

Commission on the  
Future of Health Care  
in Canada



Commission sur  
l'avenir des soins de santé  
au Canada

ISSUE/SURVEY PAPER

# Sustainability of Canada's healthcare system

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JUNE 2002

*This paper is one of a series of nine public issue/survey papers designed to help Canadians make informed decisions about the future of Canada's healthcare system. Each of these research-based papers explores three potential courses of action to address key healthcare challenges. Canada may choose to pursue some, none, or all of these courses of action; in addition, many other options are available but not described here. These research highlights were prepared for the Commission on the Future of Health Care in Canada, by the Canadian Health Services Research Foundation.*



Thank you for your interest in shaping the future of Canada's healthcare system.

This issue/survey paper on the sustainability of Canada's healthcare system is one of a series of nine such documents the Commission on the Future of Health Care in Canada has developed in partnership with the Canadian Health Services Research Foundation. They were designed to enable Canadians to be better informed about some of the key challenges confronting their health care system and to express their preferences on proposed solutions. We have worked hard to summarize relevant, factual information and to make it as balanced and accessible as possible.

Each of our nine documents follows an identical format. We begin by briefly summarizing a particular health issue. Next, we identify three possible courses of action to address the issue and their respective pros and cons. Last, we ask you to complete a brief survey relating to the courses of action.

To make it easier to provide us with your responses, the survey questions are included on the final pages of this document. Please detach and forward these pages to us by fax at: (613) 992-3782, or by mail at:

Commission on the Future of Health Care in Canada  
81 Metcalfe, Suite 800  
Ottawa, Ontario  
Canada K1P 6K7

You can also complete the survey on-line through our interactive website at:  
[www.healthcarecommission.ca](http://www.healthcarecommission.ca).

There are no "right" or "wrong" answers, and the results are intended to be informational only. They are designed to illustrate how each person's response fits within the context of others who have responded, not to have scientific validity in and of themselves. The survey results are only one of many ways the Commission is studying and analyzing this issue. To order other titles in this series, please write to us at the address above, or call 1-800-793-6161. Other titles include:

- Homecare in Canada
- Pharmacare in Canada
- Access to healthcare in Canada
- Consumer choice in Canada's healthcare system
- The Canada Health Act
- Globalization and Canada's healthcare system
- Human resources in Canada's healthcare system
- Medically necessary care: what is it, and who decides?

We are grateful for your contribution to shaping Canada's healthcare system and hope that this document will be as informative to you, as we know your survey responses will be valuable to us.

Sincerely,



Roy Romanow



# Sustainability of Canada's healthcare system

Canadians once took for granted having one of the best healthcare systems in the world. The professionals who gave us our care were superbly trained; the institutions they worked in were plentiful, well-stocked and had room for us when we needed it. We raised our glasses to each other's good health, secure in the knowledge that great care was available if wishes alone weren't enough.

But our confidence is getting shaky. Stories abound of a system riddled with problems. We hear about lengthy waiting lists, ambulances turned away from hospital doors and Canadians going to the U.S. because we don't have enough modern equipment to go around. Canadians are worried we won't be able to maintain medicare's essential promise of care for all who need it, free of direct charges.

Numbers speak volumes, telling the story of a system with a growing appetite for dollars. In the last 10 years alone, the average portion of provincial and territorial budgets spent on healthcare rose from 33.2 to 38 percent. We're a healthy nation, overall, but our good health comes at a high and ever-increasing cost. At 9.3 percent, Canada spends more of its gross domestic product on healthcare than most other industrialized nations (although we are about in the middle of the pack when it comes to spending per person). In 1974, it was only 6.7 percent.

It's not, however, physicians and hospital care that have increased costs. We're spending about the same on doctors as in the 1980s, and hospital costs actually take less from healthcare budgets than they did then. The rising costs have come from the shift to types of care not traditionally included in medicare. Spending on drugs has shot up as more and more pharmaceutical treatments are developed, and homecare costs are also exploding.

All these changes in how care is delivered, combined with demands for expensive new technology, have the public worried. Many people fear that an aging population will overwhelm the system and leave us unable to pay for all that's needed. The question is, can we sustain a universal healthcare system?

