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E-BRIEF

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HEALTH POLICY

The Naylor Report and Health Policy: Canada Needs a New Model

by
Åke Blomqvist and Colin Busby

- The federal government is engaged in discussions with the provinces about a new Health Accord. The outcome of these discussions could put the provinces on a road to healthcare reform or delay change.
- The federal government should recognize the limited success of past attempts to achieve healthcare reform with conditional transfers to the provinces and instead look at independent initiatives, for example those promoting better information technology dissemination to providers and patients, or more systematic cost-effectiveness evaluations of new drugs and devices.
- There are many ways the federal government can contribute to improved health system performance through innovative measures in areas that it already oversees such as health services for First Nations. It should support provincial initiatives mainly by reporting on and evaluating their outcomes, and perhaps also via an innovation fund of the type recommended by the Naylor report.
- Attempts by the federal government to negotiate a new set of transfers for a single nationwide pharmacare plan, akin to the way we pay hospitals and doctors, could prove to be counterproductive and delay needed reforms – provinces seeking improved drug coverage for their citizens could take the initiative and lead the way.

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In the last federal election campaign, the Liberals signalled new initiatives on access to pharmaceuticals and on home care, and announced their intention to negotiate a new federal-provincial-territorial Health Accord to replace the one that expired in 2014. Discussions about a new Health Accord have already begun, with a meeting of federal, provincial and territorial health ministers in Vancouver in January; another is planned for mid-2016.

The outgoing Conservative government had no plans for another round of negotiations with provincial and territorial governments about health policy, but one of its more important initiatives in that area was the commissioning of the Advisory Panel on Healthcare Innovation. The panel, chaired by David Naylor, former president and dean of medicine at the University of Toronto, received its mandate in June 2014 and completed its report in July 2015 (see Advisory Panel on Healthcare Innovation 2015). It now looks as though the Naylor report might provide ideas for the new Liberal government as it strives to define a more active federal role in health policy. In an interview shortly before the Vancouver meeting, Jane Philpott, the federal health minister, declared herself a "huge fan," and said that the report contained "some fantastic ideas" (Church 2016).

In this E-Brief, we argue that the Naylor report does indeed advance a number of sensible ideas for healthcare reform, ideas that should be part of the discussion about future health policy in Canada. But in deciding how to use the panel's recommendations and how to structure a new Health Accord, the federal government should use a new model. It should give priority to initiatives it can undertake on its own, with or without the collaboration of provincial and territorial governments. With respect to reforms that would require those governments to take costly and controversial measures, beyond offering clarity about transfers, a new Health Accord should act primarily as a clearing house for research and information, including providing funding for pilot projects and for the scaling up of clearly successful experiments. If the federal government were to go beyond this – and especially if it were to try to use the old model of enhanced federal transfers as a carrot for the provinces and territories – it might actually weaken momentum toward the reforms the system so urgently needs.

The Panel's Recommendations

In economics, "innovation" traditionally has meant the "invention of new technology." The Naylor report, however, defines the term broadly, following much of the recent literature on innovation in healthcare, where "innovation" has also been applied to novelty in processes and organizational structures – things previously called "reforms" or "redesigns." It outlines a federal role that would be more active than before in encouraging innovation, but that would continue to respect the primacy of provincial governments in organizing the supply of healthcare.

The recommendations of the Advisory Panel are organized under five themes. Two of them – "patient engagement and empowerment" and "technological transformation via digital health and precision medicine" – depend on the increased application of information technology. Two others – "health systems integration with workforce modernization" and "better value from procurement, reimbursement and regulation" – relate to policies on the financing and regulation of the core inputs into the healthcare system: physicians and other professionals, hospital services and drugs.[1]

The panel's original mandate asked it specifically to identify innovations that would save money, but its focus, in the end, went beyond cost containment. Instead, the Naylor report emphasizes improving the performance of the healthcare system by exploiting opportunities created by new technology more intensively or by emulating approaches that have been developed in other countries. Some forceful language in the report makes it clear that the panel considered better use of existing resources in the medicare system as the most important issue: "Medicare is aging badly" (Advisory Panel on Healthcare Innovation 2015, 125), and "absent federal action… Canadian health care systems are headed for continued slow decline in performance relative to its peers" (iii).

