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BACKGROUNDER

Separating the Twins

SPLITTING ALBERTA'S HEALTHCARE MINISTRY IN TWO WILL SPLIT PURCHASERS FROM PROVIDERS

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Canada, and Alberta, are behind on health reform. We should not be.

If a grocery store ranked sixth highest for the cost of food, but among its competitors it ranked 23rd out of 30 for consumer satisfaction, few would say the store is a venue of choice. Twenty-third place is where Canada falls on the healthcare satisfaction scale when it is compared to most European countries.

In this comparison of European and Canadian health care according to consumer sensitivity, Canada ranks below many European nations. The 2008 Euro-Canada report by the European Health Consumer Powerhouse and the Frontier Centre compares European countries with Canada based on 27 indicators including patient's rights and information, waiting times, outcomes, generosity of pubic healthcare systems and access to pharmaceuticals. On such measurements and others, Canada scored 550 out of 1,000 possible points. (Frontier Centre, 2008)

A 2007 study by the Fraser Institute had similar results. At least seven Organisation for Economic Co-operation and Development (OECD) countries – Austria, Belgium, France, Germany, Japan, Luxembourg and Switzerland – had shorter wait times than Canada and superior healthcare outcomes in almost every category. (Esmail and Walker, 2007)

A suggestion for Alberta: Separate the provider from the purchaser

In a closed loop, there's little room for competition.

The World Health Organization reports that an increasing number of countries contract out health-service delivery. It is an alternative to traditional publicly delivered healthcare.

There are alternatives to the Canadian model where a provincial government owns much of the health infrastructure, collects much of the money to pay for healthcare and contracts with itself to deliver the healthcare. In this closed loop, there is little room for competition in service delivery, which is as necessary to healthcare as it is to the provision of food.

The purchaser-provider split is one of the main findings in the Euro-Canada comparison. The top six providers – Austria, the Netherlands, France, Switzerland, Germany and Sweden –have purchaser-provider splits, as do other countries trying to move up in the rankings. My report details two models, Sweden and the Catalonia region in Spain.

Purchaser-provider splits in Sweden

On its English-language web site that explains the Swedish healthcare model, the Swedish government notes, "The Swedish healthcare system is government-funded and heavily decentralized." Most healthcare is provided in "health centers" where a variety of health professionals (doctors, nurses, midwives, physiotherapists and others) work and "around 25 percent of health centers are privately run by enterprises commissioned by county councils." (Sweden, 2008)

The responsibility for providing healthcare is decentralized to the county councils, a political body whose representatives are elected by the public every four years on the same day the national general election is held. Sweden is divided into 20 county councils. As the Swedish government notes, the purchaser-provider split is routine and there is no political involvement.

Most county councils use some form of purchaser-provider system in which a council negotiates compensation agreements with healthcare units – for example, performance-based compensation determined by diagnosis-related group (DRG), that is, a system to classify hospital cases into one of approximately 500 groups expected to have similar hospital resource use. This allows hospitals to become more independent of political bodies. In some cases hospitals have become corporations owned by the council. It is now more common for county councils to buy healthcare services – 10 percent of healthcare is financed by county councils but carried out by private healthcare providers. (Sweden, 2008)

In one of the more famous examples of the purchaser-provider split, in 1999, Capio, a private company, bought one of Stockholm's largest

hospitals, the St. George, from the local city council, which until then was responsible for running it. Since the early 1990s, Capio has run a hospital in Gothenburg as well as X-ray clinics, laboratory services and other healthcare infrastructure. The St. George operates at a cost level that is 10 to 15 per cent below its most efficient public counterpart in Stockholm, the South Hospital. (Hjertqvist, 2000)

This move was supported by Sweden's National Union of Nurses. The chairwoman of the union, Eva Fernvall, was an articulate advocate of change. In 1997, Dagens Nyheter, Sweden's largest daily, published a discussion of ideas that Fernvall co-authored with, among others, the chairman of the National Union of Doctors, four other healthcare unions, a large private healthcare company and the Union of Swedish Industry.

