

A Brief Submitted by the Medical Reform Group of Ontario to the Romanow Commission

October 26, 2001

Introduction

This document presents the key issues that the Medical Reform Group believes the Romanow Commission should address, and the substantive policies that the Commission should suggest. The document begins with a brief description of the Medical Reform Group. We present our view of the issues of sustainable funding and co-operation. We then address the funding of health services, the spectrum of publicly covered services, possible improvements in the delivery of publicly funded health care, for-profit delivery of health care, and the determinants of health.

What is the Medical Reform Group?

The Medical Reform Group of Ontario (MRG), formed in 1979, is a group of 200 practising physicians and medical students. The MRG represents the views of its members on health and health care matters through research, public statements and consultation with other groups who share our aim of maintaining a high quality publicly funded, universal health care system. The MRG believes that health is political and social as well as medical in nature and that health care is a right.

Sustainability and Co-operation

The flawed picture of out-of-control health care spending

For the last 15 years, Canada has lived in an atmosphere of growing uncertainty regarding the availability of public funds to provide universal, widely accessible, high-quality health care.

The media has, by and large, presented a picture of rapidly escalating health care costs. This presentation has, for many Canadians, created the impression that ensuring high quality care without financial penalties for illness is becoming unfeasible.

The reality differs greatly from this picture.

The real picture of health care cost containment

In 1992, Canada spent 10.2% of its GDP on health care. In that year, responding to concerns about deficits, both federal and provincial governments began to rein in health spending. Between 1992 and 1997, per person spending on health care actually decreased across the country.

Since 1997, spending has picked up again. The increases have been gradual, and we have only just returned to 1992 levels of per capita spending on health care.

In the meanwhile, the economy had grown. The result is that Canada now spends only 9.6% of its GDP on health, still less than the 10.2% in 1992. Canadian spending on health, as a proportion of GDP, has also dropped in relation to other countries. In 1992, we were second in the world on health care spending as a proportion of GDP. Now, both Germany and France spend more than Canada. The United States, spends almost 14% of its GDP on health, and its per capita health care expenditures is almost twice that of Canada.

Canada has thus maintained an extraordinary record of constrained health care spending. In contrast to the United States, Canada provides uniform coverage of physicians and hospital services to the entire population. Canada has, to a far greater extent than the United States, and to a greater extent than a number of European countries, contained the last decade's pressures to increase health care spending.

How has Canada succeeded in constraining spending?

The primary reason for Canada's success is that a single payer, the government, is responsible for provision of almost all physician and hospital services, and for an appreciable proportion of home care and drug expenditures. This allows governments virtually absolute power in setting global hospital budgets because hospitals have very little leverage in any negotiations with the government. Physicians have considerably more leverage, but the government also has considerable power in these negotiations. The Romanow Commission must ensure preservation, and indeed expansion, of the single-payer structure of health care funding.

The problem of sustainability

By sustainability, we mean the necessity for putting in place mechanisms to ensure continued access to high quality care irrespective of ability to pay.

Even today, we have considerably more effective health care interventions than we have resources to deliver those interventions. Technological advances in medicine are likely to lead to an increasing gap in what is physically possible, and what is economically practical. Thus, rationing is inevitable, and the need for rationing is likely to increase.

This situation raises the challenges of alternative allocation of societal resources. These include health, education, social services, and a wide variety of expenditures outside the public sector. Our view is that public education and social services are, in general, underfunded. On the other hand, most expenditures in the private sector go far beyond human necessities, and have a very unbalanced distribution in society. Thus, relative to private sector expenditures, one can make a strong argument for increasing public health care expenditures. This is particularly the case in a political environment in which pressure to decrease the share of societal resources that are allocated to the public sector is relentless.

Sustainability is threatened by this political environment, and by the current inadequate mechanisms to ensure equitable access to health care other than physician and hospital services. Alternative services in which inequities in access currently exist, and may worsen, include home care, drugs, eye and dental care. Sustainability is further threatened by inefficiencies in health care delivery, and by resistance from governments and the medical profession to institution of major structural changes in health care delivery. We deal with these issues in a subsequent section of this document.

However, arguably the most serious threat to sustainability is the reluctance of both federal and provincial governments to commit adequate funds, in a planned and consistent fashion, to health care delivery. That this reluctance constitutes a major threat is not arguable.

