

The following is a summary of IRPP's latest release in the Health Care Series entitled *WHO IS THE MASTER? A BLUE-PRINT FOR CANADIAN HEALTH CARE REFORM*, by Monique Jérôme-Forget and Claude Forget

The goal of our study was to propose a plan for the reform of the Canadian health care system. Our underlying premise was that to identify the best solutions, Canada should draw its inspiration from models now in operation in other OECD countries. Based on our research into these systems, we were able to formulate concrete reforms that would affect both the organization and funding of our current health care system. We regard our work as a step toward improving the quality of the health services offered to the general public, since quality is a concern that far surpasses issues of a purely monetary and financial nature.

In our study, we look first at the dangers of using national aggregate numbers to assess the wisdom of increasing or decreasing spending on health services. All governments look at aggregate spending in other countries to justify their own health care funding decisions, yet the logic of doing so is faulty. Such figures do not allow us to address the major issues at stake with regard to health services. The hypothesis that there is a "right" percentage of the GDP that should be devoted to the health sector does not stand up to analysis, particularly comparative analysis. The United States, which allocates 15 percent of its GDP to health services, spends much more money than Canada in this area. Yet Canadians categorically reject the US system, and rightly so, above all on moral grounds, since a large number of US citizens have no medical coverage whatsoever. Moreover, national aggregates do not allow us to draw conclusions regarding the quality/price ratio. At best, such figures provide food for thought.

In chapter two, we focus on the type, rather than the amount, of health care expenditures in Canada, in an effort to determine to what extent increased spending translates into better services. If higher spending improves our quality of life, then clearly it is justified. If, on the other hand, additional costs turn out to be largely inflationary, then further increases in health care spending are unjustified. Our findings indicate that rising health care costs in recent years have been primarily inflationary in nature.

It should be remembered that the health care sector defies the traditional rules of economics. For example,

we cannot simply establish a ratio between spending and life expectancies and stop there. Choosing to reduce treatment waiting time or reducing physical and mental suffering have no direct bearing on life expectancy, yet such factors can hardly be overlooked. Similarly, hip replacement or cataract operations are highly beneficial to those who undergo such treatments, yet they do not increase life expectancy.

To differentiate between justified and unjustified health care costs and thereby point up the sources of inefficiency, we examine the specific example of a major teaching hospital in Montreal. Among other factors, we observe that wages and salaries explain a large portion of the increase in this institution's spending. We suggest various incentive measures to encourage reform within an environment that is little inclined to change, but which has been undergoing a veritable technological revolution for a number of years.

We devote particular attention to market-type mechanisms that several countries have undertaken to reform their health care systems. These countries have clearly identified health care purchasers and providers with a view to sparking competition among the various providers. It is critical to bear in mind that these reforms have not jeopardized either the universality or public nature of the health services offered. In our monograph, we look at the experiences of three countries: the UK, Sweden and New Zealand. The reforms in these countries have had some drawbacks, but we maintain that decentralization and the creation of internal markets have proven beneficial in all three instances. Hospitals have regained their autonomy and changes have been made to the mission of regional health care institutions, which must now purchase quality services at the best possible price. General practitioners have become purchasing agents and managers. Moreover, patients have retained their hallowed right to choose their own doctors. These factors, coupled with the introduction of capitation-based funding, have radically changed the motivation of the players in the health care systems described. Undoubtedly, Canada has much to learn from these experiences.

"Made in Canada" Reform

In chapter four of our book, we propose that an internal market be established to mesh with Canadian realities. We know that for any reform to be successful, it must take the existing system into account, yet be radical enough to force change. One of the major drawbacks of the current system is the lack of follow-up and coordination among the various players. Any reform should necessarily begin by cultivating relations among these players. It should also promote choice for patients, restoring them to their rightful place at the heart of our health care system.

Several aspects of the reform we are proposing reflect the above principles, particularly capitation-based funding and its most noteworthy consequence, *i.e.*, that the money follows the patient. "Targeted med-

ical agencies" (TMAs) form the backbone of our proposed system. Large in number and small in size, these agencies would purchase medical services on behalf of patients. Their smaller size would help avoid big bureaucracies, monopolies and uncontrolled budget increases. They would also ensure adequate dissemination of information and greater attention to patient needs. The creation of such agencies would radically change the role of physicians and decentralize financial responsibility.

In concrete terms, how would such a system work? Each patient would register with a physician, who in turn would belong to a targeted medical agency. The sums of money assigned to the patient would be channeled to his or her physician, who would then provide the patient with the full range of medical services required. Physicians would bear the responsibility for managing the funds, which would cover most of their patients' medical needs. We believe it is crucial that physicians, not the agencies, should be the financial gatekeepers for their patients. Historically, Canadians have had close relationships with their "family doctors," which partly explains why we are opposed to the idea of introducing US-style health-maintenance organizations, criticized by many for having created an overly bureaucratic medical system.

In our proposal, the physician responsible would commit to providing the best possible medical care to patients who have registered with him or her. There would have to be many TMAs to ensure healthy competition and real choice for patients. General practitioners would group together to form agencies, some of which would purchase specific expertise from specialists. Other agencies would opt to specialize, catering to clienteles with specific chronic diseases. Individuals with diabetes could, for example, choose to go to a specialized agency for all their medical needs and treatments. They would stay with a particular physician for one year, after which, they would be free to shop around for another practitioner if dissatisfied. It seems unlikely, however, that many people would exercise this right, since continuity of care is an important concern to both patient and physician.

The purpose of the proposed reform would be to ensure that patient needs are at the forefront of the health care system rather than to save money. Another aspect of the proposal concerns comprehensiveness. Contrary to the UK experience, we suggest that the reform should encompass all public health care services.

We also discuss the potential impact of this reform on hospital institutions, which would see their sources of funding shift from the centralizing hand of government to numerous TMAs, with which they would have to conduct innumerable transactions. Hospitals cannot be sustained without patients and would therefore have to learn to be directly accountable. Several problems have arisen in this regard in the UK and New Zealand, stemming from the fact that the agent purchasing ser-

vices from hospitals — the district health authority — was a cumbersome bureaucratic mechanism that imposed its own standards with little room for negotiation.

The reform we are proposing should not daunt institutions that already benefit from a degree of autonomy in management. Allowing performance to dictate budget size would effectively mean giving hospitals control over their own futures: by providing the best possible services at the most effective price, they would be able to establish and keep their clientele. Likewise, it is conceivable that there would be instances of budget surpluses or deficits and even outright hospital closures. The delicate issue of health care institutions in rural areas is also addressed in our book.

We do not overlook the dangers inherent in our proposed reform. These include the perverse process commonly known as "cream-skimming," which means that a health care provider selects those patients who offer the greatest financial benefits for the least amount of physician time and effort. However, these problems can be resolved by implementing certain control measures.

Our proposal offers concrete guidelines for a much-needed reform of the Canadian health care system. We believe it does so with an open-mindedness that requires us, before undertaking any change whatsoever in a system that some consider to lie at the heart of the Canadian identity, to profoundly rethink our basic attitudes and fundamental assumptions.

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Who is the Master? A Blueprint for Canadian Health Care Reform est en vente pour 15.95 \$ aux bureaux de l'IRPP et dans plusieurs librairies à travers le Canada.

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