The divided responsibility for health policy between the federal and provincial and territorial governments is reflected in the panel's mandate: Its wording explicitly called for not only substantive recommendations, but also suggestions on how the federal government could best contribute to their implementation. Several of the panel's recommendations clearly refer to organizational and management issues that fall squarely under provincial jurisdiction – especially under the themes relating to integration of care, workforce modernization and methods of paying for the services of physicians, hospitals and drugs. These recommendations are framed, however, as ways the federal government could "work with" provinces and territories and "encourage" them to follow the panel's advice.

As the experience with the previous Health Accord showed, however, influencing the way provincial and territorial governments respond to policy recommendations on matters under their jurisdiction is difficult.[2] Conditional cost sharing is more of a barrier to improvement than it is a solution: colourful claims of nation building aside, conditional transfer discussions are fraught with opportunities to distract from priorities, duck responsibility and delay change (see Box 1). This time around, the federal government should pay particular attention to measures it could take on its own while limiting itself to a targeted supporting role in the policies of provincial and territorial governments. The panel's recommendations regarding information technology and pharmaceutical pricing and regulation are examples.

1 The Naylor report also discusses industrial policy toward firms engaged in developing new healthcare technology, and the treatment of medical expenditures in the income tax code.

2 The panel explicitly refers to the limited success of the previous Health Accord in many dimensions; see Advisory Panel on Healthcare Innovation (2015, 28).

Box 1: Conditional Cost Sharing and Healthcare Reform

Under the Constitution, health policy is a provincial responsibility. For many years, however, the federal government has used its "spending power" to influence the way the health system is managed. It does so by transferring some revenue to provincial and territorial governments, provided they accept certain conditions.

Those who defend the current method of conditional cost sharing and shared responsibility for health policy between the federal and provincial/territorial governments do so in part because that strategy was used to create the system of universal insurance for hospital and physicians' services in many provinces. Although federal "health" transfers today are just part of the provinces' general revenue, they remain conditional on the provinces' abiding by the principles of the *Canada Health Act* (CHA).

The CHA might have served a useful purpose when Canada's universal healthcare system was established, but today its provisions are often misinterpreted (Boychuk 2012) and used by interest groups opposed to the efficiency-enhancing measures that provincial and territorial governments are trying to push through. In this opposition, these groups might find allies among federal politicians trying to score political points by "defending medicare" and the CHA against its largely imaginary enemies.

Conditional cost sharing might also be counterproductive when it comes to reforms intended to strengthen medicare by extending it to items currently not universally covered, such as pharmaceuticals, dental care and continuing care (home and long-term care). Provincial politicians, who respond to the same concerns of citizens as do federal politicians, are already hard at work finding ways to address these gaps. Federal offers of an additional layer of targeted cost-sharing initiatives – for example, for home care – might derail such on-going efforts, and divert provincial politicians' energy to new and lengthy arguments about who should pay for what, and away from efforts to strengthen the system. If an activist federal government wants to use new cost-sharing initiatives to promote better health policy in a divided federation, such initiatives should be limited and impose only basic conditions on the provinces and territories (Blomqvist and Busby 2015).

With an aging population and a constant stream of new medical technology, provincial and territorial politicians face a daunting task in trying to reconcile the interests of patients, taxpayers and interest groups representing providers. In our view, the federal government's most helpful contribution would be to negotiate a Health Accord that provides long-term certainty about revenue transfers and clarity about what rules will be enforced under the CHA.

