LESSONS FROM 2004, PERSPECTIVES FOR 2014

PHILIPPE COUILLARD

Dr. Philippe Couillard, PC, MD is presently a Strategic Advisor, at SECOR Group. From 2003 – 2008 he served as Québec's Minister of Health and Social Services. He has held many positions within medicine, including as Professor at the Université de Sherbrooke and chief surgeon and director of the Surgery Department at the Centre Hospitalier Universitaire de Sherbrooke. He is the chairman of the Health Research Foundation of Canada, a director of two Canadian biotechnology companies and a partner at Persistence Capital Partners, a private equity investment firm. Dr. Couillard is a member of the Queen's Privy Council for Canada and sits on the Security and Intelligence Review Committee.

"There is nothing wrong with change, if it is in the right direction"

Winston Churchill

Seven years ago, our country's first ministers gathered in Ottawa with the intention of achieving an accord that would fix healthcare "for a generation". Sadly, this ambition remains unrealized.

What progress there has been has taken place on the "production" side of our healthcare system: wait-times for targeted procedures have improved (albeit at considerable cost). On the negative side, there remain significant cross-country disparities in coverage for prescription drugs, home and long-term care. Attempts to improve accountability have fallen short of expectations.

As 2014 approaches, some would like the existing accord – including the 6% escalator – to be renewed as is. This would be a missed opportunity. Our country's leaders must learn from the experience of 2004 and use the forthcoming *rendez-vous* as a unique opportunity to make real and perceivable improvements in healthcare for all Canadians.

WHAT WAS MISSING IN 2004?

Looking back at 2004, what is striking was the lack of detailed and meaningful discussion of healthcare, *per se*. Most of the discussion centered on funding, volumes and wait-times, leaving quality, performance and most of the core healthcare issues facing Canada on the sidelines. In hindsight, this focus on the production line rather than on the real value delivered to the user was highly predictable, given the often anecdotal level of most media coverage of healthcare and the realities of our modern political world.

This is not to say that reducing wait times is not important. Shorter wait-times help bolster user-confidence in our healthcare system. But even more pressing is the need to improve the performance of overall healthcare networks. Healthcare services should address our society's changing needs and the resulting patient experience should be comparable to that of citizens of other affluent countries. The focus should be on delivering high quality, seamless, safe services in a timely fashion.

THE ROLE OF THE FEDERAL GOVERNMENT

Since most healthcare responsibilities lie at provincial/territorial level, the federal government is one step removed from the immediate delivery of services. In spite of this, the federal government can – and should – assume a position of leadership, leveraging its financial contribution to become an influential agent for change and focusing the entire country's attention on healthcare (still most Canadians' number one priority).

My first piece of advice follows from Hippocrates' aphorism: "First do no harm…" The federal government should be a facilitator and a collaborator, not a self-appointed policeman in this very complex sector. There is much that is good in our healthcare system and it could easily be destabilized by succumbing to the temptation of a scorched earth policy. Change, in order to be long lasting, has to be incremental and feasible: services are delivered as we deliberate, 24 hours a day, 7 days a week, thanks to the efforts of some of the best teams in the world.

Having said that, the key areas that require attention are as follows.

Securing better value for money

It is difficult to argue that Canada's healthcare sector is not well-funded. In 2009 we ranked 6th among OECD countries in both *per capita* healthcare spending and health spending as a % of GDP. Since the budgetary drought of the mid-nineties, healthcare costs have increased rapidly. Globally, all developed countries face the same decoupling of healthcare expenses and GDP growth. Variations in funding mechanisms across countries – subsidized private insurance, social insurance, tax-based funding with or without user fees – have limited impact on countries' ability either to "bend the cost curve" or to improve performance (with the exception of the poor performance and equity of the very few systems that are based purely on private, unsubsidized insurance).

The reality is that healthcare is a "luxury good" accessible to affluent societies such as Canada. As such, it is unlikely that the annual rate of increase in expenses can be brought down to less than 4-5% without adverse consequences, followed by rebound overspending. So, the focus should not only be on mitigating costs but also on pursuing better value for money.

