



WANTED: Leadership for Healthcare

A presentation by **Don Drummond** and **Duncan G. Sinclair** to the C.D. Howe Institute's Health Policy Council, June 8, 2016.

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Healthcare in Canada needs governance – clear, determined leadership to pull its poorly coordinated elements together into a real system and put it on course to meet the needs of the 21st century. That is what we elect governments to do. But leaders have to make decisions that are not always popular, especially when they require changes to an icon, and the imperative of politics continues to prove compelling despite the long-term benefits transformative change promises to bring beyond the political timetable.

That is not to say healthcare's status quo continues intact. Faced with cost escalation well above growth in their revenues, provincial and territorial governments have quickly "bent the cost curve" remarkably; an achievement for which they deserve much credit. But slowing the rate of healthcare's spending has been the result of applying constraints on budgetary allocations, particularly those to hospitals and doctors. They have not been the result of transformative changes to the cherished but fragmented 'non-system'; the one that provides services of mediocre quality at best,¹ and still leaves a host of vulnerable people, especially poor folks and the frail elderly and their families, exposed to the risks of failing health and financial ruin.

What would a leader or a group of leaders do?

They would begin by envisioning the system they would create if they started afresh – a genuine system with all its components smoothly connected, fully informed, synchronous, affordable, equitable, and providing the wide range of high-quality healthcare services needed to optimize the health of the population it served. And then they would figure out what steps to take to realize that vision.

1 www.commonwealthfund.org/publications/pressreleases/2014/jun. www.bloomberg.com/visual-data/best-and-worst/most-efficient/health-care-2014-contries. www.oecd.org/eis/health-systems/49105858 (2011).

The first would be to put in place a secure, electronic health information management system capable of maintaining for each resident of every province and territory his or her own comprehensive health (including medical) record. It would contain, together with other information relating to that person's health status, an account of his or her every interaction with a provider of a health or healthcare service, including the outcome and quality of each interaction as assessed both by the person receiving it and, if provided by a specialist, by his or her primary care provider.

The creation of such an information system would require many changes to the welter of incompatible technologies, software 'packages' and the like now employed by individual and institutional providers of healthcare services to record and keep track of interactions with the people they serve. To get from here to there, an indispensable first step would be to establish a governance body for the system with the authority² to direct the adoption by all healthcare providers of technologies and standards that support the ready and secure sharing of health information. This sharing would take place among all providers, the healthcare system's managers and governors and, on an individual basis, with patients.

Given its nature and importance, the health information management system would itself be governed/led by an expert agency reporting to an independent, arm's-length healthcare system governance authority answerable ideally to the federal and provincial/territorial governments working together. Sadly, it may be that such an ideal could not be achieved in Canada. If so, as a distinctly second-best alternative, independent governing bodies would have to be appointed by each province and territory³ and by the federal government, each empowered to direct adherence to that government's policies and to take responsibility for its system's management and operation. This would include setting common data and communication

standards, developing and monitoring adherence to clinical and service guidelines, as well as conducting analyses and reporting on the system's functions and results. The danger of not achieving inter-governmental collaboration, of course, would be different standards of healthcare throughout the country and failure of the principle of portability of coverage⁴ so long enshrined in the *Canada Health Act*.

Absent such a health information management system to meet the needs of patients, their providers, and those who must govern and manage the system, no real health/healthcare system can exist, whether in a province, territory, or in Canada as a whole!

The second step would be to return to the origins of Medicare, establishing a publicly governed and administered insurance plan that is:

- based, as it is now only in part, on the fundamental principle that nobody is denied access because of inability to pay for the services s/he needs to preserve and/or regain good health;
- universal (covers everybody...);
- accessible (...with comparable services that are reasonably available...);
- portable (...throughout all Provinces and Territories...); and
- comprehensive (with a full range of health and healthcare services).