Current funding arrangements avoid making either federal or provincial governments accountable for ensuring adequate resources for health care.

For instance, the Established Program Financing was originally tied to the gross national product, but the federal government moved away from linking transfers to national wealth during the 1980s. In 1995, the federal government was able to unilaterally make massive cuts in health care funding available to the provinces. Furthermore, even in the face of huge budget surpluses, the federal government was able to delay returning funding to 1995 levels for 6 years. Finally, when they have returned funding to 1995 levels, they are able to characterise their actions as huge new funding commitments for health care.

At the same time, the provinces are able to avoid committing increased resources of their own to health care, and effectively use the federal money to fund tax cuts. For instance, the Harris Ontario government has increased health care spending by little more than the federal increase in transfer payments, and only after considerable public pressure, while instituting huge tax cuts.

The situation allows both levels of government to accuse the other of being responsible for health care delivery problems, and for inadequacies in funding. Many Canadians are troubled at the spectacle, repeated now year after year, of the two levels of government engaged in acrimonious name-calling. Nevertheless, governments appear to prefer to engage in this activity rather than assume responsibility for adequate funding. The current funding structure compromises both sustainability and co-operation.

The solution to sustainable funding

Nothing short of a change in funding formula will reverse this situation, and ensure accountability by both levels of government.

We believe any solution must conform to the following principles:

- An acknowledgement by both levels of government of their responsibility to ensure adequate funding for universal access to needed medical services without financial barriers to care for all Canadians.

- An acknowledgement by the provincial governments that the federal contribution to spending entitles the federal government to a say in how the money is spent.
- Transparency of what the two levels of government are contributing to health care spending.

Mechanisms to ensure that both levels of government will do their share in responding to population health care needs by providing the funds necessary to maintain high-quality health care delivery. These mechanisms must be sufficiently prescriptive that they leave little room for either level of government to withhold or delay needed funding.

One could imagine a variety of funding formulas that meet these principles. Any solution would begin with the provincial and federal governments agreeing to establish the current funding levels as a base situation.

One possible subsequent mechanism would see the federal and provincial governments agreeing to an absolute minimum per capita public spending level on health. The per capita funding would be indexed to inflation. The federal and provincial governments could then agree on the proportion of additional expenditures that the federal and provincial governments would contribute to additional mandated expenditures as the population grew. The extent to which the federal government had a say in provincial health care policies could depend on the amount of their contribution, and might be a central point in negotiation of the specific funding formula.

Advantages of this strategy would be that mandated increases in health spending would be limited by population growth and inflation. A second potential advantage is that it would not tie the federal government to particular provincial policies.

One disadvantage of this approach would be that it makes no allowance for changes in health care that create needs for increases in per capita funding. These would include technological advances, and changes in population demographics that result in need for more intensive services per person. Such changes could include aging of the population, or a changing immigration policy that would admit populations with greater health care needs.

A second disadvantage of this approach is that it would not take in to account growth of the economy. If the economy grows at an average of 3% per year, simply maintaining per capita expenditures would, over a period of years, lead to a substantial fall in public health care spending in relation to the economy. Given the need for health care rationing, the desirability of maximizing access to health-improving interventions, and the uses and distribution of societal resources allocated to the private sector, relative contraction of the public health sector is undesirable.

Thus, more appealing would be a commitment to a second options, maintaining health care expenditure at a proportion of the GDP. This would ensure growth of the public health sector at least in relation to the economy. Once again, an agreement would fix the relative contributions of the federal and provincial government to the increases in health care expenditures that would be mandated as the economy grew.

A third proposal would see the federal government matching, in some fixed proportion, new health expenditures by the provinces -- as they did when Medicare was introduced. In return, the federal government should be entitled to place conditions on the transfer of funds – also a key point in the arrangements when Medicare was introduced.

Advantages of this approach include its incentive for provinces that increase health care spending. A second advantage is that governments have experience with the strategy and, in terms of establishing and maintaining adequate health care funding, and achieving national standards of health care delivery, it worked very well. We find arguments in favour of this third approach particularly compelling.

