

### REPORT II:

## Access, Quality and Affordability: Real Health Care Change for Albertans

A Discussion Paper By Diana Gibson and Colleen Fuller

September 2010



PARKLAND INSTITUTE

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### THE NEW ALBERTA HEALTH ACT: RISKS AND OPPORTUNITIES

REPORT II: ACCESS, QUALITY, AFFORDABILITY: REAL HEALTH CARE CHANGE FOR ALBERTANS

A Discussion Paper

by Diana Gibson and Colleen Fuller This report was published by the Parkland Institute September 2010 © All rights reserved.

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#### ABOUT THE AUTHORS

Colleen Fuller and Diana Gibson are co-authors of the book, *The Bottom Line: the truth behind private health insurance in Canada*. Colleen Fuller is a Vancouver-based health policy researcher, and author of *Caring for Profit*, and a contributing author to *The Push to Prescribe: Women in Canadian Drug Policy* amongst other reports and articles. Diana Gibson is the Research Director of the Parkland Institute and author of numerous reports, book chapters and articles on social policy issues.

#### ABOUT THE SERIES

This report is the second in the series *The New Alberta Health Act: Risks and Opportunities*. The first addresses the risks associated with the legislative reforms as proposed. It is based on analysis by a broad cross-section of researchers, lawyers, health activists and practitioners. The second report examines the opportunities presented by the *Alberta Health Act* conversation, and the question: How can an *Alberta Health Act* be used to strengthen public health care and make it more sustainable? It incorporates feedback from Albertans in town halls and other public forums held around the province by the Friends of Medicare, Parkland and other groups.

#### ABOUT THE PARKLAND INSTITUTE

Parkland Institute is an Alberta research network that examines public policy issues. It is based in the Faculty of Arts at the University of Alberta and its research network includes members of most of Alberta's academic institutions as well as other organizations involved in public policy research. Parkland Institute was founded in 1996 and its mandate is to:

- conduct research on economic, social, cultural, and political issues facing Albertans and Canadians;
- publish research and provide informed comment on current policy issues to the media and the public;
- sponsor conferences and public forums on issues facing Albertans; and
- bring together academic and non-academic communities.

All Parkland Institute reports are academically peer reviewed to ensure the integrity and accuracy of the research. For more information visit http://parklandinstitute.ca.

### **Executive Summary**

Alberta's provincial government has embarked on an initiative to reform the existing health legislation and create a new *Alberta Health Act*. The initiative was recommended by the Minister's Advisory Committee on Health and is outlined in a January 2010 report entitled "A Foundation for Alberta's Health System" and the September 2010 "Putting People First" report. The Parkland Institute published an overview of the risks associated with such an Act (Risks and Opportunities: Report 1: Risks of the Alberta Health Act) in June, 2010. In this report we discuss some of the opportunities being presented to strengthen the health care system and improve affordability, quality and accessibility for all Albertans.

The first report in this series and the public feedback we heard reinforce that it is not a new health act that is needed but practical solutions on the ground to real health care problems. The principles of the Canada Health Act already go unenforced in many cases. Both the public feedback and the research indicate that the implementation of a new set of principles is not only redundant, but it does not inspire confidence.

Alberta's existing legislation already allows for initiatives such as primary care teams in public clinics or increased continuing care and home care supports. Those are the kinds of initiatives this report identified as critical priorities. That said, the debate on the AHA

does provide an opportunity for more broadly exploring what action is needed to improve health care today and how that could be funded.

First, we need to look at the key challenges facing Alberta's health system then we turn to the solutions.

### THE CHA STRENGTHS AND WEAKNESSES

A number of the challenges facing Alberta's health system stem from weaknesses in the Canada Health Act.

- It is silent on the delivery side, allowing for a fragmented system where profit driven providers are increasing in number.
- It only vaguely and narrowly defines "medically necessary," the key criteria used to determine what is within and what is outside of the public system. With this open to interpretation, governments have been shrinking the medicare basket.
- Medically necessary is defined as being hospitalbased services. However, with improvements in technology that allow for more day surgeries and fewer hospitalization and the shift to communitybased care, that is no longer an adequate definition.

- The CHA also does not adequately address important aspects of health care like prescription medicine, dental and home care.
- Who decides what is included lacks guidelines and has largely been left to physicians to decide in their negotiations with the provinces over funding.

### WHAT WE HEARD FROM THE PUBLIC FORUMS

The feedback from participants across the province is summarized in the report. A clear message was received that it is not legislative overhaul that is needed but real change on the ground to make health care more accessible, affordable and of higher quality. To accomplish this, current legislation would only need to be changed slightly. The other clear message was that there should not be for-profit involvement in health care delivery and that the public, universal health care system should be expanded significantly. The key challenges identified in this report and recommendations are built on what was heard in those forums.

### KEY CHALLENGES FACING ALBERTA'S HEALTH CARE SYSTEM

Certainly there are serious challenges to be dealt with in Alberta's health care system. Hospital stays are becoming much shorter, and community or day-surgery alternatives have been increasing. But the services outside of hospitals are fragmented, mostly private, and not under the umbrella of the CHA. Many rehab services are being shifted out of hospitals to the private sector. These and other services are being de-listed and de-insured. For-profit companies are increasingly key players in long term care, which is being reduced to assisted living.

This shift to private services is expensive – Albertans now have the highest out-of-pocket spending on health care in the country.

The report identifies the following key challenges facing Alberta's health system:

- the fractured and increasingly profit-driven delivery system;
- the narrowing of what is covered in the public system;
- · rising pharmaceutical costs;
- · the move to activity based funding;
- the failure to address prevention and social determinants of health; and
- · health care human resource shortages.

#### RECOMMENDATIONS

This report makes a broad range of recommendations for the path forward to make health more affordable, accessible and of higher quality.

1. Reorganize the delivery system to make it more integrated and limit the role of for-profit involvement.

Albertans need strategies to ensure that services provided outside of the hospital system are publicly funded and universally accessible, just like physician services. Since 1964, royal commissions, inquiries, studies and reviews have all concluded that services that can be provided in the community should be provided with block funding just as hospitals are. Public community health centres can provide a range of those services – from physio and occupational therapy to pharmacy and multicultural programs – in an interdisciplinary environment and in a cost-effective manner with staff, including doctors and pharmacists, on salary. This would include rehabilitation and home care services which need comprehensive coverage and increased levels of service, for both seniors and post-op patients.

Place a moratorium on the further expansion of forprofit delivery of hospital services across seniors' care, surgeries and rehabilitation services and reintegrate these services within the publicly delivered, globally funded system. Explore possibilities of exiting existing contract with for-profit providers.

A continuum of comprehensive care for seniors should be covered by the public health plan including adequate publicly funded long-term care beds. All services that are necessary for quality of life should be covered including those services unbundled such as assisted living accommodation, feeding, bathing, etc.

### 2. Make decisions on what is covered in the system more transparent.

Establish an arms-length Core Advisory Group made up of scientific and medical experts; physician and health professionals; academic and community-based researchers that is free from conflict of interest. Establish a process for decision-making that is evidence based and draws on university research. Make it free from limits related to budget parameters and sustainability. Those are political questions. Have the decisions made by this body open to the public through a website.

The minister should also establish an arm's-length, independent and university-based body to review evidence of drug safety and effectiveness.

#### 3. Take action on pharmaceutical costs.

Join with other provinces to demand a national Pharmacare program

Place pharmacists on salary in public pharmacies within multi-disciplinary, non-profit and publicly funded community health centres and in physician group practices as part of the primary care reform. This would remove the distortions that come with pressures from lobbying and kick-backs from generic and brand-name drugs competing for market shares, and allow pharmacists to base prescriptions instead on best evidence and lowest cost.

While the primary care reform is taking place, cap rebates paid to pharmacy owners by generic companies and regulate dispensing fees more aggressively. Implement a ban on rebates similar to the bans in Quebec and Ontario.

#### 4. Reject activity-based funding.

The province should not move forward with activity-based funding. It is a solution looking for a problem in the Alberta context and is not without risks.

### 5. Invest in prevention and the social determinants of health.

Introduce a junk food tax and use the revenues to increase funding for preventative health. Increase funding and programs to target social determinants of health such as poverty, inequality, early learning, child care supports and labour rights.

#### 6. Tackle the health care human resources challenges.

Conduct long-term planning based on demographic and health care trends and set targets for health outcomes and health care human resources. Link those targets to the number of seats at universities and colleges. Increase funding for educating health care professionals. Make education, especially medical schools, much more accessible and affordable.

The use of community clinics with multi-disciplinary teams may relieve some of the doctor shortage pressures. Expanding the role of non-physician professional such as nurse practitioners as part of those teams could also help.

### WE CAN'T AFFORD NOT TO

Data shows that costs are rising fastest outside of medicare, both in pharmaceuticals and in private health care. The increasing cost of managing the fragmented community sector has also meant administration costs have been increasing at double digit rates. Public universal health care has been shown to stabilize and control costs. We cannot afford not to expand the public system.

Alberta can easily afford a strengthened public health care system. Parkland Institute research shows that the province gave away \$5.4 billion in 2009 alone with the flat tax. The province has chosen to implement a tax

structure that is the lowest in the nation and far below the national average. At the national level, there has also been a concerted agenda to cut taxes to the tune of \$14.9 billion in annual lost revenue.

Albertans consider public health care to be their highest public priority and consistently rate it higher than tax cuts in polls. They have shown an appetite to pay more for valued public health care services including supporting the reinstatement of health premiums in order to avoid service cuts.

The recommendations in this report include a broad range of specific changes that could be made to improve health care affordability, access and quality. It clearly addresses the question of how those changes would be financed and the sustainability of an expanded public system through measures such as returning to progressive taxes and other revenue reforms. It does not require and new health act, though such an act may be useful if it prohibited private delivery and implemented a new protocol for how decisions impacting the medicare basket are made, making them transparent.

And Albertans are ready to move forward.

### I. Introduction and Background

Alberta's provincial government has embarked on an initiative to reform existing health legislation and create a new *Alberta Health Act*. The initiative was recommended by the Minister's Advisory Committee on Health and is outlined in the January 2010 report "A Foundation for Alberta's Health System" (subsequently referred to as the Foundation report).

That report recommended that a new law, the Alberta Health Act (AHA), be built around core principles. The committee also recommended a patient charter, the affirmation of Canada Health Act principles, a consolidation of core legislation, stronger support for evidence-based decision-making and ongoing citizen engagement. The minister accepted those recommendations on behalf of the government. He tasked MLA Fred Horne with leading consultations and reporting back to the government. On September 15, 2010, Fred Horne publicly released the results of those consultations in a new report "Putting People First." The rhetoric in the AHA heavily emphasizes individual responsibility, flexibility of delivery systems, and the marketization and corporatization of health care delivery. It replicates rhetoric seen in Ralph Klein's Third Way and the Mazankowski report.

The first report in this series, *The Risks*, deals with the problems with the AHA as proposed. It notes that the health legislation that already exists in Alberta goes

beyond the Canada Health Act. It concludes that a new act and legislative overhaul are not necessary to address the current problems of access in health care. Finally, it identified serious risks of losing public health care protections with the consolidation of the legislation. This is the second report in the series and will explore the opportunities offered by the *Health Act* conversation to strengthen public health care and take real steps toward improving affordability, quality and accessibility of health care in Alberta. The papers in this series are meant to stimulate public debate about the *Alberta Health Act* and broader health care reform across Canada.

The Alberta Health Act conversation opens an opportunity for Albertans to debate how the public health system can be improved and expanded. It allows us to ask questions like: What are the strengths and weaknesses within Alberta's system of medical and hospital services as well as community health services? How can Albertans use the current discussion about the Alberta Health Act to propose a stronger and expanded health system? Has the health system changed with new technologies and approaches to care and should the legislation and delivery system be changed to keep pace?

