AIMS Commentary
Atlantic Institute for Market Studies

Healthy Alternatives

Fresh perspectives on the Canadian health care system

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AIMS is pleased to provide a forum for fresh perspectives on the Canadian public health care system. AIMS Health Policy Fellow David Zitner and AIMS Board Director George Cooper offer their points of view on what can be done to fix a system in need. Both articles were originally published as op-eds in The Chronicle Herald.

MEDICARE MALAISE: A REMEDY

by: David Zitner

Health care in Canada is not the same for everyone. Access to care differs based on education and socioeconomic status, for simple problems like acne, for diagnostic and preventive medical services, including investigations for colorectal cancer, and for access to ongoing cardiac care for people who have cardiac disease.

Tommy Douglas dreamed of a world where rich and poor alike had access to worthwhile and high-quality care. Instead, we have a system where rich and poor alike pay the same amount when care is received — nothing — but the care they receive is different.

Canadians suffer and wait for important surgery, and diagnostic tests. Canadians wait for consultations to pain clinics and several other expert medical services. Governments use rationing, by waiting, to constrain costs.

In Nova Scotia, despite the Department of Health initiative "Better Care Sooner" (just not now) hospitals have had their budgets slashed even though too many patients have extraordinarily long waits. What good is insurance that doesn't cover you when you most need timely care?

Surely, we'd all be better off if those who could afford it paid directly for some of their care. The money government gets from you and spends on your behalf could be better used to support those services that most people can't afford. We might even use the extra money to support timely care for those who can least afford it.

The Romanow commission suggested that government subsidize catastrophic, but not ordinary, drug costs. Why not the same for other medical expenses? Generating additional revenue by encouraging people to pay for inexpensive services would free resources to support rationed expensive care.

Economists, left, right and centre, agree that monopolies, whether public or private, rarely produce the most effective and efficient results. Economists also agree that price controls lead to rationing, poor quality and black markets. The empty shelves of the Gum department store in Communist Russia and decayed and abandoned housing in the South Bronx showed the pernicious effect of price controls.

In health care, Canadian governments maintain a monopoly and look after themselves by outlawing competition. You have no choice: take what government offers you or buy a ticket to Bangalore or Boston.

Would you like to call your own family doctor or communicate by email? You can't because your insurer, the provincial government, won't pay for these services. But government will pay about $60, on average, for an 811 telephone call to someone who doesn't know you and only $30 when you see your family doctor in person.

Governments, as health insur-ers and administrators of health care, fail when it comes to regulating and evaluating their own performance.

People suffer and die because of an unacceptable number of recurrent preventable health system mistakes. Yet the Nova Scotia government hasn't even bothered to ask and report whether mistakes are increasing, decreasing or are the same as reported in 2004. Airline safety records are public.

When was the last time you heard a provincial government insist that your hospital has sufficient funds to meet its mandate? Were you or your neighbours ever compensated when a scheduled surgery or diagnostic test was cancelled at the last minute? Airlines regularly reimburse people who are bumped from a scheduled flight.

Credit unions are co-operatives (groups of people who collaborate for mutual benefit) that succeed in areas normally dominated by traditional banks. Health care co-operatives, in Canada and the United States, formed to meet member needs, succeed today in areas normally dominated by insurance companies and government. They enable people to direct their money to services that work best for them, instead of to governments that spend according to political priorities. Low-income people benefit from reduced membership costs or other subsidies.

Patient co-operatives are one way to focus health spending and improve access and quality of care. Co-operatives moderate the pernicious effect of price controls and provide choices for patients. Effective co-operatives succeed, ineffective ones lose members. Co-operatives also free government from the unethical conflict that arises when governments are asked to regulate and evaluate their own performance.

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GOOD GOVERNANCE FIRST STEP TOWARD CURING SYSTEM ILLS

by: George Cooper

No progress in health care, including technological advancement, will ever happen until we fix the governance of our health care system.

I was chair of the governance sub-committee of the Halifax Chamber of Commerce's Health Care Committee 10 years ago. About five years ago, I chaired the Nova Scotia Wait Times Advisory Committee for a couple of years. It's clear that the hands-on health care experts are the doctors, nurses and administrators; the rest of us are ignorant bystanders.

But our present governance system prevents the experts from acting.

The governance problem is that the people who conceive the health care project — the government — are:

- The same people who define the scope of the project — what's in and out.
- The same people who set the budget for the project.
- The same people who raise the money for it through taxes.
- The same people who build the facilities and install the other capital assets it needs.
- The same people who operate it.
- The same people who fund those operations.
- The same people who measure — or don't measure — the results.
- The same people who judge it after the measurements are made.

The system is bizarre.

After all, the reason we have a government and a civil service is to set standards and exercise oversight, so as to hold other people accountable. But when government or the civil service step into a management role, they become management. At that point, there is no one left for management to report to, no one left to exercise oversight, no one left to hold management accountable, no one left to do the job that government and the civil service were set up to do in the first place.

Politically, this state of affairs is understandable. In health care, the government is the full and only payer, so all problems are laid at the feet of the government. Consequently, the government feels vulnerable and wants full control.

But with the best will in the world on the policy and administration side (and there is no question about that), and with the highest skill levels at the delivery end (and there is no question about that either), our health care system as it now exists simply cannot work in an optimum manner, because there is no accountability mechanism.

So, how do we build accountability into our health care system? Here are a few ideas:

- Let the Department of Health develop the scope of the health care project, fix the budget and set the standards that health care providers have to meet. Then let the department get out of the way.
- Let there be a separate Crown corporation to operate the system itself.

Let it be self-sustaining, have its own board of directors, hire the CEO and management, and report to the Department of Health and the public through quarterly and annual reports. Let this Crown corporation have the responsibility for spending the budget and entering into contracts for services with the hospitals.

- Privatize the hospitals, as they did under the socialist government of Sweden. They will enter into contracts with the Crown corporation for the supply of health care services. Terminate those contracts if they don't meet budget, or fail to meet the applicable standards.
- Let those private hospitals in turn sub-contract for all their services, with the surgeons, the X-ray technicians, the cleaning staff, the pharmacists, and everyone else.

- Set up an independent government agency to measure the results. This agency does not report to the Department of Health. It reports to the public.

- If you really want to get radical, go to a consumer-driven, market-based system. Let the public's money follow the patient. Your hospital only gets paid if the patient or his GP chooses you, instead of someone else. The U.K. began moving down that path under the (socialist) Labour government.

Better governance will do nothing to fix the problems of the health care system. Only those in the system can do that, through their enterprise, innovation and determination.

But good governance is an essential pre-condition.

Without accountability mechanisms, including financial consequences, no one will set out on the path to improvement.

I realize changing health care governance is anything but easy. But it is not impossible. It is being done elsewhere, such as Sweden and the U.K.

All it takes is political courage, and maybe not very much of that. After all, every government gets defeated eventually. So my practical, non-courageous question to our politicians is this: Instead of getting defeated for doing nothing, why not get defeated for doing the right thing?

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