



The Canadian Council on Integrated Healthcare

**From Isolation to Integration:
Bridging the Divide Between
Public and Private Payer Communities
in Canada's Health Care System**



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W H O W E A R E

The Canadian Council on Integrated Healthcare (www.ccih.ca) is an independent, non-aligned think tank whose mandate is “to influence and catalyze change...[and to] build bridges between sectors in the health care system”. Founded in 1997, we are dedicated to helping Canadians understand emerging health issues. Our vision is for an integrated health care system that balances quality, access, and cost, and creates better health for all Canadians. Our membership includes key opinion leaders from the private health sector, labour, consumers, and health professions.

The CCIH has recently been focused on the concept of greater collaboration between private and public payer communities. We held a ‘Payers’ Forum’ in 2006, where a broad range of stakeholders gathered to exchange views and consider new approaches. We are currently working on one specific issue area – access to pharmaceuticals – to explore how a more integrated approach could benefit all Canadians. Please see our website for further information about our various past and present initiatives.



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“Though the Canadian health care system is described as publicly funded and administered, this description ignores the significant role played by private funders. Employers, unions, and individuals pay tens of billions of dollars for services outside the mandated public funding envelope of hospital and physician services. Indeed, each year in prescription medicines alone, employers fund over \$7 billion in costs.”

*(Dr. Russell King, Past Chair of the Canadian Council on Integrated Healthcare (CCIH),
in his opening remarks to the CCIH-convened National Payers' Forum, 2006)*

Overview

Private and public payers of health services in Canada have been separate 'solitudes' for far too long. And Canadian employers have not, to date, had an ongoing and meaningful role in decisions related to health care policy and financing.

The Canadian Council on Integrated Healthcare (CCIH) believes that:

- Health care and health protection is every Canadian's problem; and
- There is an urgent need for greater consultation, better understanding, and more inclusive and effective decision-making around the costs associated with health services.

This paper explores how greater employer engagement in decisions around health care funding and policy making is one type of integration that could help bridge the current gap that exists between largely isolated groups of payers within the Canadian health care system. Specifically, the paper looks at two issues – access to health care and managing demand – where greater convergence and collaboration between public and private payers could yield important returns.

Introduction

The CCIH holds the view that the distance between payer communities in the Canadian health care system is simply an artefact of neglect and reflects the failure to provide adequate, integrated planning as the system has developed over the last forty years.

What is also apparent to us, based on our own discussions, collective experience, and our review of current literature, is that both public and private payers are struggling to rationalize and explain their current roles in financing health care. For instance, funding demands well in excess of the general inflation rate have caused both groups to consider how and where to invest in the future, but particularly where and how to reduce their obligations. Such cost-avoidance steps -- usually taken unilaterally, without dialogue between the payer groups -- often endanger the timely access of Canadians to necessary health services.

It is the view of the CCIH that the current lack of coordination in health care funding must be addressed through increased interface and engagement between employers and public policy makers. We anticipate that the resulting synergy from such exchange could at last bring order to what has so far been an accidental division of funding.

Through our work in this area for the past two years – including gathering employer input and hosting a ‘Payers’ Forum’ where a broad range of stakeholders gathered to share their views – the CCIH has concluded that Canadian employers need a stronger and more regular voice in the health care debate. We suggest that to enable that voice, certain steps are necessary, including:

- Uncovering where patients want to go, and should go, within the health system to get the care they need – what the CCIH is calling ‘health services desire lines’.¹
- Encouraging re-allocation of private and public health system resources to close service gaps and create a system that is more responsive to patient needs and preferences.
- Making funding coordination and service planning more urgent and compelling to both governments and private payers. Such an agenda would give policymakers and politicians some ‘good news’, and prevent the national embarrassment that occurs when gaps in coverage become a “headline” matter.
- Pointing out the cost of inaction in maintaining an arbitrary and ineffective funding model.