As they did at the beginning in Saskatchewan, people would pay fees for all the healthcare services they receive. Currently many people think such services are free in Canada. That is not true. It is true that there are no up-front fees or co-payments for in-hospital and physicians' services. However,⁵ the most recent data available show that, in 2015, people paid \$844 out-of-pocket for healthcare services, \$719.60

2 Derived from the Scot's principle "He who pays the piper....".

3 Although some could collaborate on the establishment of a healthcare services governing body in common.

4 For hospital and physicians' services.

5 www.cihi.ca/sites/default/files/document/nhex_trends_narrative_report_2015_en.pdf p.11.

for private insurance and \$180.30 for private hospital accommodation and related things, a total of \$1,747 per capita. This heavy cost falls disproportionately on lower income people now. The point of re-introducing fees for all services would be to make fairer the distribution of this private-sector spending among all segments of society. It would also make fairer the distribution among the many forms of care, including primary care (where fees would be very low), pharmaceutical care, and rapidly growing mental health and community care.

But rather than being paid directly to individual providers, the fees/co-payments would be collected by the organizations and institutions to which the providers belong. Poor people would be exempt from paying fees and the total paid out-of-pocket annually by an individual or family for publicly insured services would be capped at an amount variably related to taxable income. Fees paid over the maximum would be rebated as a refundable tax credit. As in many other OECD countries, the reintroduction of fees at the point of service would serve to enhance transparency, counter the widespread notion that healthcare services are free, and modestly supplement public money with money from those Canadians well able to pay directly a portion of the cost of their healthcare services. They already are accustomed to paying in full for many of the services not covered by Medicare. Whether the publicly funded insurance system itself were to be financed primarily by the tax base, as now, or as in the beginning, partly by premiums and partly by taxes, is a decision to be made by the federal and provincial/territorial governments themselves. However, it would be more efficiently done at lower administrative cost using existing tax systems.

In addition to this change aimed at removing the financial barrier between those who need health services and their providers, changes would also be made, as Tommy Douglas

said in 1982, to “*reorganize and revamp the delivery system,*” a task he referred to then as “*the big item we haven’t done yet.*”⁶

Since Premier Douglas’ day, a great deal has been learned about the determinants of health. The in-hospital and physicians’ services originally and now covered by Medicare, together with all the other healthcare services like prescription drugs, dentistry, eye care, rehabilitation, etc., enhance the health of the population by 25% at most. Fully 75% is attributable to what are commonly referred to as the social determinants of health – education (especially in early childhood), personal and financial security, good housing and nutrition, useful work, supportive communities, and the like.⁷ If starting from scratch to optimize the health of the population, government(s) should arguably concentrate first on securing support for those social determinants, especially in communities where they are most deficient, (remote aboriginal communities come especially to mind) as the most effective approach to improve and safeguard peoples’ health. Doing so should remain one of government(s) highest priorities.

But meanwhile Premier Douglas’ “revamping” challenge remains.

Adhering to the principle that the coverage be genuinely comprehensive, the range of insured healthcare services would be broadened to include, in addition to hospital and physicians’ care, prescription drugs, mental health and addiction services, home and long-term institutional care, dentistry, eye care, rehabilitation, counseling and perhaps others. That decision would be made by the delivery system’s governance body and confirmed by the governments that commit to finance from tax revenues and/or premiums the publicly funded insurance system. Expanding the range of insured services would be expensive but would cost the

6 T.C. Douglas. 1982. An interview as quoted in Alberta Roundtable Report, Government of Alberta, August, 1993, p. 17, from Decter, Michael B. 1994. *Healing Medicare*. McGilligan Books, p. 14.

7 <http://www.parl.gc.ca/content/sen/committee/402/popu/rep/rephealth1jun09-e.pdf>.

economy little more than is being spent now on such services from the combined public and private purses⁸ in Canada. The advantages would be that:

- the benefits would be distributed far more equitably, being available across their whole range to people now excluded by their inability to pay the cost of many essential healthcare services, prescription drugs and home care, for example; and
- over time, the high cost of providing hospital⁹ and other acute care services would fall as the benefits of more comprehensive primary and enhanced community care services were realized.

