A Brief Presented by

The Edmonton Social Planning Council

to the

Premier's Commission on Future Health Care for Albertans

HEALTH CARE FOR ALBERTANS: MAKING A GOOD HEALTH CARE SYSTEM BETTER

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1.0 INTRODUCTION

The Edmonton Social Planning Council is an independent, non-profit organization, that has been influencing the development of social services and community groups in Edmonton for forty-eight years. One of our roles is to provide information on major social issues affecting Edmontonians and Albertans. To this end, we monitor the effects of existing social policies; identify some of the social costs of economic and physical planning, highlight the difficulties faced by disadvantaged groups; and assist social agencies and community organizations in responding to issues that are of concern to them. In practice, this means that we often represent people whose voices are seldom heard. Our brief and our presentation to the Commission today reflects this role.

We would like to thank the Premier's Commission for the opportunity to express our opinions and share our views about future health care in Alberta. The Edmonton Social Planning Council does not provide any health services. We therefore do not have any health care professional turf or health care budget to covet and defend. Our perspective is the overall health of our health care system. A number of ideas and recommendations expressed in our brief have been gleaned from briefs prepared by others with concerns about the future of health care in our province. Other recommendations are based on actual Canadian projects. We highly recommend the Hon. Emmett Hall's report Canada's National-Provincial Health Program for the 1980s. This report describes dozens of new approaches to health care and cites numerous health care studies for further information.

In researching this brief we were astounded by the number of health care and health care related studies that have been carried out over the last twenty years. The June 1988 Interim Report of the Premier's Commission On Future Health Care For Albertans states that at least 15 studies and reports just on nursing in Alberta have been produced since 1977. Is the Commission's Final Report going to

be just another study? Many concerned Albertans have spent many hours and dollars preparing briefs for this commission. The Government of Alberta has made a substantial financial commitment to ensure that the concerns and ideas of these Albertans are listened to by the commission. We can only hope therefore, that the Alberta Government will demonstrate the same commitment in responding to these concerns and ideas.

1.1 Guiding Principles

Our brief and presentation are guided by five principles. They are:

1. Health care insurance is the cornerstone of our health care system.

2. Health involves more than just the treatment of disease. Health is a critical resource for achieving other personal goals such as happiness, personal fulfillment and a good standard of living. Health is the product not only of individual behavior but also such factors as housing, the workplace, education and the environment.

3. Throwing more money at health care is not the answer to improving the health care system. We need to consider creative and innovative approaches to the utilization and delivery of health care services in order to make more effective use of the money we do spend.

4. Health care personnel and the general public should be represented in the health care planning process.

5. The Government of Alberta must make its commitment to our health care system known to all Albertans.

1.2 Recommendations

The Edmonton Social Planning Council makes the following recommendations:

Recommendation One: *Health care premiums should be phased out. The general revenues of the province should be used to fund the costs of the health care insurance plan.*

Recommendation Two: *A formal process should be established to determine and review what services should be paid for by the Alberta Health Care Insurance Plan. Lay persons and health care professionals such as physicians, nurses and chiropractors should be involved in this process.*

Recommendation Three: *An Alberta Health Council should be established to advise the government and the general public on the utilization of health care services, the costs and alternative models of delivering health care by a variety of health professionals and identify ways consumers could make more effective use of the health care system. The Council should have wide representation from the general public and from all people involved in health care delivery and usage. The reports of the Council should be part of the planning process in departments involved in health care.*

Recommendation Four: *The province should establish an arms length fund for innovative and experimental health programs that demonstrate ways of shifting the focus of our health care system onto alternative points of entry.*

Recommendation Five: *The province should encourage and help establish centres such as storefront clinics, home care services, public health units and work place clinics that emphasize community-based health services. Such centres would make use of a variety of health care professionals including physicians, nurses, nutritionists, chiropractors, midwives, physiotherapists, and the like. This requires a shift from an institution-based system that emphasizes curing, to a health care system that promotes the physical, mental and social well-being of people.*

Recommendation Six: The province should utilize the Extended Health Care Services portion of the Established Programs Fiscal Arrangements agreement to develop and maintain a variety of health care services.

