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The Rebirth of Medicare in Saskatchewan: Steps Toward an Accessible, High Quality, and Sustainable Health Care System

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Executive Summary

In June 2000, Saskatchewan conducted a major review of its health care system. Headed by health consultant Ken Fyke, the Saskatchewan Commission on Medicare issued its report in April 2001. The provincial government also invited comments from the public and health care providers; more than 100 individuals and organizations appeared before the Standing Committee on Health.

Based on the ideas proposed in the Fyke report and on the findings of the public consultations, the government issued *The Action Plan for Saskatchewan Health Care,* a "blueprint to secure the future of health services" in Saskatchewan. Despite the intended reforms, the government states that, "paying for the health care system we want and need will continue to be a challenge for the future" (Saskatchewan Health, 2001a, p. 68). This study looks at some of the reasons why the government's reforms will not succeed in permanently solving the province's problems of waiting lists, a lack of medical technology, a shortage of providers, and other issues. The Fall 2002 month-long strike of Health Sciences Association workers—the longest strike in Saskatchewan's history—is one example of the problems that will continue to arise in Saskatchewan's health system.

Saskatchewan's Action Plan for Health Care

In its health plan, the Saskatchewan government's stated commitment to the people of the province is an accessible, quality health care system that is sustainable for the future (Saskatchewan Health, 2001a). The action plan's highlights include the following:

- The establishment of primary health care teams of doctors, nurses, and other health providers
- A 24-hour, toll-free phone line offering immediate health advice
- A province-wide network of community, northern, district, regional and provincial hospitals
- More funding to reduce waiting times for surgery
- Funding to train more health providers and for students studying in selected health programs
- Funding to train ambulance attendants to become emergency medical technicians
- The formation of 12 regional health authorities to replace 32 districts
- The creation of Canada's first Quality Council
- Increased financial support for health research.

In addition to a $129 million increase in the health budget from the previous year, the 2002/2003 provincial budget included additional patient fees that were to have been implemented to help make Saskatchewan Health's action plan more affordable. (Another $185 million was allocated to health care in the 2003/2004 budget.) There was supposed to be a rise in the maximum monthly charge for residents in long-term care (about two-thirds of residents would see the fee rise from $1,561 to $3,875). However, this cost increase has been dropped. The other measure, which has been implemented, was the removal of the semi-annual deductible on the province's

drug plan, which means that people pay the full costs of their pharmaceuticals, although anyone whose drug costs exceed 3.4 percent of their income may apply for special assistance from the government.

Does the action plan appropriately address the problems the system faces?

Saskatchewan's action plan suffers from the same drawbacks as those of most other provinces whose governments attempt to reform their health systems. The most fundamental problem is that the main solution offered is to spend more money. Another problem is that most of the solutions lead to more centralized decision making by the Ministry of Health, with little responsibility being placed on, and few incentives provided to, hospital administrators, physicians, other health practitioners, or patients, to use resources more efficiently.

Adding to Saskatchewan's challenges is its poor migration record: relative to other provinces, Saskatchewan's outflow of knowledge workers and high-income earners is significant. As well, a study by Sask Trends Monitor came to the conclusion that retirements are going to affect the health sector in increasing numbers (Elliott, 2001). The same study noted that the aging population will generate more health care spending and could potentially reduce the government's revenues (Elliott, 2001).

With the changes in primary care, the province is hoping that the entire population will have access to primary health care teams within the next decade. In these teams, family doctors will be remunerated on a contract or salary basis rather than fee-for-service. The government's hope is that changing the method of remuneration will give doctors more time to spend with their patients, will result in more efficient use of resources, and will give greater predictability to funding. However, there is ample evidence that replacing fee-for-service with strict salary or capitation reduces the services that providers offer—all services, not just "unnecessary" care or services.

As for the problem of waiting times, the Saskatchewan government's answer of increased funding likely will not achieve any permanent increased patient access to the system. Provincial governments have frequently allocated more money to health care in order to reduce waiting lists, yet the lists continue to grow in Canada. Additional government health spending does not seem to result in reduced waiting times or increased rates of treatment by specialists.

Certainly Saskatchewan appears to have enough acute care institutions. The province has 67 hospitals in 64 communities, as well as five other facilities. The Commission on Medicare determined that many of the small hospitals could take on the role of primary health centres. Nonetheless, the government's action plan promises only to designate hospitals by the services they provide—there will be no hospital closures.

The Commission on Medicare and the government's action plan do agree that the number of health districts in the province should be reduced. In response, the government has created 12 regional health authorities (RHAs) to replace the districts. They will act in an advisory capacity only, and have no significant decision-making or financial authority. As a result, the RHAs likely will not make a positive difference to the efficiency and effectiveness of the health care system.

In addition to the weaknesses of many of the government's reform recommendations, a number of important areas receive little or no mention in the government's action plan. There are no reforms

to ensure that the millions of dollars of additional health funding will be well spent: the government *hopes* that administrative costs will be lower with fewer RHAs; it *hopes* that the Quality Council will result in more cost-effective use of resources; and the list goes on. There is almost no reference to the drug program (6.6 percent of total government spending on health) in the action plan. As well, the action plan does not consider any changes in the structure of the labour market, even though 67 percent of government health spending goes to paying health workers and professionals.

The main failing of most reform efforts in Canada is that they start with the same faulty premise as did Saskatchewan's: they equate the *ideals* of medicare with the *structure* of medicare. Nothing about the principles of universality, comprehensiveness, accessibility, and portability inherently require exclusive public funding of medically necessary services. All industrialized countries have mixed health systems in which both the public and private sectors contribute to the financing and the delivery of health care. Canada could learn from the experience of any one of them. The health systems of Australia, Germany, New Zealand, Singapore, Sweden, Switzerland, and the United Kingdom are briefly summarized in this report.

Recommendations

The following recommendations are broken into two groups: those that are possible without violating the Canada Health Act, and those that are not. The recommendations are all based on national and international experience and on numerous studies on the role of the private sector in health care. The latter group, though not possible within the confines of current federal legislation, still maintains the first four principals of the act itself: universality, accessibility, portability, and comprehensiveness. These recommendations would only violate the sections on extra-billing and user charges, and the principle of public administration.

Recommendations that fall within the current bounds of the Canada Health Act

- Privatize the operation of hospitals and the management of other health facilities
- Permit private, for-profit clinics to compete with government hospitals for the delivery of covered services as is currently underway in British Columbia
- Define the roles of regulator, purchaser, and provider and remove the conflicts of interest between them by requiring competitive tendering for service provision.
- Remove all restrictions on medical school enrolment and withdraw subsidies for medical school education
- Define core services to be financed by the public sector as a system to replace the current rationing-by-waiting list system
- Consider public-private partnerships (P3s) for the construction and operation of new health services infrastructure, in which the private sector participant can be a for-profit business or a nonprofit organization.
- Charge risk-based premiums for health care, but reduce income taxes accordingly.
- Remove any and all restrictions on a parallel private health care system
- Encourage citizens to save for their own possible long-term care needs by allowing withdrawals from RRSPs to pay for long term care.

- Open up access to all publicly-held information on health care provider performance

Recommendations that would not be possible without violating the Canada Health Act

- Implement a cost-sharing structure within the public health care system in Saskatchewan
- Move from the single purchaser model to a system of many competitive insurers where individuals are required to be insured for a basic set of health services
- Deregulate the mandatory social insurance sector to permit the formation of medical savings accounts.

Section 1: Introduction

In June 2000, Saskatchewan conducted a review of its health care system. Headed by health consultant Ken Fyke, the Saskatchewan Commission on Medicare issued its report in April 2001. The provincial government also invited comments from the public and health care providers, and more than 100 individuals and organizations appeared before the Standing Committee on Health.

Based on the ideas proposed in the Fyke report and on the findings of the public consultations, the government issued *The Action Plan for Saskatchewan Health Care,* a "blueprint to secure the future of health services" in Saskatchewan. It identifies four main areas requiring change:

1. Doing more to support good health and prevent illness
2. Providing better access to health services
3. Improving health work places and addressing shortages of key health providers and
4. Placing a greater emphasis on quality, efficiency and accountability

The action plan's highlights include the following:

- The establishment of primary health care teams of doctors, nurses, and other health providers
- A 24-hour, toll-free phone line offering immediate health advice
- A province-wide network of community, northern, district, regional and provincial hospitals
- More funding to reduce waiting times for surgery
- Funding to train more health providers and for students studying in selected health programs
- Funding to train ambulance attendants to become emergency medical technicians
- The formation of 12 regional health authorities to replace 32 districts
- The creation of Canada's first Quality Council
- Increased financial support for health research

Though the action plan focuses on areas where problems currently do exist within the health care system, the reforms outlined in the report will do

little to resolve the issues with health care and health care delivery in Saskatchewan. The principle failing of the reforms is that they deal only with small problems peripheral to health system design and do not address the major problems inherent in the structure of Medicare itself; namely, that the health care system in Canada has evolved from a health insurance program to a "free health care" provider. This single characteristic of the Canadian health care system is the core problem with health delivery in Saskatchewan; any reform package that does not deal with this core issue is doomed to fail.

This study begins with a brief discussion of the basic economics of health care and the implications of the Canada Health Act for meaningful health care reform in Canada (section 2). Section 3 examines the current state of Saskatchewan's health care system, providing an overview of cost, access, and quality. In this context, Section 4 analyzes the government's action plan to determine whether it appropriately addresses the problems faced by the system. In particular, it questions the government's statement in its action plan that, "Not only is publicly funded health care proven to be the most cost-effective model, it is also the best way to make health care equally available to all." Section 5 looks at how health care is organized in countries other than Canada to see whether there are alternative reform measures that should be considered by the Saskatchewan government. Finally, Section 6 offers several policy recommendations as to how Saskatchewan could proceed to improve its health care system.

Section 2: The Basic Economics of Health Care

In Canada, the public sector—all levels of government and the Workers' Compensation Boards—accounted for a forecasted 70.7 percent of total health care spending in 2002; the private sector accounted for 29.3 percent (Canadian Institute for Health Information, 2002d).

Governments pay mainly for medically necessary services, which generally comprise acute care, physicians' fees, and a portion of pharmaceutical charges. Private sector spending includes money spent on health care providers other than doctors (for example, chiropractors), institutions other than hospitals (nursing homes and other facilities), pharmaceuticals, dental care, eye care, and private insurance premiums. Though Saskatchewan is one of the few provinces where private insurance contracts for publicly insured services are permitted, this insurance sector has yet to develop (Flood and Archibald, 2001).

The current health care system in Canada has its origins in the 1948 Hospital Construction Grants Program, in which the federal government made grants available to the provinces for planning and hospital construction. In the 1968 Medical Care Act, medical services provided by a physician became insured by another federal-provincial cost-sharing program. To qualify for federal funding, a province's program has to be *universal* (cover all residents of a province), *portable* (cover residents of one province requiring medical services in another province), *comprehensive* (cover all medically necessary services) and *publicly administered* (a nonprofit program). The Canada Health Act (1984) added *accessibility* to the requirements and the federal government tries to

achieve this by reducing its payments to the provinces, on a dollar-for-dollar basis, by the amount of user fees charged by hospitals and extra billing by physicians.

In effect, for medically necessary services, the Canada Health Act attempts to separate people's financial contribution to the health system from their health risks and from their use of services. But is there really a need to do this?

The health care system and a population's health

A health care system generally encompasses, for the most part, acute care and physician services. However, there have been numerous studies, including by the World Health Organization, showing that there is little or no correlation between the health care system (spending) and a population's health status (Ramsay, 2001; WHO, 2000; Oxley and MacFarlan, 1994). This is why there are always policy discussions about redirecting resources to public health and primary care, as there is evidence that public access to sanitation, safe water, immunization, screening services such as mammograms, and other preventive care have a positive effect on the health of a population.

Given the tenuous connection between the health system and population health, governments really should focus on simply ensuring universal access to and the availability of basic health care. Beyond this, governments should be concerned only with ensuring that those who cannot afford to pay for medical services have access to them when they require care and, perhaps, requiring their citizens to purchase (public or private) health insurance for catastrophic events. However, because of the structure of the Canadian health care system and the entrenched position of health care providers, the majority of government health funding still goes to acute care services and its providers. This is largely due to the fact that the Canada Health Act applies to these services.

The idea of establishing multi-disciplinary health centres in which different providers (physicians, nurses, perhaps a nutritionist, chiropractor, naturopath, or other practitioner) would attempt to "service" the whole patient has been around for decades. As well, spending on physician services and acute care as a percent of the total health care budget has been decreasing over the last number of years. But "physician-centered solo and small group private practice remain the norm" (Canadian Institute for Health Information, 2002a, p. 8) and hospital closures always meet with public outcry. The latter situation is one reason why the Saskatchewan government did not accept the Commission on Medicare's recommendation to convert up to 50 of the province's rural hospitals into health centres (Saskatchewan Health, 2001a, p. 2). Acute care expenditures still account for the largest portion of government health care expenditures—35 percent in Saskatchewan in 2002 (see table 3.5 for dollar figures).

As long as medically necessary services are under the purview of government only, more funding will be directed to physician and hospital services. As well, politically motivated actions such as keeping inefficient hospitals open to keep residents happy will remain commonplace. One can only guess at the opportunity cost (the life-improving and life-saving care forgone) of such decisions.

Insurance

There is no reason to use government intervention to separate the financing of health care from the risks of needing care. Insurance markets have developed in the health care sector, as they have in other markets, to deal with the uncertainty and

risk of illness. People pay a fee to an insurer so that, in the case of a heart attack or an injury, the insurer will pay them a certain amount of money, thereby reducing the financial cost to them of such an event.

With insurance, society also benefits because many people share (pool) the risks. So when something terrible happens, an individual is compensated for their loss out of the fees paid to the insurer by everyone who insured themselves against this risk.

With health insurance, there is also a morality aspect: people who are not properly insured may not be able to afford care when they need it. However, there are problems when people do not face any direct charges for care. When a third party, which could be the government or a private insurance company, covers their medical expenses, people have no incentive to restrain their use of services. This is called moral hazard: insured patients demand more services than they would in the absence of insurance because the marginal cost of care to them is lower than if they did not have insurance. In insurance literature, moral hazard is often seen as a moral or ethical problem. However, Pauly notes that moral hazard is more a result of rational economic behaviour than of lower morality (Pauly, 1968). Individuals may recognize that their excessive use of health care will result in higher premiums or taxes, but their increase in benefits from over-consumption is large, while the incremental cost of their excessive use is small, because the entire population bears the cost. This situation can result in excessive demand and wasted resources, to the extent that the costs of producing these services are greater than what individuals would be willing to pay for them directly.

On the other hand, if people are not insured, they may delay seeking care, which may be more costly and harmful to their health, and even to the people around them, than if they had received more timely treatment or medical advice. The incentives to under use and to over use medical services must be balanced. It is for this reason that cost-sharing, such as co-payments and deductibles, has been introduced into the insurance market.

For those of us who are worried about the potential impact that such a connection may have on lower income Canadians, any form of cost-sharing can be adjusted so as to protect this group from being denied the care they need because of an inability to pay for it. Catastrophic insurance, which is simply an insurance policy that has a high deductible, creates an incentive for people to restrain their use of health care services (however, once the deductible has been reached, medical care is, in essence, “free”). High deductibles may prevent or limit access to medical care; therefore, the optimal deductible faced by low-income people, or by people who are chronically ill, may be lower than that of other individuals, even zero. User fees and co-insurance rates also can be linked to income, and the chronically ill can be exempt from any cost sharing. Such mechanisms are already in place in many provincial pharmaceutical plans and, nationally, the GST credit system is an example of how those who cannot afford to contribute more financially are protected from such costs.

