Taking Stock

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A report on the risks to consumers (and their employers) from current Health System Reforms

Consumers' Association of Canada (Alberta Chapter)

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1. THE CONSUMER INTEREST IN HEALTHCARE

Defining the Consumer Interest in Healthcare

Healthcare has always been an important issue for consumers - not just in Canada, but around the world. This is because the cost, quality, and availability of medical care has such a strong influence on the safety and financial security of both individuals and the community in which they live. The high costs of medical care can lead to financial hardship or ruin: the inability to obtain necessary care can lead to suffering, disability, or death.

These high stakes are also the reason that prices for medical services and products are so difficult to control. In fact, the very nature of the need for medical care restricts the influences of traditional market forces.[1]

Faced with pain, anxiety, the inability to work and enjoy life - or the loss of life, patients and their families are in no position to negotiate price at time of need. Even in non-urgent situations such as elective surgery, patients are primarily reliant on their doctor's advice for both diagnosis and treatment. The increasing complexity of medical care over the past three decades has further complicated this unlevel playing field.

The Role of Consumers' Association of Canada

A strong consumer voice is essential in any marketplace. Tolerating defective products or unproductive activities that drive up the cost of essential services does not benefit either the community or the economy.

Founded in 1947, the Consumers' Association of Canada (CAC) is an independent, non-partisan organization. It was formed from a coalition of community groups dedicated to uniting the strength of individual consumers faced with little bargaining power in an increasingly complex and industrialized world. Since its beginnings, the organization's staff and volunteers have consistently worked to protect Canadian consumers' rights to health, safety, information, and fair treatment. The activities of CAC have contributed significantly to the standards and quality of life that most Canadians now take for granted, particularly in the area of medical devices and drugs, as well as the funding and delivery of medical services. [2]

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1 A good reference is Strained Mercies: The Economics of the Canadian Health Care System by health economist, Dr. Robert Evans, Butterworth, Toronto, 1984.

The availability of safe, effective, and affordable medical care has always been an important priority for Consumers' Association of Canada. It is still a priority because the unique characteristics of medical needs and medical markets mean that constant vigilance and effort is required to make even the best designed system work well.

"The availability of safe, effective, and affordable medical care is still a priority, because the unique characteristics of medical needs and medical markets mean that constant vigilance and effort is required to make even the best designed system work well."

[2] The rapid proliferation of often poorly assessed and poorly monitored technology and drugs has been a major driving force behind rising health care costs. According to Health Canada, this year Canadians will spend more (as a percentage of the GDP) on drugs than on physician services - and studies continue to document the high human and financial costs of poor drug management.

Two extensions to the Federal Patent Act within the past ten years have further driven up the cost of drugs. The Alberta government has recently supported or entered into a number of joint ventures with PMAC, the trade association for patient pharmaceutical companies, and lauded their consumer information campaigns. Yet these same companies are spending millions of dollars lobbying politicians, sending detail salesmen to doctor' offices, and running full page advertisements (at $10,000 per day) in Alberta dailies. These ads often provide leading and incomplete information on new and very expensive medications. The high price of drugs continues to be the most frequent concern identified on CAC National consumer surveys on healthcare.

2. THE EVOLUTION OF CANADIAN HEALTHCARE

In the 1950's and 1960s, Canadian consumers were faced with rapidly rising medical expenses which left many people forced to sell the family farm or other assets in order to pay for care or treatment for a sick child or ailing parent. Many families could not afford escalating private health insurance premiums or were unable to obtain affordable coverage because of their inability to get into a group plan. Others were denied coverage because of a previous history of illness. There was a patchwork of local and regional plans across the country. Coverage varied significantly. Changing jobs or location of residence usually resulted in the loss of benefits. [3]

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[3] In-depth studies, published in 1993 and 1994, by the Families USA Foundation, a national health consumer group, provide a frightening reminder of the financial and human costs of increased reliance on private insurance. (How Americans Lose Health Insurance, 1994 & Skyrocketing Health Inflation, Families USA, 1993) The United States dedicate more of their resources to medicine than any country on earth - $647 billion per year. Yet, by widely used count, thirty seven million Americans have no health insurance, a deficiency that, according to study after study keeps them from getting the care they need. About fifty million more carry insurance that won't pay for a major sickness.

Two common fears Americans have are that they will lose their health insurance because of high costs and that they will have to pay expensive medical bills not covered by insurance. These fears are justified. Over 2 million Americans a month lose their health insurance: 23% lose it following a job loss, 22% lose it following a job change, 2% lose it following a decrease in number of hours worked and 16 % lose it without a change in job status. Immediately prior to losing health insurance, nearly two out of five Americans (38%) had family incomes above $30,000 and one in six had family incomes of $50,000 and above. One out of five (21%) who lose insurance have non-employer coverage and lose it because claims cause premiums to become unaffordable, insurance companies cancel coverage or go out of business or changing circumstances mean they cannot afford the higher premiums of individually assessed plans.

