Our Health Paradigm in Peril

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SYNOPSIS

HEALTH CARE SYSTEMS are rapidly shifting attention from providing health care to producing health, profoundly altering how and which services are provided. To free up individual and collective resources for investment in activities with a greater impact on health, less care will be given.

This paper posits that the current model—increased health resources make for better health care make for better health status—is too simplistic a system. Structural problems inherent in this model are being observed as the boundaries of the paradigm are pushed. Resources are limited, and health outcomes are no longer being improved despite the application of large percentages of Gross National Product.

A new health paradigm is emerging, one with increased focus on health prerequisites such as housing, minimum decent income, food, education, and good social and physical environment.

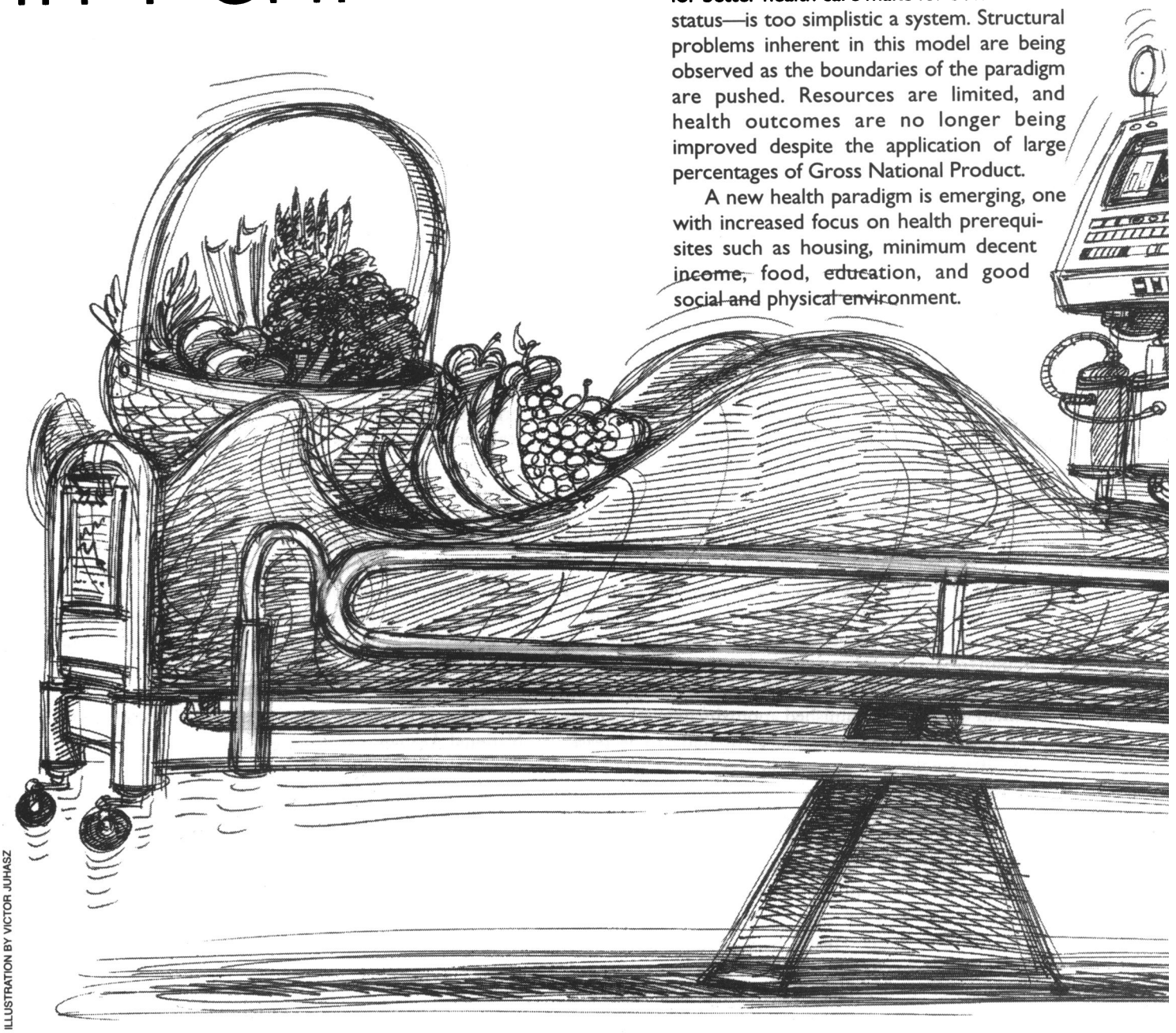
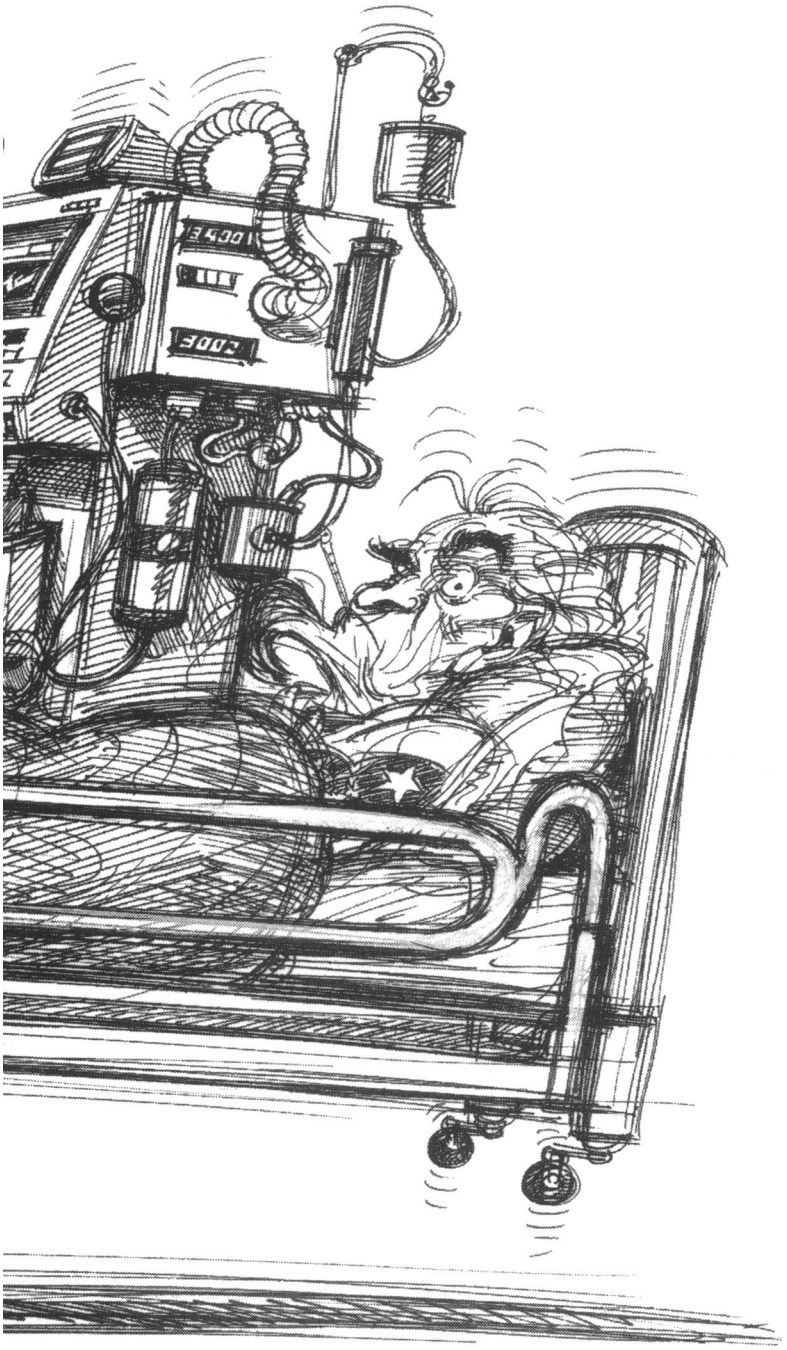