The rest of our brief provides supporting background information for these recommendations.

2.0 MEDICARE: THE CORNERSTONE OF OUR HEALTH CARE SYSTEM

In his report Canada's National-Provincial Health Program for the 1980s, the Hon. Emmett M. Hall summed up the importance of Medicare to Canadians.

"Canadians understand the full meaning of the Hospital Insurance and Medical Care Acts. They said, through these two acts, that we, as a society, are aware that the trauma of illness, the pain of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability. The Canadian people determined that they should band together to pay medical bills and hospital bills when they were well and income earning. Health services were no longer items to be bought off the shelf and paid for at the checkout stand. Nor was their price to be bargained for at the time they are sought. They were a fundamental need, like education, which Canadians could meet collectively and pay for through taxes."

Our health care insurance plan, better known to most of us as Medicare is the foundation of our health care system. Through medicare all Albertans, regardless of health and income, can access basic health and hospital services.

2.1 Before Medicare

Medicare has only existed in Alberta since I969. The best way to describe the health care system we had before then is "cash register health care". Before medicare, patients got the kind and quality of care that they could afford to pay. For low income Canadians, this meant having to resort to doctors who donated their services, charity wards in hospitals, and help to the indigent through private agencies such as the V.O.N., the Red Cross and the churches. Such health services were acts of charity - you took what you were given. Middle income Canadians often sought treatment after an illness became serious, rather than pay the cost of seeing a doctor for a check up or diagnosis of health problems. A major illness or accident, especially if a long stay in a hospital was required, was literally a one-way ticket to financial ruin and poverty. Only the affluent could afford to ride out a serious illness or accident.

Private health insurance was available for those who could afford it. Health insurance plans operated much like car insurance does. There were deductibles, that is, patients paid an initial fixed amount and insurance covered the rest. There were increased premiums for frequent or serious illness. People in poor health were considered poor insurance risks and were either charged high premiums or refused coverage by private insurance plans. As with car insurance, a person needed to shop around to find a plan that provided the coverage he wanted at a price he could afford. Despite the proliferation of plans, many Canadians did not have insurance coverage. The Royal Commission on Health Services calculated that in 1961, more than 40% of Canadians (7.5 million) had no insurance whatsoever to help pay their doctor's bills.

2.2 THE EVOLUTION OF MEDICARE

The success of a national hospital insurance plan brought in by the federal government in 1957 led to an increased public interest in a comparable system of medical insurance. The 1961 Royal Commission on Health Services chaired by The Hon. Emmett Hall was set up to propose reforms.

The Canadian Medical Association, the insurance industry and several provincial governments pressured the Royal Commission to adopt a two-tiered system of medical insurance - private insurance for most Canadians and government subsidies for those who could not afford premiums. The Royal Commission rejected this view. They opted instead for a universal health care plan that was prepaid through taxes and available to all Canadians regardless of income. The Commission envisioned a health care plan that went beyond health insurance to cushion patients from the financial costs of medical and hospital bills. They recommended a comprehensive system of health care that would also be dedicated to prevention and health promotion.

In 1966 the federal government enacted the Medical Care Act. This act incorporated many of the Commission's recommendations. Under the Act, the Federal government offered to share the cost of the provincial plans as long as the province met four program principles. The program principles were: universality, accessibility, portability and public administration. In 1972 the Yukon Territory joined the national health care plan and for the first time, the hospital and medical costs of all Canadians were covered by a national public health insurance plan.

3. MEDICARE UNDER ATTACK: THE RECORD IN ALBERTA

Under the original health care cost-sharing arrangements, the federal government provided 50% of whatever amount the provinces collectivey spent on health care expenditures. From the federal government's perspective, they had no control over the amount the provinces wished to spend. Over the last 13 years, the federal government has tried to limit its spending on health care. The federal government accomplished this by changing cost sharing arrangements with the provinces. The most recent change, announced by federal Finance Minister Michael Wilson in l986 will have cost Alberta $530 million in health and education transfers by 1991.

