

# ideas matter

WINTER 2003

## **AIMS PROPOSES REAL WORLD REFORMS FOR CANADIAN HEALTH CARE**

**Definitely NOT the  
Romanow Report**

**AIMS Establishes Terms  
for National Debate**

**National Media Cover  
Groundbreaking Report**

**AIMS Research Sketches  
Out Where Health  
Care Reform Must Go**

**Johan Hjertqvist**  
Swedish Health Care Reformer

Atlantic  
Institute for  
**AIMS**  
Market Studies

# Praise for AIMS' Health Care Work

On April 20, 2000, the Atlas Economic Research Foundation awarded its coveted Sir Antony Fisher Memorial Prize to AIMS for its paper on Canada's health care system. "Operating in the Dark: the Gathering Crisis in Canada's Public Health Care System" was published by the institute in November 1999. This was the second of three times in the past six years that Atlas has recognized AIMS with this prestigious international award for think tank excellence.



**AIMS' Brian Lee Crowley (centre), accepting a Fisher Award from Atlas director of institute relations Jo Kwong and Alex Chafuen, Atlas president and CEO.**

A jury of some of the world's leading economists, including a Nobel Laureate, awarded the Fisher Prize for the publication that, in the jury's collective opinion, made the greatest contribution to public understanding of the economy. More than 20 nominations for the prize were made in 2000, from public policy institutes in Turkey, Belgium, UK, Venezuela, Ecuador, the US and Canada. Topics covered globalism, welfare privatization, environmentalism, social security, health care, free trade, liberty and democracy.

AIMS won in the "new institute" category, sharing the prize with a Turkish think tank, the Association for Liberal Thinking, for its book *Islam, Civil Society and Market Economy*.

On Dec. 1, 1999, Alberta Premier Ralph Klein tabled "Operating in the Dark" in the Alberta legislature, and referred to it in a major interview in *The Globe and Mail* as helping to show the way forward for the Canadian health care system. AIMS president Brian Lee Crowley was subsequently invited to become a member of the Premier's Advisory Council on Health in Alberta, dubbed the Mazankowski Committee.

AIMS' efforts to expand the base for informed public debate had continued success in 2002. The release of "Definitely NOT the Romanow Report," the culmination of three years of effort by AIMS, and its accompanying 12 background papers placed the Institute front and centre as a leader in the national debate on health care. ■

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# Consumer Power: Health Care's Future



Johan Hjertqvist

## International health care reformer lauds AIMS' work

In almost every Western society today there is an intense debate on the future of health care: How to guarantee a better outcome from the growing (but apparently still insufficient) resources allocated for health care? How to transform public health care from a bureaucratic monopoly into a dynamic network of services, responding not only to need but even more importantly to demand? How to balance the conflict of interest between the roles of citizen/taxpayer, patient and consumer? How to move from a sterile focus on costs to a total preoccupation with improved health outcomes? How might the wishes of health care consumers be met by making each individual not only a more powerful decision maker within the system but also more responsible for the decisions that he or she takes?

And what do the tools look like in practice that will make these radical changes possible? How can we introduce new incentives to the system, create a new relationship between funding and provision, purchasing and delivery, and decentralize influence in a way that will engage the health care workers of today and tomorrow? How can we build a health care network that is guided by best practices and consumer-centred benchmarks, and that integrates all of the vital elements of public and private, big hospitals and small-scale entrepreneurs, established methods and new communications solutions?

Everywhere you find the same questions regarding costs, waiting lists and the lack of services that fail to meet the demanding expectations of the Western health care consumer and provider. In Europe more and more national governments understand the political ramifications of this discussion and the need to put a consumer focus at the heart of health care provision. The old political blinkers are rapidly being shed, new instruments and forms of co-operation are suddenly becoming not only thinkable, but doable. Rigid ideology is falling out of fashion. The European Union, for example, has named health care a growth

industry with a major contribution to make to the goal of seeing the Union become the most competitive economy in the world by 2010.

To a keenly interested outside observer, such as myself, Canada lacks much of this openness to new ideas. Of course one finds new bold thinking here and there, as in Alberta and among the nation's think tanks,

**The old political blinkers are rapidly being shed, new instruments and forms of co-operation are suddenly becoming not only thinkable, but doable. Rigid ideology is falling out of fashion.**

but these examples on the whole look like exceptions. However, the numerous reports now emerging from different sources, together with the vivid public debate now seizing the country, lead me to think that Canadian health care policy is moving into a vital new transformative phase. Sharp analysis and bold proposals are badly needed to lay out the case for the tough policy decisions to come.

AIMS' "Definitely Not the Romanow Report" contributes to this exchange of ideas and knowledge in a way that merits applause and congratulations. Focused, sharp and constructive, it cuts through the arguments and illusions of a conservative establishment that advocates minimal change. Change is badly needed and change there will be. The question, as this report so eloquently makes clear, is whether politicians want to be influential in reshaping the country's health care system or are they going to leave its future in the hands

of others? It is up to them to decide. The best way to lose credibility is to neglect the system's genuine problems and to deny the need for reform. Or, as a close advisor to the German Social Democrat Chancellor Gerhard Schroeder recently told me at a centre-left think tank welfare seminar, "To tell the world not to rock the health care boat is the best way to lose the next election!"

AIMS has done a great job commenting on the Commission on the Future of Health Care in Canada — the Romanow report — and thus on the whole pattern of today's health care reform agenda, an agenda that is not unique to Canada but is common to the Western industrialized world. This report delivers not only powerful, efficient and telling criticism of the status quo and its defenders but, even more importantly, it offers challenging and thoughtful proposals for the future. The consumer will come to power in the health care system regardless of the political biases of parties and interest groups. Those who first seize on that insight and turn it into a strategy for reform today will create an indispensable foundation for the future. AIMS has performed a great service for Canadians in laying out the intellectual case, in your national context, for the changes that are to come. ■

*Johan Hjertqvist*

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*Mr. Hjertqvist is a prominent author on health care reform, not only in Sweden, but internationally. He has acted as adviser to the Greater Stockholm Council on its health system. A keen observer of the Canadian system, Mr. Hjertqvist has written and lectured extensively on the subject, including having done a cross-Canada lecture tour that included a talk on Patient Power and Provider Competition at an AIMS event in Halifax in October of 2001. This piece was originally published as the Foreword to AIMS' seminal study, "Definitely NOT the Romanow Report."*

# Why Definitely NOT the Romanow Report?

AIMS tells the story of its involvement in the health care debate

Even before the Commission on the Future of Health Care in Canada (the Romanow Commission) released its report to the Government of Canada, it was clear that something was seriously amiss in the approach that the Commission was taking to thinking about the future of medicare. Early on, the sole commissioner, former Saskatchewan Premier Roy Romanow, expressed scepticism that there was any problem of sustainability facing Canadian medicare, and underlined that in his view our health system needed only superficial tinkering. He also gave scant support to some of the other major enquiries on health, such as Mazankowski and Kirby, that made a powerful case that sustainability was an inescapable challenge.

In the face of such disquieting complacency, the Atlantic Institute for Market Studies — AIMS — decided some months ago to create an alternative enquiry on health care to place before Canadians a realistic range of evidence-based policy changes that will put medicare on a sustainable footing, increase the resources available to the system, make health care more responsive to the needs of the population and ensure that we have the information necessary to manage our health, both individually and collectively.



Because the authors of the AIMS report do not believe that the recommendations contained in the Romanow report will accomplish any of these key objectives, we have, somewhat irreverently, named this report and its myriad background papers “Definitely Not the Romanow Report: Achieving Sustainability, Accountability and Consumer Empowerment in Canadian Health Care.”

Our starting point is the inadequacy of what Commissioner Romanow is offering as a prescription to fix medicare’s ills. What are the inadequacies of his analysis of and his solutions to Canada’s health care problems?

- **Complacency about the problems associated with medicare.** Mr. Romanow has rejected any analysis that might call into question its sustainability, yet all other major inquiries place sustainability at the forefront of the challenges we face.
- **Belief in a command-and-control approach to health care.** When medicare was created, people deferred to their doctors, who were a control point for access to services. But people are taking more responsibility for their own health, and their options have expanded with the rise in alternative care and technology. Health care predicated on the notion of a closed national system in which people must take what public authorities decide they should have will not and cannot survive.
- **Indifference to trade-offs.** Although Mr. Romanow says that his proposals could be paid for by projected federal surpluses, which amount to some \$70 billion over the next five years, there are many competing claims on this money, including reducing taxes, renewing the armed forces and improving educational opportunities for our children.
- **Naiveté.** Mr. Romanow has equated solving the problems of Canadian medicare with

# Chronology of Events

more spending, but has failed to establish that the system's problems actually flow from a lack of money. He also believes that large federal transfers to the provinces can be made to flow into health care and not be drained off to other provincial priorities.

- **Unfounded suspicion of private sector contributions to health care provision.** Mr Romanow prefers to see health care totally and completely insured, delivered and administered by the same kind of monopoly that runs the post office.

Our starting point is the inadequacy of what Commissioner Romanow is offering as a prescription to fix medicare's ills.

- **Ideological blinkers.** Many of Mr. Romanow's concerns are ideological and have little to do with the quality of care delivered within the public system.

- **Inadequate provision of information on system performance.** The little information we possess on the tens of billions of dollars the public sector spends on health care is a national scandal. Contrary to widely held opinion, we know almost nothing about the outcomes the health care system produces for Canadians.

The rest of this edition of *Ideas Matter* lays out in summary form the story of this project, ranging from the content of some of our alternative prescriptions, to a review of the success we have enjoyed in helping to create a national debate around the real alternatives that are available to us to fix our ailing health care system. ■

## 1999

**Nov. 25** - AIMS publishes "Operating in the Dark: The Gathering Crisis in Canada's Health Care System," by Dr. Brian Lee Crowley, Dr. David Zitner and Nancy Faraday-Smith.

## 2000

**Jan. 11** - *The Medical Post* publishes the op-ed "Don't Close the Shutters," by Dr. Crowley and Dr. Zitner, in which the authors write about their 1999 paper "Operating in the Dark."

**April 3** - *The National Post* publishes an op-ed by Dr. Crowley and Dr. Zitner entitled "What we Don't Know About Health Care: Lack of Information on Waiting Times, Outcome Prevents Effective Action."

**April 20** - AIMS' paper "Operating in the Dark" wins the Sir Anthony Fisher Memorial Prize from the Atlas Economic Research Foundation.

**Nov. 24** - Dr. Crowley gives a talk to the Nova Scotia Association for Quality in Health Care entitled "How Politics and the Economy Affect Risk Management and Ethics in Health Care."

## 2001

**June 20** - "Health Care System Needs Swedish Massage," an op-ed by Dr. Crowley, appears in the *Halifax Chronicle Herald*.

