



DEFINITELY NOT THE ROMANOW REPORT:

ACHIEVING EQUITY, SUSTAINABILITY, ACCOUNTABILITY AND
CONSUMER EMPOWERMENT IN CANADIAN HEALTH CARE

AIMS' Report on Health Care Reform

BRIAN LEE CROWLEY
BRIAN FERGUSON
DAVID ZITNER
BRETT J. SKINNER

Foreword by Johan Hjertqvist

Preface by Rt. Hon. Don Mazankowski, PC, OC



December 2002

Atlantic Institute for Market Studies

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2000 Barrington Street, Suite 1006, Halifax, Nova Scotia B3J 3K1

Telephone: (902) 429-1143

Fax: (902) 425-1393

E-mail: aims@aims.ca

Web site: www.aims.ca

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The authors of this report have worked independently and are solely responsible for the views presented here. The opinions are not necessarily those of the Atlantic Institute for Market Studies, its directors, or supporters.

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ABOUT THE AUTHORS

Brian Lee Crowley is the founding President of the Atlantic Institute for Market Studies (AIMS). He holds a PhD in political economy from the London School of Economics and has been a member of the Editorial Board of the *Globe and Mail*, president of the Atlantic Provinces Economic Council, and professor at Dalhousie University. He was a negotiator of the Meech Lake Accord (representing Manitoba) and the Charlottetown Accord (representing Nova Scotia), has been a diplomat for the European Union, an aid administrator for the United Nations, an advisor on parliamentary and electoral reform for the province of Quebec, an intern at the House of Commons in Ottawa, and a Salvatori Fellow at the Heritage Foundation in Washington, DC. He is on the board of directors of numerous national and international organizations, including the Society for the Advancement of Excellence in Education, the Maine Public Policy Institute, and the Nigerian Institute for Economic Affairs

Brian S. Ferguson, PhD, is currently an Associate Professor in the Department of Economics at University of Guelph. Dr. Ferguson earned a BA at Mount Allison University, an MA at the University of Guelph, and a PhD from Australian National University. He has worked at Health Canada and taught at McMaster University in Hamilton, ON. He has also been visiting faculty at the Australian National University, a consultant economist to the Statistical Research section of the Addiction Research Foundation of Ontario, visiting researcher at the Kansas Health Institute and visitor at the department of economics, University of Kansas. He is the author, with G. C. Lim, of *Introduction to Dynamic Economic Models*, 1998, Manchester University Press.

David Zitner, MD, 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 the Federal/Provincial/Territorial Deputy Ministers of Health working group. Dr. Zitner is currently chair of the Utilization Committee at the QEII Health Sciences Centre and a board member of the Canadian Council for Health Services Accreditation.

Brett J. Skinner is a PhD candidate at the University of Western Ontario, where he studies public policy and Canadian politics and is a research intern at the Atlantic Institute for Market Studies. He earned a BA in Political Science and an MA, majoring in Public Policy and Public Administration, from the University of Windsor in Ontario and has also done graduate studies at Wayne State University in Michigan. His research specialty is health policy and administration.

FOREWORD

by Johan Hjertqvist, Swedish health care reformer

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 decentralise 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 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, 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.

The AIMS *Definitely Not the Romanow Report* contributes to this exchange of ideas and knowledge in a way that merits applause and congratulations. Focussed, 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: Do the 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 which is not unique to Canada but is common to the Western industrialised 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
The Timbro Health Policy Unit
Stockholm

Mr. Hjertqvist, the former deputy mayor of Tyreso, is an author and research director on the reform of social services in Sweden. He has acted as adviser to the Greater Stockholm Council on its health system and as a director of "Health in transition," a four-year pilot project whose objective is to describe and analyse the operation of a competitive market within the public system.

PREFACE

*by Rt. Hon. Don Mazankowski, PC, OC
former Deputy Prime Minister of Canada and
Chairman of the Alberta Premier's Advisory Council on Health*

The need to reform Canada's Health Care System has been uttered over and over as the inadequacies of the current system are debated across the land.

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 Canadian's expectations.

Some fundamental choices will need to be made if we are to assure all Canadians that their health system will be there to provide the best quality service in a fair, equitable and accessible manner when their health care needs arise.

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.

Don Mazankowski
Vegreville, Alberta

EXECUTIVE SUMMARY

Medicare is not sustainable in its present form. While overall health spending has been relatively stable recently, this has been accomplished chiefly through reductions in services, the closure of facilities, limits to the supply of health professionals, controls on the compensation paid to doctors and nurses, substituting waiting lines or “time-prices” 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 criteria like “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 already publicly rejected these arguments. In the face of Mr. Romanow’s already 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 Mr. Romanow has already indicated will inform his report.

In order to put the system on a sustainable course, the authors of the AIMS report, drawing on the research contained in the background papers, recommend:

- Rigorously separating 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 providers who can meet stringent tests of quality, accessibility and value for money.
- Encouraging the emergence of 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.

- Introducing a fee-for-service element into hospital funding formulas. Among other things, shifting to fee for service for the non-physician component of hospital-based services would, by putting those elements of a patient's treatment on the same footing as the physician's fee-for-service component of his treatment, facilitate the development of the sort of multi-specialty comprehensive clinics that many proposals for primary care reform envision.
- Incorporating 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 hospitals provide to their patients.
- Removing all quantity controls on health care professionals to increase their supply and reduce their market power.
- Involving Canadians in each province 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.
- Defining "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.
- Requiring 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.
- Establishing 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.
- Ensuring 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.
- Establishing 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. Provincial departments of health should then be held to the same standards as other insurers, including honouring their



commitments to make timely payment for insured services. Similarly, public or private institutions that contract with the department of health to provide insured services should be held accountable for their performance under their contracts.

- Creating a powerful, arm's-length health care information commissioner in each province, and possibly at the federal level as well, to: 1) set the regulatory requirements for the type of information that must be collected and publicly provided by all health care providers, public and private; 2) ensure that the information required is actually produced in a timely manner, under penalty for non-compliance; and 3) analyze and publish, on a regular, expeditious and comparable basis, the outcomes of care provided in all settings within the province. The federal commissioner would ensure that all information provided was nationally comparable and published. 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.

The report reviews some of the major criticisms levelled against these approaches to health care reform and offers detailed responses to these criticisms. The general conclusion is that, while there are limitations to what a private competitive market can accomplish in health care, it is also 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, and 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.

SECTION 1

BACKGROUND: WHY THE “DEFINITELY NOT THE ROMANOW REPORT”?

The Commission on the Future of Health Care in Canada (the Romanow Commission) is about to make its report to the Government of Canada. The sole Commissioner, former Saskatchewan Premier Roy Romanow, has, however, made no secret about the tenor of his report. Because the recommendations that Mr. Romanow has indicated he is preparing will do little or nothing to deal with the fundamental challenges that Canadian health care faces, the Atlantic Institute for Market Studies (AIMS) decided to create an alternative commission 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 this report do not believe that 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*.

In a report called *Definitely Not the Romanow Report*, our starting point is the inadequacy of what Commissioner Romanow plans to offer 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

News releases from the Commission and speeches given by Mr. Romanow show that he is complacent about the well-documented problems associated with medicare and will recommend not only retaining but even expanding the centrally planned, government monopoly model of health care in Canada.¹

In a speech to Canadian nurses in Toronto this past June, the Commissioner was quoted as saying that medicare was the right road to take nearly four decades ago and is still the right path. Mr. Romanow

¹ T. Arnold. 2002. Romanow wants more of the same: tells Harvard audience system is sound, but needs more money and warrants expansion. *National Post*. Thursday, October 17: A1.



also explained his view that the system was neither too costly nor grossly under-funded. However, in the same speech he also stated that the main problem with medicare is that it was designed for an era dominated by acute-care ailments treated in hospitals, and that Canadians want timely, quality care with equity and efficiency.² It is therefore, hard to agree with Mr. Romanow that the medicare model was, and still is, the right health policy for Canada when even its chief defender readily admits that it is outdated and fails to provide Canadians with timely, equitable access to quality care at an acceptable level of efficiency.

In other words, Mr. Romanow has rejected any analysis that might call into question the sustainability of medicare. Yet virtually all other major inquiries into health care, including the Kirby, Mazankowski and Fyke reports, place the sustainability of the health care system at the forefront of the challenges that we must face. This message was reinforced by Mr. Romanow's own former minister of finance in the Government of Saskatchewan, when she appeared to testify before his commission, and by former Quebec minister of health Claude Forget, who has written that we have created a "ludicrous situation whereby governments manifestly cannot cope with the increases in the costs of their present responsibilities and at the same time consider the feasibility of implementing new programs (such as long-term care and drugs)."

This complacency extends to Mr. Romanow's repeating the tired old mantra that Canada's health care system is superior to others at containing health care costs. But, as the background papers to our alternative commission show, the alleged superiority of the cost-containment ability of Canada's health care system is simply a myth. We have been lucky in the past, not better. Luck is something we cannot and should not count on.

Moreover, Mr. Romanow professes to find evidence of the sustainability of our health care system in the fact that we have been spending a fairly constant share of Canada's national wealth on publicly funded health care over the last 30 years. If a little more than seven per cent of GDP was sustainable in 1972, why, Mr. Romanow asks, is that same percentage unsustainable today?

The answer is that Mr. Romanow is asking the wrong question. The problem is not how much we are spending, but how we are paying for it and what we are getting in return. As is detailed later in this report, throughout much of the 1970s and 1980s we actually borrowed a great deal of the money we spent on health care (and many other public services), so that we consumed these services but were unwilling to pay the taxes to cover the costs. Today, however, not only are we paying the full cost out of cash flow (that is, out of taxes collected today), but we are also paying the interest on money we borrowed to pay for health care and other things in the past. So while spending has remained constant as a share of GDP, the tax burden needed to cover that spending has increased substantially while the quality of the system has declined.

² Mark Kennedy. 2002. Romanow: Few changes to medicare. *The Windsor Star*, Wednesday, June 26: A11.

Belief in a Command-and-Control Approach to Health Care

Mr. Romanow has made it clear that he believes the foundations of medicare are sound. But there is little evidence that he has really reflected on how much the world has changed since the days of the Hall Commission and the creation of medicare. For example, in those days, it was clear that people deferred to their doctors, who were the control point for access to medical services. People took their doctor's advice. Now people are indicating that the old doctor-patient relationship is dying, if not already dead. Doctors say that one of the biggest trends of recent years is patients showing up with print-outs from the Internet about their medical conditions and reams of documentation about appropriate treatments. Many people are seeing alternative medical practitioners as their primary caregivers, and these caregivers are frequently outside the medicare system altogether. According to a survey of health care consumers by The Change Foundation in Ontario:

One out of every two people appears to be a “responsibility-taker”, taking control of their health and actively searching out options. They believe that most of the responsibility lies with them. About half of respondents believe that, in general they have as much medical knowledge as physicians. About half (53%) agree that they are the prime decision makers on their own health and about half (48%) regard healthcare as offering a wide range of choices. These survey results point to a very empowered consumer who feels very able to make health care choices.³

Add to this the fact that technology is changing fundamentally the way we relate to medical practitioners. Virtually any kind of pharmaceutical product can now be purchased over the Internet from providers who are not in Canada and not subject to our government's controls. It is possible to have many kinds of diagnostic and other procedures carried out remotely, again by people who need not be in Canada. Your x-rays can be read just as easily by a radiologist in Boston or Bombay as by one in Toronto or Truro.

Just a few months ago, surgeons at Dalhousie University medical school operated on the brain of a patient in Saint John, New Brunswick. Nothing too exceptional there until you realise that the surgeons never left Halifax. They were in a specially equipped facility using video cameras and computer controls on robotic arms that actually carried out the surgery in real time hundreds of kilometres away. In a world in which 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, 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.

³ Julie Gilbert, Gale Murray, Ruth Corbin. 2001. *Consumerism and Healthcare in Ontario: Are Patients Becoming Consumers?* The Change Foundation. Online: www.changefoundation.com.



Indifference to Trade-Offs

Mr. Romanow has made it clear that he believes that health care is Canadians' number one priority and that it must take precedence over all other claims on the public purse and Canadians' incomes. But health care does not exist in isolation. Canada's fiscal burden remains relatively high at a time when most of the industrialized countries are struggling to reduce taxes and when our chief trading partner, the United States, is engaged in a major tax-cutting exercise. And the tax burden is clearly related to national prosperity. Ironically, wealth is a far better determinant of health than national tax-financed spending on health care, so that any trade-off between health spending and lost economic growth will likely damage, not improve, the health status of Canadians overall.

While it is often claimed by the supporters of the status quo that Canada's health care system is an economic competitive advantage, this claim is not supported by the evidence either, as shown in one of the background papers to this report (Ferguson 2002: *Consumer Issues in Health Care*).

Mr. Romanow has said that all of his proposals for health reform could be paid for by the projected federal surpluses recently announced by Ottawa.⁴ But this in itself is a very significant amount of money, some \$70 billion over the next five years.⁵ And there are many competing claims on this money, including reducing taxes to competitive levels, the renewal of our armed forces, replacement of a crumbling infrastructure, improved educational opportunities for our children, encouraging innovation, research and development and so forth.

Naiveté

Mr. Romanow has equated solving the problems of Canadian medicare with more spending, but has failed to establish that the system's problems actually flow from a lack of money. Moreover, in the teeth of contrary evidence of decades of intergovernmental transfers, he believes that it is possible to ensure that large federal transfers to the provinces can be made to flow into health care and not be drained off to other provincial priorities. He said "I believe Canadians are prepared to see more health spending, and if necessary pay more for health, if they can be assured that the money that is supposed to be for health is actually being spent on health, not lawn mowers, and that any additional money buys transformational change and delivers real improvements" (*The Globe and Mail*, November 9, 2002: A1). But the impossibility of attaching real conditions to federal transfers to the provinces in areas of provincial jurisdiction is well established. Any claim Mr. Romanow can make about forcing provinces to spend the money in accordance with federal priorities is just empty rhetoric.

⁴ *National Post*. 2002a. Romanow: surplus can cover my plan. November 7. Online: www.nationalpost.com.

⁵ *National Post*. 2002b. Hands off the surplus. November 2. Online: www.nationalpost.com.

Canadians and their governments have all too often had the experience of putting new money into the current system, only to see it swallowed up without a trace. This is one of the major reasons Ottawa has largely given up on the idea of making major long-term commitments to new funding for health care and is unlikely to change that stance significantly. Ottawa was too used to seeing the money disappear into the health system through increased administration costs, salaries and wages, with no increase in either the quality or the quantity of medical services. There are systemic reasons (which this report expands on later) that new money is unlikely to produce any different result today than it has in the past. Exhortations to do better with new money are just background noise in the absence of a real plan to tackle the wasteful features of the tax-financed public sector monopoly on health care provision.

Unfounded Suspicion of Private Sector Contributions to Health Care Provision

In his published statements and commentary during the hearings, it has become clear that Mr. Romanow is deeply suspicious of private sector participation in health care provision. Indeed, he greeted with enthusiasm one study purporting to show that private for-profit hospital care kills⁶ people, and has recently repeated the old canard that there is little evidence that private sector providers can add anything by way of efficiency and better access to needed health care services.

Yet, on a daily basis Canadians receive publicly insured primary health care services from physicians who are private business people. And drug therapies that improve the lives of many Canadians are manufactured and provided by private sector companies, as are x-ray machines and magnetic resonance imagers (MRIs). Hospital buildings (and even legislative buildings) are constructed by the private sector and the food served in hospitals to staff and patients is often produced and delivered by the private sector. Mr. Romanow seems to prefer to see health care totally and completely insured, delivered and administered by the same kind of monopoly that runs the post office.

The evidence reviewed in this report and its background papers shows that the private sector can and should be given more responsibility for health care provision. Not only would this allow private capital and techniques to flow into a system starved for investment and innovation, but it would also provide a way to introduce the competitive pressures that alone can lead to genuine improvements in the public health care system. No part of the system, public or private, should be able to consume scarce health care dollars without demonstrating that it is providing value for money. Only a competitive private sector presence within a properly regulated health care system can achieve these goals.

⁶P. J. Devereaux et al. 2002. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *CMAJ* 166: 11. Note that neither this study nor Mr. Romanow has commented on the cost in lives of publicly run health care in Canada through excessive queuing, yet the data we possess, though inadequate, now show there is every reason to believe that this is a serious problem. See *Waiting lists for health care: A necessary evil?* Richard F. Davies. *CMAJ* 160: 146; and William McArthur. Memo to Al Gore: Canadian medicine isn't cheap or effective. *The Wall Street Journal*, January 28, 2000.