Proponents of user fees and cost sharing argue that, if required to bear a portion of their health care costs, individuals will curb their consumption of medical care and medical services of lesser value eventually will be eliminated. As well, they maintain that fees can reduce the tax burden of Canadians because they redirect health care financing from taxpayers to users. Lastly, they believe that if the health system is more efficient and more funding comes directly from users rather

than from taxpayers in general, then governments will be able to decrease the size of their health care budget. (For more detail on these and other arguments in favour of cost-sharing, see Ramsay, 1998; Gratzer, 1999; McMahon and Zelder, 2002.)

Opponents of cost sharing point out that, because of ignorance or cost concerns, individuals may delay seeking care or forgo preventive care when faced with medical expenditures, potentially resulting in higher medical expenditures if, for example, the illness reaches a more advanced stage (for example, Beck, 1974, 1980; Roemer *et al*., 1975; Evans, 1993). As well, it is often argued that, due to consumers' ignorance, physicians (suppliers) are able to induce demand. For these reasons, they argue, publicly funded health care and government intervention in the health market are necessary. However, the hypothesis that suppliers of medical care control the demand for health care is a controversial topic in the literature about health economics (Ferguson, 1994; Rice and Labelle, 1989) and uncertainty and risk are not unique to the health care market.

It can and has been argued that the health care market is different from other markets because of the severity of market failures: uncertainty of incidence of illness, economies of scale, insufficient information for rate making, and moral hazard. For the discussion of public policy, however, "market failure" should be used to describe instances in which the government can improve welfare in a way that the market cannot. The mere existence of problems with the market is not reason enough to support government intervention, especially given that there has been documentation of government failures that are as serious as market failures: poor public accountability, information asymmetry, abuse of monopoly power, and failure to provide public goods. (For example, see Tullock *et al*., 2002; Harding and Preker, 2000; Mitchell and Simmons, 1994.)

The Canada Health Act and health system reform

While the Canada Health Act's provisions attempt to solve the absence of insurance problems, the act ignores the problem of moral hazard. Consumers are not charged for their use of most health care services, and providers of medically necessary services either bill the government fees that are collectively negotiated with the government, or are provided with a global budget based on past service provision and other considerations. Market prices are not used to allocate resources.

A basic economic concept is that, everything else being equal, the quantity demanded of a good will rise as the price of that good falls. This "law of demand" applies to the market for health care as much as any other: if the price of health care to consumers is negligible, the demand for it will be high. It would be possible to spend the entire government budget on health care and still have unmet demand for many health services. It is not surprising, then, that the Canadian health system exhibits the symptoms of excessive demand: waiting lists, overcrowded emergency rooms, shortages of care providers, etc.

Thus, there is a role for market forces in health care even if we agree that all money comes from one source (yours by choice, or yours by taxation) and that there should be a public system to ensure that quality care is available to everyone and no one is bankrupted by a medical crisis. As many royal commissions and government inquiries into the health care system have determined, the system needs better and more efficient management of resources (for example, see Romanow, 2002), but this will only happen if the benefits and costs of decisions can be measured. Market prices are the best method of doing this. A system without any financial connection between use and costs will never be able to allocate resources effectively.

Section 3: Saskatchewan's Health Care System

There are many ways of organizing a health care system to achieve the goal of improving the health of the population. Despite many structural differences, most systems take into account three basic principles: affordability, broad access to care, and high-quality care. This section provides an overview in numbers of how Saskatchewan fares in these areas.

Cost

From 1996/1997 to 2001/2002, nominal health spending in Saskatchewan grew by approximately 37 percent, well above the province's rate of economic growth (Saskatchewan Health, 2002d, p. 41). The percentage of government program spending consumed by health care expenditures increased from 37.4 percent in 1997 to 38.4 percent in 2002 (table 3.1).

The 2002/2003 provincial budget added another $129 million to health care, bringing health spending up to $2.3 billion, a 5.8 percent increase from the previous year, and the 2003/2004 budget brought public sector spending on health up to $2.5 billion (Saskatchewan Health, 2002b; Government of Saskatchewan, 2003). Already, health expenditures comprised 41 percent of program spending in 2002/2003, with education a distant second at 19 percent (table 3.2).

In an attempt to contain rising health costs, the 2002/2003 provincial budget included changes to long-term care fees and the drug plan. The $850 semi-annual deductible was removed from the drug plan and people must now pay the full cost of their pharmaceuticals, unless the expenditures are more than 3.4 percent of their family income (adjusted for the number of dependents under 18 years of age). If their expenditures exceed this amount, they can apply for special assistance from the government for a reduced co-payment, the amount of which depends on the family's income and the type of drug being purchased. Approximately 111,591 families receive drug plan benefits (Saskatchewan Health, 2001b, p. 42) and the deductible change has meant that some 11,000 families are paying a greater share of their drug costs than in previous years (Saskatchewan Health, 2002a).

However, the planned increases in long-term care fees—which would have generated almost $15 million annually for the government—have been cancelled (Government of Saskatchewan, 2002a). The existing fee structure was considered to be "in line with public expectations that long-term care should be treated as part of the province's medicare system," according to Saskatchewan Premier Lorne Calvert, who expects that the fee shortfall will be covered by higher provincial rev-

Table 3.1: Saskatchewan Health Spending as a Percentage of Provincial Program Spending

	1997	1998	1999	2000	2001*	2002
Nominal Health Spending ($ Millions)	1,608.0	1,677.2	1,774.6	1,955.7	2,075.6	2,199.8
Percentage of Provincial Program Spending	37.4	38.4	36.7	38.5	39.5	38.4

* Includes $49.8 million from the federal Health Transition Fund
Source: Saskatchewan Health, 2002d, p. 41.

Table 3.2: Allocation of Planned Spending by the Saskatchewan Government in the 2002/2003 Budget

	Percent of Total General Revenue Fund (GRF) Operating Expenditure ($5.69 Billion)
Health	41%
Education (Includes Post-Secondary Education and Skills Training)	19%
Social Services	11%
Agriculture	5%
Highways and Transportation	5%
Other Agencies and Departments	19%

Source: Saskatchewan Finance, 2002, p. 26.

enues, or taken from the Highways and Transportation budget (Government of Saskatchewan, 2002a).

Table 3.3 shows that all categories of health funding in Saskatchewan increased by 23 percent or more from 1996/1997 to 2001/2002, except that of capital spending, which saw a decrease of 16 percent during that time. The prescription drug plan and other special assistance programs saw the second largest increase in funding: 69 percent over the five years up to 2001/2002.

Overall, physicians account for 16.6 percent of the budget, while drugs account for 6.6 (table 3.5 for dollar figures). Hospitals still comprise the largest portion of the health care budget, at 35.0 percent. This situation is unlikely to change, as the government's health action plan does not entail any hospital closures.

Given the Canada Health Act, it is not surprising that the majority of hospital funding comes from the government (95.8 percent), that the government is the main funder of other health institutions (78.1 percent) and that it pays nearly 100 percent of physician costs (tables 3.5 and 3.6). In only two categories does private financing comprise the majority expenditure: other professionals (chiropractors, naturopaths, and other practitioners) and drugs. In these two categories, private financing accounts for 81.6 percent and 64.6 percent, respectively.

Table 3.7 and figure 1 show per capita health spending in Canada. The Saskatchewan government spends $2,642 per capita on health care, which is more than the Canadian average ($2,526) and which makes the provincial government the fifth highest spender after Manitoba ($2,965), British Columbia ($2,812), Newfoundland and Labra-

Table 3.3: Change in Provincial Health Funding, Saskatchewan

Major Categories	2001/2002 ($ 000s)	One-Year Increase in Nominal Spending	Five-Year Increase in Nominal Spending
Acute Care, Rehabilitation and Emergency Response	820,446	8%	39%
Long-Term Care	326,284	1%	30%
Home-Based and Community Care	215,623	6%	23%
Provincial Health Services (Provincial Lab, Health Research, Cancer Agency, Saskatchewan Health Information Network, Immunizations, Canadian Blood Agency)	126,177	20%	131%
Physicians' Services, Medical Education, and Other Medical Services (Chiropractic, Optometry, Dental, Out-of-Province)	482,602	7%	35%
Prescription Drug Plan and Other Special Assistance Programs	159,072	13%	69%
Capital and Other	69,549	65%	-16%
Total	2,199,753	6%	37%

Source: Saskatchewan Health, 2002d, p. 42.

Table 3.4: Health Expenditure by Use of Funds in Saskatchewan, 2002 (forecast) (Total Public and Private Spending on Health Care)

	Expenditures ($millions)	Percent of Total
Hospitals	977.8	28.0
Other Institutions	453.7	13.0
Physicians	444.1	12.7
Other Professionals	328.5	9.4
Drugs	500.5	14.3
Capital	99.6	2.9
Public Health and Administration	344.3	9.9
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	341.1	9.8
Total	3,489.7	100.0

Source: Canadian Institute for Health Information, 2002d.

Table 3.5: Health Expenditure by Use of Funds in Saskatchewan, 2002 (forecast) ($millions)

	Public	Private	Total
Hospitals	936.8	41.0	977.8
Other Institutions	354.2	99.6	453.7
Physicians	442.7	1.4	444.1
Other Professionals	60.5	268.0	328.5
Drugs	177.2	323.2	500.5
Capital	95.0	4.6	99.6
Public Health and Administration	344.3	0.0	344.3
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	262.6	78.6	341.1
Total	2,673.4	816.4	3,489.7

Source: Canadian Institute for Health Information, 2002d.

Table 3.6: Health Expenditure by Use of Funds in Saskatchewan and Canada, 2002 (forecast)–Percent Public and Private Spending on Health Care (percentage)

	Saskatchewan		Canada	
	Public	Private	Public	Private
Hospitals	95.8	4.2	90.9	9.1
Other Institutions	78.1	21.9	74.1	25.9
Physicians	99.7	0.3	98.6	1.4
Other Professionals	18.4	81.6	9.5	90.5
Drugs	35.4	64.6	36.2	63.8
Capital	95.4	4.6	89.4	10.6
Public Health and Administration	100.0	0.0	100.0	0.0
Other Health Spending (includes such expenditures as home care, ambulances, prostheses, research)	77.0	23.0	67.7	32.3
Total	76.6	23.4	70.7	29.3

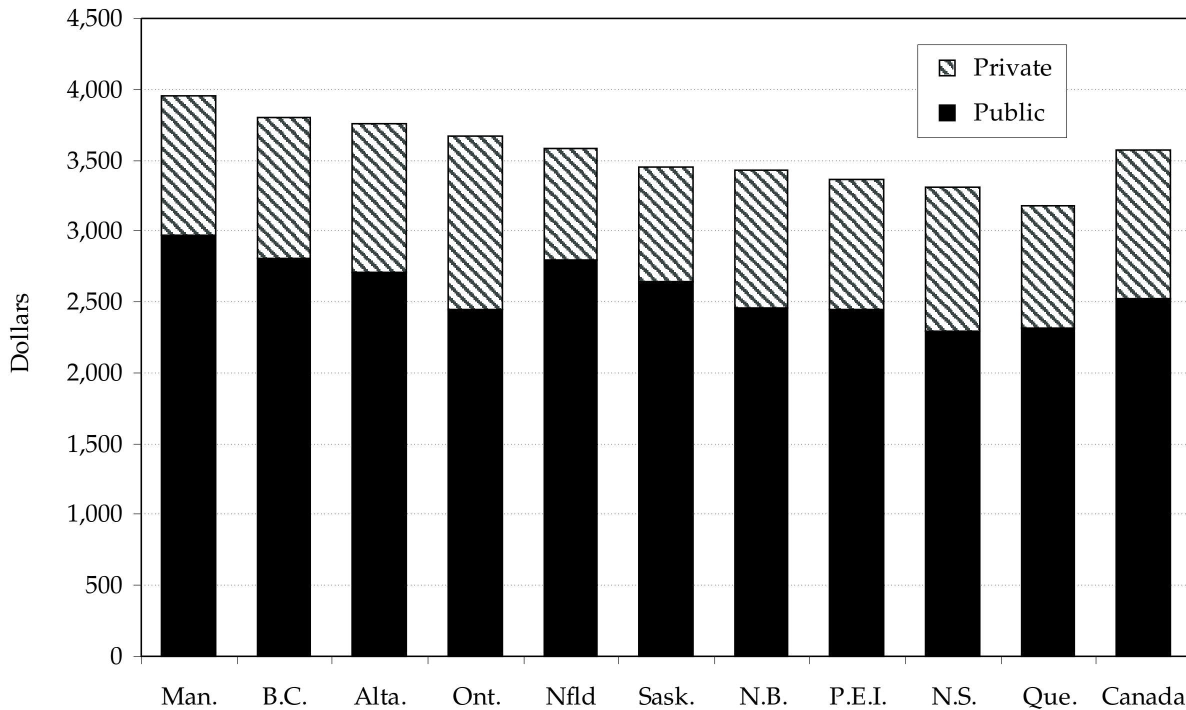
Source: Canadian Institute for Health Information, 2002d; authors' calculations.

Table 3.7: Per Capita Health Expenditure, 2002 (forecast)

	Public ($)	Private ($)	Total ($)
Newfoundland and Labrador	2,800.31	786.24	3,586.55
Prince Edward Island	2,448.63	916.02	3,364.66
Nova Scotia	2,296.26	1,007.77	3,304.02
New Brunswick	2,459.66	972.58	3,432.23
Quebec	2,314.34	867.52	3,181.85
Ontario	2,447.63	1,226.24	3,673.86
Manitoba	2,965.47	989.14	3,954.61
Saskatchewan	2,642.19	806.83	3,449.01
Alberta	2,711.57	1,049.46	3,761.03
British Columbia	2,812.07	986.42	3,798.49
Yukon Territory	3,904.08	663.81	4,567.89
Northwest Territories	5,588.28	553.75	6,142.03
Nunavut	6,152.44	314.14	6,466.58
Canada	2,526.06	1,046.01	3,572.07

Source: Canadian Institute for Health Information, 2002d.

Figure 1: Health Spending Per Capita 2002
(Canadian Institute for Health Information forecast)



Source: Canadian Institute for Health Information, 2002d.

dor ($2,800), and Alberta ($2,712). Per capita private health care expenditures in Saskatchewan, at $807, are lower than the national average ($1,046), with the province ranking ninth in private spending among the provinces. In terms of total health spending, Saskatchewan's expendi-

tures ($3,449) are below the national average ($3,572), with the sixth highest per capita expenditures of the provinces.

Using 2000 data, the Canadian Institute for Health Information (CIHI) calculated provincial government spending adjusted for provincial differences in demographics. Saskatchewan's population is, on average, older than that of most other provinces—one in seven residents is over the age of 65 (Saskatchewan Health, 2001a, p. 40). Therefore, in the age- and sex-adjusted ranking government of spending on health care, Saskatchewan falls to sixth spot, after Newfoundland and Labrador, Alberta, Manitoba, British Columbia, and Ontario (table 3.8).

CIHI expects nominal health spending per capita to increase at a faster rate in Saskatchewan than the national average. According to the CIHI data, the expected increase from 2000/2001 to 2001/2002 is 8.5 percent in Saskatchewan compared to an expected increase of 5.1 percent for Canada as a whole (Health Services Utilization and Research Commission, 2001/2002).

Table 3.8: Age- and Sex-Adjusted Provincial Government Health Expenditures Per Capita by Province in 2000, Ranked Highest to Lowest

Newfoundland and Labrador	$2,379
Alberta	$2,242
Manitoba	$2,196
British Columbia	$2,191
Ontario	$2,068
Saskatchewan	$1,915
Quebec	$1,906
New Brunswick	$1,890
Nova Scotia	$1,812
Prince Edward Island	$1,793

Source: Canadian Institute for Health Information, 2002d, p.31.