ILLUSTRATION BY VICTOR JUHASZ

A single paradigm has guided our countries' health actions for the last half century. And as with every model of reality, it necessarily simplifies. Unfortunately, these simplifications are proving to be the downfall of our dominant health paradigm that has been used implicitly or explicitly over the last 50 years.

The current model posits a simple relationship between health, health care, and health resources (figure 1). Where in reality health status is determined by a large number of factors, the model simplifies to assume that health is determined primarily by the care provided. With the acceptance of this simplification, it follows that if one wants to improve a population's health, the quality of health care must be improved, and this is achieved through the application of increased health resources (infrastructure and workforce).

No weight is given to the innumerable other factors that we know contribute to health such as poverty, education, environment, and social well-being. As industrialized countries push the dominant paradigm to its limits, we begin to perceive the consequences of our oversimplification. It has taken us a long time to get here.



The Paradigm in North America

For the last half century, our countries have implicitly or explicitly adopted this model to choose and prescribe health actions, following a logical sequence that moves from health resources to health care to health.

In the first phase, North American countries took collective actions to develop health resources in their efforts to improve the health of their populations. In the '50s, the United States accelerated the development of hospital resources with the Hill-Burton Program. Canada followed in the '60s with the creation of a special Health Care Fund. Mexico initiated the process in the '60s and pursued it during the 1980s reform, building rural medical units and hospitals, and urban local health centers.

Our countries soon realized that health care resources were not sufficiently accessible to ensure that people who needed health care could in fact benefit from it. A second set of actions followed. Assuring financial and geographic access to health services became the chosen way to improve a population's health.

Mexico entered this phase as early as 1943, creating the Mexican Institute of Social Security, and the investment process continues today. Gaps in access to and quality of care for large segments of the population remain a major weakness of the present Mexican health care system. Major components of the '80s reform were aimed precisely at reducing these gaps.

With the introduction of Medicare and Medicaid in the '60s, the United States also took action, although timidly, to improve access to health services. In the United States too, the work remains incomplete. A main aim of the Clinton health care reform proposals was to create a basic benefit package finally accessible to all Americans, no matter their employment or health status.

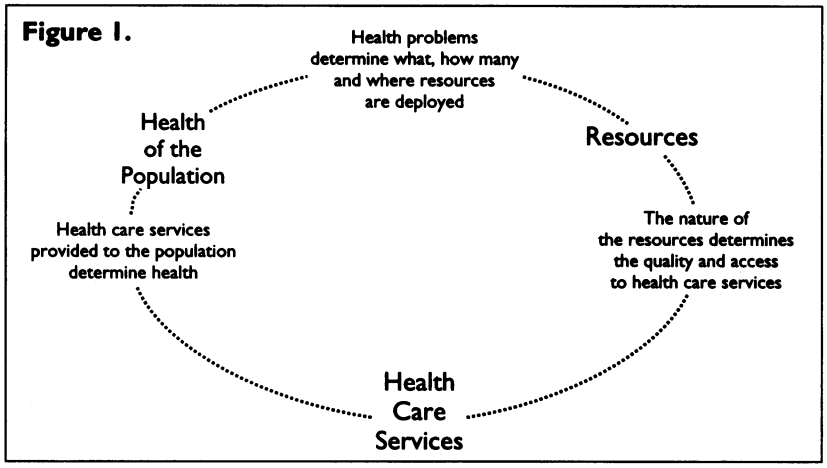
Canada launched, also in the '60s, several insurance programs to guarantee financial access to medically-required physician and hospital services for all Canadians. Provinces then expanded these benefits including, for example, home care for all citizens, drugs for the elderly, and dental care for youth. Canada was so successful that it is often cited for its universal access to health care (*1*).

So What Went Wrong?

If the dominant paradigm or model were valid, Canada would have already reached health Nirvana. But Canada, like other industrialized countries who have extended government health insurance programs, now seriously questions its health care system. Three issues seem particularly problematic.

Limitless spending without health. Is there a limit to the amount of resources that a country can invest in health care? Canada and the United States have the two most expensive health care systems in the world in dollars per capita and fraction of Gross National Product (GNP)(*2*).

The dynamic of our health care systems drives us to use more and more services that are more and more sophisticated and more and more costly. As a result, the annual rate of increase of health care expenditures seriously challenges the financial capability of countries like Canada and the United States. In Canada, at present, health care expenditures grow four to five times faster than its collective wealth *(3)*. In the United States, if the current annual growth rate is maintained, spending on health care will reach 19 percent of GNP by the year 2000 and will consume as much as 111 percent of the real increase in Federal tax revenues *(4)*.



The closed system of old paradigm left little or no room for factors other than health care services to influence the health of the population.

Canada and the United States are not the only countries in the world that seriously question the high costs of health care. All industrialized countries find their health care systems costly or too costly. What is interesting, is that the intensity of the questions raised about costs is approximately the same in all countries, no matter the real cost. It has the same intensity in the United States that spends close to 14 percent of its wealth on health care; in Canada, Sweden and France that spend about 9 percent; in Germany with about 8 percent; and even in Great Britain and Japan at 7 percent.

If cost were the real issue, one would expect the intensity of discontent to be proportionate to real costs. This is not the case. Strange, is it not! There must then be something hidden behind the cost issue, that leads countries to question their spending on health care.

