



Canadian Care: So Many Lessons, So Little Time

Testimony at the Pennsylvania State Capitol
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Brian Lee Crowley, President, AIMS
Suite 1302, 2000 Barrington St
Halifax, NS B3J 3K1
(902) 429-1143
aims@aims.ca

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Testimony before the Pennsylvania House of Representatives

Health and Human Services Committee

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Thank you for the kind invitation to be here to speak to this important committee dealing with one of the great defining political issues of our time: access to and quality of the health care available to our citizens.

Before I get into the substance of my discussion, perhaps you will allow me to say a word about the two institutes I represent. I am the president of the Atlantic Institute for Market Studies (AIMS), a public policy think tank based in Halifax, Nova Scotia.

In the 15 years since its founding, AIMS has brought a distinctive and influential Eastern Canadian voice to regional and national debates over public policy in areas such as transfer payments, social policy, fiscal and tax policy, health care, education performance and accountability, regulatory burden, Canada-US relations and much more. AIMS is one of the world's most honoured think tanks. It is a four time winner of the prestigious Sir Antony Fisher Award, which recognizes excellence in public policy think tank publications and projects. No think tank in the world has won this honour more times than AIMS. In its tenth anniversary year (2004-05), AIMS also won the Templeton Freedom Prize for Institute Excellence. More than 200 think tanks world-wide are eligible for the Fisher and Templeton prizes. Of the nearly 100 recognized think tanks in Canada, AIMS is one of only 5 to make the 2008 global "Go-To Think Tanks" list published by the Think Tanks and Civil Societies Program of the Foreign Policy Research Institute in Philadelphia. While still the Leader of the Opposition, Rt. Hon. Stephen

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Harper, today Canada's Prime Minister, called AIMS, "dollar for dollar the best think tank in the country."

I personally have co-authored two projects on the Canadian health-care system, both of which won the Sir Antony Fisher Award. In recognition of my health-care work, I was named to the most influential recent provincial health-care inquiry in Canada, the Alberta Premier's Advisory Council on Health (the Mazankowski Committee). The Council's Chairman, former Canadian Deputy Prime Minister Don Mazankowski, called me the "intellectual architect" of the committee's report. I am a frequent commentator in the media in both Canada and the US on health-care policy and I have spoken to scores of national and international conferences in recent years on health-care reform in Canada. In March, 2008 my health care policy work was further recognized when I was named Senior Fellow at the Galen Institute, a health policy think tank in Washington, DC. I am extremely proud of my relationship with Galen, and its founder, Grace-Marie Turner, one of this country's best know thinkers on the future of health care. Galen has carved out a vital niche for itself in thinking creatively about how to deal with the problems of access to health care for the millions of uninsured in the US while preserving the many highly desirable aspects of the current health care system, including its economic dynamism and innovativeness in the discovery of new procedures, treatments and medicines to improve the quality of life for Americans and the many others who benefit from the US health care system.

Many of you have heard about the Canadian health care system, but not really understand how it works, so let me start my talk with a simple diagnosis of the present health care system because it offers some extremely clear lessons about the kind of health reforms *most people would agree are to be avoided*. Indeed here is the sneak preview of my conclusion: at least some of the fashionable ideas being bandied about here will ultimately lead to the emergence of the worst features of the Canadian system...without that having been anyone's intention.

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Canadian medicare, as we call it, operates essentially as an unregulated, tax-financed, pay-as-you-go monopoly. Our provincial governments are the monopoly provider. They not only pay for necessary care, but also govern, administer and evaluate the services they themselves provide. They define what constitutes “medically necessary services” and then pay for virtually all such services provided in Canada.¹ They forbid the provision of private insurance for these services. They negotiate payment schedules with the powerful provider groups. They often set the budgets for nominally private health care institutions, appoint the majority of their board members, and have the explicit or implicit power to override management decisions.

