Two Keys to Excellent Health Care for Canadians:
Provide Information and Support Competition

A submission to the:
Standing Senate Committee on Social Affairs, Science and Technology
for its study of Canada’s health care system, its sustainability, and the federal role in any reforms that may be needed.

by

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Recommendations

**Recommendation 1:**
That proposals to change health care delivery should only be considered if they are accompanied by a testable estimate of how the new structures and processes will influence access to care or patient and/or population health.

**Recommendation 2:**
That the conflict of interest arising from government acting as health services insurer, as a health care provider and as an evaluator of health care delivery be reduced by separating these functions.

**Recommendation 3:**
That, as a first priority, health jurisdictions develop and implement appropriate systems to measure access and results and that they use the new evidence to build consensus towards other health system changes. Gathering appropriate data about access and results before and after changes are implemented must be a prerequisite to health care reform.
The Context: Plus ça change…

1994:  
That timely access to services either in the hospital or the community must be guaranteed and information about waiting times made public. That quality of care will be ensured by ongoing monitoring and publication of patient outcomes as changes are implemented.  
from *When Less is Better*, a report prepared for and unanimously endorsed by the Federal/Provincial/ Territorial Deputy Ministers of Health, 1994

1997:  
[Bringing more and better evidence to bear on decisions is crucial whether by providers or by patients or managers or policy-makers. Evidence offers the prospect of improving the quality of health care. That is why we are committed to closing many of the gaps that now exist in the information relating to medicine, as well as improving its quality and the use to which it is put, including through working towards a country-wide health information system. We must develop reliable, complete and objective information upon which to make judgments and upon which to make policy.  
Alan Rock, Speech to Canadian Medical Association, Victoria, August 20, 1997

1999:  
Many bad decisions about healthcare are made every day in Canada because decision makers lack the right information, at the right time, and in the right place. These bad decisions can cost the country millions of dollars and rob Canadians of the health care they need and deserve. Decisions that are made about the health system – like funding for diagnosis and treatment of many diseases – are only as good as the information on which they are based.  
Press release entitled “Gap in Health Information Management Puts Canadians at Risk” by Healnet (Health Evidence Application and Linkage Network), October 15, 1999, dateline Hamilton, Ontario

2000:  
In relation to the Canada Health Act, I observed that Health Canada does not have the information it needs to effectively monitor and report on compliance. So … it is clear that better quality information is required.  
Denis Desautels, Auditor General of Canada, Jan. 2000, private communication to authors

Through the effective use of information and communications technology and the appropriate sharing of information, the fragmentation of services among health care and related sectors will be resolved and replaced with a “seamless” continuum of care within and across all services. However, major new investments will be required in information systems to support community providers.

From the Provincial/Territorial Deputy Ministers Paper, August 2000, "Understanding Canada's Health Care Costs"

2001:  
“On September 11, 2000 the First Ministers agreed to work together to 1) strengthen a Canada-wide health infrastructure to improve quality, access and timeliness of health care for Canadians; 2) develop an electronic health record system and enhance technologies like telehealth over the next few years; 3) work collaboratively to develop common data standards to ensure compatibility of health information networks; 4) ensure stringent protection of privacy, confidentiality and security of personal health information; and 5) report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services.”  
Introduction:

An aim of the Kirby Committee is to launch a public debate and discussion about healthcare in Canada. However, a serious lack of valid and reliable information makes it difficult not only for the general public, but also for health services administrators to develop thoughtful evidence-based opinions about the existing system; although all of us can provide anecdotes about our own experience. For example, Michael Dector, Board Chair of the Canadian Institute for Health Information, reported at the year 2000 Canadian Health Informatics Association (COACH) meeting that there was not systematic evidence of delayed access and that his daughter had received timely emergency care, thank you very much! But, the absence of evidence is not evidence of absence and many Canadians have experienced excessive waits and consequently are losing confidence in our health care system.

After a lengthy period of expert-driven and noisy change in Canadian health care, the proportion of the public saying that the system needs only minor changes has dropped from 56 percent in 1988 to 20 percent in 1998. There has been a dramatic loss of confidence in our health care system.

Some of the opinions the Kirby committee receives will be based on personal health care experiences; others will reflect potentially misleading published material - for example, the Maclean’s magazine report on health care. Numerous reports have called for substantial reforms, “but achieving a consensus-based solution remains elusive.” The lack of regular, reliable and vital information about health system performance makes it virtually impossible for policy makers and the public to choose among competing alternatives, or to understand, subsequently, if changes have been beneficial, neutral or harmful.

A major challenge for the Kirby committee will be to define those policy recommendations which will ensure the Canadian public finally has access to pertinent information about access to care, the results of care and the efficiency of health care delivery.

