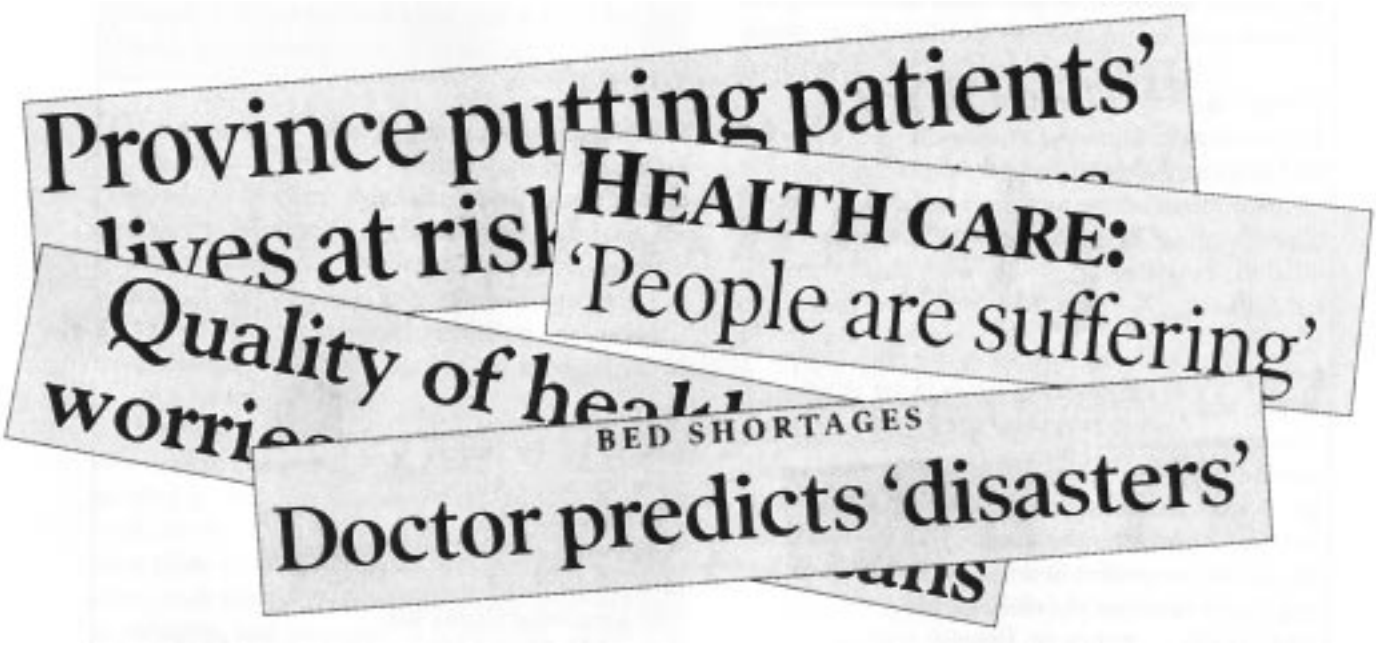
Cutting Health Care: The Hidden Cost

BY GREG FLANAGAN



Health care reforms have left almost 50 per cent of Albertans doubtful whether the system will be able to care for them when they need it. With hospital closures, backlogs in emergency wards, doctors leaving for more stable practices elsewhere, long waiting lists to see specialists, and the delisting of services previously insured under medicare, health care is making headlines. And Albertans are alarmed.

Amid this climate of crisis, Jim Saunders tours visitors through the new 45-bed private facility in the former Grace Hospital in northwest Calgary. Saunders is justifiably proud of the Health Resource Centre, which was completely renovated at a cost of $2.5 million. The president of Health Resource Group points out the features of the private hospital. The attractive decor, colourful carpets, wallpaper, oak and brass trim, recessed lighting and hallway wall sconces create an environment as welcoming as a first-class hotel. The comfortable private, semi-private, and four-bed rooms include ensuite bathrooms, cable TV, telephone and computer outlets. The hospital's three state-of-the-art operating theatres, completed at a cost of $2 million, have welded-seam plastic walls, air exchange and digital air monitoring equipment, and brand new medical equipment.

