

**SUBMISSION TO
THE COMMISSION ON THE FUTURE OF
HEALTH CARE IN CANADA**

By:
The Canadian Council on Integrated
Healthcare



www.ccih.ca

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EXECUTIVE SUMMARY

The Canadian Council on Integrated Healthcare (CCIH) acknowledges the importance of the Commission on the Future of Health Care in Canada, and appreciates this opportunity to contribute to the Commission's research and recommendations to the Government of Canada.

The CCIH has provided evidence of a system that is essentially sound, but stagnant. Its huge traditions and infrastructure make our system very resistant to change. However, we believe inaction presents huge risks to all Canadians in this rapidly changing world. We strongly recommend that principles of sustainability and accessibility should be adopted as governing principles, and quality and accountability as system-wide operating values.

Leadership is the first and greatest challenge. The federal government must take a leadership role with the provinces and other stakeholders to renew a national healthcare agenda. This should include a definition of core national healthcare services, within a single payer system. The federal government must coordinate the determination of non-core health services and ensure a comprehensive framework that clearly defines the roles and responsibilities of the public healthcare system, other public systems (for example, social services and Workers' Compensation), private insurance (workplace and individual), and the consumer. The federal government must assume leadership in developing a new culture that consults broadly, accommodates continuous change, adopts new management technology, strives for global best practices, educates Canadian consumers in responsible healthcare use, and implements and evaluates necessary improvements. We recommend the federal government convene a forum of healthcare funders representing all sectors (federal, provincial, territorial, local, public, private, and individual) to define a system that clearly defines responsibilities, reduces gaps in funding, and brings order and structure to the financial flows of this \$100 billion health system.

The second challenge for the federal government is human resource (HR) management. The complexity is two-fold: first, forecasting human resource needs, and second, managing recruitment and attrition in today's stressful work environment. Access to the right health professional on a timely basis is an urgent priority for Canadians. The federal government must assume responsibility and develop the capacity for ongoing health human resource planning across Canada. The federal government, in collaboration with the provinces, universities, and healthcare professional bodies must continuously monitor the supply and demand for key health professions to ensure the optimal number of students is trained, and supportive immigration policies exist. Due emphasis for currently licensed professionals must be placed on upgrading and continuing education. The work environment must be thoroughly overhauled to allow greater flexibility, and significantly reduced work hours, in order to prevent burnout, and attract new medical and paramedical practitioners. The CCIH recommends the federal government establish a Task Force to address human resource issues, increase university enrolment as soon as possible, and establish ongoing HR management as a federal priority.

The third and final challenge we present is to determine federal and provincial/territorial funding as well as the boundaries of the public and private payers in Canada. The roles of governments, private insurers and consumers have developed quite by accident, and the result is neither optimal nor sustainable. Private payers already contribute about 30 billion dollars to Canada's health expenditures, principally for drugs, dental and vision care, and community and long term care. Cost-shifting from federal to provincial to regional authorities, to private insurers and employers, has been the rule for many years. The net impact on consumers, who are at the end of the line, is that they are often obliged to pay for access to needed diagnostics and therapies.

Private payers have clear interests in faster access to care that enables quick return to work, consultation on public plan changes, and new legislation to protect privacy and confidentiality while still allowing effective claim management. The debate over a two-tier system ignores the reality that many tiers of care exist in Canada today, and private funding remains an essential element of the health financing picture. The federal government should lead a dialogue to address the provision of core medical services, and examine the implications of various shared-cost models for non-core health-related services.

The CCIH concludes that the key contribution of the federal government is to boldly foster debate and assure *decisions* on issues of importance to Canadians regardless of province of residence or financial means. Principles of sustainability, accessibility, accountability, and quality must be enforced. The public-private boundary must be clearly defined. The critical driver of effective change in our view is leadership, and it is the fervent hope of the Canadian Council on Integrated Healthcare that this forms the central tenet of a renewed national vision of our healthcare system.

INTRODUCTION

Why the Canadian Council on Integrated Healthcare (CCIH¹) is making this submission:

Our goal is to assist the federal government to develop a process that will not only move the healthcare system from its current state to the desired state, but will also assure that the system can continuously adapt to changing needs in the future.

Recognizing that there are a multitude of issues confronting Canadian healthcare, in this submission we will focus on three major challenges and clearly articulate steps the federal government could take to meet these challenges. These steps strive to achieve some balance between responding to what the public wants and recognizing some of the realistic constraints faced by government.

The CCIH has sought to be both strategic and specific in this submission; our intention is to create dialogue and encourage collaboration so that workable, actionable results can be achieved. Recognizing the importance of all four themes that the Commission seeks to address, our primary focus here will be accessibility and sustainability.