Under the Wilson plan, the federal government reduced the rate of growth of revenue sharing to the provinces. This is the "G.N.P. Minus 2%" proposal. In this scheme, the G.N.P. increases used to calculate the E.P.F. adjustment factor are reduced by two percentage points each year. The effect of this action is to reduce the federal contribution to health and education program costs.

Although federal transfers to the provinces will increase in absolute terms, because of the changes to the adjustment factor, the real value of these transfers will decrease. In dollar terms, the impact on the provinces and Alberta, in particular, is dramatic. As mentioned earlier, Alberta will lose a projected $530 million. While the losses to Alberta are small in the first two years, they escalate rapidly. Alberta loses $30 million in the first year but by 1990/91 the losses amount to $191 million annually.

For its part, Alberta delisted services from our plan, decreased the coverage of some services, permitted extra-billing, increased the range of user fees and raised health care premiums. All of these are attacks on Medicare.

In 1984, the federal government passed the Canada Health Act to eliminate direct health care charges by imposing financial penalties on provinces which permitted extra-billing and user fees. It is worth noting that this Act was passed unanimously in the House of Commons - it was supported by the Conservatives, the Liberals and the New Democratic Party. Under the Act, federal funding is withheld on a dollar for dollar basis. David Russell, Minister of Hospitals at the time stated that he would do all he could to recover the money and at the same time try to preserve the right of Alberta doctors to extra-bill, and hospitals to impose user fees. While the Alberta government complied with the federal government's wishes in 1986, it appeared to do so for pragmatic financial reasons rather than any fundamental disagreement with extra-billing by medical practitioners. By agreeing to ban extra-billing and other user fees, the province received nearly $30 million in funds that Ottawa had withheld since the Canada Health Act was passed in 1984, and future savings of about $12 million per year. The Canada Health Act does not eliminate extra-billing and other user fees and any province that is willing to accept the financial penalties is free to allow these practices to occur.

The public silence by the Alberta government on the issue of federal cutbacks is strange given the strong public stance the province has taken regarding the recovery of extra-billing and hospital user fee penalties imposed by the Federal government. The notion of a universal, publicly funded health care insurance plan is regarded as a right by most Canadians and Albertans. However, there are trends today in Alberta which, if left unchecked, could return us to cash register medicare.

What is the Alberta government's commitment to health services in general and medicare in particular? It is our hope that the Commission will urge the Government of Alberta to make a strong public commitment to support and expand the Medicare program.

3.1 Health Care Premiums - Taking From the Poor

Only Alberta, British Columbia, Ontario and the Yukon charge health care premiums. Alberta families pay $432 per year and singles pay $216 per year.

In theory, low income Albertans are exempt from these premiums. Because the premium exemption and subsidies are set so low, however, they do not fully protect all of those living below the poverty line. For example, a family of four with an employment income of $20,000 is not eligible for any assistance.

As well, subsidized premiums are not granted automatically. Eligible persons must apply. It is likely that many people who qualify for a subsidy have not applied. Some who are eligible for assistance may fail to apply either because they do not know about the program, do not think they are eligible, do not like the stigma of having to ask for a subsidy, or are unwilling to go through the bureaucratic red tape in applying for reduced rates. Such people are paying higher premiums than the law requires. This problem does not exist in the seven provinces that do not have health care premiums.

The health care premium is a tax that discriminates against low income Albertans. A family with an employment income of $100,000 pays the same $432 premium as the low income family with an employment income of $20,000. For the family with a $100,000 income this premium amounts to a tax of 0.4%. For the $20,000 family, this premium represents a tax of 2.1%, more than 5 times the rate paid by the rich Alberta family. This runs contrary to the principles of a progressive tax system that most Albertans accept as being the fairest approach.

There is a further injustice in that premium waivers or subsidies are based on taxable income. In l985, 977 Albertans earning more than $50,000 paid no income tax. All 977 were eligible for a full premium exemption!

