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Shortening the Queue by Jumping It

Since 2005 when most of the following material was written, the cost of healthcare has risen, governments' ability to fund it has been reduced. Additionally, modern science has been doing its job, and researchers and clinicians have found new ways to diagnose and treat disease. If we cannot afford our current system of healthcare, how will we afford to offer personal genomic testing and treatment, and how will we utilize nanotechnologies? Ontario leads the country in terms of restricting access to healthcare by citizens willing to pay. And, of course, Canada is now the only country in the world that forbids its citizens access to privately funded healthcare. Will Canadians and Ontarians be forced to go elsewhere to purchase proven clinical breakthroughs that government cannot afford to offer everyone?

The recently released Drummond Report has suggested a number of worthwhile changes to policy and operations for Ontario's healthcare system. Unfortunately, the commission's mandate forbade it from considering revenue and more private funding of healthcare. The muzzling of this commission was unfortunate but predictable, given the political sensitivity of the day.

Drummond identifies that quality and efficiency go hand in hand. The discipline of the marketplace – where consumers choose to spend their own money to purchase a service – would benefit this quest for efficiency. If government could devise a process that enables the discipline of the marketplace while ensuring a minimum level of access for all, and could also ensure that private revenue for healthcare services does not siphon or divert essential human and physical resources from their vital public mandate – shouldn't government at least consider it? Likely it won't, but the methodology outlined below would work for elective surgical procedures and non-urgent diagnostic testing, and would likely work in the future for personal genomic testing and utilizing nanotechnology for healthcare interventions.

Many Canadians are waiting for life-benefiting surgery, for diagnostic tests that will inform and enable treatment, for access to human and physical healthcare resources. At the hospital level, the need for urgent care and diagnostic testing is being accomplished well. Canada is deservedly proud of how all its citizens have access to public and life-saving healthcare. However, care and treatment that is not urgent but necessary to improve and sustain the quality of life must wait its turn. For many patients, that turn seems to come later and later, with increasing limitations on the services funded. Published studies over the past several years comparing the healthcare systems of the leading countries in the world have indicated that all counties are struggling with how to provide and pay for healthcare for their citizens. These studies have also shown a disturbing trend in terms of Canada's ranking among industrialized countries and their healthcare systems. All these systems are publicly run and financed – "socialized medicine." Every other country that provides a comprehensive, publicly run and funded healthcare system has a mechanism for

individuals to purchase care personally or privately. In this respect, Canada now stands alone in the world.

There is much rhetoric about "two-tiered healthcare" from both sides of the debate. One side would have us believe that the private, for-profit provision of care coupled with the purchasing of that care is a business solution we cannot overlook. The other side would have us believe that any "private money" would water down the availability of essential healthcare professionals who would be naturally drawn – like moths to a flame – to the profits, concomitantly higher pay and better working conditions resulting from private money in the system.

The solution suggested here combines the important points of both these arguments to form a different whole.

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

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

This model could be applied to fully elective surgeries, non-approved and non-funded pharmaceuticals, enhanced medical devices such as titanium knee implants and, of course, limited diagnostic testing including MRI, CT and PET scans.

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

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

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

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

About the Author

Paul Faguy is a senior healthcare executive with 30 years of experience in hospital management at both academic health sciences centres and large community hospitals. This commentary reflects both his personal and professional views, as a private citizen.

Acknowledgment

The original article can be found here: http://www.longwoods.com/content/17128