Regardless of income, many Americans cannot afford the higher premiums or even obtain insurance because of chronic illness or pre-existing condition such as diabetes or multiple sclerosis. Premiums vary significantly. Many run around $500 per month, although that amount can be reduced by increasing the deductible to $5,000 or more. Too many claims result in escalating premiums and/or refusal to renew the policy, so many Americans are afraid to use the coverage they do have. A history of illness can drive premiums up to more than $2000 dollars per month. Many workers in lower level entry jobs cannot afford private insurance and are **not** eligible for Medicare. For example, Trina Moore, twenty-four, an assembler at a North Carolina foam factory that provides hospitalization insurance but, like a lot of cost-conscious employers does not cover doctors' visits. A private doctor insisted that Moore pay $700.00 up front for prenatal care, unimaginable on her $5.40-an-hour wage. She applied for Medicaid - but was told she earned too much. The country clinic turned her away because she wasn't on Medicaid.

According to a study by the Kaiser Family Foundation about one in four California families have a member suffering "job lock" because he or she fears losing health benefits. People with serious health problems or sick family members are the least able to change jobs because of fear of losing insurance. Even many individuals in good health are often reluctant to start their own business or go into free-lance work because of concern that health insurance will be unaffordable or unavailable.

During this period, the Consumers' Association of Canada was part of a strong lobby to introduce a comprehensive national public insurance program so that all Canadians would be able to obtain medical care, irrespective of changes in employment, place of residence, or history of illness.[4] Gradually, one by one, Canada's ten provinces developed public medical insurance programs, making deductibles, co-payments, and exemptions for pre-existing conditions a thing of the past for most required care. They also began to pay for health care services from general taxation. Eventually these plans became the national health care system which Canadians are familiar with today.

Finally, in order to ensure that Canadian citizens would receive maximum value for their investment in this national health insurance program, a number of key principles were enshrined when the 1984 *Canada Health Act* was written. These principles (or terms and conditions of provincial plans required in return for cost sharing by the federal government) provided guidelines to provincial governments, which in turn were responsible for the actual delivery of the insured services. The principles that were written into this Act are universality, comprehensiveness, accessibility, public administration, and portability.

1. Universality

Pooling the risks and pooling the costs for all citizens through *universal coverage* in one large group plan ensures that no one with medical needs is left facing a "seller's market" for medical services or insurance coverage. Individuals do not have to go into crippling debt to avoid death or disability. This principle also helps to contain costs by maximizing the bulk buying power of the plan in negotiating prices with suppliers of goods and services.[5]

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[4] "South of the border, Daniel Gresek Jr. needed three heart surgeries before the age of two. Although his bills topped $300,000, the family had insurance. When Daniel was six months old their insurance company informed them their $198 premium would increase to $766 a month. When the company upped the premiums to $1, 375 a month a year later, the family shopped frantically for cheaper insurance, but no company would take Daniel. So they rented out their house, and moved to a summer cottage - all of three rooms for a family with six kids." ("In Sickness and In Debt" by Steve Fishman, newspaper clipping provided by Families USA Foundation)

[5] Institutions and programs can buy in volume at substantial discounts. When individuals have to go out and purchase small quantities of supplies, equipment, and services from retail suppliers, prices are significantly higher. Industry sources have advised CACA that there is a minimal 167% mark-up on medical supplies. A June 1995 Survey conducted by CACA found an average 30% increase in the cost of routine adult eye exams, five months after this service was dropped from the Alberta Health Care Insurance Plan. Current average charges in Alberta are around $46.00. In Manitoba, with universal public coverage of all ages, the cost of a routine eye exam is $28.00 (Edmonton Journal, September 13th, 1994)

2. Comprehensiveness

By making the plan as *comprehensive* as possible, benefits can be obtained by early medical interventions and public health measures. This in turn reduces demand for higher cost alternatives. Adequate coverage of a range of services also provides maximum choice to meet the individual circumstances or the unique medical condition of a patient.[6]

3. Accessibility

Linking payment for the plan to progressive taxation ensures that coverage for medical care is *accessible* to all individuals, regardless of the changing circumstances of a family or an employer. It also puts an obligation on the public plan to ensure an adequate and cost-effective supply of medically necessary services for citizens. The lack of a co-payment, deductibles or extra billing prevents appropriate and timely medical treatment being delayed or denied, and *maintains control over inflation* by not allowing doctors or hospitals to increase their charges without good reason and oversight.[7]