Access

Statistics Canada recently released *Access to Health Care Services in Canada, 2001*, which examines access to health care services in Canada, including 24-hour, 7-day-a-week access to first contact services and specialized services, highlighting barriers to care and waiting times. In the survey, a higher percentage of the Saskatchewan population (15 and over) reported that they had a regular family physician than the national average, 90.2 percent versus 87.7 percent. However, a slightly lower percent of the Saskatchewan population (91.9 percent) rated the care they received from their family physician as good or excellent than the Canadian average (92.2 percent), and slightly more Saskatchewan residents said that they had unmet health needs, 11.3 percent versus Canada's 11 percent.

Looking at the distribution of waiting times, *Access to Health Care* found that 87.1 percent of Saskatchewan respondents who had waited for specialist services reported wait times for specialist visits of three months or less (the Canadian average was 88.3 percent). Approximately 75.8 percent of the waits for non-emergency surgeries in Saskatchewan were three months or less compared to the Canadian average of 80.8 percent (data for this category are to be interpreted with caution for Saskatchewan because of high sampling variability). Finally, the percent of wait times for diagnostic tests that fell into the one-to-three-month category was 46.5 percent for Saskatchewan and 36.1 percent for Canada.

There are some provincial waiting list measures and Saskatchewan Health introduced the $12 million Waitlist Fund in 1999 to help districts increase surgical volumes (Saskatchewan Health, 2001b). The government is developing a computerized booking system, examining the way in which procedures are booked, and creating a

standard set of criteria to rank patients for elective surgery—the action plan allocates additional funding for the reduction of waiting lists. As well, Saskatchewan is participating in the Western Canada Wait List Project, started in 1999, with 19 partner organizations from the four western provinces. The project aim is to develop and test clinical assessment tools to help physicians prioritize patients for certain procedures: total hip and/or knee replacement, cataract surgery, general surgery, children's mental health services, and diagnostic magnetic resonance imager (MRI) scans.

According to Saskatchewan Health, almost half of the patients on wait lists for elective surgery in the province are waiting for either eye or orthopaedic surgery, and 60 percent of the people waiting longer than six months for surgery are waiting for these types of surgery (i.e. cataract, or hip or knee replacements). An analysis of waiting times in Regina and Saskatoon showed that almost two-thirds of patients received their surgery in less than two months in 2000 (Saskatchewan Health, 2001b, p. 44).

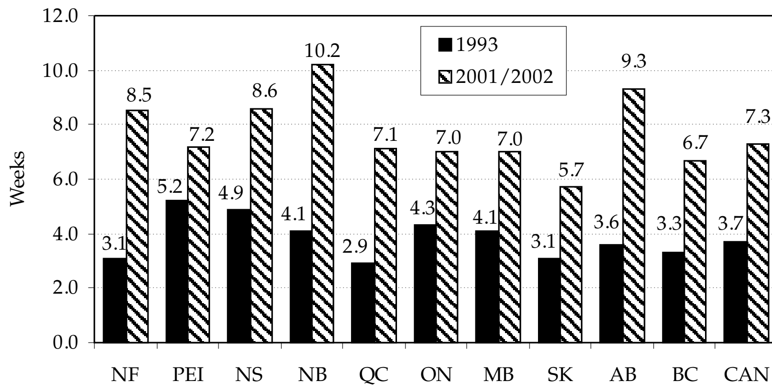
Waiting Your Turn: Hospital Waiting Lists in Canada, published by The Fraser Institute, is still the only comprehensive, nationwide measure of waiting lists in Canada. Published since 1991, *Waiting Your Turn* surveys specialist physicians across the country about their average waiting times for a number of elective procedures, with the exception of cardiovascular surgery where emergent, urgent, and elective waits are measured. Among the specialists questioned are general surgeons, orthopaedic surgeons, ophthalmologists, oncologists, cardiovascular surgeons and seven other specialties. Among the included procedures are coronary artery bypass, radiotherapy, hip and knee replacements, cataract removal, and many others. *Waiting Your Turn* measures a wait in two parts: from the time a general practitioner (GP) refers a patient to a specialist and the patient receives an appointment with the specialist, and from the specialist visit to the patient's receipt of treatment for their condition. Figure 2 shows the first part of the wait, figure 3 the second, and figure 4 the total wait from GP referral to treatment.

Saskatchewan has waiting times comparable to other provinces for the GP-to-specialist portion of the wait measured. However, for treatment after having seen a specialist, Saskatchewan residents have the longest waits in Canada by far, at 26.9 weeks in 2001/2002 versus the next worst province, British Columbia, in which residents wait 11.6 weeks for treatment. The Canadian average was 9.2 weeks from specialist to treatment (figure 3). As a result, Saskatchewan has the longest total waits for treatment from GP referral, at 32.6 weeks, up from 9.8 weeks in 1993 (figure 4).

Among the trouble spots recognized by the Saskatchewan government and the Western Canada Wait List Project are hip and/or knee replacements, cataract surgeries and waits for MRIs. According to *Waiting Your Turn*, Saskatchewan has extremely long waits for these procedures: 116 weeks from specialist to treatment for arthroplasty (hip, knee, ankle, or shoulder) in Saskatchewan (British Columbia has the next longest wait at 45 weeks); 52 weeks for cataract removal (Manitoba has the next longest wait at 24.5 weeks); and a 14 week wait for an MRI (versus 20 weeks in Newfoundland and Labrador and a Canadian average of 12.4 weeks). Saskatchewan has the largest proportion of waiting times that fall into the one-year plus range; 33.2 percent as compared to Nova Scotia (5.3 percent), which has the next highest percentage of waits longer than one year.

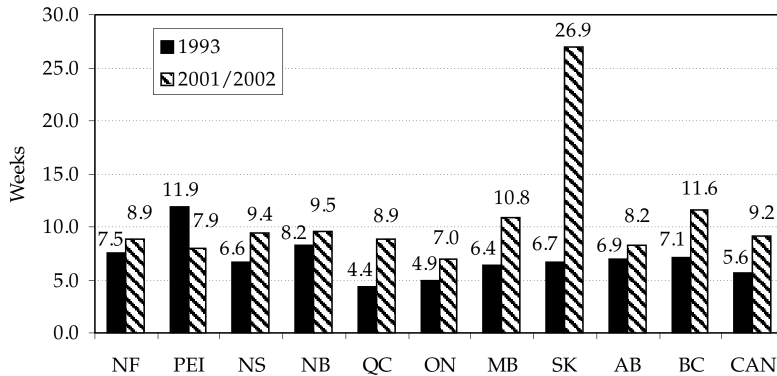
An interesting note to these waiting times is that Saskatchewan has among the highest rates of hip

Figure 2: Median Wait Times Between Referral by a General Practitioner and Appointment with Specialist, 1993-2001/02



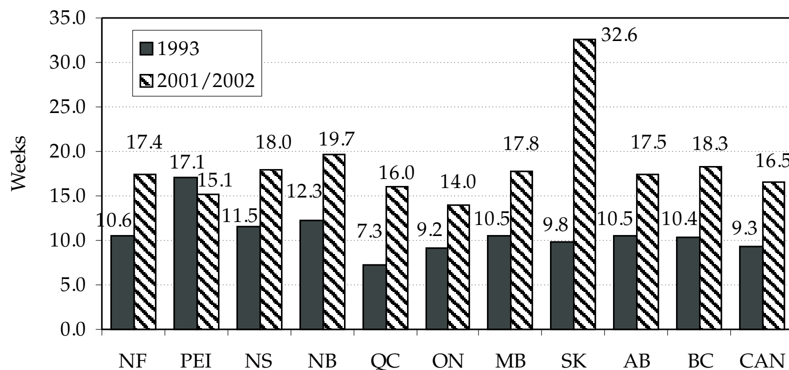
Source: Esmail and Walker, 2002, p. 42.

Figure 3: Median Wait Times Between Appointment with Specialist and Treatment, 1993-2001/02



Source: Esmail and Walker, 2002, p. 43.

Figure 4: Median Wait Times Between Referral by a General Practitioner and Treatment, 1993-2001/02



Source: Esmail and Walker, 2002, p. 42.

and knee replacements in the country (table 3.9). As well, cataract surgery rates are relatively high in Saskatchewan and the number of surgeries of all types increased from 80,000 in 1989/1990 to 93,000 in 1999/2000, with little increase in the overall provincial population (Saskatchewan Health, 2001b, p. 20).

With respect to the availability of such diagnostic tools as MRIs, Saskatchewan compares favorably to the Canadian average, while Canada, including Saskatchewan, fares poorly relative to other industrialized countries (table 3.10). Saskatchewan has three operational MRIs and nine computerized tomography (CT) scanners (CCOHTA, 2002). A comparison of provincial access to health technology shows that Saskatchewan ranks eighth of 10 provinces for access to CT scanners and fifth of 9 provinces for access to MRI machines (table 3.11). In both cases, Saskatchewan has worse access than the Canadian average.

Saskatchewan also has nearly three acute care beds for each thousand residents, whereas larger provinces such as Ontario and British Columbia have fewer than two beds for each thousand residents (Commission on Medicare, 2001, p. 26). It is not surprising, then, that Saskatchewan residents use hospitals more than other Canadians: at a rate 38 percent higher than the national average (table 3.12). They also spend 11 percent more days as hospital inpatients than do other Canadians on

Table 3.9: Rates of Hip and Knee Replacement Surgery, 1999

	Age-standardized rate of total hip replacements on inpatients in acute care hospitals (per 100,000 population)	Age-standardized rate of total knee replacements on inpatients in acute care hospitals (per 100,000 population)
Newfoundland and Labrador	35.5	36.2
Prince Edward Island	63.5	67.1
Nova Scotia	76.4	99.1
New Brunswick	60.5	75.8
Quebec	36.0	34.2
Ontario	66.8	78.2
Manitoba	74.2	94.5
Saskatchewan	71.1	71.4
Alberta	74.5	75.8
British Columbia	64.2	65.0
Canada	59.5	65.5

Source: Canadian Institute for Health Information, 2002b.

Table 3.10: Computerized Tomography (CT) Scanners and Magnetic Resonance Imagers (MRIs) Per Million Population, 2000-01 *[NADEEM, PLEASE CHECK]*

	Saskatchewan	Canadian average	OECD average[1]
CT Scanners	8.2	8.2	16.2
MRIs	3.1	2.5	5.8

[1]The OECD average includes only those countries with universal access health care systems.
Sources: OECD, 2002; Government of Saskatchewan, 2002d; Saskatchewan Health, 2001b; authors' calculations. Canadian and OECD figures are for 2000 and Saskatchewan figures are for 2001.

Table 3.11: Population Per Unit, Canadian Provinces, 2002

	CT-Scanners			MRI		
	# of Units	Population Per Unit	Rank	# of Units	Population Per Unit	Rank
BC	37	110,701	7	11	372,358	6
AB	24	127,677	9	18	170,236	2
SK	9	112,865	8	3	338,594	5
MB	13	88,464	6	3	383,345	7
ON	91	130,488	10	44	269,874	3
QC*	87	85,178	5	23	322,196	4
NB	9	84,120	4	5	151,415	1
NS	14	67,335	2	2	471,346	8
PE	2	69,257	3	0	—	—
NL	9	59,307	1	1	533,761	9
Canada	296	105,006	—	110	282,563	—
Canada (without Quebec)	209	113,260	—	87	272,085	—

*The CCOHTA states that Quebec data is under reported.
Source: Canadian Coordinating Office for Health Technology Assessment (2002). *National Inventory of Selected Imaging Equipment*. Available on the Internet at *www.ccohta.ca*.

Table 3.12: Hospital Visits per 1,000 Residents, for Selected Provinces, 1998/1999 (Adjusted for Age and Sex), Ranked Highest to Lowest

Saskatchewan	133.4
Manitoba	112.8
Alberta	107.0
British Columbia	94.5
Ontario	87.9
Canadian Average	96.7

Source: Commission on Medicare, 2001, p.27.

average, using 1998/1999 data (Saskatchewan Health, 2001b, p. 19). However, the average acute care hospital stay declined from 7.2 days in 1989/1990 to 5.6 days in 1999/2000, while the total number of day surgeries performed grew 16 percent over that period (Saskatchewan Health, 2001b, p. 19).

Looking at the number of physicians per 100,000, which is a common way to compare the supply of physicians across jurisdictions, Saskatchewan has seen more than average growth since 1996 (table 3.13). A 6.1 percent increase in family doctors per 100,000 population and a 6.9 percent increase in specialists per 100,000 population is impressive given the national averages of -0.3 percent and 3.7 percent, respectively. However, Saskatchewan has fewer family doctors as a proportion of its population than the national average and the second lowest proportion of specialists.

As well, both Canada and Saskatchewan rate poorly compared to other countries in terms of physicians per 1,000 population. According to Organization for Economic Co-operation and Development (OECD) data,[1] Canada's 1.8 doctors per 1,000 population put the country at sixteenth of 20 countries in 2000; Germany ranked first with 3.4 doctors per 1,000 population, and Turkey last with 1.3 (OECD, 2002). Saskatchewan's rate of 1.5 doctors per 1,000 population in 2000 (extrapolated from table 3.13) would have put it at eighteenth in the OECD ranking, tied with New Zealand, ahead of only the Netherlands and Turkey.

Table 3.13: Number of Physicians per 100,000 Population by Physician Type, 2000

	Family Medicine		Specialists	
	2000	% Change (1996-2000)	2000	% Change (1996-2000)
Newfoundland and Labrador	106	4.8	66	2.8
Prince Edward Island	75	4.1	52	0.9
Nova Scotia	101	2.2	100	14.1
New Brunswick	90	2.1	63	2.8
Quebec	106	2.2	108	2.2
Ontario	85	-4.2	95	3.3
Manitoba	92	6.0	89	3.0
Saskatchewan	91	6.1	62	6.9
Alberta	86	1.0	80	7.8
British Columbia	106	0.8	88	3.2
Canada	94	-0.3	93	3.7

Source: Canadian Institute for Health Information, 2002c.

1 Only those countries with universal access health care systems are included in the ranking. The United States and Mexico do not have universal access health care systems, and thus have not been included for comparison in this document.

And, as in other provinces, the medical expertise in Saskatchewan gravitates to the urban regions. In 1999, the number of family physicians per 100,000 population was 100 in Regina, 107 in Saskatoon and 92 for the province as a whole: the number of specialists per 100,000 population was 76 in Regina, 130 in Saskatoon and 61 for the province (Canadian Institute for Health Information, 2002b).

The number of registered nurses (RNs) per 10,000 population saw little change in Saskatchewan, while it fell in most parts of Canada between 1994 and 2000 (table 3.14). However, according to the Saskatchewan Registered Nurses' Association (SRNA), the total number of practising nurses in Saskatchewan decreased from 9,511 in 1990 to 8,665 as of mid-2001; a decrease of 9 percent (Saskatchewan Registered Nurses' Association, 2001). SRNA data show that half of the nurses leaving Saskatchewan head to Alberta, while 16 percent go to the United States. The association claims that the out-migration is the result of the loss of full-time nursing positions, dissatisfaction with the workplace and working conditions, and lack of satisfactory remuneration, recognition and support for nurses in the province.

Table 3.14: Number of Registered Nurses per 10,000 Population, 2000

	1994	2000
Newfoundland and Labrador	90.7	100.2
Prince Edward Island	86.5	90.3
Nova Scotia	98.8	92.3
New Brunswick	101.2	97.4
Quebec	84.7	79.6
Ontario	74.7	69.7
Manitoba	89.6	87.5
Saskatchewan	83.9	83.5
Alberta	80.3	73.6
British Columbia	73.8	68.1
Canada	80.3	75.4

Source: Canadian Institute for Health Information, 2002c.