It allows for a conversation about whether more needs to be done to accomplish Phase I of Tommy Doug-

las's vision: the removal of financial barriers between those giving the service and those receiving it. That vision included universal, public long-term care and coverage for dental services as well as prescription medicines. For many types of health services such as long-term care, continuing care and home care, the financial barriers are still enormous. Albertans pay the highest out-of-pocket costs for health care in the nation, meaning that costs still create significant barriers to access.

This AHA debate also opens the door for a conversation about Phase II. Tommy Douglas envisioned the extension of medicare to home care, long-term care, community care, medicines and a much greater focus on illness prevention, health promotion and the policies required to address the social determinants of health, particularly poverty and inequality.

The Canada Health Act is an important backdrop to this conversation, not only because of its critical role in defining the public health system, but also because the government has made it clear that the CHA will form the basis for the new Act. Albertans should not be reassured by this commitment; Alberta's existing legislation already exceeds the CHA in a number of areas. Further, as this report explains, the Canada Health Act has serious limitations and weaknesses that could lower the protections for public health care and patients in Alberta.

Thus, we begin this report with a discussion of the *Canada Health Act* including its strengths and weaknesses. The report will also include a summary of what we heard at public forums around the province. We will then discuss key challenges currently facing Alberta's health system and potential reforms. The focus will be on six key areas:

- 1. The increasingly fractured and for-profit delivery system.
- 2. The narrowing definition of what is covered within the public system.
- 3. Rising pharmaceutical costs.

- 4. The move to activity-based funding.
- 5. The failure to address prevention and the social determinants of health.
- 6. Health care human resource shortages.

The report then makes recommendations for the path forward including:

- 1. Reorganizing the delivery system to make it more integrated and limit the role of for-profit delivery.
- Making decisions on what is covered by the system more transparent, representative and accountable.
- 3. Addressing pharmaceutical costs.
- 4. Rejecting activity-based funding
- 5. Addressing the social determinants of health.
- 6. Addressing health care human resource challenges.

Finally, the report explodes the myth that we can't afford public health care and makes the airtight case that we can't afford private for-profit care. It explores where costs are rising within the system and issues of sustainability and affordability.

## II. The Canada Health Act: Strengths and Weaknesses

"The principles of the Canada Health Act began as simple conditions attached to federal funding for medicare. Over time, they became much more than that. Today, they represent both the values underlying the health care system and the conditions that governments attach to funding a national system of public health care. The principles have stood the test of time and continue to reflect the values of Canadians."

(Roy J. Romanow, Q.C., November, 2002)

### 1. WHAT ARE THE STRENGTHS OF THE CHA?

The CHA protects public funding for health care services deemed "medically necessary" and included within the basket of medicare services, prohibiting private financing for those services. Other strengths include the principles of public administration of provincial health plans, universality and accessibility. The principle of comprehensiveness is also critical but not as well articulated and somewhat less clear.

The key strengths of the CHA lie in the principles it articulates and in the authority it gives to the federal health minister to impose financial penalties on provinces that fail to comply with the Act. Federal funding (both direct transfers and tax points) supports the ability of provinces to achieve – at a minimum – na-

tional standards for medically necessary hospital and physicians' services. This is because a basic principle of the Act is that Canadians are entitled to an equal level and quality of service regardless of where they live or how much they earn. It is the job of the federal government to ensure this standard of equality is maintained in the health care system.

To achieve this balance, the federal government provides equalization payments designed to ensure that provinces with lower per capita incomes will be able to afford levels of public services comparable to provinces in which people earn higher incomes. This enables poorer provinces that might otherwise engage in a 'race to the bottom' to fund health services adequately.

## Five Principles of the Canada Health Act

PUBLIC ADMINISTRATION

Provides that the provincial health care insurance plans are to be administered on a non-profit basis by a public authority, which is accountable to the provincial or territorial government for decision-making on benefit levels and services, and whose records and accounts are publicly audited.

COMPREHENSIVENESS

Requires that the health care insurance plan of a province must cover all insured health services provided by hospitals, physicians or dentists (i.e., surgical-dental services which require a hospital setting) and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

UNIVERSALITY

Under the universality criterion, all insured residents of a province or territory must be entitled to the *insured* health services provided by the provincial or territorial health care insurance plan on uniform terms and conditions.

PORTABILITY

Residents who are temporarily absent from their home province or territory or from Canada, must continue to be covered for insured health services during their absence, at the host province's rate.

ACCESSIBILITY

Requires that insured persons have reasonable access to insured hospital, medical and surgical-dental services on uniform terms and conditions, unimpeded, either directly or indirectly, by charges (user charges or extra billing) or other means (e.g., discrimination on the basis of age, health status or financial circumstances).

Source: Summarized from Health Canada, Canada Health Act Annual Report 2004-2005, http://www.hc-sc.gc.ca/hcs-sss/pubs/cha-lcs/2004-cha-lcs-ar-ra/2004-05\_chap1-eng.php.

The Canada Health Act is also a symbol of social solidarity among Canadians and their commitment to ensuring that health care services are available to all on equal terms and conditions.

### 2. WHAT ARE THE WEAKNESSES OF THE CHA?

Though the Act is strong on protection of public funding and accessibility, it is silent on or lacks definition in key areas, leaving those areas open to broad interpretations and private involvement. Key problem areas include:

- The delivery side is not addressed, leaving it open to for-profit involvement.
- The services that are covered or considered "medically necessary" are not defined. This leaves what is included in the public system open to interpretation by provincial governments and manipulation by powerful interests.

These important challenges each are discussed in more detail in the next two sections.

### a. PUBLIC DELIVERY NOT PROTECTED

The term "public health care" has been used to mean taxpayer funded and publicly paid. The system is divided into funding and delivery with public funding addressed in the CHA, but not delivery. Though the CHA specifies that the insurance plans must be publicly administered, this does not prevent delivery by private for-profit agencies. Public funding and administration is specific to the insurance plan itself, and not the health care system. It merely says, "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."

First, it is important to distinguish between debates on the issues of public/private and those related to profit/non-profit. Private facilities such as hospitals can be for-profit or not-for-profit. Alberta's health system has many pieces that are private but NFP, such as hospitals. This report does not focus on the private/public debate but deals more specifically with the profit/non-profit issues as this is where differences in quality and cost have been seen.

The other distinction that is important is that between investor-owned for-profit and fee-for-service. Most physicians are either reimbursed for services provided under medicare on a fee-for-service basis or work in hospitals where they are on salary. Physicians are predominantly self-employed in their own private practices (solo or small group partnerships), though some are employed full- or part-time in hospitals or in practices owned by other professionals.<sup>2</sup> In contrast, investor-owners make a profit from the provision of services, usually provided by other individuals, in a for-profit setting, be it a hospital, long-term care centre or surgical, diagnostic or radiology clinic.

Investor-owned health care companies argue that it matters how services are paid for but not how they are delivered. This is a false divide for the reasons mentioned earlier in Report I: academic research shows that for-profit clinics, hospitals and long-term care facilities provide poorer outcomes at higher cost and lower quality with generally lower salaries and worse working conditions (see Report I in this series). Thus,

This means that the question of who delivers health care services – whether for-profit or not-for-profit agencies – is not addressed in the Act. As long as services deemed "medically necessary" are publicly funded, the criteria of the *Canada Heath Act* are being respected. This is because insurance systems establish a payer-provider split within the health system and maintain a "payer is blind" ethos that does not distinguish between public, for-profit (FP) and not-for-profit (NFP) providers.

<sup>1</sup> Canada Health Act, as quoted in Flood, Colleen and Sujit Choudhry, 2002, Strengthening the Foundations, modernizing the Canada Health Act, Commission on the Future of Health Care in Canada.

<sup>2</sup> Bob Evans, 2000, Canada: how the system works a summary, Journal of Health Politics, Policy and Law - Volume 25, Number 5, October 2000, pp. 889-897.

there are important differences between FP and NFP entities and the provider matters for both affordability and quality.

The fact that the CHA is silent on how health care services are delivered has allowed for investor-owned surgeries and clinics as well as seniors care services and facilities to proliferate. It has meant that the delivery of health care is open for business. Consequently, Alberta has private investor-owned MRI clinics, surgeries and growing numbers of continuing care facilities and services for seniors. This is discussed further in the section on challenges facing Alberta's health care system.

services. The hospital and physician services category generally includes nursing; lab, radiology and diagnostic procedures, and drugs administered to patients in hospital. The use of services provided in radiotherapy and physiotherapy facilities were, until recently, considered part of this category but many rehabilitation treatments have been de-insured.

the health aspects of home care and ambulatory care

### b. MEDICALLY NECESSARY IS OPEN TO INTERPRETATION

The term "medically necessary" is used in the Canada Health Act to describe services that should be included in each province's medicare plan. Other terms for this include "insured" services and "basic" services. Currently, whatever is not medically necessary can be sold as a product by the private health insurance industry and can be charged a user fee, making the definition a critical one for the health care debate. Albertans receive medically necessary services regardless of their ability to pay. However, services which are defined as beyond what would be considered medically necessary can be purchased as an "enhanced service or product."

The Canada Health Act intentionally leaves "medical necessity" only very generally defined, as it would be too quickly outdated as new treatments and technologies are discovered and previously accepted treatments and technologies are replaced by more effective ones. Also, what is medically necessary for one patient may not be effective for another depending on overall health and stage of life.

Although these terms are not defined explicitly within the CHA, the standard definition includes hospital and physician services, a limited portion of dental surgeries, a limited portion of certain long-term residential care (nursing home intermediate care and adult residential care services), and, to a varying degree,

Section 2 of the CHA defines insured (those which must be fully insured by provincial health care insurance plans) and extended health services (those not subject to the two provisions relating to user charges and extra-billing).

#### Insured health services

- hospital services, both in- and outpatient, that are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, including accommodation and meals, physician and nursing services, physiotherapy, drugs and all medical and surgical equipment and supplies;
- any medically required services rendered by medical practitioners; and
- any medically or dentally required surgical-dental procedures which can only be properly carried out in a hospital.

Extended health care services include intermediate care in nursing homes, adult residential care service, home care service and ambulatory health care services.

In addition, provincial health care insurance plans may cover other health services, such as optometric services, dental care, assistive devices and prescription drugs, which are not subject to the CHA, and for which provinces may demand payment from patients. The range of such additional health benefits that are provided under provincial government plans, the rate of coverage, and the categories of beneficiaries vary greatly from one province to another.

#### **Definition of a hospital service**

There are two challenging issues with regards to the wording of medically necessary services as including hospital services. The first is the question of what constitutes a hospital, and the second is what constitutes a hospital service.

Alberta has been the nexus of debates on the definition of a hospital with the Bill 11 debate on for-profit surgeries. The definition of a hospital as meaning overnight stays has been an Alberta interpretation. The increase in technologies allowing day surgeries makes that very controversial, however, as it allows for an expanding the role of for-profit surgeries.

With regards to the definition of a hospital service, as mentioned earlier, there has been a trend towards the shifting of services outside of hospitals and redefining formerly insured services as extended. Outpatient rehabilitation services such as physiotherapy and occupational therapy have moved from a mainly public to a mainly private, for-profit environment within the last 15 years in every province of the country. Auto insurers are the now largest payer for outpatient physiotherapy in Canada, something that was unthinkable not that long ago.

Interpretations of the CHA helped to clarify the definition of hospital. In 1995, then-federal health minister Diane Marleau advised her provincial counterparts that "as a matter of legal interpretation, the definition of 'hospital' set out in the act includes any facility which provides acute, rehabilitative or chronic care. This definition covers those health care facilities known as 'clinics'." The Act, she said, "was clearly intended to ensure that Canadian residents receive

all medically necessary care without financial or other barriers and *regardless of venue*."¹ Although Marleau's letter was prompted by facility fees charged to Alberta patients by private surgical clinics, the legal interpretation of the term "hospital" is also relevant to nonsurgical facilities. For example, patients who obtain radiology services outside of a hospital but in a clinic cannot be billed by the provider because radiology is a hospital service. However, those who obtain physiotherapy in a community clinic can be, and are, billed in whole or in part for the service.

