The times they are confusing

What lies ahead for the new health minister and physicians in Canada?

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Editorial

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Résumé

L'AVENIR DES SOINS DE SANTÉ AU CANADA semble balisé par peu de vérités concrètes mais par beaucoup de rêves en couleurs. Le moment est venu d'aborder les enjeux de façon plus réaliste. Malgré les promesses électorales des politiciens, les 5 principes de la Loi canadienne sur la santé ne peuvent plus durer. Ce qu'il nous faut, c'est un financement stable et prévisible et une stratégie réaliste face à des questions comme l'assurance médicaments et la planification des effectifs médicaux. Nous devons examiner attentivement les gains limités qu'offre la recherche fondée sur des données probantes, être constamment à l'affût de nouvelles maladies et reconnaître les facteurs comportementaux et sociologiques importants qui sous-tendent la maladie. Les Canadiens méritent mieux que des solutions miracles politiques aux problèmes qui assiègent le système de soins de santé.

Now that a new government is in place in Ottawa, it seems an appropriate time to contemplate what lies ahead for health care in Canada. Will current trends in health care policy take the new minister of health in the right direction? From our perspective the future is signposted with few solid truths and much wishful thinking.

Despite last-minute election promises to increase federal cash transfers to the provinces, spending on health care will not likely increase. Politicians have finally recognized the health care paradox: almost all voters want universal, comprehensive, first-dollar health care coverage and almost all voters (and the same ones) want lower taxes. The federal and provincial governments know that health care spending cannot continually increase. Politicians should resist the impulse to bribe us at election time; our health care system is too valuable for crass vote-mongering.

What Canadians and health care professionals need and deserve is stable funding. Health care funding must be disconnected from the meanderings of gross domestic product (GDP) — which, although a useful long-term barometer, can increase or decrease abruptly in the short run. We are now enjoying an increasing GDP. This sets the scene for more jobs, more revenue, more taxes and more bribes. What we *want* is stability. To this end, a health care trust should be considered. In good times it could be used to set funds aside; in bad times, when money is needed for deficit reduction, it could serve to mitigate and even prevent the painful ravaging of the health care system that we are now witnessing.

The new federal minister of health must also recognize that the 5 principles of the Canada Health Act are no longer sustainable. Before the Liberal's election promise to raise the floor of the cash component of the Canada Health and Social Transfer (CHST), cash payments were scheduled to decrease from $16.6 billion to $8.7 billion between 1995/96 and 2000/01 — a 48% reduction over 5 years. Even if the promised new minimum of $12.5 billion were held, we could expect a 40% reduction in cash payments. Moreover, the distribution of CHST funds between health, postsecondary education and social assistance is at the provinces' discretion. Holding the line on CHST payments is no guarantee of stability.

Now that almost all funding for health care is derived from provincial taxes and (for an increasing proportion of noninsured services) from personal spending, the provision of health care has become a provincial responsibility. Like grown-

up children, the provinces are on their own. Existing interprovincial differences in the organization of health care services and in the provision of specific services will dramatically increase. Wealthier provinces will provide more services; poor provinces will provide fewer. The extent of these differences will depend on the willingness of the provinces to continue to support transfer payments to have-not provinces.

The new health minister can expect to hear more moaning about the cost of pharmaceuticals, coupled with suggestions to regulate the industry and to create a tax-funded comprehensive "pharmacare" program. Such moaning should be ignored. Partly as a result of the huge costs of pharmaceutical research and development, the industry has become concentrated. A spate of mergers in the past decade has made the industry multinational. A small player such as Canada cannot hope to control a global industry. However, we can consolidate our purchasing power. All provinces have partial drug plan coverage for some residents (e.g., seniors and welfare recepients). Roughly 44% of Canadians are covered by such plans, and another 44% have some coverage through their employment benefits or private plans. Serious efforts should be made to develop a universal formulary for provincial plans and to negotiate prices jointly. The federal government could play an important coordinating role.

Pharmacare is a nonstarter. The provinces will guard their new-found fiscal responsibility for health care and will not accept the pharmacare fad. Drugs now account for 12.7% of health care spending, and this proportion is increasing rapidly. Provincial governments would prefer to muddle along as they are rather than accept the financial risk of universal drug coverage.

Naturopaths, herbalists and other alternative practitioners should not be regarded as a means to controlling health care costs. Paradoxically, these new players will *increase* costs. When we are ill, we need the help of highly trained people with the potential to understand disease processes all the way from our genes to our needs, desires and relationships. Simple systems lead to simple solutions, with potentially expensive (and dangerous) consequences. Alternative practitioners can play only a marginal role in treating illness in our patients. At the same time, as a profession we need to pay attention to the message that our patients are sending when they turn to alternative disciplines: there, they get the hearing that they perceive conventional medicine doesn't have time for. We also have the opportunity to subject their treatments to the same standards of evaluation that we apply to our own.