For the purpose of this paper, we offer the following definitions:

Accessibility – All Canadians can obtain a defined range of necessary healthcare diagnostics and services in a timely and equitable manner, regardless of their location or ability to pay.

Sustainability – Financial resources are invested and spent in the health system at a rate that does not exceed society’s willingness to pay, given its other priorities (e.g., education, social programs, environment, infrastructure, etc.).

Values informing this submission:

The expectation of the CCIH is that much of what is discussed in this submission resonates broader societal values in terms of what Canadians expect from their healthcare system.²

¹Background information on the CCIH – including its mission, origin, and members – can be found in [Appendix A](#).

² A Canadian Medical Association poll (conducted by Angus Reid, released August 13, 2000) indicates that Canadians rank access to affordable and high quality healthcare among their top three priorities for the future; Canadians are skeptical about how an affordable healthcare system can be sustained; and they believe that a multi-stakeholder response is necessary for healthcare reform.

The CCIH believes:

- An effective Canadian healthcare system is a major element of our nationhood. The Canadian healthcare system can and must be revised to meet the needs of Canadians now and into the future. The current system is under stress and unable to respond in a timely and patient-centred manner.
- The health of the population requires not only appropriate treatment and care, but also disease prevention – primary, secondary and tertiary – and health promotion.
- The health of a society depends on the effective functioning and integration of three societal systems: healthcare, the physical/social environment, and financial support.
- Our nearly \$100 billion health system would benefit from a professional, business-like approach to management, tempered with compassion for the individual. It is the engine of health and productivity management for this country, but requires the efficiencies of reorganisation and technology. It must have a “board level”, *national* accountability to all Canadians, including employers and consumers, as well as politicians, bureaucrats, and health professionals.
- An effective healthcare system can be achieved only if there is integration³ of public policy, private interests and roles, accountability, function, and sustainable funding. A defined, structured, and effective public-private interface is necessary but missing.⁴ The roles and responsibilities of each level of government and the private sector in both funding and delivery must be clearly delineated to assure that services are complementary and integrative, not duplicative, wasteful, and counter-productive.⁵
- Our health system must be built to evaluate and accommodate change at consumer, administrative, technological, and system levels. We believe in the value of critical analysis, and therefore resist the temptation to treat the healthcare system as a “sacred trust” that is immune to challenge or timely progress. Continuous change must be guided by, among other things, sustainability and accessibility.

³ The CCIH defines integration as the merging of elements of healthcare into a coordinated functional system taking into account both clinical and financial considerations to manage quality, access, and cost.

⁴We define “private-sector” financing as the nearly \$30 billion annual contribution to the healthcare system by consumers and employers. It is our view that both groups need a greater voice in strategic and operational issues.

⁵ Dr. John Millar, Vice President of the Canadian Institute for Health Information, said: “It is often estimated that as much as 40% of healthcare funding is used in inappropriate or unnecessary ways.” (Maclean’s, June 7, 1999, p. 21).

With reference to the Canada Health Act (CHA), the CCIH believes:

- The CHA and its predecessor legislation have played an important role in defining Canada's initial principles⁶ for our healthcare system.
- The principles of the CHA remain viable, but need to be expanded to accommodate the development of new policies, guidelines, roles, and accountabilities.
- The CHA must incorporate the principles of sustainability, accountability, and quality, and expand on the existing principle of accessibility, to assure universal access to necessary healthcare.

The format of this submission:

Two questions are at the heart of this paper:

1. Do and will Canadians have **access** to quality healthcare into the future?
2. How can healthcare remain a **sustainable** resource for all Canadians?

To develop a framework to address these key questions, the CCIH has defined three major challenges that must be dealt with by the federal government in the years ahead.

For each challenge area, the paper presents a brief background, a list of the issues the CCIH feels are most pressing in the area, and CCIH recommendations to the federal government. Those recommendations focus both on broader design/structural solutions and more specific management or “action” solutions. Sidebar pieces offer case studies on each of the three challenge areas.

⁶ These principles are: universality, accessibility, portability, comprehensiveness and public administration.

CHALLENGE ONE: LEADERSHIP

The Commission⁷ is an important effort to articulate a clear, meaningful national viewpoint on healthcare, which the CCIH believes needs to be developed. It is our position that the federal government needs to define key problems facing Canadians, articulate its intent to fix these problems, and then move with resolve to implement change following appropriate research and consultation. We believe there ought to be a more proactive approach to managing all parts of the system. Unfortunately, funding, which is the priority, appears to have ebbed and flowed based on the economic cycle rather than according to the defined needs of Canadians. It is important to recognize that medicare will be sustained by effective change and integration, not by simply adding money to fragmented programs.

