

Submission to the Standing Senate Committee on Social Affairs, Science and Technology

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Presentation for the Medical Reform Group

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.

Introduction

The MRG appreciates the opportunity to respond to the Committee's report on health care in Canada. It is beyond the scope of this submission to respond to the Issues and Options document, Volume 4, in its entirety.

Overall, we have major problems with aspects of the Senate Committee's presentation of policy issues and options. The report is disappointing because it fails to acknowledge and support Canadians' desire for equity, fairness and compassion through a universal and accessible publicly funded system. Instead of presenting approaches to strengthening public access to health care, the report focuses on policy options that will undermine equitable access to high quality health care.

The report fails to respond to the World Health Organization's criticisms in its 2000 report that Canada has the lowest public expenditure on health care, other than the United States, of all the G7 countries. Canada fared worse than other industrialized countries because of Medicare's failure to provide comprehensive coverage of health care expenses. The report ignores evidence that demonstrates the superiority of public

finance and delivery.

In contrast to the 1997 National Forum on Health, the Senate report does not serve the best interests of Canadians. Given Senator Kirby's ties to the Liberal party, we find the failure to support Canadian values contradicts Liberal traditions of strengthening social solidarity. We wonder if the Chair's conflict of interest as a member of the Board of Directors of Extendicare, a for-profit health care corporation, has influenced the Committee's work.

We would like to present, in some detail, our response to issues and options raised in the report's discussion of the financing of health care in Canada. In addition, we will respond to the Committee's recommendations on Pharmacare and Primary Health Reform. *The Role of Government: An Overview.*

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 have, 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 per cent 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 per cent of its GDP on health, still less than the 10.2 per

cent 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 per cent of its GDP on health, and its per capita health care expenditure 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 Senate Committee must recommend preservation, and indeed expansion, of the single-payer structure of health care funding.

The Canada Health Act: Fairness and failures

Equitable access to health care is a key Canadian value. This has not been given appropriate emphasis in the report's analysis and recommended options. 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 extended to other areas of currently inequitable access, including home care and prescription drugs.

Although the Committee recognizes the failure of the Federal government to enforce the Canada Health Act, the Committee itself fails to hold the

government accountable. Canadians need the Senate as an advocate. Despite warning letters from Health Minister Rock, MRI clinics in Alberta and Quebec currently charge patients for necessary, publicly insured health services.

This leads to queue jumping since privately paying patients are able to access diagnosis and treatment sooner. Access to care based on ability to pay is not a rationing mechanism that Canadians support. The final recommendations of the Senate Committee must address the appalling Chretien government's failure to effectively enforce the Canada Health Act, and must demand a timely and effective resolution of this ongoing irresponsible behaviour.

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 per cent. The total decrease in physician use was, however, only 6 to 7 per cent.

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 minimize user fees for other necessary health services such as home care and prescription drugs.

The Spectrum of Publicly Ensured Services: Improving Comprehensiveness

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 per cent in 1976, to 31.8 per cent 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 per cent 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 Forum on Health, a non-partisan and widely representative group of health care analysts and community representatives, held consultations with citizens across the country. They recognised 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.

Prescription Drugs: Expanding Coverage

The MRG does not share the Committee's depiction of drug coverage in Canada. Despite theoretical "100 per cent" coverage provided by some provinces like Ontario and Quebec, the reality is that co-payments and deductibles still result in inequity, lack of access, and poor health for many.

One option for expanding coverage put forward in the Senate Committee report is a comprehensive public/private model to extend drug insurance to the entire population. Superficially this may seem to be an attractive proposal, as it limits government expenditures. However, a public/private model forfeits the potential to actually decrease overall costs.

While all public plans utilize generic drugs to reduce their costs, fewer than 16 per cent of 401 companies surveyed by the Conference Board of Canada had introduced generic substitution and even fewer were using other methods such as formularies or caps on pharmacists dispensing fees. Dispensing fees represent 21.7 per cent of prescription costs for public plans but 25.8 per cent of private plans. Administrative costs in private plans run at about 8 per cent of total costs versus figures as low as 2 per cent in large provinces such as Ontario and Quebec. Retaining private coverage means the loss of as much as \$118 million in nationwide savings in reduced administrative costs.

