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Thomas J. Courchene

# Medicare as a Moral Enterprise: The Romanow and Kirby Perspectives

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Born in Wakaw, Saskatchewan, Thomas J. Courchene is the Jarislowsky-Deutsch Professor of Economic and Financial Policy at the Queen's School of Policy Studies and is Senior Scholar of the IRPP. He is the author of some three hundred articles, monographs and book chapters on a wide range of Canadian policy issues including monetary policy, fiscal policy, trade and exchange rates, regional disparities, social policy, equalization, federal-provincial relations, financial deregulation, comparative federalism, and the machinery of Canadian and international governance. His C.D. Howe book *Social Canada in the Millennium* won the 1994 Douglas Purvis Prize for the best contribution to Canadian economic policy and *From Heartland to North American Region State: The Social, Fiscal and Federal Evolution of Ontario* (with Colin Telmer) won the inaugural Donner Prize for the best book on public policy in 1998. He is a past president of the Canadian Economics Association (1991/92) and the North American Economics and Finance Association (2002/03), is a Fellow of the Royal Society of Canada (elected 1981), was awarded the Canada Council's 1999 Molson Prize for lifetime achievement in the Social Sciences and Humanities, and holds honorary doctorates from the universities of Western Ontario and Saskatchewan. In 1999 Thomas Courchene was inducted as an Officer into the Order of Canada.

Courchene's recent publications for the IRPP include *A State of Minds: Toward a Human Capital Future for Canadians* (2001), *Half-Way Home: Canada's Remarkable Fiscal Turnaround and the Paul Martin Legacy* (2002), *Embedding Globalization: A Human Capital Perspective* (2002), and *The Case for a North American Currency Union* (2003). He and Senior Fellow Donald Savoie co-edited *Governing in a World Without Frontiers*, the inaugural volume in the IRPP's *The Art of the State series*.

Tom and Margie Courchene live by the St. Lawrence River in Kingston, Ontario.

# Summary

*Medicare as a Moral Enterprise: The Romanow and Kirby Perspectives* compares and contrasts the values (or operating principles) that underpin the Romanow and Kirby health care reports. The author, IRPP Senior Scholar Thomas J. Courchene, begins by highlighting the four underlying principles in Commissioner Roy Romanow's personal introduction to the report, *Building on Values: The Future of Health Care in Canada*. Put succinctly, these principles are: 1) medicare is a moral enterprise, not a business venture; 2) private money should not enable one to jump the queue; 3) existing private diagnostic providers should be incorporated into the public system, while private treatment providers should be discouraged or prohibited; and 4) Canada has latched onto the best approach to health care, therefore there is no need to encourage experimentation with alternative approaches.

While these operating principles may have been suitable at some point in medicare's history, the thrust of Courchene's analysis is that they fall well short of a blueprint for ensuring the successful transition of Canada's health care system into the information era. To buttress this assertion, he presents an overview of the likely evolution of key aspects of the health care system in the 21st century and then contrasts that evolution with the likely outcomes of the Romanow Report's operating principles.

First, health services is emerging as one of the leading-edge economic sectors for employment, innovation, research and exports. If Canadians continue to view health care as falling largely or entirely within the social policy envelope (a moral enterprise), it will never receive the requisite infusion of physical, intellectual and financial capital it needs to become a dynamic engine of economic growth, much less provide them access to state-of-the-art services.

Second, the future will likely be characterized by rapid growth of innovative and specialized diagnostic and treatment centres that will operate independently of, although perhaps in alignment with, the hospital sector. Since many of these centres will be privately run, they will clearly run afoul of the report's guiding principles.

Finally, as baby boomers reach retirement age they will be healthier and wealthier, have longer life expectancies, and, thanks to changing lifestyles and the Internet, will be much better informed about treatment options (and hence much more assertive in their health care demands) than were earlier generations. How do we tell them that they can spend their higher pension incomes and savings on anything they want *except on their health care*? This prohibition alone has the potential to undermine the entire structure of Canadian medicare.