**Aug. 8** - Dr. Crowley appointed to the Premier's Advisory Council on Health for Alberta, also known as The Mazankowski Committee.

**Sept. 12** - Dr. Crowley's op-ed, "Debate on Health Care Reform: No End in Sight," appears in *The Chronicle Herald* in Halifax.

**Sept. 25** - Swedish health reformer Johan Hjertqvist's talk, "Patient Power and Provider Competition: Is the Swedish Health Care Approach Right for Canada?," is held at the Delta Halifax.

**Nov. 1** - Dr. David Zitner presents "Two Keys to Excellent Health Care for Canadians: Provide Information and Support Competition" to the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby.

## 2002

**Jan. 8** - Alberta Premier's Advisory Council on Health releases its report (the Mazankowski Report).

**Jan. 17** - AIMS releases "Public Health, State Secret," its report on the state of Canada's health care system, by Drs. Crowley and Zitner.

**Jan. 28** - Dr. Zitner's op-ed, "Drug Use in Canada: Opportunity Lost," appears in the *Ottawa Citizen*.

**Jan. 28 - Feb. 1** - Dr. Crowley's op-ed, "Health Care: Competition and the Single Payer," appears in *The Chronicle Herald* (Halifax), *The Moncton Times & Transcript*, *The Vancouver Sun*, *Calgary Herald* and *Ottawa Citizen*.

**Feb. 14** - Dr. Crowley gives a talk to the Conference Board of Canada's Leaders' Roundtable on Health, Wellness and Health Care entitled "The Mazankowski Committee Report and the Future of Health Care in Canada: A Personal View."

**April** - Senator Michael Kirby's senate committee studying health care reform issues a report that draws heavily on AIMS papers and commentary on health care, quoting extensively from both AIMS' award-winning 1999 paper "Operating in the Dark" and its more recent "Public Health, State Secret."

**April 8** - Dr. Crowley speaks on the emerging directions in Canadian healthcare reform at Pharmac 2002, a Canadian Institute conference focused on the pharmacare industry

**April 9** - Dr. Brian Ferguson appears on CBC Radio's Maritime Noon Phone-in to debate the future of medicare.

**April 17** - Drs. Crowley and Zitner present "Two Keys to Excellent Health Care for Canadians: Provide Information and Support Competition" to the Romanow Commission on the Future of Health Care. Roy Romanow expresses much gratitude for the work that AIMS does, and emphasizes the value of AIMS' thoughtful and scholarly research to the Canadian debate on the health care sector.

**April** - A revised version of AIMS' paper "Public Health, State Secret" is republished in *Better Medicine: Reforming Canada's Health Care*, a collaboration of essays by some of Canada's leading authorities in health care policy, edited by Dr. David Grutzer.

**May 2** - Dr. Crowley delivers a talk focused on recent health-care initiatives to the Public/Private Strategies for the Funding and Delivery of Health Care conference in Toronto.

**May 6** - *The Vancouver Sun* publishes Dr. Zitner's op-ed, "Operating in the Dark - Again and Again."

**May 21** - Dr. Crowley delivers a brief in Halifax to the Capital District Health Authority Board about the Mazankowski report.

**May 23** - Dr. Crowley speaks to the Canadian Pension and Benefits Institute in Toronto on the subject of the preparedness of private plan sponsors for their role in the future of health care in Canada.

**May 27** - Dr. Crowley gives a talk on public health and the private sector at the National Healthcare Leadership Conference in Halifax.

**October 1** - Dr. Crowley speaks at the Toronto Board of Trade to the Ontario Hospital Association about the role of the private sector within a publicly funded health care system.

**November** - AIMS begins releasing health care reform background reports. The 12 publications appear over the next six weeks.

**Nov. 18** - Dr. Crowley, Dr. Zitner and Brett Skinner present "Definitely NOT the Romanow Report" to the Ontario Hospital Association Annual Conference in Toronto.

**Nov. 26** - AIMS publishes "Definitely Not the Romanow Report." Dr. Crowley is interviewed by most major national news and current affairs programs.

**Nov. 28** - The Romanow report, "Building on Values: The Future of Health Care in Canada," is released.

**Dec. 11** - Dr. Crowley gives a talk at a conference by the Maine Public Policy Institute in Portland, Maine called Charting a New Course: Health Care Reform for Maine. His talk is entitled "The Top Ten Things People Believe About Canadian Health Care, But Shouldn't."

# Achieving Equity, Sustainability, Accountability

## Consumer empowerment in Canadian health care

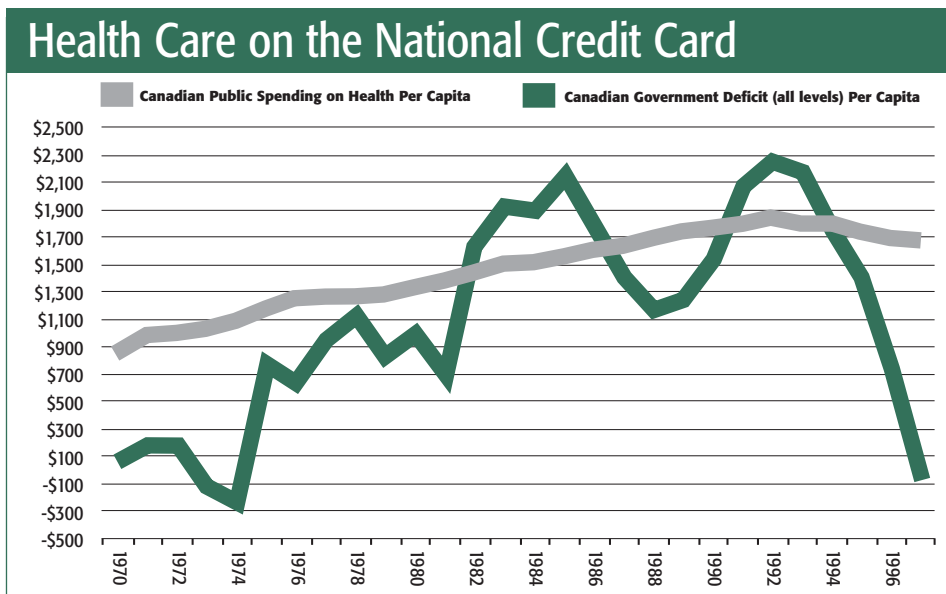
**M**edicare is not sustainable in its present form. While overall health spending has been relatively stable recently, this has been accomplished chiefly through reducing services, closing facilities, limiting the supply of health professionals, controlling the compensation paid to doctors and nurses, substituting waiting lines for tax increases and consumer co-payments and discouraging the adoption of innovative but expensive new treatments. The World Health Organization now ranks Canada's health care system 30th in the world, measured on such criteria as "bang for the buck" for health care spending, disease prevention and how fairly the poor, minorities and other special populations are treated.

Medicare as we know it can be sustainable only if Canadians are willing to accept decreasing levels of service or increasing levels of taxation. Public opinion polls indicate that neither is acceptable. And given the realities of increasing consumer demand for expensive health technologies and procedures, and the expected health demands from an aging population, medicare's cost problems are only going to grow. Yet Roy Romanow, head of the Royal Commission on the Future of Health Care in Canada, has publicly rejected these arguments. In the face of Mr. Romanow's clearly expressed complacency, belief in the discredited command-and-control philosophy behind medicare and naiveté about how the federal government can drive provincial health spending, AIMS has commissioned its own report on the future of health care in Canada.

Our report is based on a number of research papers that address the key issues in the debate over health care policy. The findings directly challenge many of the fundamental assumptions that inform Mr. Romanow's report.

### RECOMMENDATIONS

✓ Rigorously separate the functions of universal insurer, provider and evaluator of



Ferguson, "Expenditure on Medical Care in Canada," AIMS 2002

health care, making the public sector a neutral purchaser of publicly insured health care from all providers who can meet stringent tests of quality, accessibility and value for money.

✓ Encourage free-standing, specialized, not-for-profit and for-profit clinics based on the French or Norwegian models, selling services to medicare on a fee-for-service basis, similar to Toronto's Shouldice hospital and the so-called Klein clinics in Alberta.

✓ Introduce a fee-for-service element into hospital funding formulas.

✓ Incorporate an element of fund holding into fee-for-service medicine by increasing general practitioners' fees and at the same time billing them for diagnostic and imaging services that hospitals provide to patients.

✓ Remove all quantity controls on health care professionals to increase their supply and reduce their market power.

✓ Involve Canadians in a comprehensive public consultation, under appropriate rules and safeguards, to elicit from them a picture of the things they believe it is essential that medicare cover for everyone, with potentially insured services ranked in order of importance.

✓ Define "comprehensiveness" so that the public sector pools everyone's risk of sophisticated and expensive interventions ("catastrophic coverage"), but leaving ordinary interventions, whose cost can easily be borne by the average person, to individual consumer choice, supplemented by private insurance and subsidies for those on low incomes.

✓ Require governments, in consultation with Canadians, to determine what share of GDP (averaged over the economic cycle) should be devoted to public health care. Publicly insured services would then be all the services Canadians give priority to, up to the cash limit imposed by the fixed GDP share. All other services would be covered by individuals and private insurance.

✓ Establish a deductible for all Canadians for their use of health care services, with suitable subsidies for low-income people to ensure that no one is denied medical services on grounds of inability to pay.

✓ Ensure universal access to medically necessary pharmaceuticals in a separate but analogous plan by removing drug coverage from the set of workplace benefits and creating national, large pool insurance plans to ensure catastrophic coverage. The plans should involve a significant deductible, with tax-based transfers if necessary to ensure that out-of-pocket payments do not impose an excessive burden on lower-income consumers.

✓ Establish in each province an arm's-length regulator of the health insurance function, modeled on the stringent regulatory regimes that apply to other forms of insurance.

✓ Create a powerful, arm's-length health care information commissioner in each province, and possibly at the federal level as well, to collect information, analyze and publish it. This would ensure an objective basis for public purchasing of health care services from competing suppliers and give consumers sound information on waiting times, accessibility and service quality at institutions competing to provide them with health care services, whether publicly or privately insured.

While there are limitations to what a private competitive market can accomplish in health care, it is clear that most of the major arguments against implementing such reforms are not based on sound economics or on a fair analysis of existing empirical research. They also give too little consideration to the fact that a properly regulated market for health care provision and health care insurance can overcome any limitations in private health care much more efficiently than the medicare approach.

