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FAST FACTS

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Sustainable health care begins with the social determinants of health: It's time to get it right

On May 13, 2011 the Conference Board of Canada announced the formation of the *Canadian Alliance for Sustainable Health Care (CASHC)* to “provide Canadian business leaders and policy makers with insightful, forward-looking, quantitative analysis of the sustainability of the Canadian health-care system and all of its facets.”

A central purpose of the CASHC is to clarify the financial sustainability of the system with a focus on “current and future health-care spending, fiscal balances, and public and private investment and expenditures, current funding structures, and the challenges these present.” They also aim to look at “the relationship between health-related costs, workforce health and firm performance... [and] ways in which the health-care system can be improved, while addressing quality of care.”

The Conference Board is calling on private and public sector investors to support their project. Their website lists current investors from both sectors but particularly notable is the strong representation from the financial sector.

While the CASHC’s aim is to fix a system that is assumed to be broken, there is a growing body of evidence indicating that Canada’s health problems have more to do with the ongoing deterioration in the economic and social conditions that promote health. But the source of the CASHC’s financial support and the exuberance

with which they present a picture of an ailing system suggests a focus on opening up the public health-care system to greater private-sector involvement. It is unlikely that broader systemic weaknesses that create inequities and inevitably put pressure on the system will be addressed.

In *The Social Determinants of Health in Manitoba* (CCPA-MB, 2010) York University Professor Dennis Raphael describes the living conditions that are the primary determinants of health of individuals. He goes on to explain how “a social-determinants of health approach sees the sources of health as being how a society organizes and distributes resources, [and] directs attention to economic and social policies as a means of improving health. It requires consideration of the political, economic, and social forces that shape these policy decisions.”

Two of the key social-determinants of health relate to the inequalities in the distribution of income and rates and levels of poverty. Research that focuses narrowly on the health-care system, without considering the flaws of an increasingly inequitable social and economic system is unlikely to prove fruitful. What we are likely to get from the CASHC is a series of recommendations that will simply accentuate the bias already inherent in our approaches to health and health care.



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for POLICY ALTERNATIVES
MANITOBA OFFICE

309 - 323 Portage Avenue
Winnipeg, MB R3B 2C1
T 204.927.3200 F 204.927.3201
ccpamb@policyalternatives.ca
www.policyalternatives.ca

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Inefficiency and Poor Performance?

The CASHC research focus appears to be shaped by the Conference Board's recent study *How Canada Performs: Health Spending Rankings*. It shows Canada's health spending to be the fourth highest of the 17 countries they assessed, while ranking 10th in overall health performance. Canada's scores on infant mortality and potential years of life lost are shown to be especially shabby, placing us at 16 and 12 respectively in the rankings. As a result of these and other scores, the Conference Board vice president concludes, "Canada has relatively high overall spending and middle-of-the-pack outcomes."

The study suggests that expenditures on health-care in Canada as a proportion of GDP is, at 10.4%, out of step with other countries in their sample. But according to OECD data, we spend less than the U.S. (16.0%), France (11.2%), Switzerland (10.7%) Germany and Austria (10.5%), and we are in-line with Belgium (10.2%), Netherlands (9.9%), Denmark (9.7%), and Sweden (9.4%).

It is also notable that total expenditures include both public and private spending. Further breakdown shows that the U.S. has the lowest public expenditures at 46.5% followed by Switzerland (59.1%), Australia (67.5%), Canada (70.2%), and Finland (74.2%). Public expenditures in Sweden, Japan, Norway, U.K and Denmark exceed 80%, with Denmark the highest at (84.5%). This is important to know because governments are better able to control public expenditures.

Countries also commit resources to an array of programs and policies that affect living conditions and health outcomes. OECD estimates of net public social spending (including public expenditures on health care) indicate that "on average public social spending accounts for 24.4% of Net National Income (NNI) across OECD countries." The countries that spend the most are: Sweden (33.6%); France (33.2%); Austria (32.1%); Denmark (31.5%); Germany (31.1%); Belgium (31.0%); and Finland (30.5%). The countries that spend the least are

the U.S. (18.1%); Canada (19.3%); and Australia (21.2%). These data confirm that most countries in the Conference Board sample spend much more on programs designed to maintain and/or improve the living conditions of their populations than do the U.S. and Canada.

Income determines Outcome

Finally, it is important to recognize that income inequality and poverty are critical determinants of the health. When countries are ranked on the basis of Gini Coefficients, the United States at 17 is the most unequal, followed by Italy 16, the U.K. 15, Ireland 14, Japan 13 and Canada 12. Sweden is the most equal followed by Denmark, Austria, Finland, France and Belgium. As for poverty rates (based on a 50% median income threshold), the U.S. ranks poorest with an 18% rate. Canada's rate is 13%. The U.S. also has the highest poverty rate for children at 21%, followed by Ireland and Italy at 16, and Canada at 15%. Denmark, Sweden, Norway and Finland have the lowest child poverty rates 3, 4, 5 and 4%, respectively.

The CASHC focus on the relationship between health care spending and selected health outcomes is overly narrow and creates misconceptions about the nature of health problems and their impact on the health-care system.

The sustainability of our health-care system cannot be examined outside of the broader social and economic context. Indeed, the Conference Board itself has shown in previous research that social and economic policies effect population health and living conditions.

The evidence shows that more equal societies are healthier societies. If we want "sustainability" we must focus our attention on improving the conditions that will contribute to good health rather than focusing all of our efforts on the limited dimensions proposed by the CASHC.

Errol Black is a CCPA-MB board member; Shauna MacKinnon is the director of CCPA-MB



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