Issues related to the challenge of leadership:

- The federal government must assume a leadership role in articulating and resolving emerging healthcare issues and developing a plan with national vision, to transform the healthcare system to meet current and future needs. We trust the Romanow and Kirby reports will help settle this key issue.
- The federal government must take the lead in engaging provinces, territories, and the private sector to work cooperatively in the design and implementation of national standards for existing healthcare services relative to access, quality, and affordability.
- As well, the federal government needs to provide leadership in coordination of standard setting and implementation of new health services. For example, the National Forum on Health recommended national pharmacare, home care, and health infostructure initiatives in 1997 that remain essentially inactive four years later.
- The need for apparently endless consultation is a means of delaying action and true accountability for policy and program promises. Failure to execute pharmacare, home care, and health information technology standards and databases means delays in resolving important, well-defined issues.
- Leadership includes a willingness to experiment with different funding and delivery models. Such efforts should be formally observed and evaluated, rather than occurring in an ad hoc and isolated manner.
- Leadership also requires that accountability and quality measurement strategies be developed.

⁷ The CCIH values the opportunity presented by both the Commission on the Future of Health Care in Canada, and the Standing Senate Committee on Social Affairs, Science and Technology (*The Health of Canadians*, Chair, The Honourable Michael JL Kirby) and is submitting this paper to both forums.

- There is ongoing tension and constant media battles between various levels of government as to who pays, how much, and for what services. This is counter-productive and a poor use of time and taxpayer money.
- Technology investment, as well as an understanding of the broader issues raised by certain technological advances⁸, is part of providing leadership in the healthcare field: Canada is in the bottom quartile of OECD countries in terms of spending vis-à-vis healthcare technology, in spite of being in the top quartile in overall healthcare spending.⁹ Measurement of the value of medical technologies is also lacking in Canada.

Case Study: The Health Transition Fund

From the perspective of the CCIH, one example of successful federal leadership is the Health Transition Fund (HTF). Announced in the 1997 Federal Budget as part of the government's initial response to the final report of the National Forum on Health, the HTF offered \$150 million to support projects across Canada to test and evaluate innovative ways to deliver healthcare services. While the funding was provided federally, the HTF was a collaborative effort involving federal, provincial, and territorial governments. These participants collectively agreed to focus projects in four priority areas – Home Care, Pharmacare/ Pharmaceutical Issues, Primary Care/Primary Health Care, and Integrated Service Delivery. In addition to project funding, the HTF supported three national conferences in 1998 and a workshop in 1999. A national dissemination strategy has been developed to guide the analysis and communication of what is learned through the HTF projects. Information on the final results from the HTF projects is expected this fall.

It is the view of the CCIH that the HTF has allowed for the development of creative projects to test, monitor, and evaluate methodologies of proposed change to the healthcare system. We see the HTF as an excellent example of innovative leadership on the part of the federal government. We are anxious to see the consolidated knowledge of the many research projects translated into a more integrated health system, and improved service delivery and outcomes.

Source: "The Health Transition Fund" – available on-line at www.sc.gc.ca/htf-fass.

Policy Recommendations:

The CCIH recommends the federal government:

- Articulate the federal role in healthcare by modernizing the Canada Health Act to include principles of sustainability, quality, and accountability.
- Establish regular federal reviews (for example, every five years) of the funding and operation of the health and related social systems to ensure Canadians are progressing towards defined national healthcare standards, are obtaining value for money, and that change is being effectively accommodated.

⁸For example, in areas such as genomics.

⁹ OECD, Health Data, Electronic Version #3.6, released May 1995.

- Ensure that federal healthcare policy is developed on the basis of need. “Need” must be defined, either according to some level of vulnerability, medical necessity, beyond a defined percentage of income, or exposure to certain chronic or catastrophic diseases. At another level, “need” may occur when interprovincial variances in care or funding exceed a certain level, for example when waiting times for bellwether surgeries exceed a certain timeframe.
- Ensure integrated policy development in other sectors at all levels of government (federal, provincial, and territorial) to address the financial and social support needs essential to promoting health and treating illness.

