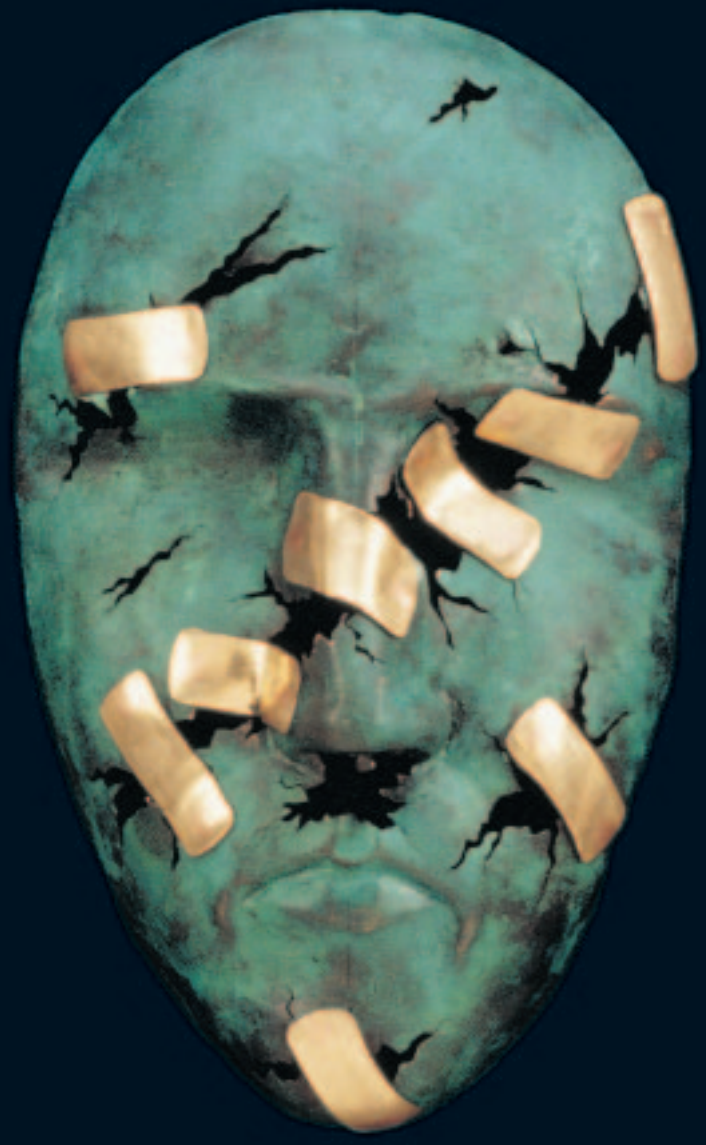
Can Medicare Survive?

A response to the Mazankowski Report

by Greg Flanagan



JEFF DE BOER

Nearly a decade ago, the Klein government initiated massive cuts to public services, including health care. Along with those cuts came other system changes, such as the replacement of more than 250 hospital, continuing care and public health boards with 17 regional health authorities (RHAs). By 1997, our province was experiencing hospital closures, backlogs in emergency wards, a loss of doctors to more stable practices elsewhere, long waiting lists to see specialists, and the delisting of services previously insured under Medicare. Seeing a situation ripe for private investment in health facilities, the Health Resources Group (HRG) sought approval to be the first for-profit hospital in Alberta. The government considered their plan an innovative approach to improving health care delivery and introduced Bill 37 to enable it.

Just five years ago, the government began reinvesting in health care, and funding (in terms of real dollars per capita) in Alberta has now been fully restored to its 1993 peak (see Figure 1). In addition, the federal government has restored, if not increased, its contributions to health. Whereas formerly all RHA board members were appointed, half are now elected. Bill 37 was withdrawn, only to reappear as the equally controversial Bill 11, which, when passed and proclaimed, became the Health Protection Act. While including a reaffirmation and declaration of adherence to the Canadian Health Act, the Act also paved the way for overnight stays at the private, for-profit HRG [now called HRC] hospital in Calgary.

Funding has reappeared, but the controversy about health care continues.