Many argue the system can be sustained very well — we still spend far less than the U.S. — provided we make substantial improvements in how it's managed. Others insist medicare can't be sustained and either we change the system, or we put more money into it. But Canadians don't want higher taxes, and politicians don't want to raise them. So if cash is the problem, how do we find new funds or spend what we've got differently?

This paper focuses on three of the many potential courses of action for Canada. They are:

- I. Governments should expand the role of user fees for services usually covered by medicare;**
- II. Governments should set a limit for healthcare expenditures to encourage greater innovation in how the healthcare system deals with new technology and the aging population; and**
- III. The majority of any new health expenditures by government should be devoted to disease prevention and health promotion, not acute care.**

# I User fees

There are already user fees in Canada's healthcare system. Some things — notably prescription drugs — are not covered by medicare outside of hospitals. They may be partially covered by provincial health insurance plans or private coverage, or not covered at all. When we talk about user fees in this paper, we're talking about introducing them for care received from a physician or in a hospital — which is not allowed under the Canada Health Act.

We wouldn't be the first country to introduce user fees for those services. But it isn't clear what Canadians think of the idea. Opinion polling on the subject has produced mixed results. How people respond is affected by how a question is asked, and results can be interpreted in different ways.

## **Course of Action: Governments should expand the role of user fees for services usually covered by medicare.**

There are several ways to collect user fees for healthcare. It's possible to have patients pay a flat amount (usually just a small portion of the cost) for every visit to a doctor or hospital. Another way to collect fees would be by having the public pay deductibles for care — like the share of the bill paid for car accident repairs even though the driver has vehicle insurance. As with auto insurance, after the deductible was paid, the rest of the healthcare bill would be covered by the provincial health insurance plan. A third option is to have people declare their use of healthcare on their income tax forms and be taxed on how much care they used over the year.

What all of these have in common is that the more care you use, the more you pay out of your own pocket. So that those who are very sick aren't excessively burdened, a limit could be set on what an individual pays in a year (for example, in Sweden payments are capped so no one pays more than the equivalent of \$135 CDN annually). To protect the poor, user fees could be adjusted based on income or even waived for those with the lowest incomes.

Whatever the means of collection, the amount charged for user fees will influence their impact on healthcare. Moderate charges may not bring enough money into the system and could be offset by administrative costs. Higher charges would hurt those with relatively low incomes who don't qualify for a fee exemption.

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## ARGUMENTS FOR

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**Some say user fees will discourage frivolous use of the healthcare system.** They could make people more aware that there is a cost to using healthcare services. In Canada and abroad, research tends to conclude that user charges reduce some people's use of the system.

**User fees might raise additional money for the healthcare system.** Instead of reducing costs, user fees, if high enough, could provide an additional source of revenue.

**User fees may help guide patients towards more cost-effective alternatives.** There is little research on this topic, but user fees for inefficient services could persuade people to choose more efficient services that are free. Fees could be charged if a patient goes to a specialist for something that a general practitioner could do or goes to an emergency room for care they could get elsewhere.

**The overall public cost of providing healthcare might be reduced if people pay user fees.** A massive study by the RAND Corporation, a U.S.-based think tank, shows that user charges reduced use of services and costs for those who had to pay them.

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## ARGUMENTS AGAINST

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**User fees hurt the poor and the elderly.** Most research shows that user fees cause the poor and the elderly to reduce their use of health services more than others, although they are statistically the people who need the most care. One study found low-income patients were more likely to die when they faced user charges. A recent study on the Quebec pharmacare program found that elderly people took 90 percent less of their needed medication when charged user fees.

**The biggest costs to the healthcare system aren't usually from choices made by patients.** Big-ticket items in healthcare — like hospital admissions, drugs and surgery — must all be ordered by doctors, so user fees for patients won't do much to discourage use. And services like visits to the family doctor, which the public has some choice in and thus might use frivolously, just don't cost a lot.

**Patient over-use of the system is quite low.** Based on the limited opportunities for over-use, some researchers estimate that patient over-use may account for as little as one percent of healthcare costs. In contrast, research has consistently shown that as much as 30 to 40 percent of all services ordered by doctors may be unnecessary or inappropriate.

