

## **More spending doesn't always mean better health care**

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**(Spectator headline:** Making wise use of our Canadian health care dollar)

Consider the following headlines. "Hospitals overcrowded, patients wait in emergency for scarce hospital beds". "Intensive care units near capacity, doctors frantic."

Both sound like bad news, right? Maybe, but maybe not.

In Canada, out-of-control health care spending is a myth. As Canadians, we spend less of our resources, as represented by the Gross Domestic Product, on health care than we did ten years ago. Spending per-person on doctors and hospitals has not changed over that decade.

At the same time, pressures on health spending are real. Highly trained health workers demand high salaries. Often, new technology generates increased costs. The bottom line is an international trend toward increases in health care spending that began about 40 years ago and shows no sign of ending. Cost pressures mandate that we spend our health resources as efficiently as possible.

In considering the efficiency, we should ask how much we gain when we increase health spending. An important new study from the U.S. suggests that the answer is, sometimes, not much.

The US Medicare program covers physician and hospital services for people over 65 the way that Canadian national health care covers doctors and hospitals for our entire population. As it turns out, American Medicare expenditures vary dramatically across the country. For instance,

Medicare spent \$8,414 per enrollee in Miami in 1996, compared to \$3,341 in Minneapolis.

A group of researchers have asked whether high-spending areas get better quality of care, or superior health outcomes, for the extra money. The researchers divided the US into five regions according to Medicare

spending. Yearly per-person Medicare costs in the top-spending region were \$6,304, and in the lowest-spending region \$3,922. In other words, residents in the top-spending region received 62% more Medicare resources than those in the lowest-spending region.

The study team looked at four groups of patients. Three groups had experienced a serious illness – a heart attack, a hip fracture, or a new diagnosis of colon cancer. The fourth group was a random sample of Medicare recipients. For each group, the investigators looked at measures of quality, satisfaction with care, and death rates.

What did the big spenders get for their money?

Regions with higher expenditure indices did not, in general, do any better on measures of good health care. For instance, of four classes of drugs that reduce death rates after heart attacks, there was no difference in two, patients in high spending regions were more likely to receive a third, but less likely to receive the fourth. Patients in high spending regions were less likely to receive preventative measures such as influenza immunization or pap smears.

What about access? Patients in the high-spending regions were more likely to see a specialist, patients in low-spending regions more likely to see a family doctor. But waiting times were longer in the high spending areas. Furthermore, patients in the high-spending regions were no more satisfied with their care.

The ultimate goal of health care is improved health. Did increased health spending reduce death rates? Spending did not effect the risk of dying in the random sample and hip fracture groups. Death rates in patients with colon cancer and heart attacks went up, not down, with increased spending.

To fully understand the results, we should know where the extra money was spent. The big differences were in higher rates of hospitalisation, more tests and minor procedures, and seeing more doctors, particularly specialists. Some of the biggest differences were in care reserved for the sickest patients, such as use of artificial breathing machines.

These results provide a message about how to deliver efficient health

care. Doctors use the resources available to them. Open more hospital beds, or more beds in intensive care units, and doctors fill them. In other words, when more beds are available, doctors apply a lower threshold for admitting patients to those beds.

The results suggest that the Canadian system of rationing care, in which we make sure hospitals and intensive care units operate at full capacity, makes sense. At the same time, we must remember that Canadian health care spending is already at the level of the lowest-spending American regions. Patients needing hospital admission often spend hours to days waiting for scarce hospital beds. Intensive care units are frequently full, leading to cancellations in elective surgery. Waiting times for heart catheterization and radiation therapy suggest that targeted increases in funding are necessary to ensure optimal care.

How tight can we run the system before quality does deteriorate, and patients suffer worse health outcomes? No one knows the answer, and even if governments allocate adequate funds for health care delivery, health care planners will struggle to find the right way to spend the limited money.

Nevertheless, the American study suggests that health care Commissioner Roy Romanow got it right when he didn't focus on hospitals. Instead, he wisely recommended targeted new public spending on home care, protecting Canadians from catastrophic expenditures on prescription drugs, up-to-date diagnostic technologies, and strengthening primary care.

So, next time you see those frightening headlines about tight hospital services, think twice. They may mean we are making wise decisions about efficient use of health care dollars.