The debate on the definition of medical necessity is messy. Many proponents of private health care have argued in favour of strong definitions of "medical necessity" because this would clarify which services fall within medicare – and which services can be privately insured. Others argue that the only way to ensure the safest, most effective and cost-efficient medical care is covered by our public health insurance system is to define what is and isn't medically necessary. And finally, there is a growing faction who argue that the term "medically appropriate" is...well, more appropriate than "medical necessity." There are also those who argue that the definition should include reference to sustainability or affordability.

This debate is an important one in Alberta. Certainly, the lack of clarity has resulted in services being excluded from medicare over the past decade.

#### How is it decided?

Also controversial is the mechanism by which decisions about what is medically necessary are made and how transparent those decisions are.

Today, doctors are the gatekeepers to the system and they decide what constitutes necessary and appropriate treatment for an individual patient. They have a dominant influence over what services are placed under the umbrella of publicly insured services. However, they also negotiate what is on that list – in other words, what is considered "medically necessary" at the provincial level. The list of what is an included medical service is part of regular negotiations between government and doctors over the size of the annual

budget for doctor's services. These decisions are not necessarily based on evidence of improved patient outcomes or cost effectiveness.<sup>3</sup> Thus, the list of services that are considered medically necessary varies between provinces and changes over time. There are no national standards.

The system as structured lacks accountability and transparency.

<sup>3</sup> Romanow, Roy, 2002, Building on Values: the Future of Health Care in Canada, Commission on the Future of Health Care in Canada, Cat. No. CP32-85/2002E-IN, p. 5.

## III. What we Heard in our Public Forums

In a series of public forums, Parkland and Friends of Medicare solicited feedback from participants on their concerns with the health care system, with the AHA debate and their recommendations for the path forward for health care in Alberta. The forums were open to the public and advertised publicly. Though we heard from hundreds of Albertans in our forums, we do not claim to have done a representative or scientific survey. Instead, we are reporting what we heard and what was submitted in the written comments. We used an unstructured, exploratory survey/questionnaire. Many of the participants were seniors, reflecting perhaps both that a number of the forums were held in seniors' facilities and that seniors in Alberta feel particularly dissatisfied with their access to health care.

Attached in Appendix 1 is a summary of the feedback with a thematic analysis showing the frequency of common comments. Below is a summary of some of that feedback including quotes from participants and representative statements. The input we received which was extensive and broad-reaching, and this report did not have the capacity to address all of the issues raised.

"We don't need legislation, we need reform"

What we need is change on the ground to improve access today, and it can be done under the existing legislation. The existing health acts could just be slightly improved and no new health act would be needed. The current legislation is needed. The *Nursing Homes Act*, for example, was put into place in the first place because the private sector could not be trusted to meet the necessary standards. The shift to "enabling legislation" will result in legislation being replaced by regulation which can be changed by fiat outside of the legislative process and away from public debate.

## ACCESS — THE CURRENT SYSTEM IS FRAGMENTED AND NEEDS REFORM

The system is too centralized. This is leading to a lack of access to care, especially for seniors. Forcing people to travel large distances to centralized care juts transfers costs onto the family and environment, it is not cheaper. The system is also fragmented. Lack of continuity of care was raised frequently as was the lack of supports for long term care, lack of supports in the homes, and gaps in services for seniors.

Solutions: Decentralize services, especially diagnostics. Stop contracting out of important services such as cytology, lab services, diagnostics, etc.as well as non-medical staff such as cleaning, maintenance, dietary, etc.

We need to pool our resources for a comprehensive public system, not a fragmented number of private companies competing for dollars. This includes homecare. Explore and implement more integrated health delivery services where physicians are on salary supported by other professionals such as dieticians, physiotherapists, social workers, etc.

## ACCESS — EXPAND MEDICALLY NECESSARY AND UNIVERSAL COVERAGE

"Over my life I have paid my taxes and never needed health care. Not even so much as a broken leg. Now I need help and cannot afford private care."

Aids to daily living cost too much and have been escalating outrageously. There are gaps where problems are not covered by private health insurance due to pre-existing conditions.

"Government should be responsible for funding all medically necessary services, not just those offered in hospitals or by doctors."

Expand universal coverage for chiropractors, physiotherapy, dental (non-cosmetic), pharmacare, continuing care and vision care. These all need to be brought within the public system. The cataract surgery may be covered but not the \$600 corrective lenses that have to be used afterwards.

To have to pay for being fed, bathed or taken to the dining room is not respect and to get a lesser service because you can't pay for them is not respect. All of those services should be part of comprehensive care for the ill and injured that includes all costs including housing, food, personal care, and other medical care. All services for people who are frail should be considered medically necessary and should be publicly

funded.

There are not enough hospital and long term care beds. Establish minimum bed ratios for acute care and long term care. Need to ensure that we have enough hospital beds to be ready for a crisis. Stop closing long term care homes and opening them as assisted living. Extend nursing home standards to all facilities serving people needing long term care.

### PREVENTION AND SOCIAL DETERMINANTS

Put a tax on junk food that goes directly in to the health system, specifically public health including heart disease and diabetes. Make sure that this is new spending, not replacing spending, but is above baseline. Public health and preventative health need more public funding and public delivery.

### HEALTH CARE HUMAN RESOURCES

Doctor shortage was raised frequently. Also, wait times for specialists. One participant commented that two doctors were turned away from Medicine Hat and are now practicing in BC. De-skilling of nurses and lack of adequate skilled nursing staff also appeared often.

Infrastructure planning and health care human resource planning should be done together in order to ensure staffing for new facilities. Establish a minimum doctor-patient ration for the province and set targets for education including reducing costs/paying for their education if they commit to practice in the province for ten years. Make human resources planning and university and college spaces linked to long term plans based on population growth and health care trends.

#### PHARMACEUTICALS

Pharmaceuticals cost too much. Why do pharmacists get a consulting fee? Drug costs need to be controlled with bulk buying even in conjunction with other provinces.

### PUBLIC MONEY SHOULD NOT FUND PRIVATE HEALTH CARE

Any private facility that gets government funds should be required to open their books to the auditor and the public. Remove private health care facilities from government funding. Prohibit government from paying for any for-profit health care services.

### PROGRESSIVE TAXES SHOULD PAY FOR HEALTH CARE

We should have a publicly delivered, efficient, all-encompassing, accountable, system paid for by progressive taxes and responsible and fair royalties on our natural resources. Stop tax cuts to big business and use those funds to take care of Albertans through the public route. Convert high cost out of pocket medical expenses being paid by Albertans into tax funded services. Get rid of the flat tax and use the revenues to fund public expanded health care. Do away with the flat tax, it is simply not fair and we have lost billions of dollars in revenue.

## IV. Key Challenges Facing Alberta's Health Care System

Certainly there are serious challenges to be dealt with in Alberta's health care system. As mentioned earlier, services are increasingly being shifted out of the hospitals and public system into the community and for-profit involvement has been increasing. Hospital stays are becoming much shorter, and community or day-surgery alternatives have been increasing. Services such as rehabilitation that were previously offered in hospitals are being offered in communities and homes, but no longer covered under the public umbrella. Long-term care is being downgraded to assisted living, and the sector is becoming increasingly dominated by for-profit providers. On the flip side, the province has under-funded hospitals for many years, causing shortages of beds, nurses and physicians and has not adequately funded quality public services for seniors needing long-term care. The resultant and expanding community sector is fragmented and mostly outside of the public health system and protections of the Canada Health Act.

The growth of the for-profit involvement in the provision of those service areas has come at a cost. As mentioned earlier, Albertans now have the highest out-of-pocket spending on health care in the country.

This section of the report will define the key challenges facing Alberta's health care system. It will focus on the following areas:

- 1. The increasingly fractured and for-profit delivery system.
- 2. The narrowing definition of what is covered within the public system.
- 3. Pharmaceutical costs out of control.
- 4. The move to activity based funding.
- The failure to address the social determinants of health.
- 6. Health care human resources shortages.

## 1. THE INCREASINGLY FRACTURED AND FOR-PROFIT DELIVERY SYSTEM

As mentioned above, there are a number of trends that are reshaping Alberta's healthcare delivery sys-

tem. Those trends and their implications are explored in more detail here.

### TRENDS IN ALBERTA'S HEALTH CARE DELIVERY SYSTEM

Hospital services – On the basis of new technologies and changing health care approaches, the mix of services available at hospitals in Alberta has been changing. This parallels the trend across Canada where overnight stays in hospital have become less common over the last decade and day-surgery programs are growing. Hospitals cared for almost 57 per cent more day-surgery patients in 2002/2003 than in 1995/1996.<sup>4</sup> This has increased the need for post-acute care in the community,including home care and rehabilitation services. It has also meant that the for-profit surgeries (where patients do not stay over night) have been able to offer a wider variety of services paid for by the public insurance plan.

Seniors Care – The other trend worthy of note is that Alberta has prioritized an "aging in place" strategy with strict limits on the number of long-term care beds available in the province. The emphasis has been on providing those services through alternate community care options ranging from assisted living to home care. Many of these patients, however, have ended up in much more expensive acute care beds due to a lack of access to appropriate care.

**Rehab and other therapies** – Alberta has followed the trend elsewhere in transferring many rehabilitation therapy services outside of the hospitals and long-term care facilities into the community.

These trends have meant that the health system today is characterized by an increasingly narrow set of publicly funded hospital services physicians, on the one hand, and private, increasingly for-profit "community" based providers, on the other hand. This has contributed to longer wait times, a fragmented, disjointed system of health care and the re-establishment of the private insurance industry in areas from which it was

4 Canadian Institute for Health Information (CIHI), 2006,, Waiting for Health Care In Canada, CIHI, p.29.

previously excluded.

Problems of fragmentation and a lack of coordination have increased in part due to commercialization (competition replaces cooperation) and increased dominance of for-profit providers. Companies providing private surgeries or other hospital services are expanding and fighting for market share, and they are competing not only with one another but with the public system as well. Such companies are also pushing for greater access to a broader group of payers, both public and private.

## COMMUNITY-BASED AND OUTPATIENT SERVICES A GOOD DIRECTION

In many cases, the move to community-based services is a good one. As early as 1964, the Hall Report provided evidence that the provision in the community of allied health services such as physiotherapy, occupational therapy, speech language therapy and nutritional counselling would save provinces many millions of dollars each year in hospital costs. The report noted that the move away from institutional care was a positive one for patients as well as public insurers. Indeed, a submission from Nova Scotia's hospital insurance program – which funded one of the most extensive outpatient programs in the country - supported this view. The provision of services in the community, the Nova Scotia public insurer told the Hall Commission, "very substantially [relieved] the pressure on needed hospital beds" in that province.

The evidence, in fact, was so persuasive that the Commission recommended that the federal government provide funding for the construction of new, and the extension of existing, outpatient clinics, and that these be designated as "facilities" in law. It further recommended that federal payments to provinces for inpatient hospital services should be contingent on provincial funding for outpatient services – and it wasn't referring only to hospital outpatient departments.

While the Canada Health Act (and its predecessor, the

*Medical Care Insurance Act*) included language that reflected the views of the Commissioners, it did not fully adopt this recommendation.

## THE NARROWING DEFINITION OF WHAT IS INCLUDED IN THE PUBLIC SYSTEM

The debate on what should be included under the public system in Alberta has been framed by the question of sustainability and affordability. The "unsustainable" myth will be addressed in more detail later in this report. Issues of what should and should not be included in the public system have been discussed in a number of Alberta health reviews including the Mazankowski report, the Graydon report and more recently the Foundation report.

The openness of the definition of medically necessary has been used to reduce, rather than increase, the types of health care services covered under the public system in the past decade. For example, some rehab therapies were de-insured (delisted), as were vision care and other services. Also, the grey area has been used to limit the types of services covered for seniors and define services as supplementary which were previously covered in the public system. Long-term care has been downgraded to assisted living and care services are being "unbundled" - that is, services are being separated out and hived off to different payers, both public and private. These include housing costs, feeding a resident, bringing them to the dining room, toileting assistance, etcetera. The "unbundling" of services has meant a significant transfer of costs to seniors, many of whom are struggling with poverty and declining extended health benefits.