Quality

One of the many measures of health system quality is public satisfaction. According to a January 2001 public opinion survey, 85 percent of Saskatchewan residents rated the quality of services they had *received* as good or excellent. The general public's perception of system quality is lower, with 65 percent describing it as good or excellent (Saskatchewan Health, 2001b, p. 16). As well, the proportion of Saskatchewan residents who rated their health status as very good or excellent was 57 percent in 2000/2001, which was below the national average of 61 percent (Saskatchewan Health, 2002c, p. 4).

In terms of health status measures, life expectancy at birth in Saskatchewan was 78.5 years in 1999, which is slightly less than the Canadian average (79 years), and life expectancy at age 65 was 18.6 years in 1999, which is about equal to the national average of 18.5 years (Statistics Canada, 2002e). Saskatchewan's disability-free life expectancy is in line with Canada's: it was 68.3 years in 1996 compared to the Canadian expectancy of 68.6 years (Statistics Canada, 2002c).

Table 3.15 shows how Saskatchewan's mortality rates compare to the Canadian average. While Saskatchewan has fewer deaths per 100,000 people from all types of cancer and from cardiovascular disease than the Canadian average, the province has a higher infant mortality rate (6.3 deaths per 1,000 live births) than the Canadian average of 5.3 deaths per 1,000 live births.

In Saskatchewan, the age-standardized rate of hip fractures for seniors (65 and older) is lower than that of most provinces except Nova Scotia and Quebec (table 3.16). However, Saskatchewan's rate of pneumonia and influenza hospitalizations for seniors is the highest in Canada (table 3.16). These two measures can be used to approxi-

Table 3.15: Mortality Rates, Canadian Average versus Saskatchewan

	Saskatchewan	Canada
Number of deaths per 100,000 people from all types of cancer (1997)	167.4	181.4
Number of deaths per 100,000 people from cardiovascular disease (1997)	231.1	238.8
Infant mortality rate (per 1,000 live births, 1999)	6.3	5.3

Source: HSURC, 2000a, p. 8; Statistics Canada, 2002d.

Table 3.16: Rates of Hip Fractures and Pneumonia/Flu Hospitalizations, 1999

	Age-Standardized Rate of Hip Fractures per 100,000 Population 65 and older	Pneumonia and Influenza Hospitalization per 100,000 Population 65 and older
Newfoundland and Labrador	618	1,450
Prince Edward Island	641	1,687
Nova Scotia	538	1,515
New Brunswick	428	1,779
Quebec	521	1,036
Ontario	601	1,235
Manitoba	597	1,625
Saskatchewan	556	1,793
Alberta	604	1,744
British Columbia	611	1,230
Canada	575	1,297

Source: Canadian Institute for Health Information, 2002b.

mate the quality of preventive care in a province and, in this respect, Saskatchewan has mixed results.

To evaluate the quality of acute care, the proportion of women delivering babies by Caesarian section and the hysterectomy rate have been used as measures of the amount of "unnecessary" surgery being performed. While this concept can be debated, table 3.17 uses these two indicators as examples of surgeries that are more likely than other surgical procedures to be deemed inappropriate. Saskatchewan's C-section rate (16.7 per 100,000 population) is lower than the national average (19.9)—which is positive—but on the negative side, the province's hysterectomy rate (515 per 100,000 population) is higher than the national average of 452. The hysterectomy rates for Regina (465) and Saskatoon (472) are lower than that of Saskatchewan as a whole and closer to

Table 3.17: Numbers of Surgeries that are More Likely to be Deemed Inappropriate, 1999

	Proportion of Women Delivering Babies in Acute Care Hospitals by Caesarean Section	Hysterectomy Rate per 100,000 women aged 20 and older	Age-Standardized Inpatient Acute Care Hospital rate for Conditions Where Appropriate Ambulatory Care Prevents or Reduces the Need for Hospital Admissions (per 100,000 Population)
Newfoundland and Labrador	23.9	658	558
Prince Edward Island	22.1	619	1,095
Nova Scotia	20.9	581	450
New Brunswick	24.6	791	642
Quebec	17.7	427	355
Ontario	20.2	431	345
Manitoba	18.3	467	495
Saskatchewan	16.7	515	590
Alberta	19.5	459	493
British Columbia	23.2	414	399
Canada	19.9	452	401

Source: Canadian Institute for Health Information, 2002b.

the Canadian rate (Canadian Institute for Health Information, 2002b).

Compared to other regions in Canada, Regina and Saskatoon have lower readmission rates than the national average for heart attacks at 7 percent (Canadian Institute for Health Information, 2002, p. 46). The cities have mortality rates following a heart attack (within 30 days of an initial hospitalization for a heart attack) between 1997/1998 and 1999/2000 that exceed the national average of 12.6 percent by at least 1 percent, but they have lower than the national average rate (19.2 percent) of mortality within 30 days of an initial hospitalization for a stroke (Canadian Institute for Health Information, 2002, pp. 42, 44). Regina has lower than the Canadian average of a 6.4 percent readmission rate for asthma, while Saskatoon exceeds that national average by approximately 4 percent (Canadian Institute for Health Information, 2002, p. 47).

Conclusion

Relative to other provinces, Saskatchewan's health care system is neither exemplary nor appalling. One notable problem is the occurrence of exceptionally long waiting times from specialist visit to treatment, especially for arthroplasty and cataract patients—waits that are not being alleviated by relatively higher rates of surgery. Otherwise, Saskatchewan manages a middle-of-the-road performance in spending, with middle-of-the-road outcomes, but a low rank for access.

Relative to other OECD countries, however, Saskatchewan ranks poorly in terms of access to health services and spending. Canada, as a whole, manages to outspend all other universal access health care systems in the OECD while its ranking for providing access to health services for the population is very low (Esmail and Walker, 2002a). A middle-of-the-road performance within Canada, then, is not one that appears to serve the population's needs or provide value for money. In fact, no system in Canada meets these important goals.

What is clear from a review of its health care system is that Saskatchewan has serious hurdles to overcome in providing access to health services. Further, Saskatchewan turns in a mediocre performance in a country that, as a whole, performs poorly yet costs a great deal. Can the Fyke report's recommendations and the reforms emerging from those findings deal with any of the current health care problems in Saskatchewan?

Section 4: Saskatchewan's Action Plan for Health Care

In its health plan, the Saskatchewan government's stated commitment to the people of Saskatchewan is to provide an accessible, sustainable, quality health care system. It plans to do this by focusing on four areas of change: (1) doing more to support good health and prevent illness, (2) providing better access to health services, (3) improving health workplaces and addressing shortages of key health providers and (4) placing a greater emphasis on quality, efficiency and accountability.

Change 1: Doing more to support good health and prevent illness

The action plan includes:

- Primary health care teams of doctors, nurses and other health providers will be established with the goal that 25 percent of doctors will be working in non-fee-for-service group practices within four years and 100 percent will be doing so within 10 years.
- Saskatchewan Health will work with the health authorities on a health promotion strategy that targets programs and funding to where they will be the most successful. Little detail is given as to the definition of "success" and the process by which it will be measured or attained.
- A northern and Aboriginal health strategy is being developed by the northern communities with the support of Saskatchewan Health. It is to be based on the principles of health promotion and disease prevention, recognizing the circumstances that have led to higher rates of accidents and illness in the north.

Change 2: Providing better access to heath services

The action plan makes the following points:

- Primary health care teams are part of this change, too. The action plan refers to 20 demonstration projects that are serving more than 80,000 people and offering the services of 44 salaried (versus fee-for-service) doctors, 21 primary care nurses and other care providers. It states that "this allows doctors to spend more time with patients who have complex health problems" (Saskatchewan Health, 2001a, p. 13), but gives no data, by whatever measures, that demonstrate the success of these demonstration projects.
- A 24-hour toll-free phone line offering immediate health advice is to be set up. According to the Commission on Medicare, province-wide telephone health services have reduced the number of emergency room visits in New Brunswick and Quebec, as well as in jurisdictions in British Columbia and Alberta (Commission on Medicare, 2001, p. 18).
- A province-wide network of community, northern, district, regional, and provincial hospitals is to be maintained: there will be no hospital closures, only a labeling of hospitals (as community, northern, etc.) according to each hospital's location and the services it provides. Whereas the Commission on Medicare recommended the conversion of up to 50 of the province's rural hospitals into health centres, the government has rejected that idea as being too "disruptive" to residents (Saskatchewan Health, 2001a, p. 2).

- More funding will be provided in an effort to reduce waiting times for surgery: increased funding to surgical centres, a province-wide surgical waiting list with guidelines, programs to recruit and retain providers, and a web site about waiting lists and other information.
- There will be increased funding to train ambulance attendants to become emergency medical technicians, a centralization of emergency services dispatch to five from 26 call centers, and the introduction of provincial regulations to minimize the cost variations in ambulance services across the province that exist because of the many providers of emergency transportation.
- The province will remove the 40-bed limit on personal care homes, provide more support for seniors in social housing, and direct funding to seniors and those with disabilities to arrange their own care.

Change 3: Improving health work places and addressing shortages of key health providers

The action plan makes the following points:

- The importance of primary health care teams in Saskatchewan Health's action plan is evident in that they are also considered to be a solution to the problems of low provider morale and shortages of health providers in the province.
- The province will increase funding to train more health providers and for students studying in selected health programs, as well as for retraining and skill upgrades, and recruitment of aboriginal people into the health care sector.
- The budget for health research and an Academic Health Sciences Network will be increased by 40 percent in the 2002/2003 budget, with further increases to follow.

Change 4: Placing a greater emphasis on quality, efficiency, and accountability

The action plan makes the following points:

- Twelve regional health authorities (RHAs) will be formed to replace 32 health districts. The responsibilities of the RHAs will be to organize, manage, and deliver health services.
- The government will clarify and strengthen the authority of the Minister of Health to set priorities for the health system, and organize, manage and deliver health services.
- Canada's first Quality Council will be established. Members to the council will be appointed and a board of experts will guide the council's activities and report to the minister of health. The council is intended to help the government make evidence-based policy decisions by, for example, evaluating new technologies, drugs, and other clinical developments, including value-for-money assessments; by promoting effective practices to the province's health professionals; by monitoring and assessing the performance of the health system; and by providing the public with information about the quality of health services in Saskatchewan.

Costs of the government's action plan

Saskatchewan plans to spend more than $2.3 billion on health care in 2002/2003 (Saskatchewan Finance, 2002, p. 4). This level of expenditure rep-

resents an increase of $129 million or 5.8 percent from the previous year's budget (Saskatchewan Health, 2002b). The additional funds are to be allocated to the following initiatives:

- Funding to health regions is to be increased by $93 million, which includes $10 million in capital funding for new medical equipment
- $3 million is to help train and recruit more health providers
- $1.5 million will go to develop a province-wide waiting list based on patient need
- $5.3 million will increase the funding for the Canadian Blood Services
- there will be a $4 million funding increase for the Saskatchewan Cancer Agency
- there will be another $4 million increase in health research funds
- $18.2 million will be spent on other aspects of the system, which, although not explicitly stated by the action plan or the provincial budget, most likely will be allocated to those reforms without costs attached, such as upgrading the training of some 80 emergency providers, the 24-hour telephone health hotline, and the formation of primary health care teams/networks.

The budget included additional patient fees that were to have been implemented to help make Saskatchewan Health's action plan more affordable. There was supposed to be a rise in the maximum monthly charge for residents in long-term care (about two-thirds of residents would see the fee rise from $1,561 to $3,875). However, this cost increase has been dropped (Government of Saskatchewan, 2002a). The other measure, which has been implemented, was the removal of the $850 semi-annual deductible on the province's drug plan, and its replacement with a ceiling on pharmaceutical spending by families (and individuals, as an individual is a family of one) of 3.4 percent of family income. Families who spend more than this ceiling can apply to the government for financial support with their co-payments, which will range from zero percent to 100 percent, depending on the family's income (adjusted for the number of dependents under 18 years of age) and the pharmaceutical being purchased.

However, the government of Saskatchewan may have to consider other methods of making the health system more affordable, as the funding increases in the 2002/2003 budget have already proven insufficient to meet the action plan's goals. In the 2003/2004 budget, an additional $185 million was allocated to health care, "boosting health care spending by 8 percent, to a record $2.5 billion" (Government of Saskatchewan, 2003).

Does the action plan appropriately address the system's problems?

Saskatchewan's action plan suffers from the same drawbacks as most other attempts by provinces to reform their health systems. The most fundamental problem is that its main solution—for everything from access, to primary care, to improved quality of services—is to spend more money without changing the overall structure of the system. Another problem is that most of the solutions lead to more centralized decision-making by the Ministry of Health, with little responsibility being placed on, and few incentives provided to, hospital administrators, physicians, other health practitioners, or patients to use resources more efficiently.

Government spending

The proportion of program spending dedicated to health care has been steadily rising in Saskatchewan for at least five years and it is unlikely that Saskatchewan will be able to sustain such increases. While the province's real per capita consolidated revenues are still higher than the national average, they have declined by 1.6 percent over the last decade, from $9,307 in 1990/1991 to $9,157 in 2000/2001; Saskatchewan is the only province to have experienced a decline (Clemens, Emes, and Esmail, 2002, p. 10).

As well, the Commission on Medicare made this warning in its report:

> Simply to maintain health services as they are, with no additional services or personnel, and no new programs, the health budget will have to grow about 6.5 percent a year merely to cover inflation, collective agreements and other cost pressures. On the other hand, government revenues to fund health are estimated to grow by a maximum of 3 percent per year, which includes the additional $175 million a year in federal funding the province will receive by 2003-04. The costs to change the health system [estimated to be $100 million] would be additional to this…. Based on these future costs and revenue estimates, a "health gap" of over $300 million is projected by the end of four years…. (Commission on Medicare, 2001, p. 75)

Saskatchewan's labour market

Adding to Saskatchewan's challenges is its poor migration record: relative to other provinces, Saskatchewan's outflow of knowledge workers and high income earners is significant and, overall, there are estimates that Saskatchewan lost about 15.1 percent of its population between 1972 and 1999 (Clemens, Emes, and Esmail, 2002, pp. 24-25).

A labour market analysis conducted for Saskatchewan Health estimated that if the current rates of attrition persisted over the following five years, the shortfall of RNs/RPNs (registered nurses/ registered psychiatric nurses) would range from 105 to 331 per year; the shortage of licensed practical nurses (LPNs) would range from 64 to 129 per year (Elliott, 1999). The analysis attributed the shortfall to such factors as a decline in the number of RPNs practicing in the province, an increase in the number of RNs eligible for retirement, and fewer RN/RPN graduates from post-secondary institutions.

A later study by the same organization, Sask Trends Monitor, on the implications of the demographic trends in Saskatchewan, came to the conclusion that retirements are going to affect the health sector in increasing numbers, at least over the short term. That is because employees in the health and social services have one of the highest average ages (41.2 years) and the largest proportion of workers aged 50 years and older (Elliott, 2001). The same study noted that the aging population will generate more health care spending (both private and public), and could potentially reduce the government's revenues (i.e., will contribute lower income and consumption tax revenues) at a time when there will be increased public pressure to provide health care services (Elliott, 2001).

Saskatchewan Health is aware of these problems and its action plan attempts to resolve them by the creation of primary care networks, more funding to train (and retrain) health providers, and through various other recruitment and retention policies.

However, the Saskatchewan Medical Association (SMA) notes "that little or no evaluation has been performed on primary care projects that have been in existence in Saskatchewan for several years. Proper evaluation should have been an essential first step before recommending a massive move in this direction" (Karras, 2001, p. 2). Nonetheless, the organization has established a primary care committee to work with Saskatchewan Health. As well, despite that the fact that most physicians in Canada are supposedly independent and self-employed businesspeople, the SMA wants to achieve in primary care reform "a centrally bargained physician contract acceptable to the medical profession" (Karras, 2002, p. 2).

