MISSION: seeking solutions to the health and social impacts of development.

SHAPING HEALTH IN BC – OBSERVATIONS AND SUGGESTIONS
Submission to the B.C. Conversation on Health

EXECUTIVE SUMMARY
Pacific Health and Development Sciences Inc. is a public health systems consulting firm. We view health as a human right and as a complex social and economic goal for all countries. In support of the principles outlined in the Canada Health Act, we observe that no society anywhere has achieved health with equity without a unifying public policy and substantial investment in the public sector. Our submission takes note of inter and intra-jurisdictional comparisons, the critical role of social determinants, and the fundamental need to emphasize primary health care and public health. We make 9 suggestions by which BC may continue to improve its health care.

Our Perspective on the Health System

In the popular viewpoint, the most valued features of our health care system are its universality, portability and lack of direct charges for publicly insured services. These features are rendered feasible by compatible systems of government administered financing consistent with the Canada Health Act (1984). Valued as well, but mostly at the professional level, is the scientific evidence for the efficacy of many of its interventions at individual and population levels, and the quality of training of health care occupations. Also valued by most health professionals is the inherent sense that the work they do makes a difference to people, is interesting and even challenging, and earns the respect of society: these aspects are the least often measured, but may be just as important to the overall quality of health care as are universality and scientific efficacy.

1 The preamble to the Act states: “continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians”. The primary objective is “to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” (Section 3).
The Canadian health care system is not comprehensive. While this has never been one of its stated goals, elements not fully recognized in its design include: home care, long term care, home support, dental care, physiotherapy and pharmaceutical coverage, among others. To the extent that the system delivers on equity, it approaches this for fully insured and hospital-based services; but where coverage is not universal, ability to pay is a critical factor. This contrast reflects how society views health as a public good, what it considers to be essential, the extent of equity it seeks, and the resources it is prepared to allocate to these ends. Ultimately, commitment and sustainability are functions of social values and political will, as is the question of expanding the system to include additional health service domains: do Canadians see the universality principle being applied in the future to services which are not fully financed today?

The health field therefore entails a struggle among competing interests - past, present and future. While the principles under the Canada Health Act resonate politically, not all health modalities are equally recognized. Nor are they equal in terms of need, quality of supporting evidence, nor necessarily affordable. Choices have always been made. As health care has moved historically from being a private matter between patient and caregiver, to a public sector enterprise that values effectiveness and efficiency, so too has its design, standards and management moved from the grass-roots to more centralized systems, be the latter government ministries, regional authorities or university faculties of health professions. Whether these systems are now sufficiently in touch with local needs is a legitimate question.

Health therefore is both a complex social goal and a major enterprise in Canada, mostly now based in the public sector. While compassion and human rights lie at its base, there is also a need to see it in terms of social and economic benefits for whole populations. The United Nations links health to human rights, as in the World Health Organization constitution: "enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being..." However, WHO also promotes utilitarian concepts of health which portrays it as an investment eg., health as a resource for everyday living; health as an ultimate purpose and outcome of society’s economic pursuits. No society anywhere has achieved health with equity without investing substantial amounts from public expenditures; virtually all nations failing to meet this human right are demonstrably deficient in related areas of public policy and financing.

Inter and Intra-jurisdictional Comparisons

A systematic review of 38 studies recently confirmed that Canada’s system leads to health outcomes that are favourable overall when compared with the US private for-profit system, at less than 50% of the cost. However, perhaps more relevant is WHO’s landmark study in 2000 of health systems performance in almost 200 countries, ranking

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the UK in 18th place, Canada at 31st, and the US (most expensive health care in the world) at 37th. Most European countries performed better than Canada, while Australia’s performance (with similar socio-demographics) at 32nd place was virtually tied with ours. Several other countries also scored better than Canada eg., Singapore, Japan. In our view, we should be prepared to study and learn from those systems which appear to be doing better than we are, and – while staying consistent with the core principles of the Canada Health Act – we should be more prepared to innovate, test and evaluate new approaches. We should also show much more interest in the internal comparisons being revealed from within our own health and social sectors, specifically: why are conditions so different for different groups within the province, and what can be done about this?