Things Ottawa Can Do on Its Own

Information Technology

Disseminating knowledge about new technology is a function where the federal government should play the leading role.[3] The Naylor report's recommendation that Ottawa support the collection of evidence on the effectiveness of precision medicine ("personalized medicine"), should be non-controversial, as should its recommendation that the federal government coordinate and regulate the collection and dissemination of data through electronic health records that can be used to advance research in the field. Information technology also is a central feature of the theme relating to "patient engagement and empowerment." Practices such as electronic appointment scheduling and prescribing are convenient features that patients appreciate, and e-health technology can help provide cost-effective care to populations in remote communities. Electronic health records that are shared both by the patient and among all providers that supply care to the patient are a powerful tool for involving patients more in decisions about their care.

As the panel notes, the federal government is already working extensively with other jurisdictions to encourage the development of electronic health information and communications technology through Canada Health Infoway. Even with this initiative, however, the panel also notes that "[t]he comparatively slow rollout of electronic health records…has put Canada at a disadvantage compared to better-performing…peers" (Advisory Panel on Healthcare Innovation 2015, 71), and recommends that federal support should continue as part of the mandate of a new Health Innovation Agency.[4] Making health records available to both patients and researchers, however, would raise sensitive legal questions of confidentiality and privacy, with an obvious role for the federal government in formulating and enforcing appropriate rules.

Pharmaceuticals: Evaluation, Pricing and Regulation

There is widespread agreement that ensuring more complete access to drugs without financial barriers should be a priority for Canadian health policy (see Blomqvist and Busby 2015; Morgan, Daw, and Law 2013). In international comparisons, Canadian drug prices are among the highest in the world, and even though most residents are covered either by a provincial or private drug plan, the principle of universal first-dollar coverage that applies to hospital and physicians' services does not extend to pharmaceuticals. Not surprisingly, therefore, surveys have suggested that, for some Canadians, out-of-pocket drug costs are a financial hardship or cause them not to comply fully with the drug regimen they have been prescribed.

3 This is a classic public good function.

4 A recent discussion of how Canada compares with other countries in the use of health care system information technology and recommendations for the future can be found in Protti (2015). Canada might be catching up in this respect, however: the December 2014 National Physician Survey shows as many as 77 percent of Canadian family doctors were using electronic medical records. An issue that continues to require attention is ensuring that all electronic devices used for records-keeping are interoperable, so that all data can be shared.

The federal government has highlighted pharmaceutical strategy as a priority area, and the Naylor report also endorses the call for a more complete insurance coverage against drug costs. Interestingly, however, the report does not endorse accomplishing this by simply adding pharmaceuticals to the coverage under provincial universal health insurance plans. This approach, the report says, "risks creating another silo of spending" (Advisory Panel on Healthcare Innovation 2015, 89), and would do nothing to address the problem of insufficient incentives for doctors or primary-care teams to take both cost and medical effectiveness into account when they prescribe drugs.[5]

In our view, any attempt by the federal government to get agreement on a single, nationwide plan, equivalent to how we pay hospitals and doctors, would require negotiating an extensively revised schedule of healthcare transfers to provincial and territorial governments, which we think would be counterproductive. There is a good chance that such a strategy would lead to the same gridlock that has stymied many other attempts at health system reform in Canada. We believe, instead, that a more targeted intervention for individuals without drug coverage would be a more feasible option to spark change within the federation (Blomqvist and Busby 2015).

The federal government could also take a stronger leadership role in more indirect ways, including working with provincial and territorial governments to strengthen the drug insurance plans they already have in place. Ottawa has already announced its intention to join the pan-Canadian Pharmaceutical Alliance, formed by provincial and territorial governments to negotiate lower prices for drugs funded by their existing plans, but the federal government could go further and offer to act as the Alliance's secretariat. The Naylor report further recommends that the Alliance's members consider allowing private insurers to join, so that private plans could purchase drugs on the same terms as the government plans. Another possibility would be for the federal government to take the lead in developing a model drug formulary, to which it could contribute by strengthening the role of comparative economic evaluation in the regulatory process that already exists as the basis for decisions about what drugs can be sold in Canada (Blomqvist, Busby, and Husereau 2013). An enhanced role for the economic and cost-effective evaluation of new drugs, including through closer collaboration with foreign agencies that do such work, could also be an element in a revamped model for the way the Patent Medicines Prices Review Board regulates the prices at which new patented drugs can be sold.

