



True North In Canadian Public Policy

Commentary

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Why Health Care's Broken and How to Fix It

THREE DRIVERS OF SYSTEM REFORM*

Brian Lee Crowley

One of the most cherished beliefs held by Canadians is that we have “the best health care system in the world”. This belief has been remarkably resistant to evidence, but when even Jeffrey Simpson, voice par excellence of the Canadian establishment, points out in his latest book that it is utterly contradicted by the data, we know something important is shifting in the Canadian political and policy firmament. After all, we know that Canada’s actual performance is only mediocre when compared to many other western industrial democracies, in terms of indicators such as waiting times, access to the latest technologies, access to physicians, paraprofessionals and specialists, and coverage of health services beyond hospital and physician care. And we also pay over the odds for this under-performing system, especially when you adjust for the age of our population, which is still relatively young compared to most of Europe and Japan.

But what I have come to understand about our commitment to the Canadian health care system is that it is resistant to facts because the statement about it being the best system in the world isn’t actually a statement about facts. It is a statement about morals, beliefs and desires. It encapsulates a belief that Canadians have that there is something especially morally worthy about our system that elevates it beyond mere criticism of outcomes. Our system is based on values, and especially values of equity and fairness that apparently transcend any assessment of the quality of care actually received.

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* *This Commentary is based on the keynote talk given by the author to the national conference of the Canadian Association of Healthcare Reimbursement held in Ottawa in 2013.*

What is great about our system, then, if my reading is correct, is that its intentions are good and pure and any falling short in practice, while deplorable, is really only an accident caused by insufficient reverence for the intentions. Oh, and of course an inexplicable unwillingness by governments, and especially Ottawa, to fund the system adequately.

Most people in the health care establishment share the analysis of the Romanow Commission, more than a decade ago, that there is nothing wrong with the Canadian health care system that more money won't fix. Ottawa's job was, through a vague and unspecified "leadership" role, to rescue the health care system from its torpor and decline, and to make the reality of the system equal to its moral intentions.

One is reminded of Dorothy, believing she could put on the ruby slippers, close her eyes and wish really hard to be home in Kansas and the ruby slippers of good intentions, federal leadership and more money would magically take her there.

But magical thinking is not going to make disappear the factors that are re-shaping the Canadian health care system. Some day we must face the reality that, a decade after Romanow, the federal health accord and record high levels of federal cash contributions to health care that were supposed to buy us reform, the system is essentially what it was, except it's 10 years older, more expensive than ever, and the money got us almost nothing in the way of reform. We have not abolished the factors driving reform, merely masked them for a decade, at great cost in terms of lost momentum and wasted cash.

There are many, many things shaping the system and guaranteeing that it will be quite different in the future than it has been in the past, but three key factors can be identified to be discussed in the following order:

1. Central planning doesn't work (which is why "leadership" cannot fix the system);
2. What we've learned about federal "leadership" in areas of provincial responsibility (there's leadership and then there's leadership);
3. The moral and economic sustainability of the system.

The Failure of Central Planning

The Berlin Wall fell for a reason, and that reason is that no matter how hard you try to isolate yourself from the real world there are certain realities that you cannot escape, even if your intentions are good. You may have highly ethical reasons to want to be able to fly, but they will not allow you to overcome the law of gravity.

The impossibility of central planning is one of those realities, but not nearly enough attention is paid to what we learned about the failures of central planning in Eastern Europe and elsewhere, for we learned that there are systemic reasons why it fails, reasons that have nothing to do with the specific circumstances of Eastern Europe. It is doomed to failure by its own inherent contradictions and flaws, no matter how beautiful the theory that disinterested Platonic administrators will take from each according to their means and give to each according to their need.

What we learned was that centrally planned economies couldn't feed themselves, couldn't clothe themselves and couldn't house themselves. And the most fundamental reason why, we discovered, was that central planning made impossible demands on central planners. It demanded that they know things that they couldn't possibly know.

It demanded that they know how many shoes people would want, in what styles and sizes and where they would need them. It demanded that planners know whether people would prefer more shoes or fewer if they had to make a choice between them and say coats or cars or food. And it repeated this across every

possible area of human activity. The centrally planned system failed because it could only operate on the basis of what planners knew, which was always much less than what people knew about their own particular circumstances.

