

CANADA NETWORKING CONFERENCE AND EXHIBITION 2008

PANEL DISCUSSION ON

“WHAT SHOULD THE CONSERVATIVE MOVEMENT DO ABOUT HEALTHCARE?”

On February 29th, 2008, Joanne Marcotte, Vice-Chair of Quebec’s Task Force on the Financing of Quebec’s Health System, was invited to participate on a panel with the Honorable Mike Harris, and Dr. Brian Day, President of the Canadian Medical Association.

Here are her introductory remarks.

*Joanne Marcotte’s remarks
Vice-Chair of Quebec’s Task Force on
The Financing of the Health System*

First, I would like to thank Mr. Manning for inviting me to this event and allowing me to see for myself how dynamic the “right-of-centre” movement is all across Canada.

As for the contents of my introductory remarks, there are two specific questions that I will cover.

- ↳ **One:** What are the **major findings and recommendations** of the Castonguay Task Force;
- ↳ **Two:** How can some of these recommendations **move Quebec (and Canada) closer to a more “mixed” system** (that is a combination of public and private) with respect to health-care delivery, financing, and insurance.

LET US START WITH THE CASTONGUAY TASK FORCE’S FINDINGS.

In May 2007, the Quebec government announced the creation of a Task Force that would make recommendations on how best to ensure adequate funding for health care. Also, one of the avenues the government wanted to explore was the role the private sector could play in improving access to health care and reducing wait times.

Of course, the Task Force’s recommendations needed to be compatible with the principles that have characterized Québec’s health care system since its inception. That is:

- ↳ The importance of **maintaining a strong public health care system**, of **protecting the most disadvantaged** regardless of their social status and income level, and the **importance of maintaining high-quality criteria** for both the public sector and private delivery of care.

Mr. Claude Castonguay, who is considered to be the “father” of Quebec’s public health care scheme, back in the 1970’s, was named chair of this Task Force, while the two vice-chairs were named by the two opposition parties: the ADQ and the PQ. I, of course, was the choice of Mr. Mario Dumont, leader of the ADQ and of the Official Opposition.

The title of our Report, which is “**Getting our Money’s Worth**”, says a lot about what needs to be done if we want to secure our healthcare system as a whole. In fact, our Task Force is convinced that **action needs to be taken on both the revenue AND spending sides of the equation**. Simply put, we need to slow public spending (or State spending) so that it does not exceed that of the economy, while at the same time, improving access to care and quality of services. Refusing

to do either would result in speeding up health's share of Quebec's program spending from 44% today to 54% by 2017-18, which is totally unacceptable, considering other important needs such as education.

Now, how do we do this?

First, we need to introduce some measures that will help the increase of productivity. Investing in efficient front-end primary care, better use of drugs, taking advantage of information technology, are some of our recommendations. These are far from being new ideas, by the way, but are nonetheless part of the solution. **The creation of a NICE-equivalent**, NICE being England's National Institute for Health and Clinical Excellence is another one of our recommendations. This credible and independent organization would be formed by merging three already existing agencies and would have the mission of defining the public coverage, determining performance indicators, periodically reviewing the list of insured drugs, as well as recommending best practices and clinical protocols to practitioners.

To help increase productivity, **we must also instill a new culture of governance.** Whereas today, the ministère de la Santé et des Services sociaux all but micro-manages each and every one of the institutions offering care to individuals, our Task Force firmly recommends the ministère to withdraw from care delivery altogether. In our model of governance,

- ↳ **The ministère** would refocus on its primary mission: that is setting health objectives and policy, defining insured services, setting national standards and performance indicators.
- ↳ **The regional health boards or agencies** would become “buyers of services” from suppliers of care and services, whether these suppliers belong to the public sector, the private sector, or whether they are community-based or co-operative providers.
- ↳ **As for hospital or specialized-care providers**, the Task Force recommends that they have substantial autonomy, but in return, be fully responsible for their management.

