



PUBLIC HEALTH, STATE SECRET



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RESEARCH REPORT



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Atlantic Institute for Market Studies

The Atlantic Institute for Market Studies (AIMS) is an independent, non-partisan, social and economic policy think tank based in Halifax. The Institute was founded by a group of Atlantic Canadians to broaden the debate about the realistic options available to build our economy.

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- a) initiating and conducting research identifying current and emerging economic and public policy issues facing Atlantic Canadians and Canadians more generally, including research into the economic and social characteristics and potentials of Atlantic Canada and its four constituent provinces
- b) investigating and analysing the full range of options for public and private sector responses to the issues identified and to act as a catalyst for informed debate on those options, with a particular focus on strategies for overcoming Atlantic Canada's economic challenges in terms of regional disparities
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FOREWORD

Ottawa and virtually every province in the country are struggling with the reform of our health care system. The current system consumes an ever-growing share of the economy and is rapidly cannibalising almost every other form of public spending. Canadians are clearly exercised about what they see as declining standards of care, closure of hospital beds, lengthening waiting lists, labour disputes and shortages of skilled personnel.

Yet while virtually everyone has their pet schemes for reforming medicare, the stark truth is that we know very little about the operation of the health care system in Canada. We know how much money is spent, of course, and how many doctors and hospital beds there are. In fact, we are brilliant at measuring inputs, or what we put into the system in terms of people, equipment and money, to provide health care services. But we know shockingly little about what was actually produced with those resources, and especially whether and to what degree anyone got better or worse as a result of their contact with the health system.

That means that almost everyone is whistling in the dark when it comes to reform proposals. If we don't know what works well and what works badly, all our grand schemes for change are like trying to execute a brilliant chess strategy wearing a blindfold and oven mitts.

Public Health, State Secret does the following two things:

First, it identifies the reasons why Canadian health care is such a puzzle. The answer lies in the system's nature as an unregulated public sector monopoly. Those who run the system, also decide what information to collect about its performance. They face no competition from alternative providers, and consequently have no need to attract health care consumers with facts about their performance as service providers.

Second, it suggests how to create the right incentives so that information is gathered and disseminated on the operation of the Canadian health care system — by unbundling the system, introducing competition between suppliers of health care services, and arm's length regulation of the system. Competitive suppliers of health care services would contract to provide agreed upon levels of services, results, and access with penalties for non-performance.

This plea for health care reform, based on evidence and guided by healthy incentives, is one that could not come at a more opportune time for Canadians who are constantly struggling to see how they can preserve the key features of a health care system that they highly value.

ABOUT THE AUTHORS

Brian Lee Crowley, a former member of the Editorial Board of *The Globe and Mail*, is the founding president of the Atlantic Institute for Market Studies (AIMS). Prior to joining AIMS, Crowley was president of the Atlantic Provinces Economic Council (APEC), and before that he was a professor teaching politics, economics and philosophy at Dalhousie University. He acted as Secretary to the Nova Scotia Working Committee on the Constitution (the Kierans Committee) after which he became Constitutional Advisor to the government of Nova Scotia in the negotiations resulting in the Charlottetown Accord. He advised the Manitoba government during the Meech Lake negotiations. He has been a diplomat for the EEC Commission, an aid administrator for the UN in Africa and an advisor to the Quebec government on parliamentary and electoral reform. He holds degrees from McGill University and the London School of Economics, including a Ph.D. in Political Economy from the latter. He appears regularly in the media to comment on economic and political matters.

David Zitner, a family doctor, is Director of Medical Informatics at Dalhousie Medical School and Medical Quality Consultant to the QEII Health Sciences Centre. 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 which produced “When Less is Better: Using Canada’s Hospitals Efficiently”. Dr. Zitner was diverted from an active family medicine practice when he chaired a medical audit and utilization committee at a large tertiary care teaching hospital and learned that Canadian communities are lacking the information which is essential to manage and understand our large and complex health system. Dr. Zitner found a continuing absence of regular, pertinent and reliable information about access to care (waiting times) and information about the results of care. Consequently, his research interests relate to the collection and use of timely information including outcome measures, to support clinical care, teaching, research and health services administration. Dr. Zitner is currently chair of the Utilization Committee at the QEII Health Sciences Centre and board member of the Canadian Council for Health Services Accreditation.

THE CONTEXT: PLUS ÇA CHANGE...

1994:

That timely access to services either in the hospital or the community must be guaranteed and information about waiting times made public.

That quality of care will be ensured by ongoing monitoring and publication of patient outcomes as changes are implemented.

– from *When Less is Better*, a report prepared for and unanimously endorsed by the Federal/Provincial/Territorial Deputy Ministers of Health, 1994

1997:

Bringing more and better evidence to bear on decisions is crucial whether by providers or by patients or managers or policy-makers. Evidence offers the prospect of improving the quality of health care. That is why we are committed to closing many of the gaps that now exist in the information relating to medicine, as well as improving its quality and the use to which it is put, including through working towards a country-wide health information system. We must develop reliable, complete and objective information upon which to make judgements and upon which to make policy.

– Alan Rock, speech to the Canadian Medical Association, Victoria, August 20, 1997

1999:

Many bad decisions about healthcare are made every day in Canada because decision-makers lack the right information, at the right time, and in the right place. These bad decisions can cost the country millions of dollars and rob Canadians of the health care they need and deserve. Decisions that are made about the health system- like funding for diagnosis and treatment of many diseases- are only as good as the information on which they are based.

– Press release entitled “Gap in Health Information Management Puts Canadians at Risk” by Healnet (Health Evidence Application and Linkage Network), dateline Hamilton, Ontario, October 15, 1999

2000:

In relation to the Canada Health Act, I observed that Health Canada does not have the information it needs to effectively monitor and report on compliance. So, ... it is clear that better quality information is required.