In July 1987, medicare premiums were raised 29% for individuals and 22% for families; this despite the fact that at the same time some services were de-insured and others were cut back in a move to discourage service usage. Funding to active treatment hospitals was also cut 3%, further limiting patient access to hospitals. Albertans are therefore being asked to pay higher premiums for fewer services.

We must also question the millions of dollars spent by the government to track down and bill individual Albertans when health care expenses could be drawn from general revenues. In view of the fact that premiums raise only 40% of the cost of basic health services, it is questionable whether the bureaucracy and paperwork necessary to collect premiums is an efficient use of taxpayers' money.

Finally, one of the weaker arguments often given to justify health care premiums is that they make people aware of health care costs. It is difficult to believe that Albertans are any more aware of health care costs than the residents of Saskatchewan just because Albertans pay health care premiums.

Recommendation One

Health care premiums should be phased out. The general revenues of the province should be used to fund the costs of the health care insurance plan.

3.2 Cutbacks in Medicare Insured Services

Most Albertans believe that with the passage of the Canada Health Act, Medicare is safe. This is not the case. Since this Act was made law in 1984, the Alberta government has moved to cut back the actual number of Medicare insured services. This has been accomplished by de-insurance of services, fee freezes and reductions in service coverage. Each of these actions represents an erosion of medicare. The Canada Health Act does not protect our Medicare plan against these erosions.

De-insurance of Services

The de-insurance of services means that patients must pay for the entire costs of these services. In 1987, Hospital Minister Marvin Moore de-insured the deliverance of contraceptive counselling, vasectomies, tubal ligations, and insertion of intra-uterine devices. As well, Albertans between the ages of 18 and 65 were forced to pay the full cost of routine eye examinations. After sustained public opposition, these services were re-instated in 1988. There is no assurance, however, that there will be no cutbacks in the future.

Fee Freezes

When fees for medical services are frozen, doctors may choose to refuse to provide those services. As part of his cutback package in 1987, Hospital Minister Marvin Moore froze the fee payable to doctors for an abortion procedure at $84.75. The result has been that many doctors who feel this fee is too low have been refusing to perform abortions. This situation has made it more difficult for women to get an abortion, forcing some to go to the United States for the procedure.

Coverage Reductions

There are a number of services for which Alberta Health Care covers part of the costs to patients. Cutbacks in the amount of a service are a way of limiting access by patients. Cutbacks announced by Hospitals Minister Marvin Moore in 1987 included a 12.5% reduction in benefits payable to chiropractors, physical therapists and podiatrists and a 50% reduction in certain dental procedures. Patients are expected to pay the difference. As well, limits to the amount of insured coverage for these services have been amended. Family limits of $400 annually have been eliminated. Each family member is now limited to $200 annually. Statements by Deputy Premier David Russell in the last year indicate that there may be additional cutbacks in some services.

Cutbacks in medicare insured services, whether by de-insurance of services, fee freezes, or coverage reductions, are a way of limiting patient access to medical services. Such actions are a tax on sick people who are already paying for our health care system through medicare premiums and income taxes.

What is very worrisome is that the cutbacks in Medicare insured services seem to have been political decisions taken in government caucus without any public consultation. The College of Physicians and Surgeons is the body responsible for setting standards and approving various medical procedures and services within Alberta. In a letter sent to the Consumers Association of Alberta in December 1987, the College indicated:

"...that the College of Physicians and Surgeons was not consulted in regard to the matter of de-insuring certain services previously paid for by the Alberta Health Care Insurance Plan..."

The Edmonton Social Planning Council does not believe that coverage reductions, fee freezes and de-insurance of services are the ways to deal with rising health care costs. All Albertans have a stake in our health care system, and therefore all proposed major changes to the system should receive full public debate before being introduced.

Recommendation Two

A formal process should be established to determine and review what services should be paid for by the Alberta Health Care Insurance Plan. Lay persons and health care professionals such as physicians, nurses and chiropractors should be involved in this process.

