MEDICARE AND THE INFORMATION ERA:

Romanow and Kirby Perspectives

by

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CV1: Medicare is a Moral Exercise, Not a Business

It has been suggested to me by some that if there is a growing tension between the principles of our health care system and what is happening on the ground, the answer is obvious. Dilute or ditch the principles. Scrap any notion of national standards and values. Forget about equal access. Let people buy their way openly to the front of the line. Make health care a business. Stop treating it as a public service, available equally to all.

But the consensus view of Canadians on this is clear. No! Not now, not ever. Canadians view Medicare as a moral enterprise, not a business venture. (Romanow 2002, xx)
CV2: Prohibition of Private Money

Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care. Romanow (xx)
CV3: Co-opt Diagnostic Providers: Discourage if not prohibit private treatment providers

Governments must invest sufficiently in the public system to make timely access to diagnostic services for all a reality and reduce the temptation to "game" the system. In order to clarify the situation in regard to diagnostic services, I am therefore recommending that diagnostic services be explicitly included under the definition of "insured health services" under a new Canada Health Act. (Romanow,xxi)

As I interpret the reasoning in the above quotes, the rationale for bringing private provision of diagnostic services under the banner of Medicare is not so much to reduce waiting lists per se but to prevent Canadians from using their own money to move them up the waiting list.
CV4: We have the best system, so experimentation with alternatives can be discouraged

Early in my mandate, I challenged those advocating radical solutions for reforming health care — user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system — to come forward with evidence that these approaches would improve and strengthen our health care system. The evidence has not been forthcoming. There is no evidence these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets).

The principles on which these [alternative] solutions rest cannot be reconciled with the values at the heart of Medicare or with the tenets of the Canada Health Act that Canadians overwhelmingly support. It
In the Human-Capital/Information Era (HC/I henceforth) knowledge is increasingly at the cutting edge of competitiveness.

Health Care is emerging as a leading sector for human capital employment, research, innovation and exports.

Failure to remain in the forefront of the remarkable diagnostic, treatment and service-delivery innovations will mean that we will also fail to provide Canadians with state-of-the-art Health Care.
The essential point is that we must view Health Care in the HC/I era as both an essential social institution and a dynamic economic sector for production, employment, innovation, and exports.

Viewing Health Care as a “Moral Enterprise” or as predominantly as social policy will almost certainly guarantee that the sector will never receive the requisite inflows of capital—physical, financial, intellectual, entrepreneurial—that are essential for success in the Century 21.
The Boomers will retire wealthier, healthier, with longer life expectancies, and much better information about their health than previous generations.

Who will tell them that they can spend their higher incomes, pensions and savings on anything they want except on their health care despite lengthening waiting periods.

This has the potential for undermining the entire Canadian health care structure.
Romanow’s approach is to put money into the public diagnostic sector so it can match the private sector time lines.

This will ensure that private spending on diagnostic tests will no longer generate leapfrogging in the waiting queue.

This will be very expensive and while it will serve to equalize waiting times, it will not likely reduce them. Indeed the opposite is more likely.

For this and other reasons we need a fresh approach to our health care system.

Enter Kirby.
Kirby argues that inordinate waiting periods for medically necessary procedures are the Achilles Heel of the Canadian health care model and the single payer system.

Drawing from legal research by Stanley Hartt and Patrick Monahan (C.D. Howe Institute), Kirby argues that in the face of continued waiting periods the courts will very likely allow Canadians to buy health insurance to cover the costs of purchasing health care outside the publicly funded system. (See the later slides re: Supreme Court)

This could spell the end of the single payer system.

To avoid this Kirby proposes the Health Care Guarantee.
THE HEALTH CARE GUARANTEE

For each type of major procedure or treatment a maximum needs-based waiting time will be established and made public.

When this maximum time is reached, the insurer (government) will pay for the patient to seek the procedure or treatment immediately in another jurisdiction including, if necessary, another country (e.g., the United States).

The process to establish standard definitions for waiting times will be national in scope. An independent body will be created to consider relevant scientific and clinical evidence. Standard definitions will focus on four key waiting periods -- waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery.
Kirby interprets the “Public Administration” principle of the CHA to apply only to the administration of public health care insurance and not to the delivery of publicly insured health care services.