**User fees didn't reduce inappropriate use when tried before.** User charges for physician services were tried out in Saskatchewan in 1968 and abolished seven years later. Overall healthcare costs didn't go down in the period because doctors charged more and people with more money received more physician services. In the RAND study, use declined with heavier user charges, but for necessary as well as unnecessary visits. Strikingly, though, the proportion of inappropriate antibiotic use, hospital stays and admissions remained the same.

**User fees mean more administration costs.** Billing patients and government for the same service costs more. Screening tests to measure people's ability to pay would add yet more to the administrative bill. Keeping track of what people used in order to issue income tax receipts could also be quite cumbersome.

**The Canada Health Act was created to stop medicare user fees.** Canadians are quite passionate about their medicare system and the fact that it shuts no one out. The main focus of the development of the Canada Health Act in 1984 was to get rid of the emerging trend in the late 1970s and early 1980s for physicians to collect user fees by extra billing. A health services review by Justice Emmett Hall in 1979 warned that extra billing by doctors and user fees levied by hospitals were creating a two-tiered system that threatened accessibility of care on the basis of need and how much a patient would likely benefit.

**Costs could be shifted on to businesses.** Healthcare benefits are common for employees, and businesses could well be expected to pick up the tab for insurance coverage against the cost of user fees. This could add greatly to their costs, making them less internationally competitive and making Canada a less attractive place to do business.

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## SURVEY QUESTIONS

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Please refer to page 11 for the survey questions for this section.

## Limiting the amount government spends



Former New Brunswick premier Frank McKenna said that setting limits on provincial budgets is the way to make healthcare reform happen. If budgets keep growing, he reasoned, the incentive to be creative and change the system is diminished.

Such limits — called spending caps — may be one way to manage the growing costs of the healthcare system brought on by new technology and an aging population. Under a cap, provinces and healthcare providers can't just "buy" their way out of problems. They have to be innovative in dealing with the problems facing them, like the need for new technology or the ever-increasing demand for services.

**Course of Action: Governments should set a limit for healthcare expenditures to encourage greater innovation in how the healthcare system deals with new technology and the aging population.**

There are two points in the healthcare system where spending can be capped by governments. One is when the federal government gives money to the provinces for healthcare. Capping these funds forces provinces to either raise taxes or to find ways to manage on the funds they receive. In turn, provinces and territories can cap the amounts they give care providers.

Spending caps can be very sophisticated, based on a technical estimate of what care should cost and accompanied by a multi-year contractual guarantee that this amount will only go up or down in response to economic or demographic conditions. This isn't very different from how the federal government funds healthcare now under the Canada Health and Social Transfer, except for the idea of a multi-year contractual commitment from both sides.

Sudden extraordinary needs could be allowed for by leaving a portion of the budget free from the spending cap, as is done in Connecticut. Under this system, the government would be able to identify one-time, emergency circumstances that require extra funding. Another portion could be set aside for investing in beneficial long-term programs.

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### ARGUMENTS FOR

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**A cap could give providers the incentive to diagnose and treat patients in the most cost-effective manner possible.** They know their spending limit, and they have to stick to it.

**A capped budget means you can predict total cost in advance.** As the system stands, we usually don't know what healthcare has cost until well after the end of the budget year. This is a challenge for provincial treasuries trying to do their financial planning.

**If healthcare spending keeps increasing, it will drain money away from other areas.** Between 2000 and 2020, the amount of money spent by the provinces and territories on healthcare is expected to grow more than twice as fast as the money spent on other goods and services — like education, social services, and transportation. We need to find ways to sustain the healthcare system and all the other services the public needs.

**More money doesn't always mean better health.** Research shows that spending more on healthcare means that at first health would get better and better with increases in the amount spent, but then it would plateau, regardless of increasing expenditures.



**There is evidence that there is room for cost-saving innovation in the healthcare system.** When budget cuts reduced the number of resident doctors in the 1990s, specially trained nurses were used to replace them in intensive care units for adults and children. Treatment for the youngsters was just as successful and their parents were equally satisfied with both types of care. Use of nurse practitioners, who have more training than other nurses and can provide many of the types of care regularly done by family doctors, actually leads to higher patient satisfaction and similar results when compared with care from a doctor.

**Budget limits led to some innovation in the 1990s.** When budgets tightened in the last decade, many institutions successfully used day surgery and other out-patient programs to reduce costs. A 1995 study on whether shorter hospital stays reduced the quality of care found that people were not more likely to go back to hospital or visit their doctors more often with shorter hospital stays.