Action Recommendations:

The CCIH recommends the federal government:

- Take the lead in defining healthcare policy and setting national standards for quality and accessibility, even if some of the provinces decline to endorse such an initiative. When program responsibility is devolved to a province, the federal government must ensure public accountability for funds and commitments provided. The respective responsibilities of the federal, provincial, and territorial governments must be structured to avoid gaps, overlap, and undesirable duplication.
- Define national standards on important healthcare issues such as wellness, immunization, human resources, access to home care and drugs, and provide funding to support the fulfilment of these standards. These will help assure that the provinces and territories fulfil their responsibilities to deliver healthcare that has equal access, quality, and affordability, regardless of location. The roles of all levels of government should receive ongoing evaluation of need, implementation, and outcomes.
- Set up an ongoing process for educating the public about healthcare issues, the status of the healthcare system, and public responsibility for assuring access and affordability. This process should include working with the provinces and territories and with private sector funders. Part of the government’s educational program could be piloted with Canadian seniors (e.g., appropriate use of medications), or younger families (e.g., immunization programs).
- Call a National Funders’ Forum to explore the current and desired framework for funding and delivery of health services between various levels of government, consumers, private insurers, and employers. The Canadian system has evolved in a haphazard manner that is not sustainable with spiralling cost pressures and continual introduction of new technologies.

- Design and implement standards for health information management to ensure accountability of all funders and users of health services, perhaps through the Canadian Institute for Health Information. This would include creating structural databases that allow for the development of performance measurements (i.e., quantity, quality, implementation, and outcomes) in the healthcare system. While respecting privacy and confidentiality, this system must provide essential research, e.g., on best practices, and equitable access to health services regardless of where Canadians live.
- Establish an independent Health Commissioner, modelled after the Auditor General. This office would instil arms-length accountability for almost \$100 billion of healthcare spending in Canada.

CHALLENGE TWO: HUMAN RESOURCE MANAGEMENT

Human resource management has been identified as one of the key issues facing Canadian healthcare in the years ahead.¹⁰ It is the view of the CCIH that effective human resource management is not an end in itself, but is rather a critical foundation piece that is necessary in order to build an accessible and sustainable healthcare system.

The documented delays in receiving healthcare services, including emergency room service, certain lab and diagnostic services, primary and specialist care, are the result of many factors (for example, poor distribution of qualified professionals, overlapping scope of practice, silo governance and management, lack of familiarity with changes in the rest of the healthcare system¹¹). What is clear is that when the complex subject of human resource management is considered, federal involvement is crucial.

Issues related to the challenge of human resource management:

- We recognize that forecasting health human resource requirements is a very complex undertaking,¹² but we believe it must be an ongoing priority. To date, forecasting has either not been developed sufficiently, used inappropriately, been ignored, not been adequately promoted, or has been insufficiently sensitive to accurately identify future surpluses and shortages.¹³ At present, Canada faces a shortage in many healthcare professions, while there was a surplus in the early and mid-1990s.¹⁴ It is clear that we do not yet know how to smooth the volatility of the demand and supply curves: Long, lead times mean models must accommodate changes in the environment, budget, priorities, and collective bargaining agreements.

¹⁰ From January to March 2001, five national organizations undertook a consultation to identify research themes that respond to the needs of policy makers and managers in the healthcare system for the next two to five years. *Listening for Direction*, the report that evolved from that consultation, states that, "Health human resources [HHR] was seen as the dominant issue. . .by policy makers, managers, and clinical organizations."

¹¹ New trends in the healthcare system include things such as the focus on prevention, the introduction of new technologies, and the impact of revolutionary new fields such as genomics. For a discussion of issues related to genomics, please reference the CCIH Genomics Working Paper, October 2001, at www.ccih.ca.

¹² The CCIH recognizes that many uncertainties affect the ability to accurately forecast health human resources needs. For example, physician numbers may be affected by immigration patterns, shifts in consumer preferences, shifts in university enrolment, regional practice variations, the mix in GPs vs specialists, etc. We also recognize that decisions to change the number of healthcare professionals take many years to work through the system. For example, it takes ten years to train a physician, and many things can change the employment prospects and career path of that student cohort over that period of time.

¹³ Shah (1998) reports the Barer-Stoddard report of 1992 (Toward Integrated Medical Resource Policies for Canada, *CMAJ* 146(3): 337-351) recommended that the then oversupply of physicians be corrected through an immediate decrease of 10% in medical school enrolment. Actions based on this recommendation have contributed to the current physician shortage experienced in many parts of Canada.

¹⁴ In a report released on October 25, 2001, the College of Family Practitioners of Canada (CFPC) has confirmed that Canadian family practitioners have untenable working conditions, specifically long hours (averaging 70 hours per week), that are simply not sustainable. The CFPC also cited a national shortage of 3,000 physicians.