According to the research for this report, and the experience in countries with similar social and political traditions to Canada's, the sort of reforms outlined here have achieved considerable success in moving various national health services in the direction of greater value for money, cost-containment and guaranteed access to health care for vulnerable populations. Canada has little reason to fear real reform and much to gain from embracing it. ■

*This is the executive summary from "Definitely Not the Romanow Report." To see the report in its entirety, go to AIMS' website, at [www.aims.ca](http://www.aims.ca), and click on "Issues/Areas of Focus," then on "Health care."*

## AUTHORS



**Dr. Brian Lee Crowley**, founding president of AIMS, holds a PhD in political economy from the London School of Economics. He is a former member of the Alberta Premier's Advisory Council on Health and has been a professor at Dalhousie University. He represented Manitoba during the Meech Lake Accord negotiations, and Nova Scotia during the Charlottetown Accord. He serves on the board of directors of national and international organizations, including the Maine Public Policy Institute and the Nigerian Institute for Economic Affairs.



**Dr. Brian Ferguson** is an associate professor in the department of economics at the University of Guelph. He has worked at Health Canada, taught at McMaster University and has been visiting faculty at the Australian National University. He was a consultant economist to the statistical research section of the Addiction Research Foundation of Ontario and visiting researcher at the Kansas Health Institute (and visitor at the department of economics, University of Kansas).



**Dr. David Zitner**, a family doctor, is director of medical informatics at Dalhousie Medical School. He has been a member of the Physician Advisory Committee to the Canadian Institute for Health Information and was on the Federal/Provincial/Territorial Deputy Ministers of Health working group that produced "When Less is Better: Using Canada's Hospitals Efficiently."



**Brett Skinner** is a PhD candidate at the University of Western Ontario studying public policy and Canadian politics. His research specializes in health policy and administration.

# In world terms, a lowly 30

How Canada's health care system compares, according to the WHO

Rank	Country
1	France
2	Italy
3	San Marino
4	Andorra
5	Malta
6	Singapore
7	Spain
8	Oman
9	Austria
10	Japan
11	Norway
12	Portugal
13	Monaco
14	Greece
15	Iceland
16	Luxembourg
17	Netherlands
18	United Kingdom
19	Ireland
20	Switzerland
21	Belgium
22	Colombia
23	Sweden
24	Cyprus
25	Germany
26	Saudi Arabia
27	United Arab Emirates
28	Israel
29	Morocco
30	Canada

*Ranking reflects overall health system performance, which is a composite measure of achievement in level of health, distribution of health, level of responsiveness, distribution of responsiveness and fairness of financial contribution. Source: World Health Organization*



# AIMS Papers Offer a Health Care Alternative

“Definitely Not the Romanow Report,” the summary of which begins on page six, draws on the research presented in these background papers that address key issues in the debate over health care policy. The authors investigate the assumptions underlying Canada’s current direction in health care and suggest viable alternative models of reform. Here are capsule descriptions of each of the background papers; all are available on the AIMS website.

**“Medicare and User Fees: Unsafe at Any Price?”** seeks to provide a second opinion about the practicality and implications of introducing some form of cost sharing to the Canadian health care system. Numerous studies, including one of the largest social science experiments in history, suggest that user fees do change patient behaviour. These studies also suggest that, if properly employed, user fees have no impact on health outcomes. User fees, thus, are safe and effective.

The authors of *“Unsafe at Any Price”* do not suggest that user fees are a panacea for Canadian health care. Instead they point out that the problems facing medicare are numerous and complex but, that being said, governments have been increasingly willing to

experiment with new initiatives over the past decade and the time has come for a serious look at user fees.

**“Improving Canadian Health Care: Better Ways to Finance Medicare”** takes a serious look at the alternative mechanisms available to introduce new money into the health care system in Canada. By combining a flat deductible and a medical savings account (MSA) targeted at low-income individuals, for example, it’s possible to cut medicare costs, improve accountability, build in market incentives for service improvements and give people more power in the health care system. As with all other forms of insurance, a health care deductible would set the maximum amount that individuals would pay toward their own care. An MSA is a tool that allows people to build, tax free (like an RRSP), a pool of money for future health care needs. *“Better Ways to Finance Medicare”* looks at the health care usage of Nova Scotians over the past 10 years and determines that combining a flat deductible of \$325 and a government-financed MSA targeted at individuals who make less than \$32,000 would save medicare \$88.3 million in Nova Scotia alone. It would also reduce

overall demands on the system by approximately 5%, while ensuring that people on low incomes face no financial obstacles to obtaining needed medical care.

**“Medicare, the Medical Brain Drain and Human Resource Shortage in Health Care”** demonstrates how the limitations of public spending are making it obvious that a centrally planned medical system is unable to provide the same opportunities and rewards for doctors and nurses as a more market-oriented system. As Canadian medical professionals begin to realize the degree to which the public health care monopoly exploits their services and suppresses their earnings, the more likely it is that they will leave this country for the US.

A much greater role for the private sector in health care delivery is becoming imperative in order to ensure that the medical system will have adequate supplies of highly skilled professionals to provide for the health and well-being of Canadians. Only the private sector can provide the new financial and capital resources necessary to compete for human resources in health care, and the injections of cash proposed by the Romanow Report to the public system do nothing to change this reality.



*“The Benefits of Allowing Business Back Into Canadian Health Care”* provides a review of the direction of health policy reforms in the rest of the world that indicates that Canadians are not alone in preferring balanced approaches to health policy reform. The consensus that is emerging internationally is primarily concerned with: ensuring universal access to a defined package of medically necessary services; maximizing consumer choice; controlling cost pressures on public budgets; and satisfying consumer demands for timely access to high-quality health care services.

There is a wide scope for competition and private sector involvement in the arrangement and provision of health care under this emerging set of public values. Health policy research identifies a number of benefits that would result from private, for-profit provision of medically necessary services and health insurance. These advantages include reduced waiting times and queuing for services, increased consumer choice, rationalized demand for medical services, reduced cost pressures on government budgets, better overall quality of medical care, and the elimination of the conflict of interest that occurs when governments regulate services that they themselves provide.

*“Doctors Have to Make a Living Too: The Microeconomics of Physician Practice”* delves into the misconceptions about cost drivers in the health care field. Looking at the arguments supporting two common cost-cutting and service expanding ideas — the

**“In their analyses and their policy discussions, the [AIMS] authors show originality and rigour. From this point senior analysts can hardly discuss questions related to the health care sector in Canada without referring to the AIMS studies.”**

— Jean-Luc Migué, national public policy author and analyst

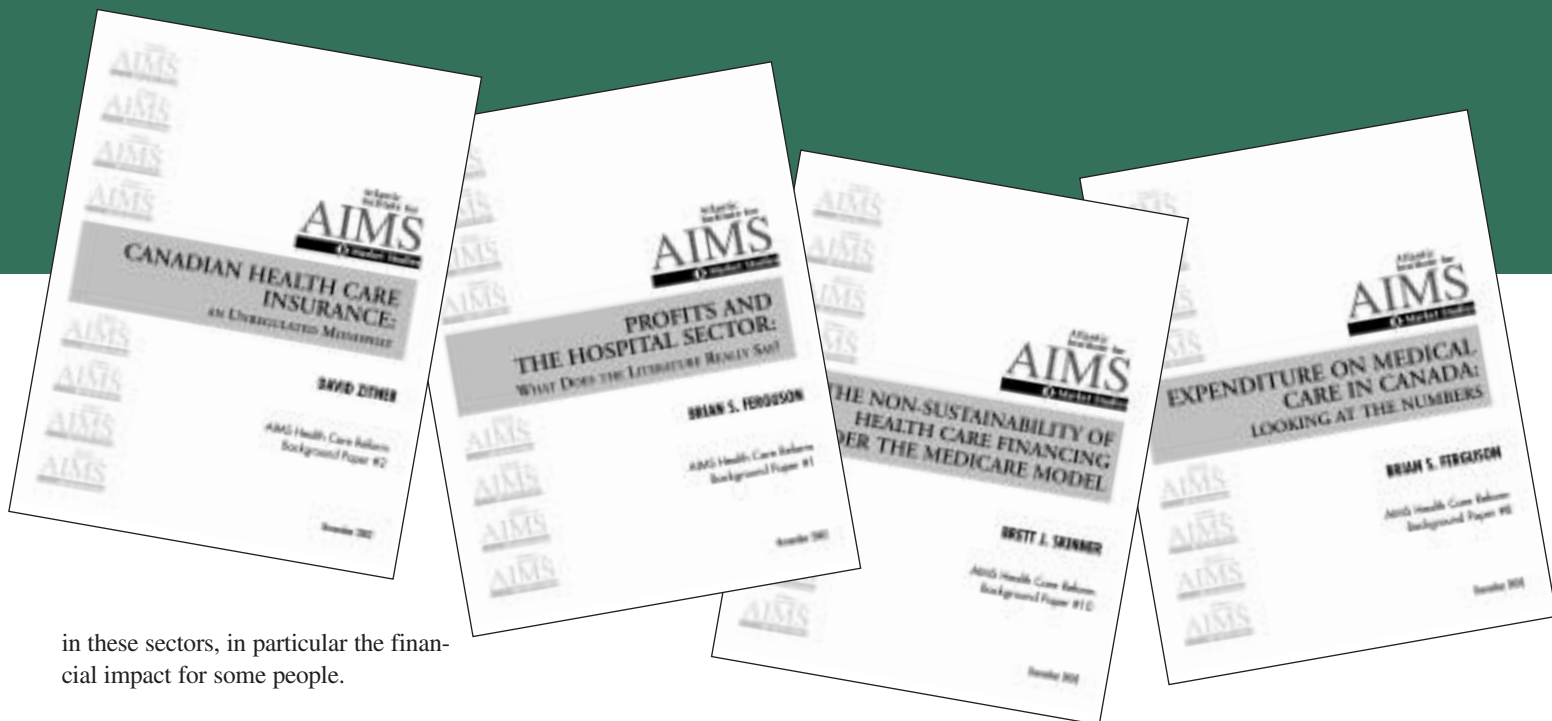
introduction of non-physician practitioners or the introduction of doctor’s salaries in place of fee for service — the author finds these ideas ignore fundamental economic realities and have exactly the opposite impact to what was intended.

*“Issues in the Demand for Medical Care: Can Consumers and Doctors Be Trusted to Make the Right Choices”* explores the concept of physician-induced demand, one of the fundamental underpinnings of the policy

in which government limits enrolment in medical schools and artificially limits the number of Canadian physicians. Correlating high demand for health care services with the number of doctors practising in an area does not in itself confirm physician-induced demand. In fact, it is far more likely that the demand for medical services in an area induces physicians to practise there.

*“How Should We Decide What to Cover Under Medicare?”* looks at the Oregon approach to health care coverage decision-making, demonstrating how an improved version of the Oregon model would result in a truer reflection of the collective values of society’s members in deciding which medical services should have first claim on the scarce public health care dollars available. “We need to generate a healthy and constructive public debate about what our priorities are in health care,” says author and health economist Julia Witt, “removing decisions about listing and delisting from the bureaucratic and unaccountable process where they are now taken.”

