

# Canadian Health System, Like UK, 'Stretched To Max Capacity'



By *Jamie Wells, M.D.* — August 28, 2017



Credit: Wikipedia [1]

As highest quality of care continues not to be the emphasis in the health care debate— let alone be on par with discussions around access, Canadian health systems remain in the spotlight. This time, multiple hospitals in southern Ontario shut their doors to the sickest of babies due to lack of beds for a [10% patient surge](#) [2] compared to the same time period last year.

[According to Shawn Whatley](#) [2], president of Ontario Medical Association, while pleading for increased funding, “These are our sickest patients. This is a reflection of our whole system. Our system is stretched to max capacity. We’re often forced to do more and more with less and less.”

[It is reported the Toronto Central Local Health Integration Network \(LHIN\)](#) [2] insists “no babies have been turned away as they started using temporary beds for the babies when they got to capacity.” This statement baffles me. In fact, it exemplifies a fundamental lack of understanding of what is required for resuscitation of an extreme premature baby as well as those born with the most serious of health conditions.

Placing a baby in a bassinet that is temporary does not save a life, let alone maintain one. These are infants necessitating neonatal intensive care services. If the appropriate equipment is not provided along with one-to-one staffing to monitor continuous vital signs, apnea (cessation of breathing), potential hypothermia or hypoglycemia (too low blood sugar) among innumerable other challenges that are common occurrences in this population, then what does a crib actually do?

The answer: not provide medical care.

Electrolyte repletion in infants—as well as medications in them and pediatric patients, in general—

is based on weight. Each calculation is crucial and must be precise or literally fatal arrhythmias, fluid overload and the like can develop. While they can be quite resilient, newborns with certain congenital disorders requiring timely surgical correction or those with severe lung immaturity demanding basic supplemental oxygen from nasal cannula to mechanical ventilation won't necessarily survive, let alone thrive. Delays in this arena mean the difference in life or death as well as short- and long-term disability.

Again, not doing things correctly from the outset in the medical realm not only places an individual with a disease at a deficit, but it initiates a trajectory that leads to more heroic costly and invasive measures, increased anxiety and suffering, progression of illness, unnecessary adverse effects and poorer ultimate outcomes. Band-aids don't repair ruptured arteries. And, as a policy tenet they yield not only what Ontario is battling, but also the recent struggles of the United Kingdom's National Health Service (NHS).

In [More Bad News For Single Payer Health System](#) [3], I wrote about an NHS [recent report](#) [4] generated out of London that paints a grim picture about systemic failings in healthcare of the sickest patients. Citing high mortality rates —more than one in three died— due to sub-standard practices, [The National Confidential Enquiry into Patient Outcome and Death. Inspiring Change](#) [4] reveals the sad reality of care quality reduction when resources limit appropriate staffing and equipment supply for ever increasing patient volumes. The care was rated as less than good for every four out of five cases. In this article, I touch upon the much improved survival rates in the United States compared to these populations.

In [Rough Week For Government-Run Healthcare](#) [5], I focus on news from NHS England that the number of people waiting for routine surgery now exceeds 4 million. The highest in a decade. The [BBC went on to report](#) [6] “Other targets missed include the four-hour target in A&E and urgent referrals for cancer care.” [Sky News wrote](#) [7] “Dr Mark Holland, president of the Society for Acute Medicine, said the latest figures were "shocking" and represent "another damning indictment of the crisis we are experiencing in the NHS.” The sentiment further echoed by “Danny Mortimer, deputy chief executive of the NHS Confederation, which represents health organizations in England, Wales and Northern Ireland, and chief executive of NHS Employers, called the system “unsustainable.””

Even childbirth had catastrophic ramifications leading to a reversal of the “normal” or “natural birth” campaign by the Royal College of Midwives. Infant and maternal morbidity and mortality cannot best be avoided when training is disparate and physician involvement or obstetric care is withheld. See [here](#) [8] to learn more about the investigations into unnecessary deaths and the perpetuation of dangerous deliveries.