The Alberta government's response is *A Framework for Reform: Report of the Premier's Advisory Council on Health*—popularly known as the Mazankowski Report, after the committeee chair, Don Mazankowski, former deputy prime minister of Canada. Released in late 2001, the report makes more than 40 individual recommendations grouped around 10 suggested reforms. The report is delivered in the language of the marketplace, and many of its recommendations incorporate market solutions to the perceived problems. Among its most controversial suggestions are the "delisting" of specific medical services not deemed "medically necessary," the establishment of personal "medical savings accounts," and the proposed "diversification" of the health system's "revenue stream." The Klein government has accepted all the report's recommendations and has already begun to implement some, including a 30 per cent increase in health insurance premiums and an increased tax on tobacco products.

The Mazankowski Report is not without merit. Yet its major premise—"The current health-care system is not sustainable if it is solely funded from provincial and federal budgets"—is wrong. Moreover, the health care "crisis" so touted in public discourse was, to a large degree, created by the government's own cutbacks of the mid-nineties. The report argues that health expenditures are rising fast and are out of control, but it uses statistics from only the last five years. A longer perspective shows those cuts were drastic (see Figure 1). Over the last half-decade, major reinvestment was necessary simply to rebuild. The high and rising percentage of the provincial budget spent on health care is a function of cuts in other areas. It stands to reason that when taxes and public services are cut the health *percentage* will rise, even if actual spending remains the same.

Consider the opening remarks of the report of the National Forum on Health, convened in 1994: "The ultimate goal for everything we do in the health sector is the improvement in health status and quality of life at the level of both populations and individuals. The acid test is whether services, programs and policies have improved health beyond what could have been achieved by doing something else with the same resources or by doing nothing at all." A worthwhile objective to keep in mind when evaluating the Canadian health care system.

Chaired by Prime Minister Jean Chrétien, with then Minister of Health Allan Rock as vice-chair, the National Forum included 24 experts from across the country and made its final report in 1997. Its major findings are still significant for the current discussion:

> (1) Health care is not in crisis. The system is fundamentally sound but needs improvement. Health reform is desirable. The Canadian system could be more efficient and effective. Health care workers as well as patients require better information.
>
> (2) The basic principles of Medicare accurately reflect people's values of equity, compassion, collective responsibility, respect for others, efficiency and effectiveness. The public will not support changes unless these values are preserved.
>
> (3) Total health spending is high by international (not U.S.) standards and sufficient. However, international evidence suggests that public funding and administration are the best ways to achieve fairness and efficiency.

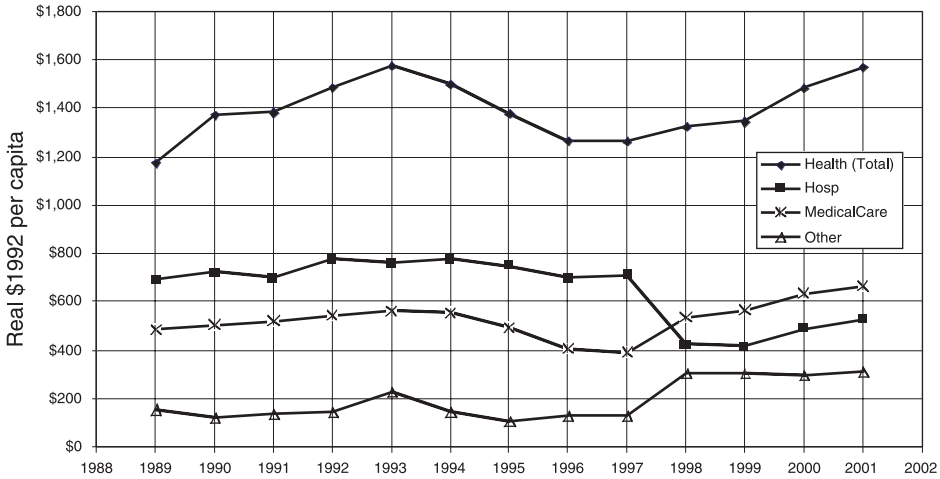


Figure 1. Health care expenditures in Alberta,1989-2002. (Source: Stats Canada, Provincial Expenditures, AB)

The Forum affirmed the five principles of the Canada Health Act (see box below) and recommended stable and predictable federal transfers sufficient to ensure full public funding for medically necessary services within a single-payer model. The Forum recommended that we rely less on hospitals and doctors and deliver a broad range of community health services with multidisciplinary teams and a strong emphasis on prevention. It also advised an increase in the scope of public expenditure for homecare and pharmacare. And it cautioned against both the arbitrary de-insuring of services and the introduction of user fees.