Health Resource Group was incorporated by a small group of investors — Frank King, Peter Burgener, Steve Miller, Tom Saunders, Jim Viccars, and Nigel Patchett — with an initial capitalization of $6 million. The number of shareholders has expanded to approximately

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ALBERTA HOSPITALS CLOSED OR CONVERTED 1993 TO 1997 • CALGARY GENERAL (BOW VALLEY)

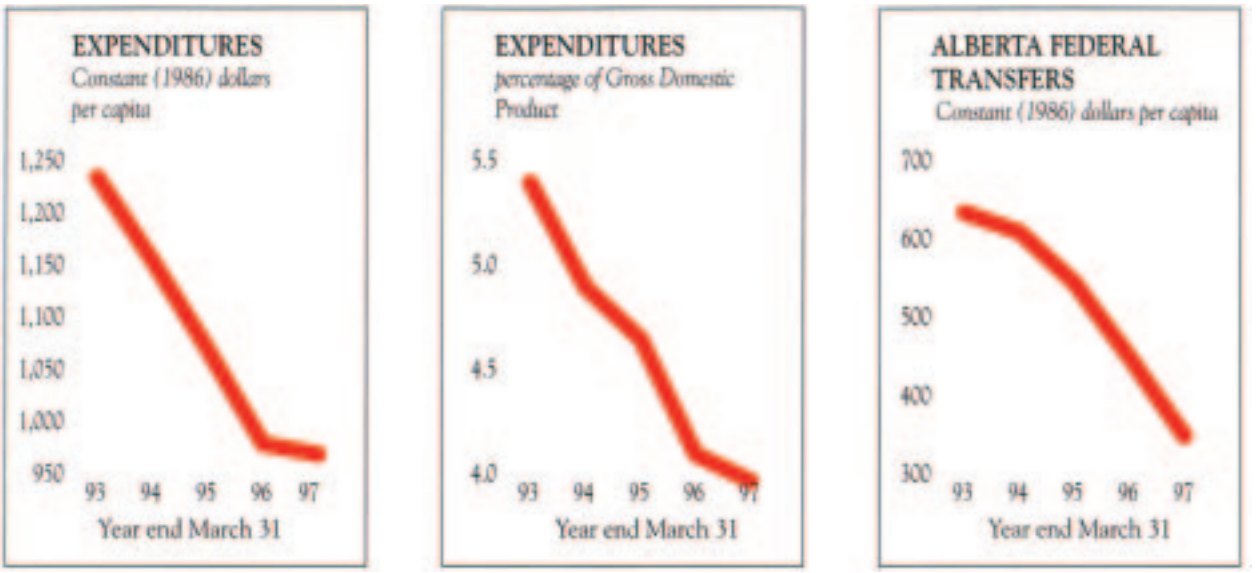
60 and the total amount invested has risen to $10 million. HRG investors, Saunders says, are dedicated to customer service and quality. Above all, emphasizes Saunders, a 25-year veteran of the public health care system, the private hospital wishes to operate in full compliance with the Canada Health Act.

HRG's proposed clients include: out-of-country uninsured persons, mainly Americans; contract work tendered by regional health authorities under medicare; third-party insurers such as Workers' Compensation Board; and those seeking services not considered to be "medically necessary," such as cosmetic surgery (facelifts, tummy tucks, breast implants and liposuction) and dental surgery. Since "medically necessary" has never been defined and services vary among provinces and over time, the list of these services is expected to change and grow.

Since August 1997, the Health Resources Centre has been fully accredited to provide ambulatory services for its eight day-surgery beds. In this respect, it is not significantly different from many clinics operating around the province. However, in order to implement its business plan and make full use of the facilities in which it has invested heavily, HRG needs approval to provide more extensive surgery requiring an overnight stay. The Alberta College of Surgeons and Physicians has deferred its approval and HRG's proposal has been referred to the Minister of Health. (At the time of writing, this approval has not been granted).

