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The Reallocation Challenge: Containing Canadian medical care spending to invest in the social determinants of health

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Abstract

We argue that Canadian provincial governments should contain medical care spending in order to invest more in the social determinants of health. Others have said this, many times. Doing it has not proven easy. We therefore emphasize the potential contribution of the priority setting and resource allocation literature. This literature identifies formal tools and approaches which have built cultures of support for resource shifts, while providing pragmatic means for advancing efficiency and equity. Although re-allocation towards SDH from other areas of the health care system is financially viable and supported by existing research, it will require new emphasis on the design of population health interventions that make reallocation politically expedient.

Keywords: priority setting, resource allocation, social determinants of health

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There are several reasons to contain Canada's medical care spending. These include: (i) efficiency considerations reveal we are not getting bang for our buck; (ii) medical care is a modest contributor to population health outcomes relative to social determinants; and (iii) current policies risk compromising intergenerational equity by prioritizing inefficient illness treatment for an aging population at the expense of promoting well-being for their children and grandchildren.

In the first section of this commentary, we summarize these arguments, and conclude that Canadian governments should pursue health improvements by reallocating medical care spending to the social determinants of health (SDH). In section two we argue the priority setting and resource allocation literature includes the tools to guide the implementation of cost savings in medical care. We conclude by emphasizing that scholars and practitioners must pursue population health interventions that build political will for such reallocation.

The case for containing medical care

Spending too much for too little

Like other OECD countries, Canada has a healthcare system which is expensive and geared toward intensive, technology-heavy, biomedically-oriented forms of care. Canada's total public health expenditures grew from 6.4% of GDP in 1995 to 8% in 2010;¹ combined with private spending, this puts Canada in "the top quartile of spenders in the OECD with regard to total health expenditure per capita".^{2,p.85} At the provincial level, health sector spending accounts for a projected 37.7% of total program expenditures for 2013.² The majority of provincial health spending is on hospitals (29.6%), physician services (15.5%), and pharmaceuticals (15.8%).² The

first two are covered by the Canada Health Act, generating incentives for provinces to structure their systems to rely on these costly components.

Despite spending more than most countries, Canada sits at best in the middle of the pack of OECD countries in terms of health outcomes and satisfaction with the system. We get only average results in terms of amenable mortality and health adjusted life expectancy.¹ Canadians enjoy below average access to physicians and MRIs.^{1,3} And Canada ranks second last among 15 countries in the number of people who say the health system is working well, rather than needing fundamental change.³

Health is not equal to healthcare

At least since the Lalonde Report, there have been persistent calls to reorient spending away from medical care toward investment in SDH. The WHO Commission on the Social Determinants reports that health outcomes, and inequities in health, arise primarily as a result of the conditions in which people grow, live, work and age, along with the political, social, and economic forces or policies that shape these conditions.⁴

There are known barriers to making SDH a policy priority:

- long time horizons^{5,6} mean impacts are out of sync with political cycles;⁷
- dominance of biomedical, individualist and neo-liberal philosophies and the interests which benefit from them;^{5,7}
- the challenges of intersectoral collaboration within and across governments and civil society organizations;^{6,7}
- perceived lack of evidence on effectiveness of many population health promotion or SDH initiatives;^{5,6} and

- the popular momentum that medical care spending enjoys in the cultural psyche of Canadians.⁸

Recent analyses show that Canada allocates relatively little towards population health promoting policies in such areas as taxation, income support, housing, urban development, and early childhood education.⁹ According to Kershaw and Anderson, for instance, Canada meets only one of ten international benchmarks for human development in the early years.¹⁰

Intergenerational considerations

Younger Canadians want their aging parents and grandparents to enjoy healthy, financially secure retirements, while elders want to leave their offspring a legacy that is health-promoting. Yet macro health care policy decisions diverge from commitments to intergenerational solidarity. Kershaw finds that Canadian governments have substantially increased annual medical care spending on the population aged 65+ by 1.89% of GDP since 1976 – over \$32 billion in 2011 currency.¹⁰ Yet governments did not increase general revenue as a share of GDP in order to pay for this additional medical spending. This policy choices contrasts with our national approach to expanding income security in retirement. While spending on the Canada and Quebec Public Pensions grew by 1.47% of GDP over the same period, C/QPP revenue rose by 1.59% of GDP.

