A Tool for Assessing Health Care Delivery Models

Introduction

Canadian Doctors for Medicare (CDM) is committed to the *improvement, and expansion* of Canada's publicly funded health care system. We support the principle that medically necessary health care be provided on the basis of need, rather than ability to pay.

Within Canada's publicly financed health care system, some physicians and other advocates are promoting *delivery* models that deliver service outside the traditional structures, some of which incorporate market elements including privatization, investor-ownership and profit from fees beyond the provincially-approved fee schedules. A number of variants of these models already exist in Canada, and more are developing.

Provincial and territorial health policymakers are challenged to ensure that service capacity is sustainable, and that it meets the health care needs of Canadians. Policymakers are grappling with the questions of whether it matters who delivers health care, and whether new delivery will adversely affect the public system. A framework for approaching these questions in a transparent, thoughtful, and principled way is long overdue.

This **policy tool** will assist Canadian policymakers, the public, and the media in analyzing whether particular proposed models of health care delivery should be encouraged, regulated, or opposed. We begin with the principles, inscribed in the Canada Health Act, that health care should be universally and equitably accessed by all Canadians, regardless of ability to pay, and provide a framework for examining the ways in which delivery models might affect that principle.

Context of Physician-Delivered Services in Canada

Most physician services in Canada are already privately delivered. This has, however, traditionally been in the context of private not-for-profit institutions, such as hospitals, or in private models such as community-based practices where the physician-owner is bound by the ethical codes of the profession, where there are no shareholders in the practice beyond immediate family members, and where there is adherence to the provincial fee schedule.

In recent years, and in contrast to the traditional Canadian understanding of "private delivery" of physician services, there has been an increase in investor-ownership of private facilities, and a concomitant drive for profit, in some parts of the health care system (such as long term care facilities, surgical facilities, imaging centres, and some primary care clinics). This proliferation of investor-owned, profit-driven health care facilities has moved service delivery beyond the smaller, community-based, not-only-for profit model, toward practices previously not seen inside our publicly funded system.

There are multiple factors contributing to the development of new models, including:

- Constrained access to care within existing models of service delivery
- Movement of service delivery from hospital-based to community-based outpatient settings
- Failure of government stewardship
- The perception among some members of the public and of the health care professions that care delivered in traditional models is neither of the highest quality nor is convenient to access.
- Rapid evolution of expensive technology with consequent elevation of public expectations
- Ideological belief in the primacy of markets
- Perceived opportunity by physicians and entrepreneurs to generate more revenue

Rather than making blanket statements about "good" and "bad" models of health care delivery, CDM seeks to understand how particular delivery models interact with the public health care system. We recommend a systematic, principled, criteria-based approach to assessing any proposed clinic, hospital, surgical centre, or other health care body intended to deliver services within the publicly financed system. The criteria used by governments, physicians, and the public should be transparent and in the public interest. We suggest the following criteria:

1. Equitable access to medically necessary physician and hospital services

Equitable access does not necessitate the same, or equal, access in all circumstances. However, the guiding principle of access should be equity rather than ability to pay. Within some investor-owned profit-driven models of private delivery this principle is undermined by the imposition of ancillary fees. These fees are barriers if they are applied directly or through the co-mingling of insured and uninsured services or through the imposition of longer wait times for patients who do not pay fees. Where physicians are involved in non-profit hospitals and for-profit facilities, a potential conflict of interest arises, threatening medical professionalism if self-referral is allowed to take place.

Access is best supported by using models:

a. In which insured services are not linked to, or co-mingled with, uninsured services or fees, i.e. where payment for an uninsured service is not required as a condition of access to an insured service

b. That do not permit queue-jumping, or bypassing the public queues altogether, for extra fees

c. That do not prolong wait times in the public system

d. That do not facilitate self-referral, i.e. where the referral destination does not provide private or extra payment to the referring physician owner or investor

2. High-quality care

In all circumstances the goal should be to provide the highest quality of care. Assuring quality requires attention to several areas:

<u>Measurement:</u>

Across the country, methods are being developed to measure and track quality of care and health outcomes. These measurements, and a variety of continuous quality improvement mechanisms, are central to the sustainability of the health care system, and should be facilitated in all models.