This is particularly important for Canada. Over the past two decades we have slipped backwards in performance relative to our peers. This has not escaped notice: the OECD estimates that by increasing our efficiency in healthcare we could save (or reallocate) up to 2.5 % of our GDP by 2017.[1]

We are not facing a black hole, nor are we likely to see the apocalyptic downfall of our healthcare system. However, if we do not make improvements, we will see a growing gap between supply and demand and an increasing level of dissatisfaction leading to "default" and anarchic privatization of the financing of services, instead of a harmonized and regulated integration of providers, for the benefit of patients.

Payment reform should stand as the cornerstone of the next wave of healthcare reform

Rather than seeking to change the way we fund the current basket of publicly insured services, we should look to reform our payment models. How we pay providers and institutions has a profound impact on the choices they make (or do not make) and on the performance of the overall healthcare system. Thus, payment reform should stand as the cornerstone of the next wave of healthcare reform. The key is to reward the creation of real value (high quality outcomes for patients) rather than only volumes of procedures or interventions.

[1] OECD (2011) *Economic Policy Reforms: Going for Growth 2011*. Paris: OECD. Chapter 6, p.229.

Practically speaking, the value of reducing the wait-time for knee replacement surgery to less than six months is much reduced if the patient does not also have good access to better integrated care (including seamless transition between outpatient treatment and hospital, home care and rehabilitation, followed by preventative measures aimed at avoiding other similar ailments). Such a scenario is not a fantasy. It is a concept elegantly described by Michael Porter,[2] amongst others, and one that is being implemented in many of the foremost managed care organizations around the world. In such a system, value is defined and measured from the perspective of users rather than system managers. Evaluation focuses on high quality outcomes rather than the number of procedures performed in defined clinical situations.

We need physicians to participate in the management of the system

In helping to define – not implement, that is a provincial responsibility – such changes, and ensure that they are adapted to the varying realities of our system (rural, urban, teaching, etc.), the federal government has an opportunity to spell out what a "patient centered system" really means.

The current block funding of institutions, with annual indexation, provides little or no incentive to innovate or improve efficiency (and if efficiency gains are made, savings cannot easily be identified, captured and reallocated to other parts of the healthcare network, such as primary care). Savings on paper fail to materialize in reality, more money is requested the following year and another circle of virtual savings – and very real expenses – begins.

Many argue that the best way to address this problem is with activity-based funding (ABF) for our hospitals, the equivalent of fee-for-service for physicians. While this would be a move in the right direction, ABF is not the whole answer. Isolated ABF risks being inflationary and putting too much emphasis on hospital care in the continuum of services. A better response would be to base a substantial portion of payment on outcomes (assessed from the perspective of the patient) rather than solely on the number/type of procedures performed. Timely access then becomes an important, but not unique, determinant. Employing, once again, the example of knee replacement surgery, the desired outcome would be an integrated, timely, safe and patient-centered management of the condition: osteoarthritis of the knee.

When it comes to physicians, we should move in the opposite direction. Rather than the current fee-for-service model, new models combining some form of capitation (being paid for keeping a defined population healthy), with incentives for productivity, good practices and outcomes should be identified and promoted.

Fixing the dysfunctional relationship between physicians and healthcare institutions

At the birth of our public healthcare system, a Faustian bargain was struck. Many medical organizations opposed Medicare and physicians in both Saskatchewan and Quebec went on strike, in the middle of the October crisis. In response, governments allowed physicians to retain a free entrepreneur status within publicly-funded hospitals, a feature unique in the OECD and, to this day, the source of constant tension between managers and professionals. The other promise of 1970, that a competitive level of compensation for physicians would be maintained, has been honoured, despite bumps along the way.

It is now time for a "new deal" to be struck between the medical profession and public organizations. Most importantly, we need physicians to participate in the management

[2] Porter, M.E. & Teisberg, E.O. (2006) *Redefining Health Care: Creating value-based competition on results.* Boston: Harvard Business School Press.

of the system (with adequate compensation for doing so). The best healthcare institutions have strong physician leaders who collaborate with administrators.

Under such a model, physicians and other health professionals (including nurses) would play a pivotal role in identifying best practices and making decisions about optimal resource use. I observed, first hand, enormous benefits from the active involvement of physicians in dealing with a major epidemic of *C. Difficile* in 2004. Based on this and other experiences, I truly hope to see the emergence of a new generation of physician/leader/managers collaborating with administrators and other health professionals, to the benefit of patients.