More recently, the federal government's Commission on the Future of Health Care in Canada, headed by former Saskatchewan premier Roy Romanow, was given a mandate to recommend policies and measures to ensure the long-term sustainability of a universally accessible, publicly funded health system. In its second phase, the commission undertook dialogue with Canadians on the future of Canada's public health care system and commissioned some 40 research and discussion papers covering a range of health topics. While not due to release its final report until November, the commission did release an interim report in April 2002.

The report finds that Canadians' views coalesce (but without agreement) around four major concerns: more public investment, shared costs and responsibilities, greater private choice and reorganization of service delivery. Its interim findings are similar to those of the Forum. It finds that the "Medicare house needs remodeling but not demolishing." Currently, for example, hospital and physician services account for less than half of the health system's total cost. More money is spent on drugs than on physicians, and much health care is delivered outside the hospital environment through a variety of health care providers. "In short, the practice of health care has evolved. And despite efforts to keep pace, Medicare has not."

"The lack of stable, long-term, predictable funding," the Romanow Commission reports, "is jeopardizing long-term planning and, in turn, eroding public confidence in the system's future." Canadians are concerned, it says, about waiting lists and timely access to medical services. They want both levels of government to "stop the corrosive and unproductive long-distance hollering and finger pointing that currently passes for debate on how to renew the health care system."

Having declared an urgency to get on with reform, and unwilling to wait for the Romanow Commission's final report, the Alberta government has accepted the recommendations of the Mazankowski Report. Clearly the most controversial of the three studies, and the one most affecting Albertans, the report's main point is that our current health care system is financially unsustainable—health expenditure is increasing yearly and taking up an increasing proportion of the provincial budget. The report suggests 10 reforms (see box on p. 29).

The first is for Albertans to stay healthy. A laudable objective—but how is it to be implemented? Population health is highly correlated with socio-economic conditions, education, housing, nutrition and environmental pollution, among other things. Richard Wilkinson, a professor of social epidemiology at the University of Nottingham who studies the relationship of inequality of income and health, has found that, regardless of the level of *average* social wealth or income, the greater the

THE FIVE PRINCIPLES OF THE CANADA HEALTH ACT

"The primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial other barriers."

1. **Universality**: The health care insurance plan of a province must entitle 100 per cent of the insured persons of the province to the health services provided for by the plan.

2. **Accessibility**: The health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons. Those providing the services must receive "reasonable compensation."

3. **Public Administration:** The health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province.

4. **Comprehensiveness**: The health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

5. **Portability:** The health care insurance plan of a province a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for and entitled to insured health services; and b) must provide for the payment for the cost of insured health services provided to insured persons while temporarily absent from the province.

www.hc-sc.gc.ca/medicare/Documents/CHA-html.pdf

income *inequality*, the poorer the population health. University of Toronto's Dennis Raphael recently wrote a book on the connection between low income and heart disease. "Poverty, and not medical and lifestyle factors, is the leading cause of cardiovascular disease in Canada," he writes, "and recent political decisions exacerbating income and wealth differentials have only made the situation worse." In reforming our health care system, we must address the social determinants of health.

Another Mazankowski recommendation—investment in technology and the establishment of personal electronic health records—is long overdue. In order to make the health system more efficient and effective, we as citizens will have to give up some privacy to "Big Brother." Of course, we need to make sure these records are as secure as possible from misuse or access by unauthorized individuals.

Another good proposal is salaried physicians. The health minister, Gary Mar, wants half the province's doctors paid on salary, rather than fee-for-service, and working in primary-care community health centres within teams of health care professionals by 2004. In this, the Mazankowski Report is in agreement with the Forum and the Romanow Commission.

