with/avec Michael Kirby

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Q&A

# HEALTH CARE: FROM REINVESTING TO REINVENTING

*With the release in late October and November of the Kirby and Romanow reports, the debate on reinvesting in health care, and even reinventing it, has reached the point where Ottawa has no shortage of recommendations, only decisions to make about where to find new funding. In his office on Parliament Hill, Michael Kirby, Liberal chairman of an epic three-year Senate inquiry that produced five volumes of research and analysis, discussed his committee's bipartisan recommendations with L. Ian MacDonald, editor of* Policy Options*.*

*Avec la publication toute récente des rapports Kirby et Romanow, le débat sur l'opportunité de réinvestir dans les soins de santé (ou de les réinventer carrément) s'est encore enrichi d'une masse de recommandations, si bien qu'il ne reste plus à Ottawa qu'à déterminer de nouvelles sources de financement. Depuis son bureau de la colline du Parlement, Michael Kirby, le président libéral d'une commission bipartite sénatoriale dont les travaux auront duré trois ans et produit cinq volumes de recherches et d'analyses, discute des recommandations qui en ont résulté avec le rédacteur en chef d'*Options politiques*, L. Ian MacDonald.*

***Options***: Senator Kirby, these two reports that came out about the same time: the Romanow Commission report and the report of the Kirby Committee on Health Care: to what extent are they complementary? To what extent are they conflicting? And to what extent might the public be confused about the two?

***Michael Kirby***: Well, I think it's probably a good idea, rather than a bad idea, to have two different views—assuming that they're not categorically different, that they have some overlap and some differences. I think it's useful for the public debate to have more than one opinion out there.

***Options***: Are the conclusions of the Kirby report bipartisan?

***Michael Kirby***: Absolutely. It's a unanimous report, and not unanimous as we sawed off on things. Unanimous because the group came together. And it's a rather remarkable group of people on the committee. Just let me give you a couple of illustrations. Yves Morin happens to be a Liberal, but Yves Morin was the dean of medicine at Laval for many years. Willy Keon, who happens to be a Conservative, was and still is the chief executive officer of the Ottawa Heart Institute. Brenda Robertson, who is a Conservative, was minister of health in New Brunswick for nearly a decade. Catherine Callbeck was both the minister of health and the premier of PEI and happens to be a Liberal.

> Can government afford to put the money in to keep the system going in an effective way, while keeping tax rates competitive? And are Canadians prepared to pay what is required to pay for a collective system?

***Options***: So there was a critical mass of both public policy and health expertise.

***Michael Kirby***: Huge amount of expertise. Look, frankly, I began knowing less about health issues than most members of the committee. But the interesting thing is we've all come together into a very consistent view of what needs to be done.

***Options***: It's interesting that nine of the thirteen members of your committee are women.

***Michael Kirby***: Well, it's interesting you should say that. It certainly does something to the image some people have of the Senate as being just tired old men. First of all, the group collectively is not that old. But secondly, as you say, there is a significant majority of women.

***Options***: You concluded that the health-care system as it is now is not fiscally sustainable. What do you mean by that?

***Michael Kirby***: What we mean by that is the issue that is really at stake is how much money are Canadians prepared to put into a collective form of health care. Look, there is no question that, in a large measure, the money is going to be spent. The question is, are we spending it individually, that is to say, spending it privately in a sense, or are we spending it collectively by having government manage the system.

And so the issue is, given the fact that it's important for economic policy purposes to keep Canadian tax rates competitive with OECD tax rates, and particularly US rates, the fiscal sustainability test really has two components. One, can government afford to put the money in to keep the system going in an effective way, while keeping tax rates competitive? And secondly, are Canadians prepared to pay what is required to pay for a collective system, rather than a system where some individuals pay privately?

*Options*: And are they?

*Michael Kirby*: Within reason, they absolutely are, if you can convince them of three things: one, that the inefficiencies they perceive to be in the system are taken care of; two, that the waiting time issue can be addressed in a reasonable way; and three, that any new money that they put into the health-care system is actually going to be spent on health care—doesn't go into the consolidated revenue fund; that there are iron-clad ways of ensuring that the money is spent on health care. Our sense is that Canadians, because they believe sufficiently strongly in the collectivist approach to this issue, will be prepared to do that.