How does this redesign of governance improve the system's productivity, you may ask? A key component, and the general rule in many other European countries, is in the way hospitals are funded. **We must change the way in which hospitals are funded.** Currently, hospitals are funded each year on the basis of last year's budget plus a little more. No incentive to perform, no incentive to do better.

The Castonguay Task Force recommends that hospitals should instead get money from the government for each medical act performed. **This is called “Service-based funding”, and has proven to be quite effective in other countries to enhance productivity.** Managers, doctors and professional teams are encouraged to work together and improve their operating efficiencies, since they would get to keep any money saved. **Different types of producers may compete to offer services**, whether they are publicly or privately-owned, non-or- for-profit organizations. Smaller and more highly specialized clinics and facilities would achieve better outcomes for patients and make optimal use of costly equipment.

Hence, enhancing productivity in our healthcare system is a must if we want to get our money's worth.

Secondly, if we are serious in boosting healthcare productivity, we also need to let go of certain dogmas, features that other countries have questioned long ago, particularly when it comes to the production of services. It means giving people more freedom of choice on how to meet their health needs, while making essential improvements to the public system by introducing elements that will foster vitality and emulation. To do this, **we absolutely need to lift the taboo that is the role of the private sector and call into question our conception of what a universal healthcare system really is.**

In Canada and of course, Quebec, a universal publicly financed healthcare system **is often wrongly interpreted to mean that government is also responsible for the delivery of the services it funds**. This is why we have a monopoly situation in the provision of hospital care, where most of the money goes. A universal healthcare system **also wrongly implies absolute free access for all services and a single-public-insurer**, which is the State. Hence, we were brought up to believe that a universal public system would have to cover 100% of available care, that it must be 100% publicly funded and that it has to be 100% delivered by the public sector.

Looking at other OECD countries, **this is simply not the case**. Certain countries, such as ours, choose to have a more limited scope of what Medicare pays for; others have a wider scope. Certain countries, such as ours, have managed to avoid user fees, while others have no problem with charging user fees on top of the public coverage, even for medical access. Finally, certain countries do encourage a public-sector monopoly in the delivery of services, while others have a mixed public and private delivery system and a decentralized system of delivery.

Let us be clear. **All these countries have universal healthcare systems**. In all these instances, access is not determined by the personal wealth of the patient, but by his medical needs.

WHICH BRINGS ME TO THE SECOND PART OF MY REMARKS:

How can some of our Task Force's recommendations move Quebec (and Canada) closer to a more "mixed" system (that is a combination of public and private) with respect to health-care delivery, financing, and insurance?

I have already demonstrated that redesigning the healthcare model and **separating the "buying agencies" from the "producers" opens up possibilities for a diversity of healthcare providers. Introducing service-based funding will encourage more efficient providers to offer their services**. A centre of excellence could qualify for complex surgical procedures, for example. A community-based organization could offer long term care and suggest other ways to answer to the needs of its aging population. **Hence, the "taboo" regarding the private sector's role in the delivery of health-care can and should be lifted**, and a more "mixed" system with respect to health-care delivery is and should be encouraged.

In fact, considering the circumstances and the difficulty for the public sector to renew itself, I personally have no trouble in saying that **we have a moral responsibility to open up to new possibilities**. As you well know, a monopoly does not, by nature, have a great interest in becoming more efficient. Many Reports and Commissions have preceded ours, with the same recommendations, without significant gain in productivity. If one thing is sure, it is competition that does the trick, and it is competition that guarantees that the system as a whole will renew itself. Otherwise, **injecting new funds in the system as it is, is in my view, an approach that could be summarized as follows: "You take the money and run."** As for putting one's faith into a public sector that did not, could not, and probably will not reform itself on its own, sorry, but again, in my personal view: **"Been there, done that."**

Now, as for bringing about a mixed system approach to healthcare financing, the Castonguay Task Force suggests that we have come to a point where a combination of taxation and of user contributions is necessary. Remember that our central objective was to slow public spending (or State spending) so that it does not exceed that of the economy. According to our plan, during a 5 to 7 year period, the growth of public spending in health goes from 6.5% to 4% (which is the predicted growth of Quebec's economy over the next ten years). **During this transition period**, to bridge the gap between the rates of growth of public health spending and of the economy, **our Task Force recommends the creation of a special fund with dedicated revenue sources**.

