Mechanisms of Health Care Reform

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On Tuesday June 7th, *Maclean's* magazine, the Canadian Medical Association and CPAC hosted an open dialogue on health care at the National Gallery of Canada in Ottawa. It was entitled: *Health Care in Canada: Time to Rebuild Medicare*.

The two-hour, video-taped conversation demonstrated how passionately many Canadians feel about health care and that the delivery of health care in Canada isn't meeting their needs and ought to be changed. One participant referred to the health care budget in Ontario, for instance, that now represents 40% of the Province's overall budget and is beginning to crowd out other concerns like education, social and correctional services. CIHI estimates that health care spending in Canada was $191 billion in 2010 or 12% of GDP and that by 2031 this should rise to 19% of total GDP -- a rate of growth that seems unsustainable. So the question was posed: what would a reformed health care system look like?

Strangely there was no actual discussion of what health might mean to people, although most people seemed to assume it meant getting access to care and services. And maybe this wasn't so strange given the lack of a definition in the Canada Health Act which despite its being essentially an insurance act is regularly misperceived as a health act. For some, health seemed to have something to do with a state determined by professionals while to others it was a state determined by themselves.

Still, the preponderance of comments suggested that health is not simply a state where there was an absence of illness or disease or being on the receiving end of emergency treatment. Reading between the lines, people seemed to use the term 'health' to describe a condition of wellness capable of incorporating a sense of physical, psychological, sociological, environmental and spiritual well being for each individual -- no matter what challenges life threw their way.

Moderator: Ken MacQueen, Vancouver Bureau Chief, Maclean's
Panelist: Dr. Jeff Turnbull, President, Canadian Medical Association
Panelist: Scott Dudgeon, Health care executive, policy consultant and author
Panelist: Irwin Elman, Provincial Advocate for Children and Youth, Ontario
Panelist: John Geddes, Ottawa Bureau Chief, Maclean's
Panelist: Nadine Henningsen, Executive Director, Canadian Home Care Association and President, Canadian Caregiver Coalition.

Maybe avoiding a definition of health was an unconscious, Canadian way of avoiding precision in order for the term to remain all things to all people. I suspect that if such a definition became more broadly accepted, then 'health care' would come to refer to those practices which helped produce that sense of wellness for individuals and 'health care professionals' would be those people who provided the guidance and services necessary to achieve that wellness. That added clarity might in itself begin to shift elements of the health care system in a new direction.

But, along with this vagary about what health was, there was the equally unspoken challenge that no government can actually legislate health for anyone. However we want to define it, the quality of our health is the responsibility of each of us. Government can help but the burden is on us. While no one explicitly expressed this, it was the elephant in the room.

That said the conversation was thoughtful, passionate, personal and at times tearful and in the end Dr. Jeffrey Turnbull, head of the Canadian Medical Association, did an excellent job of summarizing the evening's discussion in seven main points:

1. It was evident that the audience was in broad agreement that the health care system is failing Canadians. While it does quite well with acute and emergency care, there are many groups of Canadians -- the young, the old, those in rural areas, aboriginals, the disabled especially those with chronic conditions like autism -- who are not receiving a level of care that can be deemed equitable. They do not experience the level of wellness shared by many of their fellow Canadians. And if value in health care was determined by getting one's needs met, then these people and many others were not getting the value they expected.

   It was mentioned, for instance, that although Canadians generally feel they have one of the best health care systems in the world, the WHO has ranked Canada 35th in terms of overall levels of health, certainly ahead of the USA but behind Italy and France, not to mention 'developing' countries like Jamaica, Morroco and Costa Rica.

   Many people felt that the system fails to put their needs ahead of the needs of the system, health professionals, the institutions and the politicians. Basically, the system was perceived as failing to deliver good customer service or recognize the unique and individuated needs of the people who try to utilize it. While all people are not the same, the way in which health care delivery is set up in Canada assumes that they are.

2. The way in which our health care system delivers services is fractured. It functions in silos and is neither integrated among its various streams nor is it patient-centred. As a result this leads to inequities in health outcomes even when that is not the intention. It was reported, for example, that a young person who was receiving psychological care and making progress and subsequently diagnosed with Asperger's syndrome was then refused further treatment because that clinic didn't provide services for Asperger patients resulting in the patient's care to begin from scratch.

By contrast, the apparent belief among the audience was that the services should follow the patient not the patient the services. Such a patient-centred approach would require that services be integrated, and that both patient and health policy be constructed to foster an individual experience of health instead of a hypothetical average person. Supporting citizens in their pursuit of their own individual health goals would naturally require a very different approach from that required to deal only with acute care and emergencies – one much less paternalistic and more facilitative.