A lot of people, when they talk about medicare, which is hospitals and doctors, they say "the health-care system," which is now more than double the size of the hospitals and doctors system. So we have to be careful in using terminology, and the other area where the terminology is confused is the public-private question.

*Options*: Is this an opportunity to revisit the nature or the process of funding health care when it started out with the 50-50 straight up funding in 1966, then went to the Established Programs Financing formula.

*Michael Kirby*: I think this is an opportunity to have Canadians understand that issue from the federal standpoint: how much money they are putting into the health care system by getting out of mixing health care with other social programs or post-secondary education? And making it very clear that the money is going into health care. I don't think we should get back into some of the excessively bureaucratic and rigid programs like we had early on in the 50-50 days. These are big businesses people are running. You've got to give the people running these hundreds of millions of dollars worth of hospitals—some of them have over a billion dollars as a budget—you have to give them flexibility.

*Options*: When you have a hundred billion dollars a year spent on health care in Canada and only 30 percent of that, i.e., thirty billion dollars, is in hospitals, where is the rest going?

*Michael Kirby*: The rest is going all over the place. It's going to drugs, it's going to doctors, it's going to walk-in care, nursing homes, that kind of thing. It's going into a lot of tests of various kinds and things like physiotherapy. Hospitals and doctors combined is 46 percent. We've had a tendency in the public debate in this country to confuse health care with hospitals and doctors. A lot of people, when they talk about medicare, which is hospitals and doctors, they say "the health-care system," which is now more than double the size of the hospitals and doctors system. So we have to be careful in using terminology, and the other area where the terminology is confused is the public-private question. In Canada, going way back to the beginnings of medicare—all the talk about single payer, public funding—no piece of legislation, federally or provincially, has ever dealt with the issue of who owns health-care service delivery institutions, i.e., the ownership structure. What has happened is a lot of

CP Photo

Michael Kirby
"Health care is not free"

people who don't like the notion of for-profit health-care institutions have deliberately confused the debate—I say deliberately, because it's been to their advantage to do so—by claiming, for instance, that the *Canada Health Act* says something about private delivery. It doesn't say anything about private delivery. It only talks of public funding. And public administration was exactly that: it was public funding, it was not public delivery. But you find the words "public" and "private" used interchangeably by people to make a case, even when in fact they're using it incorrectly.

*Options*: So there is 71 percent of the money in the health system that is public, and 29 percent that is private, as your research indicates. Don't we already have some kind of two-tier health system?

*Michael Kirby*: No, because two-tier—again, that is one of the terms that is being confused—really means that someone is able to use some money to buy preferred access to the hospital and doctors system. That 29 percent that is now private doesn't go into hospitals and doctors. It may go to upgrade. But it goes to drugs, it goes to nursing care, they're starting to use it in home care, it goes to all kinds of other things.

*Options*: Canada ranks number four in an OECD survey of GDP

invested in health care. But it drops to number fourteen when it's denominated in US dollars. Is that an unfair comparison?

*Michael Kirby*: Well, I don't think that GDP number matters. You see, what the GDP number is measuring is the number of dollars spent in health care. Those dollars *are* going to be spent, the issue in Canada is are those dollars going to be public dollars, that is to say, spent collectively, or private dollars. And so the real issue is the amount of money that is spent by government, it's not the amount of money that is spent in the whole system. So I've never thought that the GDP number was a very useful comparison. There is one exception: the American number is so much higher than any other OECD country, it absolutely establishes that the US system is the most expensive system in the world, by any measure you want to use. Now the other interesting thing is it also has among the worst outcomes of the major industrialized countries. So it's the worst possible combination in the sense that the system as a whole—society as a whole—is paying more for health care, substantially more, on a per capita basis, but getting less, in terms of outcome, than other countries.

*Options*: How does the US manage to spend 14 percent of GDP on health care when 41 million people aren't covered? That's larger than the population of Canada.

*Michael Kirby*: That's a very good question. They underline its huge additional administrative cost in hospitals. Two things. It's very expensive for the very expensive treatments, and therefore the market forces have driven the price up. But secondly, it's very inefficient. I mean a typical US hospital has overhead costs, related to having to deal with the multiplicity of insurance companies and funders, that Canadian hospitals don't have. We're inclined to underestimate, in this country, the huge efficiencies that come from a single-payer model. By the way, the efficiencies come from it being a single-payer model, not the fact that the payer is government. I mean, if you're going to have a single funder, in our case it is government, but you'd have all the same efficiencies if you had a single-payer model and it was the private sector. It's the multi-payer model in the US that makes it so expensive.