Adapting the system to meet our changing needs

At its inception, Canada's Medicare was narrowly defined as covering services provided by physicians, especially in hospitals. This made sense at the time. In the second half of the 20th century Canada's population was young and acute health issues were the major concern. This is no longer the case. We therefore need to adapt our system to meet our country's changing demographics and needs.

Canadians too often face a "disease lottery". In acute situations patients receive excellent care and incur few out-of-pocket expenses, apart from prescription drugs, coverage of which varies considerably by province. But the system's response to more contemporary challenges (such as Alzheimer's disease) is highly deficient. Only rudimentary home care is provided and families and caregivers are left facing significant financial challenges.

Overall, Canadians pay more privately and out-of-pocket for healthcare than most of our western European counterparts: in 2009 Canada ranked 22nd among OECD members in terms of the percentage of total healthcare spending that is publicly funded (70.6%). This is a direct consequence of the exclusion from the initial definition of Medicare of many of the services required to meet our current challenges (an aging population with chronic health issues).

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The solution seems obvious: extend public coverage of non-core services. But this raises funding issues. Unless we choose to modify physician-hospital coverage to balance this extended basket of services (which would be very difficult, politically), we would need to find extra funds. Efficiencies deriving from reform of payment models should yield some money, but there is no escaping the fact that if new services are to be covered, new money will be required. In the world of healthcare, money always comes from citizens' pockets, one way or another, so a form of co-payment (or social insurance model) would need to be introduced, or else taxes would need to be significantly increased. It is the responsibility of all governments to present these choices to the electorate, clearly and with their respective costs and benefits explained.

Finding better ways to manage demand

Historically, our system has managed to control costs only by reducing supply. This led to one of the worst decisions of the nineties: cutting medical school enrolment without increasing the supply and influence of allied professionals, such as nurse practitioners. The irony is that today the shortage of professionals (a self-inflicted wound) is invoked as a key argument against proposed changes… the typical story of the dog biting its own tail.

Managing demand does not necessarily mean introducing user fees or other forms of co-payment. Although there is nothing inherently wrong with these widely-used methods, my view is that they would simply waste

energy and resources and yield little positive impact. Where such revenue models are in place, there have been constant demands for exclusion, leading to a decreasing number of payers supplying an increasingly marginal amount of money, at considerable administrative cost. There is also evidence to show that, when faced with fees, users reduce their utilization of all services, both unnecessary and necessary, which can cause problems down the line.

Nevertheless, an open discussion of the merits of these funding options should be part of our political debate. Taking refuge in the "prohibition" of user fees in the Canada Health Act is not an adequate response, underestimating, as it does, the capacity of informed citizens to engage in a meaningful conversation on the question.

In my view, though, there are more equitable ways to control demand. First, an evidence-based process should be put in place to establish optimal use of new technologies and pharmaceuticals. Once more, the focus should be on outcomes: it is not so much the number of MRI machines that matters (above a certain minimum) but how they are used.

On the budgetary side money should flow to integrated primary care organizations that purchase specialised services "upstream" in the system, based on outcomes and documented needs. (The National Health Service in the UK is presently moving in this direction, an experiment worth studying.) Lastly, efforts should be made to induce competition among providers who vie for public payment.

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While such implementation decisions take place, of course, at the provincial/territorial level, there remains a powerful role for the federal government in signalling the type of system that is mostly likely to be able to meet the needs of Canadians in 2020 and beyond.

Supporting a more meaningful discussion of private vs. public

This is the most difficult, sometimes obsessive, part of our conversation on healthcare. Proponents present the private sector as a panacea, opponents see it as the devil incarnate. Both sides are wrong.

Across the political spectrum, most observers agree that family medicine groups in Ontario and Quebec have improved primary care delivery and that they demonstrate the public sector's capacity to innovate. Such groups are essentially a form of partnership between the public system and a private (often for-profit) corporation. Their hybrid nature has not, though, stood in their way. Likewise, when the state acts as an insurer (in the context of workers' compensation, for example), it loses its statist inhibitions, employing the services of private providers, negotiating prices and encouraging competition just as the private sector would. But bring the discussion round to other types of services (e.g. high volume, low intensity procedures such as minor surgery and diagnostic procedures) and endless objections are raised.