The CCIH has identified two pressing concerns where greater convergence and cooperation between public and private payers could really make a difference: access and managing demand. We believe that Canada needs to better ‘organize the market’ to coordinate employer and government funding so gaps in access are minimized or eliminated, leading to better patient access and more optimal management of the resources we do have.

Identifying the problem: *Why the integration of payer groups?*



Why now?

In a vicious cycle, separate public and private payer communities have ensured separate planning and, as a result of indiscriminate cost-shifting, significant gaps in third-party coverage have emerged. Consequently, certain essential health services have become unaffordable for many Canadians. This is particularly true in fast-growing sectors dominated by private financing, such as pharmaceuticals, home care, community care, and funding of regulated health professionals other than physicians.

The danger in this scenario is its potential to be divisive, setting up an ‘us’ (who can access and afford care as needed) and ‘them’ (who cannot) polarity. This is particularly troubling when it is so clear that all

Canadians regard health care as a common value and want the best system possible, while simultaneously considering the need for significant resources invested in other critical national priorities such as the environment, education, social programs, and security – all major determinants of health in their own right.

¹ In parks planning, “desire lines” reflect paths actually taken by park users, rather than those paved by planners. Of course, planners simply cannot foresee everything in advance, especially if they are not regularly walking the paths themselves. Similarly, we believe that in health services, there is a will and a momentum that reflects the user experience, and these trends need to be recognised and acted upon by health planners and policy makers.

There is another important, rarely considered truth: employer contributions to health service financing are essentially voluntary. While supported by decades of practice, goodwill, and collective bargaining, health cost increases are running ahead of virtually all other expenditure types, and smaller employers are already abandoning plans and capping their exposure to those that remain. This generous source of funding needs to be protected and retain its complementary positioning with publicly funded services.



The bottom line: Canada has the resources to do better, and assumes important risks if it simply maintains the status quo... but do we, collectively, have the will to change?

Service gaps have been the subject of considerable study over several decades, but many of these gaps have yet to be eliminated. As a society, we have been afraid to substantially upset the 'sacred trust' of health care funding and delivery. The health care market remains fragmented, and unable to change in tune with the needs, attitudes and preferences of Canadians. Too often, government policy is a lagging indicator of the public mood, and initiatives are both tentative and reactive. Leadership must emerge: this will enable better organization, better care delivery, and higher public confidence. The following trends and issues illustrate this concern:

- Chronic disease is a rapidly emerging health management and affordability issue for payers, health professionals and patients. The most recent Burden of Illness estimate by Health Canada (1998) was almost \$160 billion. Few diseases have national control and prevention strategies.
- Increasing emphasis on prevention, screening, and early intervention will increase costs, at least in the short-run. So will investments in technology to create electronic patient records and enable electronic prescribing.
- Organizing the marketplace is fiscally responsible, because reasonable access to drug and other health services should promote better health and prevent disease progression. In a policy and program vacuum, health plans will shift costs to individuals, creating a greater burden of affordability. Private health delivery organizations will continue to emerge to fill gaps.
- Canada does not need a repeat of what happened with the Canada Pension Plan: The CPP was allowed to languish without action for many years before new funding rules were established to ensure its long-term solvency. Fundamental change to improve accountability and transparency simply comes too slowly to health services.
- The proposed National Pharmaceutical Strategy presents a significant opportunity for better integration between public and private drug plans, but there has so far been only limited interaction and consultation, and no meaningful third-party payer consultation. Any 'national' strategy requires the involvement of employers, whose plans reimburse some \$7+ billion in prescription drug claims annually. This is not just an economic case, but has huge human consequences as well.
- Finally, integration between private sector technology and publicly-run and governed health systems will be necessary to introduce long-delayed and much needed technology, such as electronic health records and electronic physician ordering systems. These are essential tools for monitoring and managing health access, quality and cost.

All these issues and trends are already upon us. They will only be made worse by inaction and the effects of our ageing and increasingly unhealthy population.