*Options*: Yet they do have centres of excellence, such as the Mayo Clinic and the Sloan Kettering, which we don't.

*Michael Kirby*: Well, because they are able to pay the dollars they pay, they are certainly able to attract absolutely the world class of people. But the reality is that in the US, if you have the money to pay for it, it's the best country in the world to get sick. But if you don't have the money to pay for it, among all the OECD countries, it's absolutely, if not the worst, very close to the worst.

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*Options*: Looking at some attitudinal data over the years, 45 percent of Canadians felt health care was working well in 1989, and in 1999 only 14 percent felt that way. And if you look at the data over time, the trend line is straight down. What does that tell you?

*Michael Kirby*: Well, the question you then have to ask is, why do Canadians feel that way? And the answer, it seems to me, is very clear. The answer is that waiting times for major events, including critical list like radiations and chemotherapy and also hip replacements and that sort of thing, have lengthened enormously as a result of the cutbacks federally and provincially of the 1990s. And that's the part of the system people see. If you look at the polling data, it's interesting that if you're in the system, that is, once people start getting treatment, generally speaking the system gets pretty good ratings. So what those numbers reflect is the length of waiting times, which is not only medically difficult, it's psychologically difficult. And I'm almost convinced the psychological problem is the bigger problem. You worry—you know there is a lump inside your body and it's going to take six weeks to get a CAT scan and you're worrying: is it growing? How do we deal with it? So that's why our report gives specific proposals for dealing with that problem.

*Options*: In 1993, when the present government came into office, 49 percent of Canadians had health care as a top-of-mind issue, and by end of the decade it had moved to 69 percent. What does that tell you?

*Michael Kirby*: Well, the same thing. It tells you that the cutbacks in expenditures of the 1990s, federally and provincially, and their subsequent impact on waiting times, have driven concern about the system. Essentially, the issue with Canadians is: will the system be there when I need it? And they used to be very, very convinced it would be, and now they're not convinced at all.

*Options*: Let's look at a sort of diagnostic. What about the outcomes? What about your recommendations?

*Michael Kirby*: Let me put the recommendations into three different categories. One category being efficiency measures, the second sustaining the infrastructure—they're kind of related—and the third is some expansion to begin to close some of the most glaring gasps in the health regime. On the efficiency side, everybody is in favour of primary-care reform: we're in favour of it, but it doesn't save a huge dollar. To really begin to save money in the system, you have to change the way hospitals are funded. You've got to move to a service-based system in which hospitals, instead of being given an annual

budget, are in fact paid for what they do. That will mean a whole variety of changes. Number one will be a psychological change. The minute you say that a patient brings revenue as opposed to costing you something, the psychological effect is significant. But in addition to that, it allows you to tell which institutions are efficient; it allows you to drive volume into the efficient institutions. And one of the great things about health care is that quality goes up as volume goes up, which is unusual. In most businesses, that isn't true necessarily. In the health-care business, the more of a particular procedure or operation an institution does, not only does it get better at it in efficiency terms, it gets better at it in quality terms. All the research worldwide has shown that the key driver of quality is volume.

*Options*: And the other points?

*Michael Kirby*: On the infrastructure side, the most expensive part of the health-care system is the so-called teaching hospitals. Why? Because it's where all the most sophisticated equipment goes. It's where all the toughest cases go. Our view is that we should look at the teaching hospitals—or what are technically in the business called academic health science centres, because they include the medical schools—essentially as a national resource, not a provincial resource.

*Options*: Is this where the preoccupation of the public lies? With bricks and mortar?

*Michael Kirby*: It's not with bricks and mortar. The preoccupation of the public lies with the hospitals' ability to deal with the cases. If it was just the bricks and mortar, the vast majority of them would be unequipped. But the public very much wants the leading-edge equipment.

We have a specific recommendation related to health-care technology. One of the dangers is that you start buying new bells and whistles, *because* they are new bells and whistles. But increasingly, around the world, governments are looking at various procedures and actually trying to assess whether or not the outcome benefits are worth it relative to the money that's being invested. And they're doing the same with drugs. It doesn't automatically follow that some new drug that is more expensive than the one it's replacing is enough of an improvement that it's worth the investment in cash. So you've got to evaluate. You've got do technology evaluation.

