Intelligence MEMOS

From: Åke Blomqvist

To: Canadians concerned about healthcare

Date: February 26, 2019

Re: **Hallway Medicine vs Two-Tier Medicine: The Canadian Dilemma**

The promise to end "hallway medicine" was an important element in the victorious campaign of Doug Ford and the Ontario PCs in 2018. If they are serious about reaching that goal, the government should change the rules that currently make it close to impossible for privately funded medicine to compete with OHIP, even if any move in that direction will provoke shrill cries about the threat of "two-tier medicine."

The recent report of the Premier's Council on Improving Health Care and Ending Hallway Medicine reviews the major problems in Ontario's healthcare system: excessive use of hospital emergency rooms, hospitals overcrowding with many beds occupied by patients who could be treated elsewhere, long wait times, lack of resources for community care, and so on.

The problems are familiar and have been discussed many times in recent years. While the report does not offer much in the way of concrete suggestions about how to deal with them (there will be a follow-up in the spring), council chair Rueben Devlin has been quoted as supporting more use of digital technology, and "a little bit of organizational change" to create "a Ministry of Health and an organizational structure that is nimble and effective."

The government will need a lot of good luck for these kinds of administrative measures to end hallway medicine. The history of health policy in Canada is replete with examples of reform proposals that have had little or no effect on costs or system performance. Healthcare management in Canada has been very resistant to change, to the point where, in recent international comparisons, the only country whose system is consistently ranked as inferior to Canada's, is the US.

One reason may be the Canadian model of divided federal-provincial jurisdiction over health policy; politicians at both levels tend to spend more energy blaming the other guys, rather than attacking problems head-on.

But another reason is the Canadian obsession with not allowing any meaningful competition between the provincial plans and privately funded healthcare. Even though all industrialized countries other than the US now have universal health insurance, all of them allow more public-private competition than Canada does, either because people are allowed a choice among public and private insurance plans (Switzerland, the Netherlands, Australia), or because doctors are allowed to treat both public and private patients (U.K.).

A system where all healthcare must be supplied through a single government plan, makes innovation and reform much harder than in a model where there is more choice, for patients and providers, about the ways in which care is supplied and providers are compensated. With a monopoly government plan, any proposal for innovation or reform becomes highly political, and gets bogged down in long and complicated negotiations between government and stakeholder interests. In a pluralistic model with public-private competition, providers and insurance plans have more freedom to experiment, since patients or doctors who don't like what is being tried, have alternative choices. The result may well be more innovation and, in the long run, a more efficient system.

Devlin has spoken favourably about the "possibilities of virtual care" and cited US Health Maintenance Organizations as examples of insurers that have made good use of digital technology in setting up their clients' care. A proposal to convert OHIP into a US-style HMO would obviously be dead on arrival, but allowing Ontarians to choose a private HMO-plan as an alternative to OHIP coverage might not. If Devlin, Ford, and Health Minister Christine Elliott want to go down in history as having set Ontario's health policy in a new course, they should consider introducing more freedom for privately funded medicine and insurance to compete with the public system.

Defenders of the current model will object vociferously, citing the danger of two-tiered medicine. Reasonable people recognize, however, that preventing wealthy people from getting the healthcare they are willing to pay for out of their own pocket is not an end in itself, but a means to an end: To ensure that everyone, rich and poor, can have access to good healthcare when they need it.

If a model with more public-private competition can give us a more efficient healthcare system that will give everyone better care than they have now, shouldn't we consider that option, regardless of ideology?

Åke Blomqvist is Adjunct Research Professor at Carleton University and Health Policy Scholar at the C.D. Howe Institute.

To send a comment or leave feedback, email us at blog@cdhowe.org.