Other Mazankowski recommendations, however, are just plain bad—among them, increased competition, diversification of the revenue stream and medical savings accounts (MSAs). Why increase competition? And why diversify the revenue stream? These suggest a movement toward a user-pay, market-modelled scheme, or at least to an increase in the proportion of revenues obtained in this way. Why the market rhetoric? The strength of Canada's health care system (as the Forum, the Romanow Commission and other studies have found) is precisely its monopoly status, which provides lower costs through economies of scale and scope. The Alberta government showed that it understood this advantage when it collapsed the province's health administration system into 17 regional health authorities (and it has recently suggested reducing this number further). It also closed hospitals—the Calgary General, for example—to eliminate costly and inefficient competition.

Ironically, the health care premium paid by Albertans, recently increased on the recommendation of the Mazankowski Report, does not model market pricing. Its application has no impact on the use of health services. Those on both the right and the left of the political spectrum agree the premium is nothing but a tax. It's the worst kind of tax—a poll or head tax—and should be eliminated, not increased.

One can only surmise that the government has kept and increased this premium to use as deposits for MSAs (health information cards acting also as account debit cards). MSAs would give citizens an annual government allowance to buy their own health care, thereby bringing market incentives in through the back door without introducing user fees directly. They would give people the

RECOMMENDATIONS OF THE MAZANKOWSKI REPORT

1) The first reform is to stay healthy—providing a strong commitment to education, setting clear health objectives and targets, providing better information to Albertans and taking steps to encourage Albertans to stay healthy.

2) It's time to put "customers" first—including a 90-day guarantee for certain health services, establishing centralized booking and posting waiting times on a website, and implementing new models of care.

3) Redefine what we mean by "comprehensiveness"—establishing an expert panel to make decisions on what health services are publicly insured in addition to those required under the Canada Health Act.

4) Invest in technology and establish an electronic health record—implementing electronic health records, establishing a debit-style electronic health card and providing long-term funding for technology.

5) Reconfigure the health system and encourage more choice, competition and accountability—setting distinct responsibilities for government and health authorities, establishing multi-year contracts between health authorities and government, encouraging service agreements with a wide variety of providers, and integrating mental health services with regional health authorities.

6) Diversify the revenue stream. Instead of rationing health services, we need to find better ways of paying for the health services Albertans want and need—ensuring government continues to fund the majority of health care costs, implementing a "made in Alberta" approach for funding health care services tied to Alberta Health Care premiums, and working with other provinces to manage and contain increasing drug costs.

7) Put better incentives in place for attracting, retaining and making the best use of health providers—developing a comprehensive workforce plan, improving workforce morale, implementing alternative ways of paying physicians, and encouraging health providers to implement new ways of delivering services.

8) Make quality the top priority for Alberta's health system. Set standards, measure results, and hold people accountable for achieving better outcomes in health—establishing a permanent, arm's-length Outcomes Commission to measure results, track outcomes and report to Albertans.

9) Recognize and promote Alberta's health sector as a dynamic, powerful asset to the provincial economy—continuing to support research, maintaining support for education programs for health providers, and sustaining Alberta's reputation as a leading centre for health and medical research.

10) Establish a clear transition plan to drive the process of change, oversee implementation of recommendations, consider options and monitor the impact.

www.gov.ab.ca/home/health_first/documents_maz_report.cfm

EXPERT ADVISORY PANEL TO REVIEW PUBLICLY FUNDED HEALTH SERVICES

Chair: Bob Westbury	community leader	Edmonton
Marvin Moore	RHA rep	Debolt
Dr. Franco Pasutto	pharmacy	Edmonton
Dr. Kevin D'Amico	chiropractic	Calgary
Greta Cummings	nursing	Edmonton
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Dr. Martin Atkinson	specialty medicine	Calgary
Dr. William Black	specialty medicine	Edmonton
Jeff Kovitz	legal	Calgary
Brad Neubauer	public	Irvine
Thomas Clark	public	Leslieville

financial incentive to not use the system, which, like a user fee, causes harm by interfering in the early diagnosis and prevention of more serious afflictions. As Evelyn Forget argues in her paper "Medical Savings Accounts: Will they Reduce Costs?", MSAs would not save money, and sick people would have to pay more. When it comes to health care, market incentives do not work.

