CALL FOR CHANGE IN CANADA'S HEALTH CARE

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Canadians almost universally see health care as a source of national pride (Jedwab, 2012). Unfortunately, the idea that Canadian health care is among the best worldwide is a myth. Marred by low efficiency, Canada's system ranks poorly compared to other developed countries (Davis et al., 2010). This is disconcerting as health care directly affects the wellbeing of every Canadian. An aging population will test the system beyond current limits. Structural changes to Canada's

health care system are needed to address the major issues of cost, access to care, and timeliness of care.

Canada's universal single-payer health care system (often referred as Medicare) is governed by each province. Canadians enjoy physician and hospital services as well as immunization and screening programs without having to pay user fees. Hospitals are mostly publicly-funded, privately-owned non-profit organizations. The government also finances 45% of prescription drug spending (Canadian Institute for Health Information, 2013a).

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In 2010, the Commonwealth Fund compared health care in developed countries using factors such as access to care, care quality, and equity. Canada placed second-last, ranking only above the United States. Evidently, something needs to change.

For starters, current expenditure trends threaten long-term sustainability. Research by the Canadian Institute of Actuaries (2013) has indicated that the present system is economically unsustainable. Health care expenditures have increased every year since 1997. Adjusted for inflation, this reflects more than double the spending per capita in 1975 (Canadian Institute for Health Information, 2013b). Health care spending is expected to increase significantly from 8.2% of GDP in 2012 to 12.7% in 2037 (Levert, 2013). Medicare is the single largest expense in all provinces and is expected to outpace economic growth in every province (Levert, 2013). If spending continues on its current course, funding for education, infrastructure, and social services will suffer.

Patients also suffer lengthy wait times for surgery, specialist referrals, and emergency care. Waits for emergency department care far exceed the recommended times by the Canadian Association of Emergency Physicians (Canadian Institute for Health Information, 2012). The median wait between referral from a family physician to treatment is 18.2 weeks (Barua & Esmail, 2013). Compare this to the United Kingdom, where the median is

8.5 weeks and patients have the legal right to treatment within 18 weeks (National Health Service, 2013). The OECD (2013) reports that out of its 34 member countries, Canada has amongst the longest wait times despite ranking sixth in spending. This is not only tremendously frustrating, but dangerous to patients with underlying medical conditions.

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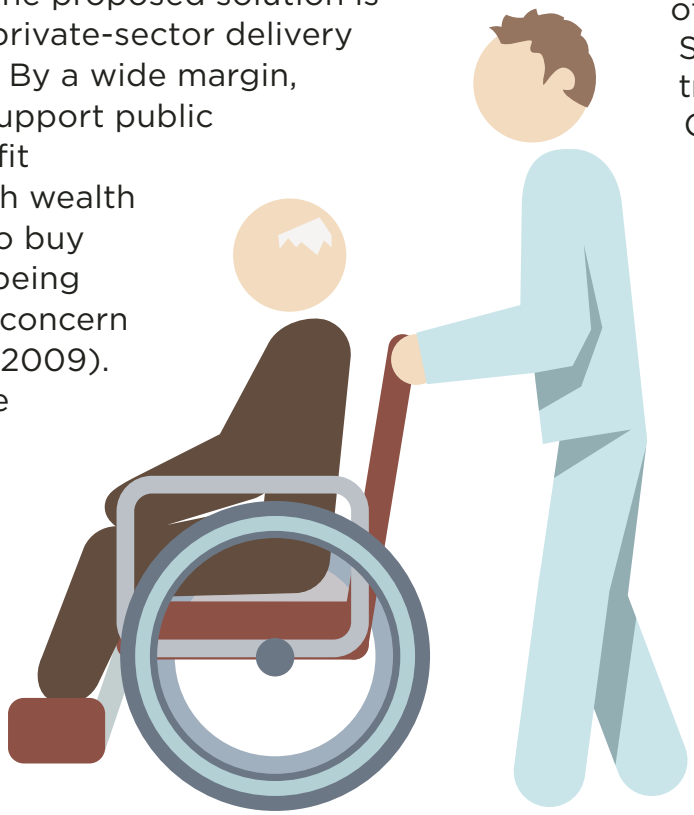
Medicare trails in providing timely care despite high expenditures, suggesting that the issue is not lack of funding, but poor management of resources. One proposed solution is to increase private-sector delivery of Medicare. By a wide margin, Canadians support public over for-profit services, with wealth being able to buy better care being the primary concern (Ipsos Reid, 2009). However, the Commission on the Reform of Ontario's Public Services (2012) recommended using more private clinics while retaining the public-payer system to ensure equal access. This method is used in Singapore, where citizens enjoy universal health care delivered largely through private facilities, while the government regulates quality and prices.