There is a need for flexibility, entrepreneurship and new channels.

Union leader Fernvall argued the following:

- "From different points of view we have come to the conclusion that a completely different, more independent organization than the present one can offer very large gains for Swedish welfare – a better function of healthcare with the same or lower costs."
- "Today, in many fields there are uncertain mechanisms for decision-making within sometimes-conflicting hierarchies. The system suffers from petty political interference. Operations therefore ought to be led by professional, non-political management."
- "When it comes to organization, it cannot be very complicated for the Greater Councils to get rid of most of the parts of the ownership of hospitals and other healthcare institutions. There are great numbers of new owners ready to take over if the price and terms are correct."
- "Co-operation and confrontation between enlightened buyers and sellers can be made a developing force in the system's details as well as its whole. In today's society the old [healthcare] model no longer works. Now there is a need for flexibility, entrepreneurship and new channels to let loose the complexity of demand and supply, held back for decades…." (Hjertqvist, 2000)

Since then, Fernvall has repeated her message that "[h]ealthcare pluralism" is the official standpoint of the nurses' unions. (Hjertqvist, 2000)

In 2005, Stockholm city council signed a new long-term contract with Capio for 2005 to 2012. (Nordic Business Report, 2005) Capio is well established in the private and public sectors in Europe. For example, its diagnostics division is established in the United Kingdom, France, Spain, Switzerland, Italy, Portugal, Russia, Norway, Denmark and Finland.

Increasing accessibility for emergency hospitals and pre-planned care through private contractors

The Swedish government reports that while county councils own all emergency hospitals, healthcare services can be outsourced to contractors. Further, for "pre-planned care (i.e., non-emergency services) there are several private clinics from which county councils can purchase certain services to complement care offered within their own units. This is an important element of the effort to increase accessibility." (Sweden, 2008)

Purchaser-provider splits in Catalonia, Spain

For another example of a purchaser-provider split, consider the case of Spain, and specifically the Catalonia region's drive for reform.

- Spain decentralized its publicly funded healthcare system. In Catalonia, public authorities split the provision of health services from the financing and contracted with private sector providers for delivery.
- The principles that guide Spanish healthcare are similar to Canada's, with two exceptions. They do not mandate a strict adherence to public ownership of facilities, and they include a focus that favours preventative medicine.
- These principles require a decentralized and distributed business-style management of publicly owned health institutions.
- Although Catalonia requires co-payments for a variety of health services, citizens personally pay less than Canadians do.
- Although public funding is national, provinces have autonomy in designing their local healthcare systems.
- Catalonia's Ministry of Health funds the system and sets standards, and the Health Service monitors the performance of providers, the majority of which are contracted. About 70 per cent of facilities are privately owned. (Frontier Centre, 2008)

Funding is national, but provinces have autonomy.

Healthcare organization in Catalonia

The administration of health care is organized according to function. This means services are delivered to the public without the conflict of making the purchaser of healthcare also responsible for delivering healthcare. The purchaser of healthcare can change service providers; this is an incentive to the provider to offer the best quality healthcare at the best possible price.

In Catalonia, government legislation requires the following:

- the separation of the funding and the purchasing of healthcare services,
- the diversification of service providers,
- a mixed market of planned and regulated authority,
- diversity in forms of management,
- decentralization of services,
- decentralization of organization in health regions and sectors. (CatSalut, 2008).

The healthcare players in Catalonia

- **The Department of Health and Social Security (the Catalan Autonomous Government Ministry of Health)**

  The department is in charge of political leadership, healthcare financing and planning, system regulation, authorization, accreditation and evaluation. The Department of Health is roughly akin to Alberta's Ministry of Health and Wellness, but it does not act as the insurer.

- **The Catalan Health Service – CatSalut – the insurer and purchaser**

  The Catalan Health Service, known since 2001 as CatSalut, is the sole public insurer. In 2001, CatSalut's funding function was removed from its brief and turned over to health authorities that are under the jurisdiction of Parliament.