- A contributing factor to the Canadian shortage of healthcare professionals is the competitiveness of the global market, which is influenced by international free trade agreements and further frustrated by deliberate interprovincial recruitment.
- Canada has not paid sufficient attention to professional, integrated health human resource management. We do not understand how to attract people to the healthcare professions, how to attract them to regions of need, and how to retain them.
- There has been an apparent shift in attitude and work ethic (work-life balance), and healthcare professionals are less willing to subject themselves to stressful work environments, including long hours of practice and lack of recognition for service excellence (vs tenure or seniority).
- Consumers are prompting changes in what is expected of health professionals. Not only do Canadians want accessibility to qualified practitioners, but they also want access to treatment options. For example, average Canadians do Internet research on options and are more knowledgeable than they ever used to be.¹⁵
- We recognize that changes to the organization of healthcare (e.g., primary care reform; home care) present many challenges to managing health human resources, including:
 - The complexity involved in taking on new roles within a new organizational framework: for example, the physician as “gatekeeper” becomes the “coordinator” within a primary care reform model; looking at healthcare providers as members of a spectrum vs traditional hierarchy.
 - Simple resistance to change (fearing the unknown).
 - Communication and acceptance of different payment schemes: fee for service, capitation, salary.
 - Technological support for new initiatives is in place.
 - Dollars allocated for patient healthcare must be protected from re-structuring costs.¹⁶

¹⁵ *Listening for Directions* suggests that the patterns of care-seeking are undergoing rapid change. The Price Waterhouse Cooper “HealthCast 2010” (a survey of 380 thought leaders in 10 countries) also suggests that empowered consumers and e-business are two of the forces of change in the healthcare field in the years ahead.

¹⁶In Ontario, experience has been reportedly poor in this regard. The Ontario Hospital Association has reported situations where they believe patient care has been compromised by hospital re-structuring.

- It is critical to improve access for marginalized groups (either geographically remote, or specialized groups such as patients with mental health problems or addictions, aboriginal peoples, ethnic groups, and the poor) to health professionals. The social determinants of health must be addressed as part of this effort.
- The conversion of full-time to part-time employment among nurses has resulted in poor professional loyalty, and increased use of contracted staffing organizations. Employers have not yet restored stability in working hours for nurses, with profoundly negative consequences in terms of recruiting new nurses, retaining professionals who are in high demand across North America, or attracting those previously employed in the field.
- A cautionary note must be raised that short-term solutions to the lack of healthcare human resources should not allow for the erosion of qualification standards or compromised quality.

Case Study: Positron Emission Tomography

Positron Emission Tomography (PET) is a technology with a broad spectrum of uses in oncology, cardiology, and neurology. It is an imaging technique used to detect and analyze metabolic abnormalities in tissues throughout the body. Three-dimensional images are produced that can show the precise location and state of development of tumours in tissue, tissue viability in cardiovascular disease, and unusual states (e.g. seizure disorders) in the brain. For example, PET can detect the presence of tumours in various locations before structural evidence of disease is detectable by anatomic imaging. Costly and invasive exploratory surgery or other inappropriate treatment may be avoided.

Introduced as a research tool in the 1970's, PET is now widely used for clinical patient care in various parts of the world. There are only three PET scanners being used for clinical patient management in Canada, two at teaching hospitals, and one at a private facility in BC which charges patients \$2,500.

While the Institute for Clinical Evaluative Sciences (ICES) found no high quality economic evaluations of PET in Canada, it did conclude that each year, about 24,000 Ontarians might benefit from this technology.

A PET scan is not recognized as an insured service in the context of the Canada Health Act. It is not a hospital service, and has not been made a reimbursable service by any of the provincial health insurance schemes. The sole Canadian private clinic in BC does not compete with a public health service - there is no alternative provider in the region. The BC Cancer Agency has periodically accessed provincial Ministry of Health funds to send patients out-of-province for PET scans.

Among the many issues presented in this illustration, is the key HR question of how and when Canada will meet the need to train and retain highly skilled physicists, technicians and diagnosticians for this technology.

Sources: (i) ICES (*Health Technology Assessment of Positron Emission Tomography*, May 2001. Available on-line at: www.ices.on.ca. (ii) International PET Diagnostics Inc., a briefing paper prepared by Info-Lynk Consulting Services Inc. Used with permission.

Policy Recommendations:

The CCIH recommends the federal government:

- Engage in consultation to develop national standards for health human resource roles, scope of practice, interprovincial recruitment, and appropriate ratios of providers to population served.
- Recognize that the de-regulation of tuition at post-secondary institutions could mean variable access to professional training: this requires a commensurate increase in bursaries and scholarships and/or a training program where government assistance with tuition fees is paid back through a form of dedicated after-training service.