Contentious too is the issue of "redefining what we mean by 'comprehensiveness.' " A panel composed of exceptional Albertans (see box above), chosen in spring 2002, is to recommend by December 2002 what current health services and treatments are "medically necessary." By January 2003, the panel is to recommend criteria to determine what new services and treatments should be publicly funded. The vagueness of the term "medically necessary" in the Canada Health Act is problematic and leads to conflict among various individuals' expectations. It also leads to considerable differences in Medicare across the country as provinces include different sets of services and treatments. A liberal interpretation of the term can also contribute to the sense that one's neighbour is over-using the system through trivial or cosmetic services.

The panel, so important to the final look of health care in Alberta, includes only two representatives from the general public. Because the tone of the Mazankowski Report supports increased private sector involvement in the delivery of health care, the panel should have had better representation from the general public, and at least some of the members should have been elected. If the panel is wise it will take heed of the Forum's earlier recommendation not to arbitrarily de-insure services. Alberta citizens should contact panel members with their concerns about what services and procedures should be counted as "medically necessary."

The Forum and Romanow reports indicate that the system is not broken, but does need adjustment. Most other provinces are moving forward moderately on reform. By contrast, Alberta's Mazankowski Report signals major changes ahead. As Jeffrey Simpson wrote in his June 22, 2002, *Globe and Mail* column, "Whatever decisions Alberta eventually will take, it will be pushing the envelope." The question is just how big a change the Alberta government wishes to see based on this report alone.

Canadians currently spend over $100-billion per year on health care, or approximately 9.5 per cent of our gross domestic product. Of this total, about 30 per cent is spent privately by individuals and 70 per cent by the provincial and federal governments on our behalf. The provinces, which are primarily responsible for health care, are guided by federal legislation, by the Canada Health Act and by the threat of federal health and social transfers being withheld for noncompliance. The health care system is a mixture of public and private bodies, institutions and individuals. Most private agents in the publicly funded sector work on a non-profit basis, while some are for-profit businesses.

The early development of Medicare placed a large emphasis on doctors and hospital care. This bias is still reflected in the pattern of public expenditure: public money pays 99 per cent of doctors' fees, 91 per cent of hospital expenses, 81 per cent of capital expenditures and 70 per cent of other institutions' costs. However, much of health care is now delivered by drug therapies and home care; public expenditures on these account for only 31 per cent and 10 per cent respectively.

In Alberta about 75 per cent of all health expenditures are public (see Figure 2). Although public expenditures are a higher percentage in Alberta than the Canadian average, other provinces have more progressive payment methods for doctors. In Alberta the amount doctors are paid in salary or through mechanisms other than fee-for-service is only 0.6 per cent, compared to a national average of 8.3 per cent and a high of 28.8 per cent in Newfoundland.

The current overarching issue in Alberta appears to be "public versus market" methods of delivery for health care. The implicit message in the Mazankowski Report is that the rise in health care expenditures is only a problem if they are paid for with public funds. Increasing the privatized element will not decrease overall expenditures on health, but only shift the public/private split.

The Klein government has an ideological bias for market solutions—private, for-profit supply and user-pay schemes to meet "demand." It is no surprise that the Mazankowski Report uses consumer/producer market language. (Nor is it any surprise to see that the Fraser Institute, a business-backed think tank, has released a report supporting market price mechanisms in the health care sector. The institute's website masthead states its bias clearly: "competitive market solutions for public policy problems.")

At a recent Canadian Economics Association meeting, Paul Boothe, an economics professor at the University of Alberta and one of the team leading the implementation

of the Mazankowski Report, raised a question regarding the equity of health care financing: Who Cares? We do not seem to care, he asserted, how other products, such as cars, for example, are financed and distributed or about the effects of these transactions on the distribution of income. Is he suggesting that health care is just another market commodity?