Every day HRG receives numerous calls to perform medical services covered under medicare for people who would rather pay than wait. Because extra billing for covered services is clearly illegal under the Canada Health Act, HRG must refuse these requests. Its main client is the WCB, which is exempt from the Canada Health Act and can purchase services legally from accredited providers. Since the WCB incurs costs for every week its injured clients are off work, one of HRG's main objectives is to serve WCB patients ahead of the normal wait lists. For example, a patient with a common knee injury might wait up to six months before being treated in the public system. HRG can reduce this time to days and have an injured worker back on the job in weeks rather than months.

There is a demonstrated need for this hospital. But the need — as well as the investment opportunity it provides — has arisen from massive reductions in public health care funding by the provincial and federal governments.



The constant dollar per capita expenditures on health care have decreased 21 per cent over the last four years.

In the face of government's harsh financial restrictions, Alberta's health care system has undergone extensive restructuring in the past few years. To lower costs, the government amalgamated 250 hospital, continuing care, and public health boards into 17 Regional Health Authorities. The 15-member, appointed RHA boards are responsible for developing a strategic plan for their region, setting overall policy, approving the resources needed to meet the plan, and hiring a management team to implement the plan and oversee the day-to-day operations. Regionalization was to provide more co-ordinated services among health agencies, so that the same agency in each community would be responsible for the continuum of care, from prevention and promotion, to acute, continuing and palliative care.

Initially, the funding for each RHA was determined by historical factors, an arrangement that proved to be unsatisfactory and led to *ad hoc* funding adjustments. Alberta Health now has proposed a population-based funding scheme which will take into account the specific circumstances, cost factors or special health needs of each region. Starting this year, a region's funding will be based on a formula that includes age and sex distribution and the socio-economic composition of the population of each region.

The two largest regional health authorities — Edmonton's Capital Health Authority and the Calgary Regional Health Authority — will receive additional funds for "province-wide services." These include high-cost, high-technology services such as organ and bone marrow transplants, heart surgery and angioplasty, kidney dialysis, neurosurgery, selected cancer treatments, and intensive care for severely ill infants and patients with severe trauma or burns. These regional services are very costly to the urban RHAs. In Edmonton, for example, 35 per cent of all patients admitted to CHA hospitals live outside the region, mainly in northern and central Alberta.

'After four years of rampant cost-cutting, Alberta, the richest province in Canada, has the poorest health care system'

In tandem with regionalization and restructuring, the government has drastically reduced the amount of money allotted to health care. Since it began its deficit reduction plan with the 1993/94 budget, the Alberta government has reduced the absolute spending by approximately $500 million per year and increased medicare premiums by about another $250 million. The net expenditure has thus declined by $750 million. Most of the reductions have been achieved by cutting hospital beds; closing, amalgamating or converting hospitals; contracting out procedures such as eye surgery; delisting services; co-ordinating and reducing administrative costs, and by capping the total billing of physicians.

Reductions in absolute dollar amounts spent on health care do not fully capture the effect on actual service. Inflation has reduced purchasing power by another nine per cent over the last four years. And with a growth rate of 1.5 per cent, second only to British Columbia's 1.75 per cent, Alberta's population will increase by more than 50,000 this year. Taking into account inflation and population changes provides a more realistic sense of what is being spent: the constant dollar per capita expenditures on health care have decreased 21 per cent over the last four years.

Alberta's economy has been growing faster than that of any other province, and Canada itself is expected to top the G-7 industrialized countries in economic performance for 1998. Typically, demand for health care increases with increases in income. Using gross domestic product as a proxy for income, if we consider health care expenditures as a percentage of GDP (as many national and international comparisons do), the reduction in health care expenditure is even greater.

Another way to view the government's commitment to health care is to compare public expenditures on health care in Alberta with spending in the other provinces. In constant dollars per capita, Alberta ranks second lowest, just ahead of tiny Prince Edward Island. At four per cent of GDP, Alberta is dead last, well below the Canadian average of 5.5 per cent. Alberta, the richest of all the provinces, has gone from the best-funded program in Canada to the worst in four short years.