In negotiating such an arrangement, there would be two fundamental bargaining issues. The first would be the amount of federal money that would accompany each new dollar of provincial expenditures. We could imagine this being anywhere from 15 cents to a matching dollar. The second would be the extent of federal control of the conditions around how the money is spent.

Presumably, the more the federal government contributed, the more control they could demand. At the one extreme, the federal contribution would be relatively small, and they would cede control. At the other, their

contribution would be large, and they would exercise considerable control.

We believe it would be desirable if the federal contribution was relatively large, and thus accompanied by appreciable federal control. There are two reasons. First, this would provide the greatest level of health care funding, and thus the maximum assurance of sustainability. Second, historically, it is the federal government that has implemented policies (most notably the original five conditions of Medicare, and subsequently the Canada Health Act, and its sporadic enforcement) to ensure equitable access to health care. The current national scene suggests this will continue to be the case. Thus, a high level of federal control is most likely to help ensure the maintenance, and extension, of access to high quality care irrespective of ability to pay.

Any of these funding approaches would have the following salutary effects. First, provinces could not rely on federal funds to finance increases in health care expenditures, while instituting tax cuts. The provinces would be required to start the process by committing real new funds to health care.

Second, the federal government could not decline to support provinces that do commit new funds. Furthermore, they could not unilaterally decrease funding for health, as they did in 1995. Thus, the provinces could rely on stable federal funding, including increases proportional to their own commitments to health care funding.

Third, provinces would be able to plan on the basis of predictable increases in funding contingent, in the case of the third option, on their own priorities.

Fourth, with divisive funding issues out of the way, and an agreement as to the federal role, there would be a far greater chance the two levels of government would work co-operatively.

Some may suggest these proposals are unrealistic. The provinces are violently opposed to any degree of federal control. Both levels of government will be extremely reluctant to shoulder the accountability, and the lack of flexibility, these mechanisms would impose. However, if one accepts that the proposals are unrealistic, one is acknowledging the

hopelessness of the situation. If governments are completely resistant to accountability, it ensures the continued precariousness of health care funding, and guarantees that the distasteful and destructive federal-provincial bickering will continue. If the Romanow Commission recommendations are going to make a real difference, they must include a funding formula that corrects the current situation, which is characterized by provincial and federal ability to cut health care funding indiscriminately, and easily obfuscate the situation to mask their cuts.

Funding of Health Care: Who Pays?

Equitable access to health care is a key Canadian value. Virtually complete public coverage of physician and hospital services has largely succeeded in equalising public access to these health services irrespective of income. The Canada Health Act, despite its half-hearted enforcement, has played a major role in maintaining this equity. Thus, the principles of the act should be strongly maintained, and if possible extended to other areas of currently inequitable access, including home care and prescription drugs. We return to these latter areas in the next section of this document.

Compromising the principles of the Canada Health Act and allowing user fees for physician and hospital services would have deleterious consequences beyond reducing equitable access.

Advocates of user fees argue that fees may save the system money by decreasing health care use. That might be a good thing, but only if the health care visits patients avoid are for unnecessary care. If patients stay away when they need care, they will undergo unnecessary suffering in the short term. Their long term health may suffer as well.

Can patients distinguish between necessary and unnecessary doctors visits and avoid only the unnecessary ones? A major study conducted in the United States found that user charges decreased both unnecessary and necessary services.

In the end, patients may actually need more care, and more expensive services, when they avoid seeking needed care. For instance, if user fees keep patients from visiting the doctor to have their blood pressure checked, the result over the long term may be a disabling stroke.

Both Canadian and American studies of the impact of user fees for prescription drugs have repeatedly shown exactly this effect. Short-term gain of savings for reduced drug use leads to long term pain because of serious illness when patients don't take needed medication. The result is greater use of doctors and hospitals, and increased rather than decreased total costs.

This argument is particularly compelling when one considers that poor people are sicker, and need more health care. Thus, with user fees, the additional burden of payment falls disproportionately on those least able to bear it. Those most likely to reduce health care utilization because of user fees are the people who need health care the most.

A natural experiment in the province of Saskatchewan demonstrated exactly this effect. When Saskatchewan introduced a user charge for physician visits. The charge, the equivalent of about \$10 in today's prices, led to a reduction in doctors' visits by the poor of 18%. The total decrease in physician use was, however, only 6–7%.