- Recognize that current working conditions, long hours, and patterns of practice are not sustainable, especially for our older, more experienced cohorts of healthcare professionals.
- Encourage the development of flexible work environments that will both attract and retain qualified healthcare professionals.
- Encourage flexibility in how advancement and recognition take place within the healthcare professions (as above, this will make attraction and retention to these professions easier): in particular, skills, education, and breadth of experience should all be factored into performance evaluation and related rewards.

Action Recommendations:

The CCIH recommends the federal government:

- Move to increase the number of student and faculty positions in medical and nursing schools across Canada and develop strategies to attract qualified physicians and other health professionals to rural and remote areas of Canada.
- Lead an initiative to monitor and plan health human resources needs, including understanding the implications of practice pattern changes, the globalization of supply, and re-evaluating qualification standards relative to scope of practice, e.g., for nurse practitioners vs physicians, and dental hygienists vs dentists.
- In collaboration with the provinces and territories, develop a national program to recruit and train qualified healthcare professionals that supports clinical organization and practice preferences of new recruits. The plan should assure that the needs of rural and remote regions as well as marginalized and under-served groups are addressed in a sustainable way. The plan should also take into account emerging needs (for example, genetic counsellors).
- Develop an effective, practical, ethical policy for hiring foreign-trained health professionals. This could include providing incentives to train in Canada that would be matched by the recipient's commitment to practice here for a given number of years following licensing.
- Facilitate ongoing continuing education that would be delivered by recognized experts and not just by manufacturers or suppliers with vested interests in driving demand for their own products. Life-long learning should be an expectation and an opportunity for all healthcare professionals.

- Encourage and enable flexible work arrangements to accommodate new delivery models and to reflect different work-life balance priorities of new recruits; in particular, encourage the development of primary care teams across Canada (consisting of multi-disciplinary, integrated membership providing 24 hour coverage) to replace today's fragmented service delivery.
- Make investments to define, test, implement, manage, and report publicly on the quality of health providers (institutions and professionals) to improve accountability to patients and taxpayers. Quality should help define promotion and career progression (or financial bonusing for institutions) more than service tenure. Generally, this must be made more transparent to consumers who place their life and health in the hands of others.

CHALLENGE THREE: BOUNDARIES OF PUBLICLY FUNDED HEALTHCARE

Boundary confusion in the healthcare system exists in two major areas: between federal/provincial/territorial governments and between public and private sectors. This confusion means Canadians suffer from gaps and duplications in services and funding, and inequitable access. Each area will be considered separately here:

Issues related to federal/provincial/territorial boundaries:

- Government funding should assure Canadians of equitable, accessible, quality care, as well as sustainability of the system. We believe the federal government has the primary responsibility for consulting with provincial and territorial governments, and health professionals to define national standards and assure adequate funding to deliver them.
- Variation between provinces in budgeting and service provision is now affecting quality of care, resulting in a patchwork approach to service provision nationally. This was acknowledged several years ago, but the variation and accessibility to service provision gap is widening. For example, Toronto's Hospital for Sick Children is the only national paediatric care provider.
- A single payer system covering (most) hospital and physician services under the CHA is likely to decrease administrative costs, and we support this principle. However, with advances in technology, expanded use of pharmaceuticals, and the shifting of care from hospital to community, the development of new programs presently lies outside the Act. This is impacting significantly and adversely on private sector health insurance plans.
- Undue fixation on keeping administrative costs low can frustrate desired investments in better patient service and information management systems.
- Accountability by all parties – government, providers, and patients – for funding and delivery is a crucial issue.

Case Study: “Two-tier” Healthcare

There is much concern, and equal amounts of ignorance, around the term “two-tier”. Critics of a private role in healthcare delivery or funding believe a single, system-wide payer could manage the system with lower costs as a monopoly buyer of services (e.g., pharmaceuticals), and with less administration (citing the high administrative burden of the multi-player US system).

In reality, Canada already has a multi-tier system, with differential care or financial burden based on employment status, geographic location, whether costs arise from an occupational injury covered by a Workers’ Compensation plan, literacy level, or just “who you know”. Arguably, there is a point of diminishing returns after exceeding a certain scale, when the bureaucracy can’t help but lose sight of the customer. Bigger systems are not necessarily better, more responsive, or higher quality systems.

Does the existence of private insurance mean higher cost for the public system? We are unaware of any evidence to suggest this: in fact, one study (Hughes Tuohy, et al, 2001) suggested a 10% increase in private spending typically leads to a 1-3% reduction in public spending. Is access to private insurance only for the privileged few? When such a phenomenon is so widespread, benefiting 17 to 20 million Canadians (see Health Canada, 2000), it certainly cannot be called elitist.