Defining services as outside the CHA means higher costs and less access

Albertans are struggling to pay for health care services that have been de-listed or were never included in medicare. Out-of-pocket costs have been rising as the government has been cutting back the public system. Albertans have the highest out-of-pocket spending in

the nation on health care.5

Along with the privatization of funding comes reduced access. According to Statistics Canada, the number of employees with private health benefits has been falling and today only 51 per cent of working people have extended benefit plans where they work. The attached tables show that in Canada (including in Alberta) access to supplementary health insurance is highest among those with higher education and lowest among young people, women and those with lower wages (see Appendix 1). Most disconcerting, it reveals that single parents are amongst the least likely to have employer-sponsored benefits. The research also shows that those lucky enough to have supplementary insurance face dramatically increasing costs for services.

Ironically, while the province has been delisting services, the cost of private insurance coverage for working Albertans has been rising dramatically. In 2004, private insurers collected \$1.4 billion in premiums while paying out \$1.3 billion for health services and products. Four years later, insurers' premium income rose 100 per cent – to \$2.8 billion – but the amount paid out in benefits increased by only 30 per cent, to \$1.8 billion. Despite increases in the number of Albertans covered by employer-sponsored health benefits during the period, only 47 per cent of the provincial workforce had coverage in 2008, below the Canadian average of 51 per cent.<sup>7</sup>

<sup>5</sup> Statistics Canada data as calculated by Parkland Institute, 2010, More than Nickels and Dimes:

Albertans pay highest out-of-pocket costs for services, Parkland Institute, University of Alberta.

<sup>6</sup> Diana Gibson and Colleen Fuller, 2006, The Bottom Line: the truth behind private health insurance in Canada, Parkland Institute and NeWest Press.

<sup>7</sup> Canadian Life and Health Insurance Association, Inc., Facts & Figures: Life and Health Insurance in Alberta 2005 and 2008 editions

### WHAT'S IN AND WHAT'S OUT - WHO DECIDES?

In Alberta the services to be included under the medicare umbrella are still decided in negotiations with physicians. However, there has been significant pressure to reduce that basket of insured services.

The 2002 Premier's Advisory Council on Health (the Mazankowski Report) opened the door for this conversation in Alberta. The Alberta government subsequently established the Expert Advisory Panel to Review Publicly Funded Health Services to develop principles and criteria to guide decisions on public funding for health services using a three screen process including:

- a technical screen (safety and effectiveness);
- a social and economic screen (impact on individuals and health system of not providing the service); and
- a fiscal screen (financial costs and implications for health care sustainability).

That process was reflected in the recommendation of the 2003 Westbury report to remove services from medicare including chiropractic and vision care. The 2003 Westbury report included more detailed recommendations on how the process could be structured, including an appointed Board reflecting the multidisciplinary nature of the health system as well as the public. However, the report still recommended using the triple screen based on fiscal sustainability rather than cost-effectiveness.

The 2010 Foundation report makes a similar though much more modest proposal for an arm's-length entity to support evidence-based decision-making throughout the health system. It recommends the establishment of a panel that would analyze health research and other relevant evidence. It falls short of recommending any changes to the process for decision-making regarding publicly funded services.

#### THE FISCAL SCREEN

The debate in Alberta has evolved to include the three-screen test with one of those screens being the sustainability of the health care system. This is hugely problematic. The question of health care sustainability is a very different one from the medical value of a particular intervention, its necessity, or considerations regarding safety and cost-effectiveness (ie: are we getting value for money?). The question of sustainability also pertains to questions of governance including budget spending priorities and revenue generating capacity. These questions are and should be outside the purview of medical and patient stakeholder advisors. Those are the key mandate of elected government officials. Such decisions should be made by those elected government officials and debated in the legislature at budget time. With health care the first priority for Albertans, it may be that the budget should be increased to accommodate a new technology that meets the evidence test (is it needed? Will it improve health outcomes? Is it cost-effective and safe?).

#### 3. ACTIVITY-BASED FUNDING

Instead of reinvigorating our public hospital system, we are moving towards a fee-for-service payment scheme for hospitals commonly referred to as patient-focused, activity-based, or pay-for-performance funding models. Under such funding schemes, hospitals are encouraged to significantly increase volume of surgeries they provide. In other countries where this model has been implemented, hospitals are increasing the volume of services they provide to the healthiest patients, but skimping on services for patients with more complex conditions – a practice known as "cream skimming."

Albertans are getting good value for their hospital dollars, so it's not clear what the government is trying to fix. Like all provinces, Alberta has seen a dramatic decline in the portion of every health dollar going to hospitals, reflecting the efficiencies within the public sector. Activity-based funding models have sparked deep divisions in other countries such as Great Britain because they have not achieved the cost savings they

were supposed to. On the other hand, such models have boosted opportunities for large companies trying to break in to Britain's hospital system. Even in the United States where these funding models originated, many people question whether hospitals are performing better and more cost-effectively.

As mentioned earlier, Canada's health care system can be described as a "payer-provider" scheme in which the payer is public, but the provider is private (both for-profit and not-for-profit). Services that are covered by the Canada Health Act are funded using either a global budgeting (also known as block funding) reimbursement mechanism (mainly hospitals) or a feefor-service form of remuneration (doctors and other non-hospital health professionals such as physiotherapists or chiropractors). The method of payment is a provincial matter, although the Act assures physicians that they may negotiate how they are reimbursed.

The fee-for-service model has been controversial since the inception of medicare. Before medicare was introduced, doctors charged a single fee for a patient visit regardless of the procedures they performed.8 But fee-for-service was the compromise reached in Saskatchewan after a three-week doctors strike against the Douglas government in 1962 and incorporated into the Canadian health care system.

In some cases, incentives may positively impact efficiency of the health care delivery system. But the fee-for-service model has been criticized for undermining efforts to improve affordability and quality of service. For example the fee-for-service model creates incentives for doctors to treat only one problem per visit and to split physical exams into two visits, one for above and one for below the waist. The model can also inhibit broader reforms as studies have found that other reforms targeted at physician services, however well conceived, work less effectively, if at all, under a fee-for-service system.<sup>9</sup> In addition, a 2003 report

from the Organization for Economic Cooperation and Development (OECD) described fee-for-service as a system mainly used in countries dominated by private providers and multi-party payers (both private and public), stating it was an inefficient method that undermines cost controls and encourages increases both in the quantity and price of services provided. "Under this system" of fee-for-service, it noted, "macro-control is weaker than, for example, under block grants" which requires spending to be controlled by other means.<sup>10</sup>

Finally, the introduction of the volume-based system assumes that there are inefficiencies that can be easily remedied in the hospital sector. Alberta's hospital sector has been operating well in excess of capacity for many years, having suffered from extensive funding cuts and staff shortages. These exigencies necessitated that efficiencies be found. Additionally, the public wait time debate has put significant pressure on the acute care system, ensuring that any remaining inefficiencies would be found. The introduction of activity-based funding in such an environment risks significantly increasing the administrative and reporting workload and cost with no real gains to be made and risks of perverse incentives to increase volume and services.

### 4. PHARMACEUTICAL COSTS OUT OF CONTROL

With reforms such as activity-based funding governments are focusing much of their public policy lens on health care costs associated with medicare, which make up 42 per cent of the total we spend on health across the country. Drug costs, however, have been increasing at a startling rate.

According to CIHI data, hospital spending has gone down dramatically as a proportion of health spending, falling from 44.7 per cent in 1975 to 27.8 per

<sup>8</sup> Tsalikis, G. The Political Economy of Decentralization of Health and Social Services in Canada. International Journal of Health Planning and Management, Vol. 4, 293-309 (1989).

<sup>9</sup> Pran Manga, 1994,"Health Care in Canada: A Crisis of Affordability or Inefficiency?" Canadian Business Economics, Summer: 1994.

<sup>10</sup> Docteur, E., Hoxley, H. Health-Care Systems: Lessons from the Reform Experience. OECD Health Working Papers No.9, Paris: Organisation for Economic Cooperation and Development (OECD).

cent in 2009.<sup>11</sup> Pharmaceutical costs, on the other hand, nearly doubled over that same period. Since 1997, pharmaceuticals have consumed the second largest share of health dollars. In 2008, spending on drugs (including both prescribed and non-prescribed medications) is expected to account for 17.4 per cent of health care spending (\$29.8 billion), up from 15.0 per cent a decade ago and 8.8 per cent in 1975. CIHI predicts that pharmaceutical spending will continue grow faster than hospitals and doctors.

Alberta follows those trends clearly. Total drug spending has increased three times faster than physician and hospital spending.12

Controlling pharmaceutical costs has somewhat been bogged down by jurisdictional issues. Pharmaceutical policy in Canada is divided between the federal government, which sets the rules, and the provinces, which pay for the drugs. Here is an overview of how the system works.

### THE ROLE OF THE FEDERAL GOVERNMENT

Health Canada is one of the largest ministries in the federal government, composed of nine branches, plus six agencies. Federal responsibilities include regulating prescription medicines, price regulation and funding medical and scientific research, often in partnership with private industry and academic institutions. It also has responsibility for overseeing the testing, evaluation, approval and marketing of prescription drugs. Once they have been approved for market, the federal government monitors prescription and non-prescription medicines.

The federal government is also responsible for patent protection legislation, under the Prices Review Board (PMPRB). Under the Mulroney government those

patent protections were significantly increased with much longer patent windows before a generic can be introduced. This increased costs for pharmaceuticals.<sup>13</sup>

#### THE PROVINCES

There are two key areas where the province has jurisdiction that can influence drug costs. The first is what is included under the provincial health care plan, and the second is generic drug pricing.

#### **Deciding What Drugs are included**

To get their products listed on a provincial drug plan, manufacturers must submit an application to each provincial drug benefit plan. Provinces rely on the *Common Drug Review* (a process set up in 2003 and funded jointly by the provincial and federal governments) to provide recommendations regarding the inclusion of a drug on a provincial formulary or plan. Usually there is an internal committee that reviews the applications. Decisions may be based on the recommendations of the Common Drug Review or on a province's own evaluation of drugs.

Alberta has an in-house Expert Committee on Drug Evaluation and Therapeutics. <sup>14</sup> The Expert Committee is made up of physicians and pharmacists. Their recommendations are based on clinical and therapeutic value and on economic considerations.

The committee has been criticized for lacking in transparency and for too narrow a scope. Factors, such as value to society and social circumstances, are currently beyond the scope of the Expert Committee. Recent changes include plans for a new committee consisting of public members to provide the missing societal and ethical perspectives. Also, according to government, a publicly accessible, transparent reporting system that provides information about the drugs being reviewed and the reasons for listing or not listing these drugs is

<sup>11</sup> CIHI, National Health Expenditure Trends, 1975 to 2008, summarized in, Spending on health care to reach \$5,170 per Canadian in 2008, website: http://www.cihi.ca/cihiweb/dispPage.jsp?cw\_page=media\_13nov2008\_e.

<sup>12</sup> Minister Hancock as quoted by Michelle Lang, Alberta revisits drug funding, The Calgary Herald September 4, 2007.

<sup>13</sup> For a good critique, see The Real Story Behind Big Pharma's R&D Spending in Canada, Canadian Generic Pharmaceuticals Association, Toronto, Ontario, http://www.canadiangenerics.ca/en/resources/docs/The\_Real\_Story\_Behind\_Big\_Pharma%27s\_R&D\_Spending\_in\_Canada2006.pdf.

<sup>14</sup> ECDET at http://www.health.alberta.ca/AHCIP/drugs-review.html.

being implemented.

Are there positive international examples we might consider? Steve Morgan, for example, the Associate Director, Centre for Health Services and Policy Research at UBC, found that if Canada followed the lead of New Zealand we could reduce expenditures on the four largest drug classes by 21 to 79 per cent. "Such price differences," he has written, "would translate into billions of dollars in annual savings if applied across Canada, potentially offsetting the costs of the expansion of pharmacare coverage necessary to achieve both equity and efficiency goals in this sector." 15

#### **Brand Name and Generic Drugs**

Generic drugs are the same as the original brandname drugs, but much cheaper. Many experts believe that generics may also be safer because they have been on the market longer and there is more known about the benefits and side-effects associated with them when compared to newer drugs.