Canada has also seen success at improving service and decreasing costs through increasing the role of external clinics. In 2011, Saskatchewan launched the Saskatchewan Surgical Initiative. The province accepted proposals from private clinics to conduct specific surgeries in specific regions. The government regulated the cost, quantity, and the time frame for procedures. The clinics must follow hospital standards and be certified by the Saskatchewan College of Physicians and Surgeons. It was a tremendous success. Costs were lower for all procedures, with average savings of 26% (MacKinnon, 2013). Wait times fell. Notably, the number of patients waiting more than six months has fallen 65% since the program's initiation (Saskatchewan Surgical Initiative, 2013). As patients are all waiting in the same queue, nobody can "jump



the line." These results indicate that using contracted clinics can shorten waiting times and reduce costs without compromising patient outcomes. Other provinces can gradually implement similar systems. Performing surgeries in external centers increases efficiency through specialization, frees resources in overcrowded hospitals, and reduces the risk of hospital-acquired infections.

Demographic changes, namely Canada's aging population, will place increasing strain on the system.

Since 2009, U.K. patients have been able to choose which hospital to receive their procedures at, thereby introducing competition into the public system. The National Health Service hosts an online appointment booking system for publicly-funded hospitals, complete with user ratings, staff recommendation rate, and even mortality rates. Hospitals with better patient experiences and outcomes attracted more patients and received more funding. Less popular hospitals work to improve. Overall, publicly funded hospitals have become more efficient, without requiring additional funding (Cooper, Gibbons, Jones & McGuire, 2012). Canada needs a patient-centred focus that can be introduced with competition that emphasize the important aspects of good care.

Medicare must adapt. Demographic changes, namely Canada's aging population, will place increasing strain on the system. There must be greater support for home care and long-term care. Patients with chronic conditions can thus receive more specialized services in long-term care facilities while hospital beds are freed for acute care patients. Ideally, Canada should focus more on primary health care, which considers not just hospitals and physicians, but

also dietitians, psychologists, and other health professionals as key components of an individual's complete care. Auxiliary services can continue to be funded with user fees, yet a uniform communication platform would allow authorized professionals to collaborate with each other. The ongoing gradual conversion to electronic health care records will also help to modernize the patient management system. Whether public or privately-funded, these health professionals can all build and refer to a patient's file in order to create a complete medical history with diagnoses, test results, and therapies taken. This creates a more integrated, holistic view of health by focusing not only on physical health, but also mental and emotional well-being. Canada should shift from a treatment-based care approach to one that is prevention-based. Life expectancy is high and chronic conditions, not acute disease or injury, are what consume the greatest resources (Mirolla, 2004).

The issue is not lack of funding, but poor management of resources.

The challenges in Canada's health care system require structural changes. Through using more external delivery of services, regulating quality, and emphasizing an integrated patient-centred care model, resources can be managed more efficiency to provide the best possible care to Canadians. The government and the public should be willing to embrace reform by not only setting ambitious goals, but by developing clear metrics to measure progress. People do not choose to get sick. When they do, they rely on a sound health care system to help them recover. Only with a sound system can future generations continue to live long, healthy lives.

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