



College and University  
Retiree Associations  
of Canada

7-B Pleasant Blvd  
Suite 997  
Toronto ON M4T 1K2

Associations de retraités  
des universités et collèges  
du Canada

[www.curac.ca](http://www.curac.ca)

## **CURAC/ARUCC**

### **Discussion Paper on Healthcare**

**December, 2012**

***CURAC/ARUCC (College and University Retiree Associations of Canada/ Associations de retraités des universités et collèges du Canada) is a non-profit federation of retiree organizations at colleges and universities across Canada. Its primary objective is to coordinate activities that promote communication among member organizations, to share information, provide mutual assistance, and speak publicly on issues of concern to the over fifteen thousand individual college and university retirees across Canada.***

#### **Forward**

Healthcare is always a continuing concern for Canadians, but there is a sense of security that an established program is open to all citizens of the country. Nevertheless outside core coverage, there can be unevenness in delivery, and uncertainly or even alarm about costs and sustainability. Some who know well the close detail of the way health care is delivered may use the term 'crisis' to describe where we are. If that be so, then CURAC thinks it worthwhile to review the scene, and make public conclusions that it believes should be considered carefully by all, but particularly by governments that participate in the programs.

#### **Background**

The birth date of a national system of universal healthcare for all Canadians and legal residents came with the passage by parliament of the Medical Care Health Act in 1966, with service beginning soon after, and then revised in the Canada Health Act of 1984. Up until that time, - and indeed even after - healthcare and all matters related are in the constitutional domain of the provinces and territories that are responsible for the program and delivery. The Health Act brings federal funds to underscore terms and conditions articulated by the national government as defined in the Act itself, namely universality, accessibility, portability, comprehensiveness and public administration. Thus the provinces are the operators of the system and the federal government an overall coordinator and funding partner. Incidentally, healthcare in this essay means core physician and hospital services, including dental surgery, but not most paramedical services such as dentistry, vision or hearing equipment, physiotherapy and psychotherapy.

There have been many adjustments of the balance in this partnership as a result of the rise and fall of federal and/or provincial finances, and the responses of the deployed resources that make the system work. Yet the evolution of the knowledge about and management of health care for Medicare has translated into overall rising costs and a struggle to meet the needs of evolving medical practice and a growing, and aging population.

## **THE CRISIS IN CANADA'S HEALTHCARE: A NEED FOR RENEWAL OF THE NATIONAL HEALTHCARE SYSTEM**

### **Introduction**

Canada's healthcare is facing a real crisis. It rises on two fronts. The first is a seeming retreat by the Federal Government from the role of director in Medicare to a more distant senior partner function. It is a move from direct management towards encouraging the Provinces and Territories to take the lead in self-organizing the programs they deliver. The second front of the crisis is the weakening match today between the delivery of a contemporary and timely care - personnel, facilities, technology, management – and the funds needed to keep it all in a self-contained balance. Let us consider....

### **Federal Leadership**

If we review the history of Medicare and plot the trajectory of Federal Government assertion in the program, we can see a consistent fulfillment of the terms of the Health Act but with the levels of financial help reflecting, in part, the state of the country's fiscal health. The Government too responds to public opinion and has faced a dominant public endorsement of Medicare as it is supposed to work. The whole history of Medicare in the country is a story of political shying away from anything but a fully funded, freely accessible health care for all. Incidentally, a matter of some concern is the reduction of about \$36 billion from the 2014-2024 healthcare budgets, not dramatic in the context of Canada's \$200 plus billion per year for all healthcare spending, but also not without impact.

The present Federal Government is lead by Prime Minister Steven Harper and it is that leadership that has produced the move towards circumscribing the government direction of Health Act affairs, albeit with transfer funds at about 20% of costs for a defined but short period. This is quite a change from 50/50 sharing in the beginning. Altogether these events have moved the Provinces on to the front bench, with their recently formed Healthcare Innovation Working Group to begin facing a coordinating need to assume more of a lead for rational change in costs and operations.