Canadians pay much higher prices for generic drugs than most other industrial countries and there is no doubt that those prices should come down. Albertans don't obtain the full benefit of generic drug cost savings for three key reasons:

- a. generic drug prices aren't adequately regulated;
- b. the market share of generic drugs is relatively small; and
- c. pharmacies are being given large kick-backs for stocking particular generics.

#### a. Price of Generics

The costs of manufacturing and distributing generic drugs are much lower than the costs of the patented brand-name equivalents. <sup>16</sup> In a positive move, in Octo-

ber 2009, the Alberta government announced it would reduce the price of new generic drugs from 75 per cent of a brand-name drug price to 45 per cent and for existing generics to 56 per cent. However, for many drugs this still left money on the table. Some other provinces have addressed this problem by instituting tendering systems for multi-source generic products.

#### b. Market Share of Generics

Though Alberta's generic price reforms were a positive change, it falls short of what is needed. Steps also need to be taken to increase the percentage of generic drugs covered by Alberta's health plan, as on this score it compares poorly with other countries. In 2007 generic drugs represented a quarter of the government's total prescription bill<sup>17</sup> compared to 50 per cent in the United States, 44 per cent in the Netherlands and 70 per cent in Denmark.<sup>18</sup> Alberta government spending ratios on generics also compare poorly with the private sector in Alberta. In 2007, generic drugs represented 51 per cent of total prescriptions filled in Alberta.<sup>19</sup>

#### c. Pharmacy Rebates

Nor did the Alberta government zero in on *rebates* paid to pharmacy owners by generic drug companies as Ontario has recently done. The sale of generic drugs depends heavily on pharmacists who dispense the prescription medicines prescribed by doctors. But most pharmacists work for drug stores, many of them powerful chains. Retail drug prices are the net wholesale price plus mark-ups by pharmacies and dispensing fees. The wholesale price may vary as it is subject to "rebates" demanded by pharmacies as incentives to stock particular drugs. The dispensing fee is the payment that pharmacists receive for providing advice and counselling to their patients.

The rebates have been the subject of recent focus and

<sup>15</sup> Morgan, S., Hanley, G., McMahon, M., Barer, M. 2007, Influencing Drug Prices through Formulary-Based Policies: Lessons from New Zealand. Healthcare Policy, Vol. 3, No. 1.

<sup>16</sup> Hollis, A., 2009, Notes on Value for Money in Healthcare, Healthcare Papers, Vol. 9, No. 4, pp. 33-36.

<sup>17</sup> Hollis 2009.

<sup>18</sup> Löfgren, 2007, H. Reshaping Australian drug policy: the dilemmas of generic medicines policy. Australia and New Zealand Health Policy.

<sup>19</sup> Hollis, 2009.

reforms. Joel Lexchin, an emergency physician who also teaches health policy at York University in Ontario, has written that pharmacy owners are provided with "a huge stick in dealing with generic companies. In effect what the pharmacy owners tell the generic companies is that they will not stock their products unless the companies sell to them at a discount."<sup>20</sup>

According to Aidan Hollis of the Institute for Advanced Policy Research, University of Calgary, such rebates average 50 per cent of the list price. <sup>21</sup> He writes that "generic companies can increase their sales by reducing the effective wholesale prices of their products without changing the list prices ... through rebates, discounts, and free goods." He uses the term "rebate" to refer to all the different types of discounts. There may be a large difference among the fees paid by the government, private insurers and those who pay out-of-pocket for needed medicine. Consumers who are not covered by public or private drug benefits pay the full listed price for their prescription drugs.

In April 2010, the Ontario government announced changes in how it will pay for generic drugs included in the Ontario Drug Benefit Program, predicting it would shave \$750 million a year off of its annual \$4.14 billion expenditure for prescription drugs. In 2006, it was revealed that some Ontario pharmacies were receiving *rebates* from generic drug manufacturers of up to 60 per cent of the dollar value of drugs that they sold. Following this discovery, the Ontario government banned rebates, but allowed 20 per cent of the listed drug cost to be paid to pharmacies as a "professional allowance."

Quebec forbids rebates of any sort, restricts professional allowances to 20 per cent and limits the markup that wholesalers can make for drugs paid for under the public system.<sup>22</sup>

In October 2009, the Alberta government said that

"When generic drug prices are reduced, rebates will also be reduced" but did not reveal any further strategies.<sup>23</sup> Hollis has suggested a cap of 10 per cent on rebates and other discounts provided to pharmacy owners by generic drug manufacturers.<sup>24</sup>

With pharmaceutical costs rising faster than any other areas of the health system, Alberta is doing poorly on cost controls. Alberta has yet to take any real steps to address the issue of rebates, and has done nothing to increase the size of the generic drug market. In fact, its October announcement unveiled plans to provide faster access to more expensive, brand name drugs. Additionally, in 2006 it also passed legislation to allow retail and non-retail pharmacists to prescribe drugs with the potential to significantly increase utilization. None of these steps will help Albertans tackle the real problems with drug costs.

## 6. THE FAILURE TO ADDRESS PREVENTION AND THE SOCIAL DETERMINANTS OF HEALTH

Recognition has been growing in recent years that health is determined to a great extent by social factors such as income equality, job security, housing, racial discrimination, disability and education.<sup>25</sup> Ontario's Institute for Clinical and Evaluative Studies, for example, found that poverty and immigration were key factors in determining who would develop Type 2 diabetes in Toronto. It would mean better investments in education, social programs and transfer payments. And it would mean strengthening labour rights and implementing tax reforms the reduce inequality.

Strategies to address the SDH such as housing and

<sup>20</sup> Lexchin, J., 2010, Ontario's Big Pharma Drug War. The Bullet, Socialist Project E-Bulletin No. 342, April 29, 2010.

<sup>21</sup> Hollis 2009.

<sup>22</sup> Hollis, 2009, p.21

<sup>23</sup> Government of Alberta October 20, 2009 News Release, "Alberta to reduce drug costs and increase access to new drugs".

<sup>24</sup> Hollis, 2009.

<sup>25</sup> Juha Mikkonen and Dennis Raphael, 2010, Social Determinants of Health: The Canadian Facts, York University, Toronto, Ontario, ISBN 978-0-9683484-1-3 – 62 pp. Also see Glazier R, Booth G, editors. Neighbourhood environments and resources for healthy living – a focus on diabetes in Toronto. [ICES Atlas]. Toronto, ON: Institute for Clinical Evaluative Studies; 2007 Nov.

poverty need to be incorporated into health planning. The government needs to convene an arms length cross disciplinary, non-partisan committee to look into ways to integrate the activities of different ministries that have an impact on health. The committee also should look at mechanisms for reporting and accountability across ministries in the health impacts of budget and policy decisions.

Although "preventative" spending has more than doubled since 1993, it is still a very small amount of total spending. It is approximately \$77 per capita out of a total of approximately \$4,400, or about 1.75 per cent.<sup>26</sup> This is despite the amount of rhetoric placed on prevention in discussions of solutions to better health with concurrent lower costs.

The government has fared no better with the social determinants of health. Inequality is one of the key social determinants, as is poverty. Alberta is an unequal society with more than 80 per cent of income going to the top half of households.<sup>27</sup> Poverty persists amidst plenty. Social assistance rates are amongst the lowest in the nation and homelessness persists at crisis levels. The province did not index social assistance rates to inflation and those rates were significantly eroded during the boom. Alberta has also failed to invest in adequate quality child care spaces or early learning programs.

Though the Framework document is rife with platitudes about prevention and social determinants of health, the province has not reflected this in budget priorities or public programs.

### 6. HEALTH CARE HUMAN RESOURCES SHORTAGES

The health care cuts by the Klein government in the 1990s led to critical shortages of health care professionals ten years later. This is not unique to Alberta.

Human resources planning has been described as "possibly the most urgent priority for Canada's health system" by the Health Action Lobby (HEAL). The First Ministers' Accord on Health Care Renewal (February 2003) said access to health care resources was a key issue and the Health Council of Canada also said "Without sufficient providers of care working together, all other efforts will flounder." A June 2005 report of the National Health Human Resources Summit urged governments to implement fully integrated HHR plans based on population needs and, importantly, said such plans must be "pan-Canadian," meaning that provinces should cooperate with each other on HHR planning.

Part of the problem is a lack of reliable, accessible data in health trends with age and sex breakdowns. However, it is also an issue of actual shortages, allocation challenges and effectiveness.

Everyone thinks there is a physician shortage, but "the actual number of physicians per capita in Canada has not changed for the last 20 years." The "shortages" are felt in remote communities, but not in urban areas, so is the problem one of shortages or of allocation? Physician vacancy rates are higher in rural areas and specialists are particularly hard to find. For example, in mid-2003, there were 593 vacancies for general practitioners (GPs) in Ontario's rural and remote communities. Similar areas in British Columbia, Alberta and Saskatchewan had vacancies for 62, 56 and 27 physicians, respectively, while Manitoba and Nova Scotia had vacancies for 1127 and 1928 GPs, respectively.

This is partially the result of the failure of provinces to exercise the right to allocate physician resources, so it's subject merely to various kinds of incentive programs. This is a consequence, in part, of the fee-forservice system which allows doctors to bill an insurer that has no relationship with the MD accept as a payer.

The workforce is aging. This means that future popula-

<sup>26</sup> Greg Flanagan, 2008, Sustainable Health Care For Seniors, Parkland Institute, University of Alberta, p. 23.

<sup>27</sup> Alberta College of Social Workers, 2010, A Social Policy Framework for Alberta, Alberta College of Social Workers, March 2010.

<sup>28</sup> Evans, R.G., D.G. Schneider and M.L. Barer. 2010. Health Human Resources Productivity: What It Is, How It's Measured, Why (How You Measure) It Matters, and Who's Thinking about It. Ottawa: Canadian Health Services Research Foundation. http://www.fcrss.org/funding\_opportunities/commissioned\_research/projects/pdf/HHRP\_en\_FINAL.pdf

tion health needs are threatened because the workforce isn't being replaced adequately. The population health needs will increase as the population ages, at least for the next 20-25 years. Elderly people are the primary users of certain types of health services (specialist care, rehab therapists, etc.) in certain places (acute care, home care, long term care), so human resources planning not only has to plan for the numbers but where they will be deployed.

Another challenge in HHR planning is linking the resources to health outcomes. The deployment of resources, eg., MRIs (radiologists), without any evidence that they are contributing or improving health outcomes is rampant. Most, if not all, HHRP literature focuses on inputs and outputs measured in terms of activities or processes rather than health benefits."<sup>29</sup>

<sup>29</sup> Evans et. al.

### V. Making Alberta's Health Care System More Accessible, Affordable and Sustainable

The AHA initiative, though hugely problematic as proposed, does offer a unique opportunity to develop a vision for the ideal health framework. This section lays out some of that vision, building on the critiques made in the previous section of this report.

### A MORE INTEGRATED AND ACCESSIBLE DELIVERY SYSTEM

Given that provision of services through the public system is the most cost-effective, equitable and highest quality, it makes sense to include the broadest range possible of services under the public health care umbrella. This includes long-term care and other services for seniors as well as rehab therapies and other services that have been de-listed or de-insured. It also applies to services that were never included under the public umbrella such as dental and pharmaceutical services.

Eliminating for-profit providers would not only eliminate the cost inflation caused by the profit motive, but it would also reduce the competition within the system, facilitating better cooperation, coordination

and integration.

### ARE COMMUNITY HEALTH CENTRES THE ANSWER?

Numerous royal commissions, public inquiries and task forces have recommended the allocation of public funds to community health centres in order to support greater coordination and integration of services.