With the changes in primary care, the province is hoping that the entire population will have access to primary health care teams within the next decade. It believes that the formation of primary care teams will result in not only improved patient care, but a more supportive environment that will be appealing to many providers. In these teams, family doctors will be remunerated on a contract or salary basis rather than fee-for-service. The government's hope, no doubt, is that changing the method of remuneration will result in doctors spending more time with their patients, and will enable resources to be used more efficiently and funding to be more predictable, since doctors will be paid a set amount rather than for every service they render to each patient. However, while there is evidence that changing the method of paying doctors will not result in the underprovision of services (for example, see Shortt, 2001), there is compelling evidence from around the world that replacing fee-for-service with salary or capitation (a form of salary based on the physician's patient load) reduces the services offered by providers—all services, not just "unnecessary" care or services (Ferguson, 2001).

Salary payment schemes also remove the incentive to produce beyond a minimal standard, both quantitatively and qualitatively, when compared to output-based remuneration (Feldman *et al*., 1981). Notably, Hickson, Altemeier, and Perrin (1997) found that fee-for-service physicians scheduled more visits, provided better continuity of care, and were responsible for fewer visits to the emergency room than their salaried counterparts.

In the end, salary or capitation could end up making the health system more costly:

> American evidence suggests that physicians working under comparable systems provide about 25 percent fewer office visits than do fee-for-service physicians. The one Canadian study which contains the Canadian data necessary to study the question, finds that physicians working under fee-for-service provide six more patient contact hours per week than do doctors working under other remuneration systems. On the American figures, introducing capitation would require a 30 percent increase in physician stock simply to maintain current patient access, with each of those additional physicians earning roughly what the average GP does now. That translates into a significant increase in the costs of health care, just to maintain present access. (Ferguson, 2001, p. 25)

There must be room in any payment mechanism to reward, with bonuses or other measures, high-quality performance. Mixed payment systems—combining capitation and fee-for-service, for example—can reduce some of the potential difficulties that arise under a single payment system. The capitation element can moderate the tendency towards excessive treatments that can occur under pure fee-for-service approaches, and the fee-for-service element can moderate the potential for family doctors paid by capitation to

register too many patients and under serve them (Oxley and MacFarlan, 1994).

In the hospital setting, the choice of physician compensation by the hospital depends on several factors: risk, costs of supervision, the nature of the output, and the price of medical care. If there is generous insurance coverage of hospital services and limited reimbursement of physician services, then a hospital will have more salaried physicians; if the conditions are such that a hospital wishes to provide more patient services, then they will rely more heavily on incentive compensation for staff physicians (Feldman *et al*., 1981).

Ultimately, the best remuneration systems are those that are output based. Salaried physicians, unless well supervised, will tend towards less output because their pay is not dependent on the quality or quantity of services provided. Fee-for-service payment schemes, or some mixed payment scheme that has an output-based component in areas where strict fee-for-service would not provide adequate income for physicians, are clearly the superior choice for remuneration in terms of the quantity, and possibly the quality, of care provided. Moving from a fee-for-service payment scheme to a strict salary scheme would only serve to reduce the cost-effectiveness of the health care system in Saskatchewan—costs would either rise to maintain services, or service provision would fall to maintain cost. Neither would be acceptable in a province that already operates an incredibly expensive health care system relative to other OECD countries, with exceptionally long waiting times relative to the rest of Canada.

In relation to costs, another aspect of Saskatchewan's primary care reform is to increase the participation of other health care providers, such as nurses, in the care of patients. This is often considered to be a less expensive method of care provision because of the lower costs of training such practitioners. However, as Prof. Brian Ferguson points out, the cost of educating a provider is not the primary determinant of how much they get paid:

> The ultimate determinant of how much a provider earns is the value of the services they provide. If NP [nurse practitioner] services are equivalent to MD services, the price NPs get paid for each service will rise to equal that of an MD providing the same service. This is what has happened in the US, to the point where many proponents of NPs acknowledge that they have lost their cost advantage over MDs. According to one salary survey, turned up by an internet search, the average American NP salary is about $60,000 US, which translates into about $90,000 Canadian. That's less than an MD earns, but it's not cheap, and unless Canadian salaries are in the same general range, a lot of the NPs we train here will head straight for the American market.... If those NP services are in fact of comparable quality to MD services, NPs have every right to expect to be paid as much, on a per service basis, as an MD would be paid for providing them. If that isn't the case at first, one good pay equity lawsuit will make it so. (Ferguson, 2001, p.10)

It is basic misunderstandings such as these—that paying physicians differently or that by hiring other practitioners to replace physicians will necessarily save the health system money—that shed light on the problem with a government-controlled health care system. The difficulties of micro-managing the elements of such a complex organism are myriad. As another example, the idea that Saskatchewan Health will reduce provider shortages by allocating additional funds to train more health providers—in specific areas—belies its track record in doing so with any competency.

The SMA believes that "physician supply problems are due in part to the 1991 decision by provincial governments to implement a 10 percent reduction in medical school enrolment. Supply deficiencies are particularly concerning in our province, because of the aging of our population, aging of our physician stock, high turnover rates, and heavy dependence upon recruitment of foreign doctors" (Saskatchewan Medical Association, 2002, p. 1). The Saskatchewan Registered Nurses' Association also attributes to the government some of the responsibility for the shortage of nurses, pointing to the decrease in the province of some 300 funded seats in nursing programs since the early 1990s (Saskatchewan Registered Nurses' Association, 2001).

Key issues in the 2002 labour dispute between the Health Sciences Association (HSA) and the Saskatchewan Association of Health Organizations—the longest health care strike in Saskatchewan's history—were related to wages and staff shortages (Scott, 2002a). Some 2,500 HSA workers (paramedics, pharmacists, social workers, and a variety of different types of therapists) walked off the job in mid-September 2002 and did not return to work until mid-October. During the job action, regular ongoing patient needs were not met: many people requiring physiotherapy had appointments cancelled, elective surgeries were cancelled, and people who required heart surgery and other serious surgical procedures were flown to US and other Canadian hospitals to have their operations (Baiton, 2002).

Ultimately, none of the Fyke commission's recommendations will alleviate the labour market problems in Saskatchewan. The commission hopes that salaried group practices will save the province money, improve morale, and improve access to care, while evidence and experience has shown the opposite. The Fyke report hopes that increased funding for training will alleviate the acute doctor shortage, but does not realize that it was such planning that led to the shortage in the first place. Finally, the labour strikes that have generated so much attention in recent history are a result of a monopolistic public health care system that creates incentives to withdraw services and deliberately leave patients stranded in order to increase wages (McMahon and Zelder, 2002). Such fundamental problems cannot be resolved by continued commitment to the same system.

Rationing access to care

Front-line workers and patients are the ones who most have to deal with governments' attempts to manage the system. The SRNA notes that, each week, approximately 8.5 percent of the already limited nursing workforce in Saskatchewan is absent due to illness stemming from fatigue at consistently having to work overtime and other job stresses (Saskatchewan Registered Nurses' Association, 2001). The SMA points to health care reform and fiscal restraint as the sources of low provider morale, giving the example of rationing, which "has reached levels which threaten the professional integrity and morale of most practicing physicians and compromises their ability to provide reasonable patient care" (Saskatchewan Medical Association, 2002, p. 1).

Unfortunately, the Saskatchewan government's answer of increased funding likely will not achieve any permanent reduction in waiting times or increased patient access to the system. Numerous times, provincial governments have provided more money to health care in order to reduce waiting lists, yet the lists continue to grow in Canada: from 9.3 weeks from GP to treatment in 1993 to 16.5 weeks in 2001/2002 (Esmail and Walker, 2002b). According to at least one study, conducted by Dr. Martin Zelder, then-director of

health research at The Fraser Institute, additional health spending did not result in reduced waiting times or increased rates of treatment by specialists from 1993 and 1998 (Zelder, 2000c). Another, more recent study based on data from 1993 to 2001, suggests that increased health care spending, unless spent specifically on doctors' services or pharmaceuticals, is in fact correlated with increased waiting times (Esmail, 2003). Estimates are that Canadians were waiting for almost 1.1 million elective procedures in 2001/2002 (Esmail and Walker, 2002b) and that, in 2001, 1.4 million Canadians experienced difficulty getting specialist services such as diagnostic testing and non-emergency surgery (Statistics Canada, 2002a).

In Saskatchewan in 2001/2002, residents were waiting for 101,776 procedures, which represent about 10 percent of the population if one procedure is equivalent to one patient waiting, compared to a national average of 3.5 percent. Saskatchewan's waiting times, from GP to treatment, have gone from 9.8 weeks in 1993 to 32.6 weeks in 2001/2002 (Esmail and Walker, 2002b). At the same, the total annual number of surgeries in the province has gone up by about 16 percent compared to 10 years ago (Saskatchewan Health, 2001a). In 1997/1998, in a list of 16 categories of surgical procedures, Saskatchewan's age-adjusted rate was higher than the national average in 12 categories: among the western provinces for these 16 categories, Saskatchewan had the highest rate in 11, the second-highest in 4, and the lowest in one (Commission on Medicare, 2001, p. 26).

Given that Saskatchewan has relatively high service rates, yet suffers from relatively long wait lists, it is unclear how more funding, in an attempt to increase surgical capacity, is going to solve Saskatchewan's problems. While a province-wide waiting list and the creation of a waiting list web site may help co-ordinate information, they would be more helpful in a system where patients had more choice where, and from whom, they received specialist services, and in which providers (hospitals and specialist physicians) had to compete for patients.

Hospitals

About $937 million, or 35.0 percent of the health care budget in Saskatchewan, goes to hospitals (table 3.5), and spending on acute care, emergency response, and rehabilitation has increased by 39 percent over the last five years (table 3.3). Saskatchewan has 67 hospitals in 64 communities, a rehabilitation centre in Regina, a provincial psychiatric hospital in North Battleford, as well as three other hospitals operating as health centres (Saskatchewan Health, 2001a). The Commission on Medicare determined that many of the small hospitals could take on the role of primary health centres, which would be open 8-12 hours a day. Acute care services, meanwhile, would be offered in fewer locations where they could be strengthened and improved for residents of the whole province.

Some of the reasoning behind the commission's recommendation is that several studies have shown that there are better surgical outcomes in facilities with higher volumes of a particular procedure: in the studies, higher-volume hospitals tend to have lower risk-adjusted mortality rates (Canadian Institute for Health Information, 2002). As well, research by the Saskatoon-based Health Services Utilization and Research Commission (HSURC) into the 1993 acute care funding cuts to rural Saskatchewan hospitals found that residents of the affected communities experienced the largest drop in death rates from 1990 to 1996 and, though hospitalization rates have declined throughout the province since 1990, they are still above the national average (Health Services Utilization and Research Commission, 1999).

Nonetheless, the government's action plan promises only to designate hospitals by the services they provide, ranging from community hospitals to provincial hospitals. Communities with fewer than 3,500 people would have a community hospital that would focus on 24/7 emergency services, general medicine, basic lab and X-ray services, and observation, assessment, convalescent, and palliative care. There would be five provincial hospitals, three in Saskatoon and two in Regina, which would provide the full gamut of care and services. Without providing any evidence to supports its assessment, the government states in its plan that the Commission on Medicare's report "goes too far" and that "there is a need for strong community hospitals" (Saskatchewan Health, 2001a, p. 35).

The Commission's recommendation that small community hospitals should be converted to health centres, while only larger hospitals should survive seems logical when considering reductions in mortality that would result, as well as continued changes in the delivery of medicine. At present, Saskatchewan has more hospital beds per population than Ontario and British Columbia and makes more use of these hospital beds than the national average. Though the reasons for this increased use are unclear, it is fairly obvious that an increased commitment to hospitals goes against recent advances in medicine where day surgeries are more prevalent and hospital stay lengths are falling.

Health districts

The Commission on Medicare and the government's action plan agreed in their conclusion that the number of health districts in the province needed to be reduced from 32. Several of these districts have smaller populations than the provincially recommended minimum of 12,000 considered necessary to administer and deliver health services efficiently: the projections are that by 2015, 13 districts will have fewer than 14,000 residents (Health Services Utilization and Research Commission, 2001b). The government, therefore, has created 12 regional health authorities (RHAs) to replace the districts.

Twelve-member boards, appointed by the government, will govern the new RHAs. The boards will work with the government on long-term planning and co-ordination of services. They will basically act as advisory bodies, with no significant decision-making or financial authority. In fact, the action plan strengthens the role of the minister of health to set priorities for the system. As a result, the RHAs likely will not make a positive difference to the efficiency and effectiveness of the health care system in delivering services and there won't be any cost savings to the system. After all, what does it matter whether it is districts or regions that are under the control of the minister of health?

Quality council

Another reform that may prove ineffective is the creation of a Quality Council. As currently envisioned by the government, such a council would have a capacity to measure system performance but would be mainly an advisory body to government. The council would not have the authority to compel the government to take any cost-saving or population health-enhancing action, such as closing under used hospitals in smaller communities, the funds from which could perhaps be more effectively spent. At least one professional organization has voiced this concern:

> The medical profession strongly supports a health care system based upon quality and evidence-based decision making. However, the SMA is not convinced that a $20 million per year [as estimated by the

> Commission on Medicare] "super-HSURC" is the solution. If established, a Quality Council must be cost-effective and independent, with sufficient authority and accountability to accomplish the objectives [set for it]. (Karras, 2001, p. 2)

Concentration of power

Saskatchewan's action plan confirms the minister of health as the ultimate decision maker regarding health services delivery and funding. In doing so, it prevents any addition of individual initiative to the system. While many will laud this attempt to "save medicare," it ultimately will prove to hinder the program's survival. Here are two examples of how centralization of power and a lack of market mechanisms adversely affect the health care system in Saskatchewan.

Price setting

In Canada, physicians are paid a fee for each service they provide. The provincial medical society and the provincial government negotiate the overall budget for physician services in each province. The medical societies, with the input of provider groups, usually determine fees for particular services. Individual choices do not play a role in the allocation of physician services. This was made evident in Saskatchewan recently.

The Saskatchewan Medical Association has reduced the fees payable for renewal of prescriptions by phone and fax. The inclusion of prescription renewal was made possible through a separate fund negotiated in the association's current agreement with the government and it was estimated that payment of prescription renewals would cost $500,000 a year. However, actual experience indicated that if no change were made, it would cost approximately $2 million per year. Physician use of this fee code was variable, with many physicians rarely billing for this service and a smaller number billing as many as 20 per day (Karras, 2002, p. 2). Experience in other provinces and internationally has shown that, as in Saskatchewan, physicians respond to fee changes in exactly the way economic theory would predict: offer higher fees and physicians will attempt to provide higher volumes of service (Ferguson, 2001).

In other markets, if the price of a good or service is very high, fewer people will purchase that item and they will opt to go without it, or they will buy it from someone else. If the seller cannot cover their costs, they must reduce their price (in order to sell more goods), improve the product so that purchasers will value it more (and buy more of it), try other methods to stay in business, or go bankrupt. In the example of a fee for prescription renewals by phone, it wasn't the consumers of the service who paid the fee for that service—they did not decide that paying the set price was more appealing to them than going into the doctor's office. For the consumers, the call was free. Hence, if their doctor recommended that they renew their prescription by that method, they would likely do so, to save themselves time and money (no bus tickets, or gas and parking costs). Doctors were paid for each call they took by the provincial insurer, so they had an incentive to advise their patients to make the call, as an in-office patient visit would take more time and result in a lower volume of services (and fees). Neither the patient nor the doctor had any incentive to use this particular service wisely.