– Denis Desautels, Auditor General of Canada, Jan. 2000, private communication to the authors

Through the effective use of information and communications technology and the appropriate sharing of information, the fragmentation of services among health care and related sectors will be resolved and replaced with a “seamless” continuum of care within and across all services. However, major new investments will be required in information systems to support community providers.

– Provincial and Territorial Ministers of Health, *Understanding Canada’s Health Care Costs*, August 2000

2001:

On September 11, 2000 the First Ministers agreed to work together to 1) strengthen a Canada-wide health infrastructure to improve quality, access and timeliness of health care for Canadians; 2) develop an electronic health record system and enhance technologies like telehealth over the next few years; 3) work collaboratively to develop common data standards to ensure compatibility of health information networks; 4) ensure stringent protection of privacy, confidentiality and security of personal health information; and 5) report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services.

– The Kirby Committee, *The Health of Canadians: The Federal Role (Interim Report). Volume IV: Issues and Options*, September 2001

EXECUTIVE SUMMARY

Despite strong support from Canadians for the government-run health-care system, every day the evidence becomes more overwhelming that the care they want is rationed and is of declining quality. Politicians spend roughly \$60 billion every year on this health care, an amount projected to rise by roughly five per cent annually.¹ Moreover they promise ceaselessly to “fix” the system and introduce more accountability for service and performance.

Much has been said and written about the need to improve the information we possess about medicare’s performance, but little has changed. Politicians and senior health officials still lack the most basic information with which to evaluate the quality or timeliness of the care that Canadians receive, or to manage our health-care system to improve care.² They don’t know where the system is failing. They therefore have little rigorous guidance about how to spend these vast amounts of health-care dollars so as to achieve better health outcomes for Canadians. Moreover, the main instrument by which our political leaders promise to close this information gap, the Canadian Institute for Health Information (CIHI), is consuming huge resources without producing much useful information about either the quality of health care in this country or Canadians’ access to that care.

These problems, far from being surprising, are utterly predictable in an industry that functions as an unregulated monopoly, with no defined performance standards for the quality and timeliness of the services it provides. After all, the governments that finance and provide our health care are in a conflict of interest. If they collect and provide clear and easily understandable information about the system’s performance, the public and health-care professionals will use that information to criticise them and hold them accountable for poor performance. By keeping information about medicare access and service levels primitive and hard to understand, and by refusing to set public standards for system performance (e.g. acceptable waiting times for various medical conditions, or identifying poor outcomes arising from error or otherwise), governments successfully mute criticism of their management of the system.

Even the institution created by governments to help monitor the results of health care in Canada — the CIHI — suffers from at least the appearance of this conflict of interest that dogs public-sector health care. For example, both the chair, the CIHI’s board, and its CEO came from successful careers as senior administrators in provincial governments, the former as deputy minister of health in Ontario and the latter as assistant deputy minister in Alberta. Each was successful despite an inability of each province to produce reliable information about access or results. It is important to avoid even the appearance of bias if people are to have full confidence in the information being provided about the quality and timeliness of care by the public sector.

¹ Provincial and Territorial Health Expenditure Estimates, 1974/5-2000/1, CIHI, December 2000. online: <http://www.cihi.ca/facts/nhex/provnhex/ProvJan2001-4.pdf>

² Rachlis, M., Evans, R., Barer, M., Lewis, P., *Revitalizing Medicare*, Tommy Douglas Institute, 2001.

There is certainly no technical or other practical bar to collecting the information that is needed to allow Canadians to assess the efficacy and efficiency of medicare. In every competitive industry, where consumers have a choice of suppliers, each provider has a strong incentive to collect and disseminate relevant information about its performance. After all, superior performance is a competitive advantage because it attracts consumers.

When competition is either non-existent or judged insufficient by itself to provide an appropriate level of quality and public safety, regulation may be an appropriate supplement to market discipline. But for government to be an effective regulator, it cannot also be the provider of the regulated service.

The needed remedies of competition and regulation can be injected into the system by unbundling the functions — insurer, service provider, and evaluator of health-care quality — that governments now play in the health-care system. Doing so will improve incentives to collect information and make it widely available, allow consumers to hold providers accountable by abandoning those with unacceptable waiting times or treatment outcomes, and allow governments to exercise a more vigorous and demanding standard of regulatory oversight.

IMPETUS FOR CHANGE

It has been said that the chief cause of problems is solutions. If that is true, then, before prescribing solutions to the ailments afflicting Canada's health-care system, we should be sure that the problems it faces are genuine. What evidence is there that Canadians are not getting the health care they have come to expect when they seek it?

Perhaps the place to begin is with Canadians' subjective experience of health care in this country. Only 20 per cent of Canadians report having confidence in the health-care system, and slightly more than half say that the medical care they and their family personally received in the last year was "very good" or "excellent".³ A 1999 Angus Reid survey reported that over 70 per cent of Canadians believed that overall quality of care was "much worse" or "somewhat worse" than it had been five years before.⁴

Interestingly, according to a recent article on cross-national comparisons of health-care quality, a high proportion of Americans believe that their health-care system is superb. In Canada, we have a markedly lower level of public satisfaction, including among the poor and the elderly, vis-à-vis our health-care system.⁵ Yet in our country, governments insist repeatedly that the health-care system is "the best in the world". If they have information documenting this claim, the public interest would be served by releasing it.

Delays in gaining access to hospital resources have been widely reported. When they have been measured (and none of the measures currently in wide use in Canada are really satisfactory, a subject to which we shall return), waiting times for care are increasing and regarded as a problem. Citizens in several provinces have been forced to leave the country for cancer care and other services, and not just individuals seeking care they cannot get from their provincial medicare system. In fact, seven provincial governments, including Ontario, are sending certain patients for care in the United States, or have done so in the recent past. A raft of studies looking at various aspects of access to medically necessary care in Canada over the past decade have all reached similar conclusions: "a protracted and growing waiting for health services in Canada is a reality."⁶

³ Roos, N.P., The disconnect between the data and the headlines CMAJ 2000;163(4):411-2

⁴ Angus Reid Poll #53, Angus Reid Report – Jan/Feb. 1999: p. 18 "Public Policy Focus: Canadians' Perspectives on Their Health-Care System and "Social Union"

⁵ Blendon, R.J, Kim, M., and Benson, J.M., "The Public Versus the World Health Organization on Health System Performance," *Health Affairs*, May-June 2001, pp. 10-20.