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[6] In the U.S., third-party payers such as Blue Cross/Blue Shield refused for years to cover the cost of outpatient treatment, forcing patients into higher cost in-hospital treatments to avoid significant out-of-pocket expenses. Changing this policy to include outpatient treatment resulted in $30 million savings in claims payouts for the Michigan State "Blues" in one year alone. (A Consumers' Guide to Surviving Your Hospital Stay, People's Medical Society, 1993) In Canada, the vast majority of children are immunized against a number of diseases that can cause serious illness and death through public health programs and through doctors' offices. In the U.S. millions of children do not receive vaccinations. Only half of the two year old in the U.S. are fully vaccinated, and the rate is as low as 10% in some inner-city areas.

[7] Repeated studies of user fees have shown that there is no change in the ratio of appropriate and inappropriate use of medical services when user fees are implemented. In fact a Saskatchewan study found that while utilization by students, seniors and those with large families decreased, the use of services by middle and upper income families increased. A recent comprehensive look at this issue can be found in a number of independent papers written for the Ontario Health Council called User Fees Series 1994, and available through the University of Alberta Library. These include "Why Not User Charges: The Real Issues", "User Charges, Snares and Delusions: Another Look at the Literature", "The Remarkable Tenacity of User Charges", and "Who are the Zombie Masters and What do They Want". When illness strikes it often affects the earning capacity of both individuals and families. Finding the money in a family budget on short notice is no easy matter.

4. Public Administration

A single *publicly administered* plan provides value for money by dramatically reducing the excessive administration costs and added burdens on patients involved with multiple insurance carriers. All the paperwork involved in complex co-payment arrangements and authorizations, maintaining head offices, sales staff, advertising, taxes, as well as the need for profit for both suppliers and insurers, can significantly add to the total cost of healthcare. [8] Publicly administered 'insurance" plans also provide more assurance decisions are for the benefit of the insureds and the community rather than the shareholders of a specific insurance company.[9]

5. Portability

Portability of benefits allows individuals to travel and change jobs or location of residence without facing loss of coverage. The availability of this coverage across Canada functions as an incentive to the free flow of goods, services, and people across provincial boundaries. This in turn provides both opportunities and reduced costs for consumers and business, as well as decreasing the regulatory demands on provincial governments.

Over the years these principles have served Canadians well. Since the introduction of the national public health system in Canada, surveys have repeatedly shown that Canadians have been generally happy with this system.[10]

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[8] Researchers estimate that in 1987 the U.S. spent between 19 and 24 percent of its health care dollars on administrative expenses while Canada spent between 8 and 11 percent. More recent estimates place Canada's administrative costs at 12% and the US at 22%. Over 120 people work in the accounting department of Massachusetts General Hospital in Boston, while the similar size Toronto hospital employs a modest 20. This amounts to billions of dollars. Despite the highest expenditures in the world on healthcare in the United States, Canada, France, and Australia, all did more bone-marrow transplants per capita in 1992.

[9] For over two and a half years, Michael Richmond, a writer now living in Victoria, worked investigating complaints about health insurance policies and insurance salesman for the Nebraska Department of Insurance. "Every time my phone rang, it was another tragedy. Farmers and ranchers had to sell their land because insurance companies refused to pay medical bills. The company's response - "sue us". Who can afford to combat an insurance company's high priced lawyers while a family member lies ill or dying. Companies have the legal right to interpret policy provisions to avoid paying medical expenses. Insurance companies in the U.S. are making record profits. Yet public hospitals are closing and people are being turned away at the door." (personal communication, Michael Richmond)

[10] The extensive consultation conducted in Alberta by the Premier's Commission on Future Health Care found strong support among Albertans for maintaining a comprehensive public health system. In fact, many wanted to increase the comprehensiveness of the system in order to enhance patient choice and provide opportunities for reducing costs. (The Rainbow Report, Premier's Commission on Future Health Care, Volume II, 1989)

It has been a source of pride that the Canadian public chose to distribute health care resources according to need, and that families are not faced with having to sell their assets to pay for medical care or being turned away at the door. It is ultimately a value statement by Canadians.

This model has proven to be economically sound as well. The principles governing the Canadian healthcare system have effectively slowed the rapid rise of health expenditures while increasing the number of individuals and families with access to medical care. In contrast, runaway inflation and lack of access to medical care for millions of Americans continues to create both social and economic burdens on American families and their employers.[11] Yet despite Canada's success in slowing down the rising healthcare expenditures of earlier years, and the security and stability the public system has provided Canadian businesses and families, there have been legitimate concerns and growing pressures. Increasingly, consumers are recognizing the many variables and limitations in both the diagnosis and treatment of medical problems. They have been expressing a strong desire for more information and participation in decisions surrounding their care, and more flexible, responsive, and patient-friendly alternatives to rigid and often depersonalizing institutional care.