5 As the report puts it, simply expanding drug insurance coverage "runs counter to the basic principle of trying to integrate budgets and align incentives" (Advisory Panel on Healthcare Innovation 2015, 89). The report also cites a comment by health policy expert Pierre-Gerlier Forest, in an address on what Canada can learn from the Obamacare reforms in the United States: "pharmacare without managed care is nothing else but an open bar for big pharma" (Forest 2015, 10).

Things the Federal Government Cannot Do Alone

Integration of Care, Funding Reforms

The Naylor report recognizes the gaps in the coverage of pharmaceuticals as a significant shortcoming of Canada's healthcare system, but it reserves its sharpest critique for two other issues: the lack of integration among different suppliers of care, and the lack of incentives to provide hospital and physicians' care efficiently. Better integration of the care supplied by different providers has long been part of the debate on health policy reform, and has already led to major policy experiments, particularly in Quebec and Ontario. Many such experiments have featured the delivery of primary care through multidisciplinary teams of nurse practitioners, therapists, pharmacists and even social workers, along with family doctors.

The logic behind this model is compelling, and there is evidence from Canada and other countries to suggest that supplying primary care this way can both improve the quality of patient care and reduce costs.[6] So far, however, attempts at implementing such a model on a large scale in Canada have met with limited success. Part of the reason is that when health professionals are compensated via fee for service, they are not paid for collaborating with other professionals in the decision on how to treat the patient most effectively, yet doctors and other professionals in most provinces are reluctant to enter into negotiations about the widespread use of models of compensation other than fee for service (Lazar et al. 2013, 198–202).

The Naylor report recognizes that the issues related to the lack of integration of care from different providers – family practitioners, specialists, hospitals, nursing homes and so on – exists in other countries as well, but says that the Canadian system "appears to be particularly fragmented – and peculiarly resistant to change in this regard" (Advisory Panel on Healthcare Innovation 2015, 61). In its recommendations, the report asks the federal government to work with, and perhaps even give incentives to, the provinces to develop and experiment with methods such as "bundled payments based around common episodes of care," capitation in primary care and primary care commissioning, an integrative funding strategy that is being used in the United Kingdom. It also calls for Ottawa to collaborate with provincial and territorial governments and professional associations to implement the recommendations of the 2014 report of the Canadian Academy of Health Sciences (Nelson et al. 2014) to revise scope-of-practice regulations so as to lower current barriers against the use of more integrated models of care, such as multidisciplinary family health teams (Advisory Panel on Healthcare Innovation 2015, 63).

6 One of our referees stresses that some of this evidence stems from pilot projects that were undertaken many years ago with considerable financial support from the federal government. At least some of the impetus for primary care reform, therefore, has come as a result of federal initiatives.

Box 2: A Health Innovation Agency and the Scaling-up Paradox

The Naylor report devotes considerable attention to the "scaling-up paradox": despite the many examples of local experiments or pilot projects that have shown promising results, why have very few been widely adopted throughout the healthcare system?

Part of the reason is likely to be vested interests. A pilot project that originates with a small group of motivated providers does not pose a significant direct threat to anyone. But if its outcome is so successful that it calls for wholesale disruption of existing models, those who fear their interests might be threatened will resist. In part, the failure to scale up might also be due to the lack of money for the costly short-term investments such projects typically require before they begin to pay off.

Like us, the Naylor report is skeptical that a Health Accord based on new forms of conditional cost sharing would help in the tug-of-war about health-system reform between provincial and territorial governments and local provider groups. The report does suggest, however, that the federal government create a "consolidated innovation fund" (as part of the proposed Health Innovation Agency) through which it could contribute financially to the systemwide scaling-up of selected promising innovations in health-system management.