Identifying the issues:

Two focal points where integration and coordination between payer groups could help

It is clear that many issues arise from our current 'disorganized' health care marketplace. Two that the CCIH believes could benefit significantly from greater public/private integration are 'access' and 'managing demand'. In the discussion that follows, these issues will be considered from the particular vantage point of the employer as payer.



Issue 1 – Access

Access is not yet adequate, as evidenced by many 'work-arounds' that allow some people to get the care they need or want, while others go without or wait too long. Alternate channels of care reflect an approach that does not meet the need of all Canadians, and this poses a serious threat to the public system, e.g., the turmoil and politicization of the Supreme Court's Chaouilli decision. Canadians cling to outdated or unresponsive legislative, organizational and professional traditions and use these to build walls around outdated and ineffective system components.

Access is hampered by supply constraints and demand accelerators. There are significant areas of convergence between payer groups within Canadian health care generally, and access is one such meeting point. Indeed, shared issues of concern to payers, providers, and health care consumers include:

- Adequate, timely access to:
 - o Rehabilitation and physiotherapy;
 - o Pharmaceuticals, especially for high-cost drugs (e.g., biologic medications), or for patients with chronic conditions taking many drugs with high cumulative cost;
 - o Psychological counselling and mental health services.
- Missing or inadequate policy and practices:
 - o Cost-shifting from one third-party payer to another, or to patients²;
 - o Excessive out-of-pocket cost;
 - o A failure to 'organize the marketplace'.
- The need to reduce demand through:
 - o Health promotion strategies;
 - o Root cause analysis, e.g., lifestyle practices that lead to excess weight and obesity also result in heart disease, diabetes, and more hip and knee replacements;
 - o Among individuals, changing entitlement mentalities to an ownership mindset.

² Cost shifting takes many forms, for example, (i) de-listing certain medications or therapeutic classes from government or employer formularies, (ii) slow government drug review processes (e.g., Common Drug Review followed by provincial reviews), or (iii) making government plans the payer of last resort (e.g., Nova Scotia). It is important to consider here that a reasonable amount of out-of-pocket cost for most patients is unlikely to affect medically necessary utilization, and may positively affect adherence by conferring 'ownership' of the therapy to the consumer.

Employer response to date:

Employer response to access challenges to date can be characterized by two words -- haphazard and tactical. When they choose to intervene, employers are managing demand through health education and promotion activities and more integrated approaches to disability management. More commonly, however, employers choose to control cost by erecting barriers to accessing extended health care plans, such as increasing co-pays, abandoning drug plans (smaller employers), capping dollars spent on specific services, and perhaps limiting payments for dependent claims. The impact of these decisions on health status is not monitored. Furthermore, excessive cost-sharing can impede access, both in public plans (well-documented), and in private plans. In 2006, *The sanofi-aventis Healthcare Survey* of 1,500 Canadian benefit plan members reported that almost 6 in 10 (58%) said they would seriously consider not filling a prescription if it cost them more than \$50 out-of-pocket. Thirty-one percent more said they might not fill the script if it cost them less than \$50. Only 8% said cost was not an issue.



It is important to also consider that if certain employers are too aggressive and short-sighted in making changes to control costs and limit protection, they run the risk of regulation. In the 2005 edition of *The sanofi-aventis Healthcare Survey*, 71% of respondents favoured government regulation and minimum standards for private health benefit plans. When asked the same question again in 2007, even more (78%) plan members agreed. Should such a change occur, many responsible employers would lose their current flexibility in plan design and funding.

Most employer plans do not have out-of-pocket limits, so affordability for low earners is another issue. Even a 20% co-pay on a \$50 drug may be a challenge to some, but paying 20% of a \$25,000 biologic every year would be catastrophic for virtually all Canadians. These claims are already common, but Canadian governments have so far failed to plan and implement a catastrophic drug program as recommended by various government commissions and reports over the last forty years. For its part, the private insurance industry has not yet developed its own national pool for high-cost drug or other health claims, similar to what has existed in Québec since 1997. So far, all our problem-solving has been reactive. Increased spending has not bought change.