The rapid rise of both public **and** private healthcare expenditures (e.g. drugs, ambulance services, supplemental benefit plan premiums) have created even greater pressures for health care reform in order to reduce the burden of these escalating costs on hard pressed families and businesses going through difficult economic times.[12]

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[11] Although healthcare expenditures in the US and Canada were running neck and neck prior to the introduction of the Canadian public health plan, American expenditures have continued to climb. By 1991 US expenditures were $2,354 per capita, compared to Canada's $1,683 per capita. Health-care costs in the US rose 13% in 1991 and more than 20% in 1990. In 1992, doctors in British Columbia received about $349 to remove a gallbladder; and $348 in Ontario. In New York City, the customary fee paid by insurance carriers averaged $2700; in Buffalo, New York $945. *All fees are quoted in US dollars*. In the US extra or balance billing is also common practice. (Consumer Reports Healthcare Series, July-Sept '92)

[12] In the US, healthcare is financed by a combination of payments from families and businesses. These two parties also support the Medicare Program for the poor. Families and businesses together paid $7,739 per family for health care in 1993 - an increase of 18% since 1991. Families pay about 2/3 of the costs and businesses pay about 1/3. In 1980, health benefits amounted to 41% of businesses' after-tax profits, in 1991 the figure was 98%. Health care inflation is forcing more and more businesses to eliminate or reduce benefits. Between 1989 and 1991, the percent of employees who worked in firms offering health insurance benefits declined from 81% in 1989 to 77% in 1991. New accounting rules requiring companies to report potential liability for their retirees' health benefits have resulted in two major corporations eliminating coverage for their current retirees, leaving 45,000 individuals and their families with no health benefits. (Skyrocketing Health Inflation, Families USA, 1993)

3. HEALTHCARE REFORM: 1995

Here in Canada, both provincial and federal levels of government have responded to public pressure with various strategies to increase patient satisfaction and control costs. As well as restructuring the management and delivery of healthcare services in their provinces, many governments have simply reduced the money available for provincial health plans. The federal government has also reduced the level of cash transfers to the provinces in support of healthcare expenses. Almost every province in Canada has taken an in-depth look at healthcare services and spending through some type of commission or report over the past decade. There have been new joint initiatives such as the Canadian Coordinating Office for Health Technology Assessment (CCOHTA). Last year, the Prime Minister of Canada, Jean Chretien, fulfilled an election promise, and appointed representatives from across Canada to participate in a National Health Care Forum. This Forum is to consult with the people of Canada and make recommendations to the federal government.

It is important to note that these concerns and activities reflect an almost worldwide phenomenon, regardless of the organization of a country's healthcare system. This is because most of the upward pressure on healthcare spending in industrialized countries is being driven by an unprecedented global information and technology explosion combined with a phenomenal growth in the corporate orientation and sophisticated merchandising of medical tests, treatments and products.[13] Some healthcare economists have also identified a growing supply of physicians with high income expectations as a driving force behind rising costs.[14]

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[13] Much of this information and technology is being rushed to market with little evaluation by independent third parties and even less monitoring or evaluation once in use. For example, Dr. Michael Rachlis and Carol Kushner in their book Second Opinion, suggest that although Tagamet (Cimetidine) was truly a breakthrough in it's field for the treatment of ulcers, it didn't get to be number one on the hit parade by being prescribed for ulcers alone. Its use rapidly spread for many minor and self-limiting diseases for which it had never been assessed or proven effective. In 1981, Dr. Lilli Kopalla in Powell River, B.C., did a survey and found at her local hospital that this drug was prescribed inappropriately 80-90% of the time. Doctors were so impressed with the effectiveness of treatment for ulcers that they overlooked the scientific information about it's limitations, and tended to to underestimate the risk of combining it with other drug products. According to Dr. Gordon Guyatt, a professor of clinical epidemiology and medicine at McMaster University, the best available study indicates that direct medical costs have increased as a result of Cimetidine. However, physicians are now overwhelmed by an incredible array of over 1800 drugs to choose from, compared to about 50 just three decades ago. Sophisticated (and often incomplete or misleading) advertising and marketing often drives both provider and consumer demand for inappropriate use of products or services.

[14] Barer, Gafni, and Lomas, Canadian Physician Supply at a Crossroads: Warnings from Israel, 1986. & Plain, R., Physician/Population Ratios in Alberta.