The social problem associated with the presence of private providers in our healthcare environment is not their existence, but the fact that their resources are not accessible to all. Public funding of privately-delivered services is a simple concept that overcomes this problem, works to the advantage of all and is entirely compatible with the Canada Health Act. So, where there is sufficient density to ensure competition, it makes every sense that the state should determine the price of

selected procedures and that all providers – public and private – should compete for the privilege of serving patients.

It is important to note, however, that while such competition is feasible in our main cities, where many providers coexist, competition between providers has little practical meaning in our remote and sparsely-populated communities where there is only one regional provider. This is one of the factors that sets us apart from western European countries. Another is the larger number of (often less well-compensated) physicians in such countries. Healthcare systems cannot be dislocated from their social-historical context, nor can they be transferred as blueprints between societies. But we can observe lessons from elsewhere and adapt them to our reality.

Defining and promoting accountability in healthcare

Too often, federal-provincial conversations on healthcare end up as power and visibility struggles. There is no need to go down that path again. Healthcare is, in large part, a provincial responsibility and, by insisting on being visible and in control, Ottawa runs the risk of transforming the debate on improved, sustainable patient care into a constitutional battle. In 2004, as the federal government insisted that provinces should be held accountable for their use of federal transfers, the last days of the conference were spent discussing the merits of asymmetric federalism, rather than health outcomes.

Within the existing constitutional framework, credible and visible accountability must, though, be established. It is legitimate for the federal government to use its spending power to initiate change and then to receive credit for it.

A starting point would be for the federal government to state that change and experimentation (including in coverage and funding methods) are welcome, so long as universal coverage and equity are preserved. It can acknowledge that there are significant gaps in coverage and a high degree of inequality across the country. It can be open about the fact that extending health coverage to new areas will require new funding from governments and citizens. It can state unequivocally that nothing in the Canada Health Act prevents competition among providers, under public funding.

It could also facilitate the creation of an explicit and credible mechanism for ensuring accountability. We need a renewed Health Council, composed of existing provincial Quality Councils or Commissioners, with representatives from the health professions and the public. The role of this jointly-funded but independently-governed "Institute for Innovation in Healthcare" (which would subsume our existing Canadian Institute for Health Information as a data provider) would be to research best practices around the country, make them visible and promote their adoption.

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The Health Council should present an annual report directly to the federal-provincial-territorial assembly of Health Ministers. Each provincial/territorial government's response to its recommendations would be evaluated by their respective Quality Council, and ultimately sanctioned – or rewarded – by the electorate. This mode of reporting, coupled with the absence of elected officials on the Council, would ensure its credibility and independence from political/electoral cycles.

When it comes to federal funding levels, there is little doubt that arrangements will be renewed, at least at the new "baseline" level reached in 2014. But the 6% escalator

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should remain open for discussion and its continuation linked to substantial progress in performance.

One option would be to place all new funds (beyond the 2014 baseline) in a dedicated "fund for innovation", accessible to any province or territory willing to implement changes that result in increased performance from the patient's point of view. Access to the fund would be dependent on initiatives being approved by the relevant provincial Quality Council (with input from the public and health professionals). Results would be assessed through an arm's length process (for example by an academic review or the Quality Councils themselves) and the findings would be tabled and debated in the provincial legislature, which would then be accountable for results.[3]

CONCLUSION

Our healthcare system is not in crisis. But, like other publicly-funded systems, it is suffering from the classic tension between needs and resources. Thirty years from now, this tension will still be there, and a new society with its specific needs, challenges and unpredictable technological advances will have emerged.

Our responsibility is to take a step forward and to use the 2014 horizon as a catalyst for change and improved patient care. All of us – citizens and governments alike – have a role to play and bear a share of the responsibility. The present federal government has one strategic decision to take: does it want 2014 to be a low-profile, rubber-stamping event, or does it want renewal of our ailing healthcare system to be part of its legacy? If the latter, it should act accordingly and ensure that the 2014 discussions live up to their potential as a formidable lever for change.