The 1970 report of the Conference of Health Ministers, for example, recommended that resources be allocated to develop a comprehensive system of alternative health organizations and community health centres. This was followed by the 1971/72 Community Health Centre Project (the Hastings Committee) which recommended that federal funds be provided so that provinces could fully integrate health services and develop a non-profit community-based infrastructure. Under this plan, the federal government would establish a "trust fund" with a contribution of \$30 per capita to enable provinces to "plan, budget, implement, coordinate and evaluate" such a system.

Provincial medical associations opposed any move towards a community-based system because the proposals called for alternatives to fee-for-service methods of payment, enhanced community participation in decision making and a broader use of other, non-physician, health and social service professionals. Governments were not willing to take on the medical profession so this proposal didn't get off the ground.

In 1979, Emmett Hall reviewed the costs of the health system and reiterated the recommendations of his 1964 report. His recommendations regarding community-based non-profit provision of health services were not acted upon. However, the recommendations to ban extra billing for physician services and hospital user fees were incorporated into the Canada Health Act.

When the CHA was passed there were approximately 200 community health centres in Canada, 140-160 of them in Quebec. Alberta had one of the lowest numbers of CHCs at the time.<sup>30</sup> Quebec was the only province to establish a network of community health centres, called Centres Locaux Services Communautaire (CLSCs). The CLSCs include physician services, home care, public health, mental health, rehabilitation and social services.<sup>31</sup>

In 1997, the National Forum on Health recommended changes in how primary care was funded and organized. Outside of Quebec, physicians in primary care are remunerated on a fee-for-service basis with the exception of those working in community health centres. The Forum recommended that resources be dedicated to the development of a community health centre infrastructure and to home care programs. It argued that salaried health professionals, community involvement, multi-disciplinary and evidence-based provision of services was in the public interest, and would provide governments with more levers with

which to control costs. The recommendations of the NFH, and in fact its entire report, were largely ignored by both federal and provincial governments.

The Romanow Commission provided much weaker recommendations on a publicly funded community health infrastructure, but did succeed in convincing the federal government to transfer funds dedicated to home care. This was implemented in the 2003 and 2004 health accords. But the money for home care is strictly for post-op patients and provides only two weeks of nursing and rehab services. People who need longer term home care or home support are largely left to their own devices.

Community health clinics are part of the solution but such a goal is difficult, if not impossible, within a system that is divided between providers who are publicly funded and those who rely primarily on private investment and are competing with the public system for patients and staff resources.

#### RECOMMENDATIONS:

Integrate hospital and community-based services better by treating them as a continuum with constant interaction between thee different stages on that continuum and movement between by patients. Expand public, globally funded community health centres with interdisciplinary teams and where doctors are on a salaried compensation instead of fee for service. Include a broad range of professionals within these teams as is done in the Quebec CLSCs including physician services, home care, public health, mental health, rehabilitation and social, nutritionists, naturopath services. Also include salaried in interdisciplinary teams within the community health centre.

Place a moratorium on the further expansion of forprofit delivery of hospital services across seniors' care, surgeries and rehabilitation services and reintegrate these services within the publicly delivered, globally funded system. Explore possibilities of exiting existing contract with for-profit providers.

<sup>30</sup> Hastings, JEF., Organized Ambulatory Care in Canada: Health Service Organizations and Community Health Centers, Journal of Public Health Policy, Vol. 7, No. 2 (Summer, 1986), pp. 239-247.

<sup>31</sup> Rachlis, M., 2004, Prescription for Excellence, How Innovation is Saving Canada's Health Care System, Harper Perennial Canada, HarperCollins Publishers Ltd., (Toronto) pp. 83-84.

# 2. MAKING DECISIONS ON WHAT IS COVERED BY THE SYSTEM MORE TRANSPARENT, REPRESENTATIVE AND ACCOUNTABLE.

Alberta is not unique in struggling with what structures would be best for deciding on the controversial question of what is a medically necessary service and what should be included in the basket of publicly insured services. Other countries are also having parallel debates and some have turned to panels of experts to look at the effectiveness of different interventions. The Oregon Health Plan, for example, provides health care services to low-income Oregonians based on input from advisory groups set up to study issues and make recommendations. Canada has a Common Drug Review that looks at the body of evidence of safety, cost-effectiveness and quality of prescription drugs, submitting recommendations about coverage to provinces.

Other examples include the United Kingdom and Australia. The United Kingdom established the National Institute for Clinical Excellence (NICE) to take on the job of determining the effectiveness of various health interventions, including drugs, and providing guidance to health professionals on how to use them.<sup>32</sup> This panel decides on the clinical and comparative cost effectiveness of a particular intervention or drug and makes a determination on the inclusion or exclusion of that service in the public plan. Decisions are final. The Australian Medical Services Advisory Board, though similar, differs in that it makes recommendations to the Minister who makes the final decisions.

Key questions for the Alberta debate include:

 Who will make actual decisions regarding what interventions should be covered and who should make the recommendations?  What criteria should be used and should that criteria include the question of the fiscal sustainability of the health system?

Both the Mazankowski and Westbury reviews envisioned a panel as a mechanism for narrowing the range of public services to meet the aim of cost cutting. However, it may have the opposite effect. In her analysis of the Westbury report, University of Toronto Health Lawyer Colleen Flood wrote "... the report's specific recommendation to establish a permanent, independent panel to determine what services should and should not be publicly funded is a worthwhile reform, but not for the reasons envisaged by the report's authors – that is, because it will result in a reduction in the range of services funded and save public dollars. Rather, it is a worthwhile initiative because engaging in a transparent and explicit determination of what is in and out of the publicly funded basket is likely to result in more political support for publicly funding a wide range of care rather than less."33

#### RECOMMENDATIONS:

Certainly, Alberta needs a fair and transparent process to determine which items will and will not be covered by the public system. Decisions should be based on objective evidence of safety and effectiveness (including both health and cost effectiveness) and the process should be free of pressures from vested financial interests like pharmaceutical companies. It should also not deal with sustainability or affordability, considerations that are properly within the political arena.

Services that have been de-listed should be re-insured unless the evidence regarding their medical effectiveness has significantly changed.

Community provision of rehabilitation and home care services should be incorporated into the public system in a comprehensive manner.

HealthcarePapers, 2(4): 61-67.

<sup>33</sup> Colleen M. Flood, 2002, The Mazankowski Report: Can We Fix Medicare With More Private Financing?

<sup>32</sup> Romanow, 2002, p. 6.

Home supports need to be significantly increased to allow provision of the services based on need and daily living requirements.

Services like ambulances should be available without user fees.

A continuum of care for seniors should be covered by the public health plan including adequate publicly funded long-term care beds.

The downgrading of facilities to assisted living should be reversed and facilities that were removed should be returned to that status.

Who should decide? The Minister of Health should appoint a core advisory group to advise him or her which hospital and medical services are appropriate for public funding in full compliance with the *Canada Health Act*. Members of the Core Advisory Group must be free of conflict of interest, including financial ties to pharmaceutical or for-profit health services corporations. Physicians who are incorporated must be able to declare their companies conflict-free. The process of review and consultation must be transparent, open and accessible to the public. It should be structured as follows:

- Minister of Health (political accountability).
- Core Advisory Group: Scientific and medical experts; physician and health professionals; academic and community-based researchers (conflict of interest provisions apply to this group).
- Advisory panels: Drawn from health sector (physicians, nurses, health science professionals); disability rights/advocacy groups; women's health organizations; multicultural community; First Nations, rural and farming communities (no participation from pharmaceutical or health corporations).

What should the criteria be? Recommendations about what services and procedures will be funded should be based on thorough reviews of the international and domestic scientific and medical literature, as well as on needs assessments of Alberta citizens conducted at five-year intervals. The panel would

need to have access to university-based research centres with specializations in different areas that are free of conflicts of interest. Public consultations should take place with committees composed of Alberta citizens, representatives of physician, nursing and health science professionals, unions (including those representing health care and hospital employees), First Nations, children and adults with disabilities, women, community health activists and academic and community-based researchers.

The advisory panel should make decisions based on best evidence regarding safety, effectiveness and comparative costs to other similar treatments.

The criteria should not include a "fiscal screen." The panel should not be responsible for any consideration of health care spending or sustainability. That should remain the jurisdiction of the elected members of government who have the ability to raise revenues or change spending priorities.

Before deciding a service should be de-listed or approved or a new service should not be included due to sustainability issues, the Minister and government should have to prove that the revenues cannot be raised or budget priorities shifted. Defining which health services should be covered should not only be about cost containment; it should also be about making appropriate investments in the health system and ensuring that the basket of services is kept current.

### 3. CONTROLLING PHARMACEUTICAL COSTS

There are two main areas where the provinces have jurisdiction over drug policy. The first is what is included in the provincial basket of insured drugs and the second is generic drug pricing.

### DECIDING WHAT DRUGS TO COVER

British Columbia offers an excellent model for using best evidence to make decisions about drug coverage and making those decisions transparent. In 1996 British Columbia launched the Therapeutics Initiative (TI), an independent prescription drug watchdog based at the University of British Columbia. The Tl's job is to provide evidence-based information about drugs to physicians and pharmacists. It operates at arm's-length from government and from manufacturers and other interested parties, such as patient advocacy groups (many of which are funded by the industry).

The TI has been described as "the only source of critical assessment of new treatments in Canada that is not political or partisan".34 It has contributed to lower rates of prescribing in BC for some drugs that have subsequently been shown to have serious safety concerns. Vioxx, for example, was not included in BC Pharmacare because the public drug plan took the TI's advice and decided not to list Vioxx in its formulary. It has been estimated BC experienced 600 fewer Vioxx deaths compared to other jurisdictions in North America. The TI also gave a thumbs down to osteoporosis drug Fosamax (now shown to have higher risks than benefits), diabetes drug Avandia (which some experts now expect to be pulled from the US market for safety reasons) and the painkiller Bextra (pulled from the market).

The TI, funded with a \$1 million grant from the province, is housed in the Faculty of Medicine at the University of British Columbia (noted above). The cost to the public to fund the group has paid off in spades:

- The TI conducts independent, thorough and in-depth analyses of the evidence from clinical trials. This information and the rationale for its conclusions are accessible to British Columbians physicians and other health professionals, private insurers and the general public on the TI's website (http://www.ti.ubc.ca/).
- It provides on-going educational outreach to practitioners and the public, not only about drugs but in the interpretation of the latest reports about the benefits and harms that may be associated with the medicines we use.

- The per capita cost of prescribing in BC is 28 per cent below the national average. BC has the second lowest rate of increase in prescribing costs between 1998 and 2007 (after Nova Scotia).
- How much did BC save on prescription drug costs in 2007? If BC's drug utilization was the same as the Canadian average in 2007, total spending in the province would have been \$701 million higher. Around \$455 million of this saving was due to BC residents purchasing fewer drugs, while \$208 million reflects the savings from choosing lower-cost treatment options than in the rest of Canada.

Questions have been raised about whether the Therapeutics Initiative is simply duplicating the role of the Common Drug Review. But as several studies have observed, groups like the Therapeutics Initiative can act as a "knowledge broker" between the CDR and the provincial public drug plan. They bring "substantial expertise in new and old drug evaluation, class reviews, and formulary reviews. This expertise, combined with their established linkages with provincial drug plans, makes them well-suited to act as intermediaries, improving the facilitation of evidence for use in policy decisions at the provincial and regional levels."<sup>35</sup>

Nor do expert committees internal to provincial drug plans duplicate the CDR's work. The CDR recommends to provincial drug plans whether a drug should be listed. The provincial plans then evaluate the impact of adding the drug to their formularies. They consider non-drug treatment options, policy, budget impact, and other economic considerations. Provincial drug plans also assess drugs not reviewed by the CDR (e.g., generics), monitor drug utilization, promote optimal prescribing among physicians and others, and manage the overall formulary.<sup>36</sup>

Alberta's Expert Committee on Drug Evaluation and

<sup>34</sup> Silversides, A. Highly lauded drug assessment program under attack, Canadian Medical Assciation Journal, 179(1), July 1, 2008, p. 26

<sup>35</sup> McHaon, M., Morgan, S., Mitton, C. Common Drug Review: A NICE start for Canada? Health Policy 77 (2006) 339-351

<sup>36</sup> Canadian Agency for Drug Technologies in Health, Myth & Facts, undated. http://www.cadth.ca/media/cdr/cdr-pdf/cdr\_myths\_facts\_e.pdf , accessed September 7, 2010.