*“Principles to Guide a Unified Funding Model for Non-Medicare (Non-insured) Health and Social Services”* argues that Canada’s sustained health care debate has tended to focus primarily on insured medicare-hospital and medical services. While there is increasing interest in non-insured health and social services, such as continuing/long-term care, drugs, home care, and social supports, analysis has often overlooked the fragmented funding arrangements



in these sectors, in particular the financial impact for some people.

In *“Canadian Health Care Insurance: An Unregulated Monopoly,”* author David Zitner outlines how the government has abandoned its regulatory authority to ensure people receive the care they need. The government’s ability to play that regulatory role effectively is hampered because, as the ultimate provider of health care services, government is actually being asked to regulate itself – an impossible conflict of interest. “For health care in Canada,” says Zitner, “avoiding compliance with standards for access, comprehensiveness, portability and universality becomes a focus because compliance represents a cost and revenue is allocated based on political negotiation, not results.”

*“Profits and the Hospital Sectors: What Does the Literature Really Say”* explores the anti-for-profit bias in the public debate on health reform and concludes that there is, in fact, a considerable amount of evidence to show that there are no systematic differences in efficiency between for-profit and not-for-profit hospitals. The role that for-profit health care providers can play in the health care system should therefore concentrate on those areas where such providers enjoy comparative advantages over public sector providers, not on irrelevant ideological preferences for not-for-profit provision of health care.

*“Expenditure on Medical Care in Canada: Looking at the Numbers”* demonstrates that medicare’s much-heralded success at cost control is illusory. Simply put, the introduction of medicare did not introduce a period of health care cost control in Canadian health spending.

Canadian health expenditure to GDP

share fell below the US figure not because of differences in the rate of growth of health spending, but rather because Canada happened to have the good fortune to bring medicare in during a period in which the Canadian economy outdid the US economy in terms of real growth.

Had our economic growth been as weak as US growth through the 1970s and ’80s, for two decades our health spending to GDP share would have been higher than the actual US GDP share. In other words, Canada would have had the most expensive health care system in the world, a situation that would have changed only in the 1990s when governments got serious about its fiscal crisis.

*“The Non-Sustainability of Health Care Financing Under the Medicare Model”* argues that, without real substantial reform, we are not going to escape our place as the big spenders on health care any time soon. A dramatically aging population, the introduction of new and ever more expensive medical technologies and rising consumer demands for the highest quality, leading-edge health care are driving costs beyond the capabilities of the health care system to afford them while relying on public financing alone. The sustainability of the health care system ultimately depends on whether public budgets can continue to absorb the costs of health care for Canadians, and the evidence indicates that the medicare approach is failing and will not be able to fulfill expectations without fundamental reforms.

*“Public Health, State Secret”* is AIMS’ most recent report on the state of Canada’s health care system. The study demonstrates that politicians and senior health officials simply don’t know where or why medicare is failing because they still lack the proper tools to evaluate the quality or timeliness of the care Canadians receive. More to the point, the authors demonstrate why, under the current system, it is not in the government’s interests to know what is really happening in health care. ■

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# What AIMS Said Before the Romanow Commission

When the people who provide health care services are asked to evaluate their own work, they are in a conflict of interest

**COMMISSIONER ROY ROMANOW:** I would now like to call on the Atlantic Institute for Market Studies. Thank you very much for coming. Thank you for the wait and the floor is yours. Welcome.

**BRIAN LEE CROWLEY:** Mr. Commissioner, thank you so much for the kind invitation to be here today. Given the shortness of the time we have available, we would like to move directly into our presentation... So much of the current debate about health care focuses on the question of the role of the private sector. And just judging by some media reports I saw earlier today, you for instance are reported to have made some comments recently on what the private sector needs to do in order to earn a place within public health care provision in Canada. That is the area that we thought we would focus our comments on today.

**RR:** I didn't mean only in the private sector, but anybody who advocates it, yes.

**BLC:** That's exactly the part that we are going to come to. The private sector is subject to government regulation where it is thought that competition alone may not be sufficient to guarantee high-quality goods and services, where consumers may be thought to lack the knowledge to make fully informed choices.

For example, governments regulate many aspects of the production quality and safety of food. They set minimum standards that providers are, of course, generally allowed to exceed, on hygiene, freshness, quality of raw materials, working conditions, use of therapeutic agents, pesticides, many other factors.

They have to keep meticulous records. And they are often able to respond to government and other organizations with large quantities of up-to-date and comprehensive information supplied by farmers, ranchers, veterinarians and others. They require manufacturers to disclose ingredients, and even the age of product on sale to the public.

But where the government is regulating itself, Mr. Commissioner, in this particular instance, in its provision of health care services, the picture is actually quite different. Government health authorities, for instance, have failed to set standards for appropriate waiting times. I am just picking one example here. No one knows in Canada how long the health care system thinks people should wait for particular treatments. There are no official standards. So no one can be held accountable for failing to meet the standard.

In any case most publicly financed health organizations are not required to disclose to the public pertinent information about access and results or health outcomes. Not that it would do any good to require them to disclose it, because by and large they don't collect it.

In summary, an unregulated monopoly occurs when a particular group captures a market, has no competitors and is able to assess or judge its own performance without the need to comply with an external set of regulations.

Health care in Canada is largely an unregulated monopoly along these lines because: government defines what constitutes a medically necessary service; pays for all such services offered in Canada; forbids by law the provision of private insurance for

these services; prevents, again by law, Canadians obtaining such services outside the government-sanctioned channels; directly or indirectly administers and governs health care; and is responsible for defining, collecting and reviewing information on its own performance.

Fortunately, there are ways that we can improve this system. There are two ways that you can curb monopoly power. One is to inject competition. And the other is to regulate the monopoly. These are not mutually exclusive. You can inject some competition and you can inject some regulation.

In Canada the provincial governments in terms of health care provision are the monopoly. Provincial governments not only pay for necessary care, they also govern, administer and evaluate the services that they, themselves, provide.

Self-regulation in most fields has not worked and I don't think it has worked well for Canadians in the health care field. I think that's demonstrated by the lack of meaningful information about the effectiveness and the efficiency of the Canadian health care system.

To inject the needed degree of competition while maintaining the valuable aspects of the single-payer health insurance system — and I want to underline, Mr. Commissioner, that both [my co-presenter] David Zitner and I are very much in favour of the single-payer system that we have in Canada. But we think that we can inject into a single-payer system some degree of competition in the provision of health care services.

To do so, it is essential to unbundle the payment, the administration, the delivery and

the evaluation functions. These are four separate functions: payment, administration, delivery, and evaluation.

The key is to realize that saying government should ensure that no one goes without medically necessary services, a sentiment with which David Zitner and I certainly agree, is not the same thing as saying only governments should provide those services.

In fact, as we are arguing in this presentation, when government is both the payer and the provider, the evaluator and the regulator of health care services, service to the public suffers. A proper separation of the payment from the service provision would allow provincial governments to set strict performance requirements like the appropriate waiting times that I mentioned, put the actual services out to tender.

Since the provinces would no longer be

evaluating the performance of its own employees but the performance of competing arm's-length providers, the cost of getting rid of poor performers is significantly reduced. Because what we want is to put resources in the hand of high-quality, low-cost providers and move resources away from poor-quality, high-cost providers.

**“The key is to realize that saying government should ensure that no one goes without medically necessary services is not the same as saying only government should provide those services.”**

evaluating the performance of its own employees but the performance of competing arm's-length providers, the cost of getting rid of poor performers is significantly reduced. Because what we want is to put resources in the hand of high-quality, low-cost providers and move resources away from poor-quality, high-cost providers.

The principle, in fact, that we're suggesting is a principle of neutrality on the part of the public organization that is purchasing health care services on behalf of the public. It should be neutral between all providers of health care services and they should purchase health care services from those people who are providing the best quality at the lowest cost.

To win a contract, bidders would have to undertake to meet the performance criteria that are set for access and results as well as meeting cost targets.

The insurer, that is to say the public organization doing the contracting, would include the usual commercial penalties for non-performance in the contract. And as Sweden and other countries have shown, this approach can result in significant cost savings and increased effi-

ciencies while improving patient satisfaction.

Additionally, because I talked about several functions that needed to be unbundled, an independent evaluator, possibly as part of the Auditor General's office, could be responsible for evaluation and providing a regular report to the public about access and outcomes.

Increasing competition by unbundling the insurance, the governance, the administration, the health services delivery and the evaluation functions will significantly alter the incentives within the health care system. It will become more worthwhile to collect information about the performance of various health care institutions and providers.

Government regulators will be better able to set appropriate yardsticks for performance in the health care system. Consumers will be better informed about the costs and the bene-

fits of both their individual health care choices and the value that they're getting for the billions of tax dollars now being devoted to health care.

By the way, I believe that these recommendations are quite consistent with the recommendations of the Mazankowski Commission, of which I have the honour to be a member. But I want to make it clear that I am not here in any way as an official spokesman for that group.

I would now like to ask my colleague, David Zitner, director of medical informatics at Dalhousie, to add a few comments on some aspects of our presentation.

**David Zitner:** Thank you for hearing us today. The majority of Canadians feel that fixing health system management will dramatically improve the system. But improving the system by improving management is virtually impossible, because we don't collect the information that we need in order to manage.

No health jurisdiction in Canada routinely collects information about access to care. We don't know how long people are waiting,

who's waiting, what the consequences are. Although some groups like cardiology, for example, do a very good job at doing it, as a system, we don't do it.

Partly, we believe it's not available because we're in a circumstance where government does actually evaluate and regulate itself and hasn't insisted that proper information be available.

In fact, the Canadian Institute for Health Information in its technical notes says that the information in the discharge abstract database, which is one of their largest productions for Canada, might not be accurate. This is the information that people are using to manage and monitor our health care system.

So we have two recommendations related to information. One is that as a first priority, health jurisdictions develop and implement appropriate information systems to measure access and results and use the new data to build consensus towards other health system changes. And the second information recommendation is that proposals to change health care delivery including those produced by your own commission should only be considered if they are accompanied by a testable estimate of how the new structures and processes will influence access to care or patient or population health.

This recommendation is really not particularly radical, since in 1994 the Federal/Provincial/Territorial Deputy Ministers of Health unanimously committed to provide to Canadians information about access and results as changes are implemented to the health care system. This hasn't happened. Thank you.

**RR:** Thank you very much, both of you, for coming and I very much appreciate it. I know the Atlantic Institute has done a lot of good studies and they have been very interesting. I haven't read them all, but ones that I have certainly have been helpful to the Canadian debate on general issues. This is no exception.