AIMS’ Sir Antony Fisher prize-winning paper, Operating in the Dark, argues that monopoly provision of publicly insured health care services has led to a lack of accountability, politicisation of health care decision making, perverse incentives for patients and providers, and important barriers to innovation in health care delivery, administration and information gathering. A lack of vital information prevents administrators and the public from forming evidence-based opinions about the current state of health services delivery, or about what changes are beneficial.

A complete copy of Operating in the Dark is included as part of this submission. This note reflects and elaborates on two of the overall themes described in Operating in the Dark. The themes are: (1) the need to make the implementation of appropriate information systems a national priority so Canadians can get answers to their questions about access to care, and the outcomes of care, and (2) the consequences of monopoly provision of health care.
Information Systems:

The Kirby Committee report Volume 4 notes and strongly endorses the Federal/Provincial/Territorial ministers’ recent recommendation to “report regularly to Canadians on health status, health outcomes, and the performance of publicly funded health services.”ix We too strongly endorse and support this recommendation and believe that efforts to change health care delivery must be accompanied by testable estimates of how the changes will influence patients and the general public.

Recommendation 1:

That proposals to change health care delivery should only be considered if they are accompanied by a testable estimate of how the new structures and processes will influence access to care or patient and/or population health.

A major challenge for the Kirby committee and others who are seriously interested in improving health care will be to facilitate changes which encourage public access to vital information about the performance of government, private and not for profit health care systems.

Managing Change - Politicisation of Health Care Decision Making:

The absence of vital information about access to, and results of, care make it virtually impossible for any group to make clear and compelling arguments for changes to health services delivery or for changes in health policy.

Public administration of health care is one of the five principles of the current Canada Health Act. Therefore, provincial and federal governments play a major role in health services delivery. Provincial governments act as the majority shareholders in Canadian health care. Governments appoint board members, and governments directly influence the amount of capital available to invest in equipment and the amount of money available for ongoing operations. Resources are allocated by political negotiation, and not based on systematic knowledge of either the outcomes of care or access to care or testable predictions of the consequences of changes in funding.

Stephen Lewis has remarked that 48% of Canadiansx believe that changes in health services delivery will lead to a further decrease in quality of care. This public perception is not surprising since health organisations and Departments of Health have been unable to inform Canadians if previous changes in health services delivery have improved or harmed health care. Indeed, as change has been implemented, even quasi-governmental groups like Workers’ Compensation Boards have been working to achieve preferred access for their own clients, using methods which are not available to the population in general and raising the suspicion that changes have not improved either access to care or the quality of care.
Health reformers have been unable to explicitly demonstrate to Canadians the benefits and harms of recent tinkering with health care. This lack of information is long standing and remains despite repeated commitments over many years by federal and provincial governments. More recently, the Canadian Institute for Health Information noted that what is most needed, but lacking, is information about access to health care (waiting times, what proportion of people have excessive waits for care) and about the results of activity (what are the beneficial and adverse results of health care activities). The serious lack of pertinent information means that change can only occur through a process of political negotiation and not based on evidence. Monopoly provision means that the preferences of individuals receiving care might also be ignored, since monopoly providers, by definition, cannot lose dissatisfied customers to competing suppliers.

Governments in Canada are seriously conflicted with respect to health care. Governments not only collect health insurance premiums (through taxes or by special premium), and maintain responsibility for the delivery of health care services, but also report to themselves on their own effectiveness and efficiency based on information they have decided to collect. Furthermore, these same governments then decide what information will be provided to the public. Governments also decide on the interpretation of results - so health services organisations may regard 80% satisfaction rates as acceptable, when many industries would fire the management of an organisation which regularly reported that 20% of customers were dissatisfied or that over half of the employees believe the organisation is not a good place to work.

The conflict can be reduced or eliminated by separating the insurance function from the health care delivery function. Contracting out to the private sector is one way of doing this and reports from Sweden suggest that developing performance contracts with the private sector is not only effective, but also leads to improved employee morale. Conflict would also be reduced by distinguishing those responsible for health system evaluation from those responsible for health services delivery, and from those responsible for collecting insurance premiums.

Eliminating the conflict which arises from government acting simultaneously as a regulator, insurer, provider, and evaluator will produce an environment which encourages each sector seek appropriate information about health system performance.

**Recommendation 2:**

That the conflict of interest arising from government acting as a health services insurer, as a health care provider and as an evaluator of health care delivery be reduced by separating these functions.