Because governments did not plan revenue increases for additional medical care spending on the aging population in the way they did for retirement income security, policy makers have needed to find savings from other social spending priorities and/or leave larger government debts. Both outcomes are evident. This includes a nearly 1% of GDP reduction in cumulative government spending on education, childcare services, parental leave, and cash supports for families with children, equal to \$16 billion in 2011 currency.¹⁰ As a result, there are normative

questions about whether Canadian governments are finding the right balance between investing in illness treatment for the aging population and health promotion for the age cohorts that follow in its footsteps.

Prescription: Constrain and Reallocate

Given the above, there are strong reasons for Canadian governments to seek health improvements by ‘spending smarter’. Spending smarter will include containing medical care expenditure to preserve fiscal capacity to invest in SDH for the aging and young alike. There are various ways to squeeze money from the health care budget. Economies of scale can be sought through consolidation of smaller hospitals, or centralizing some services into ‘Centres of Excellence’. Changing workforce mix can save on the human resource ledger by replacing high cost providers with others equally able to carry out specific tasks (e.g., nurse-practitioners instead of physicians). Policies requiring the substitution of equivalent generic pharmaceuticals for higher-priced brand name products might rein in recent trends toward escalating provincial drug plan costs. We do not endorse these policies of constraint carte blanche, simply observe they have been tested in various circumstances and jurisdictions.

Leveraging Change with Priority Setting and Resource Allocation (PSRA) Tools

PSRA starts with the basic economic principle of the margin – which speaks to ‘how much’ of something we want or need, and at what incremental cost. The essential components of a formal PSRA approach include: a way of defining program/spending options, explicit criteria for comparing options, a means of gathering and sharing evidence related to the criteria, and an explicit weighting/scoring system. There is evidence from Canada and elsewhere that PSRA tools can achieve health spending reallocation at the individual program level and at the meso-system level (i.e., within integrated health service delivery organizations such as Regional Health

Authorities (RHAs)). In one case, up to 3% of a health authority's annual budget (over \$40 million) was shifted as a result of a priority setting exercise.¹¹ A 3% saving on Canada's total \$150 billion public health care bill would pay for half the incremental cost required to implement a population-level early childhood care/education system with a maximum fee of \$10/day.

But regionalization in Canada has failed to give adequate scope to health authorities. For example, drugs and physician services are outside their purview. In British Columbia, initial increases in the proportion of health authority resources devoted to public health have since declined, potentially reflecting reallocation back to acute care purposes.¹² Over time, the envisioned mandate for RHAs to increase "collective action on the social determinants of health" has been "pushed aside in favour of more individualist, lifestyle-based health promotion".^{13,p.643} Therefore meaningful reallocation to SDH has to happen, in our view, at the provincial Cabinet table, or through policies to initiate and support interdepartmental mechanisms in the provincial bureaucracies. To our knowledge, formal PSRA tools have never been tried in Canada at this level.

Before PSRA tools are likely to be deployed on the pillars of our healthcare system at provincial Cabinet tables, it must become more politically expedient for decision makers to question the status quo. According to the Commission on the Social Determinants of Health, "building political will... through democratic processes of civil society"^{4,p.109} is central to achieving investments in the SDH. Brown and Fee support this finding in their review of the role of social movements in achieving population health gains;¹⁴ and Raphael concludes that health promoters "have to engage more directly in building social and political movements that can shift the distribution of influence and power"^{15,p.391} in favour of SDH investments. The design and evaluation of health interventions that aim to build this political will must therefore

rise in priority for population health scholars and practitioners who recognize the promise of investing in the social determinants.

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