

American-style health care comes to Ontario

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By Dr. Gordon Guyatt

Amy was surprised. She had come to the wrong place.

In 1998, Amy was injured in a car accident, and suffered from pain in her right shoulder and arm. She needed physiotherapy, and had made arrangements to attend a clinic in Brampton. A friend who had also been injured, and believed she had attended the same clinic, provided the address.

But when Amy informed the clinic receptionist of her private insurance, the receptionist directed Amy to an associated clinic. There, Amy found a brighter, cleaner, more spacious facility, with a well-equipped gym.

Amy was assigned her own private physiotherapist, who worked one-on-one with Amy, supervising an exercise program. Amy enjoyed the exercise program so much that she continued on after her pain was minimal. The physiotherapist never made a critical assessment about Amy's need for continued therapy. Amy finally stopped the program when she started to feel guilty about using a service she no longer needed.

During her therapy, Amy compared notes with her friend. The friend's therapy had been very different. At each visit, she entered a small room where a physiotherapist applied an ultrasound machine, left her alone, and returned when her time on the machine was completed.

No exercise program, no gym, no individual attention.

Amy's story reflects the multi-tier system of care for working-age people with injuries in Ontario today. If you have excellent automobile or private insurance, you will begin therapy in a matter of days, with the full individual attention that Amy received. Depending on whether or not you are caught in the bureaucracy of the system, you may also receive prompt care if your workplace injury results in a Workplace Safety and Insurance Board claim.

If your injury is bad enough to require hospitalization, you will get

individual attention. Also, you won't face the burden of out-of-pocket payment. You have already paid for your hospital care through your taxes.

What if your injury did not occur at work or in an auto accident, and does not require hospitalization? No private insurance? You are out of luck. You will face a four to nine week delay before you get care. When your time comes, you will find yourself in therapy with a group of other injured people, or receive the low level of individual attention that Amy's friend experienced. That is all that the relatively small number of OHIP funded clinics can provide, at a reimbursement rate of \$12.20 per visit.

It wasn't always this way, as an analysis of policy change in the province by Alina Gildiner, a policy researcher at the at the Institute of Work and Health, makes clear. Fifteen years ago, physiotherapy and other rehabilitation services, such as occupational therapy, were delivered almost exclusively through public out-patient clinics, often administered and run by hospitals. Waiting times, and the care provided, depended on the severity and nature of your injury, rather than where the injury happened, or your insurance coverage.

The situation changed in the mid-1980s when the provincial Liberal government introduced no-fault auto insurance and placed greater responsibility for rehabilitation on the insurers. At the same time, the Workers' Compensation Board introduced a new rehabilitation strategy that contracted with private clinics.

A new industry of small, private rehabilitation clinics developed, catering to automobile accident victims and workplace injuries. In the early 1990's, the NDP government further increased the automobile insurers' responsibilities. The NDP government also responded to a perceived "deficit crisis" by health care cuts. Faced with shrinking resources and the availability of a thriving private rehabilitation sector, hospitals cut back on public provision of out-patient rehabilitation services.

In the latest part of the story, acquisitions and consolidations have changed clinic ownership from private practitioners to large companies.

The overall picture is a movement away from a Canadian-style system of uniform delivery of publicly funded care by not-for-profit providers. Instead, we have substituted an American-style patchwork, largely

privately-funded system. This includes an under-resourced not-for-profit sector delivering care to those who cannot provide additional payments that the for-profit sector demands.

The obvious down sides of this transition are the inequities in care. Many Canadians would be uncomfortable that the circumstances of an injury, and ability to pay, determine whether a person receives high quality care immediately, or delayed mediocre care.

There are also problems in efficiency and accountability. How is it that Americans spend almost two dollars on health care for every dollar Canadians spend, and still leave 15% of their population without health insurance?

Their patchwork system of private health care provision creates uncontrollable upward pressures on costs. For-profit health care providers must deal with administrative costs, advertising, and profit generation that not-for-profit providers don't face. Whenever possible, they deal with this problem by generating additional revenue.

A single payer system creates different motivations. In Canada, provincial governments are solely responsible for insured physician and hospital services, and are accountable to the public for their expenditures. Being the single payer allows the government to control health care spending.

Why is it that Ontario citizens still have access to physician and hospital services according to need, but that circumstances and insurance coverage determine access to rehabilitation?

The Canada Health Act, which mandates universal coverage, covers only physician and hospital services. As soon as rehabilitation services, delivered by non-physicians, move out of hospital, they are fair game for private payment. And with private payment comes inequitable access to care.

Canadians are entering a debate about the Canada Health Act. Do we want to compromise the principles of the act, and open physician and hospital services to the inequities that have developed in rehabilitation? Or should we extend the provisions of the act to necessary rehabilitation, home care, and pharmaceutical services? The choice will be critical in

determining the sort of country we are living in a decade from now.