Solving access issues will require more than a narrow wait-time strategy and reactive increases in our national complement of health professionals. With inequitable access in both public and private plans, Canada is creating 'haves', and 'have-nots', those who are healthy and those who are not, based on personal economic decisions about the affordability and need for health services. Absent a fundamental change in government strategy, employers will need to make their own decisions, running the risk of exacerbating the needs of our already fractured system.

Issue 2 – Managing demand

The implications of cost-shifting and controlling access need much greater dialogue and cooperation among the payers. Managing demand for services is a common issue and already a well-defined need among payers and providers. Eventually, patients will be affected when services are scarce (i.e., unavailable, delayed, distant, or unaffordable) and choices are required. Reasonable expectations among patients and citizens in general have to be identified, negotiated, communicated, and regularly reviewed. A number of demand-related questions come to mind:

- Should a third party government, insurer, or agency be expected to pay for all prescribed medications?
- If that seems reasonable, then where are we, as a society, going to find those additional resources, or what are we collectively prepared to give up so that patients can have unrestricted access?
- How much should patients pay out-of-pocket, and how will this amount be determined (e.g., age, income, 'high' personal drug costs)?
- How large a co-pay is enough to gently squeeze a patient's sense of entitlement without deterring necessary access?
- What effect will an ageing population have on demand? While age in itself is thought to have a minor effect on cost, ageing often brings increasing levels of expensive chronic disease. Will a larger, healthier senior generation offset the costs incurred by an increasingly over-nourished and sedentary middle-age population? How will children and teens with similar undesirable habits affect future health service demands?
- Emotions drive many health care decisions. Are patients prepared to surrender their 'wants' and 'hopes' in the face of clinical evidence or funding limits?

If some level of control is reasonable to ensure available resources are fairly distributed, then all three levels of government and employers need to be involved to create synergy and enact change at policy, regulatory, and operational levels.

Resource use must be made more efficient, and the system more effective. This will benefit all parties:

- Patients, who otherwise often struggle to access high quality care on a timely basis. Changes would allow them a faster, more successful recovery.
- Employers (and individuals), who want injured or ill employees to remain productive or return to work earlier through faster access to care of a known and consistently high standard.
- Governments, who will be able to improve and better integrate their use of system resources, achieving better value for money, and improved confidence by voters and taxpayers.

How can demand be better managed? Too often, private and corporate citizens automatically expect governments to 'fix the system', but then express frustration with the slow pace of change. Employers shouldn't wait for governments to act to manage demand; they need to arrange their own systems of care to serve and protect their employees. Indeed, there are already many examples of demand management in the world of employment:

- Larger employers often provide health-related education and supportive resources, like Employee Assistance Plans, to help employees and their families navigate the health system and become better informed consumers of health services.
- Employers have a social and legal responsibility to address the root causes of illness or injury, not only through well-established bodies like health and safety committees, but by investigating the organization's contributing or mitigating role in psycho-social dysfunction.
- Private insurers and Workers' Compensation Boards can facilitate and coordinate access and payment for high-quality rehabilitative services, as well as health services such as pharmaceuticals that minimize or eliminate gaps in provincial health plan coverage.





The proviso to such approaches is that they may or may not be in the best interest of society as a whole, so employers also need to understand that their ‘work-around’ solutions, though borne of frustration with an unresponsive public system, may be seen as elitist, unfair, and evidence of ‘two-tier’ coverage.

Overall, however, when third-party payers can organize the marketplace to minimize or eliminate gaps in coverage, satisfaction will be much improved by employees, and by the public at large. The constant threat of a squeeze-the-balloon cost-shift will be mitigated. To repeat: The implications of cost-shifting and controlling access need much greater dialogue and cooperation among the payers.