Courchene then turns to the Kirby Report and examines its underlying operating principles. First, the core value of the health care system according to

Kirby is the single-payer principle. This concords with the Romanow Report. Second, the Kirby Report proposes a health care guarantee that sets maximum waiting periods for treatment, after which the patient can purchase treatment (even go to the US, if necessary) and be reimbursed. The third principle is that the single payer (the government) will be agnostic about whether the diagnostic and service providers are government-owned, not-for-profit or private enterprises. The latter two principles are dramatic departures from those in the Romanow Report. The final operating principle is that private money will be prohibited unless diagnostic or treatment waiting times exceed those set out in the health care guarantee.

According to Courchene, the health care model envisioned in the Kirby Report is much more consistent with the likely evolution of the health sector in the 21st century. For instance, encouraging private-sector providers will facilitate the emergence of state-of-the-art health care, and the health care guarantee will directly address the Achilles heel of the current system — unconscionable waits for treatment.

While the Kirby Report model may be viewed by some as a modest attempt at reform, allowing internal markets to develop means that it will be possible for the health care system to evolve *from within* in response to economic, socio-political and health-related stimuli. This is the *sine qua non* of a viable model for 21st century.

# Résumé

Dans cette étude, Thomas J. Courchene, chercheur principal à l'IRPP, compare et confronte les valeurs (ou principes de mise en œuvre) sur lesquelles reposent les rapports Romanov et Kirby sur les soins de santé, afin de déterminer lequel est le plus utile pour faire face à l'évolution probable du système de santé.

Il identifie tout d'abord quatre principes qui sous-tendent l'introduction personnelle du commissaire Roy Romanow dans le rapport *Guidé par nos valeurs : préparer l'avenir des soins de santé au Canada*, en les résumant comme suit : 1) le régime d'assurance-santé relève d'une entreprise morale et non commerciale; 2) le système de santé ne doit pas permettre aux gens de payer pour éviter d'être placés sur une liste d'attente; 3) les services privés de diagnostic doivent être intégrés au régime public et on devrait décourager ou restreindre l'offre de soins privés; 4) le Canada possédant le meilleur système de santé possible, il n'y a pas lieu d'expérimenter des approches alternatives.

Or, affirme Courchene, si ces principes ont pu se justifier à certains moments de l'histoire de notre régime d'assurance-santé, ils sont très loin d'offrir un cadre satisfaisant pour assurer un passage réussi à l'ère de l'information. Pour nous en convaincre, il anticipe l'évolution probable des éléments clés de ce système au XXI$^{e}$ siècle, avant d'en confronter les résultats à la situation qui découlerait de l'application des principes du rapport Romanow.

Premier pronostic : les soins de santé s'imposeront parmi les secteurs économiques de pointe en matière d'emplois, d'innovation, de recherche et d'exportation. Or, si les Canadiens persistent à les considérer comme relevant essentiellement de la mission sociale des gouvernements (comme une entreprise morale, donc), on ne pourra jamais y injecter le capital physique, intellectuel et financier nécessaire à leur transformation en un moteur de croissance, et moins encore s'assurer d'avoir accès aux meilleurs soins possibles.

Deuxièmement, l'avenir se caractérisera par une croissance rapide des centres de soins et de diagnostic ultra-spécialisés qui évolueront en dehors du secteur hospitalier. Puisque bon nombre de ces centres seront privés, ils enfreindront clairement les principes directeurs du rapport.

Enfin, les baby-boomers qui sont au seuil de la retraite jouiront d'une meilleure santé physique et financière, ils profiteront d'une espérance de vie accrue et seront nettement mieux renseignés grâce à l'Internet et à l'évolution des modes de vie (et par conséquent plus exigeants sur la qualité des soins). Dès lors, comment leur expliquera-t-on qu'ils peuvent dépenser à leur guise leurs économies et revenus de pension, *sauf pour obtenir des soins de santé* ? À elle seule, cette interdiction suffirait à remettre en cause toute la structure du régime canadien d'assurance- santé.

L'auteur examine ensuite les principes directeurs qu'on retrouve dans le rapport Kirby. À l'instar du rapport Romanow, il observe que le principe du payeur unique y est présenté comme étant la valeur fondamentale de notre système de santé. Mais Courchene constate qu'on y propose en outre une *garantie de soins de santé* établissant un temps d'attente maximal au-delà duquel tout patient pourrait débourser de sa poche le prix d'un traitement (il pourrait même le recevoir aux États-Unis) qui lui serait remboursé. De plus, le payeur unique (c'est-à-dire l'État) ne ferait pas de distinction entre les services ou diagnostics fournis soit par le secteur public ou privé ou par des organismes à but non lucratif. À noter que ces deux derniers principes s'éloignent radicalement du rapport Romanow. Enfin, on interdirait l'usage de fonds privés sauf si le temps d'attente prévu par la garantie de soins de santé est dépassé.

