Rapporteur's Remarks

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In Canada nothing is sure except death, taxes and debate about rising costs and waiting lists in Medicare.

But maybe rising costs of Medicare are not the real problem and maybe excessive concern about waiting lists is really a distraction from other issues at least as important.

Four abiding myths govern much of our thinking:

- health care costs, especially those associated with our publicly financed system, are "skyrocketing" and are the culprit which will crowd out other valued government programs;
- private delivery of services will destroy Medicare;
- the best evidence that Canada's system is failing is long waiting lists afflicting Canadians. By contrast there is no such problem in the U.S.;
- even if we don't know how to fix the system, we do know what treatments are most productive and work best for patients.

A recent roundtable on health care and the economy, sponsored by the Canadian Medical Association and organized by the Centre for the Study of Living Standards revealed some striking facts.

First, the costs of Medicare - of doctors, nurses and hospitals – are not higher as a portion of our economy than they were 15 years ago. Total health care costs as a proportion of Canada's GDP have increased from 9.1% in 1991 to 10.4% in 2005; hardly a terrible performance given the ageing of our population and the advances of medical technology. But virtually all of that increase has come from outside Medicare, from areas such as pharmaceuticals and dentistry. Measured in constant dollar terms, the costs of hospitals and physicians have risen by 68.5% over 15 years, and are unchanged as a proportion of GDP, while the costs of all other health care – where most of the funding is private -- has risen two and one-half times as fast, by 168.1%.

Second, the debate about privatization of health care delivery is rather misleading. Over 1.3 million Canadians work in the health care sector and about 700,000 of these work in "ambulatory care" outside hospitals and residential care facilities. There were more than 71,000 organizations involved in ambulatory care in 2003 and most of these operate essentially as private businesses. Their objective is to serve a clientele while providing an income for those working there.

But one immense difference between a doctor's office and the local Tim Horton's is that the cost of a cup of coffee is controlled by competition while the cost of Medicare is not.

It is controlled because there is a single paymaster -- the government. Where there is not a single paymaster, for example with most pharmaceutical purchases or dental visits, the cost control record is much weaker. And in the U.S. where the system has multiple paymasters health care accounts for over14% of GDP and population health is not as good as in Canada. We should worry more about maintaining government as the single paymaster of the system and less about privatization of delivery that has long since occurred.

Of course, even if costs are reasonably well contained, don't we still have waiting lists – a problem that does not afflict our southern neighbour?

Well, there are waiting lists but they vary from province to province and from procedure to procedure and in many cases, are less than those in other OECD countries. Median waits for elective cardiac artery bypasses (CABG's) range from 56 days in BC to 21 days in Ontario. But BC, Saskatchewan, Alberta and Ontario median waits for urgent CABG's do not exceed the recommended wait time of 14 days. Ontario median wait times exceed recommendations of the Wait Time Alliance only for joint replacements (by 12 days) and non-emergency MRI's (by 7 days).

Wait times are usually reported as medians, so half the patients on the list wait longer. Across the 4 provinces listed above, 6% of patients wait longer than one year for joint replacements and in Ontario and Saskatchewan 13% wait longer than one year for cataract surgery. For some this represents real suffering but, surprisingly, Statistics Canada reports that fewer than 12% of individuals waiting for specialist diagnostic tests or non-emergency surgery reported their lives were significantly affected and fewer than 4% reported missing work because of their condition.

Waiting lists are not all bad. Any efficient system has them, otherwise there is excess capacity. They also discourage unnecessary surgery and allow that "watchful waiting" that allows the body itself to cure many conditions.

Improvement is often achieved by better administration -- ensuring that existing capacity is efficiently used and that the right patients are at the front of the queue –rather than adding more money. For example, in Ontario, where there is virtually no inappropriate wait for CABG, vast sums of money were not added. Rather, a Coronary Care Network was created, linking all the surgical centres to all the local lists and distributing patients according to the urgency of their need and the availability of places.