The problem, however, is not with fee-for-service, but fee-for-service within a third-party payer system (private or public insurance) that has no cost-sharing mechanisms. In such an arrangement, there are no measures of how much a service is actually demanded (or needed) by patients. Would patients have been willing to pay $2 million a year to avoid going to the doctor's office

to renew a prescription? In the health system as it is currently structured, there is no way to answer this question.

One employer

In Canada, physician societies negotiate with the government for the overall amount to be allocated to physician services and, hence, to physicians' incomes. Nurses' unions, hospital employees unions, and other health providers whose services are covered by the province's insurance plan all negotiate with the government for their wages. While there are hospital administrators and other bureaucrats in the Canadian system, it is the government who ultimately pays health care workers.

What this means in practice is that, if the medical society or union doesn't like the wages or fees offered by their employer and labour negotiations deteriorate, they threaten job action in the form of work slowdowns or stoppages. These actions can effectively close down most of a province's health care system. There are no alternative providers of care to whom patients can turn, so treatments are delayed and patients suffer. These costs are almost impossible to quantify, but they exist and are a consequence of the Canada Health Act's public administration principle coupled with provincial legislation prohibiting private financing of publicly insured services.

A recent SMA newsletter referred to the tense negotiating atmosphere that exists in Saskatchewan as well as other provinces across Canada:

> Prior to recently concluding an agreement, we were advised by the Yukon Medical Association of the potential need for job action to support their current contract negotiations. In response to the potential for a disruption in physician services, the Yukon government alluded to the prospect of recruiting physicians from elsewhere to cover medical needs. The Yukon Medical Association asked us to make our members aware of this threat from the Yukon government.
>
> Closer to home, our nursing colleagues recently came to a tentative agreement with Government that will hopefully improve their working conditions and make Saskatchewan more competitive with neighbouring jurisdictions. These issues will be no less important in the next round of bargaining for physicians' services which is scheduled to begin later this year (Karras, 2002).

The problem with Saskatchewan's action plan, as with any other attempt at reform in Canada, is the commitment to a monopolistic public health care system. In such a system, hospital and other support staff have the ability to halt the entire health care system with strikes, resulting in the ability to earn wage differentials above and beyond what they should normally earn in a competitive market; an effect that has been shown in British Columbia (Ramsay, 1995; Esmail, 2002). Doctors and nurses are unable to take maximum advantage of this effect because of a weaker resolve to strike, both because the withdrawal of their services can violate the commitment to medicine and caring that brought them to the profession and because of doctors' weaker bargaining tactics (McMahon and Zelder, 2002). The only way to discover what physicians, nurses, and health support staffs should be paid is to reduce their ability to hold up the entire health system for wage or benefit demands. This means moving from a single employer system to one where the employment contract is completely decentralized down to the institution level, so that a strike can only threaten the viability of a single institution and not health services for the entire population.

What the action plan did not cover

In addition to the weaknesses of many of the government's reform recommendations, there are a number of important areas that receive little or no mention in the government's action plan.

While there is $129 million in additional spending planned, there are no reforms that will ensure that the extra money will be well spent, let alone any concrete cost-saving measures offered. The government *hopes* that administrative costs will be lower with fewer RHAs, it *hopes* that the Quality Council will result in more cost-effective use of resources, and the list goes on. There is an almost total lack of reference to the drug program—which accounts for 6.6 percent of the government's health care expenditures (table 3.5)—in the action plan: "… this health plan does not prescribe changes in key areas such as the Provincial Laboratory, Health Registration and Vital Statistics, the Saskatchewan Drug Plan, or the Saskatchewan Aids to Independent Living Program (Saskatchewan Health, 2001, p. 8).

The action plan also does not consider any changes in the structure of the labour market in the health sector, despite that more than two-thirds (67 percent) of government health spending goes to paying health workers and professionals through wages and fees (Saskatchewan Health, 2001a, p. 66). The government only discusses changing the way in which it remunerates physicians, who account for 16.6 percent of total government spending on health (table 3.5). There is no examination of the effect of unionization on the flexibility of job categories and wage rates. There is talk of making the "best possible use of the skills of all health care providers" (Saskatchewan Health, 2001a, p. 67), yet there is no discussion of legislation that only permits certain providers to perform certain tasks.

The plan provides only a provisional solution, if even that, for the problems facing the health care system in Saskatchewan. Ultimately, nothing has changed in terms of the incentives faced by hospital administrators, most providers, patients and anyone else in the system. Therefore, despite the intended reforms, the government states:

> While our health plan establishes Saskatchewan at the forefront in creating a more efficient, more affordable health care system, the issue of affordability cannot be set aside. Today, we are spending more on health care in Saskatchewan than is collected through personal income taxes and the provincial sales tax. The fundamental trends that cause health care costs to grow year after year remain. Paying for the health care system we want and need will continue to be a challenge for the future. (Saskatchewan Health, 2001a, p. 68)

Saskatchewan residents should not be surprised when, a year from now, there are still excessive waiting lists, a lack of medical technology, provider shortages, minimal primary care reform, etc.

A faulty premise

The lack of inquiry into the fundamental changes required to improve the system lies within the framework of most provincial investigations of health care. The Commission on Medicare, the action plan, and other studies begin with the premise that "not only is publicly funded health care proven to be the most cost-effective model, it is also the best way to make health care equally available to all" (Saskatchewan Health, 2001a, p. 64). There is absolutely no proof to support this claim. It is a statement that is used almost as proof itself, i.e., as if saying it makes it so.

For example, the government states that its action plan “supports the Fyke Commission [on Medicare’s] conclusion that a publicly funded medicare system is the fairest, most efficient way of delivering health care” (Saskatchewan Health, 2001a, p. 4). The Commission on Medicare did no such thing; it did not investigate the statement and come to a conclusion about its validity. In fact, any exploration of this assertion was prohibited by the commission’s mandate, which included the directive to “investigate and make recommendations to ensure the long-term stewardship of a publicly funded, publicly administered medicare system” (Commission on Medicare, 2001, p. 1).

With regards to cost-effectiveness, it is not proven that Canada’s system is the best model. A country such as Singapore, for example, manages to provide care at a lower cost than Canada but has comparable health status. A glance at World Health Organization or OECD data, shows that, in terms of health status measures such as life expectancy, self-reported health status, and mortality rates, Canada fares relatively well internationally, but not always the best. The same international sources of data also show that, in terms of cost, Canada’s system is expensive when compared with other countries in the world. A recent Fraser Institute study showed that Canada has the highest age-adjusted spending on health among OECD countries with universal access health care systems, but that Canada does not rank first in health outcomes, access to care, supply of technologies, number of physicians, or any elements of system performance (Esmail and Walker, 2002a).

An Atlantic Institute for Market Studies report evaluated the growth of gross domestic product (GDP) and health expenditures in Canada and the United States from the 1970s to the late 1990s (Ferguson, 2001a). It also looked at the deficits being run by Canadian governments. The results are interesting. It is often claimed that the costs of health care in Canada were prevented from escalating uncontrollably—as they supposedly did in the United States—because of the introduction of medicare in the late 1960s. One observation of the AIMS study is that, had Canada’s economic growth been as weak as US growth through the 1970s and 1980s, for those decades Canada’s expenditures on health as a percent of GDP (national health spending/national income) would have been the highest in the world. This situation would have changed only in the 1990s, when Canada’s growth rate became weaker than that of the United States.

Ferguson concludes that the introduction of medicare in Canada happened to occur during a period in which the Canadian economy outperformed the US economy in terms of real growth rate. Therefore, Canada’s apparent success at controlling health care costs until the 1990s was “illusory. Simply put, the introduction of medicare did not introduce a period of, or efficient mechanism for, health care cost control. When it came to the question of how much of our national income we were spending on health, we weren’t particularly good, we were just lucky” (Ferguson, 2001a, p. 22).

As to the question of why it seems that the current system is so cash-strapped, Ferguson notes that the real per capita health spending by the public sector almost matches the whole real per capita deficit of all levels of government from 1970 to 1997. This suggests “that politicians of the day didn’t want to risk facing us with the tax increases that would have been necessary if we were to support not just the health care system, but the whole edifice of public expenditure without running up a hefty debt. Arguably, we put the whole of the Just Society on the national credit card” and now we are trying to pay it off (Ferguson, 2001a, p. 31).

With respect to the claim that a publicly funded system is the most equitable, there are numerous problems with this statement, too. There is a lot of evidence showing that, despite the intention of medicare to be an equitable system, lower income Canadians do not have as much access to services, nor as good survival rates, as higher income Canadians (for examples, see Blendon *et al*., 2002; Canadian Institute for Health Information, 2002; Gratzer, 2002; McMahon and Zelder, 2002; Dunlop, Coyte, and McIsaac, 2000).

As well, Canada is not the only country in the world that values universality. In terms of access to care, *all* industrialized countries have measures that attempt to ensure that their citizens receive health care when they need it, regardless of their ability to pay. Conversely, no system has successfully eliminated inequalities in health status across socioeconomic or racial groups. In Canada, Australia, the United States, and other countries, there are significant inequalities in health status between certain groups (Ramsay, 2001).

A basic lack of understanding

The main failing of most reform efforts in Canada is that they start with the same faulty premise as did Saskatchewan's: equating the *ideals* of medicare with the *structure* of medicare. There is nothing inherent about the principles of universality, comprehensiveness, accessibility, and portability that require exclusive public funding of medically necessary services. Part of the confusion, and the desire to maintain the status quo, comes from a misunderstanding about the value of market forces, such as price signals and competition. An example from Saskatchewan's Commission on Medicare illustrates this point.

In "A Tale of Three Information-Seekers," the Commission on Health Care takes readers through a hypothetical scenario. Emily wants to buy a new car, Bill needs surgery, and the Middletons want to know what they're getting for the taxes they pay to support the health system. Of these three fictional people, only Emily is able to find sufficient information: as "a savvy consumer," she searches the Internet, checks out car magazines, buyers' guides, and consumer satisfaction surveys. Emily even gets a warranty once she buys her car. "Thirty years ago, Emily would have had a much more difficult time finding any of this information. Buying a car in those days was much more of a gamble…. Quality improvement has been driven by consumer expectations and fuelled by sound evaluative data" (Commission on Medicare, 2001, p. 43).

Bill, however, is less successful in his search. Bill doesn't know much about his family doctor's qualifications, the expertise of his specialist physician (How many procedures have they done?), the types of outcomes his hospital produces, and other data, much of which "is not available to either Bill, his providers, their managers, or the provincial ministry of health. They are in a sense shopping unarmed, much like the car buyer of a few decades ago" (Commission on Medicare, 2001, p. 44). When the Middletons want to know about the new magnetic resonance imager for which their community was fundraising, they cannot get answers to such questions as How many lives would it save? or Could the money be better spent elsewhere?

The commission asks: How come Emily had such fabulous information while Bill and the Middletons remain in the dark about the health care system? It concludes:

> There are numerous quality initiatives underway in Saskatchewan's health care system. However, there is no overall framework or co-ordinating body, nor are there regular and comprehensive reports to either providers or the public… there is

> little that tells managers, the public, or providers about the quality of their labours in relation to agreed-upon goals and standards. There are no benchmarks for either utilization (how many procedures should be done in a population) or outcome (what difference should we expect from a service, what is an acceptable failure rate). (Commission on Medicare, 2001, p. 45)

There is no application of the recognition that Emily got better information because, over the last decades, quality improvement in the automotive sector "has been driven by consumer expectations." Is there an "overall framework or co-ordinating body" in the auto industry? No. There is great variability in service quality, car types, and dealers, costs, the extras offered, etc., and most of the variance is due to the industry's attempts to satisfy the different expectations and demands of different consumers. The commission fails to understand that the auto industry operates in a competitive market system and, therefore, in order to attract clientele, stay in business, and make a profit, auto dealers need to provide consumers with "fabulous information." The current health care system has no such incentives and, as such, it leaves people like Bill and the Middletons "in the dark."

The commission also notes: "It is inconceivable that American health care organizations pay less attention to quality and service than ours given their competitive insurance structure and their litigation-friendly jurisprudence" (Commission on Medicare, 2001, p. 45). It even concludes, with respect to quality, that Canada's circumstances likely are worse than the United States'. However, the commission does not follow this thought process to any logical conclusion.

It is necessary to look at more radical changes than the government is proposing in its action plan; for example, ones that break up the purchaser, provider, and regulator roles of government. Private funding can supplement the amount of money available for health care, but, more importantly, a broader role for the private sector in the funding and delivery of health care services can help provide greater competition in the health care area. It can provide incentives to increase quality and lower the cost of care. These options should not be ignored.

Section 5. The Public-Private Mix in Other Countries

All industrialized countries have mixed health systems in which both the public and private sectors contribute to financing medically necessary health care. Table 5.1 provides an overview of the market mechanisms that are in place in various countries. This section then describes briefly the health care systems in several other countries in order to generate ideas and discussion about potential models of reform for Saskatchewan.

Australia

The government accounted for 72.4 percent of health expenditures in Australia in 2000 (OECD, 2002). Its Medicare program provides "free" treatment to Medicare patients in a public hospital and free or subsidized treatment for services that are considered "clinically relevant," such as consultation fees for doctors, most surgical and therapeutic procedures performed by doctors, and public hospital services. Medicare does not

Table 5.1: Market Mechanisms in Selected Countries

Country	User Fees[1]			Contracting Out of Services to Private Sector	Purchaser-Provider Split in Public System	Private Health Insurers within Public System[2]	Private Health Care Comple-mentary to Public System[3]
	GP	Specialist	Hospital (Inpatient treatment)				
Australia	Yes	Yes	No	Yes	No	n/a	Yes
Finland	Yes**	Yes**	Yes	Yes	Yes	n/a	Yes
France	Yes*	Yes	Yes	Yes	Yes	n/a	Yes
Germany	No	No	Yes**	Yes	Yes	Yes	Yes
Ireland	Yes*	Yes*	Yes*	Yes	No	n/a	Yes
Italy	No	Yes	No	Yes	Yes	n/a	Yes
Netherlands	No	No	No	Yes	Yes	Yes	Yes
Norway	Yes**	Yes**	No	Yes	No	n/a	Yes
Sweden	Yes**	Yes**	Yes	Yes	Yes	n/a	Yes
Switzerland	Yes*	Yes*	Yes**	Yes	Yes	Yes	Yes
United Kingdom	No	No	No	Yes	Yes	n/a	Yes

[1]Indicates whether the public system charges user fees for general practitioner (GP), outpatient specialist visits (Specialist) and inpatient hospital treatment (Hospital).

*Indicates that the particular user fees are waived for some groups of patients, usually based on income, age, or health condition.

**Indicates that there is a maximum level of user fees that can be charged in a given period.

[2]In countries with social insurance models of health-care financing.

[3]A private health system is complementary if one can obtain the same services within the private system as one could in the public system. Canadians would likely term this "two-tier" health care.

Source: Irvine, Hjertqvist, and Gratzer, 2002, with updates from Esmail and Walker, 2002a.

cover such things as dental exams and treatment, ambulance services, home nursing, physiotherapy, chiropractic services, glasses and contact lenses, hearing aids, prostheses, medicines, cosmetic surgery, and medical services that are not clinically necessary.

For professional services provided in a hospital, the Medicare benefit is 75 percent of the schedule fee; for all other professional services, the Medicare benefit is approximately 85 percent of the schedule fee. Australians may insure privately for care in private hospitals, and they may insure with private insurance companies for the gap between the Medicare benefit and the schedule fee. Physicians can accept 85 percent of the schedule fee only, and no co-payment, in return for billing Medicare directly, rather than the patients; nearly 80 percent of services were billed this way in 2001 (Hilless and Healy, 2001).