Considering a solution:

Greater integration of employer and government payer groups

Clearly, the current funding arrangement for health care in Canada is not working well enough. It is too fragmented, politicized, opaque, and resistant to change. Gaps in care quality, safety, patient information, and financing become entrenched, even though the cost of such gaps can be profound.³ An increasingly well-informed population will soon demand better – specifically, that their tax dollars ‘buy change’, and that their employer plans fill in where provincial government plans have retrenched. A pervasive sense of entitlement is only beginning to mature to create a sense of ownership of the system and its long-term sustainability.

As a start, governments need to recognise the important role employers and insurers play in enabling access to health services. For example, in 2007, private insurance paid for \$7.8 billion in prescription medicines. The CCIH believes that Canadian employers must decide to become more actively involved in the decisions that are currently being made around health care funding and policy. If employers, particularly smaller ones, decide they no longer want to ante up to pay for health plans or health promoting activities, governments and individuals will be left with those obligations. The result will be higher taxes, reduced compliance with recommended treatment (leading to negative health outcomes), and generally a no-win situation for government, employers and individuals.

A more integrated approach between public and private payers must, as already mentioned in this paper, recognize the many and meaningful points of common ground. But it is equally important that points of tensions are also acknowledged. The reality is that partnerships can be cumbersome as relationships are formed, trust is established, and the scope of problems becomes better known. However, while the devil may be in the details, this should not intimidate action.

“Idealism is fine, but as it approaches reality, the cost becomes prohibitive.”
(William F. Buckley, Jr.)

The CCIH holds that different payer organizations and institutions who are trying to work more cooperatively together must turn quickly to action and implementation, and not get lost in either fine detail or huge structures: There are too many dysfunctional conversations about health care that serve only to stall progress and create unwieldy structure that protects entrenched and outmoded interests.

In addition, the CCIH believes any new relationships between health care payer groups should be ‘principled’ – that is, based on a number of key parameters like partnership, leadership, clarity, and the need for an action-oriented approach. (See Table 1 – A Framework for Dialogue. This table, which is focused on certain health issues where there could be a real opportunity for payer groups to take an integrated response, emerged from the CCIH ‘Payers’ Forum’ discussions.) Upholding such principles is critical so that changes to the status quo can survive challenges driven by fear of change, emotion, or greed.

³ As clearly demonstrated in the Baker-Norton “Canadian Adverse Events Study”. See: Can. Med. Assoc. J., May 2004; 170: 1678-86.

We also think that when looking specifically at greater integration between employer and government payer groups, some further principles should apply:

- Clarity in roles and responsibilities is a precondition for integration.
- Sustainability is still an issue for both payer groups.
- A role exists for privately-funded and/or delivered care as a complement to publicly-funded care.⁴
- A focus on demand management is necessary in order to overcome demographics and the entitlement mentality.
- Access to benefits should not be tied to employment.
- Minimum standards should be set for employer- and trust-sponsored plans.

The following are only two examples of integrated payer models:

- a. Communities of interest
 Alberta has established a pension advisory committee that meets twice annually to discuss policy options and encourage the sharing of ideas and opinions. This is a deliberate and much appreciated forum for input from employers. When the Canada Pension Plan was originally set up, it too was a cooperative and integrative model.

The CCIH would suggest here that a national strategy for access to pharmaceuticals could become a similar type of model of public-private collaboration within the health care field. To this end, we are currently working on two projects in this area (a case study to present ideas for improving access to pharmaceuticals, and exploration of the concept of industry pooling).

- b. Inside organizations
 In many organizations, safety is monitored by joint labour-management occupational health and safety committees. We think such an integrated process is a good potential ‘launching point’ for organizing the key parties (employer, union, employees and their families) within the workplace, which is a necessary step before looking outward to further integration with other payer groups (and, specifically, governments).