While there is little doubt that there are problems and inefficiencies to be resolved within the Canadian public health system, there are even greater problems elsewhere. In fact, inflation in the cost of medical services and supplies and restricted access to medical care, are bigger problems in countries which rely heavily on more privatized systems and private payers for medical expenses. [15]

"In fact, inflation in the cost of medical services and supplies and restricted access to medical care, are bigger problems in countries which rely heavily on more privatized systems and private payers for medical expenses."

[15] In Australia, where citizens have been able to buy extra private health insurance to obtain care in private hospitals, rapid inflation in the private sector has forced the premiums so high that many of the young and healthy are dropping out. This is driving up the costs for those who are left, and increasing the line-ups in the public system. This is despite the fact that Australian insurance companies are required to provide community ratings; all enrollees who wish to join must be covered regardless of risk and all pay the same premiums. Multiple private insurance companies have less leverage than a single payer system and so they are often forced to simply pass on the inflated costs of private suppliers to the insureds. ("The case of the disappearing private healthcare system", Canadian Healthcare Manager, Summer,1994)

In the US, studies have indicated that physicians who own diagnostic labs often order those tests 2-3 times more often than those who do not. (Consumer Reports Magazine, July-Sept. 1992) This has resulted in very expensive and onerous Safe Harbors Legislation and Regulations in an attempt to control self-referral and other anti-trust activities. (U.S. Justice Department, American Trade Journals) British doctors and economists have also expressed concern over an increase in the number of unnecessary, expensive, and potentially harmful diagnostic tests and treatments with the growth of a parallel private medical system. (Letters to the Editor in the British Medical Journal publications & personal communication, Alan Maynard, British health economist)

Furthermore, physicians who are able to create a demand for their higher priced private services usually choose to spend their time where they can make more money. In the United States, twenty-five percent of physicians simply refuse to treat Medicaid patients, and two-thirds of those who do treat Medicaid patients limit the number of these patients they treat. Studies indicate that nearly all doctors avoid Medicaid patients because of low Medicaid reimbursement. (Medicare Physician Participation, Conflicts of Interest in Health Care, American Journal of Law & Medicine, Volume XXI. Numbers 2&3, 1995) In England, where physicians are often salaried in the public system, but allowed to provided the same services in the private system, many spend scant time on their publicly funded responsibilities and the majority of their time in private practice.

A study in the late 1980s of 121 commonly prescribed items in Canada and the U.S. found prices 32 % higher in the U.S. (1990 CAC National Brief- Bill C91)

4. THE ALBERTA SOLUTION

Many of the more radical changes in healthcare have occurred in Alberta where there have been dramatic and rapid cuts to public spending on healthcare, and active and visible government support for increased privatization and private payment options for healthcare services. [16,17]

The Alberta Chapter of Consumers' Association of Canada has been very supportive of a number of the initiatives aimed at reducing costs and improving the quality of care. Positive steps include increased regional coordination of hospital and community service and new home care options. The increased availability of reliable information for both physicians and patients through the development of Clinical Practice Guidelines and Technology Assessment also holds promise. Over the past four years, representatives of our organization have participated in a number of committees and consultations looking at these issues.

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[16] Dr. Melville Macmillan, head of the economics department at the University of Alberta, has figures which show that Alberta will spend significantly less than five other provinces balancing their budgets this year. Planned healthcare spending per person for 1995/96 is as follows:

B.C	$1,828.00	N.B	$1,562.00
Sask	$1,536.00	Nfld.	$1,374.00
Man	$1,633.00	**Alta**	**$1,263.00**

According to another study by healthcare economist Dr. Richard Plain, the real level of per capita health spending in Alberta (in constant 1986 dollars) is planned to decrease over 3 years from $1242.20 to $930.50 in 1996/97. He also notes that when population growth and inflation are taken into account, cuts to public healthcare between 1992/93 and 1996/97 will total 27%. Current projections by Alberta Health on spending have not taken into account either population growth or inflation.

[17] Since the mid-eighties Alberta has allowed private clinics providing medically necessary and publicly insured surgery to charge patients an unspecified user charge called a "facility fee" on top of the fee reimbursed by the Alberta government for surgeon and anesthetist services. Prior to this time, the cost of overhead (or facility fees) for providing medically required services in private doctors' offices were factored into the set fee for a particular service during yearly negotiations between the Alberta Medical Association and the Alberta government. Generally 25 - 40% of the negotiated fee was been considered overhead. Since the emergence of the first private surgical clinic, the Alberta government has been active in supporting this hybrid model and has allowed the proliferation of both hybrid and totally privately funded clinics charging fees for medically necessary services. The Alberta government's refusal to change this practice has now led to a $420,000 monthly fines being levied the Federal government.