4.0 MAKING A GOOD SYSTEM BETTER

There is no blank cheque to pay for health care. The health care system has to be responsibly financed. On the other hand, the provision of health care services should not be regarded as just another budget item, where services are de-insured or cutback and fees frozen, all in the name of reducing the provincial budget deficit. We believe that instead of throwing more money at our health care system, we need a more effective allocation of resources and new kinds of institutions.

4.1 Proper Allocation of Resources

It is a well known fact that in terms of percentage of G.N.P. spent on the health care system our Canadian health care system is cheaper than the U.S. system of private health care. In terms of administrative costs, the difference is even more striking. Figures quoted in The Hon. Emmett Hall's 1980 report indicate that the administrative costs of the Canadian health care system were about 2.5 cents out of every health care

dollar spent in 1980. This compares with 7 cents and 18 cents on the dollar for non-profit organizations and commercial insurance companies in the U.S. (1977 figures). Despite these observations, our health care system could best be characterized as a system that fosters waste and inefficiency. Hospitals close whole wards for months at a time while the waiting lists for elective surgery get longer every year. While many small hospitals in rural Alberta with state of the art equipment are underutilized, more of these hospitals continue to be built. Patients occupy beds in auxiliary hospitals when home care could be provided at a fraction of the cost. Doctors earn more money if they do more tests or provide more treatment while their patients are exhorted to cut back on the use of medical services. Under the current system of payment to physicians, they have no incentive to reroute patients to less expensive health care.

The province of Alberta cannot afford to build state of the art hospitals in every village and small town in Alberta. Instead of building more hospitals, we need to make better use of the ones we have. For example, a hospital care system might be developed where patients could be admitted to their community hospitals, be diagnosed, and then referred if necessary to a regional centre for treatment. Convalescent and auxiliary care could be provided back in the patient's own community hospital. A provincial ambulance service would allow for patients to be transported to the appropriate treatment centre.

Instead of providing financial inducements based on providing more medical services, governments need to give physicians, hospitals and their staffs financial inducements to require less intensive or different levels of care than provided in general hospitals. According to figures from the Society for the Retired and Semi-Retired, the average yearly cost in Alberta of caring for a senior in an auxiliary hospital is

$36,325. The average yearly cost of providing home care is $2,280.00. Nursing home care averages $18,250 per year. A portion of the savings gained from providing less expensive services could be rebated back to the hospitals.

It is a waste of manpower and money to have physicians being engaged in certain services such as minor treatments, routine immunizations, marital counselling and prenatal care that can frequently be provided better and more economically by other health care professionals. H. Mahler, then director-general of the World Health Organization suggested in a 1975 article in The Lancet that the health establishment make a major effort to describe all the health problems and the alternative ways of dealing with them in an objective way and then accept a nationally agreed upon decision process to decide which health care professionals would be responsible for which health problems.

The Consumer Association of Canada made a similar recommendation in a brief presented at a health care forum in May 1988. The Edmonton Social Planning Council supports that recommendation.

Recommendation Three

An Alberta Health Council should be established to advise the government and the general public on the utilization of health care services, the costs and alternative models of delivering health care by a variety of health professionals and identify ways consumers could make more effective use of the health care system. The Council should have wide representation from the general public and from all people involved in health care delivery and usage. The reports of the Council should be part of the planning process in departments involved in health care.

4.2 New Points of Entry

At present, it is only by referral through a physician that one can gain access to the health care system. In order to gain access to our publicly funded health care system, one must first diagnose himself as "sick enough to see a doctor". This poses a problem for someone who thinks he may have a sickness or health problem but is not quite sure. Patients often want to consult with someone else before they "bother the doctor". Consultation may include getting advice from relatives, friends and neighbours or talking to a pharmacist. This informal process may work sufficiently well for colds and minor ailments but is less effective for those illnesses or problems a person is not quite sure about.

