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Spending more on health care does not guarantee better health outcomes

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Canada's federal election results had barely been counted when the Premiers resumed making their well-worn demands for more federal health care money. Instead of thanking Ottawa for the billions it has already provided for fighting COVID-19, or asking for short-term pandemic-related funding, the ritual chorus seeks ever-increasing amounts of money for decades to come.

Granted, the need for more money certainly feels urgent right now. Intensive care is on the brink of collapse in Alberta and Saskatchewan, with health officials preparing to make painful decisions around triaging patients as COVID-19 infections surge. A number of provinces are having difficulty even staffing their hospitals, after almost two years of burnout-inducing working conditions for front-line health care workers.

However, the premiers' multibillion-dollar asks have been for unconditional long-term funding, well beyond the scope of the current crisis. But they have not been clear on how any new money would be used. It is entirely reasonable to ask them to explain themselves—especially since spending more on health care does not automatically mean better health outcomes.

In a recent study, CIBC economists Benjamin Tai and Andrew Grantham found that COVID-related hospitalizations per one million of the population were four times higher in the U.S. and five times higher in Britain than in Canada in early 2021. “Yet, as we all surely recall, the hospital system in Canada during the second wave was at its wits’ end,” they write.

“Simply put, we reached capacity at levels that many other countries consider to be acceptable.” They conclude that Canada’s hospitals need more money.

But this is only part of the story. While the U.S. is well known for having much higher health care spending than any other country, both the U.K. and Israel spend significantly less than Canada—and yet neither came close to peaking on hospital capacity. The issue, then, cannot just be a lack of funding; how our health care dollars are being allocated must also be part of the conversation.

One reason provincial governments prefer hounding Ottawa, rather than focusing on more efficiently using the funding they do have, is that passing the buck is painless. As Canadian health economist Bob Evans says, “every health care cost is someone’s income”—that is, controlling or cutting health care costs means controlling or cutting the

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salaries of doctors and nurses, hospital budgets and pharmaceutical firm profits. It is much easier politically for provinces to demand more funding than to get into conflicts with such concentrated and powerful interests.

But there is also a deeper reason. The provinces, and the federal government, simply may not have the data to evaluate their health care spending rigorously, even if they even wanted to. If they do have the data, they certainly keep their evaluations hidden.

This is not by accident. The sawier leaders among the key stakeholders have no interest in having such data exist, because they may fear it will lead to results that could embarrass them and turn public opinion against them, possibly in ways that would reduce their incomes or autonomy.

For decades, some of the most important data showing health care waste and inefficiency has looked at variations among small geographic areas -“postal code medicine.” These variations, which are the continuing subject of the Dartmouth Health Atlas, consistently show that while some parts of the U.S. spend two to three times as much on health care as others, key health indicators, such as primary care for diabetic patients and post-surgery complications, are not correlated.

One recent study by leading U.S. health economists concluded that these variations were not due to differences in patients’ needs; instead, they were most closely associated with physicians’ beliefs that were “unsupported by clinical evidence.” The specific examples they studied suggested that 12 to 35 per cent of this health care spending was unwar-

ranted.

Canadians are rightly proud that our health care sector is nowhere near as expensive or inequitable as that of the U.S. But we are not immune. One decade-old study looked at heart attack treatments in Canada and found a threefold difference across health regions with no obvious difference in post-surgical 30day mortality.

Sadly, no one has updated or extended this study, in part because the data needed are simply unavailable. We could get better value for our health care dollars if we knew more.

Before the federal government signs over any more multibillion-dollar cheques to the provinces with no strings attached, Canadians deserve to know why the additional investment is needed in the first place, how it will be spent and whether, after all this time, our money has been well used.

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