⁶ For a brief survey of these studies on access and waiting times, see David Gratzner, *Code Blue: Reviving Canada's Health Care System*, Toronto, 1999.

Federal Minister of Health Alan Rock is concerned and recognizes the problem of increasing waiting times: “ The health industry needs better information on what’s working and what isn’t. We all have heard the stories of waiting lists and the aunt who couldn’t get the hip replacement for 18 months and the shortages of facilities and the difficulty getting access to diagnostic equipment.” ⁷

In the year 2000, Canadian physicians were more worried than their counterparts in other countries that their patients will wait longer than they should for medical treatment. For example, 84 per cent of specialists and 74 per cent of family practitioners in Canada worry about these waits, compared with 54 per cent of family physicians and 52 per cent of specialists in the United States.⁸ Increases in waiting times are clearly a reflection of problems with the organization and management of our health-care system.⁹

⁷ Spears, T. The waiting game – the elderly suffer most as Canadians across the country find themselves waiting longer for hospital treatment. *The Ottawa Citizen* – pg. D9. October 5, 1999

⁸ Sibbald, B. STATE OF OPTIMISM AND PESSIMISM IN CANADIAN HEALTH CARE. Canada’s MDs most pessimistic in 5-country survey CMAJ 2000;163(11):1496

⁹ Doctors to Rock: Don’t blame us for your mistakes, E-CMAJ- Date: Feb. 3, 2000, Time: 11:49 am <http://www.cma.ca/cmaj/cmaj%5Ftoday/02%5F03.htm>

THE INFORMATION GAP

Although we all know many people who have not had excessive waits, a shocking element of Canadian health care is that no Canadian health-care jurisdiction will be able to respond to this paper with a sound, empirically based comment about the proportion of people who have appropriate or excessive waits. No Canadian health-care-management district or region in the year 2001 is able to inform interested parties of the number of people waiting today who have already waited too long.

Despite large expenditures on health information, no Canadian jurisdiction routinely collects essential information about access to care and the outcomes of health-care activities. No hospital can give its community a meaningful estimate of how many people got better, got worse, or stayed the same as a result of health-care expenditures. We know, however, that each day the health system provides seemingly miraculous results for some people, and this is what justifies our private and public expenditures for health care. Canadians quite understandably want some evidence that the \$60 billion being spent on their behalf on health care by governments in this country is actually being well spent and achieving appropriate health outcomes for sick people. Moreover, they want assurances that providers are tracking and linking activities and results in order to stop doing harmful work and to improve and better distribute our knowledge about effective practice.

Yet no government or health-care organization in Canada can provide that evidence or those assurances. In fact, here is a brief list of just some of the questions to which, in almost all jurisdictions in Canada, no one can provide satisfactory answers:

- How many people have difficulty finding a family doctor?
- Which specialists have unacceptably long waiting periods?
- Who got better, who got worse, and whose health status remained unchanged as the result of contact with the health-care system?
- Is the cost for improvement in health status higher or lower in rural or urban centres?
- Who is waiting for care?
- How long have they waited?
- Who has waited too long, given their current health status?

One would think that having good-quality answers to these questions would be vital in guiding policy-makers in deciding how to marshal their resources to improve health outcomes for Canadians. Decisions about things like which rural hospitals to close, where waiting times need to be reduced, and where extra physicians and specialists are needed are made every day. And while the usual rational criteria are invoked to justify these decisions, the harsh reality is that they are all too often based on anecdotal

dote, “gut feeling”, or what constituents have said to powerful cabinet ministers. These decisions certainly are not and cannot be based on timely, useful, and clear information, because we don’t gather it.

There is no technical justification for this. It is not as if the means to gather and interpret the needed information does not exist and is not in widespread use today. The private sector has long been able to keep track of waiting times for things like automobiles, bank tellers, and travellers in airports, yet health-service administrators in Canada cannot identify who is waiting for care today or how long they have waited. For example, bed-management tools, common in the hotel industry, are not widely used in health care.

Provincial governments in Canada do not track changes in health associated with care, so it is not possible to use data-mining techniques to link health-care activities with the results they produce.

Caretrak, developed in Nova Scotia, identifies on a daily basis who should be in a hospital and who in another setting for care — yet the method is not widely used. A similar product, CONTINUUM, also identifies on a daily basis who is in the appropriate setting for the care they require. Both of these products produce real-time prompts to encourage appropriate use of resources. Yet health administrators in Canada continue to use diagnostic labels to measure resource use, even though we all realize that a diagnosis alone does not predict the cost of treatment. Thus, while some people with pneumonia are very sick and need intensive care services, others can take an oral antibiotic and continue with their normal activities. Linking resource use to diagnostic labels alone does not encourage the dedication of appropriate resources to those with a particular diagnosis who are most ill.

Several U.S. states have been much more successful in their approach to accountability, data gathering, and reporting. For example, Pennsylvania has required health institutions to use Medisgroups, software that takes patient characteristics and makes predictions about the likelihood of dying. In Pennsylvania, there is a regulatory requirement that all health organizations submit appropriate information to permit performance assessment of health organizations and the information is available for all to see.¹⁰ The assessments include information about the total number of cases, the number of cases in each category, the risk-adjusted length of stay, the risk-adjusted mortality rate, and the average charges per case. The major difference between the CIHI process and the Pennsylvania Health Care Cost Containment Council analysis is that health organizations in Pennsylvania collect and review information about the diagnoses attached to a patient, as well as information about illness severity.