*Options*: Do you have a view about centres of excellence along a national network basis?

*Michael Kirby*: The minute you say that the academic health centres are a national resource, then you're going to build the infrastructure nationally. This goes back to the relationship between volume and quality.

*Options*: How do you prevent this from degenerating into a federal-provincial fight?

*Michael Kirby*: I've actually gone around and talked to most premiers and their ministers of health. And I sensed that there really is a remarkable convergence of views, because the mistake the feds would make is if they tried to get into detailed command-and-control systems in which money was conditional, federal money was conditional on the province behaving in a particular way, as opposed to the feds saying, as we proposed essentially: "look, here is the part of the business that we will deal with ourselves. And you continue to deal with the other part." I think this notion of two governments jointly managing anything as complicated as a major hospital frankly just won't work. You cannot do it through a command-and-control model.

*Options*: On new investments in health care, there's the famous line from the movie: show me the money. Where is the money to come from?

*Michael Kirby*: Well, two places. It could come from existing sources, if they have a surplus. Our attitude from the very beginning has been to say to Canadians, "this is what it's going to cost you to make the changes, to fund the changes." Health care is not free. You should get away from this notion that it's free. And so we should put a cost at the end. And our proposal has a national health-care insurance premium, which is variable in the sense that it varies with the individual's income tax level. And that will raise the money: we've costed every recommendation. And it remains to be seen whether government decides to do that. I mean, if you've got the money in surplus, that's fine. But the reality is, somewhere down the road additional money is going to be needed for health care, and it seems to us to make sense to have a dedicated revenue source for that dedicated fund.

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*Options*: So this is a dedicated health-care tax?

*Michael Kirby*: I don't like the word "tax," because tax by its nature means something that goes into the Consolidated Revenue Fund and isn't dedicated to a particular purpose. A much better analogy would be the money we all pay into the Canada Pension Plan or Employment Insurance. What are we doing when we contribute to Employment Insurance? We're making a contribution into a special fund that will be there to provide you with a service, should you in fact become unemployed. That's a much better way to look at what we're talking about. We're talking about putting money into a dedicated fund that will be used only for the health-care system so that the health-care system is there when you need it. That is not a tax. It is money passed through government into the health-care sector, but it is not

a tax in any general sense of the word. It's very clearly earmarked for a specific purpose. And it's earmarked to provide a safety net so that when people need it, it's there.

*Options*: You're talking about a federal investment of $5 billion a year over how many years?

*Michael Kirby*: Well, essentially in perpetuity, because in this sense we have $5 billion dollars per year. Some of the capital investment we've rolled out over 10 years, but the reality is that you have to keep renewing the system. And the reality is that the costs in the system are going to go up, not only because of the age of the population, but largely because of technology and drugs, whose costs are increasing at a rate far in excess of the rate of growth of inflation.

We structured the premium so that it's a flat amount to pay on each income tax bracket, but it varies with your income tax bracket. So if you don't pay any income tax, you don't pay it, obviously. In the lowest income tax bracket, it's only 50 cents a day, but at the top income tax bracket, it's four dollars a day.

*Options*: Did you examine other models such as increasing SIN taxes?

*Michael Kirby*: Yes. The report in fact goes through every conceivable way of raising $5 billion. We arrived at $5 billion because that's what our recommendations will cost. And our tax structure has to be competitive with other countries. We can't lose our competitiveness for economic development purposes. And secondly, there has to be a sense of fairness. In Europe, for example, a lot of health care is paid through what they call pay-roll taxes. But pay-roll taxes are inter-generationally unfair, because they are only paid by people who are working. So your dilemma with an ageing population is if you pass health care to a pay-roll tax, you would have the whole of the older generation being funded by people who are working. And that is unfair. So we've gone through all the options and ultimately came up with this one. But we've given what is essentially a tax policy seminar on what the advantages and disadvantages of each tax scheme are.

*Options*: As between tinkering with health care and reinventing health care, where does this report come out?

*Michael Kirby*: Well, I would be inclined to say "restructuring," rather than "reinventing." Look, if we don't move to service-based funding; put in place a complete information system, including the electronic health record; rebuild the infrastructure with a particular focus on the academic health science centres; and put in place a guarantee of timely service, where time is defined by medical criteria and not by the number of people demanding it. If we don't do those four things, five years from now we'll have a parallel private system.

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