The Health Act, as mentioned above, is a federal law that defines overall a national performance standard, those being the "five pillars" of Canadian healthcare, namely universality, accessibility, portability, comprehensiveness and public administration. The Act also states that Healthcare in Canada must be government administered. The provincial management of Healthcare adds a higher level of complexity to the system with separate priorities or solutions contesting to establish a workable management/funding template for each province or territory. The new lesser level of

Federal presence may threaten the unfolding future of Healthcare, a scene that may well be alarming to those who think of federal participation as the guarantee of equitable treatment from Province to Province, and in some ways sets the central directions for a nationwide health program. CURAC is more than a little concerned about this. It would like to see this reversed, or at least a renewed, active Federal commitment to Healthcare and the Act that governs it.

### **Crisis in the System, or *is it the System?***

At this point, we do not choose to make detailed analysis of how Medicare is managed and delivered. A few Royal Commissions, independent and institutional analyses, and narrative but comprehensive overall studies - all bring to light interpretations of the continuum of Healthcare change. However, some comments on components and past behaviour may give some structure to understanding the cost of Medicare, where the costs arise, how are they managed, and how are they paid. That said, crisis is still the right word for where we are. The simple truth is that we in Canada pay premium dollars for a Healthcare system that delivers results that are only average or below quality compared to peer-group countries with national healthcare.

### **Some Measures of Canadian Healthcare**

To understand the real healthcare crisis of Canada, one has only to compare its performance with some other peer countries. Recent surveys by OECD, for example, plus similar evidence from WHO among others, reveal that Canada is at or near the top for program spending, but well down the list in measures of quality of care. This holds true irrespective of whether health-care spending is calculated on *per capita* basis, e.g. in 2011, \$ 5,800/per yr/per person, or as a percentage at 11.6% of GDP. Furthermore, Canada ranks 17<sup>th</sup> by percentage of those with total life expectancy lived in good health. Even the Conference Board of Canada awards Canada's healthcare a B grade and puts us 10<sup>th</sup> among 17 peer countries. Most embarrassingly, a 2011 UN Report ranks Canada 24<sup>th</sup> in infant mortality, a widely accepted indicator of health level in a country, below Portugal and South Korea.

To fully describe the extent of inefficiency in our healthcare delivery, we must remember that Canada's healthcare covers only 70% of all the health-related expenses in the country, - and we ranked only 19<sup>th</sup> in breadth of coverage among OECD countries. It looks like we spend more for care of inferior quality.

### **Deteriorating quality of Care but rising Healthcare Spending - the Real Healthcare Crisis in Canada.**

#### **The Current State:**

Almost from the beginning evolution of Healthcare delivery deficiencies emerged and became more glaring. Wait-times went beyond some targets; daytime delivery needed to move around the clock; everyone should have electronic recordkeeping; and there were shortcomings in drug provision and homecare. So in 2004 the Federal government with provincial agreement struck an accord to provide \$ 41 billion that was supposed to "fix" healthcare inadequacies for a generation. None of these goals have yet been even half met. Instead of facilitating transformative structural changes, much of the accord money

bled off into routine care-management. Overall wait times remained about the same or grew, dramatically in some provinces, Nova Scotia, Manitoba and PEI among them, Nationally 31% of children needing care waited too long for surgery. But Ontario managed to make improvements.

### **The Issues Involved:**

#### ***Issue 1. Sustainability - Cost-containment and Creating Efficiency***

The profile of growth of public healthcare spending from 1975 to 2011, shows three phases: i) progressive growth till 1991; ii) a short period – 1992 to 1996 - of disinvestment and retrenchment when governments faced deficits, and iii) another growth phase, 1997-2008 averaging 3.5% /yr after adjusting for inflation. This last period was a time of economic growth for Canada too, with higher income that permitted major healthcare investments including increased spending on doctors, drugs, hospitals and advanced diagnostics. Thus Canada spent more when it had more, as other OECD countries did too, but when incomes turned around, so did healthcare spending.

What is happening now? Are we in reverse? Looking at total healthcare spending, - Medicare government spending plus private costs - in Canada in 2009, the last year for which actual figures are available, was \$ 182.1 billion in current dollars. The total expenditures for 2010 and 2011 are estimated to be \$ 192.1 billion and \$ 200.5 billion respectively. A recent CIHI report - *National Health Expenditure Trends, 1975-2011, November 3, 2011*- estimates a slight decline in healthcare spending in 2011 i.e. from the historic peak of expenditure at 11.9% of GDP in 2009 and 2010, to 11.6% of GDP in 2011. Other evidence shows that the annual rate of growth in Canada's health-care spending is slowing down. For example, the expected increase in 2011 over 2010 is 4.0% (i.e. \$150/per person/per yr). This is the lowest increase in the annual growth rate of Canada's healthcare spending in the last 15 years. This shows that the rate of growth for Canada's overall healthcare spending is not out of control as some have said.