Ideological Blinkers

Mr. Romanow has made much of the Canadian values he claims underpin the health care system, and has often re-affirmed his commitment to prevent the emergence of two-tiered health care. Yet, two-tiered health care is a slippery concept whose hold over the public imagination owes more to ideology than to analysis. Everybody seems to think he or she knows what it is but there is actually a lot more confusion about what it means than people realize. There are a lot of angry discussions about “preventing” two-tiered access in Canada, and yet we clearly already have multi-tier access today, including to insured services. 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 such as the Shouldice in Toronto, if you are a member of the medical professions or a medical administrator or know someone who is,⁷ if you are just articulate and determined, or if you have the taxi fare to Buffalo, Detroit or Seattle⁸ 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. Moreover, as technology allows the remote delivery of more and more health services, so the ability of government to frustrate patients’ desire to get better and faster treatment than the government is willing to provide will decline. The debate, therefore, is really about how many tiers and under what conditions. And some of these tiers, such as travel abroad or access to remote health services via the Internet and other technologies, are not amenable to government controls.

Note too the slipperiness of the concept of multiple tiers. For some people, multiple tiers are a concern for reasons of adequate access. If some 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 have multiple-tier concerns because they are committed to an ideology of egalitarianism. Thus, two people with similar conditions may both be treated — one quickly through private payment, the other slowly — but within appropriate norms for their condition, by medicare. The complaint that this generates is not about whether some people are denied medical care based on ability to pay, because anyone willing to wait in the system will eventually get care (although we possess no figures on the number of Canadians who die while queuing for public health care). Rather, the complaint is that someone got care more quickly, a very different objection based on the notion that no one should be able to get faster treatment than the public system provides, even where 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.

⁷ Tom Blackwell. 1998. Being “A Name” Expedites Care, *The Windsor Star*. October 1.

⁸ Sharon Kirkey. 1997. U.S. medical care for sale in Canada, *St. Catharines Standard*, July 21.

It is worth noting that Canada is almost alone in the Western world in outlawing private access, through payment, to services that are also publicly insured. One consequence of this is that while medicare pays for virtually all physician services, many other services, such as drugs, home care and long-term care that are insured in other countries are not covered in Canada. One way of looking at this situation is to say that, by denying people who wish to pay the ability to do so, we satisfy our ideological craving for egalitarianism at the cost of refusing 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. However, although we frequently hear it said that Canada has the best health care system in the world, neither the United Nations nor Canada's poor and elderly agree.

The World Health Organisation (WHO), in rating health systems around the world, ranked Canada 30th (well behind countries like top-rated France). Virtually all of the industrialized countries that ranked higher than Canada allow people to gain access to health services through private payment and have a mix of public and private suppliers of care, and many of them have population health indicators that are as good as or better than Canada's and spend less per capita on health care. According to the Associated Press article that reported these findings:

That doesn't mean the French and [second-ranked] Italians are the world's healthiest people. Japan actually won that distinction. Instead, the WHO report basically measures bang for the buck: comparing a population's health with how effectively governments spend their money on health, how well the public health system prevents illness instead of just treating it and how fairly the poor, minorities and other special populations are treated.⁹

A Harvard study comparing the WHO health care system rankings with the opinions of the population of each country found that Canadians' level of satisfaction with their system was 12th in the industrialized countries, again lagging behind a long list of countries with more formalized multi-tiered access and a broader range of services covered by public insurance. The poor and the elderly in this country both ranked Canada lower, at 14th.

In sum, 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. He clings to a system that outlaws private spending on publicly insured services, usually on the basis that parallel systems of care rob the public system of resources, 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, high levels of care overall, high levels of patient satisfaction and public health outcomes as good as or better than

⁹ Article available at <http://lists.isb.sdnpk.org/pipermail/health-list/2000-June/000010.html>



Canada's. An evidence-based debate on the future of Canadian health care would seek to move beyond these unhelpful categories of public or private, single-tier or multi-tier to focus on ensuring that all Canadians get access to the best quality health care possible.

Inadequate Provision of Information on System Performance

One area where Mr. Romanow has made more constructive comments has to do with information about health care system performance, but even here his commitment to maintaining the current structure of medicare with only minor reforms means that he will not and cannot get the information he seeks.

As background papers for this report document, 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 opinions, we know almost nothing about the outcomes the health care system produces for Canadians. For example, no one in authority in any Canadian jurisdiction can reliably say how many people were made better, how many were made worse and how many were left unaffected by their contact with the health care system. We have little hard data about waiting times, although there is lots of anecdotal evidence that they are getting longer.

Recognizing that capturing and processing needed information about the health care system is vital to its sound management, Mr. Romanow will likely recommend the creation of an arm's-length health information commissioner.

Once again, Mr. Romanow is demonstrating his unwillingness to confront the systemic sources of the flaws in the system. We do not lack good information about the health care system and the outcomes it produces for Canadians merely because we have not had a health care information czar to demand it. We lack it because governments are in a conflict of interest where health care information is concerned. Good-quality information can be used to evaluate the performance of the system; poor performance will attract unfavourable media comment and political criticism. As long as the people who are running the health care system are the same ones who are collecting the information that is used to evaluate their performance, they are in a conflict of interest. Not even the creation of the Canadian Institute for Health Information, which got \$190 million from taxpayers and causes the average large hospital to spend over \$1 million to collect data, has done much to close the health information gap because it is controlled by the same public authorities who would be held accountable by good quality data.

In any case, unless health care consumers are given a broad range of competing choices about where to obtain medical care, of what use is good information about the performance of various parts of the system? Without consequences, there cannot be genuine accountability. Until Mr. Romanow is willing to address the problems created by a public sector health care monopoly, cosmetic changes such as the creation of a health care information commissioner would add to costs but do little to improve system performance.

The model Mr. Romanow proposes 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. Although Mr. Romanow suggests that more money is the answer, the empirical evidence is lacking to show how additional health care spending has ever had a sustainable long-term impact or improved the overall functioning of our health care system. Even though governments pour more and more money into their health care services, they never report how these additional funds have changed overall access to care or improved the health results in their communities. Indeed, they have avoided providing this very information while agreeing, for the last eight years at least, that such information is necessary.

Mr. Romanow's recommendations do not deserve the support of governments or of Canadians unless he is willing to state in advance what the stringent tests will be of his prescriptions' success or failure. What individuals and communities will be helped by the new experiment he is proposing in additional health care funding and new rules on the uses provinces may make of federal transfers? The people around the Commission speak a lot about evidence-based policy making, but what undertakings are they willing to make about the specific improvements their recommendations should be expected to make, and how will Canadians know if those promises have been kept? In other words, what will they offer as evidence of the success or failure of their own prescriptions?

There are other reasons to expect that the Romanow report will contain misguided conclusions and recommendations. The background papers to the AIMS report suggest that much of the research Mr. Romanow is drawing from is based on assumptions that are not supported by the literature on health policy, by careful analysis, or by empirical study. Admittedly, some of the papers the Commission has released do contain sound ideas,¹⁰ but it is indicative of the direction the Commission is taking that it does not refer to many of these studies in its communications. Apparently, findings that challenge Mr. Romanow's unwavering belief in the government monopoly model of health care are discounted.

For this reason, AIMS commissioned its own report on the future of health care in Canada. Our report is based on a collection of papers that address the key issues in the debate over health policy. The findings directly challenge many of the fundamental assumptions that will inform the Romanow report. These assumptions include miscalculations about sustainability; misunderstandings about the nature of the economics of health care; mischaracterizations about the state of the literature on private involvement in the provision of health services and reform experiences in other countries; and the misrepresentation of other key reform ideas, including user fees, Medical Savings Accounts (MSAs) and revisions to traditional understandings of Canadian health care principles, such as comprehensiveness.

¹⁰ See Jean-Luc Migué. 2002. *Funding and Production of Health Services: Outlook and Potential Solutions*. The Fraser Institute. Commission on the Future of Health Care in Canada Discussion Paper 10.



SECTION 2

THE SUSTAINABILITY ISSUE

Ultimately, sustainability is the issue that drives efforts at reform, so the debate over sustainability seems like an appropriate place to show immediately the divergence between the apparent direction of the Romanow report and our own analysis of health reform.

Sustainability is unavoidably a trade-off between levels of service and the availability of funds. There are limits to taxation, limits to spending and, therefore, limits to the quantity and quality of health services in a publicly funded health care system. Sustainability should naturally be defined in terms of whether Canadians can afford the costs associated with present and future demands for health services under the current medicare model. If resources are limited, and there are many other legitimate competing claims for the money and resources health care consumes, how can we be sure that Canadians are getting the health care they want and are willing to pay for without unnecessarily sacrificing other values they also hold as important?

Defining the Concept of Sustainability

The papers dealing with sustainability that the Romanow Commission has released and that have attracted the widest media attention appear to be complacent about or dismissive of the issue. Some of this research attempts to re-conceptualize or redefine the notion of sustainability. According to one view, service reductions or rationing are the product of an inappropriate concern with public budget deficits, debts and taxes. Instead, these researchers argue, the definition of sustainability needs to be broadened to include a concern for the viability of not just the financial resources but also the organizational and intellectual capacities of the health care system, because “organizational and epistemic capacities are necessary to ensure the sustainability of the health system.”¹¹ Of course, many of these same authors also recognize that economic development, education and other activities also contribute to health status, so spending increasing amounts on health care will hamper the ability to maintain good health if such spending causes the community to forgo economic growth.

¹¹Louis M. Imbeau et al. 2002. *The Conditions for a Sustainable Public Health System* in Canada. Commission on the Future of Health Care in Canada Discussion Paper 11. Imbeau et al. say, “While necessary, sound management of the health system’s financial resources is not enough to ensure its sustainability. Canada’s fiscal situation over the past decade has led us to focus on financial resources. In doing so we have often lost sight of the system’s organizational and epistemic capacities. Only integrated management of all of the health system’s capacities can shield us from pernicious, intolerable effects. Any change in financial management must be assessed on the basis of its impacts on the system’s organizational and epistemic capacities.” (21).

In our view, such a broad concept of sustainability runs the risk of diminishing the critical importance of viable funding for health care in Canada. While the organizational and epistemic capacities of the health system may be important, they also depend entirely on having enough money to provide the facilities, equipment and human resources that are the integral parts of health system organization and the source of its intellectual capacity.

Other papers released by the Commission seem to agree with our definition of sustainability but deny that medicare's financial picture is as serious as its critics suggest. These papers argue that the trend toward increases in expenditures over the last few years is a response to "pent-up" demand caused by earlier spending restraint and that, in fact, current provincial spending on health care is at the same level it would have been had there been no cutbacks in the 1990s and had spending remained at inflation-adjusted 1992 levels. And while provincial spending on health care, measured as a percentage of provincial budgets, has grown, it has been as a result of the reduction in levels of federal transfers. Therefore, the argument goes, "health care is crowding out the provision of other public goods...In this sense, the fiscal sustainability of health care expenditures is a very real problem *from the provincial perspective*. It is *not*, however, indicative of the unsustainability of the overall fiscal burden of health care relative to the overall ability of Canadian governments to bear this burden."¹² In addition, these papers argue, long-term doubts about sustainability can be taken seriously only if costs are greater than those associated with an aging population and moderate increases for existing services, or revenues are lower:

"the sustainability of the overall fiscal burden of health care relative to the ability of government (as opposed to individual governments) to bear that burden is not in question. However, in the longer term, the fiscal sustainability of public health care in Canada becomes a serious issue under two scenarios: rapidly accelerating health care costs or the erosion of current provincial fiscal efforts or ability of provincial governments to maintain this level of fiscal effort. In the absence of cost acceleration, other cost drivers such as aging will not increase the burden of the health system relative to the economy in the foreseeable future."¹³

Our analysis of the data on sustainability leads to significantly different conclusions. The reason both levels of government reduced spending is that budget deficits and accumulated debts limited their ability to cover the costs of social spending. Federal reductions in transfers were deemed necessary to balance the budget and to hold the line or moderately reduce tax burdens. The tax burden rose to give both levels of government the means to combat the deficit and, now that a more balanced fiscal situation has been achieved, it is quite appropriate that governments look at ways to reduce the tax burden to more normal levels while seeking to respond to a wide range of public needs.

¹² Gerard W. Boychuk. 2002. *The Changing Political and Economic Environment of Health Care in Canada*. Commission on the Future of Health Care in Canada Discussion Paper 1: 5.

¹³ Boychuk 2002: 7.



Now that Canada has moved into an era of surpluses, there are many competing claims on the extra money, and health will get, at best, only a fraction of it. Therefore, in the absence of better-than-average economic growth, it is highly unlikely that federal transfers can be raised to previous levels without risking deficits and tax increases again. And Finance Minister John Manley has already ruled out deficit financing or new taxes. Ottawa will not easily sacrifice its hard-won fiscal victories, nor should it.

Sustainability and an Aging Population

It is also important to realize the heavily skewed nature of health care utilization related to age. Most health care spending occurs after age 65 — more than 50 per cent of per capita lifetime expenditures on health care, in fact.¹⁴ Statistics Canada data from 2001¹⁵ indicate that the median age of Canada's population reached an all-time high of 37.6 years, an increase of 2.3 years from 35.3 in 1996 and the largest increase in a century. Furthermore, the birth rate is declining and the population is growing at a record low rate. As the proportion of the population over age 65 grows larger, demands for health services will drastically increase. Meanwhile, the size of the working age population that pays for everyone's health care services is expected to decline. The data show that:

“Seniors aged 65 or over accounted for 13% of the nation's population in 2001, up from almost 12% in 1991. Projections indicate this proportion will reach 15% by 2011. At the other end of the age spectrum, 26% of the population was aged 19 or younger, down from 28% in 1991. If fertility remains low, this could fall to less than 23% by 2011... The population aged 45 to 64 increased 36% between 1991 and 2001, due to entry of the baby boomers into this group. As a result, Canada's working-age population has become more dominated by older individuals.”¹⁶

Population aging has been a concern for some time, and most analysts now argue that earlier estimates suggesting that dramatic cost increases would follow from population aging were exaggerated. Still, we can be fairly sure that current, rather more optimistic estimates will fall short of the true effect on health care costs for a number of reasons.

For example, analysts have consistently underestimated long-term increases in health care costs so it seems reasonable to assume that current projections will do the same. Looking at the evidence from the rest of the world, we see that, although many countries with older populations than Canada have lower costs than ours, older populations can also be costly to care for. Many health maintenance organizations

¹⁴ Glenn G. Brimacombe et al. 2001. *The Future Cost of Health Care in Canada, 2000-2020: Balancing Affordability and Sustainability*.” Conference Board of Canada.

¹⁵ Statistics Canada. 2001. Profile of the Canadian population by age and sex: Canada ages. Census Analysis Series (CAS 2001) Cat. 96F0030XIE2001002.

¹⁶ CAS 2001: 3.

(HMOs) in the United States have got into serious financial trouble from underestimating what it costs to treat an older population. In Japan, where much health care is financed out of regional taxes, differences in population age structure translate into significant differences in tax burdens across regions.

Until recently, most projections of the cost effects of population aging have assumed that service rates and intensities would remain unchanged into the future. In fact, among the elderly, they have been increasing rapidly in most countries and can be expected to continue to increase, especially as the baby boom generation ages. Technological advances play a role here, making surgical and other treatments an option for many older people than was the case two decades ago. It may sound paradoxical, but as the older age groups become healthier, they also become better able to withstand invasive procedures, meaning that a healthy older population may actually have higher health care costs than a less healthy one. And in any case, all of us eventually get sick and want treatment to provide comfort and increase function, and perhaps even sustain our life.

Moreover, much of the care an older population demands will be labour intensive. To take a simple example, it tends to take older patients longer than younger ones to recover from surgery. The extra care provided in those extra days tends to be labour, rather than capital, intensive. Older people are more likely to want hospital-at-home care, which tends to involve what economists call a “high labour-to-capital ratio.” This is significant because of a proposition established many years ago by economist William Baumol, which holds that technological advance occurs more slowly in labour-intensive sectors than it does in capital-intensive ones, which means that costs rise faster in labour-intensive sectors.

