



Quarterly Letters

The Case for Funder as Customer

The central problem of Canada's healthcare system is that it is a \$120 billion business, which, in large part, operates without customers, and therefore without any semblance of market discipline. Provincial and federal governments are perpetuating a system that is failing Canadians. By adopting some simple new approaches, they could truly reform the system.

The vast majority of health services are delivered by private businesses, some of which are for-profit (doctors, dentists, physiotherapists, radiologists, laboratories), and some of which are not-for-profit (hospitals, voluntary organizations). Nonetheless, virtually all are incorporated businesses that strive to end the year with a surplus of money. Those that distribute their surplus to shareholders are for-profit businesses, and those that retain surpluses to advance their good works are not-for-profit businesses.

Two-thirds of the healthcare industry – about \$80 billion – operates courtesy of government (taxpayer) funding. This is the component that is in difficulty. It is also the component that has no customers, defined as persons who buy goods or services from a business. Patients are not customers because they do not pay for the service they receive.

Provincial governments also are not customers; they are benefactors. They make grants – really charitable donations – to not-for-profit healthcare providers such as hospitals. Alternatively, they reimburse private sector providers such as doctors, after the fact, for services rendered. But they do not order those services in advance, and so have no idea at the start of each year how many services they will be paying for. (This is in part due to Canada's all-you-can-eat buffet-style healthcare system.)

Whether or not a hospital, medical office or any other health delivery service operates efficiently and effectively, there is nothing provincial governments can do about it, even if they have the relevant information. They are obligated to provide annual charitable donations to hospitals and to reimburse private providers such as doctors. Worse still, the federal government's role is even more impotent; it simply writes a cheque each year to the provinces to reimburse them for costs incurred. The federal government is not a customer either.

So, there's not a customer in sight in the system. The funders still operate largely in the fashion of a nineteenth century charity, albeit on a much larger scale.

Canada's healthcare problem can best be described as a shortage of procedures: GP visits, specialist examinations, MRIs, surgeries, home care visits and so on. All are in short supply, and the healthcare system is currently unable to provide sufficient procedures. (Ancillary problems, such as a shortage of hospital beds, simply reflect an inability to provide procedures.) The under-capacity of the system manifests itself in an annual procedures deficit. The growing backlog of procedures is akin to a procedures debt. As the deficit and debt build up, so do waiting times, threats to patient health, the economic burden on individuals and society, and public dissatisfaction with the system.

The immediate issue for the healthcare system – and for individual Canadians – is to eliminate the annual procedures deficit and tackle the accumulated procedures debt. How can we do this when the system relies on benefactors and not on customers?

We propose that the principal funders – the provincial and federal governments – begin to transform their roles from benefactor to customer. Let's start with the federal government. It should use any new funds to purchase incremental procedures from the provincial governments. If province X performed 1,000 bypass operations, 1,000 hip transplants and 1,000 MRI tests, then the federal government should offer to purchase an additional number of procedures (say 200, 200, 200) at a set cost. The cost of the procedures would be established on the basis of the lowest bid price by individual hospitals in the province. (Or in an adjacent province, in the case of communities close to another province.) Hospital A might offer to perform a hip transplant for \$10,000 and Hospital B for \$9,500 and so on. Hospital B would receive the contract and the federal government would reimburse the hospital through the provincial government. And so on for each type of procedure. (To eliminate the accumulated procedures debt, it may be necessary to purchase procedures from facilities in US border states. However, this is a separate issue not addressed here.)

Suddenly, the federal government would become a customer rather than a benefactor. It would only pay for what it receives, which is the essence of being a customer. It wouldn't shovel money out the door hoping that good things (new procedures) will happen – it would place a specific order for them. No procedure, no payment. Notice that we haven't even talked about profit. All the required services would be delivered by the not-for-profit sector.

The same theory should apply to the provinces. The provinces would provide base funding to the hospitals in order to keep the doors open. But any incremental procedures would

be ordered explicitly, on long-term contracts. The province would identify how many of each procedure it needed, issue a tender to the healthcare system and individual not-for-profit institutions would bid on the requirement. The province would provide partial payment in advance and final payment on delivery.

This approach would have multiple benefits. First, any new money in the system would be explicitly tied to incremental activity. Second, Canadians would see where the money is going and what it is buying. Third, the customer approach would spur some specialization and competition among public institutions, which can't be a bad thing. Fourth, new money would go to fund the most efficient procedure providers. Fifth, total costs would probably go down as a result of specialization and competition. And finally, politicians could take credit and point to incremental activity.

Now is the time to introduce a customer into the healthcare equation. That's the only way to reform the current system and deliver maximum bang for the buck.

– **Ron Freedman**

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A Response to Stories about Wait Times for Medical Procedures

Many Canadians are waiting for life-benefiting surgery, for diagnostic tests that will inform and enable treatment, for access to human and physical healthcare resources. At a hospital level, the need for urgent care and diagnostic testing is being accomplished well. Canada should be deservedly proud of how all its citizens have access to public and life-saving healthcare. However, care and treatment that is not urgent but necessary to improve and sustain the quality of life, must always wait its turn. That turn seems to come later and later, with more cancellations and more limitations.

A recently published study by the Fraser Institute compared the healthcare systems of the leading countries in the world. All of the systems were publicly run and financed – socialized medicine. Every other country that provides a comprehensive publicly run and funded healthcare system has a mechanism for individuals to personally or privately purchase care.