Anyone who doubts that provincial governments consider themselves, and are considered by the electorate to be, the governing mind behind the entire health care system failed to observe the election a few years ago in one of our provinces -- Manitoba. In that campaign the quality of toast in hospitals was a major election issue, and it was clear that the parties thought that they could and should be able to affect this matter, and the electorate thought that this was a credible claim.

In these circumstances, no hospital or other health care administrator can be expected to take any responsibility or initiative, because decisions will always be second guessed by those in political power, so it is better to make them take responsibility up front by deferring to them rather than trying to act in a managerially rational way.

¹ For instance, the government health care system in Canada pays for 99% of all physician services, whereas the comparable proportion in France is only 60%.

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If politicisation of health care is a problem, what is the solution? My view is that the only way to ease the politics out of health care is by introducing competition and consumer choice which, by its nature, transfers power to those whose decisions produce better outcomes for consumers. Let me develop this thought a bit by reflecting on the nature of monopoly power and the effects of competition on that power.

In a competitive environment, consumers are free to “vote with their feet”. Over the years, they have come to prefer calculators to slide rules, natural gas and oil to coal, and Twitter and e-mail to “snail mail”, even though in most cases the old dominant industry that was being abandoned was powerful, rich, and well-connected.

But in a monopoly, even a regulated one, the relative power of consumers and suppliers is completely reversed. Before the advent of competition in the telephone industry, dissatisfied customers faced the massive indifference of a bureaucracy that literally could take their business for granted despite some theoretically powerful regulatory agencies.

Administrators of the Canadian health-care system likewise suffer no direct consequences as a result of poor customer service. They aren't even answerable to a regulatory agency.

Accountability is a vague political concept which cannot be enforced in any meaningful way.

Like all monopolists, Canada's health care authorities abuse their position of power. And they do so in accordance with the famous economic insight that “the best monopoly rent is the quiet life”.

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You see our public sector monopolists are in a conflict of interest, in which they are both the providers of a service as well as the people charged with evaluating the adequacy and quality of that service. By being both provider and evaluator, these monopolists grant themselves the quiet life by the simple expedient of having virtually no hard measures of success and gathering almost no useful information about the system's ability to achieve its objects, in this case, whether anybody gets better. As the health care fellow at my institute likes to say, not a single health care institution in Canada can tell you whether anyone was made better, worse or was left unchanged by their contact with the health care system.

This is a pretty amazing thing to say about the single largest expenditure of public dollars in the country. We don't know how many people are waiting for health services, or how long they've been waiting. And we don't know how many people leave Canada to get treatment in the system's secret safety valve: the United States. Eighty percent of our population lives within 100 miles of the border, and the ease with which treatment can be obtained in exchange for cash is likely one of the key factors that has prevented the collapse of our otherwise rather eccentric system. There is a trailer parked in Grafton, a border town in North Dakota, where people can drive easily from both Manitoba and Saskatchewan for their MRIs and other diagnostic services they must wait months for at home (even though Manitoba is the highest per capita spender on health care). The province of Ontario had to contract with cancer care clinics in New York state to look after Ontario patients when cancer care waiting times became politically untenable.

To put it another way, the sick pay the high cost of monopoly provision, the reason why the Supreme Court of Canada said a couple of years ago that the health care system violates our Charter of Rights because it collects taxes and promises health care in return, forbids competing

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suppliers, and then often doesn't deliver the care. As the justices said, a place in a queue is not health care.

Let me give some more shading and definition to this portrait of Canada's health care system. According to the Fraser Institute's eighteenth annual waiting list survey², Canada-wide waiting times for surgical and other therapeutic treatments decreased in 2008. Total waiting time between referral from a general practitioner and treatment, averaged across all 12 specialties and 10 provinces surveyed, fell – wait for it -- from 18.3 weeks in 2007 to 17.3 weeks in 2008. So the national average (and in many provinces the average is considerably worse – in Saskatchewan it can take a year and a half to get a hip replacement and a friend of mine was recently told that heart surgery he needs might take over a year) is that patients have to wait somewhere around 4 and a half months to get needed medical treatment after seeing a doctor.