Selon Thomas Courchene, le modèle proposé dans le rapport Kirby correspond beaucoup mieux à l'évolution probable du secteur de la santé au XXI$^{e}$ siècle. Il favorise par exemple l'émergence de soins médicaux de pointe en permettant l'apport du secteur privé, et la garantie de soins de santé qu'il comporte s'attaque de front au talon d'Achille du système actuel, i.e. les délais d'attente inacceptables pour obtenir des traitements.

Si certains voient dans le modèle Kirby une proposition de réforme trop modeste, le fait qu'il autorise le développement de marchés internes signifie que notre système de santé pourra évoluer *de l'intérieur* en réponse aux incitatifs économiques, socio-politiques et autres enjeux de santé publique. Selon l'auteur, c'est précisément la condition *sine qua non* d'un système de santé viable pour le siècle en cours.

# Introduction

*Building on Values*, the Final Report of the Commission on the Future of Health Care in Canada, begins with "A Message to Canadians," written by the report's Commissioner, Roy Romanow. The core of the Commissioner's message is that he has kept his word to Canadians — the report is "evidence-based and values-driven." Moreover, Canadians will presumably find themselves in considerable agreement with much of the introductory message. For example, few Canadians would disagree with the view that "making Canadians the healthiest people in the world must become the system's overriding objective" (Romanow 2002, xv). Canadians will also have little trouble endorsing the report's intention of sustaining the "core values on which our health system is premised — equity, fairness and solidarity" (xvi). Likewise, striving to make the health system more comprehensive, responsive and accountable on the one hand and underpinned by stable and predictable funding on the other are all features that faithfully reflect the preferences of Canadians.

However, in the section entitled "A System Based on Canadian Values," Commissioner Romanow then focuses in much more detail on what he calls selected "Canadian values" (or operating principles) which are deemed to underlie, and indeed to define, Canada's medicare system now and essential to sustain it in the future. With respect, these values, or principles, fall well short of a blueprint for ensuring the successful evolution of Canada's health care system in the information era. The purpose of the ensuing analysis is to elaborate upon and to attempt to substantiate this assertion.

Accordingly, this paper begins by distilling the four operating principles that comprise this "system based on Canadian values." This is followed by an admittedly subjective interpretation of the likely evolution of the health care sector in the information era. The stage is then set for the juxtaposition of the report's operating principles with the dictates of the information era for the future of health care. Unfortunately, the Commissioner's vision does not fare well in this comparison. The analysis then compares and contrasts the Romanow Report's set of operating principles with an alternative set that accords more closely with the prospective nature of 21st century health care. These alternative operating principles are drawn from the recent Senate report on health care (Standing Senate Committee 2002) henceforth referred to as the Kirby Report, after its Chair, Senator Michael Kirby.

# A System Based on Canadian Values

What are these "Canadian values" or operating principles that are deemed to be integral to Canada's medicare system? At least four CVs (for *C*anadian *V*alues) can

be drawn from this key section of the Commissioner's message. For present purposes, CVs 1–4 are stated largely without comment. Elaboration will come later.

### CV1: Medicare is a moral enterprise

Arguably, this is the overarching operational principle, from which the remaining values follow.

> *It has been suggested to me by some that if there is a growing tension between the principles of our health care system and what is happening on the ground, the answer is obvious. Dilute or ditch the principles. Scrap any notion of national standards and values. Forget about equal access. Let people buy their way openly to the front of the line. Make health care a business. Stop treating it as a public service, available equally to all. But the consensus view of Canadians on this is clear. No! Not now, not ever. Canadians view medicare as a moral enterprise, not a business venture.* (Romanow 2002, xx)

### CV2: Prohibition of private money

Medicare as a moral enterprise dictates that *need* rather than *money* should determine access to the system.

