Two Keys to Excellent Health Care for Canadians

Dated: 22/10/01

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

A submission to the: Commission on the Future of Health Care

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22 October 2001

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Recommendations

Recommendation 1:

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

Recommendation 2:

That, as a first priority, health jurisdictions develop and implement appropriate information systems to measure access and results and use the new data 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.

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.
**Recommendation 3:**

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.

**Introduction:**

Almost all Canadians will have an opinion about the state of Canadian health care and the Romanow commission is encouraging each Canadian to relate his own views. Some opinions 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.

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. However, all of us can provide anecdotes about our own experience.

But an informal, self-selected public poll, replying to the Romanow Commission, could provide an unreasonably rosy picture of existing Canadian health care and its lack of competition. Those people most likely and able to provide written or oral submissions will come from the most articulate segment of the population; in other words, from those people most able to negotiate high-quality care within virtually any health care system, including our own.

"Who is better qualified to judge health care systems: public health experts or the people who use them?" Although the answer is not known, there is a clear disconnect between public opinion and the opinions of experts.

After a long 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.

Canadians have major concerns about system administration (by experts), as well as funding and resource management issues, and almost half of all Canadians complain that access to specialists is somewhat, very or extremely difficult. However, when Canadians actually receive care, 84% believe the care they received was good, very good or excellent, and 89% said the care they received at the last doctor visit was good, very good or excellent. Canadians have confidence in the clinicians they choose, but much less faith in those managing the system.

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, politisisation 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 consequences of monopoly provision of health care and (2) 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.
Conflict of Interest and Lack of Accountability:

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. The result is that 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 a CEO who 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.

Recommendation 1:

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.

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.

Stephen Lewis has remarked that 48% of Canadians 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.

**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. 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? ) 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. Health organisations spend large amounts of money, but cannot specify what they have provided.

**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.

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). 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.

**Recommendation 2:**

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.

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 recommendation 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.

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. 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 organisation, has occurred without any prior estimate of the benefits and harms which 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:

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.

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

There is minimal evidence regarding practice patterns (for example, frequency of home visits and
There is suggestive evidence that capitation payment results in higher rates of referrals to specialists.
There is minimal or conflicting evidence regarding quality, utilisation, and costs of care.
There is minimal evidence regarding differences in use of physician providers in FFS versus capitated practices.
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 which 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:**

*All proposals to change health care delivery should only be considered if they are accompanied by a testable estimate of how the new structure and process will influence access to care or patient and population outcomes.*