Insurance premiums in Australia—public and private—are community rated. That is, health funds cannot discriminate against people by charging them differential premiums on the basis of their risk (age, sex, health status, and lifestyle). People can switch health funds without penalty.

The federal government's Lifetime Health Cover program takes into account the length of time that a person has had private hospital insurance (or cover) and rewards them by offering lower premiums. As well, the "Federal Government 30 percent Rebate" initiative refunds 30 cents for every dollar that people contribute to their private health insurance premium. Enrolment in private

plans is approaching 45 percent of the population (Irvine, Hjertqvist, and Gratzer, 2002).

Germany

Germany has a statutory health insurance (SHI) system made up of competing sickness funds. Sickness funds are decentralized, self-administered, nonprofit organizations, and the funds are financed by equal contributions from employers and employees. The premiums are a fixed percentage of an employee's income and are not related to his or her age, sex, or health status. Contributions to the funds are subject to upper and lower thresholds.

About 88 percent of the German population belong to the SHI system. Those Germans with an income above a defined threshold are permitted to opt out of the public system and purchase private insurance—about 9 percent of Germans have chosen this option—and only 0.1 percent of the population is not insured (European Observatory, 2000). Premiums for private health insurance are related to an individual's age, sex, and health status.

For insured persons, there are user fees for hospital and other services such as optician services and dental care. Most ambulatory care is free at the point of delivery for insured persons and local public health offices provide some services free to everybody, regardless of whether they have insurance. There are co-payments required for pharmaceuticals and the government has a list of medications it subsidizes.

Most public hospitals are being privatized and, by 2015, it is expected that only a few hundred of Germany's 1,700 hospitals will remain under control of the government (Irvine, Hjertqvist, and Gratzer, 2002, p. 264).

New Zealand

In 2001, the proportion of publicly funded health and disability support services accounted for around 76.4 percent of the total expenditure on health in New Zealand (OECD, 2002). Over the last two decades, the proportion of health expenditure financed privately has risen from 12 to 22.5 percent (New Zealand Ministry of Health 2001b, p. 13).

Most New Zealanders are eligible for publicly funded health and disability services. Eligible people may receive free inpatient and outpatient public hospital services, subsidies on prescription items, and a range of support services for people with disabilities. There is a fee-for-service system for primary care, although visits to the doctor and prescription items are generally free for children under age 6, and basic dental care for children is generally free until age 16. Most adults have to pay the full cost of their doctor visits. However, for people who have to make many visits, or who require a lot of medication, there is the possibility of getting a government subsidy. Individuals may also choose to use private health care services.

Singapore

In Singapore, private practitioners provide about 80 percent of primary health care, while government polyclinics provide the remaining 20 percent. For hospital care, the government provides 80 percent of the care and the private sector 20 percent (Ramsay, 2001). On the financing side, of total health care expenditure in 1998, government spending comprised about 31 percent and private sector spending (households, businesses) 69 percent (Ramsay, 2001).

Patients are expected to pay at least part of the cost of the medical services they use—inpatient

or outpatient—and to pay more if they demand higher levels of service in terms of comfort and amenities. Co-payments apply even to most heavily subsidized hospital wards. While no Singaporean is denied access to the health care system or use of emergency services at public hospitals, private hospitals are not required to accept all patients.

The main methods of health funding and insurance are organized through the government. Its philosophy is that Singaporeans should be encouraged to adopt healthy lifestyles and be responsible for their own health. To this end, it has devised three programs: Medisave, Medishield and Medifund.

Medisave is a compulsory savings scheme to help Singaporeans pay for any hospitalization costs they may incur, especially after retirement. It is part of the country's Central Provident Fund, a fund into which both employees and employers contribute roughly the same amount (totalling 40 percent of an employee's income) for an employee's retirement, housing needs, and health care. The contributions are tax deductible and earn interest. Singaporeans can withdraw from their medical savings account to pay for their own hospital bills or those of their immediate family. They keep any amount remaining in their account at the end of the year.

Medishield is a voluntary insurance plan designed to help Singaporeans meet any medical expenses arising from a major accident or prolonged illness. Reimbursements are based on a system of deductibles and co-insurance, and there are claim limits per policy year and per lifetime. Medishield premiums are paid from Medisave contributions.

Medifund is an endowment fund set up by the government as a safety net to help low-income Singaporeans pay for their medical care. Anyone who is unable even to pay for subsidized hospital care can apply for help from Medifund.

Sweden

In Sweden, the central government focuses more on the performance of the services and on results and than how they are organized. There are 26 county councils in Sweden responsible for purchasing from hospitals and other providers the health care services needed for their populations of between 60,000 and 1.7 million people. Local authorities are responsible for the care of elderly and disabled people in the places where they live.

Swedish residents are entitled to use health services at subsidized prices, but there are co-payments for primary health care, hospital stays, outpatient care, dental care, elderly care, and for prescription drugs. The fees vary by county, but, to limit the expenses incurred by patients, there is a high-cost ceiling. Certain population groups, such as children, are exempt from patients' fees. User fees represent less than 2 percent of the total resources devoted to health care (Hjertqvist, 2002b).

In some county councils, such as Stockholm, competition between service providers and contracting with the private sector have been encouraged. From 1992 to 1994, the Greater Council of Stockholm launched a number of competitive initiatives. With competitive contracting, the council reduced the yearly cost of ambulance service in the Stockholm region by 15 percent, laboratory costs fell by 50 percent, the cost of support staff services dropped by 30 percent, and privatized nursing homes reduced costs by 20 to 30 percent (Irvine, Hjertqvist, and Gratzer, 2002; Hjertqvist, 2001c). As well, there is evidence that, with competition, providers are offering a better service and are spending more time with patients; wait-

ing lists have been reduced by more than 70 percent (Hjertqvist, 2001a).

Seven emergency hospitals in the Stockholm region serve almost two million people. Since 1999, one of them has been privately owned—St.George's Hospital, which realized a savings of 15 to 20 percent over the average of the publicly run hospitals (Irvine, Hjertqvist, and Gratzer, 2002). In 2000, two hospitals turned themselves into publicly owned companies with formal business structures, financial statements, and a board of directors; at least two of the remaining ones plan to do the same (Hjertqvist, 2001c).

With the help of the council, some 100 health care units are in the process of leaving public ownership to become private companies. New contractors run local health care centres, GP group practices, treatment centres for mothers and infants, laboratories, and psychiatric out-of-hospital clinics. When (and if) the council completes this transformation, private GPs and other contractors will deliver around 40 percent of all health services, and about 80 percent of all primary health care in the metropolitan area (Hjertqvist, 2001c).

In the Swedish health care system, recruitment has been a problem, due to low birth rates and the poor image the system has as a place to work. Private sector advances have allowed for better working conditions, higher wages for many, and there are providers who have started up their own enterprises. The National Union of Nurses, with 120,000 members, actively supports nurses who want to leave the public sector and begin working as contractors (Hjertqvist, 2001c).

Switzerland

According to the Organisation for Economic Co-operation and Development, public expenditures accounted for 55.6 percent of total health care spending in Switzerland in 2000 (OECD, 2002).

It is compulsory for Swiss citizens to have sickness insurance, but the public and private sectors share the insurance market. Insurance companies are prohibited from refusing anyone coverage and there is a basic set of benefits that insurers must cover by law. As well, based on the required set of benefits that insurers must offer, insurers within each canton must pay a portion of their premiums into a regional fund so that, in effect, the insurers with healthier members subsidize those with less healthy members.

Insurance premiums are based on actual costs and do not include income as a factor; and they differ by region. Those citizens who cannot afford the health insurance premiums receive an income supplement (not a health premium subsidy) from the canton. There are deductibles and various cost-sharing arrangements in Switzerland for physician, specialist, hospital, and other health services.

United Kingdom

The National Health Service (NHS) is based on the ideal of universal coverage for all British citizens, paid for from general tax revenues. But initial cost estimates for the NHS were soon exceeded and fees were added for such services as prescriptions and dental care. (However, today, about 85 percent of prescriptions are dispensed to people who are exempt from the charges (British Medical Association, 1999.)) Additionally, there always has been, in the United Kingdom, a private health care system that operates parallel to the public system (i.e., that provides acute, long-term, and other types of care). While everyone is insured by the NHS, people are permitted to buy insurance and/or any medical service from private insurers and health providers, respectively, and about 11

percent of the population has done so (Ramsay, 2001).

Reforms in the 1990s formed an internal market in health care. NHS trusts are semi-autonomous bodies with responsibility for the ownership and management of hospitals. Primary care trusts (PCTs) have been formed from what were known as GP fundholders. The PCTs include GPs, other health professionals, social services, and members of the local community: they have their own budgets for the health care of their population—at least 100,000 people per trust (Ramsay, 2001). As an incentive to make efficient allocation decisions, trusts and PCTs are allowed to retain any financial surpluses (Irvine, Hjertqvist, and Gratzer, 2002).

The NHS trusts are the providers of services, and the health authorities and the PCTs are the purchasers of those services. The "internal market" required providers to compete with each other—on the basis of quality and price—to attract purchasers, which were now permitted to contract with providers outside of their regions. The Adam Smith Institute estimates that contracting out reduces costs by about 20 percent (Irvine, Hjertqvist, and Gratzer, 2002).

Section 6: Recommendations

The struggles that Saskatchewan's health care system faces include waiting lists, a lack of high-tech medical equipment, provider shortages, and low provider morale. Many of these issues arise because health care in Saskatchewan and the rest of Canada is organized mainly as a function of government and, therefore, increasing health care costs are problematic and must be contained. As such, exclusive public financing of medically necessary services has the potential to harm residents' health and hinder the future prospects of the health care sector, from which Saskatchewan's economy could also benefit.

The ultimate goals of any health care reform should include the formation of a system in which population health is improved, people have access to medical services when they need them, consumers control their own health care decisions, and there is accountability (by both providers and consumers) for the use of resources. The following policy recommendations are made with these values in mind. The recommendations are grouped into two categories: those that fall within the current bounds of the Canada Health Act (universality, accessibility, portability, comprehensiveness, and public administration), and those that would violate the Canada Health Act as presently written, but would do so without abandoning Canada's compassionate approach to health care.

Recommendations that fall within the current bounds of the Canada Health Act

1. Privatize hospitals and other health facilities. Canada lags behind most industrialized countries in encouraging various types of public and private hospitals to compete with one another for the opportunity to serve patients. Allowing private providers to care for patients in Saskatchewan would result in both improved quality of service delivery and reduced expenditures for publicly insured health care.

There is a substantial quantity of literature on the relationship between hospital ownership—private versus public, not-for-profit versus for-profit—and health care costs and outcomes. In general, the literature indicates that for-profit and not-for-profit hospitals are equally efficient, but that there are distinct efficiency advantages in relying on private hospitals vis-à-vis publicly owned hospitals. The Canadian paradigm has thus far been reliance on the latter and an abject fear of the former.

Two large reviews of the literature on private versus public hospitals can provide some insight into the general findings. A summary published by the Government of Alberta found 8 studies that gave evidence on the benefits of private hospitals relative to publicly operated hospitals (Government of Alberta, 2000). One study showed that higher administrative costs do not necessarily lead to increased overall costs, and gave evidence that private for-profits "had the lowest increase in Medicare operating costs per case in every year since 1991"; five studies indicated that government hospitals tended to be less efficient than private hospitals, even in rural areas; and two studies found that private hospitals outperformed public hospitals in terms of various performance measures. Zelder (2001), while examining these eight studies and a further seven that showed contrary findings, concluded that, on the whole, "the economics literature on the effects of hospital competition in the US reveals that, over the last 10 years, competition has been unambiguously beneficial, lowering cost and increasing quality" (Zelder, 2001a).

There is also a substantial body of evidence demonstrating that the ability to retain profits will not necessarily result in a lower standard of care. Hsia and Ahern (1992) concluded that not skimping on care under a prospective payment regime would produce significantly higher profits. Cleverly and Harvey (1992) concluded, using a small sample of hospitals, that poor quality hospitals (hospitals with higher mortality rates) were less profitable. Tomal (1998) found that higher prior-year profit margins in both for-profit and not-for-profit hospitals were associated with lower hospital mortality rates. Clearly, the profit motive is not necessarily a source of reduced quality care.

For-profit hospitals have also been known to reinvest profits from operations rather than pay out profits as dividends to shareholders (Graham, 2002). These for-profit hospitals in the US also hold more capital and fewer financial investments than do public hospitals in Canada (Graham, 2002), echoing findings that government business enterprises tend to be under-capitalized (Megginson and Netter, 2001).

International experience also suggests that private delivery of health services would be beneficial for residents of Saskatchewan. As discussed in section 5 above, St. George's Hospital in Sweden was privatized three years ago and has realized savings of 15 to 20 percent over the average of the publicly run hospitals. In Stockholm, several other hospitals are about to be privatized and some 100 health care units are in the process of leaving public ownership to become private companies. Contractors run local health care centres, GP group practices, treatment centres for mothers and infants, laboratories, and psychiatric out-of-hospital clinics. Before this process began, recruitment had been a problem, but private sector advances have allowed for better working conditions and higher wages for many.

As well, "cherry-picking" by private providers is not something to be feared by either taxpayers or patients. The fact that private providers may have an incentive to cherry pick (serve less ill patients) can in fact be beneficial for health care delivery. In

New Zealand, private health providers tend to focus on the relatively common, less invasive, and simpler procedures, allowing public providers to focus on more difficult and costly care (French *et al*., 2001).

Finally, private providers, because of their incentives to increase efficiency and provide a higher level of care in order to attract more patients, will end up enhancing care for all patients, including the very poor. Evidence from the UK has shown that the lower socio-economic classes benefited the most from the private sector's involvement in hospital care provision (McArthur, 1996).

The privatization of hospitals cannot, however, be done without the introduction of competition. As Ferguson notes: "[p]rivate clinics will produce socially desirable results only when they are introduced into a competitive environment" (2002, p. 23). Without competition between health care providers, most of the incentives to improve both cost performance and quality of care will be lost.

2. Define the roles of regulator, purchaser, and provider. Rather than increasing the power of the provincial government,

- the minister of health should only act as the *regulator* of health care, the *funder* of the regional health authorities and the *monitor* of contractual arrangements between itself and the RHAs,
- the RHAs should act as the *purchasers* of health care services and the *monitor* of contract obligations between themselves, hospitals and other health care facilities and groups of providers, and
- hospitals and health providers should be required to bid for contracts to provide acute care, primary care, or whatever care is demanded by the RHAs or individual patients. They should have an avenue for redress if the RHAs or the government break the terms of a contract.

Regions should perform a population needs assessment, put out requests for proposals, and interested providers would prepare bids for various contracts. The RHAs would monitor the provision of the contracted services. The contracts with providers would establish desired outcomes measured using such statistics as mortality and complication rates, infection rates, and patient satisfaction. The providers—not the RHAs—would determine the inputs used in the provision of health services—for example, how much labour to employ at a hospital, or how many diagnostic machines a provider group has.

Rather than focusing on primary care teams *per se*, health providers should be permitted to present a business case to the RHAs for a set of services they wish to provide and that people are demanding. Whatever the method of remunerating the providers within these groups, it should include a connection to the results achieved by their organization. If these groups choose a wrong set of services and are unable to meet their contractual obligations, then the group must determine some other way of making ends meet and be allowed to go out of business if they fail to do so.

3. Remove all restrictions on medical school enrolment and withdraw subsidies for medical school education. Much of the current physician shortage is the result of provincial intervention in the availability of medical school admissions. Alterations to the current admissions restrictions will not resolve the problem in the long term.