> *Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care.* (xx)

### CV3: Co-opt private diagnostic providers; discourage if not prohibit private treatment providers

Given the vision of medicare as a moral enterprise and the related prohibition of the use of private money in the system, the Commissioner is obviously concerned with the existence of private health care providers:

> *One of the most difficult issues with which I have had to struggle is how much private participation within our universal, single-payer, publicly administered system is warranted or defensible. On the one hand, I am confronted by the fact that the private sector is already an important part of our "public" system. The notion of rolling back its participation is fraught with difficulty. On the other hand, I am acutely aware of the potential risks to the integrity and viability of our health care system that might result from an expanded role for private providers.*

> *At a minimum, I believe governments must draw a clear line between direct health services (such as hospital and medical care) and ancillary ones (such as food preparation or maintenance services). The former should be delivered primarily through our public, not-for-profit system, while the latter could be the domain of private providers.* (xxi)

However, there are some troublesome aspects of the status quo, which serve to complicate the Commissioner's clear preference for public, not-for-profit delivery of direct health services.

> *The rapid growth of private MRI (magnetic resonance imaging) clinics, which permit people to purchase faster service and then use test results to "jump the queue" back into the public system for treatment, is a troubling case-in-point. So too is the current practice of some workers' compensation agencies of contracting with private providers to deliver fast-track diagnostic services to potential claimants. I agree with those who view these situations as incompatible with the "equality of access" principle at the heart of medicare. Governments must invest sufficiently in the public system to make timely access to diagnostic services for all a reality and reduce the temptation to "game" the system. In order to clarify the situation in regard to diagnostic services, I am therefore recommending that diagnostic services be explicitly included under the definition of "insured health services" under a new* Canada Health Act. (xxi)

As I interpret the reasoning in the above quotes, the rationale for bringing private provision of diagnostic services under the banner of medicare is not so much to reduce waiting periods, per se, but to prevent Canadians from using their own money to access private diagnostic services, the results of which could then be used to move them up the waiting list. However, since many analysts interpreted the Romanow Report as prohibiting further private provision of health services, the Commissioner utilized post-publication press conferences to emphasize that the report contained no such explicit recommendation. While this is true in fact, it is not true in spirit. Hence, CV3 reflects the diagnostic vs. treatment duality with respect to private provision that exists in the report: co-opt the former, discourage if not prohibit the latter.

### CV4: Canada has latched on to the best approach to health care so that experimentation with alternative approaches can be discouraged

CVs 1–3 lead directly to the report's claim that the health care system does not need creative experimentation in terms of design and delivery options, a peculiar position indeed when Canadians know that medicare owes its very exis-

tence to creative experimentation in Saskatchewan. The reasoning behind this position draws from the Commissioner's commitment to Canadians to rely on an evidence-based approach:

> *Early in my mandate, I challenged those advocating radical solutions for reforming health care — user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system — to come forward with evidence that these approaches would improve and strengthen our health care system.* ***The evidence has not been forthcoming****. I have also carefully explored the experiences of other jurisdictions with co-payment models and with public-private partnerships, and have found these lacking. There is no evidence these solutions will deliver better or cheaper care, or improve access (except, perhaps, for those who can afford to pay for care out of their own pockets). More to the point, the principles on which these solutions rest cannot be reconciled with the values at the heart of medicare or with the tenets of the* Canada Health Act *that Canadians overwhelmingly support. It would be irresponsible of me to jeopardize what has been, and can remain, a world-class health care system and a proud national symbol by accepting anecdote as fact or on the dubious basis of making a "leap of faith."* (xx; emphasis in original)

Canadian values CV1–CV4 represent my attempt to capture the essence of the proposals put forward in the Romanow Report. As already alluded to, these values/principles/instruments will not, in my view, ensure the viability of Canada's public health care system in the 21st century. Prior to buttressing this assertion, attention is directed to the manner in which health care is likely to evolve in the 21st century.

## Health Care in an Information Era

The health sector is emerging as one of the key sectors in 21st century Canada. In one respect, this is hardly a novel statement. Canadians have long recognized this potential when they point out that our publicly funded and universal-access health care system provides a competitive advantage to Canadian firms over their US counterparts. Former Chrysler President Lee Iacocca once lamented that his US-based operations spent more on health care than on steel! This is, and will continue to be, an important *indirect* benefit of our health care system.