In general, the public is not sure of what services to use or which are available and when to use them. Patients often go to a doctor or they may decide to go to the emergency section of the hospital, because they do not know where else to go. Much of what we hear about misuse or abuse of the health care system is really a question of uninformed use.

Going to see the doctor first is not a cost-efficient use of our health care resources. Doctors should be the last point of entry. For example, does a baby with red spots on its chest need to be taken to a pediatrician? A visit to a public health unit where a nurse could make a diagnosis and, if necessary, a referral to a doctor would be a much cheaper use of our health care system. Much routine care and many minor procedures could be removed from the physician's office.

Besides physicians, there are other points of entry that patients can use to obtain health care such as: public health units; family practice units where nurses are funded from the insurance source rather than paid by a physician; storefront health centres where people can drop in for health care advice,

counselling, minor treatment and referral; home care services and occupational nurses in a work setting. The 1980 report by the Hon. Emmett M. Hall cites working examples of each of these. All of these health care entry points used less costly health workers. In one example, two occupational health nurses working at the main branch of a post office in a major city paid for themselves in two days each month by reducing time lost by the post office employees.

In the short run, in terms of total costs, the use of alternative points of entry may not necessarily be cheaper. In the long run though, we would have a more effective and comprehensive system that would re-allocate health services among less costly health organizations and would utilize a wide range of health care personnel. Such a system could be funded in part by savings from present hospital and medical care expenditures. As well, innovative programs need to be funded by government.

Recommendation Four

The province should establish an arms length fund for innovative and experimental health programs that demonstrate ways of shifting the focus of our health care system onto alternative points of entry.

4.3 What community Health Can Be

Most Albertans probably think of health care in terms of two major programs: hospital and medical care insurance. These programs focus on curing or treatment. As we have already noted there are a range of services that can be provided outside hospital wards and private doctors' offices. These alternative points of entry are commonly called community health care.

Physicians and hospitals focus on treating sickness. Community health care broadens the meaning of health beyond treatment. An immigrant is able to go to a storefront centre, talk to a community worker in her own language and get referred to family counselling. A worker gets physiotherapy at a clinic at the work site. A mother goes to the public health unit to have her baby weighed and measured - the nurse also offers some nutrition tips. A home care worker visits a senior citizen in his home. She provides some assistance and talks to the senior over a cup of coffee. A community health nurse changes a patient's dressing in his home, teaching him and his family during the process.

As we have noted, community health care can take many forms. It can include such things as a health care professionals visiting a home; a storefront counselling clinic; community health centres staffed by a range of health care personnel such as physicians, nurse practitioners, nutritionists and community workers; workplace clinics; and public health services and programs. The Hon. Emmett Hall's report, Canada's National-Provincial Health Program for the 1980s, describes these and other community health programs in greater detail. All of these approaches are cheaper than hospital and other institutional care.

The argument has been made that the types of community health care mentioned earlier will not work because Albertans prefer to have "a doctor of their own". The popularity of medical clinics where patients are served on a first come, first served basis with no appointments indicates this assumption may no longer be valid. It is also argued that community health centres provide a lower quality of health service than a personal physician can provide. This attitude is a disservice to those physicians and health care workers who are not in private practice.

While community health services need to develop and receive their support from the local community, governments can create a favorable climate for them as well as assisting in their financing. According to the Hon. Emmett Hall, the Extended Health Care portion of Established Program Funding for health care was intended to assist the provinces to develop and maintain a variety of health care services. He recommends that the province utilize this source of funding to provide more community health care services.

One funding method suggested by the Staff Nurses of Alberta would be for the Department of Health to add a percentage of what a centre saves on hospital costs to the centre as an incentive for keeping people out of hospital when possible.

Recommendation Five

The province should encourage and help establish centres such as storefront clinics, home care services, public health units and work place clinics that emphasize community-based health services. Such centres would make use of a variety of health care professionals including physicians, nurses, nutritionists, chiropractors, midwives, physiotherapists, and the like. This requires a shift from an institution-based system that emphasizes curing, to a health care system that promotes the physical, mental and social well-being of people.

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