Presentations by academics, legal experts, physicians, and consumer groups, just narrowly defeated a Private Member's Bill, the Gimbel Foundation Act (1994). This legislation would have given one private clinic a number of tax advantages, enabling it to underbid any competition in future public contracts or in the provision of private non-insured services. This concept of a preferred tax status for private medical entities is now under consideration in a special provincial government committee, which is expected to report during 1996.

However, CAC Alberta has also been very concerned by growing evidence of publicly funded healthcare institutions and programs reducing their costs by simply shifting them to individual patients, their families, and their employers. These shifted costs are also usually higher costs.[18] **This trend carries significant risks for both Alberta consumers and business.**

Simply shifting the payment of even more inflated medical costs to already hard-pressed and debt-ridden Alberta families will not stimulate consumer confidence or spending in other sectors.[18] Shifting these expenses to employers will not help Alberta and Canadian companies trying to compete in an increasingly aggressive and competitive global marketplace. [19]

The CAC Alberta office has been equally disturbed by the lack of any systematic attempt to gather or disclose provincial wide data on the outcome of health care restructuring on the people most affected - families and their employers.

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[17] See footnote #5. It is also interesting to note that while private agencies pay non-professional and often unskilled workers (to assist ill or recovering patients in the homes) around $8.00 per hour with little or no benefits or guaranteed hours, the charge to families is around $15.00 per hour.

[18] According to Statistics Canada, household debt is building to record levels. Levels have climbed from 55% of total personal disposable income to almost 88% over the last decade. The rate of savings among Canadians has hit an all time 23 year low, much of it going toward life insurance and pensions which are involuntary savings and not readily available for emergencies. Over the last four years, family incomes have posted the longest and steepest decline in more than four decades. The amount on credit cards is at an all time high and full time jobs with benefits are rapidly being replaced by temporary and part-time jobs with few or no benefits.

[19] A recent study done by KPMG, a major accounting firm, found that it was significantly cheaper to do business in Canada than in the U.S. One big reason was that medical insurance premiums for businesses in the United States cost nearly eight times what Canadian employers pay towards healthcare in Canada.

A July 1995 paper published by the Employer Committee on Health Care in Ontario (ECHCO) points to some of the potential impact on businesses by simply shifting costs to employer benefit plans. ECHCO is a group of over 30 of Ontario's largest employers who employ 350,000 people in Ontario alone. Benefit programs sponsored by these companies also affect 156,000 retired employees, as well as the dependents of their employees. Combined payrolls are $14.9 billion in Ontario and $26.3 billion Canada-wide. This year their investment in health and dental benefits will top $700 million in Ontario and more than $1 billion across Canada. Between 1990 and 1994, ECHCO members experienced a 74% increase in the cost of providing health and dental benefits (at a time when most member companies have been hard pressed to bring their own bottom lines back up to re-recession levels). In their presentation ECHCO members attributed these increasing premiums (for both workers and employers) to the increased costs of medical goods and services, increased utilization of employer-provided health care benefits, cut-backs in government-sponsored services, and the application of a retail sales tax and premium taxes to private health care plans. A similar employer committee has been started in Alberta and Quebec, however, CACA has been unable to obtain any published data from the Alberta group.

Despite the emphasis placed on outcome measurement by the Alberta Government and publicly funded agencies and institutions, **the majority of outcomes being measured are only those which affect a specific organization's utilization and financial statements -** not the outcomes of their activities on patients and the community at large**.** This has limited both informed public debate and meaningful citizen participation in public policy.

Over the last two years CAC Alberta has lobbied many public institutions and agencies to systematically collect and provide data to monitor the impact of changes. It has been distressing to discover that little is collected, and even less is readily available.[20] The appointment of 17 Regional Health Authorities and the gradual withdrawal of the provincial government from policy direction and monitoring of many services now under the direction of these Authorities has made the problem even worse. Furthermore, these Regional Boards do not come under the jurisdiction of the new *Freedom of Information and Privacy Act*.

Finally, CAC Alberta has been increasingly concerned by the lack of provincial or federal government direction or policy in the face of what appears to be a number of anti-competitive proposals and practices in the restructuring of healthcare in the province of Alberta. Reducing or destroying internal competition among public institutions and programs and replacing it with private monopoly or quasi-monopoly contracts, (e.g. hospital waste disposal and laboratory services), compromises the ability of the public system to maintain long term cost and quality control and stability of supply. Allowing individual private businesses to use public hospitals to sell private services at a lower cost than other private competitors ignores the potential implications of these activities on any real competition, or on internal and international trade agreements. Certainly, the failure to develop rules to prevent potential cross-subsidization or self-referral with the growth of a parallel private healthcare system would be unacceptable in other industries.