This can be accomplished by contracting out service delivery to the private sector with explicit performance targets. Private-sector providers would bid for the provision of well-defined sets of services with clearly defined goals and measures of success or failure. Similarly, an independent group should report on the state of health care in Canada, including information about the effectiveness of care, the efficiency of care, and accessibility of health care services.
The Purpose of Care:

The purpose of health organisations, such as hospitals and health districts, is to deliver clinical care to improve the health of individuals.\textsuperscript{xv} However, these organisations have not implemented systematic methods to track the beneficial and adverse changes in health associated with care, nor to report on access to care. (How often has anyone reading this note been called by a health provider who wanted to know if the treatment had worked or not, or if they waited too long for care?\textsuperscript{xvi}) Consequently, Canadian health organisations cannot be accountable for the care they give. Canadian health organisations are also unable to systematically detect those clinical and administrative processes that are harmful.\textsuperscript{xvii}

Health organisations spend large amounts of money, but cannot specify what they have provided. For example, every hospital in Canada reviews the chart of each discharged patient, and sends this personal information to the Canadian Institute for Health Information located in Ottawa and Toronto. The direct cost (paid for by provincial governments) for a 400-500 bed hospital is about $1.3 million, in addition to the costs to the federal government of sustaining the Canadian Institute for Health Information. Unfortunately, this detailed review of every chart does not even bother to ask if the patient was better or worse, or how long they waited for care.

Measuring Results:

If the purpose of health care activities is to improve health, then measuring changes in health associated with care is necessary to learn if organisations are or are not fulfilling their mission.

The dimensions of health are comfort, function, and life expectancy. At each encounter clinicians must evaluate patient health in order to know what treatment is necessary; subsequently, it is necessary to evaluate health in order to decide whether to discontinue treatment, continue treatment, or modify the treatment plan. These regular and personal health evaluations are normally documented in the chart of each patient. Unfortunately, this vital information about changes in health associated with care are not routinely and systematically captured, even though the chart of each patient is reviewed in detail and information sent to a central organisation in Ottawa.\textsuperscript{xviii}

Information linking health care activities to the results they produce is essential if the public is to understand the value they obtain from public or private health care and if the general public, patients and providers are to understand whether changes to health care are beneficial or harmful. Additionally, information about access to care (waiting times and the proportion of people who have appropriate waits for care) is vital for public understanding and for health services administration.

The National Forum on Health stated, “We collect considerable administrative data about encounters in the health care system but insufficient data on results” (1997).\textsuperscript{xix} Despite this strong recommendation and large provincial and federal investments in administrative
information systems, little progress has been made with regard to the systematic collection of information about the results of health care activities.\textsuperscript{xx}

**Regulators must require that health organisations collect and publicise valid and reliable information linking health outcomes to their activities, and also provide reliable information about access to care.**

This is consistent with the recommendations unanimously endorsed by the Federal/Provincial/Territorial Deputy Ministers of Health in 1994 and with several subsequent reports including the National Forum on Health Care.

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**Solutions in Search of Problems:**

Government-sponsored Commissions regularly and repeatedly remark on the need for information to measure the value of health care services and the lack of reliable data and knowledge about the problems with Canadian health care.\textsuperscript{xxi} Yet, this information lack has not deterred various study groups from making strong arguments about the particular new structures and processes necessary to support health care in Canada. Major changes in the organisation of care, including amalgamations of hospitals and tinkering with regional and provincial health care organisations, have occurred without any prior estimate of the benefits and harms that are expected from the proposed changes. Throughout the land Canadians have suffered or benefited from recent major changes in health care delivery, yet none of our administrative or academic or political experts can state with confidence whether care has improved or declined as a result of these changes.

Recommendations for structural change are rarely associated with estimates of the changes in health or access expected to result from the new structure. Recent fads in health care administration include a push towards regional or district organisations, and reorganisation of primary care into multidisciplinary group practices and changes in funding from fee for encounter to capitation, or salary. These suggestions might be valuable and imprint, but the proponents have not indicated how many patients would benefit from these changes, nor what the benefits would be. Indeed, these solutions are often proposed without any quantitative estimate of the problem being solved. For example, how many people who are now without a family doctor will have access to care after change is implemented?

Canadian provinces are studying changes to the delivery of primary care, including the introduction of capitation and primary care teams. Yet none of these projects has explicitly defined how patients will benefit from new systems, how access will improve and how their health will be better. In fact, the existing evidence does not support a wholesale change to group practice or salary, or capitation-based service delivery models.
“As we assess the state of evidence regarding primary care physician payment methods based on the strongest, most relevant studies we have been able to identify, we see the following:

(1) There is suggestive evidence that patients' assessments of overall satisfaction and access/availability are more positive in settings with fee-for-service as opposed to salary or capitation payment.

(2) There is minimal or conflicting evidence regarding patients' assessments of continuity, comprehensiveness, co-ordination, technical quality, and interpersonal aspects of care.

(3) There is minimal evidence regarding practice patterns (for example, frequency of home visits and length of office visits).

(4) There is suggestive evidence that capitation payment results in higher rates of referrals to specialists.

(5) There is minimal or conflicting evidence regarding quality, utilisation, and costs of care.

(6) There is minimal evidence regarding differences in use of physician providers in FFS versus capitated practices.