A market does work efficiently for the production of many goods and services, and when it works, it is a rationing device which provides products at reasonable costs to those who can afford and most value them. For Canadians, however, health is not just another commodity. Most studies show that Canadians care more about health care than any other "product." Peter Drucker, the eminent American management theorist, simply dismisses the notion of using the market for health care. He writes, "Health care…is not in the 'Free Market,' does not behave according to the economist's rules of supply and demand, is not particularly price sensitive and altogether does not fit the economist's model or behave according to the economist's theories."

A recent study by P.J. Devereaux, a health care researcher at McMaster University, compares mortality rates of private for-profit care with non-profit models. It predicts that for-profit hospitals would see a 2 per cent increase in loss of life in Canada. A market-structured incentive would work against early, inexpensive interventions that are responsive to price, and would increase major, expensive interventions where price and income responsiveness is weak. In the U.S., for example, medical costs are the largest single cause of personal bankruptcy.

Canadians care deeply that health services be delivered according to need and not ability to pay. Markets address neither social equity nor fairness—the most important issues of all to Canadians when health care is discussed.

The Mazankowski Report argues that new technology, drugs and an aging population will increase health expenditures enormously. But the revolution in technology affects both supply of and demand for health services. On the supply side, some services are tremendously improved by technology, and the costs of providing them are thereby reduced. Surgery, for example, has become less invasive, requiring fewer resources such as blood transfusions. Post-operative hospital recuperation time has been much reduced. The demand side is more ambiguous. People want access to new, sophisticated and expensive diagnostic equipment to benefit from the latest analytic methods for their particular condition. Also, much more can be done medically now, such as expensive transplants. Should an otherwise healthy 70-year-old get a heart transplant? Who should decide? Rationing decisions must be made to contain costs. Overall, though, further technological innovation will likely continue to *reduce* costs as they have in most other industries.

The concern about an aging population creating a dramatic increase in health care costs may also be overblown. Certainly, the population is aging. Recent census data shows the average age of Canadians has risen

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2.3 years since 1996. The group over 80 years of age has increased 41.2 per cent in the last decade, for a total of almost a million people. It's also true that, at a given time, health care use and costs correlate with age. However, this does not predict a future increase in costs overall. A recent study led by UBC's Robert Evans takes a novel approach by reconsidering old data. Taking a historical point in time, the authors predict physician costs from that time forward, with current knowledge about costs and patients' age. The predicted costs rise with increasing population age. However, despite the rise in population age, the actual physician costs fall, due to social and technological changes. What does this tell us? Predicting anything too far into the future is an unproductive exercise when important variables like technology are in flux. In 1943 Thomas J. Watson, the chairman of IBM, reportedly predicted, "I think there is a world market for about five computers."

Figure 2. Alberta public and private expenditures ($ million), 2001 forecast, Canadian Institute for Health Information

	Hospitals	Other Institutions	Physicians	Other Professions	Drugs	Capital	Public Health & Admin	Other Health Exp	Total
Private	200.0	146.4	17.4	1083.7	832.6	45.6	0	204.8	2530.4
Public	2853.5	580.4	1175.4	167.8	489.2	415.9	1259.8	723.0	7665.0
All	3053.5	726.8	1192.8	1251.5	1321.7	461.5	1259.8	927.8	10195.4
Private %	6.5%	20%	1.5%	86.6%	63%	10%	0%	22%	24.8%
Public %	93.5%	80%	98.5%	13.4%	37%	90%	100%	78%	75.2%

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Our health system clearly is sustainable. The proportion of GDP spent on health care has not been increasing. Our system costs 50 per cent less than the American system and only slightly more than European (two-tier) systems, while serving proportionally more people with more services. As Gerard Boychuk of the University of Waterloo writes in *The Changing Political and Economic Environment in Canada*, "A fiscal crisis of health care in Canada is not evident in current expenditure patterns; however, public beliefs that there is a funding crisis in health care are, nonetheless, real."