<u>Balance:</u>

Quality of care is best assured when the resources of the provider are not overtaxed. A balanced case load, with a mix of complex and simple cases helps manage those stresses. Shifting to a caseload of greater complexity will stress a system unless it is accompanied by new resources.

<u>A Learning System:</u>

Health care is a complex and interrelated discipline. Diverse learning experiences are critical in the training of health care workers. Care models should not undermine those learning opportunities.

A focus on patients, not profits:
The evidence on investor-owned profit-driven health care suggests that it does not deliver care of comparable quality to the care delivered in traditional not-for-profit models. If pursuit of profit causes medical professionals to consider issues other than patient well-being, that can have a negative impact on quality of care.
Therefore, quality is best supported in models:
a. In which quality can be measured, and where raw data are shared across the system
b. That do not threaten the viability and the capacity of public hospitals, e.g. by selecting only lower-risk patients, or recruiting skilled professionals out of the public system
c. That do not fragment the education of health professionals. Residents, medical students and other learners should be exposed to a wide variety of patients, communities, and practices. Models of delivery that fragment or distort such exposure should be discouraged
d. In which there is no risk that the interests of investors (physician or non-physician) may interfere with care that is in the best interest of the patient
e. In which there is evidence that the care offered will be of comparable quality to that delivered in not-for-profit hospitals or in traditional community-based models

3. Delivery of effective, clinically indicated services
The use of evidence in making clinical decisions has become increasingly relevant. Even so, variations in care exist across institutions. Profit-driven institutions have a potential financial incentive to encourage patients to undergo expensive testing in the absence of standard clinical indications or to recommend more expensive tests or treatments when there is no evidence of their superiority to less expensive options. In these circumstances, there is potential harm both to the patient's health as well as to the solvency of the publicly-funded health care system.
Therefore, effective clinical practice is best supported in models:
a. In which medically unnecessary or otherwise uninsured services are not linked to insured services
b. In which patients are not encouraged to undergo testing or treatment for which there is no clinical evidence or support
c. In which practitioners do not have an incentive to recommend or provide medically unnecessary services
d. That do not augment administrative costs by means of redundant processes and higher transaction costs

4. Effective planning and integration of health care
The legitimate goals of a publicly insured health care system include integration of services, planning across jurisdictions or regions, the maximization of seamless service delivery, and continuity of care. Any delivery model within the public system should be oriented towards these goals. Publicly funded health care must be sustainable for generations to come. Governments have an interest in supporting health care delivery models that are cost-effective and use public money most efficiently. Evidence on investor-owned for-profit delivery of health care services suggests that it is more costly than non-profit delivery.
Therefore, effective planning is best supported in models:
a. That are likely to promote collaboration rather than competition through the continuum of care
b. That do not reduce or prevent meaningful public accountability and transparency
c. That do not cost more per procedure or per patient interaction without delivering measurable increased value for public money
d. That promote evaluations based on assessment of health outcomes rather than only on indicators such as volumes of patient procedures or patient transactions

The following questions provide a tool for assessing new models.

Health Care Delivery Assessment Tool

Canadian Doctors for Medicare (CDM) supports the creation of new delivery models that improve Canadian health care. However, some delivery models can undermine equitable access and reduce the quality of care provided to most Canadians. Therefore, we recommend a systematic, principled approach to assessing any proposed clinic, hospital, surgical centre, or other health care entity intended to deliver services within the publicly financed system.

The field of alternative delivery is now mature enough that operators can be clear about which service models support the principles of the *Canada Health Act* and which ones subvert them. The criteria used by governments, physicians, and the public should be transparent and in the public's interest.

The following questionnaire will help determine whether a proposed delivery model meets those criteria:

Equitable Access

To confirm the new model provides equitable access with no financial barriers, please answer the following questions:

1) Will the new model charge fees for any services that are normally covered by your province's health care system?

