

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 (SDH). 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 that have built cultures of support for resource shifts, while providing pragmatic means for advancing efficiency and equity. Although reallocation 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.

KEY WORDS: Priority setting; resource allocation; social determinants of health

La traduction du résumé se trouve à la fin de l'article.

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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.

The first section of this commentary provides a summary of these arguments; in section two, we look to the priority setting and resource allocation literature to see what tools it might offer to guide the implementation of cost savings in medical care.

THE CASE FOR CONTAINING MEDICAL CARE

Spending too much for too little

Like other OECD (Organisation for Economic Co-operation and Development) countries, Canada has an expensive health care system geared toward intensive, technology-heavy, biomedically-oriented forms of care. Canada's total public health expenditures grew from 6.4% of GDP (gross domestic product) 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".^{2p.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 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 medical resource imaging.^{1,3} And Canada ranks second last among 15 countries in the number of people who say the health system is working well as opposed to needing fundamental change.³

Health is not equal to health care

At least since the Lalonde Report, there have been persistent calls to reorient spending away from medical care toward investment in the social determinants of health (SDH). The WHO Commission on the Social Determinants reports that health outcomes and inequities 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} which mean impacts are out of sync with political cycles;⁷
- dominance of biomedical, individualist and neoliberal 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}

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- 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.⁸ According to Kershaw and Anderson, for instance, Canada meets only one of ten international benchmarks for human development in the early years.⁹

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 choice 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 in evidence. 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 younger cohorts.

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 centralization of 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*, but simply observe they have been tested in various circumstances and jurisdictions.

LEVERAGING CHANGE WITH PRIORITY-SETTING AND RESOURCE ALLOCATION TOOLS

Priority-setting and resource allocation (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 Canadian evidence 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.

Regionalization in Canada, however, 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 at the provincial Cabinet table.

For example, the BC Cabinet approved in 2015 another \$500 million increase for health care, which was already 41% of provincial spending. The same Cabinet decided not to find *half* that amount of additional money for public transit, putting to a plebiscite the question of raising new taxes to pay for transit. The plebiscite failed. Given the public health community’s strong advocacy for transit during the plebiscite, had Cabinet applied PSRA tools, they might have opted to reverse the tradeoff: putting to plebiscite whether/how to raise additional taxes for medical care in order to redirect currently available funds to transit. Alternatively, application of PSRA tools might have inclined Cabinet to redirect the newest health money to early childhood education in light of the BC Health Officers Council’s endorsement of \$10/day child care.

The reality is that political considerations, including re-election, shape priorities set by Cabinets as much as marginal cost/benefit calculations. Before PSRA tools will be deployed on the pillars of our health care system, it must become more politically expedient for Cabinet decision-makers to question the status quo. That is why the Commission on the Social Determinants of Health emphasizes that “building political will... through democratic processes of civil society”^{4,p.109} is central to achieving investments in the SDH. Brown and Fee’s findings in their review of the role of social movements in achieving population health gains support this argument;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 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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RÉSUMÉ

Nous soutenons que les gouvernements provinciaux du Canada devraient limiter les dépenses de soins médicaux afin d'investir davantage dans les déterminants sociaux de la santé (DSS). D'autres ont dit la même chose, à maintes reprises. Mettre ceci en pratique n'a pas été aisé. Nous insistons donc sur la contribution possible de la documentation sur l'établissement de priorités et l'allocation de ressources. Dans cette documentation, on répertorie les outils et les approches qui renforcent des cultures de soutien à la réorientation des ressources, tout en proposant des façons pragmatiques de favoriser l'efficacité et l'équité. Bien que la réaffectation vers les DSS à partir d'autres éléments du système de soins de santé soit financièrement viable et étayée par la recherche existante, elle nécessitera une nouvelle insistance sur la conception d'interventions en santé des populations qui rendent une telle réaffectation politiquement rentable.

MOTS CLÉS : établissement de priorités; allocation de ressources; déterminants sociaux de la santé