Baumol’s thesis is implicit in the argument, heard increasingly often, that hospital-at-home care places heavy time demands on the family. The policy implication typically drawn is that families need government assistance to enable them to support this burden. Such assistance would replace family labour with hired labour, but the care would still be labour intensive. As the population ages, the demand for hospital-at-home labour will increase, which will inevitably drive up the wages earned by this group of workers. Even when the care is restricted to nursing care, and does not include home help care, the fact that this care is intensive in the use of skilled labour will make it expensive.

Sustainability and Population Movement

Population movement will also increase pressure on the health care system. As Canadians become increasingly concentrated in a few large urban areas, we can expect costs to increase in those areas. This would not be a problem if cost increases were balanced by cost reductions in areas experiencing out-migration, but they are not. Residents of parts of the country that are losing population are becoming increasingly vocal in demanding that, for example, their local hospital not close. Keeping these hospitals open is not cheap; they tend to operate at output levels associated with high unit costs of production. To the extent that governments accede to these demands, cost per unit of care will tend to increase.



Sustainability and Technological Change

Technology will also continue to be a cost-increasing factor. It has often been noted that the health care sector is one of the very few in which technological advances tend to be cost increasing rather than cost saving. While unusual, this is not inexplicable. For decades both Canada and the United States paid for health care the way, as one observer put it, the Pentagon pays for screwdrivers — on a cost-plus basis. This was the pattern in both public and private insurance plans. It meant that, unlike other sectors where finding a less costly way of doing things gave a supplier a competitive edge, there was no great reward for cost-saving innovations in health care. The reward structure more often favoured finding ways to do things nobody had been able to do before. For a long time, research into health care technology focussed on expanding the scope of what could be done rather than on reducing the cost of what was already being done. Most industries have a more balanced mix of the two types of innovative activity. While this focus translated into improved health outcomes in a wide range of areas, it created a tendency to settle for halfway technologies, and meant that the trend to long-term reduction in costs of production present in most sectors was much weaker in the health care sector. In recent years, concern with budget constraints has turned attention toward the development of cost-reducing technologies, but there is a lot of catching up to be done, including in the creation of appropriate infrastructure to support communication and the collection and use of health information.

Other papers released by the Romanow Commission recognize that the introduction of new technologies in health care will drive increasing demand for these expensive services. This is expected to heavily influence health care costs overall.¹⁷ In fact, the Interim Report of the Provincial and Territorial Ministers of Health (2000) conservatively projects annual average cost increases of almost five per cent over the next 27 years. These projections do not even include the effect of new technologies, increased quality and access expectations, information technologies and labour costs, which the report treats as cost accelerators, not merely cost drivers.¹⁸ Actual growth rates in 2000 and 2001 were even higher than that: 7.1 per cent and 6.9 per cent, respectively.¹⁹ Although recent figures show a slower rate of increase in the past year, there is little reason to think this is representative of what lies ahead.

More Money is Not the Solution

Growth in health expenditures is predicted to outpace population growth by a substantial margin. Between 2000 and 2026, Canadian health expenditures are projected to grow by 247 per cent while the

¹⁷ Steve Morgan and Jeremiah Hurley. 2002. *Influences on the Health Care Technology Cost-Driver*. Commission on the Future of Health Care in Canada Discussion Paper 14.

¹⁸ The Interim Report of the Provincial and Territorial Ministers of Health. 2000. *Understanding Canada's Health Care Costs*.

¹⁹ Canadian Institute for Health Information (CIHI). 2001. Total health care spending surpasses \$100 billion, reports CIHI. News release. CIHI Website. December 18.

population will grow only 19 per cent. The annual expenditure growth is also expected to exceed annual economic growth.²⁰ At rates such as these, the \$5 billion of new money that Senator Michael Kirby's recent report recommends be injected annually into health care via a new health care premium would quickly be swallowed up by annual increases, meaning that even significant new amounts of money (in absolute terms) will only serve to put off the day when Canadians have to confront the unsustainability of the way medicare is organized. The federal government's much-vaunted \$11.5 billion cash injection into the health care system before the last election represented a mere three per cent annual increase over five years, well below the pace at which costs traditionally rise within the health care system.

What this means for health care is that, as the baby boomers age, costs will become unsustainable at current levels of taxation and economic growth. So, although much of the Romanow Commission's research seems to remain complacent about sustainability, the evidence we have found indicates that aging and other factors will raise expenditures beyond current levels. In our opinion, the sustainability issue cannot simply be dismissed. All reasonable projections show that health care costs will increase and that government sources of revenue are not expected to keep up.

To drive home this point, William Robson, in a paper for the C.D. Howe Institute,²¹ compares current spending levels, projected into the future, with projections taking into account a number of reasonable assumptions about rising costs, driven by demographics, technological change and assumptions about growth in the economy. The most conservative projection shows the medicare system with an unfunded liability of \$500 billion over the next three to four decades — an amount equivalent to roughly the current national debt. If Robson's worst set of assumptions were realised, the unfunded liability would be \$1.2 trillion. This is the amount by which taxes would have to rise (over and above the increases in revenues generated by normal economic growth at current tax rates) in order to finance the current unreformed system.

But even if Mr. Romanow is right that all the system needs is more federal cash and a few superficial reforms, there are few if any signs that we can expect the federal government to make significant increases to its funding of health care.²² In the debate over reform, policy makers must address the ability of medicare to sustain projected cost increases without resorting to reductions in access to timely, quality health care services. Unfortunately, the early signs are that Mr. Romanow prefers to consume the entire predicted federal surplus and raise taxes to boot, in order to fund the future costs of health care in Canada instead of considering fundamental reforms to the system itself.²³

²⁰ CIHI 2001: 31.

²¹ C. D. Howe Institute. 2001. *Will the Baby Boomers Bust the Health Budget? Demographic Change and Health Care Financing Reform*. Commentary 148: February.

²² Vernon Clement Jones. 2002. Doctors disappointed by Manley's views. *The Globe and Mail* Wednesday, August 21: online edition.

²³ Brian Laghi. 2002. Romanow supports medicare tax boost. *The Globe and Mail* Thursday, June 27: A10.



Rationing

Recent decisions by governments of all political persuasion to rein in spending and reduce taxes indicate that policy makers realize the limits of existing revenue sources and are increasingly willing to use rationing to sustain the façade of a comprehensive, universal health care system. This use of rationing is making itself conspicuous in the lengthening waiting times for access to health services in Canada. Although the available empirical information is inadequate, a recent estimate of waiting times shows that they have increased on the whole by 69 per cent since 1993. In 1999, the national average waiting time to see a specialist was 13.11 weeks. By 2000/2001, this wait had increased to 16.2 weeks.²⁴ The Canadian Institute for Health Information (CIHI) received \$190 million to report on the state of health and health care in Canada, yet information about waiting times across the full range of services and in each province is noticeable by its absence. CIHI chair Michael Dexter has repeatedly remarked that we need information about access and results, yet this has not been forthcoming. Incidentally, in 1994 the Federal/Provincial/Territorial Deputy Ministers unanimously committed to make public information available about access to care and the results of care as change is implemented. Little has come of this commitment.

Even ardent supporters of medicare acknowledge the growing public dissatisfaction with longer waits for access to health services. Yet there remains a reluctance to admit that the problems are the result of the medicare model of health care finance and delivery. One paper submitted to the Romanow Commission recommended that the problem be addressed by amending the Canada Health Act (CHA) to guarantee “reasonable access” to health care for all Canadians.²⁵ It is hard to see how adding a few words to the legislation will reduce waiting lines or generate the funds to fulfill the promise. How would the federal government enforce such an amendment? How could the provinces be forced to spend more to ensure adequate staffing, equipment and facilities in order to reduce waiting times? Which level of government would be accountable to taxpayers for this decision? Would the amendment attempt to coerce doctors and nurses into working 16 hours a day? (In Quebec, doctors are now being forced to serve a certain number of hours each week in emergency services in rural areas.) What would happen to quality of care under those circumstances?

Cost Control

Our own research suggests that Canadians were lulled into a false sense of confidence in our health care system by exceptional economic circumstances during the years when medicare was first introduced. What looked like superior cost control in Canada versus the United States was merely superior eco-

²⁴ Fraser Institute. 2001. *Waiting Your Turn (11th Edition): Hospital Waiting Lists in Canada*.

²⁵ Ingrid Peritz. 2002. Guarantee fast health care, study urges. *The Globe and Mail* Thursday, August 15, 2002: A1. The article refers to Colleen Flood and Sujit Choudry. 2002. *Strengthening the Foundations: Modernizing the Canada Health Act*. Commission on the Future of Health Care in Canada Discussion Paper 13.

conomic growth in Canada, a circumstance on which we cannot depend. In fact, if we had had US levels of economic growth during that period but had kept the same spending levels, we would quickly have had the most expensive health care system in the world, bar none.

Similarly, with respect to our ability to pay, surely it is important to underline that when we were borrowing eight or nine per cent of GDP to finance public services, we were spending the same share of GDP on health care as we are today except that now we pay it out of “cash flow” (rather than borrowing) and we have to pay the interest on the debt to boot. Another pertinent issue is the fact that when medicare was introduced, the infrastructure existed and had been paid for. Since then, the system has been starved of capital investment. For example, failure to invest in appropriate health system infrastructure, many believe, is one reason that health services administration is so poor and health system error unacceptably high.²⁶

At medicare’s outset, doctors, hospitals and others had a modern (for the day) infrastructure but professional fees and hospital budgets did not include adequate infrastructure and capital investment components, so clinicians and the system did not invest in the infrastructure needed for modern care. At a time when information technology is transforming industry after industry, information about patients in the Canadian health care system is still written on pieces of paper and passed around by snail mail. Airlines and hotels can tell you with astounding accuracy how many seats or beds they have booked months in advance. Canadian hospitals have enormous difficulties tracking beds or patients.

Shortages of Personnel

The Romanow Commission research largely ignores the issue of shortages among health professionals under medicare. The health care system cannot possibly sustain timely, quality access to services without sufficient numbers of doctors, nurses and technologists to provide the necessary specialized care. The data show that Canada has one of the lowest doctor-to-population ratios among OECD countries.²⁷ Migration statistics continue to show significant net losses of highly qualified health professionals from Canada due to dramatically better compensation and working conditions in the United States.²⁸ The problem is made worse by government decisions to limit medical school enrolments, in

²⁶ A. Vass. 2001. Emergency cancer patients receive poor care *BMJ* 323 (8 December): 1323; P.G. Norton, E. V. Dunn and L. Soberman. 1997. What factors affect quality of care? Using the peer assessment program in Ontario family practices. *Canadian Family Physician* 43 (October): 1739-44; Hermann K. Wolf, Andreou Pantelis, R. Bata Ibal et. al. 1999. Trends in the prevalence and treatment of hypertension in Halifax County from 1985 to 1995. *CMAJ* 161: 6.

²⁷ Michael Walker and Nadeem Esmail. 2002. *How Good is Canadian Health Care? An International Comparison of Health Care Systems*. Fraser Institute.

²⁸ Brett J. Skinner. 2002 *Medicare, the Medical Brain Drain and Human Resource Shortages in Health Care*. AIMS.



the mistaken belief that physicians induce unnecessary demands for their services.²⁹ In reality, the policy has reduced costs by reducing access, not by controlling the effect of physician-induced demand.³⁰ So the question of sustainability must also address the issue of human resources in health care, and do so by avoiding the ugly coercive measures the Quebec government is taking in its attempt to force the redistribution of physicians to sparsely populated and under-serviced areas.³¹ This strategy is likely to succeed only in further exacerbating the medical brain drain in Canada or in discouraging enrolment in medical schools altogether.

So what is to be done about the future of Canadian health care?

²⁹ M. Barer and G. Stoddart. 1991. *Toward Integrated Medical Resource Policies for Canada*. Report to the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.

³⁰ Brian Ferguson. 2002. *Consumer Issues in Health Care*. AIMS.

³¹ Andre Picard. 2002. Doctors on war footing over Quebec moves. *The Globe and Mail* Thursday, August 22: A9.

SECTION 3

DIAGNOSIS OF THE CURRENT SYSTEM³²

The place to begin our alternative prescription for Canada's health care system is with our diagnosis of that system's ills. The underlying problem with the system is that it operates essentially as an unregulated, tax-financed, pay-as-you-go monopoly, which means that:

- all spending is regarded as a cost, resulting in counterproductive policies such as restricting the supply of trained health care professionals, an environment unfriendly to innovation in one of the world's most dynamic industries, an inability to make needed investments, and reduced opportunities for a vibrant health care industry;
- most spending is negotiated behind closed doors with powerful provider groups and with little input from users of the system;
- the regulatory and oversight function government should play is frustrated by its conflict of interest as the ultimate provider of many health care services;
- users of the system have relatively few choices and there are few incentives for them to be well served or for them to economize on their use of health services;
- health care administrators are constantly second-guessed by senior officials, undermining management authority and accountability;
- no reserves are being accumulated against foreseeable future demands on the system; and
- there is no logical connection between government's role as insurer of health care and guarantor of health care quality on the one hand, and its current role as health care provider on the other, and there is little evidence that a public sector monopoly provider is as effective or efficient in its use of scarce resources as a system of competitive providers under appropriate regulation.

³² Readers familiar with the report of Alberta's Mazankowski Committee will recognize much of what follows. One of the authors of the present report was a member of the Mazankowski Committee.



The Shape of the Alternative Approach

If this analysis is correct, then the prescriptions Mr. Romanow has been shopping around will do nothing to correct the flaws in Canada's health care system. Yet, if we take Mr. Romanow's advice, we will put off for perhaps another decade the need to come to terms with the reforms that could actually put the system on a sustainable basis. In the meantime, many more people will suffer from unjustifiable waits for needed health services, we will lose more health professionals to other countries, the buildings, machinery, information technology and other aspects of the capital stock of the system will continue to decline, and Canadians will grow increasingly restive under the system's prohibition against seeking services outside medicare.

In brief, here is what the alternative should look like:

- The functions of insurer, provider and evaluator of health care should be rigorously separated.
- Users of health care should be made powerful actors within the system by giving them more choices and more control over and accountability for at least some share of the health care spending they trigger.
- Providers of health care should be given more autonomy and responsibility, but in turn be held more accountable for results, meaning that there should be more competition among providers for the health care dollars controlled by their patients and more and better quality information gathered on quality and results of the health care system.
- Public resources should be concentrated on health services that confer the greatest public benefits and where individuals are least likely to be able to obtain appropriate and cost-effective insurance on an equitable basis.
- Contracting out and privatization should be used to introduce autonomy and accountability where appropriate, as well as to stimulate private investment and reward innovation in all aspects of health care, including in treatments, administration, timeliness and quality. If the Swedish experience is any guide, one of the benefits of this would be more job satisfaction and higher wages for many types of health system employees, whose options are limited by the artificially restricted number of employers under the current model.³³
- Governments should focus their efforts on ensuring that no one suffers economic hardship to obtain needed medical care, that access to care is equitable and that maximum information is made available on the performance of the health care system and its various components.

³³ Johan Hjertqvist. 2002. *In Sweden, Employees are Taking Over Health Care*. AIMS online: www.aims.ca.

- New ways must be found to encourage both individuals and non-governmental insurers of health services to invest more resources in health care, and to do so in a way that sets aside reserves against future demand and does not penalize low-income Canadians.

The model we lay out here involves more participation by private providers and more competition among all providers as a strategy for breaking down the unattractive features of monopoly. Why should we think that this is a superior solution to Mr. Romanow's recommendations and how can it be made to work concretely?

The Conflict of Interest at the Heart of Medicare

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 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 (which providers are generally allowed to exceed) on hygiene, freshness and quality of raw materials, working conditions, use of therapeutic agents, pesticides and many other factors. They require the keeping of meticulous records and are able to respond to problems with large quantities of up-to-date and comprehensive information supplied by farmers, ranchers, veterinarians and others. They require manufacturers to disclose ingredients, best-before dates and, in some cases, dates on which the products were packaged for sale to the public.

But when governments regulate themselves and their provision of health care services, the picture is radically different. Government health authorities, for instance, have failed to set standards for appropriate waiting times. No one knows how long the health care system thinks people should wait for particular treatments, so no one can be held accountable for failing to meet the standard. And in any case, most publicly financed health organizations are not required to disclose pertinent information about access and results — not that it would do any good today to require them to do so, since they do not collect such information to begin with.

The conflict of interest in which governments find themselves as both the insurers and providers of health care is best summed up by the different ways the provinces regulate private providers of other kinds of insurance (auto, life, home) and the way they regulate themselves as monopoly providers of health insurance. (For details of the ways governments let themselves off lightly, while demanding very high standards of performance from private insurers, consult David Zitner's background paper for this report, entitled *Canadian Health Care Insurance: An Unregulated Monopoly*.)



