americans for example, we spend far less money for a better result in terms of life expectancy. There is near universal agreement that we should have a well financed public health care system in which the best health care goes to the sickest people.

But over the years a much broader and unsustainable expectation has emerged. This narrative states that the public system should be the exclusive supplier of a very broad range of insured services; that these services should always be provided at no cost to the patient; and that the services should reflect the most up-to-date technology and treatments, provided within prescribed time limits. This narrative is a straight-jacket that prevents needed efforts to provide more cost-effective care.

The narrative is unsustainable now and will be less and less sustainable as time passes. Health care is already consuming close to half of provincial program spending and, at present rates of growth, will displace all other programs within twenty years. (The NS Health budget has
increased 8.6% per year over the past decade in comparison to 5.6% for other programs and services and only 1.9% for CPI). It will be easier to have thoughtful debate if there is open recognition of some hard truths.

There will be no end to the upward pressure on health care costs. Pharmaceutical companies will continue to develop new drugs both to provide new treatments and to incrementally improve existing treatments. They will charge as much as they can get. Medical equipment companies will continue to develop new diagnostic technologies, new surgical equipment, and new prostheses. They will charge as much as they can get.

Patients and their families will use the internet to become more aware of these possibilities and will be more demanding. With an aging population the one guaranteed growth industry in Canada and the world is health care. With or without unions, marketplace pressures will push up the cost of doctors, nurses, and other health care professionals.

There is always more care possible than can be funded by the public system. In a single payer system where providers are paid per unit, the only way to limit costs is to limit supply. This manifests itself in long waits for certain treatments—for example, hip and knee replacements. The challenge must be defined not as meeting every patient’s perceived needs in a timely fashion but rather as getting the maximum possible benefit from the limited resources available. Most senior players in the system know this and practice it every day but it considerably hampers their efforts that they cannot say so explicitly.

It does the public system no harm if someone buys a service or treatment outside the system. In fact, it shortens the line-up for everyone else and saves the system money. No Newfoundlander’s health care suffered because Danny Williams went to a private facility in the US for treatment. Nor would it have been hurt if that facility was in Toronto, or Halifax, or St. John’s. It would in fact be beneficial to have people support jobs at home for private treatments rather than leaving the country.

New equipment and treatments must be evaluated on a straight cost/benefit basis. New technologies usually supplement rather than replace existing equipment; they should only be purchased when they can be shown to have better health care impacts than the other technologies competing for limited funds.

Decisions about health care facilities must be made solely on the basis of health care outcomes. Decisions cannot be subordinated to other considerations such as economic development. This is hard. Dwindling rural communities mourn the loss of any service or facility—post offices, bank branches, churches, and especially schools, clinics, or hospitals. But to create or maintain a facility where the numbers are too small is to worsen health care results for everyone.

Within the public system what matters is not whether a facility is public or private but rather whether it is cost effective. Experiments should be encouraged. Some of these experiments will be successful, others will not. We can learn from both.

Emergency departments are abused. Of the people coming to emergency departments about 70% are seeking non-urgent care. The excessive wait times for non-emergency care are almost as demoralizing for the involved health care professionals as they are for their patients. They need a definition of success that is achievable within available funding.
RECOMMENDATIONS

There have been many well researched reports in Nova Scotia on how to improve the health care system, most recently the Corpus Sanchez report released in December 2007. Lots of good ideas have been presented—what has been lacking is the political courage to implement them.

We must be willing to try different delivery models and expand the ones that work well. Here is a possible list:

Most of the emergency departments in rural areas should be converted to primary care facilities with normal operating hours. The small number of true emergency cases will get more appropriate care in regional centres—in fact most of them are sent there anyway—the trip to the understaffed local emergency department can lengthen the time to receive appropriate care.