The province of Saskatchewan must realize that the law of supply and demand has not been re-

pealed for physician services. Abandoning the medical admission restrictions would mean that the supply of doctors would be determined by patients' needs, not on an arbitrary funding decision. By allowing medical schools to price medical training at cost and allowing admissions at the school to be determined by the school itself, students can decide if a career in medicine is profitable given open supply to the marketplace. Regions of Saskatchewan where doctors are scarce could also opt to contract with students to provide health services for their area by offering to pay a portion of the student's school fees. Thus, doctor shortages will be mitigated as students would expect greater returns to their education (more patients available to attend the practice, patients with unmet health needs, etc.), while excess physician supply will have the opposite effect. The remaining causes of the doctor shortage, that of excess demand for medical services and prices set by government for medical services, cannot be resolved within the confines of the Canada Health Act.

4. Define the core or basic services to be financed by the public sector as a system to replace the current rationing-by-waiting list system. Governments are beginning to realize that the current interpretation of the comprehensive principle of the Canada Health Act is unattainable, and that they cannot fund every health service for everyone. The Alberta and Quebec inquiries into the health care system both recommended that their provincial governments define a core set of services to be funded by the public sector. A priority ranking of interventions should be established based on cost-effectiveness criteria and public involvement in the decision-making process. This approach is not intended to merely reduce public expenditures, but to prioritize them so as to optimize the health of the population and to get the most out of every public dollar spent. The government should evaluate and continuously review the set of insured services, new medical technologies, and new drugs. These core services would form the required basic coverage offered by competing private insurance companies in an updated universal health care system. This idea has already been tried successfully in the State of Oregon, which could serve as a model for implementation in Canada, where the funding line on the prioritized list of services (the point above which treatments are covered by the insurance plan) would serve as the definition for "medically required services" in order to maintain comprehensiveness under the Canada Health Act.

5. Consider public-private partnerships (P3s) for the construction and operation of new health services infrastructure, in which the private sector participant can be a for-profit business or a nonprofit organization. P3s are entirely in accordance with the Canada Health Act and there is evidence to support such partnerships. A review of the literature in this area found it is not unusual to find reported savings (improved value-for-money) to the public sector of 20 percent or more relative to traditional procurement, which allows for increased availability of social infrastructure and more public funds for other budgetary needs (Allan, 1999/2000). Other reviews are more cautiously optimistic about the success of P3s, pointing to such potential problems as governments not properly enforcing contractual arrangements and governments contracting with the private sector without considering competitively priced public ventures (Commission on Public Private Partnerships, 2001). Note that all of these potential problems are related to inappropriate action on the part of governments and not the inability of P3s to provide new infrastructure at a lower cost than would have been possible without competitive bidding.

6. Charge risk-based premiums for health care, but reduce income taxes accordingly. In fiscal year 2001/2002, BC's premium revenue of $955,671,000 represented about 10 percent of the province's $9.5 billion spending on health care that year (British Columbia Ministry of Health Services, 2002). Premiums in Alberta cover about 11 percent of the health costs in that province (Premier's Advisory Council on Health for Alberta, 2001). However, these percentages may not represent enough of a cost to serve as a reminder that the costs of health services are significant, which is the main purpose of such a proposal, given that it will not increase government revenues. These premiums would simply replace a portion of current government tax-based financing of health care in Saskatchewan.

Rather than being a simple alternative form of financing, as they are in Alberta and British Columbia, which does not provide any different incentive to the individual as these premiums are generally paid transparently by employers, the premiums should be paid on a risk-adjusted basis and should reflect the scope of services covered. The risk-adjustment should be tied to actions that individuals take to stay healthy (such as increased exercise levels) or behaviour that results in increased reliance on health services (such as smoking or heavy alcohol consumption). The risk-adjustment should not account for pre-existing conditions or family history, since these conditions are part of the reason that public or mandatory health insurance schemes exist. The "sin taxes" that are associated with certain behaviors (such as taxes on liquor and cigarette consumption) should be discarded once the risk-adjusted premiums are levied, so as to avoid double-charging smokers and consumers of alcohol. Low-income individuals and the chronically ill can be exempt from premium payments, and there could be subsidies for other groups.

7. Remove any and all restrictions on a parallel private health care system. At present, contracts for private health insurance are legal in Saskatchewan, and doctors are permitted to leave the public health insurance system and practice in the private sector (Flood and Archibald, 2001). Doctors should be permitted to practice simultaneously in both public and private health systems, in order to facilitate expansion of this sector. Patients should be permitted to contract for private health care services in Saskatchewan and be encouraged to do so through a program similar to that in Australia or Germany, where patients who contract privately for health services are reimbursed or exempted from paying the premiums that apply to the public health insurance scheme (Hilless and Healy, 2001; European Observatory on Health Care Systems, 2000). Actively encouraging the development of a private market could have many benefits for health services in Saskatchewan, principal among which is better service for patients.

The lack of choice in the health care system at present has resulted in a common and uncontested standard of health services, leaving patients in a situation where they have not been able to protest for better quality by choosing to purchase health services from a different provider. The monopolistic provision of health services in Saskatchewan has abolished the need for hospitals to be efficient and innovative due to a lack of competition. Since patients have not been able to opt for higher quality accommodations, surroundings, or care, the public health system is not motivated to offer them (Boucher and Palda, 1996).

Further, patients who buy private health services with their own money free up services in the public system for patients who are still waiting to get them. Increased resources could either be used to provide more care to public patients, or removed

from the health sector entirely and given back to the citizens of Saskatchewan in the form of a tax cut. Either way, the people of Saskatchewan would be better off.

8. Have citizens start a savings account for long-term care. The proportion of Canadians older than age 65 is increasing in Canada, and Saskatchewan is no exception. While the aging of the population may or may not indicate a future crisis in health care funding, seniors do consume more health care dollars and it makes sense to prepare for that eventuality. This proposal is an adaptation of the recommendation made by the Clair Commission on health care in Quebec that its government take a comprehensive approach to the risk of long-term loss of autonomy (that is, the long-term health care needs for individuals unable to care for themselves) by using collective plans for funding universal services. The Clair Commission also proposed that the government manage the plan, although they noted that the funds must not be redirected for the purpose of covering the province's general expenditures. The plan would be funded through a mandatory contribution based on personal income from all sources, as well as a portion of the funds that the government currently dedicates to long-term care services. Monetary benefits for home care would be determined, as needed, through the care plan and they would be non-taxable in the hands of the beneficiary or recognized caregivers, depending on levels and circumstances to be determined (Commission d'étude sur les services de santé et les services sociaux, 2001, p. 181-185). A full discussion of the tax implications of such a plan was beyond the scope of the Clair Commission report.

Rather than a collective insurance plan, why not individualized savings accounts for long-term care that could cover home support and institutional care as well? Rather than having the government manage it collectively, individuals could determine how to use the account when they require care. An even easier proposal would be to abandon the limits to RRSP and RPP savings plans and allow withdrawals for health purposes, thus allowing a long-term care savings account to be implemented within current savings plan systems. There are currently mechanisms in place to protect someone's health and financial interests when they lose their autonomy and are unable to manage their assets, and these could apply to any savings account. Capitalization would guarantee the availability of adequate services for an aging population without placing undue stress on the coming generation to fund that budgetary burden.

9. Open up access to all publicly held information on health care provider performance. In Saskatchewan, patients may choose which hospitals to go to for health services, but have no information about the relative effectiveness and quality of each to guide their decision. The Commission on Health Care noted that purchasers in the private market for automobiles have remarkable quantities of information at their fingertips on the relative quality of both the vehicles they are purchasing and the agents who sell and service these vehicles (Commission on Medicare, 2001), yet did not realize that the same type of information is available in the United States to consumers of health care.

Currently, in Canada, this type of data is being maintained in Canada by the hospitals and provincial ministries of health, but is not readily available to the public. Making access to these data easier for research-oriented and consumer organizations would allow patients to find information about where the best health services are delivered and would allow institutions to compete on the basis of quality. Performance reviews done by government bodies and health authorities would not make an acceptable alternative to

the free access of information because of the perverse incentives associated with doing a final review of your own performance.

Recommendations that would not be possible without violating the Canada Health Act

1. Implement a cost-sharing structure within the public health care system in Saskatchewan. When individuals do not face any charges for health services (i.e., a third party—the government or a private insurance company—covers their medical expenses), they have no incentive to restrain their use of health care. Such a situation can produce excessive demand for care and result in wasted resources, to the extent that the costs of producing these services exceed what individuals would be willing to pay for them. This phenomenon is known as “moral hazard.” (See “Insurance” in section 2 above.)

Co-insurance, deductibles, and co-payments are commonly used to control excessive use due to under-valuation of insured consumption, and have a number of advantages. The first is that they increase efficiency in the health delivery sector and reduce costs: if required to bear a portion of health care costs, individuals will curb their consumption of medical care, and medical services of lesser value will eventually be eliminated. A second advantage is that these payments can reduce the tax burden of Canadians because they redirect health care financing from taxpayers to users.

Unfortunately, cost sharing can have an adverse effect on the health of the poor and the sick poor. According to the RAND health insurance experiment (Newhouse *et al*., 1993), the seminal study on the effect of cost sharing, the health of this segment of the population is severely affected by cost-sharing—both mortality rates and high blood pressure worsen among high-risk individuals. For this reason, there should be a cost sharing exemption for low-income groups and others found to be adversely affected by the cost-sharing program.

2. Move from the single purchaser model to a system of many competitive insurers where individuals are required to be insured for a basic set of health services. A system of social insurers has a number of benefits over the general taxation model that has been followed thus far in Canada. The general taxation model, though administratively simple, suffers from a lack of transparency, as there is no easily established link between the payment into and the benefits received from health care. The lack of transparency also appears when an increase in the tax rate that is claimed to be for health services can be far larger in revenue terms than any increase in funding to health care. Also, a system with general tax financing and no cost sharing—i.e., care that appears “free” to the consumer—can lead to what Pauly (1968) described as an “inconsistency,” where individuals demand health care as though it were free, and yet consider the positive costs of that care when voting on changes in tax rates. In other words, general tax financing can potentially lead to chronic shortages in health care financing.

A social insurance system overcomes this drawback through a system of either public or private insurers (or some mix thereof) that provides health care to citizens once enrolled with the insurer. Universality is maintained through mandatory insurance enrolment. Although some tax financing may still be required to provide coverage by an insurer for the poor, the unemployed, and possibly the elderly, this system is less likely to suffer from politically-motivated intervention than a fully tax-financed system, as independent bodies collect the insurance payments and disperse the funds for health services. In addition, allowing users the choice of insurer—as the Czech

Republic, Germany, and Switzerland do—has the added benefit of creating competition among insurers and generating efficiencies in the health care system as a result of competition and the possibility of varying cost-sharing schemes that allow lower insurance costs for those willing to pay more out of pocket. Countries that have opted for a social insurance system of finance appear to have fewer problems with the promptness of care than those who have chosen a tax-financed system (Altenstetter and Björkman, 1997).

A recent comparison published in the *British Medical Journal* of Britain's publicly funded National Health Service with California's private, non-profit Kaiser Permanente found that the per capita costs of the two systems, adjusted for such aspects as differences in benefits and population characteristics, were similar to within 10 percent. However, it found that Kaiser members experienced more comprehensive and convenient primary care services and more rapid access to specialist services and hospital admissions. Kaiser's superior access, quality, and cost performance was attributed to better system integration, more efficient management of hospital use, the benefits of competition, and greater investment in information technology (Feachem, Sekhri and White, 2002).

3. Deregulate the mandatory social insurance sector to permit the formation of medical savings accounts. Medical savings accounts (MSAs) are health accounts that are established in conjunction with high-deductible health insurance. The Saskatchewan government could provide its residents throughout the province with catastrophic insurance and deposit funds into MSAs. The size of the government contribution could be all, or a fraction, of the catastrophic insurance policy's deductible, depending on people's health status, age, and income level. The Premier's Advisory Council in Alberta described how, in basic terms, a medical savings account system could be set up in that province:

- Individuals have a set amount allocated to their medical savings account for the year. This could be the equivalent of their health care premium (at whatever level that is set) or it could be a combination of their health care premium and additional funding from the province. The amount each person receives is adjusted for certain factors including sex and age. Government would continue to pay premiums on behalf of low-income people and deposit that amount in their medical savings account.

  Individuals could use their medical savings account to pay for insured health care services used during the year [including prescription drugs]… If individuals use up all the money in their medical savings account during the year, two options are possible. They could be required to pay for additional services up to an annual maximum amount (the so-called "corridor" between medical savings account coverage and the point at which medicare coverage kicks in). Or government would pick up all costs of needed health services just as they do now…

  At the end of the year, if individuals have not used all the money in their medical savings account, they get to keep it… Accumulated savings might be used to purchase a wider array of health services including services to help people stay healthy such as smoking cessation programs, dietary counseling, fitness training, or other services currently not publicly covered… (Premier's Advisory Council on Health for Alberta, 2001, p. 57)

MSAs would give people more control over their own health care, more knowledge about what

heath care costs, potentially more health care options from which to choose, and most importantly, incentives to save money for the more expensive health care they will need as they get older or if they fall ill. This allows for capitalization of the health care market, which is contrary to the current system in which today's tax dollars pay for people's health care today; because health care funds are spent immediately, there is no opportunity for them to be invested and to grow.

There is evidence from American firms, and from Singapore's health system, that MSAs are conducive to more prudent health spending without compromising individuals' health (Gratzer, 2002c; Ramsay, 1998). While there are studies indicating that MSAs could reduce expenditures by up to 20 percent in the United States, a RAND analysis concluded that "MSAs would be attractive to both sick and healthy people," and that enactment of federal MSA legislation could change total spending by between –2 percent and +1 percent (Ramsay, 1998; Miller, 1996).

Opponents of MSAs argue that individuals may delay seeking care or forgo preventive care when faced with medical expenditures and when allowed to retain any health care funds not spent in their MSA. Therefore, costs of the system will increase when these people end up requiring more expensive tertiary services. However, studies have shown that, on the whole, cost sharing can reduce the use of health care services substantially with little or no net adverse effect on people's health status (Gratzer, 2001). Even if the use of certain important preventive services, such as large-scale immunization, were negatively affected by the introduction of MSAs, these services can always be provided to all by the provincial government or the health regions.

Another argument against MSAs is that, due to consumer ignorance, physicians are able to induce demand. However, there is great uncertainty as to whether supplier-induced demand is a large problem in the health care sector. As well, providing individuals with financial incentives may make it harder for physicians to induce demand if they were so inclined.

Finally, a recent article in the *Canadian Medical Association Journal* attempted to refute the potential of MSAs by demonstrating that a terribly designed, or ill thought out, MSA program would fail (Forget *et al*., 2002). Using Manitoba data on health care access costs between 1997 and 1999, the authors showed that allocating each individual in the province the average physician and hospital costs ($730) as an MSA—thus assuming that all accounts would be the same regardless of age, sex, or health status—would lead to an overall cost increase. Critics have pointed out that the crucial flaw in this article is its lack of understanding about how an MSA would actually work. An appropriately designed MSA system would allocate funding for each citizen based on age, sex, and health status—a critical point missed by Forget *et al*. in their analysis of the MSA concept.

Surveys have shown that a majority of Canadians are willing to consider the idea of an MSA as a way to encourage responsible use of the system (72 percent), allow patients to choose services more suited to their needs (67 percent), and increase physician accountability (55 percent) (Angus Reid, 1997). Several researchers have laid out a plan for how MSAs could work in Canada (Gratzer, 2002a; Holle and Owens, 2000; Ramsay, 1998; McArthur, Ramsay, and Walker, 1996). The Consumer Policy Institute has constructed a detailed outline of a Canadian MSA system, including cost projections, potential changes in the use of various services, and a definition of insured and uninsured services (Litow and Muller, 1998).

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