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.

There are two ways to curb monopoly power: (a) inject competition; or (b) regulate the monopoly. These are not mutually exclusive.

In Canada, provincial governments are the monopoly. Provincial governments not only pay for necessary care but also govern, administer and evaluate the services they provide. They define what constitutes “medically necessary services” and then pay for virtually all such services provided in Canada. They forbid the provision of private insurance for these services. They negotiate payment schedules with the powerful provider groups. They often set the budgets for nominally private health care institutions, appoint the majority of their board members and have the explicit or implicit power to override management decisions. Anyone who doubts that provincial governments consider themselves, and are considered by the electorate to be, the governing mind behind the entire health care system failed to observe the last Manitoba provincial election. In that campaign, the quality of toast in hospitals was a major election issue, it was clear that the parties thought that they could and should be able to affect this matter, and the electorate thought that this was a credible claim.

What Monopoly Means in the Health Care Sector

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 service administrators must relate health services activities to 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 interaction between patients and the system, 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 is available about an organization’s success in meeting its goals, the people administering the organization can be held accountable. Successes can be rewarded, failures overcome and health care consumers and citizens can make informed personal and political choices.

As with 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 was common even though politicians, answerable to voters, had a theoretical hand on the tiller through 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 are not 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 CHA. Other than notoriously ineffective channels of complaints to politicians, letters to the editor and calls to talk radio shows, dissatisfied consumers have little choice but to deal with the local health monopolist.

Another phenomenon is the emergence of various markets for health care services outside medicare. They include the ability of wealthier Canadians to travel outside the country to get the care they need, the emergence of in-house medical services provided by employers in medical facilities that exist on the margins of the CHA and forms of queue-jumping that include the ability of favoured public-sector agencies to push their clients into care more quickly. Indeed, the public sector finds ways to accelerate diagnostic and treatment services for preferred patients to the point that the general public is becoming impatient. A *Moncton Times & Transcript* article reported that, “off-duty N.B. doctors and nurses are hired to operate on injured workers who jump waiting lists.” The author noted that the Workplace Health, Safety and Compensation Commission of New Brunswick, growing impatient with excessive 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.³⁴ Yet despite what critics say, these alternatives to medicare have not endangered the health care system but instead have provided extra revenue to at least some parts of it.

³⁴ D. Frances. 2000. For rent: medical devices. *Moncton Times-Transcript* December 20.



The harm from a health care monopoly is continuous and by no means limited to Canada. Before its internal market reforms in the 1990s, the British National Health Service (NHS) was a gridlock of perverse incentives.³⁵ 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.

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 functions of payment, administration, delivery and evaluation. 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. In fact, when government is payer, provider, evaluator and regulator of health care services, service to the public suffers.

A proper separation of the payment function from the service provision function would allow provincial governments to set strict performance requirements (such as appropriate waiting times for high-quality care) and put services out to tender. Since the provinces would no longer be evaluating the performance of their own institutions but that of competing arm's-length providers, the cost of eliminating poor performers would be significantly reduced. Replacing an under-performing contractor would be relatively straightforward. And having many competing suppliers would mean having access to many different management and other techniques that could be tried in real-world conditions to see which offered the best results. Furthermore, it would be much less expensive to experiment with different health care delivery systems under such a scheme than is now the case with inflexible and highly unionized public sector monopoly providers.

To win contracts, bidders would have to undertake to meet performance levels for access and results, as well as cost targets. The insurer would include the usual commercial penalties for non-performance in the contract. As experience in Sweden and other countries has shown, this approach could result in significant cost savings and increased efficiencies while improving patient satisfaction.³⁶ Indeed, such a purchaser-provider split is far from foreign to Canada; in provinces that have embraced regionalization, provincial departments of health increasingly are seeing themselves as insurers, rather than providers of care.

³⁵ C. Enthoven. 2000. In pursuit of an improving National Health Service. *Health Affairs* 19 (3): 102-19.

³⁶ Johan Hjertqvist. 2001. *The Purchaser-Provider Split: Swedish Health Care Reform – From Public Monopolies to Market Services*. AIMS online: www.aims.ca.

The Alberta Model and International Experience

This purchasing function on behalf of the population was precisely the role that Alberta's Mazankowski Commission foresaw for regional health authorities. They could be thought of as large buyers' co-ops, not providing services themselves, but rather making contracts with a variety of providers within their boundaries or outside, on the basis of cost and quality considerations.

Another part of the Alberta model has been the emergence of the so-called Klein clinics, or private, for-profit, free-standing clinics, designed to provide precisely the kind of competition to public sector providers that our report envisages, within a single-payer system. Despite the enormous criticism leveled at Alberta's approach, what the province is doing is really quite a minor innovation and a logical extension of the current structure of medicare. Alberta's approach is certainly not "Americanization" of the health care system. A great many countries, not just the United States, permit Klein-like clinics to operate within their public health care systems, and those countries have health outcomes at least as good as ours. In some cases, private clinics contract with the public system to perform a certain number of services for a predetermined payment; in others, they supply services on a fee-for-service basis. In Sweden in the late 1980s, 25 per cent of coronary bypass surgery was performed by private suppliers under a contracting system. In France, under fee for service, private clinics handle surgery for digestive diseases and eye surgery, and fully one third of hospital stays are in private facilities. In Norway, private clinics specialize in open-heart and hip surgeries, among other procedures. None of these countries spends a significantly higher proportion of its GDP on health than Canada does, none has a higher private expenditure share, and all have life expectancies at birth on the same order as ours. In Japan, where both male and female life expectancy at birth are the highest in the OECD countries and where expenditure on health takes up 7.4 per cent of GDP, a very large proportion of hospitals are, in fact, small private clinics with facilities for overnight stays, and 54 per cent of beds are classified as investor-owned.

Other countries — notably Australia and the United Kingdom — have full-scale private hospital systems running in parallel to their public systems. In the United Kingdom, the private hospital system is well established and used regularly by the NHS to handle excess demand when public sector waiting lists get too long.

The Australian private hospital system is probably less important in the overall health care system than is its British counterpart but it is a well-established part of that system. At least one Australian government report concludes that private hospitals are probably slightly more efficient than their public counterparts, although the difference is not large. Both countries have very respectable life expectancies at birth, and in both cases health takes up a smaller share of GDP than in Canada.

Canadians have been told that no serious studies have found that for-profit hospitals are less costly or more efficient than not-for-profit hospitals. Alternatively, they have been told that even if for-profit hospitals are less costly, it must be at the expense of lower-quality care. Neither of these statements is



true. The US peer-reviewed literature,³⁷ from which the bulk of the evidence is drawn, contains numerous studies that find that for-profit hospitals are less costly and more efficient and that there is no significant difference in quality between for-profit and not-for-profit hospitals in general. The literature also contains studies that find that not-for-profit hospitals are *more* efficient and *less* costly, and still other studies that find no significant differences at all between the two types of hospitals. The only edge not-for-profit hospitals have is that teaching hospitals, which tend to be not-for-profit, have better outcomes than either for-profit or other not-for-profit hospitals. This does not mean that introducing for-profit hospitals into Canada would result in tremendous cost savings or efficiency gains, but it does mean that, contrary to the widely held view, for-profits are not automatically more costly. In any event, in the current circumstances, health services administrators are too often held to account for going over budget (which is measured) but not for delivering poor-quality, error-ridden care (which, by and large, is not).³⁸

International experience gives us a fairly clear picture of what we can expect from Klein clinics. They will almost certainly not grow into full-fledged hospitals, such as are found in Australia and the United Kingdom. They are more likely to remain specialized clinics on the French or Norwegian model, selling services to medicare on a fee-for-service basis. There is a Canadian precedent for this in Toronto's Shouldice Hospital.

Cherry-Picking

Opponents of Klein clinics argue that they will “cherry-pick” patients. The only logical response to that charge is to say that we certainly hope they do. Cherry-picking would mean taking less-severely-ill, and thus less-costly, patients out of public hospitals, freeing beds for those more severely ill.

It has been argued that up to 30 per cent of patients in Canadian hospitals are “bed-blockers,” patients who do not really need to be in hospital but who cannot be treated on an ambulatory basis and for whom no other inpatient facilities are available. If this is so, any change that has the potential to move some of those patients out of hospitals, making beds available for sicker patients, should be welcomed. True, cherry-picking by private facilities would leave public hospitals with a more costly case load, but keeping hospital costs down by keeping really sick people out of hospitals hardly seems to be in the spirit of medicare. The cherry-picking argument is really one in favour of adjusting the fee paid to hospitals and clinics according to the severity of the patient's medical condition, rather than for outlawing private clinics.

³⁷ This literature is fully reviewed in Brian S. Ferguson's background paper for this study, *Profits and the Hospital Sector: What Does the Literature Really Say?* AIMS, 2002.

³⁸ On growing the awareness of the dimensions of the problem of medical error in Canada, see Ross Baker and Peter Norton. 2001. Making Patients Safer: Reducing Error in Canadian Health Care, in *Healthcare Papers*, Longwoods, vol. 2, no. 1.

While the literature does not give a cost edge to for-profit or not-for-profit hospitals, it does support the assumption that specialization leads to greater efficiency and better outcomes. From that point of view, anything that allows pools of specialization to develop within the hospital sector would tend to improve sector efficiency, with no necessary increase in cost. Even in hospitals, practice makes perfect.

How to Fund Hospitals and Clinics

Introducing a fee-for-service element into hospital funding formulas would ensure that funds would flow to any hospital that was carrying an unusually heavy or complex case load because the population it served had poorer-than-average health. A hospital's budget could contain two elements: a global budget element to cover the fixed costs associated with the basic operations of the hospital; and a fee-for-service element to reflect the mix of services the hospital actually provided. Basing part of the hospital's revenue on the mix of services it actually provided would automatically build a needs-based element into the funding process and allow that component of the hospital's budget to adjust to the needs of the population it served. Global budgeting using a needs-based formula would be less responsive to changing circumstances since the budget, apart from ad hoc fixes, would change only in response to periodic adjustments in the formula. Since the kind of detailed demographic information needed for needs-based funding could be reliably obtained only from census data, there would be an automatic five-year delay in responding to changes in local population structure.

Shifting to fee for service for the non-physician component of hospital-based services, by putting those elements of a patient's treatment on the same footing as the physician component of his or her treatment,³⁹ would also facilitate the development of the sort of multi-specialty comprehensive clinics that many proposals for primary care reform envision. One consequence of technological advances in medical care over the past several decades has been that services that once could be provided only on an in-patient basis in hospitals can now be provided in free-standing clinics. However, so long as the non-physician elements of the cost of those services are paid for out of hospital global budgets, there is no straightforward mechanism for funding them in clinics. The current system permits moving them from in-patient provision to provision in some other wing of the hospital, but does not encourage their provision in an independent multi-specialty clinic across the street from the hospital.

Paying for these services on a fee-for-service basis, with the fee including an allowance for fixed as well as variable costs, would put different delivery sites on an equal, and equally flexible, financial footing. Services could then be provided in free-standing clinics.

³⁹We recognize that specialists in hospitals increasingly are being paid on other than a fee-for-service basis in some provinces, but fee for service is still the dominant model and has many virtues that are often ignored in the current debate.



Paying for hospital services on a fee-for-service basis would also recognize that the traditional distinction between ambulatory and hospital care has become fuzzy in recent decades. In the 1960s, “ambulatory care” referred to care given to patients who could walk into the doctor’s office, while any patient requiring more intensive treatment had to be hospitalized. There was nothing much in between. One of the consequences of technological advances in medical care is that it is now possible to set up intermediate sites. Unfortunately, by clinging to inflexible budgeting systems, such as global budgeting, Canada’s health care system continues to use a funding mechanism better suited to the technology of three decades ago.

Primary Care Reform

Multi-specialty clinics and primary care group practice clinics are part of most proposals for reform of medicare. Interestingly, very little attention has been paid to why those clinics have not sprung up naturally. The majority of primary care physicians in the United Kingdom are in group practices, and many US primary care practices make use of nurse practitioners, an innovation Canada is still trying to fit into medicare’s rigid structure. The short answer is that medicare tends to be administered in a manner that discourages innovation. The result has been that the typical GP’s office is probably, in its use of ancillary personnel, less efficiently organized than the typical general practice dentist’s office. This inefficiency is probably not a result of doctors’ deliberately choosing to be inefficient; it is more likely a result of their being constrained in how they can organize their practices if they want to work within medicare. It is also no doubt due in part to the requirement that the doctor lay hands on the patient in order for a visit to be regarded as an insured service. In the current environment, the patient who is not seriously ill represents the financial cream, and such visits subsidize those by truly sick patients.

Other countries permit doctors greater flexibility in how they organize their practices. The best-known example is the system of fund-holding GPs developed in the United Kingdom under the Margaret Thatcher Conservative government. Under fund holding, a GP is given a budget for diagnostic, specialist and hospital services for his or her patients. While fund-holding physicians were never given as much freedom as originally planned, they do have considerable flexibility in managing their budgets, and the attitude of the medical profession toward the whole idea of fund holding has shifted from very suspicious to very favourable over the years. With flexibility goes efficiency. A chart in a recent issue of *The Economist* (September 28, 2002: 53) shows NHS productivity increasing steadily until the election of the Labour government in 1997. Labour immediately began undoing the Thatcher reforms, and, according to *The Economist*, productivity began to fall. Within two years of Labour’s coming to power, more than half of the productivity gains from the Thatcher reforms had disappeared. Admittedly, under fund holding, some GPs and GP groups did well while others did not; the key to success seems to be the level of management expertise and business acumen available in the practice, a point it is useful to bear in mind in the Canadian context.

It is often assumed that fund holding can only work in a system where physicians are paid on a capitation or salaried basis. In fact, an element of fund holding could be incorporated into fee-for-service medicine. This would work by increasing GPs' fees while billing them for diagnostic and imaging services provided to their patients by hospitals. While any such system would have to be the subject of careful design to avoid rewarding doctors for not ordering needed diagnostic testing, the prime advantage of such a reform would, again, be flexibility. Funds would be directed toward whatever type of imaging services local physicians made most use of, and hospitals would, presumably, acquire the appropriate capital equipment and skilled labour. At present, even if there is clear demand among local doctors for the services of particular types of imaging equipment, the local hospital generally cannot make those services available until the provincial health ministry adds the funds to its budget. Again, greater flexibility is essentially just another term for needs-based budgeting.

Changed Incentives

Increasing competition by unbundling the insurance, governance, administration, health services delivery and evaluation functions would significantly alter incentives within the health care system. It would become worthwhile to collect information about the performance of various health care institutions and providers. Government regulators would be better able to set appropriate yardsticks of performance. Consumers would be better informed about the costs and benefits of both their individual health care choices and the value they are getting for the billions of tax dollars that are devoted to health care.

An essential element of what is being suggested involves a much larger role for informed consumers of health care. It also involves an expanded role for the private sector and for-profit medicine. Accordingly, let us examine the reasons for these reforms and some of the criticisms that are usually made of them.



SECTION 4

WHAT DO CANADIANS SAY THEY WANT?

Commissioner Romanow has made the case that the debate over the future of medicare is all about Canadians' values. But the way that Canadians express those values, unfiltered by the work of the Commission, is much different from what Mr. Romanow implies Canadians want.

According to a recent poll entitled *The National Pulse on Health Strategy*, 80 per cent of Canadians want major reforms to the health care system:

“Two-thirds of Canadians (66 per cent) tend to be supportive, more or less, of a host of new models of financing in order to reduce stress on the system – for example, where everyone (except those with low incomes) pays a small amount for health care services out of their own pocket. They also tend to support strategies such as using nurses or other health practitioners rather than physicians to provide certain services. Just under half (45 per cent) tend to be supportive of market-oriented reforms – greater efficiency, accountability and customer service, including private sector companies delivering health care services” (Environics, October 17, 2002).

The *National Post* reported that the same Environics poll found that fewer than half of respondents would support increasing taxes to pay for health reforms. But notably, only 10 per cent of Canadians would accept a health care system that excluded those who could not afford to pay for services.

These results need not be seen as a contradiction. As Jane Armstrong, senior vice president of Environics Research Group, says, “Canadians, ever-constant champions of fair play and equity, are devoted to maintaining a system that ensures access to quality health care for all... They're willing to make changes, even if this includes new and varied ways of financing the system as well as a greater dependence on market forces such as private companies delivering certain health services” (Environics, October 17, 2002).

