

A Decade of Health Care in Crisis

Released October 10, 2000

It has now been over a decade since we heard the first cries of "health care in crisis". What is the real story at the end of a decade-long crisis?

The crisis began in the midst of budget deficit hysteria. The result was near-zero increases in public expenditure on health. The proportion of spending on health care decreased from over 10% of the gross national product to just over 9%.

With population increases, the continuing explosion of expensive medical technology, and an aging population, stable spending meant real resource cuts. Health care administrators, and health care workers, scrambled to do more with less.

Large numbers of hospital beds, and eventually hospitals, closed. Patients spent much less time in hospital for surgery, after having babies, and for medical illness. Nursing and administrative staff were chopped, and hospitals recruited less skilled, and lower paid, personnel for nursing roles. Canadian governments instituted a 10% cut in the number of medical school positions, and closed the border to foreign-trained doctors.

The result has been enormous increases in stress for health workers, and instances of decreased convenience for patients. Health workers often feel their ability to deliver top-quality care is threatened.

But have the changes in health care delivery had an adverse effect on health? In a recent commentary in the *Canadian Medical Association Journal* (2000;163) Winnipeg health research and health policy analyst Naralou Roos reviewed the evidence.

Focusing on a recent study that monitored the effects of a 30% bed closure rate in British Columbia, Roos notes no increase in death rates. Did fewer people get in to hospital? No, the system adapted, and shorter hospital stays kept the proportion of people, particularly the elderly, unchanged.

Did the shortened stays mean that people discharged quicker were also

discharged dangerously sicker? Roos cites data from Winnipeg, where 21% of hospital beds were closed between 1992 and 1995. In Winnipeg, not only did death rates stay the same, but there was no increase in hospital readmissions, and no increase in emergency room or doctors office visits in the 30 days after discharge.

Despite the evidence, the media continues to depict the system as falling apart. Calls for abandoning universal care, and moving to a private system that would give superior care to those who can pay, accompany the horror stories.

The evidence suggests the validity of a more balanced view. The public system has adapted in an extremely effective way to the resource crunch. Stressed health workers continue to deliver top quality care. As a result, health outcomes have not deteriorated.

So where are we now, as the end of a decade of crisis? Instead of budget deficits, governments are enjoying large surpluses. Federal and provincial governments are instituting tax cuts.

The obvious, and appropriate, response to this increased funding would be an increased investment in health care. Governments have been extraordinarily slow in responding, and their level of response remains niggardly.

Canadian health care needs changes. Structurally, reform of primary health care is long overdue. Home care is inadequate, and ordinary Canadians often face drug costs that are hard to manage.

Nevertheless, the message from the evidence is clear. There may have been a crisis in health care delivery, but the system has adapted well, and there has never been a crisis in health. With increased resources available, we should have no difficulty in decreasing the stresses within the system, while continuing to maintain the quality of health care delivery.

This solution will, however, require that Canadians opt for increases in health and social service spending, instead of tax cuts. The wrong choice might mean an ultimate crisis in which top quality care is restricted to rich Canadians, and the crisis for ordinary Canadians will mean poorer health care and poorer health.