Indeed, the information-gathering methodology used in Canada (and described below in the section on the CIHI) tells us little of value, such as whether anyone got better as a result of their contact with the

¹⁰ Examples of the kind of detailed evaluations of health care institutions this makes possible (including data appropriately adjusted for the severity of individual patient illnesses) online: <http://www.phc4.org/reports/hospitals.htm>

health system. Under this approach, a patient who is discharged alive but dies the next day at home will be counted as having had a successful encounter with the health system.

And there is, of course, the additional issue of what is done with the data once it has been collected. Much CIHI data, leaving aside its methodological problems, lays dormant waiting for some researcher to decide to analyse it. In the United States, by contrast, data on health care is widely published and discussed. Some of the hospital rankings published in the media have been profoundly influential, not only on patient decision-making, but also on error rates in heart attacks.¹¹ State licensing boards, such as Massachusetts', are leaders in publishing accurate health information on-line, and there are a great many health-information news services offering accurate and timely information in a variety of forms.

The information gap on health care's front lines

Unfortunately, even those who recognize that Canada suffers from a dearth of information about the health-care system and how it works tend to think that the only important information gaps are system-wide ones regarding waiting times and access. Sadly, important as they are, they represent only one small part of the inadequacy of the information system that underpins the Canadian health-care system.

Thus, it is vital that doctors have timely access to quality and relevant information during the time that they spend with individual patients diagnosing their ills. It has been estimated that the average physician must be able to marshal some two million pieces of information in order to properly diagnose and treat the range of illnesses with which patients will present in a normal practice. This is far more information than any human being can reasonably expect to keep in their head, especially while the stock of information itself is in rapid evolution. The quality of information available to the physician sitting face to face with a patient in the office is thus a crucial determinant of the quality of care. Yet the decision- and diagnostic-support tools that would improve the quality of that information are sadly lacking in Canada, and there is little recognition that this even represents a problem.

Not so in the United States, where there has been considerable consternation in political, medical, and consumer circles about evidence that medical error is a leading cause of death and disability. Large studies have shown convincingly that deaths from medical error exceed the number of deaths from motor-vehicle accidents, acquired immune deficiency syndrome (AIDS), or breast cancer.¹² Moreover, deaths from adverse drug events alone exceed the number of yearly workplace deaths. Preventable medical

¹¹ Chen J., Radford, M., Wang, Y., et al., Do "America's Best Hospitals" Perform Better for Acute Myocardial Infarction, *New England Journal of Medicine*, Vol. 340, Issue 4, pp. 286-292. Jan 28, 1999

¹² Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human: building a safer health system. Washington, D.C.: National Academy Press, 2000.

errors that result in injury impose a great economic cost from increased medical expenses, lost productivity, and the additional disability care.

The question of error in health care is becoming a major and important issue in Canada;¹³ however, errors are just one cause of poor results. If our goal is to improve health outcomes, then we must have systems to flag, report, and catalogue instances of poor outcomes. Proper tracking of important errors requires the development and use of systems to collect and evaluate all poor health outcomes.

Even though there is every reason to think our circumstance is at least as bad as that in the United States, Canada has not followed their lead in putting resources into encouraging error reduction. For instance, a recent report in the *Canadian Medical Association Journal* revealed the sad news that only 16 per cent of adult patients with hypertension were receiving drug treatment and had normal blood pressure. The failure of proper treatment in Canada leads to an undeniable, needless, and totally preventable increase in disability and death caused by heart attacks and stroke.¹⁴

The absence of information systems and information technology *at the point of care* hampers clinical care and health-system management. Health care is improved when information is used properly. Prompting systems reduce error.¹⁵ The collection, analysis, and distribution of information derived at the point of care clearly leads to improved knowledge and outcomes. This has been well documented for pediatric cancer patients.¹⁶

Private or public organizations that must compete to attract and keep clients or customers cannot survive if they lack essential information.¹⁷ Yet clinicians in Canadian hospitals and medical practices must work without the benefit of modern technology crucial to the collection and delivery of data. Clinicians do not generally have access to decision support at the point of care, nor are they able to maintain electronic records of vital clinical information concerning health-care activities and results.

Clinicians gather important information about patient health, and they scrawl this information onto hand-written charts. Sadly, once written and stored on a paper record, that data is not available to sup-

¹³ There have been several conferences in August and September 2001 including one in Nova Scotia organized by Dr. Pat Crosskerry, and one in Ottawa organized by the Royal College of Physicians and Surgeons.

¹⁴ Myers, M. G., Compliance in hypertension: Why don't patients take their pills? *CMAJ* 1999;160:64-5

¹⁵ Bates, D.W., Leape, LL, et.al., Effect of Computerized Physician Order Entry and a Team Intervention on Prevention of Serious Medication Errors, *JAMA*, 1998, 280, 1311-6 and;

Bates, D.W., Teich, J.M., Lee, J., et.al., The Impact of Computerized Physician Order Entry on Medication Error Prevention, *JAMA*, 1999, 6, 313-21

¹⁶ Simone, J V. Jane Lyons, J. Cancer Survival in Children Compared to Adults: A Superior System of Cancer Care. *Health Affairs* 19-6-:9-22, 2000

¹⁷ Crowley, B., Zitner, D., Faraday-Smith, N., *Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System*, November 1999

port care elsewhere or to be used to gather systematic information about the results of the care already provided.

All this is not meant to suggest that we can't have better care - on the contrary, this evidence points to clear steps that can be taken, using existing technologies, to improve the flow of information through the point of care, which is the front line of the health-care system. Yet in Canada, systems have not been put in place to routinely measure and encourage those practices that produce the best results. Additionally, readily available systems to monitor and improve performance and to identify superfluous activity are not being used.¹⁸

Poor-quality health care and the information gaps that exist within the health-care system are not separate and unrelated issues, but are intimately linked.