Nevertheless, cost containment in Canada's national healthcare program is more than desirable because: i) cost-efficiency improves quality of care; and ii) the money saved could possibly be spent to introduce additional benefits like universal pharmacare, long-term care, home care, community care etc.; also iii) a global and national downturn of the economy, as is happening now, will likely adversely affect healthcare funding ; and iv) healthcare spending is still rising faster than inflation and population growth.

Cutting costs is perhaps the single most important factor along the route to efficiency in healthcare delivery. It can be enhanced by establishing and adopting the criteria for best practices, and targeting service where it is most needed. To be effective, the cost drivers have to be identified. A CIHI Report (*Care cost Driver: The Facts, November 3, 2011*) examined public-sector healthcare spending between 1998-2008 and has identified the major cost-drivers as: Doctor Services, Hospital Costs, and Cost of Prescription Drugs. *Doctors Services* represent 14.0% of total healthcare spending, and reached \$28.1 billion in 2011, increasing by 5.6% from 2010. *Hospital costs* are 29.1% of total healthcare spending and were \$58.4 billion in 2011, rising by 3.8% over 2010. *Cost of Prescription*

*Drugs* at \$ 32 billion in 2011, increasing by 4.0% over 2010 account for 16.0% of total healthcare spending.

### **Managing Doctors' Compensation:**

The premise that doctors are independent professionals caring for their patients and receiving fees for service is basic in Canada. It is also acknowledged that to become a doctor and add specialized training is a long and costly educational and personal investment. But with the adoption of a National Healthcare system, the participation of doctors has evolved to professional medical associations of physicians speaking for their members in negotiations for remuneration by methods compatible with Healthcare. Fee-for-service remains the dominant payment template, but is increasingly supplemented by alternate payment systems, typically involving either salary arrangements or some form of capitation-based payment.

Fee-for-service costs are an open-ended liability for managers because it may encourage seeing more patients and performing more services, and is difficult for budgeting. Salary, once accepted leaves doctors to control their workload. Another algorithm is Pay for Performance that links compensation with patient outcomes; it is now well used in the UK Healthcare system.

The payment systems are all represented within the provincially managed delivery of Healthcare. It is not so much the pay method as the noticeable higher rates of growth in doctor compensation that are straining forward planning. Some provinces have resorted to a freeze to manage budgets, and generally this cost area in the system is the one with the most open and unpredictable elements in overall management of Canadian Healthcare.

### **The rising cost of doctors' services and its contributing factors:**

Between 1998 and 2008, the annual rate of growth in spending for doctors' compensation grew by 6.8% annually, outpacing the growth of hospital and pharmaceutical spending. Data from CIHI indicate that, for the fifth year in a row, doctors' compensation is likely the fastest growing item in Canada's 2011 health-care budget, again outpacing growth in spending on drugs and hospitals.

The contributing factors are:

- A real, 3.6% annual growth of doctors' compensation;
- Increase in the number of practicing doctors due to: i) higher medical school throughput, ii) increased certification of resident international medical graduates.
- Competition among jurisdictions to offer better incentives for recruiting and retaining doctors and other health-care providers;
- Controlling the size of doctors' pool by tighter credentialing procedures;
- Increased demand on doctors' services due to population growth: this accounts for 1% of the annual growth in Canada's healthcare spending;
- More visits to doctors': Canadians have been seeing their doctors more often and receiving more medical procedures. This accounts for 1.5% of the annual growth in Canada's health-care spending /per Canadian (adjusted for population aging);
- Over the same period, a significantly larger number of Canadians received priority procedures, e.g. hip and knee replacements, and new diagnostic

- procedures e.g. from 1997-2010, the number of CT scanners increased from 245 to 484, and MRI machines from 55 to 281;
- Changing patient management policies and the impact of new disease entities such as HIV/AIDS, require increased services;
  - More stringent medical/legal standards requiring physicians to perform technically unnecessary examinations for protection against possible litigation;
  - Aging population: contrary to popular perception, aging is a modest cost driver accounting for only 0.8% of the annual rate of growth in healthcare spending. The impact of aging is prominent in the Atlantic Region and Quebec, but less in Ontario, Western Canada and the Northern Territories.