Each of the publicly insured services would be then be assigned to one or another of the following categories:

- primary care (to include home and community care);
- secondary care (to include ambulance and emergency room services);
- tertiary/quaternary care.

Then it would be decided what proportion of the cost of each service, by category, would be assumed by the public purse and the share to be paid directly by consumers to the providing organization as fee revenue. Alternatively, the fee could be paid at tax time and could vary according to household income. For secondary and tertiary/quaternary care, the cost/price of each service (including the professional component of diagnostic services) would be determined against a resource-based relative value scale based on the degree of complexity of each service, the expertise, qualification, and experience, etc., needed to provide it.¹⁰

The result would be a specific, optimally economical value assigned to each service within each category; i.e., the cost of its provision by the most appropriate and efficient provider. This last would require re-examination of the scopes of practice of the several professions where there are now significant overlaps as, for example, between family physicians and nurse practitioners or nurses and registered nursing assistants or, for that matter, between family physicians and some specialists.¹¹

The next step would be to estimate within each category the number of providers in their several professions/occupations required to provide efficiently the complete range of publicly insured health and healthcare services needed to serve the population of each geographic area. For example, for primary care in a LHIN region in Ontario, using existing Canadian data together with that available from other OECD countries, the requisite number of nurses, nurse practitioners, family physicians, psychologists, pharmacists, social workers, physio- and occupational therapists, personal support workers, etc., would be calculated.

The next steps would be to:

(i) Issue by geographic area time-limited, renewable billing numbers equal to the number of required providers by profession/occupation.

- For primary care, the total number and variety of requisite billing numbers would be issued to primary health care teams,¹² enabling them to:
 - ◆ recruit the number of service providers of the several kinds they believe they require to provide to the population registered or rostered with that

8 Share of the GDP.

9 Including the accommodation of Alternative Level of Care patients.

10 This was done for the OMA fee schedule in Ontario in the late 1990s by a joint OMA/MOHLTC Committee chaired by Dr. John Wade. The report was never released.

11 General pediatricians, for example.

12 All providers of publicly-funded community-based health and healthcare services would be required to be affiliated with a primary care team.

team¹³ the range of health/healthcare services needed to meet its needs for comprehensive primary care, newly redefined to encompass care in the community;

- ◆ claim from the insurance plan payment for the annual recompense of the team's providers at the average annual rate of pay (including benefits) that is (i) negotiated with the relevant professional associations (e.g., Medical, Nursing, Pharmacists' Associations), and (ii) subject to a 10% to 20% 'hold-back' to be available as bonus payments to teams in proportion to the outcomes achieved and their served person and family satisfaction ratings;
- ◆ bill the insurance plan for fees foregone as a result of providing services to people exempt from paying fees; and
- ◆ collect fees from those non-exempt people who receive services from the team.

Given that community care would constitute a vastly more significant role within the redefined compass of primary care, particular attention would have to be paid to ensuring that primary care teams were staffed appropriately to deal with mental health and addiction services, long-term residential and home care, and other predominantly community-based services. Assessment of the efficacy with which primary care teams deployed such services to reduce the need among their registered members for access to far more expensive acute care services¹⁴ would constitute a significant component of the evaluation of their performance.

- For secondary, tertiary/quaternary care the requisite billing numbers would be issued to hospitals or other

institutions¹⁵ in which such services are provided to enable them to:

- ◆ recruit the number of service providers of the several kinds they require to provide to the population of the region served the secondary, tertiary and quaternary healthcare services needed ;
- ◆ claim from the insurance plan payment of the annual recompense of the team's providers at the average annual rates of pay negotiated with the relevant professional associations, subject to a 10% to 20% 'hold-back' to be available as bonus payments to hospitals or other institutions in proportion to data relating to the quality of their services and to patients' and their families' satisfaction ratings;
- ◆ claim from the insurance plan fees foregone by the provision of services to exempt persons; and
- ◆ collect fees from non-exempt people receiving services in the hospital or other institution.