Two dedicated revenue sources would be used: one relating to taxation, and the other relating to the use of care. By drawing simultaneously on two sources of revenue, **the government would strike a balance between social solidarity, as expressed by the tax system, and individual**

responsibility, reflected in a contribution calculated on the basis of the use of medical care. For our Task Force, it was important that responsibilities be divided in this way between the recipient of care – a question of individual responsibility – and society as a whole.

Concretely, this dedicated fund would receive its revenue from:

- ↳ **One:** An increase in the Quebec Sales Tax;
- ↳ **Two:** An annual user contribution calculated on the use of care, and capped on the basis of income. One of the scenarios submitted to the government suggests a \$25 charge per visit, which would be collected once a year with income tax based on a “T-4 Santé” issued by the Quebec Medicare board.

As we can see, **instead of a universal health premium** which is, really, an increase in income tax, our Task Force **suggests that patients contribute according to their use of care**. No visit during the year, no contribution. Also, to protect the more disadvantaged citizens, children under 18 and low-income Quebecers, would be exempt. In other words, in our opinion, this user contribution respects the spirit of the Canadian Health Act in that **it does not undermine one’s ability to go for a check-up or consultation**. In fact, as I mentioned earlier, user contributions does not in any way undermine the “universal” aspect of the system, but may, on the contrary, ensure its survival.

In summary, if we are to slow down growth in public spending on healthcare, other avenues must be available to ensure that we do not cut public services, while giving people more freedom of choice on how to meet their health needs.

Another example of a private contribution is a \$ 100 - a year annual clinic subscription, with the objective of giving every Quebecer access to a family doctor within 5 years. With this new source of revenue, doctors could employ nurse practitioners and delegate activities such as chronic care management. They could use effective information technology to establish electronic records. Delegating activities, team work and using technology are ways that have proven to be effective in increasing productivity, but need to be properly financed.

If managed properly and with the help of everyone involved, all these measures **may help maintain a strong publicly administered health care system**. But without competition, and without some measure of health care choice and the possibility to explore new ways of offering care and services, we might as well brace ourselves and accept that every public penny will eventually go down the drain.

This is why Mr. Castonguay and I insisted on measures that were viewed by our colleague, Michel Venne, as not acceptable.

- ↳ We recommend that a physician be authorized to have a mixed medical practice, within prescribed limits and provided there is an agreement with his institution. **This is called “mixed practice”**.
- ↳ We also recommend **carrying out demonstration projects to test other methods of non-profit hospital management** to identify productive new options.
- ↳ In response to the Chaoulli judgment, Mr. Castonguay and I propose that the legislation **authorize private insurance for services already covered by the public system**.

In conclusion, we must emphasize that a mixed approach with respect to the delivery and financing of healthcare **has nothing to do** with an American-style healthcare system where private insurance companies decide whether a patient qualifies for care or not.

The Castonguay Task Force's view has, however, everything to do with a **renewed healthcare model** that ensures universal access to all, but that takes advantage of the **potential of a wide range of healthcare producers**, whether they are public or privately-owned, community-based or co-operative organizations.

As for financing healthcare, if we are to cap the State or government participation in healthcare and adjust the growth of public health spending to the growth rate of one's economy, **we must allow user contributions**, whether they are in the form of out-of-pocket contributions or private insurance contributions. Otherwise, access to services will suffer even more and for sure, the survival of our healthcare system as we know it, will be impossible.

Again, I thank the Manning Centre for Democracy for this opportunity and hope that tomorrow's political leaders will take into account our Committee's findings.

Joanne Marcotte
Ottawa, February 29th, 2008