2) Will the new model allow any services normally covered by your province's health care system to be linked to, "co-mingled" with, or made dependent on other services that require fees?

3) Will the new model allow patients to get faster access to services, or move ahead of others waiting for services, by paying extra fees or by purchasing services that have fees attached to them?

4) Will the new model contribute to longer wait times in the public system by using time, physicians, nurses or other health care resources that providers would otherwise make available to the patients in the public system?

5) Will the new model refer patients to services or settings that require fees, even though similar services are available as part of your province's health care system?

A 'yes' answer to any of these questions indicates that the new model of care will likely reduce access to health care for many Canadians.

High-Quality Care

To confirm the new model supports the growth of a high quality health care system, please answer the following questions:

1) Does the new model intensify demands and pressures on public hospitals by preferentially selecting lower-risk patients, leaving higher-risk cases for public hospitals without appropriate adjustments to financial supports?

2) Does the new model recruit skilled professionals out of the public system, thereby reducing the pool of skilled staff available to address demand in the public system?

3) Does the new model fragment or distort the education of health professionals by limiting the variety of patients, communities, and practices to which students are exposed in the public system?

4) Will the new model allow investors (physician or non-physician) to place direct or implied pressure on staff to make decisions on treatment, admissions or spending based on profit?

5) In the new model, would staff be likely to select less demanding or more profitable patients? Would staff place greater weight on cost cutting rather than care optimization?

6) Is there evidence that the care offered in the new model will fall below the quality of service provided in the rest of the public system?

A 'yes' answer to any of these questions indicates that the new model of care has the potential to reduce the quality of care provided to most Canadians.

Effective, Clinically Indicated Services

To confirm that the new delivery model would be limited to providing the services patients need please answer the following questions:

1) Would the new model allow medically unnecessary services to be linked to or required for access to services normally covered by your province's health care system?

2) Would the new model encourage patients to undergo tests or treatments which are not yet supported by credible evidence?

3) Would practitioners in the new model have financial incentives (such as a share of total billings or a share of profits) that may place them in a conflict of interest and encourage them to recommend or provide medically unnecessary services that are not clinically indicated?

4) Would the new model create administrative costs that exceed the minimum necessary costs, through redundant processes, costly added elements or higher transaction costs?

A 'yes' answer to any of these questions indicates that the new model may produce waste and unnecessary spending by directing a greater share of resources toward ineffective or unproven health care interventions.

<u>Effective Integration and System Stewardship</u>

To confirm that the new delivery model would support effective planning and integration of health care please answer the following questions:

1) Does the new model promote competition between health care institutions rather than collaboration through the continuum of care?

2) Does the new model reduce or prevent meaningful public accountability and transparency by unnecessarily limiting access to data or records?

3) Does the delivery model cost more per procedure or per patient interaction without delivering measurable increased value for public money?

4) Does the new model promote evaluations based only on indicators such as volumes of patient procedures or patients, rather than on meaningful health outcomes?

A 'yes' answer to any of the questions indicates that the new model has the potential to increase fragmentation in the health care system and impede integration.

<u>Conclusion</u>

Creative approaches to health care delivery have always been a part of Medicare. However, not all options are constructive.

New delivery models within the publicly funded system that attach user fees to services that should be provided to patients without charge, either directly or indirectly (e.g. by linking insured and non-insured services) create financial barriers to care.

New delivery models that leave more challenging cases to the public system and maximize profits by treating simpler cases impose more intensive demands on the public system and decrease the resources most Canadians rely on.

New delivery models that drain resources from the public system during a time when Canada is short of doctors and nurses means that more Canadians will have a more difficult time accessing health care providers.

Finally, models that affect public policy by increasing costs, diminishing learning opportunities, restricting data access, altering evaluation criteria or allowing financial considerations to influence clinical decisions are not in the interest of patients.

Completing this questionnaire will enable governments and organizations developing or funding new delivery models to clearly identify whether or not they are undermining access, quality, efficiency or integration in the system. We encourage all health professionals and all participants in the health care sector to use this questionnaire as one way to ensure that their efforts are adding to the health and well being of all Canadians.

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