When one examines overall health status of populations using objective measures, it is tempting to conclude that the health systems of countries with similar socio-economic conditions appear to vary more with regard to cost than performance, irrespective of the public-private mix. However, the type of system does appear to have a strong influence on the indicators of equity. Beyond observing the principle of universality which we in Canada appear to hold more strongly as a core value than our neighbours to the south, this is reflected in steadily improving outcomes. A new Canadian study reveals that – over a 25 year period – differences between the richest and poorest quintiles in expected years of life lost amenable to medical care decreased 60% in men and 78% in women. Reductions in rates of death amenable to medical care made the largest contribution to narrowing the socioeconomic mortality disparities. Continuing disparities in mortality in causes amenable to public health suggest that public health initiatives have a potentially important but yet unrealized role in further reducing mortality disparities in Canada.

If we make the political decision that there is probably already enough money in the system, the challenge in achieving better performance necessarily must lie in improving leadership, priority-setting, decision-making and management at all levels: in particular, we must do better on health promotion, public health and preventive medicine. On the other hand, there are many in society and among the ranks of the health professions who believe that the system we have is already doing very well, and – while its underlying principles seem secure – we would adjust its design and the way it is working at our peril. Nonetheless, the existing budget is by definition aligned with the status quo, mostly a legacy of thinking of the early 1970s (when most provinces launched their particular version of “medicare”). Does it necessarily follow that this is the only model or formulation we are capable of, or has the time come (especially in light of yet another massive budget surplus, tax-financed) to consider whether to expand the scope of health services to more within currently underfinanced sub-sectors eg., pharmacare, dentistry.

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5 For example, with regard to early child development, findings from BC reveal large and consistent differences in developmental vulnerability across neighbourhoods, districts and regions. Reference: Hertzman C, Irwin LG. It takes a child to raise a community: population-based measurement of early child development. Human Early Learning Partnership. No 1: July 2007. [www.earlylearning.ubc.ca](http://www.earlylearning.ubc.ca)
6 James PD, Wilkins R, Detsky, Tugwell, Manuel DG. Avoidable mortality by neighbourhood income in Canada: 25 years after the establishment of universal health insurance. J Epidemiol Community Health 2007; 61:287-296. [http://jech.bmj.com/cgi/content/abstract/61/4/287](http://jech.bmj.com/cgi/content/abstract/61/4/287)
Looking Where the Object is Lost, Not Where the Light is Best

When engaged in public debate about health care, as a society we tend to focus on the high cost items that preoccupy institutional administrators, while overlooking the powerful forces that preserve our health: healthy living environments and workplaces, primary prevention (eg., nutrition education, childhood immunization, ante-natal care, physical activity, smoking prevention), and social policies (affecting literacy, employment, crime, housing quality and community wellbeing). These are the “upstream factors”. We also become so preoccupied with acute care issues, which are crisis-prone and sometimes glamorized, forgetting not only the upstream factors, but even downstream ones (eg., long-term care, home care) whose availability determines the speed with which acute care patients may move on to more appropriate levels of care.

To the extent that health systems fail, especially with regard to addressing priority needs and the ethic of equity (universality, access, affordability), this most often results from failing to deliver on basic needs, especially for groups that lack power or recognition. This is clearly a central challenge for the health system.

Our Suggestions to the B.C. Conversation on Health

There is no escaping government’s responsibility to seek “health for all British Columbians”. Equally, in its stewardship role for health as a public good, this must be done equitably and with due regard for priority setting and resource allocation based on sound evidence and good management practices. It does not necessarily follow from this that government must be directly involved in all aspects of the delivery of health care, but if it is not so involved, it must take responsibility to see that its delivery meets the intent and requirements of the Canada Health Act. Clearly we live in times when our health system is potentially under threat, especially from those who do not share in the vision of a common social contract to deliver on the principles and promise of the Act.

We therefore offer the following suggestions:

1. That the BC government continue to recognize health as a public good, recommit to the principles of universality and equity in the delivery of health services, and curtail private for-profit entities as an alternative in any area of core or essential services. While we do not believe that all health services must necessarily always be delivered by government health agencies per se, clearly government must ensure that how it puts together services must be in compliance with the Canada Health Act (1984).