Physician training is long, complex and expensive. Provincial governments are deeply involved in regulating this training with a view to controlling costs. Unfortunately, they make decisions based on assumptions that are simplistic or just plain wrong. The hapless bureaucrats who in the end control residency positions must rely on human-resources projections. The projectionists must speculate about physician supply 8 to 12 years down the road. At a time when medical technology changes in cycles of only a few years, this task is clearly impossible — at least with the modicum of precision that would be useful to the bureaucrat. The federal minister of health must recognize this and encourage provincial colleagues (who have their hands on the controls of residency training positions) to be flexible and to remember that physicians are human. There must be sufficient opportunity for physicians to change course or to be retrained as technology changes and as projections are again proven wrong. As a profession, we need to examine why training continues to grow longer and more complex. We have failed to realize the potential to shorten this time that specialization offers. We need to accept the fact that specialists do not need to be generalists first. (Just ask an engineer.)

The notion that "evidence-based medicine" is new or a solution to any of these problems is quite simply untrue. Those who claim that this term stands for a new idea that will lead us forward need to answer to their own standard: Where is their evidence? Medicine has a long and proud tradition of scientific inquiry. Its great contribution has been to improve our understanding of illness through a remarkable blending of basic science and clinical study. Evidence-based medicine leads us to rely unduly on applied research and, more specifically, on the randomized controlled trial (RCT). We do not argue that RCTs should be discontinued. We need more of them. However, endorsement of the RCT as the preferred — some would say the *only* — method of evidence-based research has led us into a long canyon with no outlet. We will have to turn around. Although the RCT magnificently reduces residual error, it often does so at the price of a profound loss of generalizability. At the bedside the physician must adapt the RCT result to a specific patient who is usually different from the highly selected RCT participant. However, the cost, duration and lack of generalizability of RCTs are handicaps. Practising physicians will always need the insights, however imperfect, afforded by other research designs. We also need to continue to integrate basic science and clinical research.

The ministers of health should not expect research — even evidence-based research — miraculously to illuminate health care planning decisions. In an ideal world we would know what works and what doesn't. Unfortunately, new drugs, new treatments and new diseases appear at a rate far faster than RCT results are produced. Thus, RCTs are always investigating yesterday's drug or treatment. Although the information they yield is valuable, it will not be of much assistance in controlling costs. We

need to pursue more research, but without subscribing to the fallacy of the evidence-based quick fix.

Health bureaucrats try to control costs by restricting access to expensive technologies. Although such policies have a surface appeal, they can cost us more by forcing us to go through a basic diagnostic work-up before resorting to more appropriate action. We need to take a fresh look at diagnosis. We were taught that an orderly and complete history, physical examination and laboratory test work-up will lead us to the correct diagnosis. That process is now often antiquated because it does not take advantage of the efficiency offered by new imaging techniques. Once it is clear, for example, that a patient has an abnormal process involving the lung parenchyma, what is the point of proceeding until the results of a chest radiogram are known? Abnormal cardiac action can be evaluated intelligently only in the light of echocardiogram findings. Evidence of a localized effect in the brain demands imaging before any action is taken. Why have we not adjusted our diagnostic approach? In doing so, we would probably be able to show the ministers where real cost savings lie.

Attention to resource use at the bedside will not by itself control spiralling costs. Other human behaviours contribute greatly to costs by increasing the overall burden of disease. An outstanding example is the growing use of psychoactive substances. Whether it is a first exciting puff of a cigarette in primary school, a sniff of cocaine at a party with pretensions to sophistication or a soothing drink at the end of a bruising day, we appear to find it difficult to accept that there are no chemical solutions to the problems of life. The use of such substances exacts a terrible toll on the nation's health. Emerging knowledge of the nature of dependence and addiction promises to open the way to effective intervention against some of these major causes of disease in Canadians. Interventions will often depend on further government action; others will have to come from medical practitioners. Physicians need to keep abreast of these developments.

And finally, we must recognize that disease will not simply go away. Not only is human biology complex beyond our understanding, but so is human behaviour. Despite wonderful progress in the treatment of AIDS, new cases continue to appear as the virus makes its way from the small gay population into the vastly larger heterosexual one. And new diseases continue to emerge. We have likely not seen the last of new-variant Creutzfeldt–Jacob disease, and there will be others. Federal and provincial governments have much work to do to improve our ability to identify and to respond swiftly and decisively to new diseases, problems in the blood supply and other threats to public health.

The problems that besiege our health care system are important and unprecedented. Yesterday's answers will not suffice. We must examine these problems as they really are and not as we wish they were. We cannot make any real progress with quick-fix promises designed to placate the voting public. The health care system needs stable, predictable funding, not the cambiata we have lived through. We need a realistic approach to questions such as pharmacare and physician resources planning. We need to take a hard look at the limited promise of the evidence-based approach, to be continually alert to new diseases and to recognize the important behavioural and social factors that underlie disease. These are themes that we are committed to following in future issues of *CMAJ*.