That is “there should be a single insurer--the government--for publicly insured hospital and doctor services delivered by either public or private health care providers and institutions”

To facilitate this hospitals should move to service-based funding

This will encourage hospitals to specialize, and by linking remuneration to the number and type of procedures they perform this will not only drive efficiency, it will also enhance quality.
Kirby’s Operating Principles

- **K1**: Maintain the Single-Payer Principle
- **K2**: Introduce the four-pronged Health Care Guarantee (primary consultation, specialist consultation, diagnostic testing, surgery)
- **K3**: The Single Payer will be agnostic about whether Health Care Providers are government-owned, not-for-profit, or private enterprises
- **K4**: Private money in the Public System will be Prohibited unless the Health Care Guarantee comes into play
Kirby’s Operating Principles: Implications

- Kirby’s principles are much more consistent with the Human Capital / Information Era.
- K3 will encourage experimentation and new entrants.
- The principles will encourage competition among suppliers that will make the system more affordable.
- Specialization will also be encouraged with positive implications for quality and cost. Full service hospitals are much too expensive for many routine procedures (the list of which is growing thanks to technology).
- Specialization will also allow more flexible employment relations as well as more flexible professional practices/procedures in the context of meeting the agreed-upon standards.
The H C Guarantee and the Private System

- There is nothing in the present system that prevents spending private money in the private medical system. The problem is that except for a very few procedures there is no parallel private system.

- An intriguing implication of Kirby (not mentioned by him) is that resort to alternative private provision if the waiting period comes into play may help to generate such a private system in Canada, especially if the only other alternative would be the US.

- Some provinces would surely be happy if a private domestic alternative existed for procedure x or y. And if established it might even attract American patients.

- Thus Kirby might also serve to provide a domestic safety valve for those wishing to spend their money on their health.
Medicare is a wonderful instrument that served Canadians well. But after more than a quarter century of service it needs some rethinking and reworking.

Unfortunately, over time Medicare has moved from being an instrument to being viewed as a societal goal.

The implications of viewing Medicare as a goal mean that it is difficult to challenge a goal, let alone propose alternatives.

All too often reformers compound the problem by proposing alternatives that are much too radical.

The value of the Kirby proposal is that it is fairly modest and that it stays within the single payer model.

But because it allows for “internal markets” it is really a powerful proposal that ensures that Medicare would henceforth have the ability to adapt from within to challenges whether technological or financial.

This could be the beginning of something grand.
Chaoulli Case:
Charter vs Medicare

- George Zeliotis tried for a year to pay for hip surgery either by buying insurance or by paying for an operation in a public hospital. He was told he could not, so he and Dr. Chaoulli took this to the Quebec courts, where he lost. So they went to the Supreme Court.
- Became a battle between two Canadian icons – the Charter and Medicare. Medicare eventually lost.
- Charter issue: Section 7: Everyone has the right to life, liberty and the security of the person and the right not to be deprived thereof except in accordance with the principle of fundamental justice.
- Chief Justice Beverly McLachin wrote: “Access to a waiting list is not access to health care.” Full impact applies only in Quebec, but it is a message for all Canada: Do something about waiting lists or else you will not be able to prevent the introduction of private health insurance which will be the end of Medicare.
- Decision came down in 2005, but the case at the SC began to be heard in June of 2004. No doubt this influenced Martin’s September 2004 health accords which focused on wait times.
Papers are available under from reading list from IRPP

Keep single payer system: US admin costs = 5.9% of costs vs. 1.9% in Canada.

K&K interpret the public administration tenet of the CHA principles to be about administration and not a preference for public over private delivery. Should be agnostic about this choice.

Hospitals: Move away from global (block) funding and move to service-based funding. Will provide incentive for institutions to focus or specialize on where their comparative advantage lies. Will attract private institutions with new and/or state-of-the-art technologies.

Need to rethink approach to collective bargaining. Unions demand wage increases. Typically, management seeks greater productivity and per unit cost decreases. However, in health care, working conditions are almost never up for negotiation. Foolish
Result: Wages in health care increased more than elsewhere, indeed twice as much in the 1990s. 80% of acute health care costs are labour costs.

Single payer could use its monopsony power to lower costs of various activities, e.g., buy 500 knee operations, cataract operations.

Flexibility in deploying human resources is essential in terms of increasing productivity.

Specialization will also increase standards (practice may not make perfect but it will certainly make better)

Good example here is Shouldice Clinic in Toronto (hernias)

Competition among suppliers will drive costs down and a more open system will attract specialized operators with the latest technologies and may lead to Canada becoming more innovative in the health care era.

One alternative that is on-going: send patients overseas. Need to adopt K&K to become more timely and competitive at home, while still embracing the heart of Medicare.
The Canadian health care system precludes competition among sellers of health care services. The resulting monopoly occurs at two levels: health care professionals and hospitals. Health care professionals hold monopoly power because they are the sole providers in their respective areas of expertise (doctors, nurses and so on). Hospitals hold monopoly power because they do not compete for patients on the basis of either price or quality of service.

