Health Care in Canada—Where? When? For Whom?

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Looking at "the Canadian *health* care system" must require special lenses; from most perspectives it cannot be identified. A national health care strategy was barely acknowledged in the recent federal election, so it is hard to see even a *plan* to have a health care system that projects into the next 10 years, never mind one that is fiscally sound. What Canada has dutifully maintained for decades is a *disease* care system, a system that is reactive, not proactive. This disease care system acknowledges the expanding presence of chronic diseases, but fails to address in any meaningful way the prevention of the most widespread of those diseases, such as obesity, dementia, coronary artery disease, and addiction, to name but a few. There is no apparent plan to reverse the horrible lifestyle patterns that lead to these conditions. This absence of a systematic approach is equally evident for end-of-life care. The lack of capacity in long-term care facilities or home care systems for our aging population is frightening. Facing ever increasing health care costs, as a society, we have failed to initiate the essential discussion around what we should care for and what we should not. This absence of a health care system is having a profound and ever worsening impact on already overwhelmed emergency departments.

Discussions taking place seem to prefer to focus on form, not results. It is not the time to focus on secondary issues, when we should be discussing how to maintain health in an aging society. The report entitled, "*Patient Care Groups: A new model of population based primary health care for Ontario*," released in May 2015, describes how the existing system discourages primary care for patients with complex conditions, and allows patients to fall through the cracks.[1] This report centres around a vision that encourages care that is "timely, comprehensive and coordinated, person-centred and community-based, interprofessional team-based, safe, with a commitment to continuous quality improvement, and of good value both financially and in improved health outcomes." Such motherhood statements, while self-evident, do not take us any closer to what is needed. Instead they encourage a different format of primary care, with no evidence suggesting that this proposed new format would optimize outcomes while decreasing costs. While Health Canada's broad objectives are laudable, there is no concrete series of actions established that would change the current health care system.[2] Even the recent Canada 2020 Health Care Summit failed to address the basic principles of what we should have, and what we can afford to have in our health care system.[3] Discussion around "disruptive technology" or biologics seems to avoid the topic of how Canadians are supposed to pay for the additional billions of dollars these advances might cost per year—with no one asking what we will no longer pay for when we do embrace these advances.

To understand why this concerns emergency physicians, let me ask you a few questions:

1) In what percentage of your patients do you actually use your emergency medicine skills, acquired during residency training and honed over years of practice? If you answered more than 10%, you need a reality check.
2) How many emergency department patients require the involvement of a social worker, a geriatric nurse, or a home care planner because of a dehiscence in primary care, or because the "system" simply failed the family involved?
3) How many patients do you treat *per shift* where opportunities for prevention have been neglected—patients with migraines, uncontrolled asthma,

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COPD, diabetes, victims of drunken violence, and the adverse effects of too many medications?

I cannot count how many times I have been told by emergency physicians that the emergency department (ED) is supposed to act as a "safety net." Yet no one can tell me for what part of our (non-existent) health care system it is supposed to be the safety net. It has become the *de facto* solution for seemingly *all* health care inadequacies. *You waited too long to find support for your demented father? You do not have or are unwilling to wait to see a family physician? Your pain is inadequately managed? You might be too violent for the weekend staff at your nursing home? No place to go tonight? Your scheduled paracentesis has been delayed again? You suffer from end-stage cancer but have no access to palliative care?* Sadly, the inevitable answer to these and many other shortcomings of "the system" is… *go to the emergency department*. Go to the part of our healthcare system that was designed for the sickest and most seriously injured patients and that is always open. Never mind that this department lacks the resources and often the expertise to manage these situations. Never mind that the ED was never built to function as a holding unit for those with social, family, or chronic medical conditions. This indiscriminate referral of people in need comes with another cost: the care for the acutely ill suffers—people die—because the ED is busy and crowded with non-urgent patients with real and complex long term problems.

The result: sick, desperate, frustrated patients *not suffering from acute illness or injury* arrive by the thousands daily to EDs across Canada, as they have nowhere else to turn. The inability of the ED to solve their problem only causes more frustration. Being told by the ED health care providers that they do not belong in the ED, or that they cannot help them, does not fix the system that sent them there—it only angers these people in need even further.

Into this non-system enters the harsh reality of finances. We cannot afford the medical care available, never mind the cost of health care five to 10 years from now. Additional funding is not the answer—a comprehensive plan is the answer. The USA spends more of its GDP on health care than any other country in the world, yet is ranked 37th in global health care by the WHO. Meanwhile, the top four or five in ranking spend only 5% to 8% of their GDP on health care. With a growing debt, it is not surprising that the governmental answer is to make cuts in health care—but without any apparent strategy. No one is told who should no longer receive care, no preventative care is established. "Just make it work, become more efficient!" seems a shameful strategy, if one can call it that. The most serious financial situation has been the almost undiscussed erosion of universal health care. When initiated in the 1960s, more than 90 cents on the health care dollar was paid for by government systems. We are currently at less than 64 cents per dollar. Our tax burden to pay for health care has not diminished, while our individual contribution has increased markedly. Health care has become more expensive as we shoulder an ever greater percentage of health care costs with our after-tax dollars.

Lower socio-economic groups cannot afford health care. Many patients I see daily in the ED cannot afford many of the medications we prescribe; physiotherapy for these same patients is an impossible dream, as is rehab for deconditioning. Private placement or private home care—not a chance. The average wait time for a parent with nursing home needs often exceed 18 months; where therefore does that family end up when no longer able to cope? The emergency department. How is this a health care system?

Emergency physicians are trained to care for acutely ill and injured patients, yet we are increasingly becoming the final common pathway for a dysfunctional system. From our daily perspective, our public health care system is beginning to resemble a late round of "musical chairs;" which group of patients will be stranded, suddenly without care, when today's chorus of "Got no beds" ends? We *are* the best witnesses to our failed system. We see where society has let our patients down. If we do not step up as witnesses to this failed system, if we do not start advocating for a comprehensive system, then who will?

Crowding is a marker of dysfunction, but I do not need that marker to recognize we need a plan to establish a true system. As I get older I worry increasingly who will care for my family, and for me. We have to hold society accountable so that people change their lifestyle to something far healthier. We have to establish a true *health* care system that prioritizes prevention in a systematic way. We have to ensure proper end-of-life care, including the establishment of parameters for when we will no longer provide active care. Fifty to 75 percent of health care costs are in the last six months of life. It is as if society has failed as a whole to accept that the natural and inevitable end point of living is dying. We have to ask at some point why we are trying so hard to extend the last six months of low-quality life, rather than

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focusing on prolonging disease-free life. And we have to answer the question that has always eluded the specialty: "What is emergency medicine, and who should be in the emergency department?"

When we have addressed that, perhaps then I can practice emergency medicine the way I should be doing it, using my skills on those who truly need it. To sleep, perchance to dream. . .

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