Canadian Doctors for Medicare

Médecins canadiens pour le régime public

Ensuring Equitable Health Care Access for Vulnerable Populations and Families

October 6, 2014

Canadian Doctors for Medicare Submission to the House of Commons Standing Committee on Finance

Pre-Budget Consultations hearings on supporting families and helping vulnerable Canadians by focusing on health, education and training.

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Background: Canadian Doctors for Medicare

Canadian Doctors for Medicare has an abiding interest in the evolution of the federal role in health care. The organization was launched in 2006 by physicians in response to events in the medical profession and the world of public policy that threatened to undermine our national commitment to equitable health care access. As medical professionals we are firmly committed to evidence-based health care policy reform. We advocate for innovations in treatment and prevention services to improve the quality, sustainability and equity of our health system. We publish numerous papers and literature reviews on health care and health care reform, all of which adhere to a rigorously evidence-based approach. The evidence is clear that reform will work best if it takes place within the existing public framework so that it benefits all our patients, not just those who can afford to pay for care.

Introduction

As practicing physicians, CDM members see firsthand the disparity in care experienced by Canada's marginalized and multi-barriered residents. CDM believes that improving the care experience of our most vulnerable communities is both necessary and achievable. We advocate for action in three specific areas: first, upholding the Canada Health Act; second, developing a new Health Accord; and third, improving access to prescription drugs through a national Pharmacare program. All three reforms begin with strong, accountable federal leadership enforcing standards across the country and improving equity of care for our most vulnerable populations.

1. Enforcing the Canada Health Act and ensuring that "alternative delivery models" uphold equity

As part of its commitment to the CHA, the federal government must recognize that "new" forms of privatization, user fees and extra billing have emerged since the Canada Health Act was passed unanimously in 1984. Some of these take advantage of legislative loopholes while clearly violating the spirit of the Act. All governments should coordinate to ensure such violations of the law will not be tolerated and commit to putting a stop to practices that undermine access to equitable, publicly funded services.

An accountability framework that requires provinces to proactively regulate or investigate clinics for compliance with these laws is clearly needed to ensure the CHA is upheld.

Clear examples of CHA violations exist across the country. These include but are not limited to:

- Extra-billing by linking insured services to uninsured services
- Exorbitant block fees in primary care
- Using third party billing to sidestep prohibitions on payment for insured services

In addition to the failure to address surreptitious violations of the Act, even outright violations have passed. The BC government's 2012 audit of the Cambie Surgeries Corporation reveals the cost of these violations to individual patients and provincial health care budgets. In roughly a thirty day period, the audit found that the CSC has over-billed patients a total of $491,654 and submitted $66,734 in overlapping bills (where both the province and the patient paid for the same treatment).[1] This is a clear

[1] http://www.health.gov.bc.ca/msp/legislation/pdf/srccsc-audit-report-2012.pdf

example of for-profit delivery threatening the sustainability of the health care system while taking advantage of individual patients.

Proponents of for-profit care claim that a parallel private care stream can take pressure off the public system. It is important that the federal government recognize that there is strong evidence showing that more private care does *not* increase efficiency or access, and in fact erects barriers to both.[2] Private, for-profit clinics drain the limited supply of doctors and other health professionals from the rest of the health care system, lengthening waiting lists and reducing access.[3] Some service providers offer faster access to insured service at their clinics, but require patients to pay a membership fee or other payments in order to have access to that service. People who have not paid the fees cannot gain access. This may shorten waits for some patients who pay, but it ties up resources for the rest of the system, lengthening wait times overall. This drain has the greatest impact on vulnerable Canadians who cannot afford to pay for priority treatment. The evidence shows that private, for-profit health care produces worse patient outcomes at higher costs than non-profit care, and order more unnecessary tests and procedures.[4][5][6]

Not only do they reduce access in general, for-profit clinics tend not to serve unprofitable markets, which tend to be Canada's most vulnerable communities, such as remote and rural communities, Aboriginal communities, marginalized urban populations, and those needing complex chronic care and emergency care. They focus on affluent populations in urban centres, who face the lowest barriers to care.[7] Private, for-profit clinics contribute least where the need is greatest, and exacerbate inequity in our health care system.

It is worth noting that failure to enforce the CHA is a disservice to taxpayers in Canada. The CHA entitles the Federal Government to reclaim public funds from jurisdictions that fail to enforce the law. Failure to recover money taxpayers are owed under the law is not the ideal management of the public purse.

2. A Strong Federal Health Accord in 2014

The 2003/2004 Health Accords were landmark developments in Canada. Though not successful in all aspects, it set goals and priorities in critical areas such as wait times and pharmaceuticals, and emphasized joint action by the federal government and the provinces. The goals of the 2003/2004 Accords were not all met, and a renewed focus on achieving their objectives, building on their successes and rising to new challenges is needed.

The absence of a 2014 Accord exacerbates current provincial disparities in care delivery, again with the greatest impacts experienced by vulnerable populations. Improving equity in care requires establishing

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[2] N Ivers, M Schwandt, S Hum, D Martin, J Tinmouth, N Pimlott. A comparison of hospital and nonhospital colonoscopy: Wait times, fees and guideline adherence to follow-up interval. Can J Gastroenterol 2011;25(2):78-82.

[3] Duckett, S. J. "Private care and public waiting." Australian Health Review; 29(1): 87-93. 2005.

[4] Journal of the American Medical Association, 2002;288:2449.

[5] N Ivers, M Schwandt, S Hum, D Martin, J Tinmouth, N Pimlott. A comparison of hospital and nonhospital colonoscopy: Wait times, fees and guideline adherence to follow-up interval. Can J Gastroenterol 2011;25(2):78-82.