While provincial governments are responsible constitutionally for health care, the federal government has the upper hand in taxation. The medicare system we have today was brought into place on a national level by the taxation and funding levers of the federal government. By proposing equal cost sharing to any province that introduced medicare, Ottawa eventually persuaded all provinces to agree to the plan. The federal government therefore was able to achieve its legislative will in an area over which it had no constitutional authority. More recently, it has been offloading its deficit problems onto the provinces by reducing funding support for programs that it initiated in health, education and social services.

Health transfer payments to the provinces have fallen from $19.3 billion in 1994/95 to $12.5 billion in 1996/97. This amounts to a 35 per cent reduction in two years, a percentage that would appear larger on a constant per-capita dollar basis. Tom Kent, Lester B. Pearson's principal policy advisor in the early 1960s, has recently written a critical review of the federal government's neglect of medicare. Kent says provincial politicians resent being stuck paying the bills for medicare while federal government leaders take political credit for "saving" medicare and upholding the principles enunciated in the Canada Health Act. He suggests the medicare system survives despite them, not

Too Fast, Too Deep

As an economist, I was complacent about the closure of some of Calgary's hospitals. Hospitals have accounted for 40 to 60 per cent of public expenditures on health care in Canada, making them the obvious target for cuts. Alberta, with about 4.3 beds per 1000 compared to the 2.4 bed goal of government reform, had a particularly strong case for cutting. While the average cost per patient day was around $600 nationally, Alberta was averaging $750. We had too many idle beds in too many small hospitals.

In the early days of medicare, too much emphasis was placed on providing health care through hospitals. The Hospital Insurance Act of 1957 offered 50/50 cost sharing with any province that would build and operate hospitals. Medical services provided through hospitals, including drugs, were free to the patient, while the same services provided on an out-patient basis were not covered. This early bias toward hospital care, coupled with the government's tendency to develop rural areas by building hospitals, led to an excess of hospital beds in Alberta as elsewhere. Technological advances requiring less invasive surgery, and reduced hospital recovery time, especially after childbirth, have reduced the need for in-patient beds.

Knowing this, I accepted the inevitability of hospital closures. Others were more appropriately concerned and active. Private citizen, Barbara Baxter and her team organized and conducted public hearings on the proposed closure of the Calgary General Hospital in May 1996. The General's operating budget of $17 million per year could have been reduced to as little as $10 million, one-tenth the amount the Calgary Regional Health Authority has already spent to build facilities and relocate programs to the three remaining acute care hospitals. The CRHA is now asking for another $70 million to deal with some of the backlog precipitated by the closure of the downtown hospitals.

Conducting those public hearings should have been the role of the CRHA. During the initial phases of system reform, the Regional Health Authorities were far too independent and unresponsive to community concerns. It appears they were driven by the need to cut drastically, regardless of the damage inflicted. This is sad, particularly in view of the sorry plight of the many mental health patients who relied on the General, and in light of Calgary's growth. The Calgary region now has 1.74 beds per thousand, far below the 2.4 beds considered necessary.

Closing the Calgary General Hospital was a mistake.

Let's admit these mistakes. Health reform was too fast, the cuts too deep. Let's truly re-invest, not hobble along with increases in spending insufficient to cover inflation and population growth.

— Greg Flanagan

because of any support on their part, and since introducing medicare in the 1960s the federal government has reneged on paying its share of the costs.

At the provincial level, the unprecedented magnitude and speed of the cuts to public spending have been something to behold. Because Alberta Premier Ralph Klein was able to capitalize on serious public dissatisfaction with government programs and the expenditure levels that existed, he and his team managed — remarkably — to accomplish all this while increasing their popular support. In 1993, there appeared to be a large and seemingly persistent deficit in Alberta; certainly there was a serious fiscal situation at the federal level, with 25 years of continuous deficit financing, a large accumulated debt, and most importantly, a huge percentage of expenditures going to pay interest on the debt.

Ironically, Alberta was never in bad fiscal shape. It had a large accumulated surplus prior to the Don Getty years of deficits, so its net debt was low. The deficit can be attributed to a recessionary economy and — to put it politely — overly exuberant expenditures of $20 billion on "industrial development," of which the losses on NovaTel, Alberta Special Waste Management System, Gainers Meat Packers, the Lloydminster upgrader, and the Magnesium Company of Canada are only the tip of the iceberg. In 1993, however, the province's economy had already started growing at a rapid rate, depressed energy prices were well on the rebound, and

unemployment was falling. Staying the course and reducing industrial development expenditures alone would have solved the deficit problem.