Another recent poll, by Decima Research (October 25, 2002) found that more than half (55 per cent) of Canadians were opposed to paying higher personal income taxes even if these funds were designated to pay for health care. An even larger majority of respondents (67 per cent) also believed that they would have to rely on their own personal savings to pay for their use of health services in the future.

These public opinion polls appear to indicate that Canadians want a system of health care that provides high-quality medical services and is financially sustainable over the long term at an acceptable economic price, without excluding poorer people from access to medically necessary services. And in a typically pragmatic way, Canadians are not worried whether it is the private sector or the public sector that achieves this; they just want results. In fact, when Canadians do express a preference for either private or public approaches to health reform, the majority are willing to fund their future medical needs themselves rather than pay higher taxes to expand the medicare model of health care.



SECTION 5

THE ECONOMICS OF HEALTH CARE

Consumer Price Sensitivity and Physician-Induced Demand

Much of the research on which the Romanow report appears to rely is based on misguided assumptions about health economics. One reason that consumer co-payments or deductibles for medical services are not even being considered is that some academics believe the fundamental economics of such proposals are unsound. For instance, standard economic theory suggests that consumers care about what things cost. Proponents of co-payments argue that, under a “free care” system such as medicare, where there are no visible prices attached to services, consumers have an incentive to overuse health care.

When medicare was introduced, it sent two messages. It told Canadians at large that if they had any concerns at all about their health, they should not worry about cost but just see a doctor. And it told health care providers that if there was some service they thought might benefit one of their patients, even if that benefit was likely to be very small, they should go ahead and provide it and not worry about the cost. It is hardly surprising, then, that a system that sent out such messages would wind up being stretched to the breaking point. Therefore, economic theory predicts and the empirical evidence (reviewed below) confirms that if consumers are made responsible for some of the cost of those services, they will better manage their use of the system by considering whether the potential benefits of a service outweigh the cost.

Although it is well established that consumers are price sensitive when it comes to medical care, a key question remains: when, in response to a price increase, consumers reduce the quantity of medical care they demand, does their health suffer? In particular, can consumers prioritize in terms of medical care, cutting back on less important contacts and maintaining more important ones?

The RAND Study

The most often-cited source on this question is the Health Insurance Experiment (HIE) conducted in the United States by the RAND Corporation in the mid 1970s. In the HIE, several thousand Americans were randomly grouped into several different types of insurance plans. For our purposes, the most important difference among the plans was in the out-of-pocket payments plan members had to make when they received care. In one plan, consumers received all care for free; in others, they shared costs in amounts ranging from 25 per cent to 95 per cent. Overall, being in a cost-sharing plan of some kind

resulted in a reduction in health care use of about 30 per cent, with most of the difference being between the free plan and the 25 per cent cost-sharing plan (a 20 per cent reduction between the two plans).⁴⁰

In terms of health outcomes, the RAND study found that cost sharing had no general detrimental effect on the health of either adults or children, although there were certain specific conditions for which results were worse in the cost-sharing plans. For low-income, high-risk individuals, free care reduced diastolic blood pressure by 3.3 mm Hg, while for high-income, high-risk individuals the difference was only 0.3 mm Hg. The RAND study also found that for those with worse than 20/20 vision, free care meant the difference between 20/24 and 20/25 vision.⁴¹ Overall, on both objective and subjective terms, free care made no significant difference to either adult or child health. The RAND researchers concluded that, although free care did appear to affect certain health measures, such a system was an inefficient approach to dealing with health problems, and that targeted screening would likely work better.⁴²

In terms of use of services, the RAND study found that, for emergency room visits, cost sharing reduced minor visits but had no effect on visits for more serious reasons: the rate of visits for lacerations requiring sutures, for example, was not affected by cost sharing, whereas the rate for less serious cuts did fall.

In looking at visits to other sources of care, the RAND researchers categorized conditions into four groups: conditions for which highly effective medical care was available (such as fractures and diabetes), conditions for which quite effective medical care was effective (asthma and hay fever), conditions for which medical care was less effective (varicose veins of the lower extremities) and conditions for which medical care was not effective or for which self-care was effective (obesity and headaches). They found that cost sharing was non-selective, in that health care use was reduced to roughly the same degree in all four categories. This is the basis of the often-heard claim that the RAND experiment showed that cost sharing would lead to a reduction in both necessary and unnecessary care. In fact, this is not what the RAND results showed.⁴³

The RAND study did not analyze individual visits but, rather, looked at the diagnosis associated with each visit. While the condition may be one for which medical care is generally effective, that does not mean that each individual visit for that condition is necessary. In any course of treatment, the initial visit is likely to have the greatest impact on health status; later visits, while they may have a beneficial effect, have a much lower impact on measured health status than the early ones. Later visits are what the medical literature refers to as flat-of-the-curve visits and what the economics literature refers to as low-mar-

⁴⁰ Ferguson 2002.

⁴¹ Although, strictly speaking, the number of deaths during the experiment was too small for statistical analysis, there was no difference in deaths between the free plan and the cost-sharing plans, except in the trivial sense that there were more people enrolled in the co-payment plans. Mathematically, death rates were identical across plans. See Joseph Newhouse. 1993. *Free For All? Lessons from the RAND Health Insurance Experiment*. Harvard University Press.

⁴² Ferguson 2002.

⁴³ K. N. Lohr et al. 1986. Use of medical care in the RAND health insurance experiment: Diagnosis and service-specific analyses in a randomized control trial. *Medical Care* 24: supplement.



ginal-productivity visits. As the number of visits increases, in response to a drop in the price of a visit, as under free care, additional visits should have very low marginal productivity and their elimination should have no significant impact on measured health status. This appears to have been what was going on in the RAND data.⁴⁴ Overall, the HIE results are consistent with standard economic theory.⁴⁵

Physician-Induced Demand for Medical Services

Those who oppose co-payment schemes argue that standard economic theory does not apply to health care. One of the typical criticisms (repeated among papers submitted to the Romanow Commission) of plans that involve user fees, deductibles or tax debits is that such schemes would not actually influence consumer behaviour because doctors can induce demand for medical services.⁴⁶ Specifically, medicare proponents do not believe that consumers would be sensitive to prices in a free market for health care because of information gaps between them and their doctor; that is, consumers know far less about medical diagnoses and the proper course of treatment for disease than do doctors. Because of this imbalance of knowledge, the argument goes, unscrupulous doctors will prescribe treatments and procedures that are unnecessary in order to boost their incomes. Therefore, a single-payer, publicly administered system must be in place to prevent this from happening by regulating the billings of physicians.⁴⁷

This argument neglects, however, the fundamental nature of the relationship between patient and physician: that the physician is acting as an agent for the patient in decisions about medical care. In a system with a choice of physician, patients select a physician on the basis of their confidence in his or her judgment. Once they have found a physician whose judgment they trust, they will be disposed to accept that physician's advice. However, the observation that patients seem disposed to take a physician's advice tells us nothing about the physician's ability to induce demand. The difference here is between physician-initiated services and physician-induced services: physician-initiated services are ones that a fully medically

⁴⁴ It has been suggested that the fact that no health effects were observed actually proves that there were harmful consequences of reduced utilization. The argument is that while visits for the first categories of conditions were helpful, visits for the last categories were, in fact, harmful, and that the damage done to health by a reduction in visits for the first categories was exactly cancelled out by the beneficial effects of having fewer harmful visits. Beyond the fact that this argument involves translating the notion of conditions for which medical care is generally not effective first into unnecessary visits and from there into harmful visits (although there is no actual evidence that those visits were harmful), the argument that the lack of any health outcome should be taken as evidence that there was a harmful health outcome is somewhat dubious methodologically. It has also been suggested that the reason that no harmful health effects were observed simply means that the subjects were not followed long enough. This argument can be invoked for any observed phenomenon.

⁴⁵ Ferguson 2002.

⁴⁶ Melissa Rode and Michael Rushton. 2002. *Options for Raising Revenue for Health Care*. Commission on the Future of Health Care in Canada Discussion Paper 9.

⁴⁷ The literature on Supplier-Induced Demand is reviewed by Brian Ferguson.1994. Physician Supply Behaviour and Supplier-Induced Demand. *Cost Effectiveness of the Canadian Health Care System Working Paper 94-08* Queen's University-University of Ottawa Economic Projects.

knowledgeable patient would have decided on for himself or herself; physician-induced services are those whose only function is to generate income for physicians. The observation that physicians initiate services tells us nothing about whether they can induce demand.⁴⁸ Moreover, since no one normally bothers to measure the benefit from physician visits or other health services, it is impossible to know if particular visits are valuable and beneficial, or superfluous and a waste of time and money, or harmful.

We mentioned above the notion of a fully medically knowledgeable patient. It is often argued that physician-induced demand is based on the imbalance of knowledge between patient and physician; That is, the patient has no way of knowing whether the physician is recommending services for no good medical reason. This is a plausible argument, and a number of researchers have tested it, using data on service utilization by groups of patients distinguished by their degree of medical knowledge. The hypothesis being tested is that more knowledgeable patients should be resistant to inducement and, therefore, should make less use of medical care, controlling for other factors such as health status, age, sex, income and (in US studies) insurance status. In fact, studies consistently find that knowledgeable patients frequently use more care, not less. Whenever the lack-of-information version of the physician-induced demand hypothesis has actually been tested (as opposed to simply being invoked as truth) it has been rejected as unfounded.⁴⁹

The empirical results suggest that the logic behind the theory of physician-induced demand is unsound. Some studies compare the number of visits patients make with the numbers recommended by physician panels and find that both well-informed and poorly informed patients make fewer than the recommended number of visits. Apparently, physicians are unable to persuade their patients to consume the recommended quantity of visits, let alone unnecessary ones.⁵⁰

Related to the knowledge gap hypothesis is another issue. If physician-induced demand is to be an effective income-generating strategy, it should follow that physicians can tell which patients are susceptible to inducement. According to the knowledge-asymmetry hypothesis, it seems reasonable to assume that physicians also know that knowledgeable patients are less likely to agree to unnecessary services. However, on the question of compliance, evidence in the literature suggests that ambulatory care patients take no more than 50 per cent of the medications prescribed to them, that patients keep only about 75 per cent of appointments they themselves initiate and only about 50 per cent of the appointments their physicians initiate. Compliance declines with the length of the treatment regimen and compliance with regimens that require changes in behaviour (quitting smoking, losing weight) is particularly low. A number of studies have looked at how well physicians predict which of their patients will

⁴⁸ Ferguson 2002.

⁴⁹ Ferguson 2002.

⁵⁰ Ferguson 2002.



comply with medical advice. Studies by Gordis (1979)⁵¹ and Goldberg, Cohen and Rubin (1998)⁵² find that physicians do no better than chance at predicting patient compliance — for all the physician's presumed influence over a patient, he might just as well flip a coin.⁵³ Physicians cannot tell which patients will obey medical orders.⁵⁴

In Canada, many patients face difficulties in finding a physician. The health care system can barely keep up, and providers are stressed. It is more likely that, under the current system, clinicians and health organizations are trying to suppress legitimate demand artificially: witness efforts by hospitals to avoid admissions, by emergency departments to discourage visits, and by primary care physicians to send patients to emergency departments. If anything, we need to test the hypothesis that the Canadian health system, as an unregulated monopoly, is engaging in strategies to avoid satisfying appropriate demand because there is no link between performance and revenue.

One benefit of co-payment (with protections against catastrophic financial loss) is that individuals are able to estimate whether or not they are receiving value for the money they spend on each service or visit. User fees have long been a part of many other countries' national health systems. In Norway, for example, patients pay the equivalent of roughly \$22 for a basic physician visit (more, if lab tests are required).⁵⁵ Since this is roughly what medicare pays a GP for a basic office visit in most provinces, implementing Norwegian-level user fees for office visits would essentially mean having the patient pay the whole shot out of pocket. The presence of user fees does not seem to have had a serious detrimental effect on Norwegians' health. In the standard broad indicators, Norway shows up as quite comparable with Canada.⁵⁶

Physician-induced demand is often invoked to counter arguments in favour of an increased role for markets in medical care. While some analysts still adhere to a belief in physician-induced demand, prob-

⁵¹ L. Gordis. 1979. Conceptual and methodological problems in measuring patient compliance in *Compliance in Health Care* edited by R. B. Haynes, D. W. Taylor and D. L. Sackett. Baltimore MD: Johns Hopkins.

⁵² A. I. Goldberg, G. Cohen and A.-H. E. Rubin. 1998. Physician assessments of patient compliance with medical treatment. *Social Science and Medicine* 47 (11): 1873-6.

⁵³ Eric Bruckert, Christine Simonetta, Philippe Giral et al. 1999. Compliance with Fluvastatin treatment: characterization of the noncompliant population within a population of 3845 patients with hyperlipidemia. *Journal of Clinical Epidemiology* 52 (6): 589-94 asked GPs to judge the likelihood of compliance by individual patients. The authors conclude, "The practitioners' impression about the patients' treatment compliance had a tendency to reveal the noncompliant patients" (593). This conclusion seems charitable to the GPs. Of those patients who ultimately proved noncompliant, 59 per cent were rated by GPs as likely to have very good compliance, 37.4 per cent were rated as likely to have good compliance and only 2.9 per cent were rated as likely to have poor compliance. Given the results of all of these studies, it might behoove MDs to be a bit less dogmatic when speaking of their influence over their patients.

⁵⁴ Ferguson 2002.

⁵⁵ Norwegian doctors protest at rising charges for patients. *British Medical Journal* 321: 1 July 2000. The protest was over a proposal to raise the level of the user fee. User fees of the same magnitude are imposed under the Swedish system with no apparent detrimental effect.

⁵⁶ Ferguson 2002.

ably because it seems to offer an easy solution to many of the problems facing the Canadian health care system, the consensus among economists is probably best expressed by Folland, Goodman and Stano,⁵⁷ who argue that it would be reckless to charge “market failure” on the basis of physician-induced demand.⁵⁸

What would happen if we increased the number of physicians and medical services per capita in a community? Medicare eliminated any out-of-pocket price patients pay for health care services. As we have noted several times, a reduction in price leads to an increase in demand. The administrative pricing structure of medicare almost certainly leads to excess demand for certain services. In the case of excess or unsatisfied demand, an increase in supply would translate almost immediately into an increase in use, roughly in proportion to the increase in supply. This means that an increase in physician numbers would lead to an increase in the use of physicians’ services and to an increase in expenditure. While this seems like the same result the physician-induced demand model predicts — more doctors mean more services and higher costs — the fact that the underlying cause is quite different means that the appropriate policy response is also quite different.⁵⁹

Paying for Medical Care

On October 13, 1961, in a special session of the Saskatchewan legislature, then Saskatchewan premier and the man known as the “Father of Canadian medicare,” T. C. Douglas, said:

I think there is a value in having every family and every individual make some individual contribution [to the cost of their coverage under medicare]. I think it has psychological value. I think it keeps the public aware of the cost and gives the people a sense of personal responsibility.

Our findings show that demand for medical services is like demand for most other things: if the price goes up, demand falls. It appears that people reduce their use of health care by as much as 30 per cent when they are expected to pay something for that care, without affecting their health status. This fact suggests that, contrary to a widely held view, there is a potential role for user fees under medicare.⁶⁰

A number of ideas have been floated that would involve imposing direct charges of one kind or another on patients under medicare. When we speak of “direct charges under medicare,” the term that prob-

⁵⁷ S. Folland, A. C. Goodman and M. Stano. 2001. *The Economics of Health and Health Care*. Upper Saddle River NJ: Prentice Hall.

⁵⁸ Ferguson 2002.

⁵⁹ Ferguson 2002.

⁶⁰ This issue is explored more fully in three of the AIMS background papers to this report: David Gratzer and Carl Irvine *Medicare and User Fees: Unsafe at any price?*, Brian Ferguson’s *Consumer Issues in Health Care*, and Brett J. Skinner’s *Improving Canadian Health Care: Better Ways to Finance Medicare*.



ably springs immediately to most people's minds is "extra-billing." Before the practice was outlawed by the CHA, physicians could charge their patients an out-of-pocket fee, on top of the fee Medicare paid for the service in question. While there was never much evidence that extra-billing was widespread or damaging to Medicare as a whole, it does raise the possibility that doctors who are local monopolists might charge monopoly prices for their services.⁶¹

Extra-billing is not unknown in other countries' national health insurance plans. In Australia, for example, physicians are allowed (with some qualifications) to bill their patients an amount above the listed fee. The Australian experience has shown two things. First, when physicians have some degree of monopoly power, they exercise it. Second, extra-billing is squeezed out by increased competition; that is, where more doctors serve the same population. The conclusion is that any such policy would have to be accompanied by an increase in physician numbers. Otherwise we would find that in areas well supplied with physicians — mainly large urban centres — physicians would be prevented by competition from extra-billing, while in less well-supplied areas — likely to be rural and probably poorer — physicians could exercise market power.⁶² This probably means that the introduction of direct consumer payments for health care would require a transitional period in which fees continued to be dictated by government in order to avoid physician exploitation of their localized market power.