However, looming more important still are the *direct* benefits the health care system can deliver. In the knowledge/information era, health is emerging as one of the leading-edge economic sectors for employment, innovation, research

and exports. Among the many promising industrial subsectors subsumed within health care are information technology; biotechnology; health care diagnostic, treatment and delivery services; health care management; knowledge/information management systems (including data collection and software development); and imaging systems. These are also leading-edge sectors for employing our high-level human capital and talent, an essential requisite if we wish to become a knowledge-based economy and society. However, there is much more at stake here than merely missing out on a major export platform in the information era: Failure to be in the forefront of these remarkable diagnostic, treatment and service-delivery innovations will mean that we will assuredly fail in our objective to ensure that Canadians will have access to state-of-the-art health care.

The underlying issue can be recast in the following terms. Canadians have tended to view the health care system as falling largely, if not entirely, within the social envelope. Moreover, our collective approach to health care has tended to emphasize cost containment, subject to some national conception of an acceptable or appropriate standard of services (which we appear willing to see decline over time). However, the reality is that in an information era the health care sector will need a massive infusion of physical, intellectual and financial capital to enable it to become a dynamic engine of economic growth with numerous spin-offs in other new technology sectors. *Viewing the health sector solely as a social policy endeavour will almost surely guarantee that it will never receive this requisite infusion of capital.*

If viability in the information era means that the health care sector must transcend the social sphere, it is *a fortiori* the case that it must also transcend the vision of medicare as a "moral enterprise." The essential point is that maintaining state-of-the-art health care for Canadians in the 21st century requires that we view the health sector as *both* an essential social institution *and* a dynamic economic sector for production, exports and employment. Achieving this dual objective means the last paradigm's conception of medicare cannot be allowed to prevent the health sector from emerging as a pivotal player in our society, in line with both the economic opportunities generated by the new knowledge/information era and the pressing health care needs of (aging) Canadians.

Relatedly, given the potential dynamism of the information-era health care industry, one can be fairly confident that the future on the health front will be characterized by a rapid growth of innovative and specialized diagnostic and treatment centres that will be separate from, although possibly aligned with, the hospital sector. In effect, what has occurred with respect to laser eye surgery will be replicated for other diagnostic and treatment areas. Not only will these specialized centres be cost effective (in part because their overheads will be far lower than those of multipurpose hospitals and in part because of greater flexibility in terms of employment

relations and professional practices), but the quality of service they provide is likely to be higher because their reputation will ride on being state-of-the-art in their specialty and because of the practice-makes-perfect feature of specialization. Moreover, these specialized clinics will in all likelihood be privately owned and operated. The policy issue here is not whether they should be allowed to proliferate, but rather how they ought to be integrated with Canada's health care system.

## Canadian Values and Information-Era Health Care

This public-private integrated vision (or version) of 21st century health care runs directly counter to the letter and even more so to the spirit of the Romanow Report's "system based on Canadian values." Advocates of medicare as a moral enterprise (CV1) would surely take umbrage at the appearance of these specialized clinics in both their commodification and private-ownership characteristics. Moreover, these clinics as well as other forms of delivery experimentation will be opposed by many Canadians on grounds that "the principles on which they rest cannot be reconciled with the values at the heart of medicare or with the tenets of the *Canada Health Act*" (Romanow 2002, xx). And in any event, as CV4 implies, there is no *evidence* from anywhere that such experimentation or initiatives can benefit Canadians and their health care system.

The remaining two values (CV2 and CV3) and the manner in which they run up against an information-era conception of the health sector merit special highlight.

### CV2 and CV3: Private money and private clinics

Among the most daunting issues facing Canada's health system must surely be the inordinately long waiting periods for some medically necessary procedures. To appreciate fully the nature of this challenge it is instructive to note that the soon-to-retire baby-boom generation will have accumulated much more in the way of pension earnings than did previous generations. Moreover, baby boomers are reaching retirement age in better health and with longer life expectancies than their predecessors. How then do we inform them that they can spend their higher pension incomes and savings on anything they want *except on their health care?* This is especially difficult since the Internet and new-age lifestyles have made them much better informed and educated in matters of health and, as a result, much more assertive in terms of their health care demands than was the case for previous generations. To be sure, they always have the option of going to the US to access health care services. But, progressively, this will become neither acceptable nor societally sustainable. Indeed, our inability to deal domestically with inappropriately long

waiting periods and, more generally, timely access to state-of-the-art health care will become an issue of such societal import that it has the potential to undermine the entire structure of Canadian medicare.