While the notion of patient-centred health care seemed largely popular in the audience, it was not without some criticism. "How patient centred do you want to make it?", said one participant. "I'm busy. I have other things to manage. I just want quality services when I want need them and I don't want to pay for them." "If more responsibility is pushed onto citizens for their own health management", said another person, "what rewards or punishments would we be willing to impose to encourage better health choices? The idea of punishing people for bad health choices is not likely to sit well."

3. The current health care system was originally built around the provision of acute and emergency care in what one participant aptly described as "Humpty Dumpty" medicine, ie putting all the pieces back together once the person is broken. Canadians, however, have moved on to more holistic considerations such as health prevention and promotion, i.e. doing things when "Humpty Dumpty" may just be cracked and not really broken. The evidence already shows that waiting until people are broken places huge physical, psychological and emotional burdens on citizens and immense financial costs on the health care system. Besides which, a growing proportion of health care costs are not related to acute or urgent care but to ongoing and chronic care whether it be for seniors or for those with genetic or long term needs. We need to get beyond "Humpty Dumpty" medicine.

4. Several participants in the audience were clear in identifying the importance of paying attention to the broader context of health that includes the socio-economic determinants of health and the need to develop socio-economic policy while looking through a health lens. Policies regarding poverty, transportation, crime and other anti-social behaviour, housing, the environment, parks and natural resources, energy, and the economy, all have significant impacts on the state of health experienced by citizens. The time has come, said the audience, to link an awareness of these impacts on health with other social and economic policies.

5. On several, sometimes emotional occasions, participants expressed a desire to see a national system of care and behavioural standards for health practitioners whom they believed were able to avoid the consequences of bad judgement and abusive behaviour behind the precincts of professional self regulation. Added transparency was needed, they said, so that people could better understand how professional misconduct was being judged and disciplined in order to ensure accountability and compliance with those standards.

Several panellists and participants also suggested developing a national care giver strategy. Others suggested developing accountability not only for specific patient services but also for the entire patient journey. In line with the notion of patient responsibility for their own health, one provider introduced the idea of "firing" patients when the patient refused to follow treatment.

6. It was not at all surprising that the audience felt it was important to reduce waste and increase efficiency in the system of health care delivery is critical to ensure the system is sustainable. Several suggestions were made including reallocating hospital beds away from seniors in need of long term care to making better use of technology. Pumping more money into health care wasn't the answer these people were looking for. Clearly, they felt the need to re-design the business model of health care delivery. And with that develop a better focus on prevention and early detection to avoid costly and painful interventions.

   The point was raised that the delivery of health services is an exercise in rationing. It is a desirable good and so when the price goes to zero (or is perceived to be zero when the government picks up the tab) then the demand for it goes to infinity (economics 101). The question was pose as to whether we were willing to
   a) demonstrate that use of the health care system was not a free good; and
   b) make clear what is free and what is not in a manner perceived to be equitable across all groups in society.

7. Lastly the experience of the evening was a clear indication of the need for further dialogue. The two hour session barely scratched the surface of the interest of the people in the audience. The notion that the Health Canada Act was somehow sacrosanct, taboo or beyond discussion and reform just wasn't accepted. It was broadly perceived, however, that for our political leaders an 'adult conversation' that could lead to needed reforms of the Canada Health Act seemed beyond the realm of possible.

   The "basic outlines of the health care system just won't change vis a vis the politicians," said one panellist. The implication was -- don't look for leadership with them. It was a moment of great cynicism suggesting the title of the evening might have been better as *Time to Rebuild Medicare – Again!* given the numerous and largely failed attempts to improve the system previously by Castonguay, Romanow, Kirby and Mazankowski to name just a few of the most recent advocates for change.

   I was also reminded of the plea from David Dodge, former Bank of Canada Governor, to re-think health care when he was speaking to the Liberal party's policy renewal conference in the spring of 2010[1]. He referred to the "stark and unpalatable choices we face with respect to health care," and that "there is no magic solution and

[1] Liberals urged to overhaul Medicare due to rising costs, *The Canadian Press*, Sat Mar. 27 2010 accessed at http://ottawa.ctv.ca/servlet/an/local/CTVNews/20100327/OTT_liberals_health_overhaul_100326/20100327/?hub=OttawaHome

we absolutely must have an *adult debate* about how we're going to deal with this." In response to which, Frank McKenna reportedly turned to Paul Martin and whispered "We're f**ked"[2].

Nonetheless, despite the lack of political appetite for change, participants at the *Macleans* event were much more pragmatic about the prospect of change and suggested that we focus on how to make things better given the existing legislation. "Could we make use of an amending formula to make adjustments to the Canada Health Act like they do with US Constitution?", asked one participant. If the major outlines won't change, then are there smaller, less controversial avenues we can pursue?