Health Insurance

As with consumer demand and the effect of co-payments for medical services, there are many misconceptions in the health policy literature regarding the economics of health insurance. Under private insurance, consumers join with others to pool the risk of unlikely, but still possible, catastrophic expenses. The insured then pay premiums to cover the cost of the pooled risk and may choose to reduce the costs of these premiums by paying directly for low-cost and ordinary expenses through deductibles.

Insurance can, however, distort the normal market relationship between consumers and the suppliers of goods and services by making consumers largely indifferent to price. Specifically, when the patient pays only part of the cost of a service, with insurance paying the rest, the price he sees is significantly lower than the price the insurer actually pays the supplier for that service.⁶³ Consumers see only the portion they pay out of pocket while suppliers see the whole price paid by insurance. This is why, historically, the spread of health insurance has been a major factor behind medical price inflation. It has also tended to have undesirable distributional effects. Most people who have had private health insur-

⁶¹ Ferguson 2002.

⁶² Ferguson 2002.

⁶³ Ferguson 2002.

ance, in both Canada and the United States, have usually obtained it through their employment as part of their benefit package. Better coverage has tended to go along with better-paying jobs.⁶⁴

Insurance thus tends to push up the price of the insured service, to be available to high-income, but not low-income, individuals and to reduce access to care among excluded groups.⁶⁵ It is often thought that the spread of insurance coverage has contributed to increased access to care. According to the model's predictions, however, although there has been some increase in quantity, most of the effect of the insurance has been in the form of rising prices and worse access to care for low-income people. The spread of this type of insurance tends to be a vicious circle: warnings about increased costs of care prompt people to buy insurance; as insurance spreads, it pushes up the price of care and causes more people to feel the need to buy insurance.⁶⁶

As the price of care increases, so too do insurance premiums since, ultimately, all insurance payments come from the pool of premiums collected from the insured. Since people usually obtain this type of insurance through their place of employment, it is often thought that the rising cost of insurance constitutes an increased cost to employers. This view is especially widespread with regard to health insurance in the United States, where it is often said that health insurance premiums make up a larger part of the cost of building a car than steel does. Canadian politicians are prone to argue that since, under medicare, Canadian companies do not have to bear this extra cost, they have a competitive advantage in world markets. As with so many statements concerning medicare, this too is wrong.⁶⁷

Economic theory predicts, and empirical evidence confirms, that the full cost of the insurance premiums is passed back to workers in the form of lower take-home pay. Canadian workers pay the costs of medicare through income taxes; US workers pay the cost of their health coverage through the pass-back of premiums. Even the part nominally paid by the employer actually comes out of the pool of funds available for paying labour and therefore comes out of the workers' pockets, in that case before it even reaches them.⁶⁸

Two further points should be made about insurance. First, there is no strong argument for obtaining any kind of medical insurance through the workplace; we do so for historical reasons and for reasons related to preferential tax treatment of employer-paid benefits, especially in the United States. Second,

⁶⁴ M. Reesor and B. Lipsett. 1998. *Employer-Sponsored Health and Dental Plans – Who is Insured?* Human Resources Development Canada Applied Research Branch, Strategic Policy Working Paper W-98-2E. The quote is from the abstract to the paper.

⁶⁵ There is, at present, a unique opportunity developing for observing this effect in action. In recent years veterinary insurance of the same basic structure as we have described above has been appearing on the market. The selling point is that it covers the cost of some of the more expensive surgical procedures vets perform on animals. Our model predicts that it will actually contribute to a significant increase in the price of those services.

⁶⁶ Ferguson 2002.

⁶⁷ Ferguson 2002.

⁶⁸ Ferguson 2002.



no other form of insurance has the structure we have described. Car insurance does not pay 90 per cent of whatever the mechanic bills; it covers costs up to a certain maximum, often with a deductible. The open-ended co-payment form of insurance that bases deductibles on a percentage of the total expense is unique to insurance for private medical care and is a major source of problems.⁶⁹ Introducing a new model of medicare with consumer co-payments and universal catastrophic insurance, such as we propose in this report, would almost certainly avoid many of these problems. The same could also be said about a private market limited to providing high-deductible catastrophic insurance. If preferential tax treatment of employer-paid benefits was ended and all forms of income treated equally, much of the incentive for insurance providers to supply, and for consumers to demand, first-dollar coverage or to use proportional co-payment devices would disappear.

So the burden of the analysis so far is that:

- consumers of health care are competent to make their own decisions about health care, in consultation with health care professionals, without implying that physicians may drum up artificial demand for their services;
- making health care services “free” at the point of consumption drives up demand for health care services without a proportionate improvement in health status as a result of this extra spending.

If that is the case, then there is a great deal of spending within medicare that cannot be justified on any public-good or improved-health grounds. This spending can be suitably identified and controlled only by making individual Canadians active partners in decisions about their health care and by giving them appropriate economic incentives to economize on their use of health care services. In our view, this conclusion means two strategic directions for health care reform.

First, we have to make a conscious policy decision to concentrate scarce health care dollars on those procedures that actually produce the most good in terms of improved health outcomes for Canadians. That means redefining what we mean by comprehensiveness and establishing some guiding principles in choosing the scope of insured and uninsured services, including citizen participation.

Second, we have to involve Canadians in deciding which health care services actually improve their well-being by attaching a cost to those services in the form of a limited consumer co-payment, encouraging the operation of an insurance market for services removed from the list of publicly insured services, and ensuring that low-income Canadians have the resources to get the health care services they need.

⁶⁹ Ferguson 2002.

Redefining Comprehensiveness

In a recent paper, former Quebec health minister Claude Forget⁷⁰ underlines the weaknesses in the policy of “comprehensive” coverage under medicare. Forget argues that the principle of comprehensiveness is driving health care costs, with little attempt to measure the well-being that this spending is creating for Canadians or to match public spending with the public’s ability to pay. Instead of a system with “a powerful engine [comprehensiveness] and no brakes,” Forget proposes one whereby the public sector decides what share of GDP is to be devoted to public health care and then matches that spending against the most important public policy objectives in health care. We support this approach, but some nuances are essential. Fixing the share of GDP to be spent each year means operating with a lag, since the GDP figures are available only after the year is over. Moreover, a strict annual target exacerbates the economic cycle, in the sense that in years when the economy is down, health care spending is also forced down. As with unsophisticated legislative requirements for balanced budgets each year, the effect of such an approach is to force unexpected cutbacks that have no long-term justification. The GDP target should therefore be defined as an average over a number of years, spread over the economic cycle.

On a related theme, Forget makes a powerful case that a rational person would not favour the Canadian system of health insurance coverage. It is a system in which we have, by and large, good access to low-cost and relatively minor health services, such as ordinary visits to the doctor, but in which we have increasingly restricted access to vital and life-saving services such as sophisticated diagnostics, surgery and cancer care, where waits can be measured in months, if not years. The more sensible arrangement would be to use the public sector to pool everyone’s risk of hugely expensive interventions, ensuring that they are available when needed 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.

We agree, but the stumbling block has always been the unwillingness of politicians to confront the debate over which services should be insured and which should be left to individuals to provide for themselves, with suitable help for low-income people. We believe that a solution to this problem can, however, be found. Canadians should be involved 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.

The most famous precedent for such a consultation, the Oregon Experiment, produced a great deal of useful experience despite some shortcomings. Health economist Julia Witt, the author of our paper on this topic, makes a powerful case that such shortcomings could be overcome by more sophisticated public consultation techniques.⁷¹

⁷⁰ Claude E. Forget. 2002. *Comprehensiveness in Public Health Care: An Impediment to Effective Restructuring*. Montreal: IRPP.

⁷¹ Julia Witt. 2002. *How Should We Decide What to Cover Under Medicare?* AIMS.



Although Canadians have been resistant to plans by governments to reduce the range of services insured by medicare, that reluctance is due in part to a justified scepticism about whether the decisions taken would, in fact, reflect the priorities of Canadians rather than those of government officials. Engaging Canadians in a dialogue on the services that must be insured and treating them as responsible and intelligent adults might well produce results that our political elites would find pleasantly surprising.

One potentially important aspect of revisiting what we mean by comprehensiveness would be the opening it creates for us to examine how, and under what conditions, important services such as home care, long-term care and drugs could be included in a national plan without simply compounding the myriad problems of the existing medicare system. Any such reform must be part of a system-wide review such as we are proposing in this report. To help guide Canadians in thinking through the issues of how to integrate these new services in an affordable national approach, health and social policy analyst Betty Newson has written a background paper for AIMS on the principles that should guide our approach to non-insured services.⁷²

⁷² Betty Newson. 2002. *Principles to Guide a Unified Funding Model for Non-Medicare (Non-Insured) Health and Social Services*. AIMS.

SECTION 6

PRACTICAL ALTERNATIVES TO THE STATUS QUO

Let us assume, for the sake of argument, that the results of such a sophisticated public consultation as Witt envisages supported the general approach of Forget and others, such as Crowley, Zitner and Faraday-Smith (1999), who argue that it makes more sense to insure publicly against high-cost but relatively rare procedures rather than against low-cost ones for which the average person can easily pay. Would such an approach introduce efficiencies in the health care system, ensuring that resources now spent on delivering low-value and affordable services could be spent on higher-value services? Could this approach be made compatible with a strong commitment to social equity, so that low-income people are not denied access to medical services because they cannot pay?

In a key piece of research⁷³ for this report, policy analyst Brett Skinner has done some detailed empirical testing of alternative ways of paying for Canadians' health care. His findings summarize several things that governments should and should not do to design a properly functioning health care system, then offers alternative models.

What Does not Work?

- The Canadian model of universal tax-financed, zero co-payment health care leads to moral hazard, over-utilization and prescription, rationing, queuing, service shortages or oversupply, tax pressures, budget limitations, and debt financing, as well as lack of clarity about what is and what is not insured, timeliness and quality of care.
- Unregulated insurance market competition suffers from adverse selection and risk selection.
- The US model of differential tax treatment of private health insurance purchases and benefits leads to a lack of portability of benefits and reliance on employment-based benefits.
- Monopoly service provision is unregulated and offers no incentives for consumer satisfaction, cost/benefit efficiency or timeliness of care.

⁷³ Brett J. Skinner. 2002. *Improving Canadian Health Care: Better Ways to Finance Medicare*. AIMS.



- Small pool risk sharing or self-insuring makes premiums unaffordable and undermines the value of insurance against catastrophic financial risks.

What Works?

- Regulated market competition offers more consumer choice, better quality and lower cost/benefit ratios.
- Consumer co-payments reduce moral hazard, rationalize demand, lower unnecessary utilization, reduce waiting times and queues and improve timeliness of access.
- Targeted income subsidies are more efficient than universal subsidies at meeting social goals, reducing costs to public budgets and making more funds available for low-income assistance as well as other programs or tax reductions.
- Large pool risk sharing captures the advantages of catastrophic insurance protection at a lower cost per person.

Based on these observations of what works and what does not, we recommend two feasible alternatives to the medicare model.

Proposal 1: Modified Medicare Model: An Incremental Approach

Elements of the Policy:

1. **Regulated medical services market** consisting of private for-profit and not-for-profit provision of health services in competition with non-subsidized, publicly administered non-profit providers.
2. **Tax-financed public monopoly, catastrophic insurance plan** consisting of medicare with a new deductible range for physician services and a well-defined, but limited catastrophic insurance plan. User fees or private insurance for extra service or charges above the catastrophic threshold.
3. **MSAs for everyone** financed by income adjusted tax-financed public subsidies for low-income consumers and tax-deferred personal savings for all.

Proposal 2: Regulated Market Approach to Universal Health Insurance

Elements of the Policy:

1. **Regulated medical services market** consisting of private for-profit and not-for-profit provision of health services in competition with non-subsidized, publicly administered not-for-profit providers (same as Proposal 1).
2. **Regulated health insurance market** consisting of private for-profit and not-for-profit health insurance in competition with non-subsidized, premium-financed, publicly administered, not-for-profit, high-deductible, catastrophic insurance under medicare.
3. **MSAs for everyone** financed by income adjusted tax-financed public subsidies for low-income consumers and tax-deferred personal savings for all (same as Proposal 1).

Proposed MSA Mechanism for Subsidizing Health Care

The Medical Savings Account (MSA) model analyzed in this study is partially based on the ones examined by Litow and Muller⁷⁴ and by Moon, Nichols and Wall⁷⁵. Under this MSA model, government would retain the role of universal insurer, but only for medical expenses above a pre-determined catastrophic threshold. This threshold would be set at an annual level of spending deemed to be beyond the ordinary costs of routine health services. Above this annual level of expense, all medically necessary health services would be fully insured at no cost to the consumer just as they are under medicare. Medical expenditures above the threshold are called insured costs.

Consumers would then become directly responsible for all routine medical costs; that is, all expenses below the threshold for that year. Like ordinary insurance (for example, automobile) these out-of-pocket consumer expenses for medical services are called the deductible costs.

In order to help consumers pay for the deductible range, governments assign everyone an MSA. Governments would subsidize deposits into this account based on the income level and the long-term health status of the consumer. For practical purposes, income determination would be accomplished via the tax system. Healthy and wealthy people would continue to subsidize, via a progressive taxation system, the health care needs of the poor and vulnerable, but that help would be much more precisely targeted toward those actually in need.

⁷⁴ M.E. Litow and S.V. Muller. 1998. *Feasibility of Health Care Allowances in Canada*. Milliman and Robertson for the Consumer Policy Institute, Canada.

⁷⁵ M. Moon, L. M. Nichols and S. Wall. 1996. *Medical Savings Accounts: A Policy Analysis*. Urban Institute.



The portion of the deductible range not subsidized by government would be paid for directly out-of-pocket or from tax-deferred deposits made by consumers in the MSA itself. In this sense, MSAs would work the same way as Registered Retirement Savings Plans (RRSPs). Money deposited into an account, either by government as a subsidy or by an individual from savings, is owned by the individual. Any funds that are not used on insured health care expenses in a calendar year can be used in subsequent years for insured or uninsured health care expenses, or ultimately become part of an individual's retirement account if savings accumulate beyond what would be needed to fund deductible and premium costs in retirement.⁷⁶

Interest on MSAs is assumed to accrue tax free as in an RRSP except that money withdrawn to pay for health expenses is not taxable. Upon retirement, funds withdrawn for non-medical purposes would be taxable and represent additional revenue for government.

Organizational changes to the health system are assumed (but are not entirely necessary) to accompany the introduction of this model of MSAs. For instance, private, for-profit health care provision would be allowed under market pricing and subject to government regulation.

Some research has been critical of the MSA approach to health financing.⁷⁷ These studies have predicted that the implementation of MSAs will actually increase health care costs to governments. However, there are two fundamental flaws in these critical simulations. One is that the models assume that the MSA deposits subsidized by governments will be the same in every consumer's account. As these studies show, designing MSAs with equal deposits for everyone would increase the overall expenditures for governments because governments would now be subsidizing people who use less than the average amount deposited, while still being responsible for the expenses of the sick.

But our model of MSAs avoids this criticism by giving subsidies only to low-income individuals.

Second, some criticisms fail to fully incorporate the reduction of utilization that would be expected to occur, once consumer co-payments are introduced, among the 80 per cent of the population who are relatively healthy. As the RAND Health Insurance Experiment showed, this reduction in utilization could be as high as 30 per cent from the level of health care usage under medicare, without any decline in health status.⁷⁸

⁷⁶ Extremely simple and low-cost technologies are now being employed to make MSAs easier to use and less costly to administer than ever. See Tux Turkel. 2002. Health-care debit card lets workers make choices. *Portland (Maine) Press Herald*. August 25: 1A.