A centrally planned system will always fail because it can only take account of what the people at the top know and think is important, whereas our system of liberal capitalism in the West is based on the idea of decentralised information and control, of the rule of law, individual decision-making and competition – not for purposes of social Darwinism, but to ensure that many people in many places in many circumstances are rewarded for trying experiments to discover what works best and then offering those improvements to consumers. Our society and the various industries and activities within it operates on more information than any individual or committee or ministry can gather and analyse and act on.

That is the secret of the West's prosperity – we have discovered the key to making use of the information in the heads of all our people. The chief difference between the central planners and us was our ability to integrate more information in our decisions, even though no one in authority possessed all the information at some central point and sent us instructions on how to act. The idea that such a fully informed control centre can exist and direct our activities successfully is what economists and information theorists call the synoptic delusion, the delusion that killed central planning.

But while we might have escaped the delusion of central planning for the most part in the West, the Canadian health care system is a lonely remaining outpost of its logic, and that is why more money and more leadership cannot rescue the system because the system itself is premised on an idea that does not work, although it can be kept afloat by ever increasing cash infusions. But as Margaret Thatcher once so sagely observed, the problem with socialism is that eventually you run out of other people's money.

Am I correct that our system is a lonely holdover of the central planning mentality? Consider this: Our provincial ministries of health 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. 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, a power that they employ with gay abandon.

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 a Manitoba provincial election of a few years ago. 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.

A different but equally powerful example occurred several years ago in Nova Scotia, where I used to live. There, the CEO of the local hospital was nominally an independent authority, but his budget came almost exclusively from the provincial government (I think the next biggest source of revenue was parking fees!). He had been given strict instructions that he was not to run a deficit, and he got into some difficult labour negotiations – then the phone rang and it was the premier of the province telling him to settle with his workers even if it meant a deficit that he had been instructed to avoid. In those circumstances, no one can be expected to take any responsibility or initiative, because your 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.

Now consider how fast knowledge is expanding in the health care world, and the incredible balancing acts that need to be undertaken to make the system work. We have to think about innovation, new technologies,

orphan drugs, insured services, doctor shortages, how to organise practices, how the pie should be sliced up between doctors and nurses and others, how to make better use of paraprofessionals, and so on.

Consider that the whole stock of human knowledge is now generally judged to be doubling roughly every five years or so, in areas as diverse as management, genetics, insurance, information technology, pharmaceuticals, chronic disease management, nanotechnology, etc. How credible is it that provincial bureaucrats can acquire all this information in a timely manner, assess it and then integrate it in a thoughtful way into their decision-making given the institutional constraints I've described? We never talk about this and yet I believe it is the single biggest problem facing the Canadian health care system and it is by definition going to get worse as the body of knowledge relevant to health care expands exponentially, but the capacity of the managers of the system and the incentives that surround them remain those of central planning that can only act on the *knowledge* of the people in charge, no matter how good their *intentions*.

Just think how likely it is that Henry Ford would have been allowed to introduce the assembly line if his proposed reform had to be negotiated with all the existing car companies and factory workers, all of whom were at the table to protect their interests. Would any of us have personal computers if some bureaucrat in a ministry who still used a typewriter had had to decide to shift productive resources to their manufacture?

How would innovation be affected if a Ministry of Pharmaceuticals had to study all proposed drug innovations in advance, decide which ones it thought worthy of pursuing, and then negotiate with industry about whether permission should be given to proceed, remembering that many competitors have reasons to prevent innovations that might render redundant some of their products.

Let me open a brief parenthesis about innovation. In most industries, technological innovation is a cost reducer, not a cost driver, but this seems to be less the case in health care than elsewhere. This is driven, in my view, by three key factors. In many cases the new technologies are not substitutes for existing techniques, but are additive – solving problems that we were unable to solve before, and yet not allowing us to dispense with already existing techniques and technologies. Second, innovation only helps to reduce costs when you can shift activities from old, less technology-intensive approaches to new, more technology-intensive ones.