Still, change is necessary—not because of a funding crisis, but because Canadians themselves are changing. Currently the containment of Medicare costs relies on the government limiting its budget and the primary-care physician—the gatekeeper to the health care system— limiting access to services. A patient first goes to a doctor, who orders tests and specialist consultations as needed. Health care services are rationed by limited numbers of hospital beds, by expensive medical equipment and by wait lists. The latter in particular are taxing Canadians' patience with their public health care system. Rationing is necessary, but people no longer want others to have the authority to determine their level of access to health services. Many Canadians have become more sophisticated in obtaining information about their needs and how to meet them. They have lost their deference to professional expertise, and this has had profound effects on health care management. In the past, people trusted their primary-care physician to make the best judgments regarding their health care needs. Knowledge and information were considered to be asymmetrical—the doctor had it all and the patient relied on the doctor's decision.

"Patients" expect concerned care; "consumers" expect responsive, high-quality service.

But public attitudes and knowledge are changing: today's patient may know more about a particular ailment and its potential treatments than the doctor does. This change is fundamental to the understanding of current pressures on the health care system. It can help explain the shift from perceiving of people as "patients" to seeing them as "consumers" of health care services. Patients expect concerned care; consumers expect responsive, high-quality service designed to meet their individual needs. Consumers want the most advanced diagnostic techniques available, and they want them fast. These new expectations put great pressure on the traditional gatekeeper function of the primary-care doctor.

Although there is no evidence to support the belief, two-thirds of Canadians think people use services unnecessarily and that fee-for-service doctors encourage unnecessary visits. Canadians want increased accountability for both doctors and patients, but they are not prepared to limit their own doctor's autonomy to prescribe services for them. They want quick access to the newest procedures.

Here is the dilemma: Canadians want services provided publicly and in a timely manner, but are concerned about overuse of a "free" good. Nonetheless, they overwhelmingly support the principle of public provision of medically necessary health care based on need and not on ability to pay. Medicare is a core component of our national identity. We believe our health care system to be the best and fairest in the world. And this belief has been steadfast in the face of tremendous challenges.

There is much hope in the considerable convergence of perspectives and recommendations from the National Forum, the Romanow Commission and the

Mazankowski Report. First, the Canadian health care system is working well: thousands of patients are treated every day with a very high percentage of success and satisfaction. The three agree there are increasing demands and pressures on the system, and that the system needs improvement. Health status and prevention need greater emphasis. Improved knowledge and information, and the sharing of those, are required. Funding should be increased and regularized. And planning, training and deployment of medical personnel must be improved.

If all the studies of the last decade, including much in the Mazankowski Report, are distilled, a solution materializes: primary care should be delivered in fully publicly funded and administered community health centres open 24/7. These centres should be staffed by a salaried team of physicians, nurses, pharmacists, psychologists, sociologists and educators all under performance contract to treat the whole person in the context of family and community. Improved population health with greater emphasis on prevention would be the driving objective. The person seeking help would be at the centre of the medical process, would be much more knowledgeable about his or her needs, and would expect to be part of the decision about his or her treatment. Personal information would be complete and accessible to the appropriate personnel. Prescription drugs and home care would be delivered as needed through the community centre. Hospitals would still be necessary, but there would be far less need for expensive emergency departments. Private walk-in clinics would become obsolete. Patients would still be free to choose a primary-care doctor, but they would have to work with their doctor as the most knowledgeable gatekeeper to the system. Dr. Carolyn Bennett, in *Kill or Cure? How Canadians Can Remake Their Health Care System*, provides a detailed explanation of the specifics of such a system.

Is there room for private medicine? "Medically necessary" services still need to be defined and will never, should never, include everything. Canadians increasingly support allowing adamant individuals to purchase extra services if they choose. Therefore, we need to continue to make room for this. It's imperative, though, that private practitioners be completely divorced from public funding. A private sector doctor should neither work in the public sector nor be funded from public moneys. This goes for private, for-profit clinics and hospitals too. The scope of publicly funded services should be increased to include medically necessary pharmaceuticals and home care. Such a system would reflect the dramatically changed and improved knowledge and practice of medicine that has come about since the hospital- and physician-oriented beginnings of Medicare.

Greg Flanagan is an economist and co-author of *Economics in a Canadian Setting* (HarperCollins) and *Economic Issues from a Canadian Perspective* (McGraw-Hill). He teaches a course in public finance at the University of Calgary.

FOR MORE INFORMATION

Our website (www.albertaviews.ab.ca) has links to dozens of official studies and reports on the future of medical care.

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