  CatSalut contracts out most health care among private, non-profit and government service providers through service-purchase contracts. The health services are geographically organized into eight health-care regions, the regions that also facilitate the appraisal of health status, healthcare needs and operational priorities.

  CatSalut is responsible for resource management. It provides organization, planning, programming, assessment and inspections of system organizations and facilities. It is also responsible for the distribution of financial resources and the establishment of agreements, covenants and contracts with entities directly and indirectly managed by the autonomous government. It must purchase health care based on three criteria: equality, quality and efficiency.

- **The Providers**

  Catalonia features a stable network of healthcare service providers. This network is made up of centres and facilities of diverse ownership that are contracted by the Catalan Health Care Service to meet the population's healthcare needs by way of public financing.

Best practice reforms

Learning from Sweden and Catalonia

Catalonia's model combines the insurer and purchaser in CatSalut but splits the purchaser of healthcare from the provider – CatSalut contracts with service providers. As noted, much of the infrastructure is privately owned (70 per cent). This gives the government choices and forces competition within the context of universality.

Relevance to Alberta

The model suggested here goes further by splitting Alberta's Ministry of Health and Wellness into two bodies – one for insuring and one for purchasing – and then splits off the providers (hospitals and clinics) within the private or non-profit sectors. This combination removes the problems of monopoly control and a government owning facilities and then contracting with itself. That leads to inefficiencies, as the government feels an obligation to use a particular facility – its own, even if another facility and staff are more effective and efficient.

The purchaser-provider split is common in Europe, and it should be emulated in Alberta. What follows here are some suggested reforms to that end.

This will allow the Ministry of Health Insurance to focus on reforms.

Reform 1: Split the Ministry of Health and Wellness into two organizations. The first would offer and manage public health insurance, and the second would buy healthcare.

In order to ensure every Albertan has enough food, the provincial government uses revenue from general taxation to give assistance (welfare) to those in need, who use the money to buy food and others necessities of life.

Provincial politicians do not envision the role of government as the owner-supplier of food – owner of the grocery stores, farms, trucks that deliver the food to the stores, or employer of grocery store employees. Instead, the province delivers the cheque and allows the profit and non-profit sector to deliver the food. Albertans can shop in any grocery store; this allows them dignity and choice. This system keeps stores competitive in terms of quality, customer service and price.

This model is hardly radical or incomprehensible. Good healthcare is no less a need than good food is. The model of government buying the services without delivering the healthcare can and does work in other advanced countries, and it will work here.

Given the reality of federally imposed mandates that accompany healthcare funding, e.g., that private and non-profit insurance is disallowed for medically necessary services, the Alberta government cannot completely replicate the welfare model. Unlike welfare, funding cannot be given to Albertans based only on need and spent on the provider of their choice. However, the Alberta government can more robustly pursue reform in how tax dollars are spent on universal health care and it can do so within the context of the Canada Health Act.

The Ministry of Health and Wellness should be separated in two – one ministry to offer and manage public health insurance and one ministry to buy healthcare services from whatever provider can best deliver the service. This would allow the Ministry of Health Insurance (as I will call it) to concentrate on reforming health insurance, and it would allow the Ministry of Health Provision (as I will call it) to concentrate on making public healthcare dollars go further.

Given that the provincial government collapsed the now-defunct regional health authorities into a single provincial health-services board, a clear delineation is possible if the existing health ministry and the new board are given distinct functions – one to collect and manage insurance and the other to purchase services. However, this alone will not complete the purchaser-provider split that is necessary for a better healthcare system.

Reform 2: Sell hospitals and clinics to the private and non-profit sectors and pay hospitals for the healthcare they deliver

Another reform that is necessary for splitting the purchaser of healthcare from the provider is the transfer of hospitals and clinics to the private and non-profit sectors. Because of this change, the new Ministry of Health Provision would not face a conflict of interest: It could purchase health services from whatever provider could best provide the service. This change would also allow hospitals, clinics and others to be innovative. In fact, it necessitates innovation in order to attract patients and thus receive reimbursement from the Ministry of Health Provision.

