Reforming Canada's Beleaguered Health Care System

Canada is facing a challenge to its ability to fund and support the crown jewel of its social welfare programs, the Universal Health Care System. As the population ages, and the ratio of working to retired continues to become more unbalanced, the ability of the State to fund the Health Care System becomes ever more in doubt.

As a libertarian and free market supporter, I would rather see the state get out of the health care business, but being Canada, the complete abandonment of state-run health-care would be political suicide for any party who would suggest it, and has a lower chance of succeeding than a woman favouring abortion as a means of birth control becoming Pope.
Instead of dreaming the impossible dream, in this essay, I will put forth ideas in an easy to understand format that will show how more privatization will help ameliorate the unsustainability of the current model of health care in Canada.

What can be done is, as has been suggested by numerous people, parallel two systems. One a publicly funded system, the second a system of private care that complements and supplements where the publicly funded system is unable to provide. Examples of such systems already exist and have been shown to work efficiently. Several European countries have this model and have better results, both from an economic aspect as well as in medical outcomes. Switzerland, France and Germany all have a blended health-care system where the bulk of the expenditure on health-care is covered by the state, and the delivery system is almost equally divided between public and private providers.

Germany, for example, has an almost equal split between Private for profit, Private not-for-profit, and publicly owned hospitals[1]. When examined closely, the private hospitals have a better patient outcome at a lower cost per patient than do the publicly owned hospitals. It may also be pointed out that German hospitals, unlike Canadian hospitals are not funded with a global budget, but rather on a per patient basis, with funding per patient not dependent on patient stay length. Which would lead one to presume that private hospitals in Germany would discharge patients quicker in order to get to the next paying customer, yet the private hospitals actually keep patients as inpatients longer, sending them home at optimum times medically rather than fiscally.

In 2009, Germany's ratio of public/private spending on health-care was 77/23% compared to Canada's 71/29%.[2] Health-care spending as a percentage of GDP in Germany was about the same level as Canada, with one significant factor; Germany has almost 30 percent more of its population over the age of 65 compared to Canada, which should statistically increase the costs of health-care.

Canadian Costs and Statistics in Health Care[3]

Health spending as a total of provincial health spending has grown at an average rate of 7.5% over the past decade, with only a 5.7% increase in total available provincial revenues which includes Federal Transfer payments. Average GDP growth for the provinces has been 5.2%.

Since 1975, government spending on healthcare has grown faster than GDP since 1975. (8.1%/6.7%)

As of 20011, Ontario and Quebec spend over 50% of their total revenues on health care.

Saskatchewan, Alberta, BC and New Brunswick are on a pace to consume 50% of their revenues on health care by 2017.
Manitoba and PEI will reach those levels by 2028.

If Federal Transfers are removed from the equation, health care spending currently consumes 87.6% of provincial revenue in Nova Scotia, 74.2% for New Brunswick, 71.9% for Quebec, 65.5% in PEI and 63.1% in Ontario.

Manitoba and Newfoundland/Labrador spend in the low 60 percent range, while Saskatchewan and BC spend in the mid 50 percent range, with only Alberta spending less than 50% of provincial revenues on Health Care.

Despite complaints from the provinces, Federal Transfers have been generous, between the period of 1997-2007, the federal government provided 115.7 Billion Dollars in cash transfers for health care. This amount was actually 36 Billion more that required to keep up with population growth and inflation over that time period.

Provinces are trying to control costs by access rationing and refusing to pay for many of the drugs certified by Health Canada as being safe and effective.
On average, across all provinces, the average total wait time between an appointment with a family doctor and final receipt of specialist treatment has grown from 9.3 weeks in 1993 to 18.2 weeks in 2010.
Only 20.3% of certified safe and effective drugs had been approved for reimbursement by the provinces as of the end of 2009.

Median wait times in Canada are almost double the wait that physicians deem clinically reasonable.

Suggestions by the Fraser Institute for correction of the Health Care spending problems:

(quoted verbatim from Fraser Institute Publication, Canada's Medicare Bubble

The federal government should:

- *temporarily suspend enforcement of the Canada Health Act for a five-year trial period to allow the provinces to experiment with new ways of financing medical goods and services.*

The provincial governments should:

- *encourage the efficient use and allocation of health resources by requiring patients to make percentage-based, co-insurance payments for all publicly funded medical goods and services they use;*
- *off-load cost pressures from the public health system by legalizing private payment and private insurance options for all types of medical goods and services, including hospitals and physician services, as is currently allowed for prescription drugs;*
- *allow health providers to receive reimbursement for their services from any insurer or payer, whether government or private;*
- *shift the burden of medical price inflation onto the private sector by allowing providers to charge patients fees in addition to the government health insurance reimbursement level; and*
- *create economic incentives for cost and quality improvements by permitting both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.*

Similar types of policies are common across the health systems of OECD countries that share Canada's social goals for health care.

Parallel Health Care Delivery Systems.