The Romanow Report's CV2 and CV3, working in tandem, will not do much to ameliorate these lengthy waiting periods. Rather, their role is to ensure that any such waiting periods will apply equally to all Canadians. By "investing sufficiently in the public system" to ensure that diagnostic services' time lines can match any private sector counterparts (CV3), the model laid out in the Romanow Report will correspondingly ensure that any spending of private money will no longer be able to secure preferential (i.e. faster) diagnoses and, therefore, preferential placement in any public system treatment queue. Depending on how one defines "diagnostic services," this could become very expensive since it would mean providing all Canadians with public-system diagnostic access as timely as that available to Canadians in the parallel private diagnostic system. Moreover, it is likely that bringing privately funded diagnostic services under the medicare umbrella would pave the way for eventually doing the same for the privately funded specialized treatment clinics regardless of the intent of CV3. This could turn out to be extremely expensive.

In summary, operating principles CV1–CV4 do not square well with the manner in which the health sector is evolving in the 21st century. CV1 visualizes health care as belonging largely or solely in the social/nonprofit sphere. CV3 ensures that private money will no longer be able to ensure privileged access to diagnostic tests, which admittedly will serve to equalize the waiting periods for all Canadians. However, the second part of CV3 (alongside CV2) will work to ensure that these waiting periods, other things equal, will not decrease. CV4 reinforces CVs 1–3 by discouraging provincial experimentation and, relatedly, by asserting that Canada's health care model has no equal anywhere. As a result, CVs 1–4 will constrain, if not stifle, the evolution of Canada's health care system, one obvious implication of which will be that it will place in the balance our ability to meet Canadians' expectations that our health care system will match best practices anywhere.

But surely all that Canada's medicare model needs is the appropriate infusion of public funding and all will be well. Unfortunately, CVs 1–4 will conspire to ensure that money, of and by itself, cannot be the key to a successful health care future. Among other reasons, this is so because the lack of competition among service providers will serve to convert increased cash into increased wages. Hence, one should not be surprised by evidence to the effect that somewhere between one-half and three-quarters of recent cash infusions into the health care system have already found their way into wage increases. Phrased differently, the problem lies with the Romanow Report's operating principles. This provides a convenient *entrée* to the Kirby Report and the manner in which it pro-

vides an alternative approach to the range of issues and options raised by the Romanow Report's proposals.

## Rethinking Canadian Values 1–4: The Kirby Report

While the Kirby Report and the Romanow Report both espouse a publicly funded, single-payer system, the former advances two fundamental departures from the status quo: on the one hand, a "health care guarantee," and on the other, a reinterpretation of the public administration tenet of the *Canada Health Act* that leads to competitive provision of insured services. Both proposals serve to lend a substantially different dynamic to the issues associated with CVs 1–4. Attention will be directed toward these two new principles prior to recasting CVs 1–4 in line with the tenets of the Kirby Report.

### The Kirby Report's health care guarantee

Inordinate waiting periods for medically necessary procedures are viewed by the Kirby Report as the Achilles heel of Canada's health care model and, in particular, the publicly funded, single-payer system. Specifically, "the failure to address effectively the issue of the lack of access to timely care is...highly likely to lead to the establishment of a parallel private hospital and doctor system" (Standing Senate Committee 2002, 108). Drawing from a C.D. Howe Institute study by Stanley Hartt and Patrick Monahan (2002), the Kirby Report elaborates on this assertion as follows:

> *Hartt and Monahan maintain that if health services are not available on a timely basis, then provincial governments cannot legally prohibit Canadians from obtaining those services in Canada, nor can the federal government use the financial penalties in the* Canada Health Act *to compel the province to enforce constitutionally invalid restrictions. In other words, governments cannot fail to ensure the provision of timely access to medically necessary health services and at the same time prevent Canadians from obtaining such services outside the publicly funded system.* ***This includes governments being unable to prevent Canadians from acquiring private health care insurance to cover the cost of purchasing such services outside the publicly funded system***. (Standing Senate Committee 2002, 109; emphasis added)

Since failure to take action on waiting periods would surely jeopardize Canada's single-payer system, the Kirby Report advances the health care guarantee:

> *Therefore, the Committee recommends that:*

> *For each type of major procedure or treatment, a maximum needs-based waiting time be established and made public.*
> *When this maximum time is reached, the insurer (government) pay for the patient to seek the procedure or treatment immediately in another jurisdiction, including, if necessary, another country (e.g., the United States).* ***This is called the Health Care Guarantee****.*

By way of further elaboration, the Committee recommends the following:

> *The process to establish standard definitions for waiting times be national in scope. An independent body be created to consider the relevant scientific and clinical evidence. Standard definitions focus on four key waiting periods—waiting time for primary health care consultation; waiting time for initial specialist consultation; waiting time for diagnostic tests; waiting time for surgery. (117-118; emphasis in original)*

Of and by itself, the health care guarantee could prove to be very expensive indeed, especially at the existing Canada-US exchange rate. However, the Kirby Report links this proposal for a health care guarantee with a creative (and information-era-compatible) interpretation of the public administration principle of the *Canada Health Act*.

## Public administration and the CHA

The Kirby Report asserts that the federal government needs to "clarify the meaning of the concept of public administration under the *Canada Health Act* so as to recognize explicitly that this principle applies to the administration of public health care insurance, *not to the delivery of publicly insured health services*." Or, with even more clarity, "there should be a single insurer—the government — for publicly insured hospital and doctor services *delivered by either public or private health care providers and institutions*" (318; emphasis added). What facilitates this position is the associated recommendation that the system move to service-based funding, namely, that prices be established for different hospital procedures based on actual costs. Thus, the Kirby Report not only views the public administration principle as relating only to the single-payer role, but also opens the door for the governments (as single payers) to actively seek out the best deals, as it were, for the provision of diagnostic and treatment services. In other words, the Kirby Report in effect recommends competitive provision of health care services, or what economists would refer to as "internal markets" in the health care sector. Senator Kirby elaborates as follows:

> *Given the significant advantages that come with service-based funding, it came as no surprise to the Committee that the vast majority of CEOs of*

> *major health care institutions with whom we consulted were in favour of this change in funding method. One of the things that most major hospital CEOs told us was that they currently spend in the neighbourhood of 30% of their time haggling with provincial bureaucrats. What a colossal waste of senior management time! Moving toward service-based funding will eliminate much, if not all, of this wrangling since the government will no longer be involved in the micro-management of hospital budgets. Amongst other things, this could contribute to a significant downsizing of provincial health care bureaucracies. It would also help to "de-politicize" the day-to-day management of health care delivery.*
>
> *There is also an important synergy between service-based funding and improving the quality of health care that patients receive. Every research study indicates that if there is one correlation that holds throughout the health care sector it is the link between increasing volume and improved quality. The more frequently a particular procedure is performed by the same institution, the better the patient outcomes. By encouraging hospitals to specialize, and by linking remuneration to the number and type of procedures they perform, we not only drive efficiency, we also enhance quality.*
>
> *Finally, the shift to service-based funding would have the effect of lowering the volume on another peculiarly Canadian debate—whether services should be delivered by the public or private sector. With service-based funding, the government as insurer or funder would become neutral, or indifferent, with respect to who actually delivers the service.*
>
> *This is already the case in many areas of the health care sector, although many people are reluctant to recognize it. The principle of public administration in the* Canada Health Act *refers only to how provincial health care insurance plans are administered, not to who actually provides the services. Not only is private delivery of publicly funded services not outlawed under the* Canada Health Act*, it is an integral part of health care delivery in Canada and has been since the inception of Medicare some 40 years ago.* (Kirby 2003)

In terms of the storyline in this section, the result will be increased institutional competition, enhanced specialization and incentives to develop centres of excellence.

## The Kirby Report's version of CVs 1–4

The Kirby Report's version of the Romanow Report's operating principles can be articulated as follows:

- K1 — The core value of Canada's health care system is the single-payer principle.
- K2 — A four-pronged *health care guarantee* will become an integral part of the single-payer model. The four waiting periods relate to primary consultations, specialist consultations, diagnostic testing, and surgery.
- K3 — The single payer (government) will, other things equal, be agnostic about whether health service providers are government-owned, not-for-profit, or for-profit enterprises.
- K4 — Private money in the public system will be prohibited unless patient waiting times exceed the health care guarantee.