But in the politicized health care system I am describing for you, these shifts of resources out of old approaches and institutions and into new ones is severely hampered. Consider the real world example I observed in Nova Scotia of the government building a new hospital in a community but not closing the old one, not because the old one made a significant contribution to the quality of health care, but because the government was not willing to take the political heat for closing the outdated facility.

Finally, there is the fact that much of the system is driven by what governments are willing to pay for. If government is willing to pay for heart surgery, but drugs are paid for by consumers, there will be tremendous pressure to keep heart surgery facilities open and resistance to moving to drug-based therapies.

The important decisions about our health care are not the macro ones taken by distant bureaucrats in office towers in our provincial capitals. They are the micro ones taken by patients and doctors and other professionals about what is good right now for the flesh-and-blood person before them who is sick and needs care. Empowering patients to get the best care and giving them incentives to do so in the most cost-effective way possible *is* applying the lessons of the West's success and rejecting central planning.

The whole point is that central planning encourages delusions of grandeur in which officials come to believe that there is a right solution to every problem. The point is that there is no one right answer to these questions, and everything depends on circumstances. *The system cannot be run successfully from the centre.*

The Failure of Federal Leadership

In the decades prior to the 1990s, welfare spending was out of control, in large part because of the way Canada paid for it. Ottawa used its spending power to entice the provinces into what was essentially a poorly designed one-size-fits-all national welfare system. The system was very effective at capturing people on welfare dependence, and was consequently very expensive, in cash terms, in lost productivity, and in lives blighted by being trapped behind the welfare wall. We saw the number of people on welfare rise in each recession, but it never declined in subsequent recoveries. It was a one-way up escalator, not a roller coaster.

The provinces had little incentive to reform because they could pass a lot of their costs along to Ottawa. As a result, by the mid-90s, well over 10% of the Canadian population was in receipt of welfare benefits, including in our then-wealthiest province, Ontario. This lovely system was the fruit, in other words, of one kind of federal “leadership”.

As everyone knows, when Ottawa decided to fix its deficit problem, it did so in part by cutting transfers to the provinces. This has become known as “downloading” and every provincial politician decries it. This is wrong – “downloading” gets a bum rap and is actually an example of the right kind of federal leadership at work.

It got a bum rap because cutting transfers was only one half of what Ottawa did with respect to welfare, and that’s why welfare reform worked. Ottawa also said to the provinces, in exchange for you accepting less money, that money will come as a block grant with no strings attached. We are getting out of the business of using the federal spending power to try to design and impose a uniform national welfare system.

It was this *combination* of reduced transfers plus *freedom* for the provinces to design their own welfare system that unleashed a wave of hugely innovative welfare reform across the country. Many of the reforms were ultimately adopted by all the provinces, but there were also important differences in focus. BC, for example, put the accent on time limits for welfare. Alberta’s priority was getting employable young people into work. Ontario’s focus was workfare. It is very important to note that provinces chose different policies because of what they judged were the most important aspects of their local circumstances, what the advocates of “federal leadership” usually refer to misleadingly as a “patchwork” that should be eliminated by the imposition of uniform national standards.

The overall result was that we cut the number of people on welfare in half at the same time as we saw a very significant fall in the number of people living in poverty and the number of people on low-incomes.

The common objection to such reform, that it unleashes a race to the bottom, whereby provinces compete with each other to abandon good quality services so as to cut taxes and spending, was not at all borne out in the evidence – and I can assure you that this is a matter that has been carefully researched. It wasn’t so much that spending on welfare declined overall, as that we got much better value out of the money and it was focused on those who needed it most.

We make a mistake when we seek the kind of federal leadership that concentrates on imposing a one-size fits all solution to our health care sustainability problem or that simply throws money at the problem and relieves those responsible of the need to think more carefully about reform.

What we need instead is to create a set of circumstances in which provinces are given the room and indeed the authority to experiment, but where it is clear that they cannot pass along the costs to Ottawa, but rather must live within their means. Remember that welfare reform did not involve ending federal transfers. It cut and then capped transfers, so that provinces could see that any improvements in their situation would come from their own actions, not from lobbying for more federal money to bail them out of the difficulties created

by a dysfunctional but centrally-imposed system. If it is true that behaviour is driven by incentives, then these new incentives were healthy and constructive ones.