Difficulty adapting to emerging problems. No matter the resources available, health care systems have great difficulties adapting to emerging health problems such as AIDS, deinstitutionalization of mental patients, and to the needs of growing segments of the population—the elderly, single parent families, and cultural minorities. Health care systems, all around the world, also have great difficulties in providing care where people live and work, not only in rural regions but in poor neighborhoods of major cities where resources seem plentiful.

Diminishing impact on health. The third problem, which I consider the most fundamental one, challenges the *raison d'être* of our health care systems. In countries where resources are available and services, of relatively good quality, are accessible to all, questions are now asked openly and publicly about the impact of health care on the health of the population.

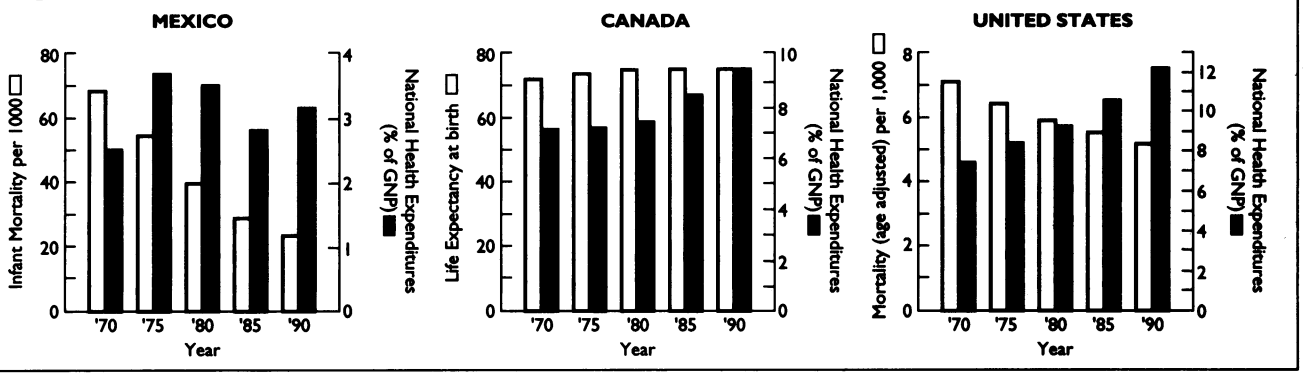
Research fails to show any clear relationship between the resources countries invest in health care and the health of their population (*5*). In the seven most industrialized countries, life expectancy at birth is not related to investment in health care. And in developing countries, the stage of economic development and the level of education of the population seem more important than health care spending. We lack a relationship over time between the improvement of the health status of the population of a given country and its investment in health care (figure 2). Most of the reduction in mortality rate in the United States occurred before the increase of resources in health care. Conversely, during the 1980s, Mexico drastically cut public funding for health care, yet we fail to observe any consequence in major health indicators (*6–9*).

Variation in the amount of care provided cannot be explained exclusively by health needs or socioeconomic characteristics of the recipient populations. Provider resources rather than the consumer needs or actions are determinant (*10*). Studies revealing that a large part of care is either inappropriate or unnecessary are also troubling (*11*).

Together, these questions challenge the validity of the model that has been used to guide health sector programs and investments. Very simply, the provision of more health care, at least as we now do it, may not be the best way to improve the health of the population or to spend our collective resources.

It is not the cost of health services *per se* but rather health value for money that is questioned and open for public debate. Investing 10 or even 14 percent of a country's collective output to improve the health of the population

Figure 2.



Researchers fail to show any clear relationship between national health expenditure and a population's health. In Mexico, drastic funding cuts in the mid 1980s show little impact on infant mortality rates. In the United States and Canada, rising health costs have only marginal impact on life expectancy and mortality.

may not be too high. But investing 14 percent, 10 percent, or even 6 percent when health return is questionable may, in fact, be too high. Health value for money, not absolute cost, becomes the critical issue in health care for decades ahead.

A New Paradigm Emerges

Shifting focus from individual people to populations. In their efforts to improve health, countries first focused on improving health resources. Health improved, but not enough. The second phase shifted focus to health care delivery and improvement of access. Still health outcomes did not match expections. And now, in the third evolutionary wave, attention is shifting to health itself. *Health outcomes* have become the name of the game.