Therapeutics differs from the BC model in a number of ways. It is not based at a university at arm's length from the government. It is not open and transparent. It is limited in scope. Albertans would benefit both in terms of cost savings and better health outcomes if it established a similar initiative at arm's-length from government and industry. Accountability and transparency would also be improved.

#### RECOMMENDATIONS:

Establish an arm's-length, independent and university-based body to review evidence of drug safety and effectiveness.

Alberta should adopt the Therapeutics Initiative model for decision making on what drugs are to be covered by the public plan. Transparency, accountability and best evidence should be improved in the decision process.

The Framework document recommends the establishment of "an arm's-length entity to support evidencebased decision-making throughout the health system." That is a step in the right direction, but Albertans need to have confidence this entity will be able to operate independently of the pharmaceutical industry, special interest groups and government. Its mandate should be to provide the public, physicians and pharmacists with up-to-date, unbiased, evidence-based, practical information about prescription drug therapy. Its mandate should also explicitly include independent assessments of evidence on drug therapy to balance drug industry-sponsored information sources. Such an entity should assess clinical evidence published in peer-reviewed journals, meta-analyses by both the Common Drug Review and Oxford Universitybased Cochrane Collaboration, and scientific material presented by the pharmaceutical industry. It should operate in a transparent manner and be focused on drug safety and effectiveness. Individuals involved in evidence reviews should be free of conflict of interest - that is, there should be no direct or indirect financial ties to pharmaceutical manufacturers. This entity should be established in an academic environment with funding from the province, similar to the Therapeutics Initiative at the University of British Columbia.

If the Alberta government was committed to tackling drug costs it would:

### 1. Join with other provinces to demand a national pharmacare program

Canada needs a Pharmacare plan that would provide equal access to prescription drugs, be publicly funded and controlled, and cover essential drug costs in the same way that medicare now covers hospital and physician services. Such a plan would be able to negotiate with both brand-name and generic drug companies to obtain lower prices for drugs. A national Pharmacare program would approve drugs on a more rigorous basis, set research standards and ensure that research findings are available to health care professionals and to the public. It would monitor approved drugs to ensure they are safe and effective. It would include a national formulary of essential drugs, approved in a transparent process that considers both safety and comparative cost effectiveness.

### 2. Remove rebates paid to pharmacy owners by generic companies and regulate dispensing fees more aggressively

Rebates should be capped at 10 per cent of the drug's price. Dispensing fees and other mark-ups should be adjusted to ensure that pharmacies are fairly compensated. For example, pharmacists located in smaller communities and rural areas should be adjusted at a higher rate than those in urban centres. Currently dispensing fees vary depending on the pharmacy and its location. In 2006, dispensing fees ranged from a low of \$5.42 to a high of \$10.94.<sup>37</sup>

### 3. Encourage and support pharmacists to practice their profession

Joel Lexchin has written that governments should "stop paying pharmacists for being storekeepers and start paying them for the knowledge that they gained from going to university for four years." Pharmacists command high levels of public confidence because of

<sup>37</sup> Employee Benefits Bulletin, Undated. Accessed April 11, 2010. http:// www.hedinc.com/ahla/pdfs/AlbertaPharmacyDispensingFees\_Mar06.pdf

their knowledge about prescription medicines. They are often the "go-to" person when a consumer has an adverse drug reaction and, for that reason, should be paid by governments to monitor medication side effects and report the information to the Marketed Health Products Directorate as well as to the province's drug benefit plan.

As part of primary care reform, pharmacists should be employed in multi-disciplinary, non-profit and publicly funded community health centres and in physician group practices. In these practices pharmacists should be placed on salary, removing the distortions that come with pressures from lobbying and kickbacks from generic and brand-name drugs competing for market shares, and allowing pharmacists to base prescriptions instead on best evidence and lowest cost. This would also eliminate costs associated with mark-ups, dispensing fees, and allowances.

#### 4. Rejecting activity-based funding

The province should not move forward with activity-based funding. It is a solution looking for a problem in the Alberta context and is not without risks. The administrative burden and perverse incentives should give the government pause. Instead of focusing on hospitals as problems, the government should pay real attention to the actual cost drivers and inefficiencies in the system, which are the pharmaceuticals and services in the private sector (see the last section of this report for a more involved discussion of this topic).

#### 5. Addressing the social determinants of health

The re-imagining of health care begs a discussion of Tommy Douglas's vision for Phase II. This would include a solid focus on the social determinants of health, public health and prevention. It would include restructuring the tax system and social programs to reduce inequality and eliminate poverty and homelessness. It would mean investing significantly in public, quality child care and early learning. It would mean making real investments in public health and preventative health care.

## 6. Addressing health care human resource challenges

In 2010 Alberta moved from a province with a critical nursing shortage to a province where there is no nursing shortage overnight by the publishing of a government press release. The politics of deficits and budget priorities was a higher priority than getting the right staff and skills mix. Alberta's health care staffing issues have been very caught up in political and budget debates and have been the victim if Alberta's boom-bust economy.

To some extent the human resources challenge can be addressed by long term planning based on demographic and health care trends and the setting of targets. Those targets should then be linked to the number of seats at universities and colleges. It would include much better funding for educating health care professionals. It would require making education, especially medical schools, much more accessible and affordable.

One of the big challenges in such planning is lack of the necessary data. The province needs to take full responsibility for collecting and managing the data needed to properly plan health care services. HHR planning also has to be linked to health outcomes. Focus should not just be on activity levels but also than health benefits of particular health care allocations. "38

However, the question of the shortage of doctors is much more subtle than just that. It involves questions of the appropriate allocation of physician resources (i.e. rural-urban) and alternatives.

Significant debate has emerged over potential solutions to the doctor shortage. The use of community clinics with multi-disciplinary teams may relieve some of that pressure. Expanding the role of non-physician professional such as nurse practitioners as part of those teams could also help. Better utilizing the training and skills of those educated in other countries is also a part of the solution. For addressing the allocation of physician resources, many provinces have

<sup>38</sup> Evans, et al 2010 2010.

created programs to draw physicians away from cities, offering incentives such as signing bonuses, loan forgiveness and differential pay structures. However, these incentive programs have had limited success.<sup>39</sup>

Part of the problem may be attributable to the feefor-service model which is totally dependent on foot traffic, meaning that FFS professionals are more likely to locate in areas with higher population density. Saskatchewan tried to address the issue of physician shortages by creating community health centres that offered salaried positions.

<sup>39</sup> Health Canada. Health human resources: balancing supply and demand. Health Policy Res Bull 2004;8:1. Available from: http://www.hc-sc.gc.ca/sr-sr/alt\_formats/iacb-dgiac/pdf/pubs/hpr-rps/bull/2004-8-hhr-rhs/2004-8-hhr-rhs\_e.pdf. Accessed 9 Sept 2010. The figures are cited in the HC document.

# VI. Expanding the Public System – We Can't Afford Not To

Sustainability has been a constant misnomer for debates on health care over the past decade. Critical elements of the sustainability debate have been missing. The debate has been short on information on the real cost drivers of health care and has lacked any consideration for revenues. Health care reform initiatives such as the Westbury, Graydon and Mazankowsi reviews failed to include any real discussion of revenue options or adequate consideration for revenue potential. Though the Graydon report did include the option of tax increases, it was unceremoniously dismissed as an option and the analysis made no mention of the damage done by tax cuts. These issues are critical to a balanced and informed debate on health care sustainability.

Also, to have a balanced conversation about health care spending, it needs to be discussed in real terms. That means that spending is controlled for population growth and inflation. Of course, spending should be higher every year, as the dollar is worth less than it was the year prior and there are more people to service. However, as costs go up due to inflation, so too do revenues. Also, as the population grows, so does the tax base. Thus, spending has to be discussed in the terms of inflation-controlled or "real" dollars per capita.

Health spending also needs to be discussed in the context of income. The usual proxy for provincial income potential is Gross Domestic Product (GDP) which basically measures the size of the economy. Health care spending as a percentage of GDP provides a picture of affordability. Health care spending as a portion of GDP is low in Alberta by any comparison. It is a fraction of the Canadian average and extremely low by international comparisons.<sup>40</sup>

### 1. REVENUE OPTIONS

Recent analysis by the Parkland Institute shows that the province is foregoing billions of dollars per year with the flat tax, and gave away \$5.4 billion in 2009 alone with the flat tax.<sup>41</sup> The province has chosen to implement a tax structure that is the lowest in the nation and far below the national average.

At the national level, there has also been a concerted agenda to cut taxes. According the economist Erin Weir, the federal government is foregoing \$47.7 billion over the next four fiscal years due to the Harper

<sup>40</sup> Flanagan, Greg, 2008, Sustainable Health Care for Seniors, Parkland Institute, p.20.

<sup>41</sup> Greg Flanagan, 2010, Giving Away the Golden Egg, Parkland Institute.

government's corporate tax cuts. By 2013-14, this will mean an annual loss of \$14.9 billion in revenue.<sup>42</sup>

Albertans consider public health care to be their highest public priority and consistently rate it higher than tax cuts in polls.<sup>43</sup> One of these was a poll conducted by the NRG Research Group which found that 61 per cent said it was unacceptable to make cuts to the health care system. In others, Albertans have consistently ranked tax cuts as a lower priority than health care funding. They have shown an appetite to pay more for valued public health care services including supporting the reinstatement of health premiums in order to avoid service cuts.

# 2. WHERE ARE COSTS RISING FASTEST?

Though Alberta's revenue potential clearly indicates that health care is sustainable, there are costs that need to be brought under control. Out-of-pocket spending by individual Albertans is now the highest in the nation. Spending on de-listed services like vision care and physiotherapy has been on the rise. Pharmaceuticals and dental costs are big cost drivers for Albertans and private health insurance premiums have also been rising faster than inflation.<sup>44</sup>

# COSTS RISING FASTEST OUTSIDE MEDICARE

A central goal of public medicare from the very beginning was cost control. Before medicare, medical

42 Erin Wier, 2010, Reversing Harper's Corporate Tax Cuts, Progressive Economics Forum, February 23rd, 2010. costs were the leading cause of personal bankruptcy in Canada and almost half of Albertans did not have access to private insurance.45 Costs were skyrocketing on a trajectory in line with the United States. After the introduction of public health care, costs flattened significantly in Canada but continued on its same trajectory in the US. Americans now pay much more per capita on health care than Canadians and the US still has tens of millions of uninsured. According to health economist Bob Evans, medicare spending – hospitals and physicians' services - has fluctuated between four and five per cent of Gross Domestic Product since 1975. He states that, "After the introduction of medicare in the late 1960s these costs stabilized because universal, comprehensive coverage consolidated expenditures in the hands of a single payer."46

It is in the area of health services not covered by medicare where costs have been rising, going from three per cent of GDP in 1975 to seven per cent in 2009.<sup>47</sup> According to Greg Marchildon, Executive Director, Commission on the Future of Health Care in Canada, "provincial expenditures on non-medicare services and private expenditures have been growing much faster than medicare expenditures not only since 1997, but since medicare was introduced in the 1960s."<sup>48</sup>

Collectively, services covered by the principles of the *Canada Health Act* make up about 42 percent of the total cost of Canada's health care system. Non-CHA services like long-term care, home care, outpatient community health services and prescription drugs total about 25 per cent, with another five per cent going to Aboriginal health services. In Alberta, private expenditures amount to about 26 per cent of total

<sup>43</sup> CBC News, 2009, Alberta health-care cuts unacceptable: poll, Tuesday, October 6, 2009. http://www.cbc.ca/canada/edmonton/story/2009/10/05/edm-cbc-poll-heathcare-cuts-alberta. html#ixz20pjCcQQnf Canadians Value public services over tax cuts: new poll, Public Values, January 14, 2009. http://www.publicvalues.ca/ViewArticle.cfm?Ref=00257. See also, CAUT Bulletin, Health Care and Education Top List, http://www.cautbulletin.ca/en\_article.asp?articleid=1951.