The picture out of Canada echoes the same recurrent themes:

- excessive wait times for countless populations— a monetary, physical, emotional and ethical toll.
- poor nurse to patient ratios and improper assignments of appropriately trained personnel
- lack of equipment exacerbating rationing of care— who's life is of greater value?
- bad patient outcomes

- increased “burnout” and staff—e.g. nursing, physician— shortages (1)

Outsourcing such deficiencies to the United States and elsewhere is not uncommon. For example, as [per the Toronto Star](#) [9], “Ontarians with aggressive cancers and blood disorders have been dying on waiting lists because hospitals here haven’t had the space, staff or funds to meet the rising demand for life-saving...transplants. And now, the health ministry has approved a plan that front-line doctors fear will create an even deeper health care crisis: outsourcing hundreds of allogeneic transplants to three American centres at a cost of more than \$100 million (U.S.)” [The Fraser Institute](#) [10] - an independent, non-partisan research and educational organization based in Canada - issued a report [Leaving Canada for Medical Care, 2015](#) [11] that revealed, among other things, more than 52,000 Canadians received non-emergency medical treatment outside Canada in 2014 which was up 25% from the previous year.

Outcomes are better again and again with the highest quality of care. This seemingly elusive policy preference actually best serves communities from enhancing their clinical status and prognosis to assuaging fears and suffering to saving money by avoiding advancement of disease and more complex procedures as well as ensuring emotional well-being and satisfying moral and ethical responsibilities. Diminish care quality — e.g. lack continuity of care, increase wait periods, reduce adequate nurse to patient staffing and equipment ratios—and patients get sicker and costs increase. (2)

Access to a bed, like access to a wait list is not healthcare. It is mere PR and politics. Until the conversation poses highest quality of care of equal consideration to access, neither will be propelled from fantasy into reality.

Note(s):

1. To review front-line understanding of some central issues in the Canadian system, see [Health care’s free in Canada, right? Wrong, and you’re paying a lot more than you think](#) [12] and [Canadian Doctors Like Me Are Starting To Look For The Exit](#) [13]
2. To review evidence of the impact of such policies on patient outcomes, review these articles: [Unhealthiest Reality of Obamacare: Lack of Doctor Choice](#) [14], [Hospital-Based Practices Do Worse Than Physician-Owned Ones.](#) [15] [See To Survive The Hospital, Make Sure Your Heart Stops On A Weekday](#) [16] and [Will More Nursing And Optometrists Lead To Erosion Of Patient-Centered Medicine?](#) [17]

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 [2] <http://www.cbc.ca/news/canada/toronto/neonatal-icub-scramble-to-find-beds-for-sick-babies-1.4263536>  
 [3] <https://www.acsh.org/news/2017/08/10/more-bad-news-single-payer-health-system-11673>  
 [4] <http://www.ncepod.org.uk/2017niv.html>

- [5] <https://www.acsh.org/news/2017/08/11/rough-week-government-run-healthcare-11682>
- [6] <http://www.bbc.com/news/health-40886598>
- [7] <http://news.sky.com/story/nhs-england-missed-ae-waiting-times-target-every-month-for-last-two-years-10982112>
- [8] <https://www.acsh.org/news/2017/08/21/'-all-costs'-health-campaigns-undermine-women-11721>
- [9] <https://www.thestar.com/news/canada/2016/04/19/ontario-to-spend-100m-outsourcing-life-saving-transplants-to-us.html>
- [10] <https://www.fraserinstitute.org/about>
- [11] <https://www.fraserinstitute.org/sites/default/files/leaving-canada-for-medical-care-2015.pdf>
- [12] <http://business.financialpost.com/opinion/health-cares-free-in-canada-right-wrong-and-youre-paying-a-lot-more-than-you-think>
- [13] [http://www.huffingtonpost.ca/adam-stewart/canadian-doctors-like-me-are-starting-to-look-for-the-exit\\_a\\_23077616/](http://www.huffingtonpost.ca/adam-stewart/canadian-doctors-like-me-are-starting-to-look-for-the-exit_a_23077616/)
- [14] <http://www.acsh.org/news/2017/02/08/unhealthiest-reality-obamacare-lack-doctor-choice-10835>
- [15] <http://www.acsh.org/news/2017/04/13/hospital-based-practices-do-worse-physician-owned-ones-11124>
- [16] <http://www.acsh.org/news/2016/11/07/survive-hospital-make-sure-your-heart-stops-weekday-10406>
- [17] <http://www.acsh.org/news/2017/03/22/will-more-nursing-and-optometrists-lead-erosion-patient-centered-medicine-11037>