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## ARGUMENTS AGAINST

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**Budget constraints don't necessarily make the healthcare system more efficient or effective.** A 1994 comparative study of health-system reforms in industrialized countries found that overall budget constraints may have weakened efforts to become more efficient or effective. Budget ceilings may have reduced costs — by reducing the number of beds, for example — but the remaining resources weren't used more efficiently.

**Budget constraints can hit workers and patients hard.** A study of hospitals in Rochester, N.Y. found that wages and benefits for workers were significantly reduced after capped budgets were introduced. Within Canada, budget constraints have led hospitals to move more and more patients into the home to convalesce after acute care. Outside hospital walls, costs for medical devices and drugs sometimes have to be picked up by patients or their caregivers.

**A capped budget can't respond to sudden, extraordinary care demands.** If all healthcare budgets were inflexible, then sudden, serious illnesses like HIV/AIDS could not be responded to. The most recent example of possible unexpected demands on the system is the threat of bio-terrorism.

**The cuts resulting from budget limits were quite painful in the '90s. In 1998, public confidence in the health system hit an all-time low.** Over 70 percent of queried Canadians thought that waiting times were worse than in previous years. Eighty-six percent attributed a lower quality of service to budget cuts.

**The aging population is not a serious threat to the sustainability of the healthcare system.** The experience of other countries, which have already experienced their “baby booms”, leads some experts to say the demands of an aging population are not the threat people think, because the increase will occur along a gradual slope, easily cushioned by growth in the economy.

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## SURVEY QUESTIONS

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Please refer to page 11 for the survey questions for this section.

# Increasing Disease Prevention and Health Promotion



It has been suggested that in order to save money in the Canadian healthcare system we need to try to stop people from getting sick in the first place. Actually, not all disease prevention and health promotion efforts save money. If we choose to spend money on these efforts, we have to be very careful that we choose the most cost-effective ones.

Disease prevention helps people avoid getting sick, becoming injured, or even dying. Everything from the work of Mothers Against Drunk Driving to putting calcium in orange juice and regulating safe working environments are prevention efforts. Health promotion work is also familiar to a lot of Canadians, whether through school lessons on the Canada Food Guide, or TV commercials from ParticipACTION, urging Canadians to be as active as the average 60-year-old Swede.

**Course of Action: The majority of any new health expenditures by government should be devoted to disease prevention and health promotion, not acute care.**

Instead of putting new funds into care for people after they've been injured or become sick, money could be put into health promotion and disease prevention. This is what Saskatchewan had in mind in 1994, when the province told district health boards they could transfer money out of acute care for promotion and prevention, but couldn't move money into acute care from other services.

If we were to put new money into prevention and promotion, dollars could be spent on things like regulating smoking, changing the fat content of foods and helping people make healthy lifestyle choices. We could also undertake public-health initiatives, such as environmental clean-up.

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## ARGUMENTS FOR

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**The healthier people are, the better. Healthcare should not just focus on keeping people alive, but on giving them the healthiest life possible.** Prevention and promotion efforts can improve the quality of the life for Canadians, which is one of the main goals of the federal health department.

**Most illnesses treated in the industrial world are preventable.** In the United States, illnesses that could have been prevented account for about 70 percent of the total burden of illness and cost of care, and the cost of care for preventable conditions is growing. Much suffering can be avoided by preventing illness, and it's cheaper than treating someone after they're sick.

**Having doctors do disease prevention and health promotion can be very cost-effective.** Patient education works well one-to-one — research shows that some programs encouraging doctors to talk to patients about quitting smoking are very cost-effective. There is evidence that patient education programs, particularly when they promote self-care, reduce costs by reducing medical visits.

**An infusion of money would help get proven programs into routine practice.** We already know a lot about how to improve health by working in schools and with communities. All we have to do now is make the commitment to put these programs in place.

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## ARGUMENTS AGAINST

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**We should concentrate spending on the most effective activities.** A wholesale investment in prevention and promotion may not be an effective use of cash; we need to make careful choices. Evidence shows that existing preventive services like screening for cholesterol are best applied to particular populations, rather than being done universally. The money saved from these targeted approaches could be used to expand prevention and promotion efforts in other areas.