To this I would say that there are. In fact, there are several things that might be done to begin shifting the system in a new, more responsive and sustainable direction. I offer three such mechanisms for change below. They include adding a preamble to the Canada Health Act; moving to incentivize change through the application of flat fees for services; and the institution of individual health accounts.

1. Add a Preamble

A preamble to the Canada Health Act could be used to define what we mean by health, health care and health care practitioner. This would help set the context for the change we would like to see. We can further establish this context if we also define the assumptions regarding health care that we share as Canadians and the principles by which we would expect the health care system to operate.

According to Vaughan Glover, CEO of the Canadian Association for People-Centred Health and author of *Journey to Wellness,* while Canadians' expectations about health care have changed since Medicare was first established in the 1960s and their demands on the system have evolved over that time, the system itself has not changed. He suggests[3] framing health care policy within three very basic and uncontroversial assumptions which include that:

i. health and health care are about people (ie. they are people-centred);
ii. the purpose of a health system is to support the health of the people (however health may be defined); and
iii. all Canadians should have access to a universal, publicly-funded level of support (the basic tenet of Medicare instituted by Tommy Douglas in the 60s and now an assumed value of Canadian-ness).

The first two assumptions lead to four basic principles which should guide the way the system supports the health of the people. These include:

[2] Dan Gardner, *Squabbling in Serious Times*, 25 March 2011 accessed at http://www.dangardner.ca/index.php/articles/item/114-squabbling-in-serious-times
[3] Vaughan Glover. "A People-Centred Model for Health: An Open Letter to the Ministers of Health", *Optimum Online*, Vol. 34, Issue 3, Oct 2004

i. *individual autonomy*, the right to personally define one's own balance of well-being.
ii. people must take *personal responsibility* and ownership for their own personal health, something that requires education, but it also requires acceptance of the consequences of one's own actions.
iii. *people must be informed* to allow them to move beyond health as treatment for acute disease to prevention and wellness, and this will require a commitment to self learning in order for a person to make informed decisions and take control of their health.
iv. people must be *free to make choices*, a natural consequence of being better informed but requiring a provider to be more like a mentor or facilitator, supporting an active participant rather than just treating a passive patient.

These three assumptions and four principles can help shape a health support system that allows people to choose for themselves the quality of care they want, and allow them the opportunity to make those choices even when they are in difficult financial situations.

This orientation isn't radical. It's accepting the obvious. "With the exception of some urgency care, no matter how good the diagnosis, long-term success is ultimately in the hands of the patients/ clients/ consumers," says Glover. "The best government can do is to provide a support system to help individuals achieve their health goals. People must learn to accept responsibility and ownership for their personal health". To some, like the participant in Tuesday's event, who preferred not to be responsible for his own health, I would say, too bad. Asking society to foot the bill for their own unwillingness to pay attention to themselves is entitlement in its most egregious form and a breach of the social contract.

2. Flat rate for services

In comments that must have raised eyebrows in health ministries across the country, former Quebec Cabinet Minister François Legault recently suggested that the supposed physician shortage was a fiction and that "there should be enough physicians in Quebec to end the family doctor shortage", and that "changes to factors such as workload and increased financial incentives would allow that to happen".[4] In a rare departure from political orthodoxy, Legault's comments focus change not on such ideological competitions as private versus public but on re-jigging the business model in which health services are delivered.

One such "factor" might be the imposition of **flat rates** for various health procedures (for example $20 for a stitch, $50 for broken leg, $10,000 for heart surgery). What such a pricing mechanism would do is shift the burden of low value adding services to those with commensurate skill levels and higher value adding services to those with more skills and training. Highly trained doctors would then choose to do the things for which they would receive the most compensation for and vacate those tasks more suited to nurse

[4] CBCnews, *Former Que. minister calls for health reform*, May 17, 2011

practitioners and nurses. No one would have to tell anyone what to do. Each person would choose for themselves based on their level of skill.

It's well known that the time of doctors is often over utilized in areas where others could do the job equally well. But if they are being paid the same for a stitch as they are for heart surgery then why do heart surgery which is so much more difficult and risky. If, however, their compensation is properly aligned with their level of effort and risk, they will pursue the activities most suited to them as it would reward them the most. This was a recommendation buried in the Castonguay report that was thoroughly ignored.

Alternatively, another "factor" might be to employ a system of '**capitation'** rather than the usual 'fee for service' system and the negotiating fixed annual fees for health practitioners working within specific institutions, hospitals, clinics, etc. As "radical' as this suggestion might seem, it has been used very successfully at the Sault St. Marie Group Health Centre in Ontario for over fifty years. In that time, the GHC has attracted world wide attention for both the quality of its health services and the economy by which it delivers them. In Canada, however, it remains largely unnoticed.