(ii) Repeal any law or regulation to prohibit providers of health/healthcare services not holding billing numbers from offering those services to the public independently ('outside' the publicly funded system); the prices charged for those services would not be regulated.

(iii) Repeal any law or regulation to prohibit private-sector insurers from offering plans to insure people for the reimbursement of fees and other charges paid for services provided privately; i.e., outside the publicly funded system.

A principal objective of this 'revamping' of the delivery of publicly supported healthcare services would be to create a more effective balance of the incentives available to providers,

13 Adjusted by age, health status, and related characteristics.

14 Reduction in the utilization of Alternative Level of Care (ALC) hospital beds, for example.

15 All those providing what would be defined as secondary, tertiary, and quaternary services would be required to be affiliated with a hospital or other institution providing healthcare service if they were not affiliated with a primary care team

both individual and collective, to enhance the availability and timeliness of their services, their quality and efficacy, and the efficiency of their provision. The 'hold-back' provision applying to the recompense of an organization's providers would provide the organization a competitive incentive to produce measureable high-quality outcomes and high ratings of satisfaction among the people and families served. Those same measures and ratings would provide providers with individual incentives to rank high among their colleagues in productivity. To a lesser extent, the fee revenue, whether billed directly or recompensed by the insurance plan, would reinforce the 'hold-back' incentive in that it would add to the resources available for distribution among the organization's providers, be it a primary care team, a hospital, or a clinic. At the same time, the insecurity engendered by the private 'market oriented' payment scheme would be alleviated by the fact that the predominant proportion of providers' incomes and entitlement to benefits would be fixed, being a component of the block grant to the organization for the recompense of its professional providers and of its support and administrative staff.

Balanced against the publicly insured healthcare system would be, as in other OECD countries, privately delivered services, a so-called second or parallel system. It is a myth that such does not exist in Canada; for years many poor Canadians have been denied access to out-of-hospital prescription drugs, to homecare and rehabilitation and mental health and addictions support, and dental care, etc., because they lack the funds to pay for them. Some physicians and other providers may well opt to proffer their services privately rather than join the publicly insured system; some may opt to do both. Experience in other comparable countries¹⁶ does not provide evidence that the availability of a parallel private tier of healthcare services diminishes the availability of qualified professionals in the public system. Those wanting to work privately on a part-time basis would have to keep a weather eye on the effect that doing so may have on their performance

(and recompense and linked benefits) relative to that of their full-time colleagues in their primary care team, hospital or clinic. It is not illegal in some provinces in Canada today for physicians to practice outside Medicare; few do so.

Each service provided and function performed in hospitals, clinics, nursing homes and other institutions, including those organizations providing diagnostic services, would, like the professional services referred to above, be examined against a resource-based relative value scale, informed by data derived from comparable institutions in Canada and internationally. The objective would be to determine the cost of each service and function¹⁷ when provided or performed in the most appropriate institution in the most efficient and effective way. Such determination would include allowance for non-professional staff costs and the operation, depreciation and renewal of facilities and equipment, including diagnostic equipment. Once determined, institutional/facility funding would be provided at those rates in direct proportion to data relating to the volume of each institution's provision of those services and functions (performance-based funding). The total funding available to each institution would then constitute the sum of facility and professional recompense grants, each related to the activities conducted in and by the institution concerned, plus fees collected directly and reimbursed by the insurance plan.

Canadians in general and our political leaders are proud, indeed to the point of complacency, of what people refer to as Medicare, touting it as one of the best healthcare systems in the developed world. If it ever was, it is no longer even close to the best, a hard but plain fact revealed clearly by repeated, objective international surveys. It got this way primarily because of the failure of our governments to get on with what T.C. Douglas in 1982 called Phase II, revamping the delivery system, "*the big item we haven't done yet.*" It is (over)time for Canadian leadership to get on with it!

16 http://www.commonwealthfund.org/-/media/files/publications/fund-report/2015/jan/1802_mossialos_intl_profiles_2014_v7.pdf

17 Exclusive of the cost of recompense of professional providers.

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