The current system wherein a hospital receives a global budget and must serve X number of patients a year is not a model for greater efficiency, it is a recipe for queues. The hospital has an incentive to create lineups, especially as it becomes apparent at fiscal year-end that the budget allotment is running out. The result is closed wards and operating rooms that could be open and serving patients.

This method should be replaced by a system wherein hospitals earn money for the number of patients treated and the services performed. In this system, closed operating rooms do not save money; they cost money. Rather than look at a patient as another expense that might be shuffled off to another hospital, the incentive will be to treat the patient soon rather than lose the patient to a clinic or hospital across town. The provincial government's new separate healthcare purchaser would pay the hospital or whatever facility best delivers the most effective service at the most efficient price.

Reform 3: Keep healthcare universal and increase choice in health care in order to prevent existing monopoly control by the public sector

Monopolies are problematic whether in the private sector or in the government sector. The Canada Health Act allows provincial governments to tap into the non-profit and private sectors for service delivery of healthcare. Most doctors' offices are private. But in practice, beyond physicians' offices and hospitals that are owned by a non-profit institution (the Roman Catholic Church, a Chinese benevolent society or a veterans' organization for example), governments contract services with public sector unions in a monopolistic fashion for much of their healthcare service delivery.

Monopolies are problematic and inefficient.

This creates potential and real bottlenecks. When most hospitals are served and controlled by the public sector, innovation, flexibility and merit are not rewarded; in fact, they are discouraged. In addition, the public is held hostage in the event of a strike. For example, in British Columbia in 2004, the Hospital Employees' Union (which provided custodial and laundry service to hospitals) went on strike. The following are some of the cancellations that occurred in just the first week after the strike began:

To funnel money to where it is needed, and avoid monopoly chokeholds, a variety of providers is critical.

Almost 4,200 surgeries were cancelled including the following:

- heart surgery for a nine-year-old Campbell River boy,
- breast cancer surgery for two Kelowna women,
- a three-year old boy who waited months to have a growth surgically removed at BC Children's Hospital in Vancouver and
- another 79 children who also had their surgeries cancelled at that facility.

Thousands of diagnostic tests were cancelled including the following:

- 514 MRIs and
- 1,852 CT scans.

Other medical and public health services that were cancelled included the following:

- 450-650 mammograms a day,
- at least 11,500 necessary laboratory tests,
- over 11,000 ambulatory-care procedures including diabetes education, cast clinics to remove casts, wound care, epilepsy-management clinics, occupational and physical therapy sessions and Holter monitoring for heart disease,
- respite services for seniors and family members were reduced or cancelled and
- public health services such as youth sexual health services, sexual health education, prenatal classes, hearing and speech difficulty assessments.

Compare the monopoly provision in healthcare to that which takes place in the provision of food. In the case of a grocery store, if one union at one grocery chain decided to strike, customers could and would shop elsewhere. The delivery of food is not imperiled by a monopoly chokehold in the system, because there is no monopoly provider for food and food delivery. Thus, to funnel extra money to where it is needed (instead of being captured by existing interests) and to avoid monopoly chokeholds in the system, a variety of service providers are critical.

The Canada Health Act allows choice – purchaser-provider splits – by provincial governments

To understand how the current Canada Health Act (CHA) functions and how the province's healthcare purchaser can choose among different providers, consider the following charts. In Chart 1, the CHA requires the government to be the payer and insurer of medically necessary health services. Recall that the CHA does allow governments to choose among providers (public sector, non-profit or private).