And good luck seeing that doctor. The doctor shortage is now so severe that Statistics Canada reports that roughly 4 million Canadians do not have a family doctor, and family doctors are now engaging in lotteries to cull their patient list³. The coming wave of Boomer-driven retirements of physicians will only exacerbate what is already a critical situation.

² <http://www.fraserinstitute.org/researchandpublications/publications/6240.aspx>. Note that I said earlier that we didn't know how many people were waiting for medical care. This is true if we are looking at actual statistical analyses of waiting times. What the Fraser Institute does is to survey medical practitioners and get their opinions about how long waiting times are. In the present circumstances, that is, I am sorry to say, the best that we have.

³ Extract from Tom Blackwell, *National Post* Published: Wednesday, August 06, 2008

MD uses lottery to cull patient list

Not first such case as lack of doctors causes huge caseloads

In the latest jarring illustration of the country's doctor shortage, a family physician in Northern Ontario has used a lottery to determine which patients would be ejected from his overloaded practice.

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Canada's public health care system is undersupplied (compared to many industrialized countries) with the latest diagnostic and other technologies⁴ such as MRIs, CT scanners, etc., because these technologies are expensive and their use leads to more consumption of health care services, as people with quicker and higher quality pictures of their health condition then expect these diagnoses to be acted upon. Just as doctors were seen to be cost centres, so too diagnostic tools "cause" health care use. As one government report underlined, new medical technologies are only a cost-driver if you use them. The logical prescription: keep your health care system primitive and your costs will be kept low.

In other words, as health care moves more and more into the public sector, politicians and bureaucrats feel the need to control outcomes (because they will be blamed for unpopular outcomes no matter how necessary, and lauded for popular ones, no matter how absurd – remember the quality of toast). The politicians also cannot face imposing the taxes that would be necessary to fund every medical service that might be requested by someone, and the only possible outcome is therefore centralization and rationing.

You will not be surprised to learn that I think that this takes our health care system in exactly the wrong direction. Today there is a vast cultural shift going on, in which the Baby Boomers, who

Dr. Ken Runciman says he reluctantly eliminated about 100 patients in two separate draws to avoid having to provide assembly-line service or extend already onerous work hours, and admits the move has divided the community of Powassan.

Yet it was not the first time such methods have been employed to determine medical service. A new family practice in Newfoundland held a lottery last month to pick its caseload from among thousands of applicants. An Edmonton doctor selected names randomly earlier this year to pare 500 people from his heavy caseload. And in Ontario, regulators have heard reports of a number of other physicians also using draws to choose, or remove, patients.

⁴ <http://www.fraserinstitute.org/newsandevents/news/6123.aspx>

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have been the most demanding generation in history, are moving into retirement and are going to bring their informed consumer mindset to bear on the health services that they expect, just as they have brought it to bear on so many other fields of life in earlier decades.

How will this affect health care? In earlier times, people deferred to their doctors, who controlled access to medical services. People took their doctor's advice. Now the old doctor-patient relationship is dying, if not already dead, and Boomers have made it clear that they do not expect HMOs to tell them what care they can have either.

Doctors say that one of the biggest trends of recent years is patients showing up with print-outs from the Internet about their medical conditions and appropriate treatments. As Richard Bohmer, a physician and professor at the Harvard Business School says, "The development of new programmes and tools for patients to take more control of their own health is based on a very important new assumption about how competent patients are...The increase in medical knowledge, and its widespread availability is the engine moving decision-making capability and therefore decision rights to the patient."

According to a survey of Canadian health care consumers by The Change Foundation in Ontario:

One out of every two people appears to be a "responsibility-taker", taking control of their health and actively searching out options. They believe that most of the responsibility lies with them. About half of respondents believe that, in general they have as much medical knowledge as physicians. About half (53%) agree that they are the prime decision makers

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on their own health and about half (48%) regard healthcare as offering a wide range of choices. These results point to a very empowered consumer who feels very able to make health care choices.