Table 1 – A Framework for Dialogue

| Health Issues | Guiding Principles | | | | | | |
|-------------------------------|--------------------|------------|---------|----------|------------------|-------------|-----------------|
| | Partnerships | Leadership | Clarity | Holistic | Macro-Meso-Micro | Demand Mgmt | Bias for Action |
| Disability Management | | | | | | | |
| Disease Management | | | | | | | |
| Health Promotion / Prevention | | | | | | | |
| Access | | | | | | | |
| Rx Drugs | | | | | | | |
| Child and Elder Care | | | | | | | |

⁴ This could work, for example, when demands exceed the intentions and resources of the public system, and align with the needs of employers, e.g., early and safe return to work following injury or illness, or worksite health promotion.

Moving forward: *A call to action*

This short paper has focused on the urgent need for a more integrated approach by employers and governments to funding health services. A better organized market, where payers work in partnership, will provide more efficient and timely access to services for patients, and achieve better value, recognition, and appreciation of the roles played by both government and private funding.

We propose an action-biased agenda, initially focusing on the funding gap for key products and services such as pharmaceuticals, rehabilitation, and mental health. Unlike today's 'illness' system, a new model will include health promotion and disease prevention as fundamental to a successful system.

Rich dialogue is the starting point to ensure sound policy, and in turn underpins strategic investments to improve access, reduce demand and help ensure the sustainability of our health system. But the time for idle talk is over; too many studies clearly identify the same important system fixes. It is time to act. We encourage readers to think about their own roles in the system (as representatives of payer groups, as health care consumers, perhaps as health care providers), consider where commonalities with others may exist, and what concrete steps could be taken to move toward a more integrated funding arrangement, rather than the separate silos that currently exist. For our part, the CCIH is continuing to focus on one of the specific health topics broached at our 'Payers' Forum' – access to pharmaceuticals. As already mentioned in this paper, this could be one critical area where a more integrated approach could prove to be extremely fruitful. We encourage readers to regularly check our website (www.ccih.ca) for further output on that subject in the months ahead. We also welcome and encourage your feedback to this article at that same site.



***Other publications
produced by CCIH...***

Access to Pharmaceuticals – June 2009

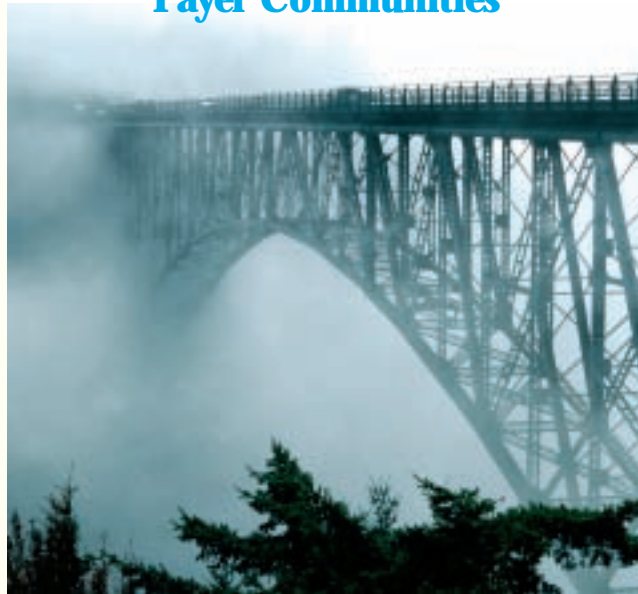
**Let's get engaged - A Preface Paper to a National
Payers' Forum – December 2005**

A Discussion Paper on Workplace Health – October 2002

**A Discussion Paper on the Looming Impact of Genomics
on the Canadian Healthcare System – December 20, 2001**

**Submission to the Commission on the Future of
Health Care in Canada – November 1, 2001**

**Bridging the Divide
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*CCIH gratefully acknowledges the contribution of
Chris Bonnett for his hard work in the development of
this paper; as well as Sharon Blaney, John Elliott, Shelley Kee,
Jacques L'Espérance, Marilee Mark, Steve Semelman and
John Yardley for their editorial assistance.*

*We would also like to thank Lisa Walters for her valuable
support in this project from beginning to end.*