How effective such a fund would be is debatable: Ottawa would have to be willing to disperse funding to specific initiatives – not necessarily to all provinces – and to put sizable amounts into a few specific projects, rather than small amounts into many projects. Moreover, negotiating the establishment of such a fund could be controversial if its resources were to come at the expense of regular transfers. Nevertheless, the idea of federal support for scaling-up, which the Naylor report recommends limiting to no more than $1 billion a year, is an attractive one.

We agree with the panel's judgment that better integration of care should be at the top of the list of urgent health-system reforms. As a means to this end, provincial and territorial governments should move toward new methods of funding physicians and hospitals (see Blomqvist and Busby 2012, 2013), and review their regulations on the scope of practice of different health professions. But again, reforms of this kind would be controversial, and opposed by interest groups that prefer the status quo. As for pharmacare, we think that making these reforms part of the negotiations on a new Health Accord actually might be counterproductive, and result in the diversion of the health policy energies of provincial and territorial governments away from efforts to reform their own systems and toward clamouring for more healthcare funding from the federal government.

To the extent the federal government wished to support provincial and territorial initiatives of this kind, it could do so indirectly – for example, by co-funding pilot projects and supplying more resources through, say, the Canadian Institute for Health Information for reporting on, and evaluating, their outcomes. Ottawa could also provide a forum where these types of reform could be debated publicly.[7] As well, Ottawa could act on the Naylor report's recommendation to create a consolidated innovation fund with a mandate to support the "scaling up" of approaches that show clear success (see Box 2). Finally, the federal government could adopt the use of innovative payment and organization methods in the programs under which it supplies healthcare to certain population groups, notably through the First Nations and Inuit Health Branch at Health Canada.

Conclusion

Ottawa's decision to once again enter into discussions about health policy with provincial and territorial governments is welcome. Healthcare is a large share of the Canadian economy and dominates the spending of these governments, but the Canadian model's performance has lagged that of its counterparts in other advanced economies for some years now. New initiatives are urgently needed if Canada is once again to join the ranks of countries with a healthcare system classified as "high performing." It is encouraging, too, that the new federal health minister has taken notice of the Naylor report, which provides a raft of ideas for ways to strengthen the current system.

Given Canada's federal arrangements regarding intergovernmental revenue sharing and divided responsibility for health policy, however, the structure of discussions between the federal and provincial and territorial governments will be critically important. In the negotiations on the 2004 Health Accord, for example, Ottawa tried to use increased revenue sharing (under the Canada Health Transfer) as a tool for extracting commitments by provincial and territorial governments to pursue politically popular health-policy goals. The result was a substantial increase in healthcare spending and, at best, only partial success in attaining the stated goals (Lazar et al. 2015, 16).

The federal government should try to avoid a similar outcome this time around, and focus on ways to strengthen the healthcare system on its own, including through more effective policies regarding the use of information technology, the pricing and regulation of pharmaceuticals, and the application of evaluation techniques to promote more cost-effective prescription and treatment choices.

7 As the Naylor report puts it, discussions between provincial medical associations and provincial and territorial governments currently "take place behind closed doors, with little or no public transparency" (Advisory Panel on Healthcare Innovation 2015, 87). Citing the characterization by Lewis (2013) of the collective bargaining process between these parties, the report uses the expression "a significant barrier to system change" (ibid).

Using the federal spending power to push provincial and territorial governments into initiatives they are reluctant to undertake on their own, on the other hand, could further muddle what is already a complex set of issues. If squabbles about how healthcare costs should be shared are allowed to dominate the politics of healthcare, less energy will be devoted to pushing through reforms against the opposition of influential interest groups. From the public's viewpoint, the question of which level of government pays for healthcare is largely irrelevant: Most people don't care whether it is the federal or provincial part of their tax bill that pays for healthcare. What the public does care about is a system in which everyone has ready access to high-quality care when they need it, and that its cost is kept within reasonable limits.

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Ake Blomqvist is an Adjunct Research Professor at Carleton University and Health Policy Scholar at the C.D. Howe Institute.

Colin Busby is Associate Director, Research, C.D Howe Institute.

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