If I may start with Dr. Zitner first, only because he was last in the presentation, may I ask this? Is it possible, doctor, and Mr. Crowley, if you want to amend or agree or however you would like to comment, fair enough. If we could get information systems and the measurement of outcomes based on the information goal-setting put into place in order to get proper management. I agree with you, as a general proposition, you cannot manage something if you don't know where your head is. They say if you don't know which

way you're going any old road will do. So you've got to know what road.

Is there anything in your judgment, doctor, that prohibits a publicly funded, publicly administered system from being properly managed with information and outcomes?

**DZ:** No, there isn't anything that prevents it from happening. However, Canadians have invested millions and maybe billions of dollars in information systems, yet no Canadian jurisdiction gives us the information that we need. In Canada today the chart of every patient discharged from a hospital goes through a detailed review. Somebody goes through each page of your chart and then sends that detailed abstracted information to Ottawa.

They don't bother to ask how long did you wait for care, did you get better or worse? At one of the hospitals within Nova Scotia, a 400-bed hospital, it costs about \$1.5 million. The Canadian Institute for Health Information has received two transits of \$95 million. We still don't have that information.

So while it's clearly possible to get the information, we haven't been getting it. And part of it is, I think, a discussion between federal and provincial governments. But that's another piece.

**BLC:** With your permission, Mr. Commissioner, I'd add a further comment to that. The burden of our presentation today has been not that it is impossible for the public sector to gather and use this information, but rather that the incentives within the public system militate against them doing so.

So as my colleague, David Zitner, often says, no good deed in the Canadian health care system goes unpunished. It may be that there are a lot of people with good intentions trying to do a good job who are gathering all kinds of information. But they have not yet, in spite of millions of dollars spent and a lot of effort, produced anything that is useable in terms of hard information that would guide good decision-making within the health care system. And we think that that's due to the incentives within the health care system.

**RR:** I agree also on the incentives. I think proper incentives, and if I may say so, proper disincentives working in concert would make it efficient. But again, not to be argumentative but so that I understand, and I do this with every presenter so sometimes you know you're not being singled out.

Is there anything in your judgment in the Atlantic Institute that inherently prohibits the — we've talked about information and outcomes, but let's add into that incentives, as well. On the assumption that one was to put aside for the moment the competition factor, which I know that you advocate, or is it your view that it's only through competition with such incentives and such information data and outcomes be finally collected and measured?

**BLC:** It would be our view, Mr. Commissioner, that it would only be when we get a kind of separation between the people evaluating the outcomes and the people providing the services that we will get the health information that we need. In other words, the argument that we've made today is that the people who provide health care

**"I want to make it very clear, Mr. Chairman, that the principle that we underlined in the presentation was one of neutrality. It's not anti-public sector provision or pro-private sector provision. It is pro top-quality provision to Canadians."**

services in the public sector are in a conflict of interest, because they are being asked to evaluate their own work. And as long as that's the case, you know, we can put all kinds of pressures on them and so on. But the incentives against them gathering information that will be used to hold them accountable for the results they produce I think is an insurmountable obstacle.

**RR:** Just on the argument of insurmountability, because it's an interesting discussion and debate, what if there was the establishment of something, for the lack of a better name and it's not quite well defined, but I throw it out, such as a Canadian Quality Council that would be appointed in sight of the Swedish model. Sweden has a Swedish Board of Health and Social Services that tries to take into account quality assessments much like CIHI but expanded beyond CIHI.

So here we have an arm's-length — I know there's always the argument about who the appointer is, and the like. But in Sweden, they've been able to do it and it's established

over a long period of time and this is now viewed as a body of experts and public, as well. And they're able to say to, in our case a province, you're not succeeding on wait list because the goals set with respect to cardiac care or ophthalmology, you name it, elsewhere, you're not following.

Is it possible to get the debundling in a way that falls short of a complete unbundling, my words, which I think is implied in your views by something like a Canadian Quality Council? Or are we back fundamentally to the point of view that you have to have in effect a separate apparatus for delivery and administration and the like?

**BLC:** You've raised a number of points there. Let me see if I can unbundle them a bit, if I may. If you go back to our remarks, one of the

things we said was an independent evaluator, perhaps, we said as part of the Auditor General's office, but Canadian Quality Council could be responsible for evaluation and providing regular reports to the public about access and outcomes.

The more we can do to put in place a strict division between the people doing the evaluation and the people providing the services, the better off we'll be. If in addition to that we can introduce an element of competition, and I want to make it very clear, Mr. Chairman, that the principle that we underlined in the presentation was one of neutrality. It's not anti-public sector provision or pro-private sector provision. It is pro top-quality provision to Canadians.

What we want to do is focus on the quality of the outcomes for Canadians. And to an extent that we can introduce that level or degree of competition, plus an arms-length evaluator, I think we will have moved a tremendous distance to where we want to go. ■

*Halifax, NS, April 17, 2002*

# We're Headed the Wrong Way

*The Globe and Mail* offers AIMS a national platform for debate

Canadians cannot sustain medicare if we stay on our present course. We've bought a modest slowdown in the rate of spending increases — chiefly by reducing services, closing facilities, reducing the number of health professionals, increasing waiting times and forgoing innovative, but expensive, new technologies. But medicare as we know it can only be “sustainable” if Canadians are

Mazankowski and Fyke, says sustainability is the system's key challenge. Mr. Romanow's own former minister of finance in Saskatchewan underlined this when she testified before his commission.

But Mr. Romanow denies there's a problem. We're spending the same share of GDP on public health care as 30 years ago. If a little more than 7% of GDP was sustainable in

object of unavoidably limited health budgets. To date, we've relieved the pressure by letting infrastructure crumble, forgoing access to the latest medical innovations, and allowing queues to lengthen and the number of medical professionals to decline.

By and large, people have access to ordinary, low-cost services like GP office visits, but they find it increasingly difficult to get vital services such as sophisticated diagnostics, many types of surgery, and cancer care (where the waits can be measured in months if not years).

This is the exact reverse of what the rational person would want. We should use the public sector to pool everyone's risk of expensive interventions to ensure that they're available when needed — but let individuals bear the cost of ordinary interventions (supplemented by private insurance and subsidies for those on low incomes).

Hardly anyone can afford cancer care, bypass surgery, gene therapy or a serious chronic illness on their own. These are the things that, without insurance, destroy people's finances. But as much as 30% of the services consumed under medicare are of marginal or no value. No one would be financially ruined by having to pay for an ordinary doctor's office visit if we ensured that people on low incomes were subsidized, and there was a reasonable maximum anyone would be called on to pay. No one would be harmed by an incentive not to go to the emergency room when a visit to the family clinic would do just as well.

The world's biggest health-care study, the RAND experiment, found that people who had to pay something toward the cost of their care consumed less of it, but that their health was every bit as good as those who got totally free care.

The extra infusion of taxes Mr. Romanow

**We must concentrate scarce public health-care dollars where they'll do the most good, and give users of the system incentives to be prudent about how they spend them. We currently spend vast sums on procedures of little or no value, while we place patients with life-threatening conditions in lengthening queues.**

willing to accept less service or more taxes. Polls indicate that neither is acceptable. Yet our expectations are increasing — for expensive health technologies, drugs and procedures, and for the normal demands of an aging population. Medicare's problems are only going to grow.

Roy Romanow, head of the Commission on the Future of Health Care in Canada, has rejected these arguments, making it clear that he will recommend not only retaining but even expanding the centrally planned, government monopoly model of health care in Canada. Virtually every other major inquiry into health care, including Kirby,

1972, why is that same percentage unsustainable today?

It's the wrong question. The problem is not how much we're spending, but how we're paying for it and what we're getting in return. For years, we borrowed and spent on health care (and other services), so we got more than we were willing to pay for. Today, we pay the full cost of current services, plus the interest on money we borrowed for health care and other things in the past. While the spending has remained constant as a share of GDP, the tax burden has grown and quality has declined.

The irresistible force of demand for services is running headlong into the immovable

will recommend will merely put off the day when we must concentrate scarce public health-care dollars where they'll do the most good, and give users of the system incentives to be prudent about how they spend them. We spend vast sums on procedures of little or no value, while we place patients with life-threatening conditions in lengthening queues.

But there's hope. If we put these facts before Canadians, they will rise to the challenge of defining the list of health services they believe merit full public insurance. They will also accept having to pay for minor services out of pocket if they're sure that the poor won't suffer (the list can be developed through public consultation, under appropri-

ate rules and safeguards, where Canadians decide how much they should pay and what medicare should cover).

Oregon has already moved in this direction. A recent paper by health economist Julia Witt for my institute makes a powerful case that the shortcomings of the Oregon experiment can be overcome by more sophisticated rules and consultation techniques.

Canadians have resisted plans to reduce the range of services insured by medicare; they suspect that the outcome will reflect what bureaucrats, not citizens, actually want. Engaging Canadians in each province in a dialogue on the services to be insured, and treating them like responsible, intelligent

adults, might produce results that would pleasantly surprise our political elites.

Mr. Romanow is wedded to an old paternalistic model — one that's been overtaken by technology and by rising public expectations. It suggests experts know best which services we should get, how much they should cost, and how long we should wait.

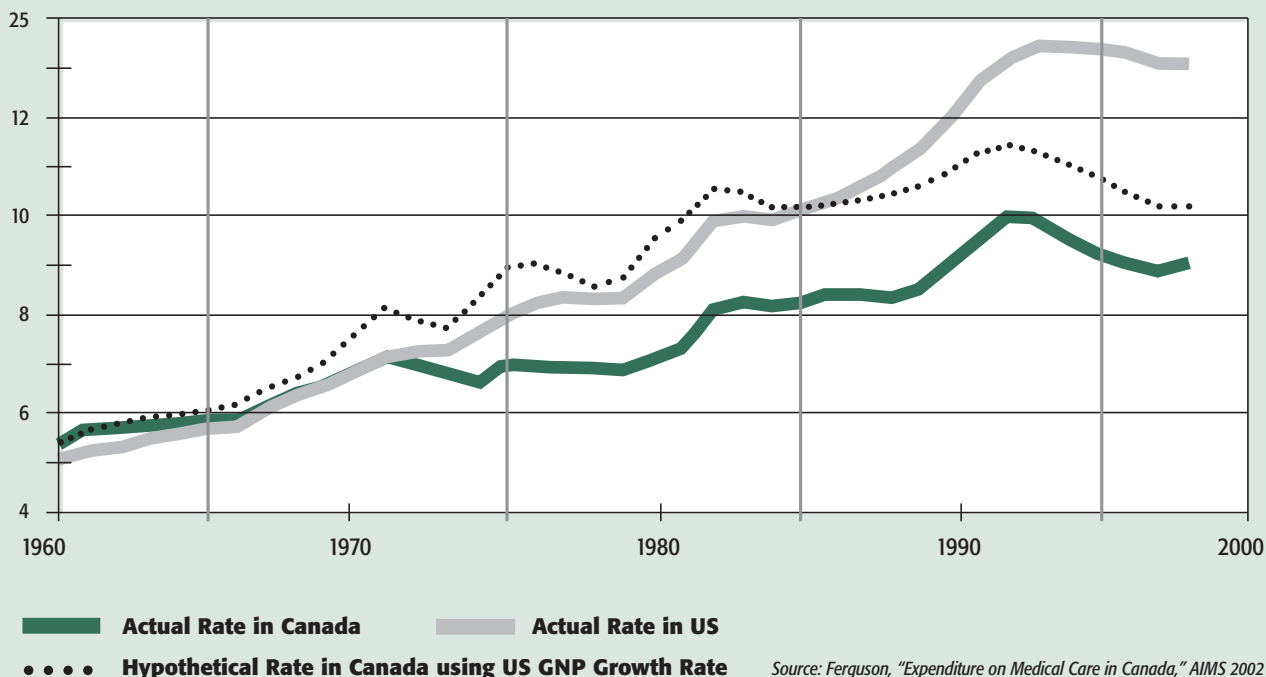
Let's tell Canadians the truth about medicare's unsustainability and involve them in making the tough choices to ensure that medicare's best features are there when we need them. ■