" CAC Alberta has been increasingly concerned by the lack of provincial or federal government direction or policy in the face of what appears to be a number of anti-competitive proposals and practices in the restructuring of healthcare in the province of Alberta."

[20] For example, contact with Alberta Health (AH), the College of Physicians and Surgeons and the Alberta Medical Association (AMA) reveals that none of these bodies considers it either their responsibility or mandate to monitor the amounts paid out-of-pocket by individuals for cataract surgeries in private clinics. Items are routinely de-listed from the public plan in closed-door negotiations between the AMA and AH, with no opportunity for public participation, and no public disclosure of the process or evidence of evaluating the impact on the public. Efforts to obtain information from RHAs and other public agencies have encountered many roadblocks.

5. MONITORING HEALTHCARE REFORM

CAC Alberta (CACA) "watchdogs" the Alberta marketplace through the 500-700 calls and letters we receive in our office each month, feedback from a network of active members and volunteers across the province, surveys through newsletters, and representation on external boards and committees. CACA also communicates regularly with other provincial, national, and international consumer groups, provincial CAC organizations across Canada, the CAC National Office in Ottawa, and a number of regulatory bodies and trade associations.

Over the past decade, calls and letters to the CAC Alberta office, categorized as healthcare, have focused on access to medical records, the right to a second opinion, and where to complain about problems. There have also been queries about the safety and value of highly advertised products and services, the privacy of personal health records, and complaints about the high cost of drugs and ambulance charges. The number of calls and letters has been relatively consistent.

Over the past two years, letters and calls from the public have been increasing. Consumers now frequently report being confronted with unexpected or high charges for care. Others call because a combination of rising healthcare premiums and changing employment circumstances have left them facing possible debt collection actions for delinquent healthcare premiums. Increasingly CACA has been receiving calls from family members of patients, desperately seeking needed medical care for relatives -which they feel is being inappropriately delayed or denied. Some report that inadequate staffing in hospitals and long-term care settings has led to dangerous situations, or that it has caused medical complications for patients and/or impossible demands on family. Recently, there have been inquiries seeking sources for private health insurance to cover shortfalls in public coverage, and requests for information on the value of specific private health insurance plans which individuals have been approached to buy. [21]

During this period of time, staff and volunteers have actively researched and responded to a number of specific issues that have been raised by callers. CACA has also conducted two surveys of specific medical services of concern to Albertans: "Access to Cataract Surgery (April 1994) and "Charges for Routine Adult Eye Exams 5 months after de-listing (May 1995)."

[21] A 1995 survey by the University of Alberta Population Laboratory found that only 63% of Albertans had some kind of supplemental health insurance and of that number 48% did not expect it to protect them from further healthcare cuts.

Not content to rely on unsolicited phone calls and letters, CAC Alberta set out in the fall of 1995 to try and determine the range and extent of the problems faced by Albertans as a consequence of healthcare reform. The Association began an intensive 3 month long effort to collect information directly from the people most affected - consumers and their employers.

Through media coverage, public service announcements, and appeals in organizational newsletters, CACA asked Albertans to provide us with details of any new or unexpected charges they'd faced over the past two years. We also asked if their ability to get medical care had changed, if home care was sufficient, and any comments on their general level of satisfaction with recent experiences seeking help for a medical condition. Our office also contacted a number of disease-specific and family-support groups (both regional and provincial) to tell us about the experiences of their members.

Over this period CACA was in contact with over 500 individuals from all seventeen Health Regions in Alberta. CACA then sought more detailed information in order to clarify information and obtain some insight into the points raised by those people who called or wrote. CACA also researched possible sources of information on the claims experience of Alberta employers' health benefit plans. Despite contact with academics, commercial consultants, business associations, trade associations, government agencies, and national organizations, our organization was unable to find any cross-industry *Alberta specific* information. Attempts were also made to obtain information on employer benefit plans through private insurance industry sources such as Alberta Blue Cross, and the Health and Life Insurance Council of Canada.

In the end, CACA worked with a consultant in the field and developed a two page survey for a convenience sample of both public and private employers. Contact was made with three public employer groups and three private employer groups to solicit their assistance with a confidential survey of their claims experience and costs over the past two years. Definite interest was expressed and surveys and explanatory notes were forwarded. To date, we have received five responses. But not all the information requested was readily available or organized in the groupings requested. Others referred us to individual members with a letter of support. These problems have delayed both the collection and analysis of the information from the employer perspective.

However, given the rapidity of changes in the public healthcare system, and the new information CACA has gathered in, we felt that publication of this report could not wait until this part of our research was completed.