The continuation of the *status quo* can not be justified because: i) Canada's present doctor density (2.3/1000 population) is below the OECD average of 3.2 and thus Canada needs more doctors for optimal care delivery; and ii) medical consultation per capita is on par with the OECD countries but access to specialists (which costs more) is less frequent. Furthermore the average doctors' compensation here is already higher than the OECD average, and the ratio of doctors' compensation to the country's average wage is higher in Canada than in many of the OECD countries especially the Nordic countries and Japan. The rate of growth in doctors' compensation in Canada is also faster than that for other healthcare workers at 3.3% per year, with the general labour market at 2.7%.

### **The cost of hospitals and contributory factors**

The factors that contributed to the rise of hospital cost include compensation for hospital healthcare providers, renewal and new general equipment but also more and better but expensive diagnostic and surgical tools, plus the impact of the length of hospital stay, and administration and management expenses.

### **Labour Costs:**

The number of workers in this category large and is increasing as the range of service needs expands, rising over 20% in the last decade. This means that compensation levels grew at 3.3%/year, more than the 2.7% for labour generally. All publicly funded healthcare facilities in Canada are staffed by public service union employers, that means that healthcare employers wanting to improve work practices are sharply limited by collective agreements and non-competitive labour practices. Also prospects of work stoppage or lock-out are so critical in the face of life-threat or life-support. Given the impact of this item on budgets, it is a caution to know labour cost accounts for about 60% of hospital budgets. That said about costs, it is well to remember that hospital workers are dedicated to the human condition in the face of suffering and anxiety that accompanies serious illness.

### **New Technology:**

Hospitals are especially endowed with specialized furniture and equipment that accompanies the life-support mandate. Add to this rapid innovation in diagnostic tools like MRI and CTScan machines, or surgical instruments that have robotic systems and hyperbaric features. Add to this Tele-Health plus a host of other procedural activities that require specialized and inventive tools. Also the infection-free environment has special cleaning and maintenance needs, to say nothing of tending patient comfort. We do not

have any measures of cost for these features, but beg awareness that all of this is well on the frontier of technology and commensurate costs.

Note, the length of hospital stay brings a small increase in the consumption of resources by patients.

### **Management:**

Medicare is a provincial/territorial constitutional responsibility and with federal transfer of funds, they pay all the bills. Thus, they also are the managers for the system and how it is organized has grown to respond to where people live. Canadian geography has presented us with a large country of a basic linear east-west string of settlement close to the southern edge with bead-like poles of metropolitan and city population densities, and scattered towns, villages and rural habitation along this corridor, but less so in areas farther north. The provincial jurisdictions are more historical than a result of geography, but these are the zones for political management. All provinces have defined Regional Hospital Authorities ( RHA's ) as the management tool for healthcare delivery. At present, the sizes of RHA budgets are in most instances based on historical spending plus an inflation factor. It does not take into account either the demography of population covered or the efficiency of the institution. There are good arguments why the money should follow the patients, that budgets be based on patient numbers and assigned where the patients are treated. This increased flexibility and competitive performance – and savings.

Budgets are central to RHA management functions, and union contracts and other labour costs meet here. Professional compensation has to be monitored although payment is by the province and not the authority. It is not just the annual personnel costs that need control but the trends for changing costs over time are essential for long-term management. There may be ways to streamline the RHA management tool including dropping unnecessary ones, use populations based and activity based budgeting, and keep hospital and RHA administration costs under a watchful eye, and rationalize practices within the provincial envelope.