⁷⁷ E. Forget, R. Deber and L. Roos. 2002. Medical Savings Accounts: Will they reduce costs? *CMAJ* July 23; 167:2; J. Schaafsma and W. Land. 2002. Budgetary implications of a publicly-funded medical savings account plan. Working Paper. University of Victoria, Economics; J. Hurley. 2001. Medical savings accounts in publicly financed health care systems: What do we know? Hamilton: Centre for Health Economics and Policy Analysis, McMaster University; J. Hurley. 2002. Medical savings accounts: Not the right prescription. *Policy Options*. July-August: 23: 5. Institute for Research on Public Policy.

⁷⁸ Newhouse, J. P. 1993. *Free For All? Lessons from the RAND Health Insurance Experiment*. Cambridge, Mass.: Harvard University Press.

Testing the alternatives

Because we accept that health care reform proposals must be evidence-based, a major piece of the effort underpinning this Report has been the testing of these alternative models using Canadian data to try to get a solid grasp on what the impact of such reforms would be. The details of the study are contained in Brett J. Skinner's background paper entitled, *Improving Canadian Health Care: Better Ways To Finance Medicare*.

We were fortunate to obtain access to data from the Population Health Research Unit (PHRU) at Dalhousie University in Halifax, Nova Scotia, that maintains a complex and comprehensive database of individual records of the utilization of medical services by everyone in Nova Scotia.

In this database, the unique identification number for each Nova Scotian insured by the province under medicare is also linked to personal demographic information. The variables collected for this study included age, gender and income. The income variable is a proxy based on the average household income for people living in each particular person's postal code area and does not represent the actual income of each person.

This data used for our study was collected for the seven years from 1995 through 2001 inclusive. The records from each year were merged so that data from different years would link to the same unique personal medicare identity in one computer file.

For the purposes of the analysis, we are using medicare spending per person on physician services as a proxy for use of health care services. These costs are calculated in terms of constant 1996 dollars unless otherwise stated.

Skinner analyzed the impact of introducing a system of catastrophic health insurance with a new deductible range for ordinary (non-catastrophic) medical expenses. The catastrophic threshold is the point at which the out-of-pocket deductibles expenses have been paid and full insurance coverage for all future medical expenses begins. This system is preferred to reduce the element of moral hazard that occurs under first dollar coverage or *full* insurance. The purpose of insurance is to protect against random, catastrophic financial expenses, not ordinary expenses. Skinner defines catastrophic medical expenses as those which exceed the mean or average expenditures of the population at large. Because the vast majority of people are relatively healthy, the mean expenditure on medical care makes a good proxy for ordinary health costs.



General Findings

According to the data made available for this study, the population of Nova Scotia in 2001 is estimated to be 978,577 based on the number of active medicare identifiers in the database. This figure somewhat overstates the actual population due to the effect of deaths and emigration throughout the year and understates it to the degree that new births and immigration were not yet entered into the system. Also according to the PHRU data, average household income in Nova Scotia, counted in constant 1996 dollars, was \$42, 875 in 2001.

Total spending on physician services reached almost \$315 million (1996\$) in 2001. Based on the data used, the mean, or average individual expenditure on physician services for the entire population in the study was \$322. The range of personal expenditures on physician services is quite large, stretching from zero expenditure on doctors' services to \$73,750 in 2001. Interestingly, the most common cost in every year is zero; accounting for about 20 per cent of the population. Only one person recorded expenditures on physician services as high as \$73,750.

The data also confirm that the vast majority of the population is relatively healthy over the course of the year. According to the figures, 81 per cent of the public spends less than \$425 per person per year on the services of doctors, including nearly 20 per cent of the population who spend nothing at all. And a relatively small number of people spend huge amounts per person on physician expenditures due to serious illness.

People who fall into the high-usage categories account for the largest proportion of total expenditures on physician services. Those spending more than \$425 per person per year account for 71 per cent of all physician expenditures. Yet the actual numbers of people in these categories is relatively small. In fact, the sickest 20 per cent of the population (those using the most services) account for 72 per cent of all spending on physician services with the sickest five per cent of the population accounting for nearly 42 per cent of total spending on physician services.

The mean annual expenditure on physician services is \$365 for females and \$276 for males. The standard deviation or average variation from these means is \$714 for females and \$733 for males. This wide variation indicates that there are large numbers of people who are generally healthy and a few people who can be quite seriously ill.

Age-Gender Specific Distributions

As expected, the data also show that there were similar distributions across age-gender specific categories. In most cases, the age-gender specific distributions followed the same pattern as that for the

entire population with, for example, about 15 to 30 per cent of the distribution showing zero expenditures on physician services.

However, in the lower age groups, newborn and age one year, the means were significantly higher than the rest of the population (especially for those less than one year old). Furthermore, the percentage of the distribution for the newborn group that had zero expenditure on physician services shrank dramatically to single digit figures. The same thing occurs for females during childbearing years and for males and females during their senior years (single digit percentages at zero expenditure).

Implications for Deductible-Based Catastrophic Insurance Design

This data could justify a targeted subsidy or reduced deductible for these groups. However, it should be noted that greater targeted assistance to these groups (based on their patterns of utilization, not income level) undermines any cost savings and reductions in waiting times for services expected from reform proposals. Subsidies by nature are designed to assist those who cannot afford to pay the ordinary costs of health care. Accordingly, to optimize efficiency, subsidies should only be applied on the basis of income. Similarly, adjusting the deductible downward based on age-gender norms for utilization would have the same negative effect on efficiency as a direct subsidy to these groups.

Therefore, flat deductibles based on the mean across the entire population are the preferred policy mechanism for introducing incentives to rationalize the use of medical services, and shift some of the responsibility for medicare costs onto those users of the system who can afford it.

The Effect of Introducing a Flat Deductible and Targeted MSAs⁷⁹

The deductible proposed here is based on the approximate mean annual personal expenditure on physician services for the entire population. This is roughly equal to \$325, according to PHRU data, and would apply to every person individually. An estimate of the savings to medicare and the reduction in demand for physician services from implementing a flat deductible of \$325 depends on the distribution of expenditures for physician services over the range of the deductible.

Since about 20 per cent of the population does not use any physician services at all in a given year, the remaining 80 per cent of the public will end up paying for physician services over some portion of the

⁷⁹This paper was originally released electronically on Tuesday 26, November 2002. Final review before publication indicated that the author's had under-estimated the savings to medicare by 28 million dollars. The original working paper estimated total net savings to medicare of a flat deductible and targeted MSA as being \$60.3 million, subsequent review has confirmed the number is actually \$88.3 million and this section has been adjusted to reflect this revision. A more complete analysis of potential funding alternatives can be found in *Improving Canadian Health Care: Better Ways to Finance Medicare*.



deductible range. According to the PHRU database, 80 per cent of the population equals 777,071 people. Therefore, any saving is equal to the number of people (80 per cent of the population) multiplied by the portion of the flat deductible amount (\$325) they would be expected to pay based on their distribution of expenditures.

In summary, about 20 per cent of the public will pay nothing at all because they do not use any physician services over the course of the year. About 24 per cent of the public will pay the full deductible because this proportion of people annually exceeds the mean of \$325. The rest of the public is distributed according to varying degrees of utilization within the range of the deductible.

As other studies have demonstrated, introducing a universal MSA with equal tax-financed government deposits for everyone is an unworkable proposal.⁸⁰ Such a design would significantly increase government health expenditures because MSAs would be subsidizing large portions of the population that used less than the deposit (\$325) under medicare and therefore would pay for services that weren't consumed. A retrospective payment system is better than this, even under the inefficient full insurance, zero co-payment model of medicare.

However, a targeted MSA subsidy for low-income people could be less costly than the universal approach and still capture some of the advantages of the RAND effect of reducing demand while allowing the less affluent to accumulate savings toward future health care expenses. The effect of the MSA depends on the distribution of expenditures for physician services among low-income groups in the province.

For this analysis, low-income consumers are defined as those whose household income is below \$32,000. This figure is based on gross household income, and is sufficiently higher than the net family income values used for the GST tax credit cut-off to be considered roughly equal in gross terms. The low-income cut-off for the GST tax credit is approximately \$28,000 net family income in 2002 dollars according to Canada Customs and Revenue Agency information. Adjusting this to 1996 dollars for comparability puts the net family income at approximately \$25,000. Converting this 1996-dollar GST tax-credit cut-off into gross income terms puts the figure just below the \$32,000 mark in 1996 dollars. Additionally, the mean annual expenditure on physician services is \$322 in 2001 in 1996 dollars, equal to about one per cent of \$32,000 in household income. This amount seems like a reasonable proportion of income per person for a co-payment at this level. As household income sinks below \$32,000, the proportion of income taken up by the deductible exceeds one per cent; therefore, the \$32,000 cut off is appropriate.

⁸⁰ E. Forget, R. Deber and L. Roos. 2002. Medical Savings Accounts: Will they reduce costs? *CMAJ* July 23; 167:2; J. Schaafsma and W. Land. 2002. *Budgetary implications of a publicly-funded medical savings account plan*. Working Paper. University of Victoria, Economics; J. Hurley. 2001. *Medical savings accounts in publicly financed health care systems: What do we know?* Hamilton: Centre for Health Economics and Policy Analysis, McMaster University; J. Hurley. 2002. Medical savings accounts: Not the right prescription. *Policy Options*. July-August; 23: 5. Institute for Research on Public Policy.

To estimate the effect of introducing an MSA, the population data from PHRU has to be adjusted upward in each income category because there is about 15 per cent missing data for the income variable in the database that leads to exclusion from final counts. Without this adjustment, the data will understate the population counts used for the analysis. Adjustments are made to final cost and savings figures only.

Cost of the Targeted MSA

According to the PHRU data, 161,376 people had average household incomes below \$32,000 in 1996 dollars. Due to missing data this figure is expected to understate the population in this group by 15 per cent. Skinner's analysis shows that if a targeted MSA deposit were provided for this segment of the population over the full range of the deductible (\$325) then the cost would be \$88.3 million in 1996 dollars.

Reduction in Demand for Physician Services in the Low-Income Group

Some of the literature assumes the RAND effect would apply only to those who do not expect to use up all of their MSA deposit of \$325.⁸¹ Based on this assumption, the incentive to reduce demand would therefore only apply to those within the deductible range. Skinner's analysis shows that if a conservative 20 per cent reduction in demand for physician services is expected from the incentives created by the MSA deposit, then the estimated reduction in usage based on the distribution of expenditures on physician services among those with incomes below \$32,000, in 1996 dollars, totals \$2,698,958.

Summary of Effects on Low-Income Group

The expected reduction in spending on physician services for people with household incomes below \$32,000 in 1996 dollars is less than one per cent of the total amount spent on physician services by the entire population. There are no savings to government because any funds left in the MSA from not using the entire deductible in services remains in the ownership of the individual account holders. But the total accumulated personal health savings from the transfer of tax-financed subsidies for low-income consumer for the year 2001 would have been equal to \$2,698,958 under this plan. This amount would have been dispersed proportionally to low-income individuals based on the distribution of usage.

⁸¹ J. Schaafsma and W. Land. 2002. *Budgetary Implications of a Publicly Funded Medical Savings Account Plan*. Working Paper. University of Victoria, Economics.



The cost to medicare of implementing an MSA subsidy over the full range of a flat deductible of \$325 would be over \$88.3 million. This subsidy would guarantee universal access to medically necessary services for the defined low-income group and could be expected to reduce overall demand for physician services by less than one per cent and demand within the group of low-income people by 4.7 per cent. The reduction in demand is a rough proxy for the expected reduction in waiting times for services.

Effects of Deductibles and MSAs across All Income Groups

The total savings to the public health insurance program from a combined flat deductible of \$325 for the entire population and an MSA for consumers in households with incomes below \$32,000 can be calculated by splitting the population into two groups: those equal to or above \$32,000 in average household income and those below that mark. The total number of people in the database with average household incomes equal to or greater than \$32,000 is 668,747. Due to missing data, this number is estimated to be 15 per cent less than the actual population in this group. Of this group, 125,952 spent nothing at all on physician services, 380,050 spent between \$0 and \$325, and 162,745 spent more than \$325.

Total Savings to Medicare

By Skinner's calculations, the total initial savings to medicare from the introduction of a deductible for this group would equal nearly \$119.1 million in 1996 dollars. This represents the amounts that are no longer spent by medicare on physician services that are now paid out of pocket by consumers. The total net savings from implementing both the deductible and the MSA program equal the savings from the new deductible of \$119.1 million, minus the costs of the MSA program of \$30.8 million. This totals \$88.3 million in 1996 dollars in net savings for medicare.

Total Reduction in Demand

If a conservative reduction in demand for medical services of 20 per cent is assumed to apply to people who pay the deductible, then the total reduction in spending on physician services would be \$11.6 million in 1996 dollars for the population at or above \$32,000 in household income, plus \$2.7 million in 1996 dollars for the group below \$32,000 in household income, totalling \$14.3 million in 1996 dollars. This represents approximately a 4.5 per cent decrease in overall demand for physician services from medicare levels. The percentage figure is a rough proxy for the expected reduction in waiting times.

The reduction of total spending on physician services within income groups is roughly the same percentage for those at or above \$32,000 in household income and for those below \$32,000 in household income.

Subsidizing the Chronically Ill

As mentioned earlier, governments would want to identify chronically high users of the medicare system for targeted MSA deposits. For Skinner's study, the PHRU data was analyzed for changes in usage for each individual medicare identifier across the seven years spanning 1995 to 2001. A regression model was used to test the relationship between a group of variables in each year and 2001 expenditure levels. The data indicates that usage in the previous year is significantly (statistically) correlated to usage in the current year at the 99 per cent confidence level. As a predictor of usage, the relationship of previous year's usage is about equal in statistical strength to the current age of the person. However, this co-relational strength diminishes as the data is regressed farther into past years, so that there is a declining relationship the farther from the current year that the data on health care usage is compared.

Notably, both current age and previous year's usage were of greater predictive strength than current income level.

The regression analysis does not estimate the probability that a person will remain in either low-usage or high-usage categories, but it does seem to confirm that movement between groups is somewhat static over short-term periods but over longer terms becomes more dynamic.

Targeting an MSA on the chronically ill would obviously increase the costs of the program. However, given the extremely small number of people that would be considered chronically ill, extending the \$325 deposit would probably not increase the costs significantly.

The Example of Pharmaceuticals

The majority of Canadians get prescription drug coverage through their workplace. In the days when pharmaceuticals played a relatively limited role in medical care, this did not matter much. With the increasing importance of pharmaceuticals in health care, however, particularly as a substitute for aspects of hospital care, access to pharmaceutical insurance is likely to be the prime determinant of unacceptable differences in Canadians' access to health care.

In the United States, workplace-based insurance is a major contributor to Americans' unequal access to insurance. Its most obvious implication is that it makes insurance coverage contingent on employment: Lose your job, lose your coverage. It also limits the ability of individuals to select the insurance plans that best suit their particular needs, since typically the choice of plans is limited. In addition, the form most pharmaceutical insurance takes, whereby the plan picks up most of the cost of a prescription and the beneficiary pays the rest, tends to drive up the price of prescription drugs, imposing a heavy burden on the uninsured who have to pay the full cost.



Canadians frequently argue that our prescription drug-pricing policies are the reason many drugs are cheaper here than in the United States. This argument does not, however, hold up well on close inspection. In fact, pharmaceutical prices in the United States have remained flat for the better part of a decade. In both Canada and the United States, increases in expenditures have been due to increases in utilization, not rising prices. In Australia, the Commonwealth Department of Health, concerned about differences in prescription drug prices between Australia and other countries, reviewed of the matter and concluded that differences in drug-pricing systems had very little to do with differences in drug prices between countries.⁸² That report and other international evidence seems to suggest that most of the differences in drug prices can be attributed to drug companies' charging higher prices in countries where incomes are higher and where extensive insurance coverage makes consumers insensitive to the full price of pharmaceuticals.

Some Canadians obtain their drug coverage through government plans, but the past performance of those plans does not inspire confidence in the prospect of a national drug insurance scheme. Faced with rising costs, governments have been every bit as quick to change the extent and conditions of coverage and to raise co-payment amounts as have private insurers. Since most of the beneficiaries of government plans are particularly vulnerable — the elderly, people with a few specific conditions, people on welfare — this policy instability cannot be regarded as good for social welfare in general. It certainly does not support the view that some kind of government pharmacare plan would be easy to implement.

Given the increasing importance of pharmaceuticals in health care, and given that our current drug insurance system is almost guaranteed to increase the gap between the haves and the have-nots, some kind of policy change is necessary. In broad outline, it should involve 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.⁸³ Participation would be compulsory, ensuring appropriate risk pooling, while competing plans would allow Canadians to choose among different levels of service over a regulated minimum.