As suggested by both the Fraser Institute and the Montreal Economic Institute, a parallel health care delivery system of Publicly Funded, Publicly Operated hospitals and Publicly Funded, Privately Operated(a mix of for profit and not-for Profit) hospitals would go a long way to reform and improve our health care systems. For as shown in the look at Germany, the privately operated hospitals have a better patient outcome than do the Publicly Operated hospitals, and a better 3-5% efficiency than the Publicly Operated Hospitals. Having such a system in Canada would, if said efficiencies were realised, would result in a savings of millions of tax dollars.

Having a parallel system that allowed the purchase of private insurance would also lessen wait times within the public operated system, by allowing those who wished to

pay the additional costs of private insurance to seek care at a private hospital, thus reducing the queue for service at the publicly operated hospitals.

The political realities of Health Care Reform

There exists two main obstacles to Health Care reform in Canada, the first being an ideological bias against any involvement in private delivery or private/self funding of health care. The second being stakeholder resistance by unionized health care professionals ie; nurses, doctors, non-professional hospital employees who are members of public sector unions and the populace which has been for years indoctrinated in the myth that any move to privatisation will lead to people being unable to afford health care, this is usually made with the dire warning of "look at the American System where a serious illness can cost you your home".

Ideological biases against Health Care Reform:

The concept of a completely publicly funded health care system began long after Tommy Douglas first developed his concept of socialised medicine. In his concept, there was a user pay aspect, as he quite rightly noted, that if there was no apparent cost to something, it would be prone to overuse and abuse.

Somehow, over the years, that part of his concept became forgotten, and the myth that Universal Health Care should be completely taxpayer-funded without any user fee became the foundation of our present model.

The leftist NDP party has adopted that viewpoint as gospel and the bedrock of their social policies. The Liberal party has also adopted this as their default position on health care, leaving Conservatives as the only major party that could bring forth a change to our unsustainable model. Unfortunately, the Conservatives have failed to make such changes as they see the loss of votes, and thus the loss of an election from the centrist voters who switch from Liberal to Conservative and back again, and as such, form the balance of power amongst the electorate.

This ideological bias has over the 50 plus years of Universal Health Care has become entrenched, not only in the political structure of the country, but by the average man in the street, who if questioned about changes to the system is instantly alarmed at the prospect of becoming part of an *Americanized* system of for profit doctors and hospitals and, the bankruptcies of families when illness strikes. This ingrained fear of change has become so entrenched, that even if it is explained that even such socialized countries

such as Germany and France have private care, the message is not even heard, but is drowned out by the “no way to American Health Care” cry.

This will be the hardest obstacle for those wishing to reform our health care system to overcome. The evidence is there, the message is being communicated clearly amongst the choir, but there is a paucity of effort to explain it in easy to grasp terms to the average taxpaying member of Canadian society.

It could be done through the education system but that field has all but been surrendered to the political left. It could be done through the media, but again, for the most part, that field is a leftist landscape unlikely to cooperate with delivery an antithetical message

The only method left is for those who understand the concepts to step out to the public and without piling the audience knee deep in graphs, charts and statistics, explain in easy to understand messages that reach their audience with both logical and emotional arguments that will both cause them to examine their current ideological position and make them receptive to accepting the need to reform the current system.

Stakeholder resistance:

This second obstacle to change is easier to explain. The self-interests of various groups impels them to resist any change to a system that has benefited them for years and has enabled them, not only to gain financially but to gain political power and leverage. These groups will not willingly let go of that leverage. One of the strongest forces in this group are the public sector unions who have seen a tremendous increase in political power and leverage by the very size of their membership within the health care field. Janitors, food service, cleaners, technologists, clerks etc are all part of the large public sector unions, and all have seen a massive increase in wages through being part of the publicly funded health care system. Where else would you find cleaning staff working for wages that rival those of university trained professionals?

Nursing unions have become very powerful political entities and have enormous clout in the public eye as they are seen as the front line of health care. They are part of the ideological bias as well and as such are wholly opposed to any reform of the health care system, unless that reform is in the increase of their salaries and power within the health care structure.

Doctors, to a lesser extent are also a force of opposition as they have been indoctrinated through their medical school, residencies and so on to believe in the current system. As in any non-competitive system, it rewards non-initiative with no incentive for the striving toward excellence(merit).

Yet all of these formidable adversaries can be met and dealt with by simple political

will. The courage to stand up and impose a solution or change. This was what was done when Universal Health Care was imposed in Saskatchewan by Tommy Douglas and the CCF party where our Universal Health Care had its beginnings. There was no back and forth dealings, the government imposed its will on the profession and never looked back.

However, until the first obstacle(ideological bias) is dealt with, there can be no success with reform simply by imposing the will of the government on the stakeholders. The hearts and minds of the electorate must be won first and then there will exist the political capital with which governments can implement reform.

1. The Private Sector within a Public Health Care System: The German Example by Frederik Cyrus Roeder, Yanick Labrie, Montreal Economic Institute
2. OECD, Health at a glance 2011, 2011, page 151
3. Canada's Medicare Bubble, Fraser Institute