Tackling the Surgery Backlog in the Canadian Provinces

Some Lessons from International Experience

by Yanick Labrie

The COVID-19 crisis that spread in the spring of 2020 has made many Canadians realize how woefully less prepared their health-care system was than the systems of other developed countries to face the health emergency. At the time of the arrival of the pandemic, Canada had no extra capacity in the hospital sector to deal with the influx of cases of patients affected by the virus. The level of health resources was—and still is—among the lowest in the developed world, despite public spending among the highest per capita. The pandemic has therefore brought major challenges to hospitals and health-care professionals. The mobilization of staff and the reallocation of medical resources to take care of COVID cases have forced provinces to cancel and postpone thousands of elective surgeries across provinces resulting in longer waiting times for patients.

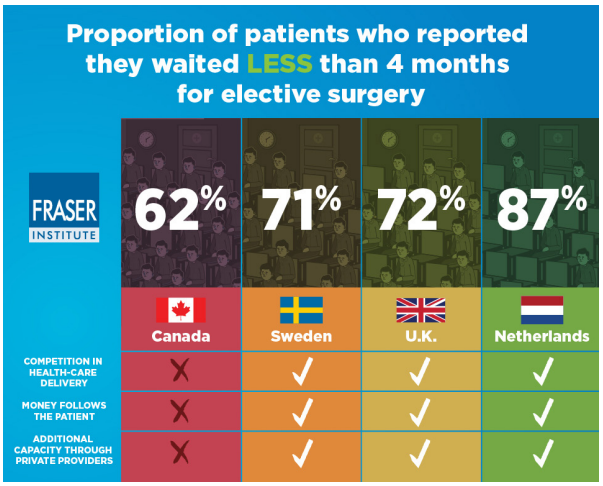
However, even before the pandemic, there were major problems with access to elective surgeries in the country. Data collected over the past 30 years reveals a steady deterioration in access to such care across Canada. International data suggests that for many years Canadians have endured some of the longest delays in the developed world while they wait for access to medically necessary care. The COVID-19 pandemic has simply put an additional strain on our already fragile health-care systems.

Over the last few decades, provincial governments have tried to address this chronic access problem in their health-care systems, but without much success. Most of the time, this has boiled down to targeted increases in public funding dedicated to certain types of elective treatments. Without the necessary reforms, targeted funding programs have done nothing to solve the problems at the root of the long waiting lists for care. While they may have temporarily increased the capacity of the health system in specific areas, these one-time funding programs have not changed the incentives in place to improve the efficiency of our health-care systems in the long run.

Hospitals in Canada, in every province, still operate in a virtually monopolistic environment, where competition and the associated pressure to remain efficient are absent. Canadian patients have very few real options for obtaining specialized health-care services. Furthermore, hospitals in each province receive a global budget that does not vary according to the activities carried out or the number of patients treated.

Many other countries with universal health care, such as England, the Netherlands, and Sweden, have moved away from these centrally planned systems where the State is in charge both of financing and delivering services. These

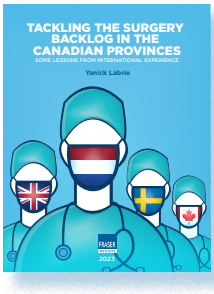
countries have sought to provide better incentives to care providers, separating the role of purchaser from that of provider of services, while at the same time regulating and monitoring the quality of care provided. Freedom of choice



for patients, competition among a mix of public and private providers, as well as a funding method that makes money follow patients are among some of the policy tools that have been used successfully to improve access and efficiency in these health-care systems. By making patients no longer a source of expenses in a fixed budget but rather a source of additional revenue, patient-based funding schemes encourage providers to deliver quality services in order to attract patients and treat them in a timely fashion.

These European countries have also allowed private care providers a more active role, increasing available capacity and diminishing the pressure on the public system. By making more optimal use of operating-room capacity, the private providers are able to increase the volume of elective surgeries performed in the health-care system, being less at risk of having to cancel or postpone surgeries due to unforeseen situations, as is often the case in large public hospitals. As a matter of fact, without the use of additional capacity from the private sector, several countries would be grappling with delays in surgeries much worse than the current ones.

Clearly, these health-care policies offer incentives for providers to become more efficient and at the same time contribute to improving the allocation of available resources. This efficiency, which replaces the rationing of care, is the source of improved access in countries like England, the Netherlands, and Sweden that have taken this path. This policy lesson should serve as an inspiration to decision-makers in their search for solutions to tackle the backlog of elective surgeries in the Canadian provinces.



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