By embarking on an ambitious cutting campaign that affected virtually all aspects of government programs, the Klein government has created a structural surplus of staggering proportions — $2 billion per year.

Although it is prudent to budget conservatively, recent revenue projections have been overly conservative. It would now take a major recession to dent the surplus.

So why did the Conservative government cut the health care budget? We couldn't afford first-rate health care, it was argued, and we were spending too much. Above all, it was said, the health delivery system was inefficient. But these arguments don't hold up to scrutiny. We can afford first-rate health care if we value it. The purpose of an economy is to produce what people want, and health care is a highly desirable and valued good. Survey after survey confirms that Albertans and Canadians want top-quality public health care and consider it a priority for a high standard of life. Other evidence indicates that people value health more as they age and as their income increases.

Premier Klein suggested the health care system had grown at such a tremendous rate that it had to be stopped or it would consume the entire budget in the future. Of course, health care expenditures have to be balanced with other spending priorities. Spending our entire GDP on health would be absurd, but spending four per cent of GDP is likely far less than the value we place on health care.

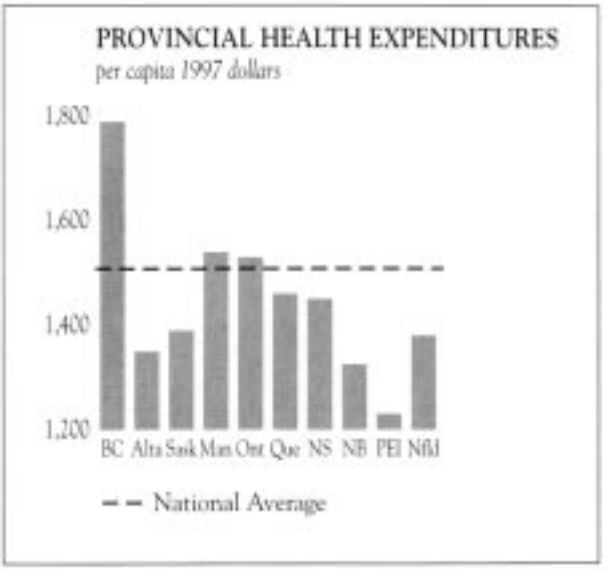
Furthermore, a reduction in publicly funded services does not equal a reduction in total expenditures on health. About one-third of Canada's total health care spending already occurs in the private sector, and that proportion is growing. Albertans' private health care expenditures have increased 11 per cent since the beginning of the government's deficit reduction plan. These expenditures include costs incurred for regular eye examinations, as well as for drugs, home care and other costs that used to be covered during longer hospital stays. Some costs are not so easy to measure as they have been shifted onto families, mostly women. It is clear, though, that cutting government expenditures on health care reduces neither our demand for health care nor our willingness to pay to obtain that care.

The issue is not whether we want health care but how we are going to pay for it — publicly or privately. If reduced public financing only shifts the costs onto individuals, then total expenditures on health are not declining.

What is happening is that the principles of delivering health care based on need (as opposed to the ability to pay) are being eroded.

As for efficiency, we buy personal computers with the capacity to manage a modern factory and use them to play games. We drive alone in vehicles that can seat four to eight people. We own houses with two to three times the square footage per person of a generation ago. Our houses are empty during the day and our office towers vacant by night. Our cultural sense of efficiency is blind to the wastes inherent in our day-to-day behaviour because these are private decisions.