*This op-ed by Brian Lee Crowley appeared in The Globe and Mail on Nov. 22, 2002.*

## The myth of cost control in Canadian health care

It is often argued that medicare has served to keep Canadian health care expenditure growth in check while other countries, like the US, saw health spending eat up ever-larger portions of their GDP. In fact, as this graph demonstrates, had our economic growth been as weak as US growth was through the 1970s and 1980s, for two decades our GDP share series would have been higher than the actual US GDP share series. In other words, Canada would have had the most expensive health care system in the world, a situation that would have changed only in the 1990s.

**Growth Rates of GDP Share Expended on Health Canada, US, Hypothetical, 1960-97**



# Shed No Tiers for Medicare

AIMS continues to focus not on ideology, but on quality of health care outcomes

The head of Canada's health care commission, Roy Romanow, has made it clear that his forthcoming report will continue to ensure that "two-tier" health care is forbidden in Canada. Too late. If you are on workers' compensation, in the RCMP or the military, if your company has its own salaried physicians, if you use a private hospital like Shouldice in Toronto or one of Henry Morgentaler's private abortion clinics, if you are a member of the medical professions, or know someone who is, or are just articulate and determined or famous and connected, if you travel to the US or any one of a number of other places, you can get better, faster or more satisfactory care than someone who just lets the wheels of medicare grind on.

Moreover, technology is allowing the remote delivery of evermore health services, so the ability of governments to frustrate patients' desire to get better and faster treatment is declining, and that decline will accelerate. The debate, therefore, is really about how many tiers and under what conditions. And many of these tiers are beyond government control.

Virtually any kind of pharmaceutical product can now be purchased over the Internet from foreign providers that can evade our government's controls. Your X-rays or MRI scans can be read just as easily by a radiologist in Boston or Bombay as in Toronto or Truro.

More powerfully, the brain repair team at Dalhousie University recently operated on a patient in Saint John, N.B. The surgeons never left Halifax. Using video cameras and computer controls, they operated robotic arms that actually did the surgery hundreds of kilometres away. When you can go to a surgical booth in Canada and be operated on

by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, the notion of a closed national health system in which people must take what public authorities decide they should have simply cannot survive.

Multiple tiers is a slippery concept. For some, if people can get a service by paying for it, while others who cannot pay do not get access, that is multiple tiers. On the other hand, there are people who oppose tiers because of an ideology of egalitarianism. Thus two people with similar conditions may both get treated, one more quickly through private payment, the other more slowly, but within appropriate norms for their condition, by medicare.

We are not talking about people being denied care based on ability to pay, because anyone willing to wait will eventually get care (although we possess no figures on how many die while queuing for public health care). The complaint is rather that someone got care more quickly. That's a very different objection: no one should be able to get faster treatment than in the public system, even where such faster access does not affect the quality or timeliness of the care obtained by people who continue to use the public system.

This peculiar brand of egalitarianism suggests that people should not be denied service because of their own inability to pay, but should be denied access because of their neighbour's inability or unwillingness to pay (through taxes) for the care an individual decides he or she needs.

Canada is almost alone in the Western world in outlawing people paying privately for services that are also publicly insured. One consequence of this is that there are many services, such as drugs or home care,

that we cannot afford to cover publicly, whereas they are often publicly insured elsewhere.

Thus, by forbidding people who wish to do so the ability to pay, we satisfy our ideological craving for egalitarianism, but at the cost of an inability to make room in the public budget for a wider range of services that low-income people might truly need. Now this might be a defensible trade-off if our system were superior to others, and indeed we frequently hear it said that we have the best health care system in the world. But neither the World Health Organization (in its ranking of world health systems) nor the citizens of Canada, nor the poor and the elderly in Canada (based on polling data), agree.

In sum, many of Mr. Romanow's concerns are ideological, and have little to do with the quality of care delivered within the public system. He clings to a system that outlaws private spending on publicly insured services, in the mistaken belief that parallel systems rob the public system of resources, while both objective and subjective international rankings show that multiple tiers of access are fully compatible with high quality public systems, high levels of care overall, high levels of patient satisfaction and public health outcomes as good or better than Canada's. In an evidence-based debate on the future of Canadian health care, we would wipe these tiers from our eyes and focus on ensuring that all Canadians get access to the best quality health care possible. ■

*This op-ed by Brian Lee Crowley appeared in the National Post on Nov. 25, 20002*

# Soins de santé : « Romanow fait partie du problème, pas de la solution »

## La voix de AIMS se fait entendre partout au pays

**R**oy Romanow, qui préside la Commission fédérale sur l'avenir des soins de santé, prépare assidûment le public à ce que son éventuel rapport recommandera. C'est dommage, parce qu'il a clairement indiqué qu'il n'a pas l'intention de même reconnaître le conflit d'intérêts fondamental qui forme les racines des problèmes affectant le système des soins de santé. L'argent n'est pas en cause. En fait, si l'on injecte des sommes supplémentaires dans le système, ça ne fera que remettre à plus tard une véritable réforme. Ce report se traduira par des coûts énormes sous la forme de qualité des soins déplorable, de citoyens frustrés, de pertes de personnel et d'électeurs irrités.

Le secteur privé doit se plier à des réglementations gouvernementales parce que la seule concurrence n'est peut-être pas suffisante pour garantir la haute qualité des produits et services, ou parce que les consommateurs n'ont peut-être pas les connaissances suffisantes pour faire des choix éclairés.

Les gouvernements, par exemple, assurent la réglementation de nombreux aspects de la production, de la qualité et de la sûreté des aliments. Ils établissent des normes minimales touchant l'hygiène, la fraîcheur et la qualité des matières premières, les conditions de travail, l'utilisation d'agents thérapeutiques, les pesticides et autres choses encore.

Ils obligent les fabricants à indiquer les ingrédients utilisés, les dates de péremption et, dans certains cas, la date où les produits ont été emballés. Mais lorsque le gouvernement assure son autorégulation et sa prestation de services de soins de santé, le tableau est radicalement différent. Les autorités gouvernementales, par exemple, n'établissent même pas de normes officielles de temps d'attente approprié.

Personne ne sait combien de temps, de l'avis des responsables du système de soins de santé, les gens devraient attendre pour des traitements particuliers. Résultat ? Personne ne peut être tenu responsable de n'avoir pas répondu à ces normes.

La meilleure façon d'illustrer les conflits d'intérêts des gouvernements, qui garantissent et dispensent à la fois les soins de santé, est d'étudier la réglementation qu'imposent les provinces aux fournisseurs privés d'autres

virtuellement, et ils interdisent aux assureurs du secteur privé de toucher à ces services. Ils négocient les dispositions de paiement avec les puissants groupes de fournisseurs. Ils établissent souvent les budgets des institutions de soins de santé nominalement privées, notamment de nombreux membres de leur conseil d'administration, et disposent du pouvoir implicite ou explicite de défaire les décisions des administrateurs.

Dans le domaine des soins de santé,

**Hormis les moyens notoirement inefficaces qui consistent à se plaindre auprès des politiciens, à adresser des lettres aux journaux et à recourir aux tribunes téléphoniques, les consommateurs insatisfaits ont peu de pouvoir pour influencer le système.**

types d'assurances (auto, vie, habitation) et la façon dont les gouvernements font leur autorégulation à titre de fournisseurs monopolistes d'assurance santé. Les provinces ne permettraient jamais à un assureur du secteur privé de se comporter aussi cavalièrement qu'elles le font elles-mêmes à titre d'assureurs de notre santé.

Notre système est-il un monopole ? Bien sûr ! Les gouvernements provinciaux ne font pas que payer les soins nécessaires. Ils régissent, administrent et évaluent aussi les services qu'ils fournissent eux-mêmes. Ils définissent ce qui constitue « des services nécessaires sur le plan médical », les paient tous

comme dans toute autre entreprise, un flux constant d'informations est nécessaire pour déterminer si l'organisation atteint ses objectifs. Ce n'est que de cette manière que les dirigeants de l'organisation peuvent être tenus responsables des résultats.

Ainsi, les succès peuvent être récompensés, les échecs, surmontés. De plus, les consommateurs de soins de santé et les citoyens sont en mesure de faire des choix personnels et politiques en toute connaissance de cause.

Cependant, comme c'est le cas dans les autres formes de monopole, le système canadien de soins de santé se prive d'informations vitales telles : qui a attendu trop longtemps

pour obtenir des soins, qui a vu sa santé s'améliorer, qui a vu sa condition empirer, et qui n'a pas constaté de différence après les services reçus du système de soins de santé ? Il en est ainsi parce que les renseignements utiles touchant la performance de notre système serviraient à mesurer la performance des responsables de ce système, et il n'est évidemment pas dans leur intérêt de recueillir ces renseignements.

Ces gens sont en conflit d'intérêts. C'est aussi parce que dans un environnement de concurrence, les consommateurs « votent avec leurs pieds ». Au fil des ans, ils en sont venus à préférer les calculatrices aux règles à calculer, le gaz naturel et le pétrole au charbon, les télécopies et les courriels au courrier postal. Et ce même si dans la plupart des cas, la vieille industrie dominante était puissante, riche et disposait des bons tuyaux.

## POUVOIR INVERSÉ

Mais dans un monopole, même dans celui qui est soumis à une réglementation, le pouvoir relatif des consommateurs et des fournisseurs est inversé. Avant l'avènement de la concurrence dans l'industrie du téléphone, les consommateurs insatisfaits devaient composer avec la monumentale indifférence d'une bureaucratie qui pouvait littéralement tenir sa clientèle pour acquis.