The reality may be that support for a privatized system is a red herring. As Colleen Flood, Law Professor at the University of Toronto, said “The whole privatization agenda is really a “cop-out”. Unfortunately what is required to make our publicly funded health care system work is a lot of complex, unglamorous work at prioritizing needs, reforming structures, instilling accountability and improving governing mechanisms. Privatization is a smoke screen.” Policy debate generally makes the assumption that private spending is “wrong”. However, it may simply be a sign of a relatively affluent society, one that demands services and standards without much thought as to whether healthcare is a consumer good, or a social or public good. Maybe the public-private issue can be better expressed as confusion over whether or not to allow competition. Competition, a distinctly private sector competency, ought not to be confused with deregulation, and might address some of these perceived problems with service quality and consumer satisfaction.

References: (1) Private financing/Private delivery: understanding the two-tier threat. health policy forum 4(2), Summer, 2001:17. (2) Health Transition Fund Project NA202 – *Canadians’ Access to Insurance for Prescription Medicines*. (3) See: Hughes Tuohy c, Flood CM, Stabile M (2001). How Does Private Finance Affect Public Health Care Systems? Marshalling the Evidence from OECD Nations. Available on-line at: www.law.utoronto.ca/healthlaw.

Policy Recommendations Related to Federal/Provincial/Territorial Boundaries:

The CCIH recommends the federal government:

- Should make federal funding conditional on provinces and territories providing established and publicly accountable standards of service, ideally standards that apply nationally, and accountability beyond simple compliance with the principles of the CHA.

- Review the combined funding of the Canada Health and Social Transfer (CHST). Whether funding remains combined or becomes separate, it is important to be clear what portions are for health, social programs, and education. This includes portions contributed in cash, and through tax credits. Since all these components roll up to determine health, the CCIH finds there is some logic to combining funding in an integrated model.
- Re-structure the CHA or its regulations to include incentives for consumers to use the healthcare system responsibly.
- Support a single payer system for core healthcare services, which protect Canadians against catastrophic costs associated with illness.
- Continue to permit private sector insurance for services over and above or outside the core healthcare services.

Action Recommendations related to Federal/Provincial/Territorial boundaries:

The CCIH recommends the federal government:

- Lead a broadly consultative, but time limited, dialogue to determine what criteria would constitute national core services under the Canada Health Act.
- Lead a similar process to determine what services are still essential, but not part of the national core services. Such services would be covered through a sustainable and equitable combination of public funding, private insurance, and patient payment.
- Continue to develop, and introduce as quickly as possible, national dataset standards through the Canadian Institute for Health Information for all kinds of health services including pharmaceuticals, home and community care, and rehabilitation.

Issues related to public/private boundaries:

While the private sector¹⁷ has always been an important component in healthcare funding, it is our view that the boundaries between government, private insurance, and the consumer must now be collaboratively developed, appropriately recognized, and then protected. There is presently no clear rationale for what is paid publicly or privately, as witnessed by the wide

¹⁷Currently the private sector, consisting of employer insurance plans and cash payments by consumers, contributes roughly 30% of the total healthcare costs and almost 60% of prescription drug expenditures in Canada, according to the Canadian Institute for Health Information (CIHI), *National Health Expenditure Trends 1975 – 2000*. Private health expenditures are concentrated in non-physician health professionals such as dentists and opticians (90% of total spending), drugs (67%), and other institutions, such as long term care facilities (30%). With de-listing of healthcare services (e.g., physiotherapy and eye examinations in Ontario), and slow adoption of leading edge products and technology (see previous sidebar on PET scans) private sector expenditure will continue to increase rapidly in subsequent years.

level of interprovincial variability in publicly-funded coverage. The private payer community includes insurers, large employers, unions, and consumers¹⁸ through out-of-pocket expenditures on health products and services. The continued willingness to pay by these stakeholders must be encouraged.

Private plan sponsors – the employers and private insurers who fund and administer employee benefits – are interested in a variety of issues, such as:

- Fast access to necessary health services to allow employees and their family members to either prevent illness and injury, or allow absent workers to return to work quickly and safely.
- Consultation on plans to introduce new services (e.g., pharmacare or home care), or to de-list existing services from medicare plans. These decisions will impact existing employer obligations to employees and retirees, especially where collective agreements exist. Basic introductory services will create an expectation that employers will ‘top-up’ coverage for any perceived shortfalls in a government plan. Predictability is extremely important to create business confidence.
- The explosion in technology development -- diagnostics, MRI, CT and PET scans, pharmaceuticals, diagnostic surgeries and techniques -- has resulted in limited and uneven access by consumers because of issues around the responsibility for payment.
- Acknowledgement of the important role employers play to provide billions of dollars for income protection schemes following injury or illness, such as short- and long term disability plans, Workers’ Compensation, etc. These indirect system costs are about twice as high as direct expenditures.¹⁹
- Involvement in research that jointly considers the efficacy and outcomes of public and private spending on health benefits. Most taxpayer-funded research only reviews public plans, e.g., drug plan cost driver and utilization reports done for provincial drug plan managers by the Patented Medicine Prices Review Board.
- Privacy and confidentiality legislation that protects personal information, but does not unnecessarily restrict the employer’s ability to manage their plans through reasonable access to claim data reported in aggregate form.