However, if hospitals have vacant beds and nurses have time to chat with patients; or if our classrooms are not jam-packed, then we think there is dreadful waste. We are much more critical of public expenditures. This



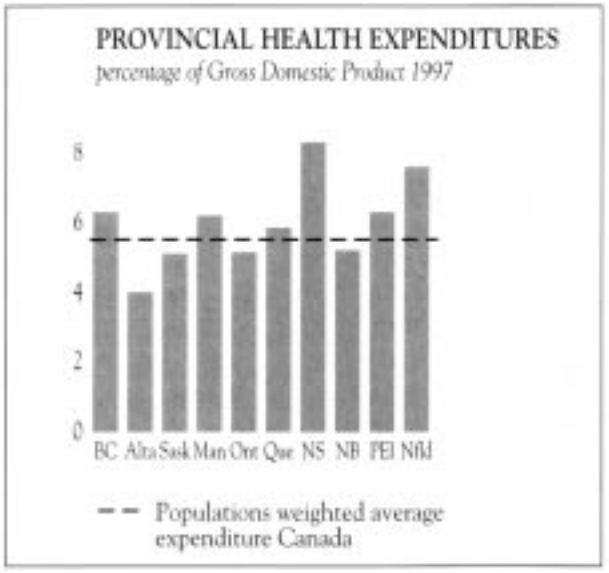
can result in what John Kenneth Galbraith described as "private splendour — public squalor."

Compared to our closest neighbour, though, Canada is relatively efficient. While health care expenditures in the United States approach 15 per cent of GDP, we spend under 10 per cent of our GDP on all health care expenditures combined — federal, provincial and private. The economies of administering a single insurance scheme are largely credited with this efficiency. The conclusion of the 1997 National Forum on Health is "that increasing the scope of public expenditure may be the key to reducing total costs."

Undoubtedly, reform of the health care delivery system was needed. Rapid technological change, bureaucratic entrenchment, and over-reliance on hospitals, concerned many across the political spectrum. Nobody wants an inefficient and wasteful system. As John Ralston Saul writes: "If a government presents cut-backs as if they were essential policy, indeed a

moral obligation, then they are probably trying to distract us from their central policy intentions."

Neither Premier Klein nor the Ministry of Health has given Albertans a clear idea where the health care system is going after years of spending cuts. Is reform through drastic cuts in public expenditures nothing but a smokescreen to undermine the health care system for ideological reasons and make privatization look more attractive? If the public system can't perform to the public's desired level will they more readily call out for private systems of delivery? Is the contracting out of day surgeries and the development of private for-profit businesses like HRG the beginning of a two-tiered health



care system in Canada as the public system deteriorates?

Jim Saunders, the people behind the Health Resource Centre, and others feel that market incentives can bring certain efficiencies to the delivery of health care. Those who believe in market solutions for health care say decisions left to market processes will ensure economic efficiency and help solve our health system's woes. Is there is a problem with this perspective?

Under special circumstances, markets can achieve a socially optimum — that is, economically efficient — outcome. The benefit people derive from something is manifest in their willingness to pay for it. Because people pay a price, it is argued, they will only buy what gives them more or equal value than what they might buy with the money. The market "disciplines" people to be efficient in their purchases. On the supply side, each producer is motivated to be efficient through the profit incentive. The more methods of production are able to lower the costs, the greater the profit. The market solution ensures that we collectively obtain the greatest total benefits possible. The goods that bring the most benefits are determined by what is in demand. Effective market demand, however, depends on consumers' ability to pay. Consumers in a market system earn according to their contribution to overall production. A person with weak or no marketable skills earns little or no income and therefore has no ability to pay.

The circumstances for an efficient market solution do not exist in health care. Market success requires competitive markets where numerous autonomous and anonymous producers can survive only by producing efficiently — that is, at the lowest cost of production. But large economies of scale in hospital services and in the system's administration require the absence of competition. In some respects, introducing the RHAs was intended, rightly, to reduce the competition that was raising costs unnecessarily. With monopoly-generated economies of scale, we do not want for-profit production. It moves us away from economic efficiency.

As all "medically necessary" health services are currently covered free of charge under the Canada Health Act, some suggest these services are overused and that a "user fee" (price by another name) would curb this abuse.

However, there is no evidence that Canadians abuse or overuse the health care system. On the contrary, international comparisons show Canadians to be in the middle of the road in terms of accessing primary care. No one can progress past this step without the referral of a general practitioner, so it would therefore be difficult to overuse the system. People don't seek out medical services as they do other goods. Nobody wants to be in a hospital, and most don't relish the thought of seeing their doctor. The normal incentives (disincentives) of price rationing do not occur. The opposite is more likely.