[6] New England Journal of Medicine, 1997, 337:169.

[7] Vaithianathan R. 2004. "A critique of the private health insurance regulations." Australian Economic Review;37(3): 257-70.

a 2015 Health Accord with improved measures for accountability and standardization of care. Canadian Doctors for Medicare recommends that federal, provincial and territorial governments do the following:

1. Initiate the timely development of a new Health Accord, negotiated jointly to ensure it reflects the needs of all regions and also reflects the priorities we share as Canadians. Individual agreements between jurisdictions damage portability and consistency of care.
2. Negotiate a long-term agreement. A 10-year Accord allows provinces and territories to plan and implement effectively. Short-term contingent deals do not.
3. Negotiate an Accord that reflects Canada's commitment to equitable access to medically necessary health care by honoring the principles of the Canada Health Act.
4. Negotiate an Accord that ensures that the federal government has a strong role in ensuring quality, accessibility and equity, and has the tools to enforce the Canada Health Act, and support standards from coast to coast.
5. Negotiate an Accord that ensures fair and equitable access to health care by explicitly committing to reforms that strengthen the principle of access to care based on need, rather than ability to pay
6. Negotiate an Accord that commits to the use of evidence in achieving health policy objectives, such that best practices are put to use in support of equity, access, quality and cost containment.

These principles will assist in developing an Accord that can overcome some of the weaknesses of the 2003/2004 Accords and lead more consistently to established objectives. The current approach, which offers little more than a funding model, provides no basis for shared strategy on care and offers no capacity for scaling up innovations on a national level. Worse still, by focussing on population growth, the funding model favours provinces that have growing economies and disadvantages the most vulnerable regions in the nation.

3. National Pharmacare Strategy

We also must start taking steps towards a national Pharmacare program - an unfulfilled commitment of the 2004 Accord. Canada pays more for prescription drugs than any country within the Organization for Economic Cooperation and Development (OECD), except the United States, and we pay 30% more than the OECD average. These costs result in 1 in 10 Canadians not being able to afford their prescription drugs. Amongst Canadians without supplementary health insurance, this number increases to 1 in 4.[8] Inability to access medically necessary prescriptions results in decreased quality of life for patients. At the same time, as untreated conditions lead to hospitalization, we see an increasing demand on hospital resources.

There are a number of ways to start down this road. For example, New Zealand has fought back against high prices and reduced their per capita drug costs to 49% of Canada's. For some drugs the savings are astronomical. Toronto's Apotex Inc. sells atorvastatin to Canadian markets for 31¢ and sells the same drug to New Zealand for just 3¢. And since they sell over half a billion dollars' worth of the drug in Canada each year, there is a lot to be save. One study estimated that a combination of strategies could reduce our prescription drug costs by as much as $10.7 billion per year, or an

[8] http://www.cmaj.ca/site/misc/pr/16jan12_pr.xhtml

estimated 43% of Canada's $25.1 billion drug bill,[9] an enormous service to the taxpayer and Canadian patients.

The 2004 Accord had the stated objective of establishing and implementing a National Pharmaceutical Strategy. It's time to recommit to this goal, and to the principle that affordable access to drugs is fundamental to equitable health outcomes in Canada.

At the provincial and territorial Health Ministers' meeting in Banff, the ministers agreed to establish a new office in Ontario for the Pan-Canadian Pharmaceutical Alliance (PCPA).
Provinces and territories are working together to reduce the cost of 53 drugs. This work results in over $260 million in combined savings annually.[10] However, the capacity of the PCPA to implement Pharmacare-like strategies is limited in the absence of a national formulary.[11] Pharmacare expert Steve Morgan cautions that any attempts to institute a national Pharmacare strategy require active leadership from the federal government.[12] In line with this, policy analyst Marc-André Gagnon's research on Pharmacare concludes that by offering first-dollar coverage, "a universal pharmacare program would generate savings of 10% to 41% on prescription drugs, representing savings of up to $11.4 billion per year" for Canada.[13] This leadership would result in a savings for health care systems across Canada as the cost of drugs decreases and hospitalizations due to medical nonadherence are eliminated.

CDM would be remiss, in speaking on care for the vulnerable, if we did not mention our shared view, along with the CMA and most health professions in Canada, that the withdrawal of care for many past recipients of the Interim Federal Health program for refugees is worth reversing. Research shows it saves no money and causes undue hardship and we encourage the government to reverse that policy.

Conclusion

Canadian Doctors for Medicare is pleased to have the opportunity to contribute to the Senate Committee's examination of progress on the 2004 Accord. As physicians, we see a larger role for federal leadership to improve progress at the level of delivery. In conclusion, we recommend that the federal government close loopholes that allow for-profit clinics to violate the Canada Health Act, demonstrate leadership and vision by reopening Health Accord negotiations with provinces and territories, and support the provincial and territorial health ministers' initiative to develop and implement a national Pharmacare strategy. Without such initiatives in place, we fear that vulnerable and marginalized individuals will continue to receive diminished care, or in the worst scenarios no care at all.

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[9] Gagnon, M-A. The Economic Case for Universal Pharmacare: Costs and Benefits of Publicly Funded Drug Coverage for All Canadians. Presentation to the Canadian Association of Business Economics, Industry Canada, Toronto, November 30, 2010

[10] http://www.newswire.ca/en/story/1420290/provinces-and-territories-talk-health-care

[11] https://nursesunions.ca/sites/default/files/pharmacare_report_0.pdf

[12] http://www.cdhowe.org/pdf/Commentary_384.pdf

[13] https://nursesunions.ca/sites/default/files/pharmacare_report_0.pdf