### **Prescription Drugs:**

Overall expenditure by Canadians on prescription drugs grew by an average of 10.1% per year during 1998-2007, but that has dropped back to just over 9% in the last decade 2/3rds of which tied to seniors. By 2011 it was \$640 per capita, and \$27 billion in total not counting what was spent by hospitals. These increases mirror volume growth in drugs for high blood pressure, cholesterol control and digestive tract medications as the main players. This pattern is behind community and preventive medicine establishments promoting of a needed healthy lifestyle. Also there are many subtleties in prescription use like more drugs for seniors, experimental new drugs with promise but unknown long-term effects or uncertain trial periods.

Given these spending patterns for drugs and the scale of the enterprise, a central concern is to find economy in costs and cost-increases. Foremost is the fact that emerging drugs are patent protected for set time periods by defined agreements, then open to generic manufacture and marketing. Brand-named drugs are notably more expensive carrying the

costs of research and development, and with base prices fixed exclusively by the originator/manufacturer as much or more by market tolerance than production expenses. These pressures on costs brought the Federal government by agreement with suppliers to set patent protection at 20 years. Generic drug manufacturers also set their prices as they determine, but are less expensive because they do not bear the research tariff and there is more competition among suppliers. Achieving economies therefore, is a combination of bargaining and legislation, but the results seem to come from tendering, a system that should be better used.

Drugs, like the rest of healthcare, fall within Provincial jurisdictions that most often have their own plans with determined formularies of eligible drugs and the balance of government/private payment. Thus it comes down to bargaining with suppliers, but so far there is no trade advantage of all provinces joined in a common market front. The Federal presence is also felt because they negotiate for and buy within-Medicare medications, and have influence in setting Trade Agreements where patent-protection, and domestic research opportunity are in the national interests.

In the early 2000's a potential inter-provincial drug management agreement was offered to Federal government hoping for joint partnership. The notion lapsed, and an opportunity missed mainly because the provinces with admittedly their mixed moods about united action did not carry the idea forward. However since 2010, most provincial governments have either implemented or revised generic drug pricing policies with maximum allowable prices ranging from 25% to 56% of brand name products. And yet the pharmaceutical industry still has a divided target and an advantage in business bargaining, where volume sales are disparate rather than unitary. We might, however, keep in the front of our minds the goal of a National Pharmacare System in Canada.

### **The Ball in the Provincial Court**

Following the 2011 declaration that the Federal government was to give a shortened commitment to share funding with future restrictions to inflation increase, and to be more passive in managing the national healthcare system, the initiative was passed to the Provinces. Their Council of the Federation formed a Healthcare Innovation Working Group to explore their own mandates, and find co-operation among themselves to strengthen Medicare in Canada. The first report in January 2012 was largely structural innovation to promote co-operation and shared leadership, and identified the following notions:

1. Pursue team-based models to increase patient access to i) collaborative Emergency Centre and other models; ii) share information on health human resource labour markets.
2. Have regular monitoring of progress towards these initiatives, and
3. Focus on two hotspots, cardiovascular disease and diabetes.

These recommendations renew much of what has already been under trial for a couple of decades, but brought together for central review by the Working Group. Successful provincial co-operation and co-ordination is a good step towards achieving the promise of a National Healthcare system, but only if it succeeds. There are also opportunities in the



future, to encourage better results. When budgets are adopted, there could be a fresh system of rewards for performance. Instead of pouring new money into plans for increasing maintenance or repair, renewed and improved funding could be applied where success in better patient care has already been achieved, so that new successes are rewarded; those who are still trying to manage change can see the benefits that internal improvement can bring.

### **And What About Seniors?**

CURAC members are associations whose memberships is likely all seniors. Aging is a concern for Healthcare as the call on services does increase with age. At present 14% of Canadians are 65 years or older and will be 20% in a decade. They consume over 40% of the healthcare budget, with per capita cost as follows:

Age <55 yrs	-	\$ 3,000 ea
Age 65-69 yrs	-	\$ 6,000 ea
Age 70 – 74 yrs	-	\$ 8,700 ea
Age 75-79 yrs	-	\$12,000 ea
Age >80 yrs	-	\$20,000 ea

The over 80 group includes terminal costs that are usually a large part of the total; of course, terminal costs come at any age.

Those who analyse these issues conclude that aging costs are only just over 1% a year and are manageable on a pay-as-you-go basis. But with increasing aging and shrinking workforce numbers, a future burden of larger proportion will be borne by a fewer number of taxpayers – another generation.

JKS: 10-12-12