¹⁸ Crowley, B., Zitner, D., Faraday-Smith, N., *Operating in the Dark: The Gathering Crisis in Canada's Public Health Care System*, November 1999 and;

Zitner, D., Paterson, G., Fay, D., Methods to identify pertinent and superfluous activity, in Tan J., *Health Decision Support Systems*, 1998

OUR DIAGNOSIS: AN UNREGULATED MONOPOLY

Banks use data-mining techniques to predict which customers are least likely to default on loans. Supermarkets use data-mining techniques to predict who is most likely to buy a particular product. In health care, these tools would be useful as part of a routine health-system monitoring which activities benefit the public, waste money, and which are harmful. However, an unregulated monopoly does not have a good economic reason to make capital investments in infrastructure or to improve care.

This lack of appropriate information tools and technical infrastructure would not be acceptable in any industry where consumers had a choice of competing suppliers. A company, 50 per cent of whose consumers were dissatisfied, would not survive for long, as its consumers would surely flee to alternative suppliers. Indeed, that is one reason why private-sector organizations are virtually obsessed with information about their performance. Consumer-driven companies regularly survey their customers to learn if they are satisfied with the product or service they have received and if it was effective. Yet how many Canadians have been called to learn if their health improved following care or if they waited too long for needed care?

In the private sector, directors, shareholders, investors, accountants, and regulators demand pertinent information. This information is a crucial tool in ensuring that resources are spent to best effect in sustaining and improving their overall performance. The right knowledge at the right time in the right hands is not only power, but also the key to improved performance.

There is a common exception to this rule, however. Monopolies, whether public or private, are notoriously indifferent to the satisfaction of their customers. This is only to be expected, since by definition a monopoly's customers are unable to choose another supplier. Thus, customer satisfaction does not necessarily contribute to business success. (Indeed, in Canadian health care, many [but by no means all] measures to improve services increase provincial costs. On the other hand, provincial health administrators are focused on decreasing cost, and the incentives within the health-care system reward this behaviour. Consequently, there is a reluctance to make appropriate investments in technical and information infrastructure even when these provide substantial and demonstrable benefit.)

Canadians instinctively understand these truths about monopoly behaviour. One has only to think about their deep concern at the near-monopolistic power that Air Canada acquired in the air-travel market following its acquisition of Canadian Airlines. They knew that being served by only one airline meant that that company could virtually set its own prices, and provide a service schedule that suited

itself, not its customers. The point was that dissatisfied air travellers would have no means to express their unhappiness in any effective way. They would be a captive market.

Yet, much as Canadians clearly mistrust monopoly in general, they seem to be oblivious to the fact that their public health-care system (i.e. medicare in each province) is a quasi-monopoly, with all the usual defects of monopoly behaviour. Thus, we cannot properly evaluate, for example, the sources of Canadians' satisfaction or dissatisfaction vis-à-vis medicare. As a virtually unregulated monopoly, the Canadian health care industry does not collect proper information about either the benefits of or the flaws in the medical care that Canadians receive. So that, while many strongly suggest we have an important quality problem, the information systems with which to measure access to and the results of care are primitive.

Health-services administration in Canada behaves as an unregulated monopoly not only with regard to information but also in several other respects. Just a few of them are listed here:

Goals

Those who operate in the private sector attempt to increase the size of the overall market, as well as their share of that market, by selling an increasing amount of those goods and services which the public values. For example, most industries would regard it as a success to say that they had captured a greater share of the GDP. But as a tax-financed monopoly whose income flows not from customer satisfaction but from political negotiation, the health-care system in Canada regards all spending increases as cost increases only, taking little or no account of whether increased spending creates more value for patients. Some provincial governments have already created obstacles to prescribing expensive but effective drugs, but do not discourage the prescribing of cheaper drugs with a higher probability of side effects.

Queue Management

Businesses in a competitive industry gain an advantage by providing timely service and minimizing waiting times. Most managers recognize a 15-minute wait in the checkout at the local supermarket as unacceptable to their customers. Banks promise cash awards to customers if they wait too long in the queue at the counter. The vast majority of people can have their car's muffler replaced or a television delivered to their home within a day, and often a few hours.

But since dissatisfied consumers cannot punish a health-care monopoly by defecting to alternative suppliers, health-care administrators often use waiting periods as a form of rationing and "cost-cutting", by deferring until later the cost of dealing with certain medical conditions. The irony is that longer waiting times are more costly than immediate treatment, because health conditions often deteriorate with

time. Rapid treatment of an illness episode prevents continuing disability and recurring physician visits for a persistent problem. Indeed, workers'-compensation boards recognize this and are implementing strategies to help injured workers jump to the front of the queue.¹⁹

Innovation and Incentives

The private sector values innovation because it leads to new services, increasing markets, and market share. For unregulated monopolies working to a fixed income, innovation is to be avoided. New products are a cost that decreases the likelihood that the monopoly will meet its budget target. This process applies whether you are considering useful, but expensive, new drugs and diagnostic technologies or state-of-the-art information technology products that support medical decision-making by doctors and could reduce medical error.

No good deed goes unpunished in the Canadian health-care system. Hospitals using case-mix groups to measure performance are penalized for treating the sickest example of a condition. Attracting additional work leads to no increase in budgets, at least in the case of hospitals, and so fewer resources per patient is the result.

Doctors who attract a sicker, more complex patient population are penalized in fee-for-encounter models because encounters with such patients are lengthy. Family doctors in fee-for-encounter systems are paid more if they see larger numbers of people. Sadly, the information is not available to let clinicians and administrators know how to price medical-office visits, so all visits are priced the same, with the hope and prayer that, in the end, it will all work out.

Regulation

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, or where consumers may lack the knowledge to make fully informed choices. For example, governments regulate many aspects of the production, quality, and safety of the food industry. They set minimum standards (which providers are generally allowed to exceed) on hygiene, the freshness and quality of raw materials, working conditions, the use of therapeutic agents, pesticides, and many other factors. They require meticulous records to be kept so that they can respond to problems with large quantities of up-to-date and comprehensive information supplied by farmers, ranchers, veterinarians, and others. In addition, they require manufacturers to disclose both the ingredients and the age of the products on sale to the public.