If we are to apply these lessons to health care reform, Ottawa needs to do two things. First, it needs to stop increasing the amount of money it gives to the provinces for health care. As long as the provinces believe that the easiest response to rising costs is simply to pass the blame to Ottawa and lobby for more money, no change will occur. Happily, Ottawa has already begun to heed this advice and when the extension of the health accord ends in 2017, provinces can look forward to federal transfers that will grow in line with nominal GDP growth with a 3 % floor and no more.

But equally importantly, Ottawa needs to give provinces more room to experiment with how they run health care. That means at the very least changes in the way Ottawa interprets the *Canada Health Act*, and particularly its five principles. On this point, a 2013 Macdonald-Laurier Institute (MLI) paper by health law expert Michael Watts, titled *Debunking the Myths: A broader perspective of the Canada Health Act*, provides evidence that this is happening as well. Put that together with the individual empowerment of Canadians by the Supreme Court's 2005 Chaoulli decision that individual rights trump government policy when it endangers the health and well-being of the individual, and we have now, largely unwittingly, created a new framework for experimentation and therefore the breaking up of the old central planning mentality.

In another 2013 MLI paper titled *Health Care Reform from the Cradle of Medicare*, Janice MacKinnon, former NDP Finance Minister of Saskatchewan under Roy Romanow, lauds her province's recent experiments with using private sector clinics to provide publicly-insured services. These kinds of baby steps toward the unbundling of the old central planning edifice, the separation of the functions of purchaser and provider of health care services will, if the old central planning reflexes are not allowed to reassert themselves, result in a system that is more experimental, more open to innovation, more entrepreneurial and, crucially, more oriented toward better care for patients, who inevitably will become more powerful voices within the system, especially as the Boomers, who have been assertive about everything they have wanted in life, age and become the major users of the system.

Moral and Economic Sustainability

As stated at the outset, Canadians' faith in the health care system in the abstract is in fact a form of endorsement of its moral or ethical foundation: that no one should be deprived of needed medical care on the basis of ability to pay.

But here is the main ethical problem the system now faces. Of all the major determinants of health, we know that the health care system itself is in fact a relatively minor one. Much more important are things like education, community viability, quality of family life, personal habits and behaviour and individual and collective prosperity. Almost all of these things depend, among many other things, on public investments, in things like schools and infrastructure, that raise our standard of living.

Health care spending already consumes basically half of provincial spending, and that is the level of government that provides many of those vital programmes and investments that underpin prosperity, itself far more important to our health than health care per se. To be more specific, government health spending is on trend to exceed half of total available revenues in six of the provinces by 2017, up from only a quarter of revenue in the early 1970s.

If health care spending continues to rise at its current rates, if in the real world you cannot raise taxes without real consequences to Canada's competitive standing, and if excessive public borrowing eventually crowds out programme spending, as we learned in the 1990s but seem to be forgetting again, the only alternative to

genuine system reform is to cannibalise other public spending. If you project current spending trends into the future we can easily foresee health care spending squeezing our universities, transport, schools and all the rest.

So what are the ethical considerations involved in devoting the solid majority of all provincial spending to a consumption good consumed in the vast majority by the population over 65, at the cost of spending on other real investments in people that pay large social dividends, such as education, infrastructure, and environmental protection? And since the genuine investment goods we will be forgoing would pay the greatest benefits to the young (since they will live as long as the useful life of the investments themselves), this will be the cause of major intergenerational conflict. We cannot impoverish the rising generation to pay for the health care of the old.

I am not suggesting this will be the outcome, because clearly the inevitable adjustments will occur. But the adjustments are made more difficult and painful by the politicised nature of our system. It may be inevitable that real reform will happen, but I am personally always amazed by how much effort it takes to make the inevitable happen. To make it happen will require a slow, incremental, ginger adjustment in the cost curve of public health care that can only be achieved by innovation, competition, and looking to the better-off to cover more of the costs of their own care. If we do that we will not only move our system toward sustainability, but we will quite likely be able to adjust the public health care coverage to ensure access to dentistry, drugs and other services for those on low incomes.

