Intelligence MEMOS

From: Åke Blomqvist

To: Canada's Ministers of Health

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Re: THE CAMBIE CASE AND EFFICIENT HEALTHCARE

Privately funded healthcare was back in the news this fall as a BC Supreme Court judge ruled against Dr. Brian Day's challenge of the province's *Medicare Protection Act*. The case has had the unfortunate consequence of focusing the public debate on the way private medicine can be used by wealthy people to jump the public care queue. This has obscured another aspect: that allowing more privately funded care could help pressure the public system to innovate and become more successful in containing costs and achieving better health outcomes.

Healthcare has changed dramatically in the half-century since Canada established its universal health insurance system. In particular, we now have a much wider range of specialized physicians and other professionals, working with increasingly sophisticated drugs and equipment in hospitals, labs, and imaging clinics. For the system to function efficiently, all components and people must be coordinated and motivated to work closely. Our 50-year-old model is not well designed for managing this new healthcare world. Most doctors in primary care and specialties continue to be funded independently on the basis of fee-for-service, and physician services, hospitals, and drugs are budgeted and managed in separate silos.

Adapting to new technology inevitably takes a certain amount of trial and error, which the private sector is generally more willing to endure than governments. Different firms try different approaches, and competition ensures that survivors are more efficient, and more likely to have found the combinations of cost and quality that consumers prefer. Profit seeking and competition are drivers that speed technology adaptation.

More room for private medicine need not imply a sacrifice of Canada's commitment to equity and universal access to needed healthcare. Healthcare *funding* can never be fully left to the market, but market-based competition can still be used as a helpful tool for organizing health services *production*.

In a model where universal access takes the form of compulsory insurance that is subsidized for those with low income, entrepreneurs (who may be providers or insurers) can be allowed to organize health plans that employ or contract with providers to supply diagnostic and curative services, and citizens can be given a choice among competing plans. Several countries have used versions of this model as do the US Medicare program, which covers those over 65, and "Obamacare."

Even though Israel, Switzerland, and the Netherlands have universal health insurance, they do not have single-payer systems: each of the different health plans that citizens can choose is a payer. That is, a pluralistic healthcare system with choice for consumers can be compatible with the principle of universal access. This is an important point for Canadians to understand since the popular debate about health policy often veers erroneously into conflating more private healthcare with a lack of commitment to universality. In principle, price and quality competition among the health plans can play a role in better cost control and expected health outcomes, all the while maintaining universal insurance coverage.

In Canada, many reform proposals flounder on resistance from provincial medical associations or groups representing particular specialties, as well as from unions representing nurses and other hospital workers. When cost-controlling reforms are proffered, provider interest groups all too frequently cast themselves as arguing on behalf of their patients. And in the public mind, and hence to politicians, adverse effects on identifiable patient groups almost always carry greater weight than any cost savings. For any individual reform, the latter will seem trivial and spread out over all the federal and provincial taxpayers who are the ultimate payers. In a pluralistic system where consumers can choose among several plans and have at least some observable financial incentive to choose a less expensive one, cost-effective models of care stand a much better chance of being adopted. That leaves more decisions on care and cost in the hands of patients, not to vested interests in the sector and governments.

One often-discussed example of an innovation that could lead to more cost-effective healthcare is the provision of primary care through multi-disciplinary teams that include family doctors, pharmacists, and other professionals. Studies have suggested that such teams can deliver care of comparable or better quality than in traditional models, and reduce costs. A pluralistic model with competing plans also need not lead to an outcome where people with low income receive inferior care (a "two-tier" system), as long as government sets standards that all plans must meet.

In the Canadian health policy debate, too much energy and too many resources are devoted to the negative task of suppressing privately funded care. Competition from funded medicine would offer – if it were allowed – an incentive for government health system managers to take on the vested interests that have so far stymied most efforts at effective health policy reform.

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