2. The Government of Canada should be kept under scrutiny and pressure regarding the steady historical decline in its financial contributions to provincially-administered health services. This in itself can be viewed as non-conformity with the Canada Health Act. The “new” federal government must additionally be held accountable for reneging on such “upstream” commitments as the Kelowna Accord and Child Care.
These failures to honour prior commitments that enjoyed broad public support reveal a short-sighted federal political agenda that undermines important determinants of health and social equity across Canada, especially British Columbia. It is notable that both federal and provincial governments have run surpluses in recent years; in our view much of this should be allocated to currently unmet health and social needs.

3. Also in the spirit of the Canada Health Act, and out of respect for heroes like Tommy Douglas, we urge government to re-examine now what services should be core or essential, and to consider expansion of the scope of publicly financed provisions, with emphasis on the more vulnerable eg., dental provisions for children and the elderly; provisions for new parents eg., maternity leave and child care, and expand the eligibility and/or scope of pharmacare for elderly. This would seem particularly timely in the context of record budget surpluses in the face of public needs. We refer here to the BC provincial surplus, proportionally larger even than the federal surplus.

4. It is our view that health care quality and outcomes for BC compare favorably with those of the US, as do other provinces. Clearly all Canadian jurisdictions must also collaborate with our neighbour to the south on issues of common interest eg., environmental influences on health, communications regarding disease importation. However, the tendency to compare ourselves with the US performance in health care and outcomes, while understandable, is misplaced. In terms of examining alternatives, it makes more sense to learn from the experience of other provinces, and also systems elsewhere in the world eg., western Europe that have proven better performers than the failing US model. To the extent that we look to the US for systems design support or contracting, we must be sure that this does not threaten privacy; in the current US political environment even its own citizens are losing trust regarding the invasion of privacy in the name of security.

5. We believe that the most critical elements of any health system are public health (in the sense of population health provisions, including health promotion) and primary health care; to the extent that systems succeed or fail, this is most often due to failure to adequately support these components. Work must be done to continue to attract talented individuals to engage in these fields. To a fair extent the responsibility for this lies with institutions for professional education eg., schools of medicine and other health professions, as well as specialty bodies and professional associations, but the relevant ministries must also be critically involved to ensure that effective action is being taken eg., enhancing the role and recognition for primary care physicians.

6. Allied to the foregoing (5), is the need to strengthen our response to the surging chronic disease burden. In this regard, the intent of ActNow BC is commendable. However, there is an important need to eschew oversimplified targets, statements and approaches, so as not to place advocacy in conflict with the evidence. Nonetheless, international literature indicates that about half of all chronic disease is potentially preventable through attention to modifiable behaviours eg., smoking, fitness, weight

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7 The second criteria under the Canada Health Act is that the provinces’ health care insurance plan must cover "all insured health services provided by hospitals, medical practitioners or dentists" (Section 9).
control; and about half of those people who do develop these conditions – according to current evidence - can be prevented from progressing to more complicated forms through additional attention to secondary prevention measures eg., blood pressure screening; active glucose monitoring for persons with diabetes⁸.

7. When one looks at population health in BC, it is fairly striking that health status compares well with virtually all Canadian provinces, and indeed North America. However, when one looks within the province, it becomes obvious that there is still a substantial amount of inequity, both regionally eg., northern BC, inner city areas, and by population groups eg., First Nations. We would therefore recommend that, when setting goals and targets for performance, equity targets must be given more attention and prominence in the public debate and in government decision making. There is also a need for improving public awareness and understanding as to why social and environmental conditions affect health so inequitably, and how this can be addressed “upstream” through more specific programming to particular areas of greater need.

8. The BC system over recent decades has witnessed transformation from a provincially directed structure with effective local input, to one now dominated by regional health authorities. Positive elements of this such as flexibility are however counterbalanced to some extent by negative ones such as artificial barriers to sharing of information and budget responsibilities. Accountability has not necessarily benefited, nor is the expertise at regional level always sufficient to speak either to the larger provincial need, or to locally unique needs. This aspect of the BC’s system design should be revisited to examine potential for improvement.

9. Politicians and administrators at best guide but do not run health systems; that responsibility ultimately belongs to the practitioners, at many levels. It is important therefore that professional and related health organizations continue to have a voice in how the system is designed and developed, operationalized and evaluated.

**ENVOI:** We wish to congratulate the Government of British Columbia, Ministry of Health, on offering this open forum through which literally anyone or any organization can submit their views and ideas on health in our province.

**THANK YOU!**

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⁸ These “50% targets” (half preventable / half modifiable) far exceed current performance in any society.