¹⁸ Consumers pay out-of-pocket an even greater portion of private health expenditures – \$13.7 billion, according to CIHI, in the year 2000.

¹⁹ Health Canada, 1997. *The Economic Burden of Illness in Canada 1993*.

- Cost-shifting is a phenomenon that occurs when, as a result of restrictions on provincial budgets, healthcare costs are absorbed by the private sector. While understandable in times of cost constraint, this can have untoward and adverse effects on patient care. Cost-shifting is recognised by insurers, employers and consumer associations as being unsustainable and unfair. It does not solve underlying budgeting problems, or manage the demand for increased or improved services. An example is found in the Ontario Drug Benefit Plan: the dispensing fee paid by the Ministry is uneconomic, so retail dispensing fees charged to consumers and private insurers are about 50% higher.
- Improved public accountability and coordinated efforts to control financial fraud and abuse by individuals and health professionals by their regulatory bodies. Governments should liaise with industry associations (like the Canadian Life and Health Insurance Association and the Insurance Bureau of Canada), or may also approach specific companies and regulatory bodies.
- Private insurers and their employer clients have required most patients to pay part of the cost of medicare supplement benefits since the 1970s.²⁰ All provincial governments require taxpayers or users to pay a portion of their drug costs, although amounts vary widely from \$850 semi-annual deductibles in Saskatchewan, to 2-3% of income in Manitoba, to as little as \$2 per prescription in Ontario.

Policy Recommendations related to Public/Private boundaries:

The CCIH recommends the federal government:

- Enhance financial sustainability through a form of insurance plan consisting of public/private components: Through a Funders Forum, the federal government should explore different mixes of public and private financing, particularly in areas that are rapidly expanding such as drugs, long term care, and community-based care.
- Establish the criteria that determine who pays for which services.
- Continue to permit private insurance for services over and above or outside core healthcare services.

²⁰ Cost-sharing may take the form of deductibles (annual, per service encounter, per member), coinsurance (generally 20% paid by the patient), and/or premium contributions.

Action Recommendations related to Public/Private boundaries:

The CCIH recommends the federal government:

- Develop in conjunction with the provinces, territories, private payers, and other interested parties, standards for quality, accountability, integration, and service consistency. The goal will be to support improvements in medical error rates, foster more appropriate prescribing, assess physician and hospital quality, improve the accuracy and utility of hospital report cards, and reduce significant inter-city and intra-provincial (e.g., urban-rural) disparities in care.
- Determine with appropriate consultation, what health services should be considered core, meaning publicly funded, and what remaining essential services will be non-core, but covered through a sustainable and equitable combination of public funding, private insurance, and patient payment.
- Study the effects of competition on health services delivery, patient satisfaction, and costs. We believe competition should not mean an unregulated, “wild west” environment.

CONCLUSIONS

The CCIH concludes that the role of the federal government should be to boldly foster debate and *decisions* on issues of importance to Canadians regardless of province of residence or financial means. Principles of sustainability, accessibility, accountability, and quality must be enforced. The public-private boundary must be clearly defined. The critical driver of effective change in our view is leadership, and it is the CCIH's fervent hope this forms the central tenet of a renewed national vision of our healthcare system.

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Appendix A

CANADIAN COUNCIL ON INTEGRATED HEALTHCARE

Who is the CCIH?

The Mission of the Canadian Council on Integrated Healthcare (CCIH) is to educate Canadians on emerging healthcare issues, with a Vision of an integrated system.

The CCIH is a unique, multi-stakeholder professional forum with members from across Canada working to encourage constructive and inclusive dialogue on challenging health-related issues. It is an independent, non-aligned body, founded in 1997.

The original intent of the CCIH was to bring together key opinion leaders from across the Canadian private health sector to exchange views and develop solutions on the evolving management of healthcare in Canada. More recently, the CCIH has broadened its membership to include expertise from labour, consumer, health professional, and political perspectives. While one particular focus of the CCIH is the interface between public and private aspects of healthcare, this submission is intended to address the perspective of the Canadian citizen and not any particular trade or professional association.

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