What will reform look like? The details remain to be seen but the principles should be clear:

- Public money will be concentrated on health services that confer the greatest public benefits and where individuals are least likely to be able to obtain appropriate and cost-effective insurance on an equitable basis;
- Contracting out and privatization will be used to introduce autonomy and accountability where appropriate, as well as to stimulate private investment and reward innovation in all aspects of health care, including in treatments, administration, timeliness, and quality. This is not the widely decried American model, as opponents of reform insist. It is in fact the Swedish model of health care reform, whose benefits are described in the 2013 MLI paper, *A European Flavour for Medicare: Learning from experiments in Switzerland and Sweden*, by Swedish policy analyst Mattias Lundbäck;

Government will focus its efforts on ensuring that no one suffers economic hardship to obtain needed medical care, that access to care is universal, that maximum information is made available on the performance of the health care system and its various components and that the transition to a new system be carried out under the watchful eye of an arm's length authority to ensure that quality and access are fully maintained under the new arrangements; That is what the 21st century holds for our health care system.



About the Author

BRIAN LEE CROWLEY

Brian Lee Crowley has headed up the Macdonald-Laurier Institute (MLI) in Ottawa since its inception in March of 2010, coming to the role after a long and distinguished record in the think tank world. He was the founder of the Atlantic Institute for Market Studies (AIMS) in Halifax, one of the country's leading regional think tanks. He is a former Salvatori Fellow at the Heritage Foundation in Washington, DC and is a Senior Fellow at the Galen Institute in Washington. In addition, he advises several think tanks in Canada, France, and Nigeria.

Crowley has published numerous books, most recently *Northern Light: Lessons for America from Canada's Fiscal Fix*, which he co-authored with Robert P. Murphy and Niels Veldhuis and two bestsellers: *Fearful Symmetry: the fall and rise of Canada's founding values* (2009) and MLI's first book, *The Canadian Century*; *Moving Out of America's Shadow*, which he co-authored with Jason Clemens and Niels Veldhuis.

Crowley twice won the Sir Antony Fisher Award for excellence in think tank publications for his health care work and in 2011 accepted the award for a third time for MLI's book, *The Canadian Century*.

From 2006–08 Crowley was the Clifford Clark Visiting Economist with the federal Department of Finance. He has also headed the Atlantic Provinces Economic Council (APEC), and has taught politics, economics, and philosophy at various universities in Canada and Europe.

Crowley is a frequent commentator on political and economic issues across all media. He holds degrees from McGill and the London School of Economics, including a doctorate in political economy from the latter.



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- *Hill Times* says Brian Lee Crowley is one of the 100 most influential people in Ottawa.
- The *Wall Street Journal*, the *Economist*, the *Globe and Mail*, the *National Post* and many other leading national and international publications have quoted the Institute's work.



"The study by Brian Lee Crowley and Ken Coates is a 'home run'. The analysis by Douglas Bland will make many uncomfortable but it is a wake up call that must be read."

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I commend Brian Crowley and the team at MLI for your laudable work as one of the leading policy think tanks in our nation's capital. The Institute has distinguished itself as a thoughtful, empirically-based and non-partisan contributor to our national public discourse.

PRIME MINISTER STEPHEN HARPER

As the author Brian Lee Crowley has set out, there is a strong argument that the 21st Century could well be the Canadian Century.

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PETER NICHOLSON, FORMER SENIOR POLICY
ADVISOR TO PRIME MINISTER PAUL MARTIN

I saw your paper on Senate reform [Beyond Scandal and Patronage] and liked it very much. It was a remarkable and coherent insight – so lacking in this partisan and anger-driven, data-free, ahistorical debate – and very welcome.

SENATOR HUGH SEGAL, NOVEMBER 25, 2013

Very much enjoyed your presentation this morning. It was first-rate and an excellent way of presenting the options which Canada faces during this period of "choice"... Best regards and keep up the good work.

PRESTON MANNING, PRESIDENT AND CEO,
MANNING CENTRE FOR BUILDING DEMOCRACY