(7) There is suggestive evidence of better preventive care performance by salaried and capitated physicians than by FFS physicians.”

These ideas are similar to those expressed in Operating in the Dark, which suggested that incentive mechanisms in general, and physician payment models in particular, must be designed to support the specific results intended. Consequently, suggestions for change or policy modification should include an estimate of what will be accomplished by the proposed change.

**What is necessary to adopt changes in health care policy and process:**

Normally businesses change the way they operate in order to improve efficiency, effectiveness and access, or to capture greater market share. One of the perversions of a centrally administered health care system is that administrators actually prefer to deliver fewer services. The common measures of administrative success in our government-managed health care systems relate to adherence to budget. Administrators are (sometimes!) punished if they go over budget, rewarded (sometimes!) if they remain below and little attention is paid to the benefit produced by the dollars spent. So, administrators may be harmed when the quantity of services demanded increases, even when the demanded services are costworthy.

Health care in Canada is managed by administrative experts, working without information, and often without direct reference to the public or providers. Unfortunately, expert opinion may not coincide with evidence-based reality or the reality perceived by the public.

This does not mean that we should not strive for appropriate incremental change. For example, “the components of recently proposed models of primary care are largely divisible and capable of independent implementation. This unbundling of primary care models would allow early, system-wide implementation of those elements with broad stakeholder support (for example, enhanced clinical information systems). Indeed, there is clear evidence that information systems
that provide real-time decision support, including reminders for patients and providers, reduces errors and improves care (and these systems will help gather the information necessary to support additional change. Action could be deferred on other elements while efforts are made to build consensus based on evidence.

In order to evaluate proposed changes, it is necessary to have an estimate of how access and results will be improved. Consequently, proposals to change health care delivery should only be considered if they are accompanied by an estimate of changes in access and results expected from the proposed changes.

**Recommendation 3:**

That, as a first priority, health jurisdictions develop and implement appropriate systems to measure access and results and that they use the new evidence to build consensus towards other health system changes. Gathering appropriate data about access and results before and after changes are implemented must be a prerequisite to health care reform.

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**How Will These Changes Benefit Canadians?**

We estimate that eliminating monopoly provision, and providing information about access and results will lead to a substantial increase in public satisfaction with our health care system. Access to information coupled with an ability to choose health care providers will lead to feedback loops and a continually improving health care system, so that public satisfaction with health care could rise to the 95% and greater levels aspired to and achieved by other industries.

We predict that real-time and continuous information about the beneficial and adverse outcomes of health care will also lead to substantial reductions in health system error because clinicians and administrators will be able to identify the circumstances associated with poor outcomes..
End Notes:

iii In focus 2000 COACH (Canada’s Health Informatics Association) conference, 2000, Vancouver, BC
x Stephen J. Lewis, Presentation, October 1, 2001, Capital Health District, Halifax, N.S.
xi When Less is Better: Using Canada’s Hospitals Efficiently, Unanimously endorsed report prepared by Federal/ Provincial/Territorial working group on hospital utilization, 1994
xii Many communications and presentations by Michael Dector, Board Chair, Canadian Institute for Health Information including MacLean’s Magazine, June 2000
xiii Health Care in Canada, 2001, CIHI http://www.cihi.ca
xiv Johan Hjertqvist, TIMBRO Think Tank, in presentations to Dalhousie University and AIMS, noted that workers felt better valued when competition was introduced in Sweden.
xx The bulk of other government spending is aimed at improving the health of populations, for example, environmental regulation, transportation, and economic development.
xxi Of course, some disciplines such as oncology and cardiology have developed effective research studies to learn about the results of particular therapies, but these do not occur regularly, reliably or throughout our health care system.
xxii This contention is consistent with recent remarks of the Fyke Commission in Saskatchewan; see Chapter 4.
xxiii Each page of the chart of each patient discharged from a Canadian Hospital is reviewed and information about diagnoses, procedures, length of stay, and survival is sent to the Canadian Institute for Health Information, an organization supported by federal government grants. However, the cost of data collection is a provincial responsibility.
xxv Statistics Canada regularly collects and reports important information about the health of Canadians. The overall health of Canadians is influenced by the context in which we live, including gamut of public and private activities. But this is different from information about the efficiency of our health services delivery system.
xxvi When Less is Better is a 1994 study that explicitly noted the need for proper information about access to and the results of care. More recently the Fyke Commission, “The Commission on Medicare: An Independent Commission appointed by the Premier of Saskatchewan”, 2001, noted the lack of pertinent information linking health care activities and results.
xxvii Hutchinson B., Abelson J., Lavis J., Primary care in Canada: So much innovation, so little change, Health Affairs, Chevy Chase, May/June 2001
xxix Hutchinson B., Abelson J., Lavis J., Primary care in Canada: So much innovation, so little change, Health Affairs, Chevy Chase, May/June 2001