**Many disease prevention activities actually increase medical expenditures.** The savings from a prevented illness are often less than the total cost of preventing it. This doesn't mean that prevention isn't worth the cost. It just isn't the missing link to a financially sustainable health system.

**There's no guarantee that big disease-prevention campaigns will help.** A large-scale study by the National Cancer Institute in the U.S. showed that prevention and promotion efforts only helped three percent of light-to-moderate smokers quit, compared to those who weren't exposed to prevention and promotion efforts. The program made no difference to quitting among heavy smokers. So, we'd have to be careful to make sure that we did not repeat the mistakes of other countries.

**Spending on other social factors may make the population healthier overall than prevention and promotion efforts.** Instead of putting all dollars into prevention and promotion, it would be better to use some of it to address the social and economic factors like jobs, education, and community safety. Making these changes would have a much larger impact on health. It is widely accepted in the research literature that people with higher incomes live longer and healthier lives than the poor.

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## SURVEY QUESTIONS

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Please refer to page 11 for the survey questions for this section.

# Acknowledgements

This document was produced by the Canadian Health Services Research Foundation, in partnership with the Commission on the Future of Health Care in Canada. The topics and courses of action reflect key issues raised frequently in the Commission's consultations to date, for which the Foundation was able to find relevant research evidence to help inform the debate.

This document has been reviewed by the following experts for accuracy and fairness, but final responsibility lies with the Canadian Health Services Research Foundation:

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A complete bibliography of the research used to prepare these documents can be found at [www.healthcarecommission.ca](http://www.healthcarecommission.ca).

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## SURVEY INSTRUCTIONS

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Please detach the following page and forward to us by fax at:  
(613) 992-3782

Or by mail at:  
Commission on the Future of Health Care in Canada  
81 Metcalfe, Suite 800  
Ottawa, Ontario  
Canada K1P 6K7

For information:  
Call toll free at 1-800-793-6161  
[www.healthcarecommission.ca](http://www.healthcarecommission.ca)

Thank you

# Survey Questions

Please indicate your opinion on each of the following questions by checking the appropriate response.

## USER FEES

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Charging user fees for services usually covered by medicare will improve healthcare in Canada.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients should pay a flat fee every time they visit a doctor or hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Patients should pay a deductible every time they visit a doctor or hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Patients should pay additional tax on the healthcare they use, through their income tax forms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. The more healthcare you use, the more you should pay.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I would visit my doctor less if I had to pay \$20 each time.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## LIMITING THE AMOUNT GOVERNMENT SPENDS

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Healthcare in Canada would be improved if governments set a limit for healthcare expenditures to encourage greater innovation in how the healthcare system deals with new technology and the aging population.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Governments should set health care budgets at least three years in advance, so that health providers can plan better.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. It's more important to spend better than to spend more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## INCREASING DISEASE PREVENTION AND HEALTH PROMOTION

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Healthcare in Canada would be improved if the majority of any new health expenditures by government were devoted to disease prevention and health promotion, not acute care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Government should increase healthcare spending in order to invest in disease prevention and health promotion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Healthcare is not just about fixing people when they're sick — it's about keeping them healthy, too.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. We should spend as much money preventing illness as treating it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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## ANALYSIS INFORMATION

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Please complete the following information for analysis purposes. Thank you.

Gender:  Male  Female

Age:  under 18  19-29  30-49  50-65  over 65

Province or Territory in which you reside: \_\_\_\_\_

*Continued ...*

Your annual household income from all sources before taxes is: (Optional)

Choose one:

- Less than \$20000
- \$20000 to \$39999
- \$40000 to \$59000
- \$60000 to \$79000
- \$80000 to \$99000
- More than \$100K

The highest level of schooling you have completed is: (Optional)

Choose one:

- Elementary School or less
- Secondary School
- Community College/CEGEP/Trade School
- Prof./Trade Certification
- Bachelor Degree
- Graduate Degree

Are you a healthcare professional? (Optional)

- Yes    No

Approximately how many times in the last year have you personally used the healthcare system? (eg. seen a doctor or specialist, spent time in the hospital, received care in a hospital emergency room, etc.) (Optional)

Choose one:

- 0-3
- 4-6
- 7-9
- More than 10

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