Chart 1: What the Canada Health Act allows for medically necessary care

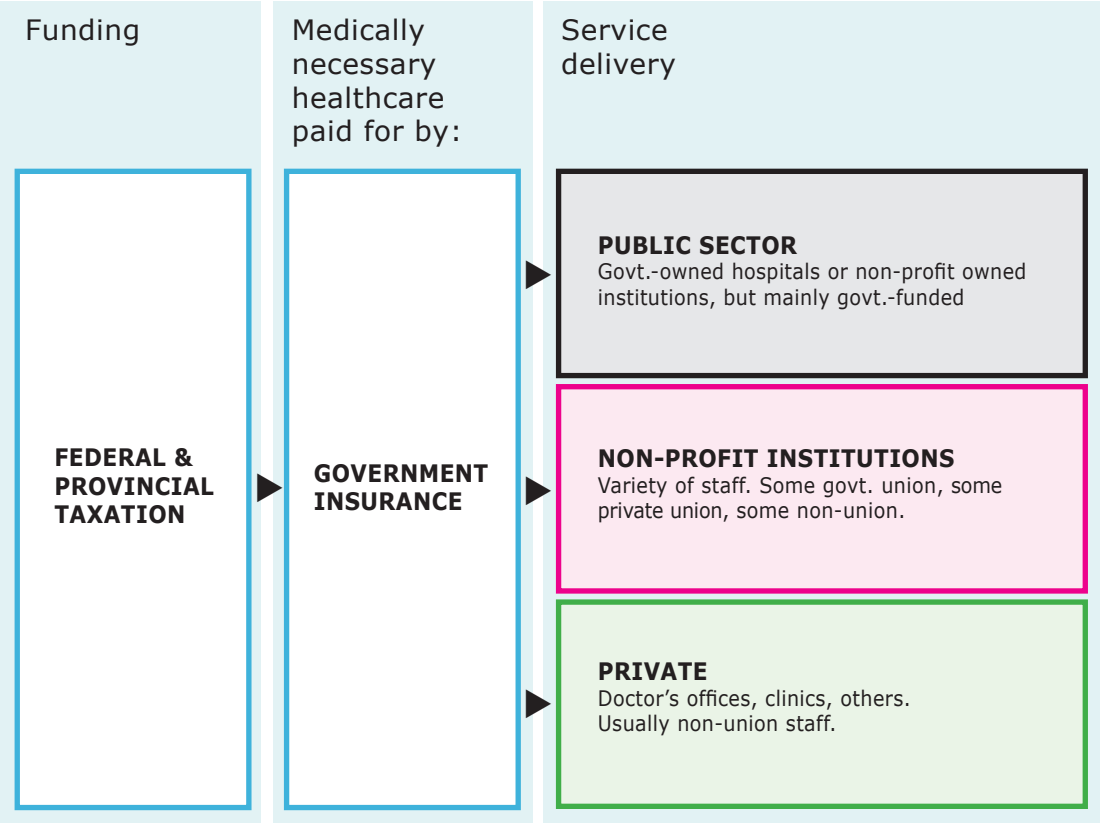
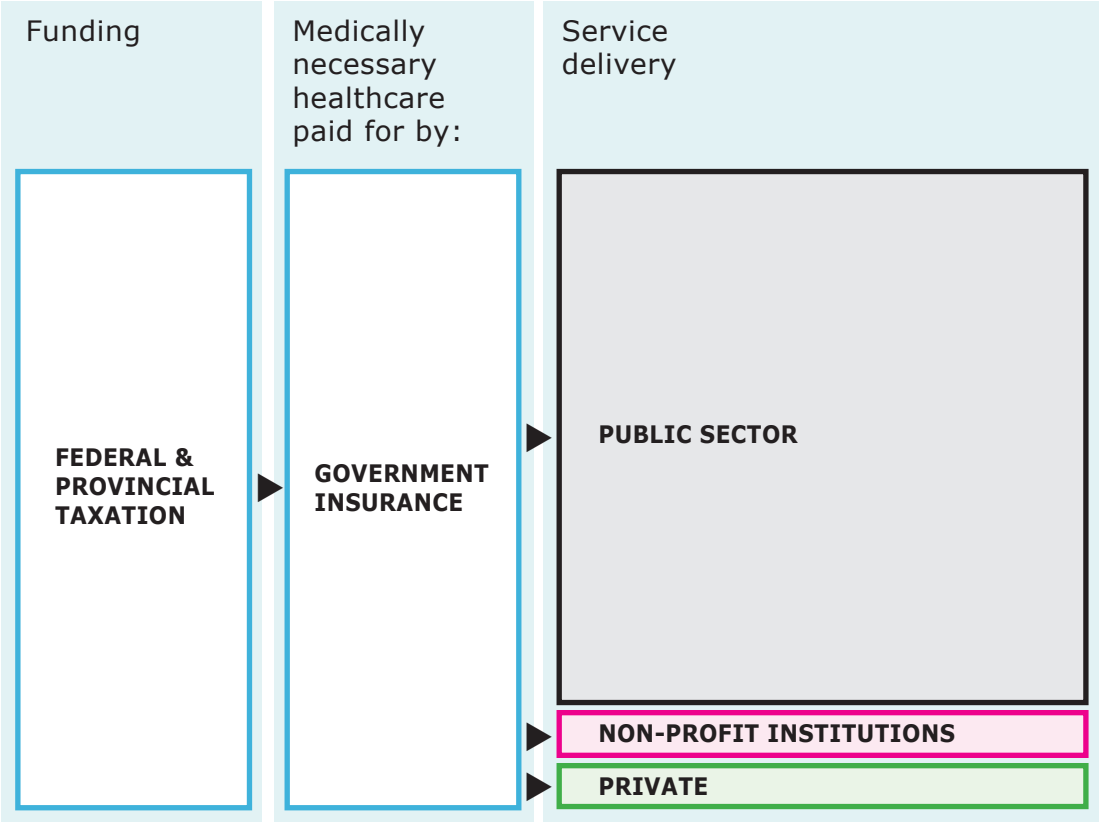