<sup>44</sup> Parkland Institute, More than Nickels and Dimes, Albertans pay highest out-of-pocket costs for services, University of Alberta. See also, Parkland Institute, 2009, Health Care Affordability in Alberta, Where are costs rising, University of Alberta.

<sup>45</sup> Gibson and Fuller, 2006. .

<sup>46</sup> Robert G. Evans, 2010, Medicare as sustainable as we want it to be, Toronto Star, June 1, 2010. Also see Robert G. Evans, Economic Myths and Political Realities, in Bruce Campbell and Greg Marchildon, 2007, Medicare Facts Myths and Promises, James Lorimer and Company, Toronto.

<sup>47</sup> Robert Evans, 2010.

<sup>48</sup> Marchildon, G., 2004. Three Choices for the Future of Medicare, Ottawa, Ontario: The Caledon Institute of Social Policy.

expenditures.49

Alberta is now spending more money managing an increasingly fragmented LTC sector, leaving less money for actual care. Between 1997/1998 and 1999/2000, the actual money spent on administration by regional health authorities increased by 15.2 per cent – more than for any other identified category except research and education.<sup>50</sup>

PHARMACEUTICALS ARE THE BIGGEST COST DRIVER

According to research by Alberta economist Greg Flanagan, pharmaceuticals are rising faster than anything else in the health care budget, increasing 50 per cent faster than the overall budget. Drugs are the most costly component of the health budget. He attributes this partially to the patent changes introduced under the Mulroney government. This report clearly articulates actions that can be taken immediately by the provincial government to control these costs.

#### FOR-PROFIT IS A COST DRIVER

Earlier sections of this report and Report I in this series summarize the evidence that for-profit health care is more expensive. In his book *Clear Answers*, Kevin Taft found that U.S. Medicare spending was 13 per cent to 16 per cent higher when it was associated with for-profit hospitals than when it was connected to not-for-profit hospitals.<sup>51</sup> A larger study by P.J. Devereaux found that it is even higher at 19 per cent.

The evidence clearly shows that Alberta can find cost savings within the system by focusing on cost drivers – pharmaceuticals and for-profit health care as well as out-of-pocket spending for services not covered by the public system. The evidence also shows that the

system is eminently affordable at current spending and the increased spending can be afforded through accessing revenues currently being foregone by the government in the form of the flat tax and other artificially low taxes.

<sup>49</sup> CIHI data as referenced in Greg Flanagan, 2008, Sustainable Health Care for Seniors, Parkland Institute, University of Alberta, p.20.

<sup>50</sup> Wendy Armstrong, 2002, Elder care on the auction block, Consumer Association of Canada.

<sup>51</sup> Kevin Taft and Gillian Steward, 2000, Clear Answers, Parkland Institute, University of Alberta, and Duval House publishing.

## VII. Conclusions and Recommendations

This report reviews the path forward for Alberta's health care system. It identifies critical weaknesses within the Canada Health Act that have created challenges for health care in Alberta. This includes the fact that the delivery side is not dealt with in the CHA which specifically mentions only that the funding side should be public. It also leaves the definition of medically necessary intentionally vague. That being the key criteria for defining what is within and outside of the public, universal system, this leaves a critical issue open to interpretation.

The feedback from participants across the province is summarized in the report and in the Appendix 1. A clear message was received that it is not legislative overhaul that is needed but real change on the ground to make health care more accessible, affordable and of higher quality. To accomplish this, current legislation would only need to be changed slightly. The other clear message was that there should not be for-profit involvement in health care delivery and that the public, universal health care system should be expanded significantly.

The report includes research on the key challenges facing Alberta's health system. These include: the fractured and increasingly private delivery system; the narrowing of what is covered in the public sys-

tem; rising pharmaceutical costs; the move to activity based funding; the failure to address prevention and social determinants of health; and health care human resource shortages.

The report makes recommendations for the path forward including: reorganizing the delivery system to make it more integrated and limit the role of for-profit involvement; making decisions on what is covered in the system more transparent; taking action on pharmaceutical costs; rejecting activity-based funding; investing in prevention and the social determinants of health; and tackling the health care human resources challenges.

The recommendations in this report include a broad range of specific changes that could be made to improve health care affordability, access and quality. It clearly addresses the question of how those changes would be financed and the sustainability of an expanded public system through measures such as returning to progressive taxes and other revenue reforms.

This discussion paper is meant to stimulate dialogue and contribute to the Alberta Health Act discussions by proposing a different framework for changes that could be made to improve health care in Alberta. With limited resources, it does not cover all areas in need of reform, nor does it propose all of the necessary solutions. However, it does propose a clear path forward that is evidence based and fiscally responsible.

# Appendix 1: Public Comments on the Alberta Health System

## KEY CONCERNS AND RECOMMENDATIONS

The following thematic analysis was compiled from a series of 157 written responses received following ten publicly advertised open house workshops hosted by Friends of Medicare, and the Parkland Institute.

Approximately 300 attendees, including many seniors and health practitioners, participated in workshops held in Edmonton, Calgary, Lethbridge, Red Deer, Camrose, Grande Prairie and Peace River. The work shops were held in spring and summer of 2010 and included speakers, presentations and breakout groups. They were supported financially by the Parkland Institute, Friends of Medicare and various other community and seniors groups.

Written responses were structured around two broad themes: 1) key issues or concerns with the current health system, and 2) key reforms that would improve the current health system. Responses were anonymous and were reviewed, generalized and categorized by theme or issue to create tables XX and YY, below. Where a theme or issue was reported multiple times by the same respondent it was only counted once. The number in the right hand column reflects the number of times the theme or issue was raised. The comments received through the open house workshops reflect

the opinions of those who chose to participate and respond in writing, and are not intended to be representative of the Alberta population as a whole.

### Table 1 Key Issues or Concerns with the current Health System

Lack of physicians (family doctors, midwives and specialists) and staff (particularly in rural areas)	38
Privatization of health care (erosion of health care system)	24
particularly seniors care	24
Underfunding by province (and accountability for spending)	17
High cost and lack of availability of prescription drugs (consultation fee)	17
Not enough beds (long-term care)	17
Equality in care (poor, elderly and disabled disproportionately effected	16
or geography)	10
Quality (particularly for seniors)	16
Wait times for specialists and surgeries are too long	15
Promote prevention (ie. local health units providing education	13
to younger people)	13
Centralization: trend to move healthcare away from local jurisdiction	13
Comprehensive care	12
Delisting services	9
Affordability (cost of long-term care)	8
Pharmaceutical (or other industry) lobby has too much influence on policy	5
Superboard ineffective (participants no medical experience)	5
Leadership of Alberta Health Care (don't provide incentives for cuts)	5
Access	4
Wait time too long for emergency	4
	3
Too much propaganda	
Lack of support to remain in the home instead of institutions	3
Government and conservative lack of support for public health care	3
Dehumanizing (need for respect)	3
Mentally ill -quality of care  Keep 911 local	3
·	3
Continuity of communication about care (from hospital to family	2
doctor or care-provider)	2
Need cost benefit analysis of seniors care in nursing homes (cost too high)	2
Lack of public input (or not listening)	2
Morale	2
Cut management (top heavy)	2
Private insurance	2
Cue-jumping through new private clinics (two-tiered system)	2
Integrate services with other ministries	2

Improve information about aftercare	2	
Separation of couples	2	
Being discharged too early	2	
Insecurity in employment for care workers (particularly nurses)	1	
Lack of stability or continuity in education or training	1	
Need alternatives to institutions such as assisted living	1	
Need increased recruitment of new professionals	1	
Need affordable physiotherapy, chiropractic care	1	
System is ignoring social determinants of health	1	
Availability of tests (i.e. Cancer)	1	
Insufficient time in doctor consultation	1	
Closing institutions	1	
No long-term planning	1	
Centralize all health funding under public system (incl. private insurance)	1	
Patient care evaluation (need individual basis)	1	
Reduction of Chaplaincy in hospitals	1	
Confiscation of property of those entering continuing care	1	
Privacy/information protection	1	
Focus on treating symptoms rather than causes	1	
Continuing education (particularly for nurses)	1	
Stability	1	
Keep ambulance separate service	1	

## Question 2 | Key Reforms to Current Health System

Need national pharmacare program (fed/prov)	28
Develop publicly funded long-term care services (don't close	24
or privatize existing)	
Keep health care public	21
Keep Alberta Health Act – don't need new laws	15
Increase numbers of care professionals in training and investment	15
(subsidize training)	
Expland community clinic system with multidisciplinary teams (with	14
publically elected boards) (walk-in attached to ER)	13
Need national dental and optical care	11
Return to progressive tax system	11
Increase ratio of nurses to patients in hospitals and long-term care	10
(and all assisted living)	
Do not allow private services to fund public service and vice versa	9
Need targets for monitoring (outcomes) and evaluation (quality and	9
safety)	
Laws to prevent private insurance	9
Move away from volume-based care – one question one visit (to	8
activity-based)	
Accountable and transparent	6
Current laws need enforcement; implement existing legislation	5
Laws against outsourcing services to private partners	5
Enhance home care delivery	4
Respect Canada Health Act in Alberta	4
Doctors on salary	3
Provide accurate and information (not propaganda)	3
Re-instate physiotherapy, chiropractic and gender re-assignment	3
Cover universal care (re-instate premiums)	3
Whistleblower (or other) protection for professionals	3
Regular review of legislation	3
Use nurses and auxiliary nurses more	3
Need detoxification centers	2
Get rid of Superboards	2
Authentic public consultation	2
Restrict doctors from working in public and private care	2
Regulations of nursing homes (and long term care facilities) and	2
enforcement of standards	
Need a patient care ombudsman and auditor general	2

Include all health services in Act	2
Standards for emergency treatment and follow-up	2
Set minimum standards for home care	2
Re-instate health care premiums	2
Develop mission statement	2
Prevent private hospitals	2
Use evidence based data	2
Shorten drug patents (17 years)	2
Bar industry investors lobbyists from appointee process	1
Enforce wait time reduction	1
No bail out for private facilities	1
Shift political will	1
Naturopaths should be covered	1
Don't change the Nursing Act	1
Keep unions strong	1
Stronger Canadian Health Act	1
No self-regulation	1
Address determinants of health in act	1
Laws to protect health care funding	1
Laws to prevent cue-jumping	1
Regionalize administration (get rid of Alberta Health Services)	1
Better coordinate community based services and hospitals	1
Restore health system to pre-1993/94	1
Increase innovation	1
Protect against workplace injury or death	1
Refill prescriptions without requiring doctor appointment	1
Enhance postnatal care	1
Decentralize diagnostic services	1
Build seniors hospitals	1
Chronic conditions	1
Cap pay for outgoing execs	1
Return to cost-share model (50-50)	1
Re-open regional hospitals that were closed	1

#### Other:

Need assessment of ratio of management staff to front line staff; need seniors lobby; "hip knee replacement clinic at Northgate is super, we need more like this"; "over the years to age sixty two I have needed minimal medical care, not even a broken leg. I have paid my taxes. Now I need help and cannot afford private care."

Expand Medicine Hat Regional Hospital.

## **Appendix 2**

Who was Insured? | 1995-2005

(11000

A summary of HRDC and Statistics Canada Data 1995- 2001

Year	AII	Male	Female	Union	Non-Union	FT	PT
1995	63.9%	68.6%	57.6%	84.3%	49.2%	*	*
1999	52.9%	58.9%	47.3%	67.4%	47.7%	59.5%	19.8%
2001	51.8%	57.1%	46.7%	66.2%	46.3%	58.1%	18.5%
2005	51.3%	56.2%	46.7%	61.6%	47.5%	57.2%	19.3%

<sup>\*</sup> In 1995 there were no data posted for full-time and part-time workers.