Finally, retaining private coverage diminishes the purchasing power of the provinces. Acting together the provinces could use their monopsony

buying power to lower overall drug costs. Australia has a national drug plan and has been able to keep its drug costs more than 30 per cent lower than the OECD average as of 1993. At that point Canada's were almost 30 per cent above the average.

The Senate Committee report also advances three other options for expanding insurance coverage: a public/private initiative to protect against high drug expenses, a tax initiative to protect against high drug expenses and a comprehensive public program. The first two suffer from the same problems as the comprehensive public/private model, namely that the ability to reduce costs is limited. Further more, both of these options would still leave low-income Canadians vulnerable to substantial out-of-pocket expenditures. For example, under the public/private model individuals would be responsible for the first \$1,000 in drug costs per year. The tax model would require up front payment for drugs with people waiting until the end of the fiscal year to receive a tax credit.

The only truly equitable model, and the one with the greatest potential for reducing overall drug costs, is a first dollar public scheme. Indeed, it is remarkable that we are even considering other systems of drug coverage. Canadians have rejected a mixed public/private system for hospital and physician costs and with good reason; as we noted above such a system in the United States costs almost 50 per cent more than Canadians pay and still leaves about 15 per cent of Americans without any medical insurance.

Improving the delivery of publicly funded care: The need for Primary Care Reform

Many aspects of medical care in Canada are sub-optimally delivered. In particular, we do a poor job of management of patients with chronic conditions. We use excessively expensive drugs, under-treat hypertension, and under-utilize 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.

We agree with the Senate Committee's characterization of our health care system as a "cottage industry" which needs to be brought into the 21st Century. We reaffirm the four principles of primary health care which you identify:

- the need for care to be coordinated,
- that it be accessible to all Canadians,
- that it be provided by the most appropriate health care professionals with the right skills, and
- that it be accountable to local citizens through community governance.

Those elements are reflected in the Community Health Centre (CHC) model, first proposed by Dr John Hastings in 1972. We support the expansion of the CHC model as a strategy for achieving a well-integrated and effective system of primary care to strengthen health and deliver high quality care to Canadians.

While strongly advocating an aggressive approach to implementing and maintaining best practices to achieve better health care, 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.

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 (for example, 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 Senate Committee acknowledge this evidence and bring it to the attention of the public and of health care policy makers. Canadians need policies that will reverse the increasing shift to for-profit health care delivery, not expand it.

Health Care Technology

Given the nature of the market for health care technologies, it is understandable that the emergence of new technology will always outpace the ability of researchers to assess and evaluate. The danger is that new technologies are adopted into widespread use before evidence for their safety or effectiveness exists. The Senate Committee recognizes that the adoption and deployment of new health care technologies is an important element of the planning and provision of critical health care infrastructure. The MRG agrees with the Committee's support for increased research into the safety and effectiveness of health care technology. In addition, linking research to education and deployment, as done by Britain's National Institute for Clinical Excellence has merit. We support increased funding for the Canadian Co-ordinating Office for Health technology Assessment.

Conclusions

The Medical Reform Group believes, as do Canadians, that the principles of universality, accessibility, portability, comprehensiveness and public administration are sound, defensible, and in need of protection. We

believe that the Canada Health Act suffers from a lack of federal enforcement. We do not support increased private financing and disagree with the Senate's quick dismissal of income based taxation as a viable and fair source of revenues. Surveys of Canadians support the principle of increased general taxes rather than user fees as the preferred method of raising funds. Canadians do not support private financing or delivery which threatens quality or access to care.

We support policy options which strengthen primary care reform and ensure quality of care. We have reservations about any Pharmacare program which is not fully publicly financed. We are disappointed in the Senate Committee's failure to support and strengthen Canadian's most valued social program, Medicare. We thank you for the opportunity to provide you with our comments and feedback.

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