There is much rhetoric about two-tiered healthcare from both sides of the debate. One side would have us believe that the private, for-profit provision of care coupled with the purchasing of the care is a business solution we cannot overlook. The other

side would have us believe that any “private money” would water down the availability of essential healthcare professionals who would be naturally drawn – like moths to a flame – to the profits and concomitant higher pay – better working conditions resulting from the private money in the system.

The solution suggested here melds together the important parts of both of those arguments to form a different whole.

Hospitals could be permitted to provide privately paid for, non-urgent care and diagnostic testing based on the following simple rules. The new care being provided would be in addition to the current volume of care. The care would be performed by hospital staff as per the employment and compensation practice of the hospital. The physician(s) providing the care would bill the hospital based on their provincial re-impairment plan. The cost of the care to the private individual or insurance company would be double or two times the pre-established actual costs as estimated by the hospital for all resources consumed including the physician's cost. For every paying patient, the hospital/physician must provide the same procedure to an individual who is not paying, but who is next on the wait list. Each hospital would sign an accountability agreement with their provincial ministry of health that outlines the types of services the hospital wishes to consider, the minimum volume levels for the procedures they wish to charge, the targeted extra volumes they believe they can do and the impact on shortening the wait list such volumes will have.

A simple example is access to CT scan. The hospital has a predicted volume of 50 scans a day working 10 hours a day, with only emergency service on weekends or paid holidays. This translates to about 11,000 scans a year. The hospital and its radiologists and the technologist get together and agree that by working Saturdays, three paid holidays and two more hours each night they can do an additional 6,000 scans. The total new cost for these scans, which includes wages, consumables, radiologists' fees and capital re-payment will be \$1,800,000. The hospital contracts with its provincial ministry that they will maintain the 11,000 plus do another 6,000. Each paying customer (3,000) will be charged \$600 to accelerate his or her particular access to the test. The actual wait list will be shortened by 6,000 with the next 3,000 waiting getting accelerated access. The queue is shortened by letting some jump it.

This model could be applied to full elective surgeries, to access non-approved and non-paid for pharmaceuticals, to access enhanced but not utilized medical devices, such as titanium knees and, of course, to access limited diagnostic testing including MRI, CT and PET scans.

The logic of this solution ought to stand on its own, no private poaching, more efficient use of existing resources, satisfying an established demand, local decision-making and effective provincial oversight. However, one more compelling point needs to be made.

The baby boom is entering the pre-retirement phase of their work and home life. These individuals, through their own work/life journey, have established one of the best standards of living anywhere on Earth. Homes have been paid for, weddings and tuition almost finished. Relaxation, retirement and quality of life purchases, such as cottages and vacation time-shares, dominate financial planning conversations. Add to this the significant inheritance of assets and estates from their parents, and Canada has a very large group of individuals with current and future access to cash for discretionary purposes. This same group is now focused not on building a life, but enjoying the one they have built. This group is not going to wait for that diagnostic test because the health issue is not life threatening. The quality of one's personal health will be at the top of the boomers' minds. The consumer giant to our south will be happy to take our money to provide the services and care we presently deny ourselves.

The demand for health services will only increase. If Canada fails to answer this demand by enabling the existing resources to produce the required supply, then the demand will go south and the economic value of those millions of dollars in expenditures will be lost forever to Canada and our provinces. Instead, the dogma of "two tiered healthcare" will compel increasing deficits and tax burdens for the next generations. The current personal wealth will be used to buy the services demanded from US providers with no benefit to Canada. Our economy loses an opportunity and our children inherit a debt.

There has to be a better way. We should all really think about this.

– **Paul Faguy** is a senior executive in a large Ontario teaching hospital. He has almost 20 years of experience in hospital management. This commentary is written as a private citizen reflecting both his personal and his professional views.

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Cover illustration by Anita Kunz. Arguably Canada's most respected living editorial illustrator, Kunz is best known for her covers of The New Yorker, The New York Times Magazine, Rolling Stone and TIME, Kunz also recently became the first Canadian artist and the first woman to hold a solo exhibition of her work at the Library of Congress in Washington, D.C. Her works can also be found in several permanent collections, including that of the Galleria Comunale d'Arte Moderna e Contemporanea in Rome and the National Portrait Gallery in Washington, D.C. To read more about her see: <http://www.anitakunz.com/images/AnitaKunz.pdf>

CCHSA welcomes former hospital executive Wendy Nicklin to the position of President and Chief Executive Officer



October 25, 2004 (Ottawa) – Dr. Murray Nixon, Chair of the Board of the Canadian Council on Health Services Accreditation (CCHSA), is pleased to announce the appointment of Wendy Nicklin, formerly Vice President Nursing, Allied Health, Clinical Programs and Patient Safety at The Ottawa Hospital, to the position of President and Chief Executive Officer of CCHSA. Wendy assumed her responsibilities at CCHSA early in October.

Wendy brings to CCHSA more than 25 years of leadership and management experience in the hospital and health care sector. Her background includes extensive experience in all levels of patient care, from bedside through to senior management. In addition, Wendy has been a surveyor, Board member for six years, and past Board Chair for CCHSA.

Involvement in a number of provincial and national boards such as the Institute for Clinical Evaluative Studies and the Canadian Patient Safety Institute demonstrates her commitment to improving the quality of health care for Canadians.

CCHSA is an independent, non-profit, non-government organization whose mission is to promote excellence in health care and the effective use of resources in health services organizations nationally and internationally in order to improve the delivery of health services. The CCHSA has been in existence for close to 50 years. It recognizes that the ultimate beneficiaries of its work are the people of Canada and beyond.



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