These operating principles are much more consistent than are CV1–CV4 with the evolving nature of the health care industry in the information era described earlier. In particular, K3 will serve to encourage both experimentation and new entrants into the Canadian health sector, which will in turn provide assurance that our health system will attain state-of-the-art status. Moreover, encouraging competitive suppliers will serve to make this system more affordable than otherwise would be the case. Allowing competitive provision of diagnostic and treatment services is absolutely essential to the working of the Kirby Report's health care guarantee, if for no other reason than domestic private provision is for a variety of reasons (malpractice insurance, litigiousness, exchanges rates, etc.) likely to be considerably less expensive than resorting to treatment in the US. But there are plenty of further reasons for believing that K3 will generate important cost savings (or allow the further reduction of waiting periods under the health care guarantee) as specialized diagnostic and treatment centres respond to the more innovative environment that will be ushered in via K1–K4. Beyond those elaborated in the earlier quote from Kirby (2003), one would include more flexible employment relations as well as more flexible professional practices/procedures in the context of meeting the agreed-upon standards. Further savings will arise as a larger number of straightforward treatments — tonsillectomies, setting fractures, limb operations, etc. — are performed in specialized clinics rather than in full-service hospitals. As a result, overheads will be much lower and, because of specialization, quality will rise.

Nonetheless, it would still be the case under K1–K4 that private money could not be used *within the public system* to "buy" one's way along the waiting list or to jump the queue entirely. However, there is nothing to prevent private money from accessing private treatment suppliers operating in a parallel private system. Actually, this is the case under the status quo, with the key proviso that these private suppliers cannot operate in both the public and private parallel system simultaneously. Effectively, this has meant that the parallel private system is essentially nonexistent. Intriguingly, however, the requirement in the Kirby Report model for a "residual supplier" to accommodate the demand arising from breaching a health care guarantee may well ensure

that some version of a parallel private system will develop. (As an aside, were a health care guarantee to be adopted nationally, it would surely be the case that several of the provinces would welcome these domestic residual suppliers.) I hasten to add that this caveat does not appear in the Kirby Report. Nonetheless, the fact that Canadians intent on spending their own money on health care may well be able to do so in Canada as well as in the US should provide an important escape valve that will aid in securing citizen support for a publicly funded, single-payer system.

## Conclusion

In many ways, the Romanow Report has been very successful. Never before has a commission, royal or otherwise, been so eagerly anticipated by Canadians. Moreover, the associated week-long media blitz prior to the release of the report served to focus, if not rivet, Canadians' minds and energies on the future of their health care system in a manner not seen since the advent of medicare. In turn, this virtually ensured that Ottawa had little choice but to begin the process of restoring health care transfers to their previous levels/shares. Beyond this, the Romanow Report lays the framework for broadening medicare in areas such as home care and catastrophic drug insurance.

Despite these important accomplishments, the thrust of the above analysis is that the Romanow Report's articulation of a set of "Canadian values" or operating principles to underpin Canada's health care system falls well short in terms of allowing medicare to make a successful transition to the 21st century. In contrast, the corresponding operating principles underpinning the Kirby Report are more incentive-compatible with the dictates and dynamism of the information era. By addressing the issue of inordinately long waiting periods and by creating internal markets through competitive diagnostic and treatment suppliers, the Kirby Report model tilts the evolution of Canada's health care system in the direction of becoming a leading sector for employment, research, innovation and exports. And in the process the system also moves toward timely access to state-of-the-art health care for all Canadians.

Admittedly, claiming that the Kirby Report model can deliver on this range of desirable attributes may well be overstating its merits. Nonetheless, the creation of internal markets at the core of its design and delivery mechanism means that the Canadian health care system would have the ability to evolve *from within*, as it were, in response to economic, socio-political and health-related stimuli. This is the *sine qua non* of a viable model for health care in the information era. Now, nearly a half-century after a bold and successful provincial experiment, Canada needs a province willing to don the "Saskatchewan mantle" and become the catalyst for 21st century Canadian health care.

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IRPP
1470 Peel Street, Suite 200
Montreal, Quebec H3A 1T1
Telephone: 514-985-2461
Fax: 514-985-2559
E-mail: irpp@irpp.org
irpp@irpp.org



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