The result of this structure is an imbalance of bargaining power between governments, as funders, and groups of providers. The imbalance stems from two facts. First, health care is an essential service, and governments (and the public) greatly fear strikes in the health care sector. Second, work rules — who does what and under what conditions — are virtually never part of collective bargaining, as they are in other industries. The excessive power wielded by associations of health care providers has enabled them to win pay increases that have surpassed those achieved in other industries. These increases were secured with virtually no consideration for increases in productivity or variations in the quality of services delivered by different providers.
What concerns us is the structure of a system in which truly essential work (health care) is performed by groups of workers whose monopoly position is not effectively counterbalanced in the course of collective bargaining. Significant productivity improvements could be achieved by better utilizing providers. Health care professionals should be able to use the full range of their skills and knowledge rather than being limited by rigid scope-of-practice rules.

However, substituting lower-cost (but fully qualified) professionals for more expensive ones is made virtually impossible by scope-of-practice rules that are under the sole control of the various professional associations. In addition, most health care workers have narrow job descriptions that excessively limit the range of tasks they are permitted to do. As a result, hospitals have relatively little flexibility in organizing their services. Unfortunately, in health care negotiations, changes to work rules are virtually never negotiated. All that is negotiated are wages or salaries. Thus, that which is crucial to the funder (the government) — how to improve the productivity of the system — is not on the table. All that is subject to bargaining are the issues that potentially benefit the providers — namely, wages/incomes. Therefore, the critical trade-offs involved in balancing wage increases against productivity improvements are not even addressed at the bargaining table, let alone resolved.
The biggest problem that governments, and hence taxpayers, face as funders of the system is meeting the fee and wage demands of the various groups of health care workers. Getting much larger wage hikes bargaining units. About 80% of all acute health care costs are labour costs.

But professional scope-of-practice rules are not the only source of organisational constraints that perpetuate inefficiencies in the system. Most health care workers have narrow job descriptions that limit the range of tasks they are permitted to do when they are capable of doing much more. As a result, hospitals, in particular, have relatively little flexibility in the way they organize service delivery.
The way in which provincial governments fund hospitals also generates inefficiencies. Today, hospitals have little incentive to enhance the quality and/or accessibility of their services, to contain or reduce costs, to improve their efficiency or to improve their productivity. This is largely because their annual budgets are not based directly on the volume and type of procedures performed in a given year, nor do they reflect the actual cost of providing these services.

A key way to encourage competition would be to change from the annual hospital budgeting system to a service-based funding system. This would lead to the establishment of specialized stand-alone facilities (or clinics) that would be able to offer lower prices for procedures such as cataract surgery, some orthopaedic surgeries, diagnostic tests and so on. These facilities would be cheaper to operate because of lower overheads and more flexible job descriptions. As well, greater specialization would lead to improvements in service quality. Finally, competition would encourage hospitals to contract out nonmedical services in order to improve productivity and reduce costs.
### Table 1
Insurance Overhead as a Percentage of Total Health Care Expenditures (1999 figures)

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<th>Canada</th>
<th>United States</th>
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<td>Private insurance</td>
<td>13.2</td>
<td>11.6</td>
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<tr>
<td>Public insurance</td>
<td>1.3</td>
<td>Medicare 3.6</td>
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<td>Medicaid 6.8</td>
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<tr>
<td>Total</td>
<td>1.9</td>
<td>5.9</td>
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Nothing in our proposals for generating competition requires, or even provides an incentive for, the introduction of for-profit delivery facilities. All of the benefits could be achieved regardless of whether service delivery facilities are publicly or privately owned, for-profit or not-for-profit.

Canada’s health care system must not only be preserved, but it must also be made more cost-effective, more efficient and more productive. These results can only be achieved through the introduction of competition into the delivery of health services.
• Home care is missing.
• If was part of the system, then could prevent hospitalization in the first place and become a substitute for institutionalized long-term institutionalized.
• Now elderly patients are admitted to hospital. If need chronic care they often need to stay in hospital because of a shortage of long term care places. Extremely expensive.
• Expert here is SPS faculty member Dr David Walker. Produced a report for Gov’t of Ontario, and he played a role in the Drummond Report (taught a class together in the fall 2011 term).
• Must move in this direction. Can look to European systems for approaches.
Miscellaneous Items: The Ideal User Fee

- Deferred user fee run through the tax system.
- Need fully electronic cards.
- Medical expenses become taxable income.
- If income is such that do not pay taxes, then is no cost.
- Cost rises with income.
- Need to set a tax rate on the expenses (say 10%), but there has to be an overall catastrophic or maximum limit of tax that would have to be paid. This limit would increase with income.
- Advantage: payment will be a function of a) use of the system and b) ability to pay.
- Would also serve to limit use of the system (since taxpayers would recognize Medicare is not free.
- Recommended by many experts and analysts.