De la même manière, les administrateurs de notre système de santé ne pâtissent pas des conséquences directes du minable service à la clientèle. Ils n'ont même pas à rendre des comptes à un exigeant organisme de réglementation, si ce n'est le vague pouvoir du gouvernement fédéral de retenir des fonds pour cause de violations des principes tout aussi vagues de la Loi canadienne sur la santé. Hormis les moyens notoirement inefficaces qui consistent à se plaindre auprès des politiciens, à adresser des lettres aux journaux et à recourir aux tribunes téléphoniques, les consommateurs insatisfaits ont peu de pouvoir pour influencer le système.

Cela se traduit par des temps d'attente excessifs, la tolérance envers l'erreur et le recours croissant à des services de santé hors des canaux « officiels ».

Roy Romanow estime que ce monopole inerte est très bien et qu'il lui faut tout juste plus d'argent, beaucoup plus. Voilà pourquoi il fait partie du problème, et non pas de la solution. ■

Par Brian Lee Crowley,  
La Presse, le 24 novembre 2002.

# Ideology Blinds Romanow

## Front page coverage for AIMS report

A major new report is harshly critical of Roy Romanow, head of the royal commission looking at the future of health care, calling him a prisoner of ideology who has avoided examining the best ideas to revolutionize the system.

The Atlantic Institute for Market Studies' research, billed as an alternative to this Thursday's widely anticipated Romanow report, concludes that Canadians must take more responsibility for their health and pay more for services in a smaller, more competitive public system.

Entitled "Definitely Not The Romanow Report," the study says what is needed is a blend of public and private medical services that are high-quality and cost-effective. It recommends:

- specialized, non-profit and for-profit clinics to deliver publicly funded services;
- medical savings accounts;
- an annual deductible of \$325 to be paid by all citizens except those in the lowest income brackets;
- asking Canadians to rank in order of importance which health services should be publicly funded.

The report says it is providing an alternative to Mr. Romanow's approach because it believes the former Saskatchewan premier "will do little or nothing" to deal with the fundamental challenges of Canadian health care.

"Many of Mr. Romanow's concerns, far from focusing on making sure that Canadians get the best value from the health

care dollar, are ideological and have little to do with the quality of care delivered within the public system," concludes the report.

"He clings to a system that outlaws private spending on publicly insured services ... while both objective and subjective international rankings show that a mix of public and private suppliers of health care services and multiple tiers of access are fully compatible with high-quality public systems."

Brian Lee Crowley, lead author of the report and founding president of AIMS, added in an interview that Mr. Romanow is trying to set the terms for the public health care debate in Canada.

"I think he is excluding a lot of very important information and potential solutions to our health care problems, which need to be properly debated."

The report, a copy of which was obtained by the *National Post* yesterday, says Mr. Romanow is proposing a system that is "an old paternalistic one that has been overtaken by events, technology and rising public expectations. It suggests that bureaucrats know best which services should be available to each of us, how much they should cost and what are reasonable waiting times." The AIMS report is to be released today.

Last week, in his final speech before delivering his report, Roy Romanow offered his strongest-ever defence of publicly funded medicine and dismissed further private-sector participation, concluding it would "demolish" medicare.

He said that while Canada's health care system is perhaps the best in the world, it needs more money and expanded publicly funded services, including home care and pharmacare.

"We are far less optimistic than he is



Brian Lee Crowley at a conference debating health care reform.

## The AIMS report concluded that Canadians must take more responsibility for their health and pay more for services in a smaller, more competitive public system.

about the sustainability of the system and why we think more money will only put off until later the real reforms that are needed,” Mr. Crowley added. “There is probably enough money in the system. We need to concentrate on getting better value for it.”

Don Mazankowski, the former deputy prime minister who led the Alberta Premier’s Advisory Council on Health, wrote in a preface to the 72-page AIMS report: “This report provides a refreshing insight into new approaches and alternatives that should be considered and evaluated by all policy makers and stakeholders.”

The AIMS report wants to concentrate funds on health services that provide the

most benefit to Canadians, noting there are many other forms of spending that have a bigger impact on health outcomes than health care.

It also calls to keep the cost of publicly funded health care within certain bounds. “Whatever the national budget can accommodate, the top priority of services, that’s what’s going to be insured,” Mr. Crowley said. “The system is driven by demand.”

The report says it wants to “end ideological preoccupation” with whether care is public or private, replacing it instead with a plan to focus on whether that care is high quality and cost-effective.

“In a world in which you can go to a sur-

gical booth in Canada and be operated on by the best surgeon in the world, who may be at his office in London or Houston or Minneapolis, health care predicated on the notion of a closed national system in which people must take what public authorities decide they should have simply will not and cannot survive,” the report concludes.

The report also looks to “reward” Canadians for prudent use of the health care system, ensuring that they only consume health care services that represent a real benefit to them, still ensuring that no one is deprived of care on the basis of ability to pay.

The reports also states it wants to make Canadians more informed consumers of medicare, ensuring that the health outcomes achieved by all health care providers are audited and made public on a comparable basis.

### HEALTH PLAN

Definitely Not the Romanow Report is recommending to:

- Separate the functions of universal insurer, provider and evaluator of health care, making the public sector a neutral purchaser of publicly insured health care from all public and private providers;
- Introduce fee-for-service for hospitals;
- Debate a definition of “comprehensiveness” so that the public sector pools everyone’s risk of sophisticated, expensive surgeries, or catastrophic coverage, leaving ordinary procedures, whose cost can be borne by the average person, supplemented by private insurance and subsidies for those on low incomes;
- Require governments and Canadians to determine what share of the gross domestic product be devoted to public health care. Publicly insured services would then be all the services Canadians give priority to, up to the cash limit imposed by the fixed GDP. All other services would be covered by individuals and private insurance;
- Ensure universal access to medically necessary pharmaceuticals in a separate plan.

*Story by Tom Arnold in the National Post, Nov. 26, 2002.*

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# CBC's As It Happens Interviews Brian Lee Crowley

## CBC Radio's flagship current affairs program spotlights AIMS report

**Mary Lou Finlay:** The Romanow Report is not even out yet and everyone is already second-guessing its contents. Today the Atlantic Institute for Market Studies came out with its own analysis on health care and it called it “Definitely Not the Romanow Report.” In it, the authors criticize Roy Romanow for his ideological blinkers. Brian Lee Crowley is lead author of the report. He is founding president of the Atlantic Institute for Market Studies. Mr. Crowley, why are you criticizing Mr. Romanow's report before he has even issued it?

**Brian Lee Crowley:** Well, Mary Lou, I don't agree that he *hasn't* issued it. I mean, all that he's done is he's gone around the country and made speeches and leaked stuff to the *Toronto Star* and made it crystal clear what he's going to say in his report. But he hasn't actually issued the paper that these recommendations are written on. I don't think it's okay for him to kind of monopolize the debate by saying, “Oh, wait a minute, I haven't put my report out yet.” And then run around the country and make it very clear what he's going to recommend. I think he has to be held to account now.

**MLF:** So what was it that he said that you take issue with?

**BLC:** It's very clear to me and to my co-authors from reading the statements that Mr. Romanow has made and from the background briefings that we've had from people who are involved with the Romanow Report that he essentially is going to say that there's nothing wrong with the Canadian health care system that more money won't cure. I don't see that at all. In fact, if you look at some-

thing like, say, the UN world ranking of national health care systems, as you know they rated Canada a pitiful 30th in world terms, well behind first-place France and lots of other countries that don't have a health care system anything like the United States. We're not talking about Americanizing the health care system but these are countries that have done a lot more experimentation,

**“Tommy Douglas said there was value in everyone making some contribution to their health care. I think he had it right, and I want to know why we're not headed in that direction”**

tried a lot more different things, and learned some lessons which Mr. Romanow says he's not even prepared to try in Canada. And I think that's a terrible mistake because the UN ratings looked, among other things, at whether or not we were getting good bang for our buck. They said we weren't. They looked at things like whether we were making appropriate spending on preventive measures that help to keep people out of the health care system. They looked at things like whether we were getting vulnerable pop-

ulations, low-income people into health care and the overall ranking for Canada was pretty bad. So I don't agree that we have a health care system that only needs more money. Because in fact most of these other countries are spending the same kind of share of national income as Canada. In many cases, they're spending less. They're servicing older populations who are more expensive to service and they're getting health outcomes that are just as good as Canada's.

**MLF:** We have to be fair. I mean, he has said some things about what he's concluded, but he hasn't laid out all the evidence he's looked at. Presumably he has looked at these other systems that you refer to and made some judgment about why they wouldn't work here, or why he doesn't think it's a good idea.

**BLC:** Well yes, he clearly has, but you know I also, and my colleagues, have looked at this evidence. In fact, we've done a number of background papers for the report that we've just put out. We think there is lots of evidence that many of these reforms are things that make sense for Canada and I don't see any reason why we should allow Mr. Romanow to say, “We're going to exclude debate about these things because I'm not convinced by the evidence.” I think we have to look at the evidence and have a debate about that.

**MLF:** Why do you think he has excluded it, if he has?

**BLC:** I actually think that Mr. Romanow has been essentially captured by a group of people who are defenders of the status quo, who have an ideological commitment to the current system in Canada and are unwilling to

# What people have to say

look at what evidence there is about how reforms might help Canada. Take one concrete example. Mr. Romanow has made it very clear that he thinks that we shouldn't allow private-sector providers, especially for-profit providers, to be involved in the Canadian health care system except in an extremely marginal way. I say to him, well, look at the French system, rated number one in the world. They have a parallel public-private system, they have a third of all hospital stays in private facilities, they get excellent value for their money. The public sector is able to offer more insurance on a wider range of services. My reaction is, I'm not at all convinced by someone who's focusing on ideological things like, is it public or private. I think what we have to focus on is what are the health outcomes that these reforms produce for people. I think what Canadians want to know is, does it work? What we have to do is we have to subject our health care system to a little bit of healthy competition so that people can actually demonstrate that they're providing top value for the money we're spending.

**MLF:** I think what people are afraid of, if I understand the expression of their fears properly, is that if you start mixing up the private and public system, two things happen. One is that money that's spent on health care is going into people's pockets as profit, which we don't need to spend at the moment. And two, that you somehow debase the public system, that you draw doctors and talent into the private hospitals, away from public ones.

**BLC:** I think these are legitimate concerns, but the point is that there are lots of national health care systems around the world in which these things co-exist, provide top-quality health care, they have good health outcomes for the population and don't spend any more money on public health care, and in fact often spend less than we do in Canada. There are lots of ways you can get people upset in the abstract about how these things will work. Nobody wants the American system but I certainly think that what the Swedes and the French and the Austrians and the Australians and the Dutch

and so on are doing is something that we can learn a lot from.

**MLF:** If Mr. Romanow has an ideological bias against private health care what would people think of a recommendation put out by something called the Atlantic Institute for Market Studies? Wouldn't they see an ideological bias there?