The explanation for this difference is that the physician, rather than the patient, initiates many visits to the doctor. Saskatchewan's physicians, paid on a fee-for-service basis, saw a potential income drop when poor people sought care less often. As a result, they increased the number of visits from those who could afford the user fee. They also used a more expensive mix of services. The result was, despite a substantial drop in use by the poor, almost no savings at all.

Given that user fees are unlikely to reduce health care spending significantly, user fee advocates suggest another possible benefit. User fees might generate money to pay for hospitals, home care, or drug benefits.

This would only be possible if the government, who funds the health care system, received the user fees. Up until 1986, Ontario allowed physicians to charge user fees. In that system, the money went to increase doctors' incomes, and did not contribute to paying for other health services.

What if, in Canada as in Sweden, which has experimented with user fees for primary care services, the government collects the user fees. This is

unlikely to be a politically viable strategy in Canada. Even if it were, collecting user fees involves administrative costs. Swedish authorities acknowledge that those costs eat up almost all the money that the user fees generate.

Finally, user fees, if determined by the health care providers, rob the government of the ability to control total levels of health care expenditures. The result is the much greater increases in health care spending in the United States than Canada since the two systems diverged.

In summary, user fees place a disproportionate burden on the sickest segment of the population, the poor, who are least able to bear the burden. They do little or nothing to reduce unnecessary health care utilization, engender wasteful administrative costs, and spawn uncontrolled health care spending. Health care rationing is inevitable. We should continue to, to the greatest extent possible, to ration by need and not by ability to pay. We should vigorously resist user fees in areas of physician and hospital services, and minimized for other necessary health services such as home care and prescription drugs.

The Spectrum of Publicly Ensured Services

National Medicare and the Canada Health Act have been extremely successful in establishing uniform, high national standards for delivery of physician and hospital services. Furthermore, they have virtually eliminated financial barriers to access, and evidence suggests that access is both equitable and tied closely to need. These are enormous accomplishments. As a proportion of total health care funding, physician and hospital services have contracted. As a result of bed closures, a shift of care to outpatient facilities, and greater utilization of day surgery and outpatient surgery, the proportion of health care spending devoted to hospitals has dropped from over 45.2% in 1976, to 31.8% in 2000.

At the same time, the relative contribution of home care and pharmaceutical products to medical care has grown substantially. Currently, a large (and so far unquantified) proportion of home care, and 66.6% of drug costs are privately funded, and thus borne directly by the ill. There are no national standards, and the extent to which governments provide financial assistance in these areas differs hugely between

provinces. Without directly addressing home care and pharmaceutical costs directly, the proportion of health care spending coming out-of-pocket, and borne disproportionately by the poor (who suffer, on average, more health problems than the affluent) will continue to rise.

In 1997, the National Health Forum, a non-partisan and widely representative group of health care analysts and community representatives, held consultations with citizens across the country. They recognized the problems associated with the sick, and their families, bearing the costs and responsibilities of home care and drug costs. Their report to the federal Liberals recommended national home care and pharmacare (prescription drug) programs. The initial enthusiasm of the federal Liberals to the recommendations has evaporated.

National pharmacare would have an additional benefit of potentially reducing drug expenditures. The federal government, as a mass purchaser for large numbers of Canadians, would have considerable bargaining power to reduce costs. In particular, the government could institute a system of reference-based pricing that has been adopted in British Columbia, and a number of other jurisdictions. This method, which for drugs in a particular class pays only the price of cheapest alternative agent, could play a major role in cost control.

National programs of home care and pharmacare should be part of the Romanow recommendations.

Improving the delivery of publicly funded care

Many aspects of medical care in Canada are suboptimally delivered. In particular, we do a bad job of management of patients with chronic conditions. We use excessively expensive drugs, undertreat hypertension, and underutilize home care and patient education.

Limitations in the delivery of primary health care services play a major role in the deficiencies of chronic care. As health researcher Barbara Starfield has documented, countries with stronger primary care delivery systems provide better care at lower cost. In Canada, the current fee for service model includes perverse incentives and fails to use the skills and knowledge of other health professionals. Canadians must make a serious effort to strengthen primary care, including reform of funding

arrangements (moving away from fee-for-service), rostering, care delivery by teams of health professionals, round-the-clock accessibility, and much more effective use of modern information technology.