So, doesn't the U.S. do better? Given the claim that the U.S. does not have wait lists, there is surprisingly little U.S. data. But in any event, we overlook one major fact about their system; whereas all Canadians can get on a waiting list for elective surgery and eventually will get it, those 15% to 20% of Americans without insurance coverage are unlikely ever to get on the list for elective surgery at all. While we measure our waiting lists in days or weeks, many Americans measure theirs as a lifetime.

If costs are not out of control and if waiting lists are not an intractable problem, then what is wrong with Medicare?

In an era of "accountability", health care delivery, not just in Canada but everywhere is strangely unevaluated.

We do not even agree on what to measure. At the aggregate level is it longevity, or days lost to work, or quality of life? At the individual level, is it morbidity, mortality or comfort? For example, for those with limited threat to life from coronary artery disease, doctors in New York state perform CABG's at 10 times the rate in Ontario. There is no difference in life expectancy for such coronary patients in New York and Ontario and in New York a few more die during a very expensive operation. But the New York patients may be more comfortable after the operation. Who is right?

And how do we relate treatments to outcomes? After all, one thing we do know is that factors outside the treatment itself, things like social support networks, nutrition, education or income may have as much effect as the treatment itself. For example, regardless of treatment the overall mortality rate for men in the top fifth of lifetime incomes and aged 65 to 70 is half that for men in the bottom fifth. And many patients arrive with more than one serious problem. In 2001, over 70% of patients over age 65 admitted to hospital had more than one serious condition. One treatment can affect another condition, so what "works"?

We also know that some treatments are unnecessary and some are downright harmful. For example, in BC, 27% of patients undergoing cataract surgery report that their vision is not better after the surgery than before.

Even if we are able to say what treatments work well or badly, what are we to do about it? For every reasonably clear instance of unacceptable levels of side effects, there are many murky ones. The pure ethics of medicine suggest that in ambiguous situations a doctor and a patient should decide what treatment is appropriate but in the real world, both may not be well informed. And meanwhile the paymaster is anxious to allocate funds to their most effective use.

To have a truly efficient health care system we must do better at evaluation. That implies a lot more work and -- yes --money. In Canada, the ten-year-old Canadian Institute of Health Information (CIHI) is a promising step as is steadily increasing attention from Statistics Canada but if we are to improve the efficiency of Medicare, this is certainly an area that needs more support.

If dealing with waiting lists is unlikely to require vast infusions of money and if Medicare costs are not "skyrocketing", then why are health care costs threatening to overwhelm our government budgets?

The answer is -- they aren't. What threatens budgets is declining government revenues combined with rising expectations about services. In 1992, total government spending in

Canada accounted for 44% of GDP. In 2005, it was bit over 35%. If health care takes even a constant bite out of a shrinking pie then other sectors will get less. But the problem is the size of the pie, not the size of Medicare expenditures. We simply cannot have simultaneously:

- lower taxes,
- increasing levels of health care, and
- increasing or even constant expenditures on other programs.

So isn't the solution to pass off some of Medicare's costs, creating a parallel private system to ease the pressure? Well, quite aside from the finite number of doctors and nurses to operate the system, both Canadian and U.S. experience proves that costs escalate far faster in privately than in publicly funded areas of health care. Conceivably governments could reduce *their* expenditures in that way but it is absolutely certain that, overall, Canadians would pay more. In fact if we really want to control the costs of health care while maintaining quality and improving equity we should expand Medicare to cover areas such as pharmaceuticals and dentistry. Taxes would rise, but the overall cost to Canadians would fall.

When we actually ask Canadians if they would be willing to pay more taxes in order to get better services they overwhelmingly say yes. Unfortunately we are unlikely to get that opportunity any time soon. Instead we may well have to watch federal and provincial governments continue to tinker while Medicare, maybe even letting overall costs rise by passing responsibilities to private financing. Lower taxes are threatening to make us all poorer.