**BLC:** What we're recommending in our report is not, let's go to an all-private or largely private system. What we say is, let's judge it on the evidence. What Mr. Romanow says is we don't like private care, and therefore we're not even going to allow it to be experimented with in Canada. And we don't want to pre-judge the outcomes for Canadians by saying, we're not even going to let you try it. I think that it's a bit like in the public sector, someone saying, we hired the best person for the job, but we didn't advertise it, we didn't interview anybody else, and so the answer is, then how do you know you got the best candidate?

**MLF:** We will be speaking to Mr. Romanow, we hope, this week. What, above all, would you like me to ask him then?

**BLC:** I'd like you to ask him if he knows what Tommy Douglas said about health care. I'm going to read it to you. He said, "I want to say that I think there's value in having every family and every individual make some individual contribution to their health care. I think it has psychological value. I think it keeps the public aware of the cost and gives people a sense of personal responsibility." And I see in what Mr. Romanow is recommending more bureaucracy, more centralization, more government monopoly control over health care, and less and less personal responsibility. I think Tommy Douglas had it right, and I want to know why we're not headed in that direction.

**MLF:** Thank you very much Mr. Crowley.

**BLC:** It's been a pleasure.

*This interview aired on Nov. 26, 2002, on CBC Radio One.*

"The Atlantic Institute for Market Studies, in a scathing report released Tuesday, criticizes Romanow for his role as head of a royal commission on the future of health care. Brian Crowley, the report's co-author, accuses Romanow of hearing only what he wants to hear, and ruling out many of the innovations that have vaulted several Western countries ahead of Canada in terms of health-care delivery."

- Steve Macleod, *Canadian Press*, Nov. 27, 2002

"This report provides a refreshing insight into new approaches and alternatives that should be considered and evaluated by all policy makers and stakeholders. As a country whose health care system is ranked 30th by the World Health Organization, it is realistic to suggest that improvements are required. It is also reasonable to assume that mere tinkering will not improve it sufficiently to meet Canadians' expectations. This report provides timely and thoughtful input into the process of reform and advances new solutions to the problems that affect our present system. It constitutes an important contribution to the national debate."

- Hon. Don Mazankowski, former chairman, Alberta Premier's Advisory Council on Health

"I applaud your thoughtful approach to these important issues. Thank you for the opportunity of reading this excellent work. I think it is important to do as you have done and talk about alternatives such as more taxes and/or cutting services. It is also important to give the readers a clear sense of the opportunity costs incurred while paying for most of health care from tax revenue. There are important calls on the public purse, such as subsidized child care, early childhood development programs, better elementary and post-secondary education, economic development programs, job-retraining etc. that together have an even greater impact on the health of Canadians than doctors and hospitals. Do we shelve these in favour of Romanow's idea of putting the entire budget surplus into health care? I shouldn't think so."

- Canadian M. David Low, Rockwell Distinguished Chair and director of the Center for Society and Population Health at the University of Texas

# AIMS Report Far More Useful than Romanow's

## Halifax author delighted that the AIMS study proposes real world reforms

I'm constrained to pour some cold water on the irrational exuberance that greeted last week's release of Roy Romanow's Commission on the Future of Health Care in Canada report. The commission's recommendations were preordained from the get-go, amounting to a waste of \$15 million of taxpayers' money, contributing nothing to address the structural problems besetting health-care delivery in Canada that couldn't have been downloaded for free from the websites of sundry socialized medicine advocacy groups.

In a column last April, I predicted: "It is increasingly evident that the recommendations from Roy Romanow's roving commission on health-care reform will be for a continued public, single-tier model with no user fees and increased funding through higher taxes. That was virtually a given when Jean Chrétien appointed a socialist to head the commission. In other words, what Romanow will prescribe is more of the same faulty policy that got us into this mess."

Aside from the higher taxes bit, I nailed it. Romanow prescribes \$15 billion in increased medicare funding over the next three years, but optimistically expects it to come from federal budget surpluses. His commission produced no new insights, and merely rehashes the prejudices and preconceptions that brought Canadian health care to its current difficulties.

The ideological baggage Romanow brought to the process is clear in his references to medicare as "a public good, a national symbol, a defining aspect" of our society, a "moral enterprise" no less, that must be preserved regardless of outcomes analysis. He is a cheerleader for dog-in-the-

manger socialism, nicely captured in Nova Scotia Federation of Labour president Rick Clarke's surly comment that, "Just because someone can afford to jump the queue doesn't mean they should be allowed to jump the queue." What was it Winston Churchill said about the inherent virtue of socialism being "the even division of misery?"

An "alternate" health-care study that does merit consideration is "Definitely NOT The Romanow Report," by Brian Lee Crowley et al of the Halifax-based Atlantic Institute for Market Studies, which, unlike Romanow's stand-pat-and-shovel-money platitudes, attempts to analyze what's wrong with medicare, and to prescribe solutions that could work.

"Medicare as we know it can be sustainable only if Canadians are willing to accept decreasing levels of service or increasing levels of taxation," declares AIMS. "And medicare's cost problems are only going to grow."

The AIMS researchers charge that "Mr. Romanow has rejected any analysis that might call into question the sustainability of medicare," instead "repeating the tired old mantra that Canada's health-care system is superior to others at containing health-care costs," something the authors say "is simply a myth," noting that Canada's health-care system is now ranked 30th in the world by the WHO.

They point out that during the 1970s and 1980s, we borrowed much of the money we spent on health care, consuming the services but unwilling to pay the taxes to cover the costs. Consequently, we are now stuck with paying interest on money borrowed to pay for health care in the past, so while medicare

spending has remained constant as a share of GDP, the tax burden needed to cover that spending has increased substantially while the quality of services has declined.

I was delighted that the AIMS folks also explicitly acknowledge that many people are consulting alternative medical practitioners, who are frequently outside the medicare system, as their primary caregivers, which skews the "constant expenditure" equation, and constitutes the quintessence of "two-tier" health care.

Speaking of which, AIMS points out that "If you are on workers' compensation, are in the RCMP or the military, if your company has its own salaried physicians, if you use a private hospital ... if you are a member of the medical professions or a medical administrator or know someone who is, if you are just articulate and determined, or if you have the taxi fare to Buffalo, Detroit or Seattle, or travel abroad to any one of a number of other places, you can get better, faster and more satisfactory care than someone who just lets the wheels of medicare grind on."

Unlike the Romanow report's "shell out more for the same old dog food" motif, the AIMS study proposes real-world reforms that actually address issues, present and future, that afflict health-care funding and delivery. I haven't room here to summarize them, but I encourage you to download a copy of "Definitely NOT The Romanow Report" and check it out for yourself.

*Commentary by Charles Moore.  
Published in The Daily News Halifax,  
on Dec.6, 2002.  
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# Striking Insights into Canada's Health Care System

## Many people don't even use the health care system

The average annual expenditures on physician services per person was \$322 in 2001, more than \$70 higher than just six years before. The range of expenditures on single individuals is also quite large, and growing, stretching from zero expenditure on doctors' services to \$73,750 in 2001 (contrasting to a high of \$37,900 in 1995). Interestingly, the most common cost in every year is zero - a large portion of the public does not utilize the services of doctors at all in any given year.

### Personal Costs of Physician Services in Nova Scotia

Year of Data	2001	2000	1999	1998	1997	1996	1995
Population	978,565	974,136	969,177	962,384	958,585	951,570	942,654
Avg. Annual Cost Per Person	\$322	\$274	\$272	\$253	\$242	\$248	\$247
Median Annual Cost Per Person	\$125	\$100	\$100	\$100	\$100	\$100	\$100
Most Frequent Cost Per Person	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Standard Deviation from Avg. Cost Per Person	\$725	\$580	\$574	\$536	\$507	\$512	\$488
Min. Cost Per Person	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Max. Cost Per Person	\$73,750	\$44,950	\$32,225	\$37,450	\$33,400	\$48,100	\$37,900
Total Medicare Cost of Physician Services	\$314,700,725	\$267,219,175	\$263,847,200	\$243,898,700	\$231,961,925	\$236,260,725	\$232,828,075

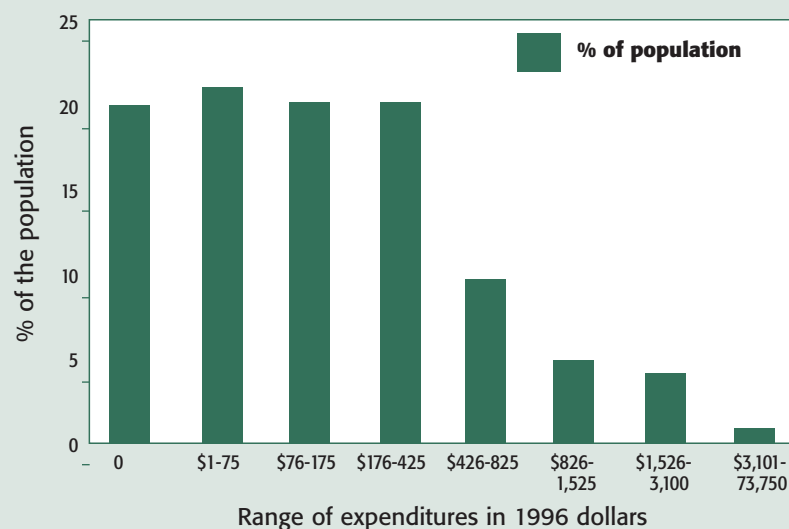
All figures in 1996 dollars

Source: Skinner, "Improving Canadian Medicare," AIMS 2002

## 20% drive health spending

The vast majority of the population is relatively healthy over the course of the year. According to these figures, nearly 20% of the population pay nothing at all for health care and 81% spend less than \$425 per person per year on the services of doctors. The remaining 20% account for the vast majority of health spending, with most of that spending accounted for by a relatively small number of people who spend huge amounts per person on physician expenditures due to serious illness.

### Percentage of the Population in Various Ranges of Expenditure on Physician Services in Nova Scotia, 2001



Source: Skinner, "Improving Canadian Medicare," AIMS 2002



The Halifax-based Atlantic Institute for Market Studies is a non-partisan, independent social and economic policy think tank founded by Atlantic Canadians to encourage and promote debate about realistic options to help build the economy. At [www.aims.ca](http://www.aims.ca)

Whether on regional issues, such as destructive federal transfers and employment insurance, or on national issues such as health care and education, AIMS brings a distinctive eastern voice to the debates shaping public policy in Canada. AIMS works to explain the public policy choices that we face on a broad range of issues and to stimulate people to think in new and creative ways about how to solve our most pressing public policy challenges. We carry out this work through independent, high-quality research, conferences, publications, the Internet, the media and collaboration with governments, universities, business and other policy institutes.