Chart 2: What actually occurs



Competition in service delivery is legal under the Canada Health Act

Alberta can and should use competition to break up the delivery monopoly of the healthcare it pays for. It is allowed and legal under the CHA. As long as Alberta continues to mandate and pay for universal healthcare for medically necessary services, there is no conflict with the CHA.

Summary of best practice reforms

Principle:
Split the purchaser of healthcare from the provider

Reform 1: **Split the Ministry** of Health and Wellness into two organizations: The first to offer and manage public health insurance and the second to buy healthcare. This reform would allow the government purchaser of health insurance to buy medically necessary services from any provider and to concentrate on receiving the best service at the best price.

Reform 2: **Transfer hospitals** to the private and non-profit sectors and pay hospitals for the healthcare they deliver.

Reform 3: **Keep health care universal** and increase choice in healthcare to prevent existing monopoly control by the public sector.

Sources

CatSalut (2008). History of the model: Principles of the LOSC. http://www10.gencat.cat/catsalut/eng/coneix_models_his.htm.

Esmail, Nadeem and Michael Walker (2007). *How Good Is Canadian Heath Care? 2007 Report. An International Comparison of Health Care Systems*. Vancouver: Fraser Institute. http://www.fraserinstitute.org/COMMERCE.WEB/product_files/HowGoodHC2007rev.pdf. Downloaded March 13, 2008.

Frontier Centre (2008). *Euro-Canada Health Consumer Index*. Health Consumer Powerhouse Frontier Centre for Public Policy Series No. 38. http://www.fcpp.org/main/publication_detail.php?PubID=2025. Downloaded March 9, 2008.

Hjertqvist, Johan (2000). *Sweden's Purchaser-Provider Split in Healthcare*
Swedish Health-Care Reform. Frontier Centre: Background Brief, http://www.fcpp.org/main/publication_detail.php?PubID=179.

Government of British Columbia (2004.) "How the HEU is hurting patients." Victoria: Ministry of Health Services, news release, May 1, 2004.

Nordic Business Report (2005). "Capio St Goran's Hospital signs long-term care contract with Stockholm city council." March 22, 2005. http://findarticles.com/p/articles/mi_m0HXI/is_2005_March_22/ai_n25106412.

Organisation for Economic Co-operation and Development (2007). *OECD in Figures*, 2007 edition. Paris: OECD.

Robinson, Walter (2001). *The Patient, The Condition, The Treatment*. Ottawa: Canadian Taxpayers Federation, September 2001.

Sweden (2008). *Swedish healthcare – Facts*. www.sweden.se/templates/cs/FactSheet____15865.aspx#2.

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