¹⁹ *Moncton Times Transcript*, For Rent:Medical Services, David Frances, December 20, 2000

But where the government is regulating itself and its provision of health-care services, the picture is radically different. Government health authorities have, for instance, failed to set standards for appropriate waiting times. No one knows how long the health-care system thinks people should wait for particular treatments, consequently, 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...not that it would do any good — they don't collect it to begin with.

Government-regulated private companies that process and sell food to the public, in common with most private industries, are able to take orders and provide service electronically by telephone, electronic mail, or the internet. In our federally and provincially funded health-care system, providers are discouraged from providing open-access advice and care because the existing payment models do not reward such behaviour; indeed, they penalize 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 a set of external regulations. Health care in Canada is largely an unregulated monopoly because government

- defines what constitutes “medically necessary services”
- pays for all such services provided 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 care
- is responsible for defining, collecting and reviewing information on its own performance

As employees of an unregulated monopoly in a complex industry, health workers would seem to have an important responsibility to inform the public about the benefits and harms of care, along with what health benefits the public is buying for the dollars spent. Unfortunately, Canadian governments cannot tell us anything useful about who got better, who was made worse off, and whose condition was unchanged as a result of their health-care interventions. Much has been made about the recent agreement by First Ministers to provide better reporting on health-care results, but such promises are hardly new. For example, in 1994 the federal/provincial/territorial deputy ministers of health formally committed themselves to informing the public regularly about access to care and the results of care.²⁰

²⁰ *When Less is Better: Using Canada's Hospitals Efficiently*, A paper prepared for and unanimously endorsed by the conference of Federal/Provincial/Territorial Deputy Ministers of Health, Ottawa 1994

THE INFORMATION BLACK HOLE: THE CIHI AND HEALTH-CARE ACCOUNTABILITY

As monopoly providers of health care, provincial governments are in a powerful position to collect valuable information about the activities and results of care. After all, virtually everyone who provides medically necessary services is paid by the government, who could make such information reporting a condition of payment.

Canada *appears* to have made a national commitment to collect appropriate information by developing the Canadian Institute for Health Information (CIHI). Indeed, an expansion of the already major role of the CIHI in the health-care-information-gathering field is the linchpin of the federal-provincial efforts to increase accountability in the system.

Unfortunately, much of this effort and investment in information gathering by the CIHI has proven itself either wasted or pernicious. And there is little sign of improvement on the horizon.

The CIHI is federally funded, to the tune of \$95 million, and has a national mandate. That mandate includes the identification of health-information needs and priorities, and the collection, processing, and maintenance of data for a comprehensive and growing number of health databases and registries. The CIHI states that “through the pursuit of these primary functions, [it] helps its many clients to make sound health decisions based on quality health information. Stakeholders include ministries of health, health care facilities, health-related organizations and associations, the research community, private sector and the general public”²¹ The CIHI has substantial influence on the use of health-care information in Canada, determining which information health organizations will collect and use. Consequently, the CIHI affects health organizations’ information-collection and -management expenditures. Because the CIHI effectively dictates what information health organizations collect, it has a special responsibility to ensure that the information it requires is appropriate and useful. Especially in times of restraint, health organizations are not able to justify the collection of anything less than useful data.

Unfortunately, this huge investment in information has not been able, in any way, to link health-care activities with their results.

In addition to the \$95 million it receives from the federal government, the CIHI enterprise gets gen-

²¹ CIHI web site, December 16, 2000. Online: www.cihi.ca

erous direct and indirect contributions from each province. Almost every hospital in every province in Canada contributes data to the CIHI discharge-abstract database, and the cost is significant. For a 400- to 500-bed hospital, the cost for abstracting discharges ranges between \$1.0 million and \$1.5 million. It can require as many as 22 chart reviewers to manually review the chart of every patient discharged from hospital.

Health-records' reviewers write down the diagnoses, but collect no information about a patient's comfort and function before and after treatment. The CIHI hospital database collects information about the diagnoses, but no information about any of the reasons a person is admitted to a hospital, despite the fact that a diagnosis on its own is rarely either a necessary or sufficient condition to warrant hospitalization. For example, most patients with pneumonia are treated at home, but for those few who are admitted to hospital typically having substantially decreased function, the CIHI makes no effort whatsoever to capture and compare their information about comfort and function. Nor, embarrassingly, does it gather data that would allow us to accurately measure critical parameters such as the access to or the results of care.

To appreciate what this means, consider the fact that the CIHI discharge-abstract database encourages hospitals to compare their lengths of stay with one another. Unfortunately, the database is based on the International Classification of Disease (ICD) codes, which describe the etiology of a disease, but not its severity. In other words, they indicate what a person is sick with, but not how sick they are.

The CIHI comparative hospital database²² makes no effort whatsoever to take into account community context, disease severity, or any of the possible reasons a person could be in hospital. Without adjustments for illness severity, comparisons between health organizations are at best specious, at worst mischievous.

Acute-care organizations today have no way of knowing if their lengths of stay are too long, too short, or just right. Nor can they determine how many people benefited from the services that were provided. Despite detailed review of each page of a discharged patient's record, health-records' reviewers do not collect any information about health status or the changes in health status associated with care, even when the information is available from physician or nursing notes in the health record. The personal information collected from the chart is summarized and sent to the CIHI for analysis. The CIHI then sends the hospital a report which includes information about the average length of stay for a particular diagnosis over a particular time period. These aggregate reports arrive long after patients have been discharged, so the data generated by each patient cannot be used to influence their own care.