Regional centres offering secondary and tertiary care need a critical mass of physicians and surgeons (typically four or five each just for foundational programs, plus as many anaesthetists) to be viable. There are not and will not be enough, nor can we afford that many. Corpus Sanchez recommended that:

More use should be made of practitioners with intermediate skill sets such as nurse practitioners, nurse anaesthetists, and mid-wives. Each regional centre should provide foundational programs (emergency care, family medicine, general internal medicine and surgery, and associated services). Non-foundational services (e.g. cardiology, neurology, plastic surgery, orthopaedics) should each be consolidated in a small number (say, two out of seven) regions in addition to Halifax and Cape Breton.

Implement a nurse call line as a first point of contact. PEI was the only other province to lack such a service. A service has now been implemented in Nova Scotia but it needs a lot more promotion. (http://nshealthlink811.ca/)

All of these recommendations should commence immediately.

Unless we can arrest the decline in rural populations (see We Need More Nova Scotians), the day will come when we have to reduce the number of district health authorities and accompanying regional centres by two or three. Several of the rural district health authorities serve fewer than 60,000 Nova Scotians; the smallest (Cumberland) serves only 32,000.

Encourage the development of alternative providers, primarily in Capital Health district. If a group of orthopaedic surgeons want to set up their own facility to do hip and knee replacements at a fraction of the current cost to taxpayers, we should be glad they do. (Of course admission to such a facility must be governed only by health care considerations).

Teaching and research are expensive but necessary. Structures should be put in place (see Scholar Dollars) to ensure that the province recovers its investment in training doctors and other health care professionals. Research funding should be tilted toward studies that would be of most benefit to Nova Scotians, including ways to establish treatment protocols that maximize health outcomes, and minimize total costs of the treatment. This may require new ideas about how to quarterback patients through the system. Study what is happening in other provinces.

Quebec has set up a convoluted process for charging user fees for visits to doctors. Ontario is making deep cuts in payments for pharmaceuticals. BC is moving to a piecework payment system for hospitals. Some of these will not succeed, but we can learn from all of them.

Likewise different District Health Authorities should learn from each other’s experiments.
Study what is happening in other countries with successful and cost-effective systems.

A particularly interesting facility is the 55 year old Shouldeice clinic in Toronto (www.shouldice.com). Their only activity is fixing hernias. They are absolutely world class. In vivid contrast to Danny Williams going to the US for treatment, the Shouldeice has attracted Americans and people from 80 other countries, creating employment. It is also able to provide very cost-effective treatments operating within the Canadian Medicare system. Past patients include Joe Clark and Jack Layton. This format contradicts many key tenets of the straight-jacket narrative and is a roaring success.

Achieving change – either experimental or systemic – is difficult. Physicians and surgeons do not always collaborate well with each other, let alone with the other health professionals. The CEO’s of the DHA’s must be given the necessary authority, including authority over the activities of physicians and surgeons, to implement new models of care.

CONCLUSION

Watching the shallow but noisy American debate on health care is dispiriting. It provides a powerful reminder of the need for thoughtful and respectful exchanges of views, and the willingness to try new ideas for health care delivery. The problems we face can not be solved with one or two big ideas. Rather we need to allow those in the system to identify, test, and implement dozens of smaller but useful initiatives.

The senior players in our system—CEO’s of District Health Authorities, chiefs of medicine, surgery, nursing—have lots of good ideas for dealing with our own slow burning crisis. They need not just permission but a mandate to try different approaches.

The Corpus Sanchez report is vivid proof that the good ideas are there. What is needed is political courage to let the health care leadership do it.

The dominant question has to be this: How do we deliver the most and best health care with the limited resources available?

The provincial government must take this position and should be supported by the other parties. It will be too easy to take cheap political pot-shots if, for example, a tiny and understaffed emergency department is closed, or if two regional health authorities are consolidated, or if a specialty surgery clinic opens and becomes the main location for knee and hip replacements.

There will always be unmet needs and wants. We must focus on whether our spending is addressing the right needs at the lowest possible cost.

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