The implementation of any kind of pharmacare plan should not be undertaken in isolation, nor should it be done as an add-on to our current system. Instead, it should be part of a major overhaul of our current health care system.

⁸² Productivity Commission. 2001. *International Pharmaceutical Price Differences*. Research Report Final Version July 2001. AusInfo, Canberra ACT: Australia.

⁸³ Some aspects of this proposal are similar to the Dutch reform proposals of several decades ago. They ran into problems with risk pooling between private insurance pools; their experience will be helpful in ensuring that Canada avoids such pitfalls.

SECTION 7

MAKING A REGULATED HEALTH CARE AND INSURANCE MARKET WORK

We looked above at how two models for reform could improve health care in Canada.

The first model would turn medicare into a deductible-based catastrophic insurance plan but leave the insurance element to be financed through general taxation. The limits to coverage under this new plan would be defined by a public system of consultation similar to the Oregon plan (Witt 2002; Forget 2002), where consumers were polled directly and asked to rank the value of specific services. Under a global budget fixed as a maximum percentage of GDP, this system would set the limits of coverage for medicare insurance, but would ensure that the public had been consulted on the menu of services and the amount they wished to contribute to the general tax system. Indeed, the public could choose to have additional coverage for all by voting to spend more on the global budget.

Under the second model, medicare insurance itself would be a competitive player in a new private health insurance market. This would require reorganizing medicare in ways similar to those above but financing would come, not from general taxation, but from community premiums where everyone in the pool was charged the same premium to fund the pooled risk. If private insurers were also required to use only community-rated premiums and uniform deductibles and to accept every person who applied for coverage, then the problems of moral hazard, risk selection and cream skimming would be reduced. And if, like auto insurance, every person was required to purchase health insurance from either the publicly administered, not-for-profit system or from competing private insurers, then the problems of adverse selection would be greatly reduced.

In either case, government limits on the number of medical graduates and artificial barriers to entry into medical practice would have to be eliminated to ensure adequate supplies of health professionals. Health professionals would enjoy better working conditions, which would help alleviate the recruitment and retention problems that are causing human resource shortages in health care.

During the time it would take for market incentives to increase the supply of health professionals, there would need to be a regulatory requirement that health professionals wishing to work in the private sector perform some services in public hospitals until the number of doctors and nurses in the system was adequate to allow market pricing to determine supply in both systems. This regulatory requirement is



more stringent than the existing one whereby clinicians can totally disengage from the “public” health care system by working for the military, RCMP, workers’ compensation or by performing occupational health work.

Earlier, we recommended the unbundling of the insurance, provision, financing and evaluative functions of the health care system on the grounds that it would eliminate conflicts of interest, improve incentives and allow government to be a stricter regulator and evaluator of health care service quality. Here follow the institutional changes required to realize this unbundling in practice.

Provincial governments should retreat from the role of providers of health care services and restore full autonomy to health care institutions for management and decision-making. In return, hospitals and other institutions should compete with an emerging private sector of health care providers. Provincial departments of health (or their agents, the regional health authorities) would then be free to become the neutral purchasers of insured health services that this report envisions. They would not be able to favour either public or private sector providers, but would have to purchase publicly insured services from whoever could provide them at the best cost-benefit ratio.

All provinces should establish arm’s-length regulators of the health insurance function, modeled on the stringent regulatory regimes that apply to other forms of insurance. Having established, through the public consultation process described above, the list of insured services they intend to provide, provincial departments of health would then have to be held to the same standards as other insurers, including honouring their commitments to make timely payments for insured services. Similarly, public or private institutions that contract with the department of health to provide insured services should be held accountable for their performance under their contracts.

All aspects of markets, including those for health care and health insurance, function best when the greatest amount of information is made available, including how the various parts of the system are performing. With the end of the conflict of interest that now plagues provincial governments that are both providers of health care and evaluators of their own performance, the stage would be set for the emergence of a powerful arm’s-length health care information commissioner in each province, and possibly at the federal level as well. The commissioner would:

- 1) set the regulatory requirements for the type of information to be collected from all health care providers, public and private;
- 2) ensure that the information required was actually produced in a timely manner, under penalty for non-compliance; and
- 3) publish the analysis, on a regular, expeditious and comparable basis, of the outcomes of care provided in all settings within the province.



The federal commissioner would ensure that all information provided was nationally comparable and published. This data 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.



SECTION 8

EVALUATING THE CRITICISMS OF PRIVATE SECTOR MEDICAL SERVICES AND HEALTH INSURANCE

Despite the significant potential of the private sector to improve Canadian health care, the health policy literature also identifies a number of arguments against an increased role for private health insurance or delivery of medical services.⁸³ Some of these criticisms are partly founded in health economics and others are demonstrably false. It is therefore important to acknowledge the limitations of markets, while at the same time correcting some of the mistaken arguments against them. In the process, policy makers may be able to selectively choose those elements of market approaches to health care that complement a new limited set of sustainable social goals for health care.

In a background paper for this report, *The Benefits of Allowing Business Back Into Canadian Health Care*, policy analyst Brett Skinner reviews many of these criticisms. They include the following:

- Parallel private systems of health care lead to a proportional net loss of subsidization for the public system.
- Private health service facilities have a higher likelihood of producing mortalities among patients than publicly funded hospitals.
- Parallel private markets lead to two-tiered health care: that is, the wealthy are able to purchase high-quality care or faster access to services.
- Private health insurance has a tendency to encourage adverse selection or cream-skimming by insurance firms. Medicare avoids the problems of adverse selection because participation is mandatory

⁸³ P. Musgrove. 1996. *Public and Private Roles in Health: Theory and Financing Patterns: Discussion Paper No. 339*. Washington D.C.: The World Bank; R. Deber et al. 1998. The public-private mix in health care in *Striking a Balance: Health Care Systems in Canada and Elsewhere*. National Forum on Health: vol. 4; R. Deber and B. Swan. 1999. Canadian health expenditures: Where do we really stand internationally? *CMAJ* 160: 1730-4; D. M. Wilson. 2000. Public and private health care systems: What the literature says. *Canadian Public Administration* 44 (2): 204-31; G. Boychuk. 2002. *The Changing Political and Economic Environment of Health Care in Canada*. Commission on the Future of Health Care in Canada; R. G. Evans. 2002. Financing health care: taxation and the alternatives in *Funding health care: options for Europe* edited by E. Mossialos et al. World Health Organization.

(no one can escape taxes) and there is no market segmentation (only one insurance option under monopoly).

- Under a market system of insurance, the healthy and wealthy benefit proportionally more than the sick and poor. Under a tax-financed system, resources are redistributed from healthier and more affluent people to sicker, less affluent people.
- Private health insurance tends to be administratively more costly due to the need to generate profits; greater overhead for advertising and marketing; more complicated claims adjusting and record keeping; and smaller purchasing power, or the loss of monopsony (“single-payer”) buying power.
- A private health care system will draw away health personnel from the public sector, exacerbating existing human resource shortages.
- There is little difference between covering escalating health costs through the tax system as opposed to private consumer payments. Because the consumer pays in both cases, separating public costs and private costs is unimportant as only total costs matter.
- Private payment does not selectively discourage demand for unnecessary care but only affects the poor who are sick.
- User charges primarily deter those with lower incomes and improve access for those most able to pay.

It is instructive to review Skinner’s findings with respect to two of the most-cited criticisms involving published work that Mr. Romanow says has significantly influenced his own reflections.

The Parallel Supply of Public and Private Health Services

Some researchers doubt one of the purported benefits attributed to greater private sector involvement in health care provision: a parallel private system would allow additional finances to be made available for public health care. According to this view, a parallel private system of health care would instead lead to a proportional net loss of subsidization for the public system. The most recent influential statement of this argument is by Tuohy et al. (2002).

The problem with this criticism is that the study that supports it is not designed to answer the questions it poses. Tuohy et al. purport to show that, in countries where a parallel private system of health care is introduced, the amount of public dollars committed to the public sector decreases. What else could they expect? Since the introduction of private health care is designed to reduce public expen-



ditures, these findings simply confirm the policy decisions of governments to rein in public health care costs.

The fact that public sector spending decreases when the private sector is allowed to operate does not indicate that the proportional amount of spending available per user remaining in the system also decreases. The introduction of a parallel private system is designed to allow health consumers to be served in the private sector and reduce the number of people accessing publicly provided services. Fewer dollars are required to fund the public system than previously, but this fact does not indicate that the proportions spent per user in the public system are less than before or that the amounts spent per person on poor people has decreased. In fact, spending on disadvantaged people might have increased. For example, if the data had shown that the proportion of public spending per person (among those remaining in the public system) had declined in absolute terms, it could be shown that a parallel private system draws existing resources from the public system, thereby making some people worse off than they would have been under a strictly public system. Tuohy et al. (2002) simply does not contain data on proportional changes in public sector per capita health care spending levels and, therefore, is inconclusive.

The Quality of Care under For-Profit Health Systems

Some opponents of a market for health services, notably Devereaux et al. (2002), make the radical argument that the literature shows that private health service facilities have a higher likelihood of producing mortalities among patients than publicly funded hospitals. This bold conclusion comes from comparisons between for-profit and not-for-profit hospital facilities in the United States. The approach is, however, problematic from the start, as it is unclear whether not-for-profit hospitals in that country can be assumed to behave in the same ways as public hospitals do in Canada; therefore, the applicability of the data to the Canadian context is tenuous at best.

Furthermore, Devereaux et al. is based on highly suspect methodology and faulty logic. A closer analysis of the same evidence reviewed in that paper confirms just the opposite conclusion from that reached by the authors. In the first place, the authors selected only 14 peer-reviewed papers among the 805 studies available to complete the analysis. Of these 14, seven (including the largest study, covering 7.4 million patients) find no statistical differences in mortality rates between private for-profit and private not-for-profit hospitals. Another of the 14 studies (the second-largest, covering 5.3 million patients) shows *lower* mortality rates at the for-profit facilities.

Devereaux et al. also neglect to note the caveats contained in the papers they do list. Many reviewers of the literature regard one paper they cite, published by the National Bureau for Economic Research, as showing that the entry of for-profits can actually raise the quality of hospital care in a region. Devereaux et al. claim that another paper, by Pitterle et al., favours not-for-profits even though most experts would

read it as favouring for-profits to a statistically significant degree. Clearly, many people who cite Devereaux et al. in support of their arguments against for-profit hospitals do not seem to have read the underlying studies. Devereaux et al. also contains many problems with comparability in the data between hospitals and with the definition of private for-profit and not-for-profit hospitals.

Devereaux et al. also assumes that for-profit hospitals are constrained by the need to make profits (that is, to earn returns for investors or shareholders) so that they have an incentive to cut corners or to rely on less-trained personnel, practices that lead to higher mortality rates. A review of the empirical evidence concludes, however, that the behaviour of private for-profits and private not-for-profits is indistinguishable in terms of “profit making” and that both types operate under similar incentive structures. In fact, both for-profits and not-for-profits share some form of the profit motive and, therefore, could be subject to the same criticism.⁸⁴

Furthermore, a properly designed information collection and reporting system, together with increased consumer choice in a private competitive market, would crowd out poor performers. It is hard to make the case that people would choose to go to institutions that had known but unexplained high mortality rates. In fact, since Canadians do not now have much access to such information about hospitals in Canada, they are unaware of how well, or how poorly, our public hospitals are performing.⁸⁵ There is certainly evidence that queuing under the public health system in Canada results in mortality. Similar observations might be made with regard to the problems of medical errors (Crowley, Zitner and Faraday-Smith 1999).

If governments took on the less intrusive role of setting standards and holding all providers to them, health quality would be better assured than it is now. If the argument of Devereaux et al. is that US hospitals are not held to the appropriate standards for health services by government, then the authors ought to explain why that is worse than the Canadian situation, where there are few government standards and where there is considerable secrecy about both the standards that are applied and the performance of health care institutions under those standards.⁸⁶

Without reviewing all of Skinner’s findings, of most interest to us here is his conclusion that there are limitations to what a private competitive market can accomplish in health care. It is also clear that most of the major arguments against implementing a competitive market are based neither on sound economics nor on a fair analysis of existing empirical research; further, they do not consider how a properly regulated market could overcome the limitations of private health care much more efficiently than does medicare.

⁸⁴ Brian S. Ferguson. 2002. *Profits and the Hospital Sector: What Does the Literature Really Say?* AIMS.

⁸⁵ Brian Lee Crowley, David Zitner and Nancy Faraday-Smith. 1999. *Operating in the Dark: The Gathering Crisis in Canada’s Public Health Care System.* AIMS.

⁸⁶ Crowley and Zitner 2001.



SECTION 9

CONCLUSION

Medicare is not sustainable on its present course. A modest slowdown in the rate at which spending increases has been bought chiefly through reductions in services, closure of facilities, a loss of health professionals, rising dissatisfaction among those health professionals who remain, and forcing consumers to endure increasing waiting times and forgoing innovative, but expensive, new technologies. The World Health Organization now ranks Canada's health care system 30th in the world, measured on criteria like "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 only be "sustainable" if Canadians are willing to accept less service or more taxation. Polls indicate that neither is acceptable. And given increasing consumer expectations for expensive health technologies, drugs and procedures, and the expected health demands from an aging population, medicare's problems are only going to grow.

Yet Roy Romanow, head of the Commission on the Future of Health Care in Canada, has already publicly rejected these arguments and has made 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, Mazankowski and Fyke, identifies sustainability of the health care system as *the* challenge we face. Mr. Romanow's own former minister of finance in Saskatchewan, underlined this when she appeared to testify before his commission.

The irresistible force of demand for services is running headlong into the immovable object of unavoidably limited health budgets. To date, the pressure has been relieved by allowing crumbling health infrastructure, loss of access to the latest medical innovations, declining numbers of medical professionals and lengthening queues. By and large, people have access to ordinary, relatively low-cost services like GP office visits, but 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, ensuring that they are available when needed but leaving ordinary interventions, whose cost can easily be borne by the average person, to individuals, supplemented by private insurance and subsidies for those on low incomes. Hardly anyone can afford can-

cer care, bypass surgery, gene therapy or a serious chronic illness on his or her own. These are the things that, without insurance, destroy people's finances.

But as much as 30 percent of the services consumed under medicare are unnecessary, not medically beneficial or even harmful. No one would be financially ruined by having to pay for an ordinary doctor's office visit if we ensured that people with 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 biggest health care study in the world, the RAND experiment, found that people who had to pay something towards 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 will recommend will merely put off the day when we realize that 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 whose conditions endangers their lives, in lengthening queues.

In the place of what Mr. Romanow has clearly indicated he will be recommending, the authors of this report commend to Canadians a strategy that holds out real hope of placing medicare on a sustainable basis. The main recommendations include:

- Rigorously separating 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 providers who can meet stringent tests of quality, accessibility and value for money.
- Encouraging the emergence of 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.
- Introducing a fee-for-service element into hospital funding formulas. Among other things, shifting to fee for service for the non-physician component of hospital-based services would, by putting those elements of a patient's treatment on the same footing as the physician's fee-for-service component of his treatment, facilitate the development of the sort of multi-specialty comprehensive clinics that many proposals for primary care reform envision.
- Incorporating 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 hospitals provide to their patients.



- Removing all quantity controls on health care professionals to increase their supply and reduce their market power.
- Involving Canadians in each province 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.
- Defining “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.
- Requiring 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.

Establishing 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.

- Ensuring 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.
- Establishing 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. Provincial departments of health should then be held to the same standards as other insurers, including honouring their commitments to make timely payment for insured services. Similarly, public or private institutions that contract with the department of health to provide insured services should be held accountable for their performance under their contracts.
- Creating a powerful, arm’s-length health care information commissioner in each province, and possibly at the federal level as well, to: 1) set the regulatory requirements for the type of information that must be collected and publicly provided by all health care providers, public and private; 2) ensure that the information required is actually produced in a timely manner, under penalty for non-compliance; and 3) analyze and publish, on a regular, expeditious and comparable basis, the outcomes of care provided in all settings within the province. The federal commissioner would

ensure that all information provided was nationally comparable and published. 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.

The report reviews some of the major criticisms levelled against these approaches to health care reform and offers detailed responses to these criticisms. The general conclusion is that, while there are limitations to what a private competitive market can accomplish in health care, it is also 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, and 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.

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