²² CIHI Health Care in Canada 2000: A First Annual Report, Canadian Institute for Health Information, Ottawa

League tables: an example of why bad information makes things worse

Hospitals' rankings by the CIHI constitute a form of league table. Those hospitals at the top of the league maintain shorter lengths of stay for a particular set of ICD codes or diagnoses than do those at the bottom. However, in the absence of appropriate adjustments for severity or of statements about the benefits of care, it is not possible to know whether the length of stay was appropriate in the particular circumstance. Restructuring or changing health-services organizations based on the current league table methodologies is "equally likely to be beneficial, harmful, or irrelevant."²³ Moreover, one of the developers of the ICD etiology-based classification system has lamented the harms caused by its widespread misuse, and he "convincingly argues that the result of these shortcomings is a wealth of inaccurate, distorted data that threaten the health-care information infrastructure in the U.S."²⁴

²³ Parry, J.G. Gould, C.R., McCabe, C.J. Tarnow-Mordi, W.O., .Annual league tables of mortality in neonatal intensive care units: longitudinal study BMJ 1998;316:1931-1935 and;

Paterson, G., Zitner, D., Davison, C., Gesener, J, Migas, M., and Alias E. Design of a system to catalogue generic and condition specific health outcomes measures used in the Cochrane library, Canadian Cochrane Symposium. McMaster University, Hamilton, Ontario. (November 19, 1999)

²⁴ Hogan, D. Book Review of "The Endangered Medical Record: Ensuring Its Integrity in the Age of Informatics" by Vergil N. Slee, Debora A. Slee, and H. Joachim Schmidt. JAMA Vol. 284 No. 20, (week of November 22, 2000)

IMPLICATIONS FOR CANADIANS OF AN UNREGULATED HEALTH-CARE MONOPOLY

A good health-care system provides timely access to beneficial services and thereby improves health. For patients, the relevant dimensions of health are comfort, function, and the likelihood of dying. Services are beneficial if they improve health. Consequently, health-services' administrators must relate health-services activities with the results they produce in order to learn which are beneficial, harmful, or merely superfluous. And, since the benefits of the health system cannot be delivered without timely patient-system interaction, it is also essential to monitor waiting times.

As in any enterprise, a constant flow of information is needed to determine whether these goals are being met. When information flows about an organization's success in meeting its goals, the people administering the organization can be held accountable. Success can be rewarded and failures overcome.

Like other forms of monopoly, however, the Canadian health-care system cuts itself off from vital information. This is so for two chief reasons. First, monopoly by its nature prevents the feedback created when customers "vote with their feet" and defect to alternative suppliers. Second, because useful information about our health-care system's performance will be used to assess the performance of those responsible for the system, it is not in their interests to collect it. They are in a conflict of interest.

Holding providers' feet to the fire

In a competitive environment, consumers are free to "vote with their feet". They did so in the 1970s, when they abandoned North American cars for Japanese imports that were cheaper and better. Over the years, they have come to prefer calculators to slide rules, natural gas and oil to coal, and faxes and e-mail to "snail mail", even though in most cases the old dominant industry that was being abandoned was powerful, rich, and well-connected.

But in a monopoly, even a regulated one, the relative power of consumers and suppliers is completely reversed. Before the advent of competition in the telephone industry, dissatisfied customers faced the massive indifference of a bureaucracy that literally could take their business for granted. The stories are legion of power and telephone monopolies that provided expensive and poor-quality service, and found myriad ways to punish and intimidate customers who complained or otherwise pointed out their failings. This behaviour is common; even though politicians, answerable to voters, had a theoretical hand on the tiller through some quite powerful, if cumbersome, regulatory agencies.

Like their close cousins in the monopoly family, administrators of the Canadian health-care system suffer no direct consequences as a result of poor customer service. They aren't even answerable to a regulatory agency, other than the federal government's vague powers to withhold funding for violations of the equally vague principles of the Canada Health Act. Other than notoriously ineffective channels of complaints to politicians, letters to the editor, and calls to open-line shows, dissatisfied consumers have little choice about dealing with the local health monopolist.

This absence of an effective mechanism for expressing and acting on poor service within Canada translates into two phenomena within the system, excessive waiting times and error tolerance. Canadians have shorter waits for car repairs and treatment of minor illnesses than treatment of major diseases. While the information that is available on this is poor and spotty, the studies we cited at the beginning of this paper give a clear indication that these problems are real and growing.

The other phenomenon is the emergence of various forms of black and grey markets for health-care services. This ranges from the ability of Canadians who can pay to travel outside the country to get the care they need, to the emergence of in-house medical services provided by employers (medical facilities that exist in the grey area on the margins of the Canada Health Act), to forms of queue-jumping including favoured public-sector agencies being able to push their clients into care more quickly. Indeed, the public sector finds ways to accelerate diagnostic and treatment services for preferred patients, and the general public is becoming impatient. A *Moncton Times & Transcript* article reported, "off-duty N.B. doctors and nurses are hired to operate on injured workers who jump waiting lists."²⁵ The author noted that the Workplace Health, Safety and Compensation Commission of New Brunswick, growing impatient with inappropriate waiting times, had found ways to reduce them for injured workers. Unfortunately, the New Brunswick government did not work out a way for all injured people to avoid improper waits.²⁶

The harm from a health-care monopoly is continuous and by no means limited to Canada. Before its 1990s internal-market reforms, the British National Health Service was a gridlock of perverse incentives.²⁷ The internal market, in an attempt to introduce some incentives, stimulated much innovation in primary care commissioning and practice improvement that led to increased efficiency. However, its effects were quite limited, because the essential conditions for a market to operate were not fulfilled. There now exists a crisis of confidence in the quality of care in the NHS. It is doubtful whether a culture of innovation, efficiency, and good customer service is possible in a public-sector monopoly whose services cannot satisfy basic demand.

²⁵ Priest, L. Hospital Reviewed Own MRI Practices - *Globe and Mail*, Page A7. December 21, 2000

²⁶ Frances, D., *Moncton Times Transcript*, For Rent: Medical Services. December 20, 2000

²⁷ Enthoven, .C., In pursuit of an improving national health service *Health Affairs*; Chevy Chase; May/June 2000; v19, 3, 102-119

A paradox: unresponsive monopoly, massive change

It has been said that the best of all monopoly rents is a quiet life.²⁸ Recent studies support the view that managers in near-monopolies have quieter, more-sheltered lives than those in highly competitive circumstances. Where there is greater competition, there is a larger turnover of management.²⁹

But Canadian health care is in turmoil, and providers have a tumultuous life. Politicians and health-care administrators in Canada have made their lives tumultuous by consistently restructuring and reorganizing, without changing the fundamental ways care is provided and without measuring the outcomes of their manoeuvres.