A program that includes reform of primary care, and implements strategies for identifying and increasing adherence to best practices, may both improve patient care and increase efficiency. There may be many instances in which better care proves less expensive.

While strongly advocating an aggressive approach to implementing and maintaining best practices, we note the enormous challenges to changing the behaviour of health care providers. We further note that the promises of increasing efficiency may or may not be achieved when best practice programs are implemented on a system-wide basis. Changes will inevitably be gradual. All these considerations suggest that we cannot rely on a move to best practice to provide resources to address evident gaps in the current system, including lack of access to home care, and delays in services such as cataract operations, joint replacements, cardiac procedures, and cancer care. Thus, even in the presence of efforts to ensure optimal care, the proposals of our earlier section on Sustainability and Co-operation remain will remain necessary.

Mechanism of Care Delivery: To Profit, or Not to Profit

With the introduction and passage of Bill 11, the Alberta government initiated an intense debate about the merits of private health care delivery. This bill allows regional health authorities to contract a for-profit private provider to supply surgical services. Contracted providers will be prohibited from charging any fee (including a facility fee) to insured persons for an insured surgical service beyond those set out in the Alberta Health Care Insurance Plan. However, contracted providers can offer 'enhanced medical services' to patients. If patients are willing to pay, they can obtain enhanced services such as a joint prosthesis that is purportedly superior to the prosthesis covered by the Alberta Health Care Insurance Plan. Although Premier Klein and Bill 11 use the terms 'surgical clinics' and 'surgical facilities,' respectively to refer to the institutions where patients will undergo major surgeries and stay for a period of days recovering with medical and nursing care, most people refer to such institutions as hospitals.

A health care system can be separated into two dimensions, financing and delivery. Both dimensions can be public or private. Public denotes government. Private can be for-profit or not-for-profit. In Canada the delivery of care is predominantly private. However, this fact is commonly obscured because Canadians commonly use the term 'public hospitals' to refer to private, not-for-profit hospitals. With few exceptions (e.g. Ontario's psychiatric hospitals) the majority of these 'private hospitals' are not government run and the employees are not civil servants. Although, these private, not-for-profit hospitals receive most of their funding from government, they maintain this formal organization independence (though the extent of their decision-making independence may be limited). These distinctions are important in formulating policy for the delivery, as opposed to the funding side, of health care.

There is no evidence to support the contention that private delivery of care can provide comparable quality care at greater efficiency. In fact, all direct comparisons of for-profit and not-for-profit care suggest that for-profit systems do worse either with respect to efficiency, quality, or both. Comparisons of for-profit and not-for-profit hospitals in the United States have consistently shown that successful for-profit hospitals do well not by enhancing efficiency, but by increasing charges to payers.

Furthermore, direct comparisons suggest that quality of care, and resulting patient outcomes, tend to suffer when for-profit providers deliver care. For example, comparisons of for-profit versus not-for-profit dialysis in the United States have consistently shown a substantially lower referral for transplant, and a substantially greater mortality, in the for-profit sector.

The calls for private delivery as a solution to health care resource constraints are bogus in the extreme. They are ideologically and financially motivated, and run contrary to the evidence. Systematic studies tell us that a transition to for-profit care will in general increase costs, decrease quality of care, or both. It is very important that the Romanow Commission help to bring this evidence to the attention of the public and of health care policy makers, and to suggest policies that will reverse the increasing shift to for-profit health care delivery.

Determinants of Health

For those who work in health policy, the evidence that social and economic conditions play a larger part in contributing to population health than does health care is widely known and widely accepted. Outside of the world of health policy experts, this is not the case.

In its focus on health care delivery, the Romanow Commission should not ignore health. Social policies that decrease homelessness and sub-standard housing, decrease reliance of food banks, and ensure the quality of our water and air, would enhance Canadians' health to a substantially greater extent than even the most successful efforts to achieve best practice in medical care. The Romanow report must vividly highlight the desirability of social policies that will contribute in positive ways to Canadians' health.

For more information please contact:

Janet Maher
medicalreform@sympatico.ca