



INSIGHTS

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The Politics of Healthcare

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The Politics of Healthcare

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History has taught us that health policy decisions are not only emotional, but very political. Changes to public policy are frequently made in response to the concerns raised by any number of constituents and 'special interest groups', and governments are disinclined to take bold steps to reform the health system, as the measure of 'bold' is often decided by popularity polls.

Take the U.S. as an example of the politics of healthcare. Many experts have labeled U.S. healthcare reform a convoluted and complex piece of legislation that really does little to fix the significant issues facing the American health system. Yes, the legislation does provide access to healthcare for many uninsured Americans, but it does relatively little to address the spiraling cost of healthcare. How did the U.S. get to this point? In a word, politics. Opponents to healthcare reform made it very difficult for the President to pass the extensive healthcare reform that he wanted.

The ink on the U.S. health care bill had barely dried before Canada's three largest provinces were moving to confront the existential challenge embedded in our own medicare system. With each passing year, health budgets rise faster than both government revenue and economic growth rates - a trend that means health cannibalizes other important programs, consuming precious dollars that need to be spent on education and infrastructure renewal.

The Alberta government developed a comprehensive pharmaceutical strategy to address the rising cost of prescription drugs and to introduce

an expanded role for pharmacists in the delivery of healthcare. An important pillar of this strategy was to revise Alberta's seniors' drug plan through the introduction of premiums, revised co-payments and to make the provincial program second payor to any plan provided by an employer.



Seniors groups in the province were outraged and the government has recently announced these changes will be delayed indefinitely to allow time for further review.

Late in March, Quebec premier Jean Charest tabled a user fee system - \$200 annually for everyone over 18, phased in over three years - designed to raise about \$1.45 billion, enough, the province reckons, to limit growth in health spending to 5%. The plan immediately triggered a barrage of criticism, with voters balking at the notion of paying extra for their health care.

At the same time, Ontario's Liberals, who took heat for imposing a health tax back in 2004, opted for a more controversial fix, by taking on pharmacy to reduce the cost of pre-

scription drugs through an aggressive generic drug pricing strategy. Pharmacy has rallied and launched an impressive public relations campaign to win the hearts and minds of Ontario voters. The government relented, albeit briefly, and delayed its announcement to allow it more time to consider pharmacy's submissions. In this case however, it managed to push its reforms through.

None of this is particularly new, as healthcare decisions have always been political. But the stakes are higher now, and the need for healthcare reform will increase in future years. In March, the Ontario Liberals summed up the dilemma in their speech from the throne: "The question now facing Ontarians is: 'How do we fund the best healthcare without crowding out all the other priorities we share?' That is a discussion that will happen, sooner or later, in every Canadian province and territory."

The dilemma is a familiar one: are Canadians willing to pay more for their healthcare or make do with less of it?

So, should plan sponsors care? They should, and here are some reasons why.

- We simply can not afford our current healthcare system. Many provinces have done long-term projections on the cost of healthcare, and the prognosis is not good. A study on Alberta's healthcare system estimates that unchecked, healthcare costs will double by 2020 from \$12.9 billion currently to \$25 billion. The role of employers and employee benefit plans will undoubtedly

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Healthcare - Equal Access is Not a Given

Canada prides itself on its public healthcare system, and rightly so. But for all its merit there are significant deficiencies. That's partly why it's important to listen to the critics who point these out and call for solutions.

The Cancer Advocacy Coalition of Canada is one of them. In a news release in February 2008 it said: "Canadians are experiencing care that is inconsistent, unfair and ineffective. Gross discrepancies exist in access to the diagnostic tools and best treatment for cancer... depending on where a person lives in the country."

The report noted the wide variations across the country in access to treatment, diagnosis, and, in particular, government-funded drugs. For example, the western provinces pay for most of the new generation of oral take-home drugs for cancer. But in Ontario, private insurance pays about seven times as much for drugs per patient as in British Columbia. And those without benefits are forced to pay for potentially life-saving drugs.

Over the course of treatment, some of the newer ones can cost \$30,000 or more. There are very few people who can afford to pay out of pocket and most of them choose to go without.

Canada ranked 23rd out of 30 countries surveyed in the 'consumer friendliness' of its healthcare system. The study undertaken by a pair of private think-tanks - the

Winnipeg based Frontier Centre for Public Policy and Brussels-based Health Consumer Powerhouse - measured Canada's performance against 29 European nations.

It found Canada scored well in terms of medical outcomes, a category that included factors such as heart attack and cancer survival rates and data on a range of other medical procedures. But the Canadian score plunged in areas such as waiting times for treatment, range of services available, ready access to new drugs and some diagnostic tools.

Some of these issues can be addressed by ensuring we have the right number of healthcare professionals in place to meet the needs of the public. Ontario's chief medical officer concluded that the province still falls well short of meeting the minimum standard for the staffing of our public health units. There are widespread shortages of doctors, nurses, and health inspectors the people of this province and country need.

Our public health units should be the first and most effective line of defence. At the moment they are not. So, when tempted to boast about public healthcare in Canada, let's remember there are major inequities in the system, and these vary depending on where you happen to live. Medicare is not living up to its promise of providing equal access to adequate healthcare for everyone. That's our national goal and more is needed to achieve it.

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change and you may have very little say in the matter.

- Governments will be forced to make difficult choices regarding access to and the funding of future care. Read that to mean current financial resources are not sufficient, taxes will need to be increased, or current services will need to be re-examined - likely both.

The First Ministers' Accord on Health-Care Renewal expires in 2014. That historic deal pumped almost \$40 billion into the system over a period of a decade, increasing federal transfers by a show-stopping six per cent per year. That agreement was signed in a period of growing government surpluses. Given the country's post-meltdown indebtedness, both provincially and federally, it is difficult to imagine a sequel to the Accord that includes comparably generous growth - or "escalator" provisions. Canadians from coast-to-coast will soon find themselves facing difficult decisions about how to address the fundamentally unsustainable nature of health spending.

As Peter Trueman used to say, "That's not news but that too is reality."

Until next time...

Quebec to fund IVF treatments

As of August 5, 2010 the Quebec government will be the first provincial government to fund in vitro fertilization (IVF). All women of child-bearing age will be eligible for up to three stimulated cycles or six natural cycles of IVF.

The new public program will cover all costs related to medical procedures and medication for ovarian stimulation, artificial insemination and IVF.

Since medications for the treatment of infertility will be added to Régie de l'assurance maladie due Québec (RAMQ), employers who offer benefits in Quebec will be required to match the RAMQ listing. This will have an impact on national and regional plans with Quebec plan members that currently do not cover fertility medications

or those employers who have an established plan maximum on these drugs.

With up to six cycles of IVF permitted under the new legislation, it is difficult to put a dollar maximum on these drugs because pricing can vary widely, usually anywhere from \$1,000 to \$5,000 per cycle. The Canadian Life and Health Insurance Association has submitted a request to the Quebec government to ask that a dollar maximum be set in order to assist private insurers; at this time there has been no response.

The projected drug cost increase to Quebec employers who do not currently cover fertility medications is about 0.5% to 1.5%. From groups with only a portion of their employees in Quebec, the impact would likely be less depending on the number of



employees residing in that province.

In response, we have been working internally to align our operations to ensure our plans are compliant with the legislation. We foresee no contract changes, however our review is ongoing to determine if specific employer changes are required.

For details on the legislation please visit: www.msss.gouv.qc.ca/en/sujets/santepub/assisted-procreation.php