There is nothing surprising in this. Those responsible for the health-care system are caught between two painful realities. On the one hand, the public's growing mistrust and anguish at the dilapidated state of health care is palpable; health care is increasingly figuring as a major issue in federal and provincial elections, often to the detriment of governing parties. On the other hand, so little useful information is gathered about the effectiveness of the health-care system that reform efforts can never really amount to more than a superficial restructuring of the existing system. Efforts to reduce spending or to make resources go further are really little more than guesses about what might work, and are probably equally likely to do good, do harm, or have no effect at all. The truth is we have no way of knowing.

Reorganization in the absence of information is the last refuge of the scoundrel.

²⁸ Hicks, J. 1935. Annual survey of economic theory: The theory of monopoly. *Econometrica* 3 (January): 1-20.

²⁹ Fee, C.E., Hadlock, C.J. "Management turnover and product market competition: Empirical evidence from the U.S. newspaper industry" *The Journal of Business*. Chicago, v73: #2, 205-243. April 2000

IMPROVING QUALITY AND ACCOUNTABILITY

Government maintains responsibility not only for payment, governance, and administration of provincial health-care systems but also for the collection of information for evaluation. So, health insurance in Canada has all of the problems produced by unregulated monopolies. Fortunately, there are ways to improve our system.

There are two ways to curb monopoly power: (a) regulate the monopoly or (b) inject competition.³⁰

In Canada, provincial governments are the monopoly: they not only pay for necessary care, but also govern, administer, and evaluate the services they themselves provide. Self-regulation has not worked, as demonstrated by the lack of meaningful information about the effectiveness and efficiency of the Canadian health-care system.

Unbundling functions

To inject the needed degree of competition, while maintaining the valuable aspects of a single-payer health-insurance scheme, it is essential to unbundle the payment, administration, delivery, and evaluation functions. The key is to realize that saying that government should ensure that no one goes without medically necessary services is not the same thing as saying that only government should provide those services, and a recent report by a Senate committee chaired by Senator Michael Kirby seems to support this view.³¹ In fact, as we have argued, when government is the payer for and the provider, evaluator, and regulator of health-care services, service to the public suffers.

A proper separation of the payment from the service-provision function would allow provincial governments to set strict performance requirements (like appropriate waiting times for high-quality care) and put the actual services out to tender. Since the province would no longer be evaluating the performance of its own employees, but that of competing arm's-length providers, the cost of getting rid of poor performers is significantly reduced. Replacing an under-performing contractor is relatively straightforward. In addition, having many competing suppliers means having access to many different management and other techniques that can be tried in real-world conditions to see which offers the best

³⁰ "Tackling monopolies" *The Economist*, February 5, 1998

³¹ The Health of Canadians – The Federal Role Interim Report Volume Four – Issues and Options The Standing Senate Committee on Social Affairs, Science and Technology Chair: The Honourable Michael J.L. Kirby Deputy Chair: The Honourable Marjory LeBreton (September 2001) online:

<http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repintsep01-e.htm>

results. The costs of experimentation are much less than those of continuing to use inflexible and highly unionized public-sector monopoly providers.

To win contracts, competing suppliers would have to meet the performance level for access, results, as well as cost targets. The insurer would include the usual commercial penalties for non-performance in the contract. As Sweden, among other countries, has shown, this approach can result in significant cost savings and increased efficiencies while improving patient satisfaction.³²

If this approach works well in the provision of health-care services, there is little reason to think that it would not also work well in the area of gathering health-care information. A requirement that all institutional providers of health care gather appropriate information about their performance would open the door to competing information gatherers and analysts offering their services in a competitive marketplace requiring their services.

For the public to have confidence in such a system, some independent agency — perhaps the auditor general's office — could be given the job of vetting the accuracy of health-care-information reports. The agency could also set the guidelines for the minimum information that needs to be gathered to allow Canadians to form an accurate picture of the state of health-care provision and make meaningful comparisons of health-care providers. We are not advocating a new health-information bureaucracy to gather the information, but rather the identification, agreement, and adoption of data standards to support and encourage the collection and distribution of appropriate information about access, results, and cost. Existing suppliers of health care will provide some of that information, and some will be collected and distributed by private groups, such as health-care-information services seeking to make a profit, or by health-care-information co-operatives operating on a not-for-profit basis. A healthy degree of competition in the collection and distribution of health-care information, within some rules set by the auditor general to ensure some degree of harmonization and consumer confidence, seems to us a major improvement on the status quo.

We have limited faith in the current movement towards report cards, since health organizations are reporting on their own performance and generally saying that the care they provide is excellent. Indeed, current report cards, such as those reported by *Maclean's* magazine using information from the CIHI data monopoly,³³ are expensive but not necessarily useful and perhaps seriously misleading.

In Canada, governments have a monopoly on the provision of medically necessary services. As the sole purchasing agents for medically necessary services, they also have substantial power to set and sustain prices. Consequently, market forces do not work to increase supply when supply is scarce, so waiting

³² Hjertqvist, J. "The Purchaser-Provider Split: Swedish Health Care Reform — From Public Monopolies to Market Services" Online: www.aims.ca

³³ Marshall, R., *The Best Health Care*, *Maclean's*, 2000, June 5: 8-32

times increase for most, while wealthy and articulate people are able to get prompt care either by purchasing it in a foreign country or by persuading a Canadian provider to allow some form of queue-jumping.

Increasing competition by unbundling the insurance, governance, administration, health-services-delivery and 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 of performance, and consumers will be better informed about the costs and benefits of both their individual health-care choices and about the value they are getting for the billions of tax dollars being devoted to health care.

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