Too bad these empowered consumers must battle every day with the health care monopoly I have described. The irony, I suppose, is that Canada's health care system, which has become this unresponsive monopoly, wasn't supposed to be this way. It was designed to usher in a grand era of choice for users of the health care system, in which people would be able to get all the health care they needed without having to worry about the cost. This was to be a great empowering system. Let me tell you about how empowering the Canadian system is.

Everything I want to say about this is summed up in a story that happened to my wife Shelley. Shelley and I were partners in a restaurant at the time, and she actually ran it. She was given an appointment at the hospital for a procedure, and she duly showed up at the appointed time, having been promised that she would be out within an hour. Two hours later she was still sitting there waiting to be called, so she approached the desk and asked if she could go and put money in her parking meter. She was curtly told that she was free to go and put the money in, but that if her name were called while she was away, that her name would fall back to the bottom of the queue. She resumed her seat.

Another two hours passed, and still she was not called, so she again approached the counter, and very patiently and politely explained (as only Shelley can, because she is the soul of graciousness) that she actually had a small business to run, that she was there at the appointed time for her appointment, that she had waited four hours, which is far longer than she had been

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led to expect the whole procedure would take, that she had other commitments because of the business and could they possibly at least give her some idea of how much longer she might have to wait?

Well, the woman behind the counter got on her dignity, drew herself up to her full height, glared at Shelley and said “You’re talking as if you’re some kind of customer”!

For me this story speaks directly to the essence of the problem – when the government supplies you with “free” health care, you are not a powerful customer who must be satisfied. They are doing you a favour, and you owe the state gratitude and deference in return for this awesome generosity. They can give you deplorable service, but because it’s free, you are totally disempowered. One of the most important lessons I have learned from my contact with the Canadian medicare system is that *Payment Makes You Powerful*. And its absence makes you risible if not invisible.

I made the point earlier that the only way to ease the politics out of health care is by introducing competition and consumer choice which, by its nature, transfers power to those whose decisions produce rewards for consumers. I also made the point that our health care scheme was intended to achieve a great expansion, not a restriction, of choice. But neither voters nor governments understood the long term consequences of what they were doing.

That is the most important lesson I wish to leave with you today. Policy makers can often, with the best of intentions, put in place policies that achieve the exact opposite of what they wished to

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achieve for people. Wishing to do good, they end up doing incalculable harm. It is not just the road to health care reform that is paved with good intentions.

My fear in the health care reforms I see debated so blithely here in states like Pennsylvania and in Washington is that laudable objectives are being offered as the justification for a huge politicization of health care. For reasons I've explained, politicization, the drawing of politicians into ever more responsibility for health care decisions and outcomes, creates a dynamic in which the politicians must demand ever more control over the system. Yet at the same time politicians are never willing to impose the ruinous taxes that would be necessary to fund a system in which people make their own decisions about their health care but governments pick up the tab; rationing is the inevitable outcome. And even though the system that is being proposed here may at the outset look like it is composed of many autonomous parts offering competing services, that was where we started in Canada as well. Most hospitals in Canada, for example, were and are private institutions. They long ago lost, however, the ability to *act* as private institutions.

And the experience has been similar in many countries where governments set up public insurance schemes in competition with private schemes. Almost universally conditions are created where private insurers cannot make money (because as demagogues so often claim, it is wrong to make money from sick people), or where they form a government-sponsored cartel and essentially cease to compete with one another in any serious way on price or quality. Where private providers face circumstances where they can only fail, government becomes de facto the monopoly supplier that I have described, even when it was the solution that no one wanted at the outset.

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The moral of this story? Be very very careful what you wish for, because the unintended consequences of changes to complex systems like health care do far more damage than can ever be compensated for by the intended benefits. Health care systems such as yours have grown up through a very slow and deliberate process of trial and error; simplistic reforms based on inadequate knowledge of these complex systems often end up upsetting delicate balances among powerful forces in the system. And once the old system is destroyed, decision makers are often drawn, as they were in Canada, ever deeper into the wholesale replacement of the system with something inferior, even when it was never part of their intentions.

Thank you.