Where fees are charged, the poor are reluctant to access the health care system for minor problems, even though early treatment might prevent more significant and costly problems down the road. The inconvenience of losing work time is enough to deter misuse of the health care system. On the other hand, in an emergency, people will use the services available at any price, even to the point of bankruptcy in countries where the user pays. A user fee has little purpose in allocating resources in the health system. All it does is determine who gets the services according to their ability to pay.

Even where a market solution is efficient, nothing is necessarily "fair" or equitable about the distribution of the good. The Canadian character is highly identified

with the universal and free provision of health care. The distribution of health care services should be by need, not through the ability-to-pay principle which drives the demand for other goods. The National Forum on Health findings show Canadians overwhelmingly support publicly funded and universally accessible medicare.

The provision of health care is thus so distant from our concept of a normal marketable commodity that using markets to decide how much to produce and who should get it is inappropriate. As patients, we don't necessarily have the information and knowledge to make treatment decisions. We rely on our physicians and other medical personnel to do so. This fiduciary relationship in medicine is important. We want these providers to be bound by the highest ethical and professional standards, not driven by the profit motive, even if that motive works well in the efficient provision of many commodities. We want the health care system to be driven by a different set of values than the production of television sets.

As the first for-profit private hospital in Canada, does the Health Resource Centre represent a threat to public health care? Saunders points out the HRG's $10-million investment is insignificant compared to the $4-billion Alberta government expenditure and the $1.5-billion current private expenditures on health. Alberta Health's point of view is that this development will free up funds and medical services in the public system.

The government appears to be encouraging this private, market-based approach in order to alleviate the strains in the public health care system. There has been no major policy announcement about this privatization direction; nor should we expect one. However, by diminishing public financial support for health we will be handing over parts of the public system to the private sector piece-by-piece, and the principles of medicare will be lost.

To avoid this, we need to reaffirm the principles of the Canada Health Act and prohibit for-profit delivery of medically necessary health care. We need to support increased funding to overcome current deficiencies in the public system. The profit opportunity for a private facility would not exist if waiting lists were at acceptable levels. Although the province is ultimately responsible for proper funding levels, federal funding needs to be enhanced to take some pressure off provincial governments. A meaningful financial presence on the part of the federal government will also give it the moral and practical authority to enforce compliance with the Canada Health Act.

Citizens must have the choice to decide how much of their taxes go to health care. If we don't properly fund public health care, talented doctors, nurses, and health care administrators like Jim Saunders will continue to leave the public system demoralized and frustrated by its inadequacies.

Finally, we need to support reform of the delivery of medical services in order to improve efficiencies and reduce costs. However, the public won't support change in the health care system if they fear that the hidden agenda of reform is the privatization of health care, placing it in the for-profit sector. For example, although it needs to be reworked and depoliticized, regionalization was a good move. We need to democratize the board selection process, and the RHAs must become more open and responsive to citizens' concerns and demands.

Most health care professionals do not want to serve in a system driven by profit and self-interest, as is seen in the call for action, *For Our Patients, Not for Profits*, signed by a group of 2,500 Massachusetts doctors and nurses. Published in *The Journal of American Medicine* in December 1997, it reads: "Mounting shadows darken our calling and threaten to transform healing from a covenant to a business contract. Canons of commerce are displacing dictates of healing, trampling our professions' most sacred values. Market medicine treats patients as profit centres. The time we are allowed to spend with the sick shrinks under the pressure to increase throughput, as though we were dealing with industrial commodities rather than afflicted human beings in need of compassion and caring."

These American medical practitioners have experienced market, for-profit medicine — and they want it stopped.

Jim Saunders and HRG see that what they are doing will bring certain market efficiencies to the health system. What they don't see is that for-profit delivery of health services fundamentally changes the nature of delivery from a physician-patient trust relationship to the processing of health as a commodity.

Regardless of the scale of HRG to overall expenditures in health, this initiative is a major shift in the values underlying health care delivery in Alberta and in Canada. If the Health Resource Centre is approved for inpatient surgery, it will only be the first for-profit provider; the gates may be open for others that will not share the current Canadian perspective on health.