Most simply 'capitation' (or per head calculation) determines from statistical records how much in the way of health services are required for a given population. Knowing this the GHC negotiates with OHIP a monthly health care cost for a given level of membership. GHC then negotiates with health care providers – doctors, nurses, technicians, etc.-- a fixed fee for their services, whether or not those services are ultimately required.

With their income capped, health care professionals then seek to reduce the amount of time needed to see their patients and so are encouraged to pursue health prevention and promotion strategies with their patients. They are encouraged to spend more time with patients to ensure that they understand what's needed and will follow through on their end. Doctors are also encouraged to use lower cost nurse practitioners and nurses whenever possible. Since patients are still to free to go elsewhere if they feel they are not receiving the level of care they desire, a review board is able to monitor effectively the quality of care by following patient choices in and out of the GHC.

Fundamentally, the system re-orientates doctors away from maximizing their number of patients in order to maximize their income towards creating patient health as a means to maximize their free time for a given level of income.

3. Adopt personal health accounts

The idea of personal health accounts (PHAs) has been around for decades. They amount to an annual credit limit to which citizens can charge their health care costs. Contributions to PHAs can be made by citizens or government. If we were to apply the concept of a personal health account in Canada, then how might it operate? The objective is to engage citizens in the management of their health and provide them with a sense of the costs that are incurred without compromising their access to services.

To begin we would need to look at existing statistical data and identify the average cost per person (much like in capitation) for health care by sex, age, number of dependents, location and genetic condition (maybe a few other but fairly basic variables). A single male, for instance, at 18 years of age living in Toronto with no previously diagnosed medical condition might receive an annual allocation of $2000 to spend on health and wellness care of their choosing. A 70-year old widowed female living in Whitehorse with cancer might receive $20,000 per year. A family of four in Ottawa with no known chronic problems might receive $10,000. In addition to public contributions to this account, individuals could make their own tax deductible contributions as well.

CIHI estimates the average cost of health care per Canadian in 2010 was $5600, ranging from $2,097 for those under 64 years of age to $18,160 for those over 80. While it seems like the CIHI averages may be understated, who am I to judge? It does, however, point to the importance of having good and reliable data. However, if this data includes only hospital type costs and does not include the scope of services Canadians may wish to utilize to maintain their wellness, CIHI's figures would be low.

The system to deal with acute or emergency care should probably remain in place. Not only is this the most effective element of the current health care system, maintaining it would also mitigate the uncertainty of unforeseen accidents, trauma or infectious illness. But elder care, child bearing, chronic treatments, common illnesses, seasonal flu etc. would be paid for by citizens directly out of their PHA.

Each adult would be responsible for managing their own or their family's care including drugs, doctors, hospital or alternative care providers. Amounts in health accounts should be transferable among spouses and among parents and their children.

From an equity perspective, a diagnosis of a chronic disease or treatment at any point, even if temporary, should cause an upward adjustment in the health account limit.

To provide a reward for healthy living, unused portions could be accumulated and applied to future years. And to provide an incentive for healthy living, payments made for services which are preventive or health promoting in nature (as opposed to being reactive treatment of illness) should be considered as investments in future health and result in a percentage (say 25%) of their value being added to the person's account in the following year. Some capacity would also be needed to draw down on the account temporarily and top it up later.

The big question is what to do with persons who choose to smoke, who choose to drive while intoxicated, and who choose to eat poorly and not to exercise? If personal health ownership is at all meaningful, it must have consequences. So when a personal account runs out because a) bad choices or b) bad luck what should society do? Turn their back?

My sense is a qualified 'yes' because you shouldn't design a system based on exceptions but on the commonly desired behaviours. Otherwise everyone's behaviour becomes exceptional. But we should recall that dealing with catastrophic life events is what social policies and the not-for-profit sector are for -- to provide a system of community supports

when people can't make it on their own. Yet despite this, maybe any unused health account value at death could be pooled into a catastrophic health fund that could be allocated on the basis of need and availability.

On a semi-annual or annual basis citizens could receive account updates showing costs incurred by them or on their behalf. Provision of this type of information would in itself have many positive effects over the current system where people have no idea what the costs of their health care actually are.

These ideas are not rocket science. Adding a preamble should be no more politically contentious than any other political statement of the obvious. Flat fees and personal accounts are no more complicated to implement than putting in place good billing practices or managing an RSP. Yet together their implementation could transform health care in Canada from an unwieldy and insensitive insurance scheme into a sustainable system of supports capable of fostering the health and well being of all Canadians.

Thanks to MacLean's, the CMA, CPAC and the many people who participated in this rich conversation.