Will a focus on health change our beliefs or will countries persist in applying the old paradigm? Instead of looking toward incremental changes in our health care strategies for improved health, aren't we likely to get better health returns from investments other than health care provided to individual persons? No longer should we use the old paradigm, asking what type of care is required to reduce major health problems. Instead, we should ask what action must be taken to solve the major health problems facing a population. The answer to our questions may be, but may not be, more health care for individual people.

And again applying the old model, we should no longer ask what type of *health* resources are needed to provide the necessary health care. Rather, we should ask what resources, from a broad realm of possibilties, are needed to initiate and conduct efficient health actions. The answer may be, but may not be, health care resources.

Using health as a starting point. Beginning with the health problems we face, rather than the care to be provided or the resources to be developed, will lead inevitably to the identification and undertaking of new and different actions for health.

In this domain, Canada has been a pioneer, starting with the 1974 publication of the Lalonde report (*12*). The report stressed the importance of lifestyles and environment as two major health determinants, initiating health promotion programs and reinforcing environmental health activities. Similar studies elsewhere have stressed the importance of economic factors and living conditions on health—the Black report in the United Kingdom, for example (*13*).

The Population Health Progamme of the Canadian Institute of Advanced Studies report in the fall of 1994 goes far beyond the Lalonde report in content and depth and is likely to achieve similar influence (*14*). The program devoted four years to providing answers to a very basic and fundamental question: Why are some people healthy and others not? The work is an extensive review of scientific evidence from several disciplines—from genetics and neurology to anthropology, sociology, and economics. The report makes these main points:

- We lack evidence to support the hypothesis that more health care leads to better health of the population.
- The social environment is particularly important to health and disease, yet our knowledge about the effect of social support on health is today comparable to our knowledge about the effect of tobacco in 1964 (the year smoking was declared a major health hazard).
- Biological pathways determine how social factors end up influencing morbidity and mortality.
- Health care spending, at a certain point, can jeopardize the development of other sectors of society that might contribute more to both health and other societal goals. (The main unanswered question is the extent to which some countries, like Canada and the United States, have already reached this point.)

Signs of the new way of thinking. Health care systems are responding to the new climate in at least three ways. In program and policy, there is a growing and marked differentiation between health and health care, as if the link between the two were less and less evident. Different and indepen-

dent authorities, one for health and one for health care, have been created.

In Canada for instance, each of the 10 Canadian provinces has instituted Health Councils responsible for health, while Ministries of Health concentrate on health care. Similar differentiation is emerging in other countries like the Netherlands, Denmark, Namibia, and Costa Rica.

Allocation of resources has shifted. Industrial countries now provide additional financial support for health through reductions in financial support of health care. Denmark and Sweden, among the first to develop modern health care systems, have reduced their health care spending. The Canadian Federal Government is also drastically reducing its contribution to financing health care, mainly in response to budgetary shortfalls. Yet Canada continues to expand Federal spending on specific health problems, such as tobacco, alcohol and drug abuse, and breast cancer screening. Canada and a few other industrialized countries have set a new course for years to come.

These same industrial countries are changing the mix of health services and how they are provided—more health promotion and disease prevention. Ambulatory care, primary care, and home care are in the ascendency and resources are reallocated from curative and hospital care, while substituting clinical nurses, physicians assistants, and midwives for physicians.

The Difficult Choices Ahead

If this analysis has validity, at least five major challenges confront health care systems in North America. The most fundamental is how to shift from providing health care to producing health. Housing, minimum decent income, food, education, good social and physical environment, and other prerequisites for health must reach all, including the most vulnerable groups of our societies. We have to acknowledge that our three countries have great improvements to make in this area.

The next challenge is to focus on providing demonstrably cost-effective care, constructing and relying on information systems capable of monitoring the costs and the effectiveness of health services. In our three countries today, decisions in health care are rarely taken on that basis.

The third is to control and contain health care expenditure increases, so that individual and collective resources will be available for those sectors other than health care found to generate better health outcomes.

The fourth is to cope with resistance to fundamental changes from within the health care sector. Recent examples, such as the defeat of Clinton's health care proposals, illustrate how important reform is frequently abandoned due to resistance mainly from within.

Finally, we are challenged to transfer the resources liberated from health care to other sectors that can contribute to health. In Canada, we have not yet shown that we can employ health care savings to generate better health. The loss has been on both sides: health care and health prerequisites.

The challenges facing health care systems in North America are tremendous. If we fail to meet these challenges, we will continue to use more and more resources for the provision of more and more care whose impact on health will be more and more doubtful. And we can predict that failing to meet these challenges will eventually damage the health of the population.

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