6. SUMMARY OF CAC ALBERTA FINDINGS

The results of CACA's research over the past threes months *should* shock and concern each and every Albertan, whether the mother of a young hockey player, the spouse of someone with Multiple Sclerosis, or the head of any one of Alberta's major corporations. Even CAC researchers were taken aback by the extent of some fundamental changes in the design and funding of healthcare services. These changes threaten both the safety and the financial security of Alberta consumers and their employers.

While there have been a number of very positive and effective efforts made within the public healthcare system in Alberta to reduce costs and provide more patient-friendly alternatives, major problems are emerging because of flaws in the design of many reforms. The principles of the Canada Health Act, which have helped to contain overall healthcare expenses for Canadians, are being eroded and largely ignored.

Alberta's public insurance plan is rapidly moving towards a private insurance model, which includes features such as co-payments, deductibles, and user fees. Albertans are also being increasingly forced to rely on more expensive suppliers, such as private clinics, and third party payers such as supplemental insurance plans. These changes not only signal the emergence of an increasingly two-tiered system, but they are creating inflationary pressures on the price of medical goods and services (inside and outside Medicare) and reducing access to necessary medical care. As prices rise, more and more people will be forced to drop out of the second tier and find themselves dependent on a shrinking first tier.

PUBLIC PERCEPTIONS

Healthcare economics is not something that ordinary Albertans or Canadians grapple with every day of their lives. In fact, most people would rather not think of being sick or ill. Even the business community in Canada, because of our national healthcare system, has been relatively free to concentrate on producing goods and services - not on healthcare policy or the healthcare expenses of employees.

When Alberta entered healthcare reform and announced budget cuts to the public healthcare system, consumers and taxpayers were told by professionals and politicians that there were savings to be had - without any compromises to the quality of care. This would be done through such initiatives as providing lower-cost options (inside the public plan) for care in alternative settings such as outpatient departments, day surgery units, community centres, and patients'

homes. Patients, families, and the community at large, would have to take more responsibility for helping out sick friends and family, but the money saved by reducing hospital in-patient care would follow the patients into the community. Albertans were also told that such a system would provide more flexibility to meet individual circumstances and increase consumer choice.

Given long-standing frustration with the frequent rigidity of hospital routines, the desire of most individuals to recover in the comfort of their own homes as long as their safety and care is assured, and the willingness of Albertans to make sacrifices to ensure a viable public system – most initially supported reforms.

However, while recent polls indicate a growing level of concern about healthcare, many of the outcomes of recent reforms are largely unseen by the general public until they personally run headlong into them when a neighbour or family member becomes ill. In fact, in many cases, the results of these changes have been invisible and poorly understood by many professionals working within the system and the bureaucrats and politicians directing them.

The majority of both consumers and health professionals also have little knowledge of the rather incredible expense of commonly required healthcare products and services. Examples include the price of intravenous solutions and tubes, dressing supplies, syringes, oxygen machines, catheters, splints, testing or monitoring equipment, special new drugs, extra home care, professional help or a ride in an ambulance.

THE REALITY

Full public insurance coverage for necessary medical treatments and care has NOT followed the patient to lower-cost settings. In fact, shifting the site of care has resulted in frequent and often quite onerous expenses being passed on directly to patients and/or their employers through employer sponsored benefit plans and higher premiums. It has also provided the opportunity for healthcare providers to “unbundle” the costs of medically related products and services and create new charges and sources of money for traditional suppliers of public health plan services which are largely untracked.

Shifting these expenses to unprepared patients and families (or employer benefit plans) has created frustration and hardship for many Alberta families. Given the size and proliferation of expenses now expected to be covered by patients and/or their supplemental health plans, even co-payments or up-front payments prior to reimbursement, can be prohibitive. Making patients and their private insurance plans pay for more medical expenses is also increasing the price that the community has to pay for medical products and services due to the loss of bulk purchasing power of the public insurance plan.

Shifting these expenses to employers is putting future workplace healthcare benefit plan coverage as well as future employment opportunities at risk by increasing the economic burden on businesses operating in Alberta. With today's tight budgets, some employers already are encouraging workers who need a lot of time off due to illness to take early retirement or part-time work. Ironically, this also reduces the employee's access to supplemental insurance at the very time they need it most.

These new direct charges in the system are also creating financial disincentives for patients and families to take more responsibility for their own care or to chose lower cost options for treatment such as home care, timely care for medical problems, and preventative care. This artificially increases the demand for higher cost, but fully paid-for, in-patient hospital care. It also means that real choice is only available to those who have adequate financial resources at the time of their illness.

EXAMPLES

Early Discharges from Hospitals

Three years ago the average length of stay for total hip replacement surgery was two weeks and included rehabilitation to a state of relative independence prior to discharge. Now reported length of stays are 4-5 days. Some patients are not sufficiently recovered to be able to manage their personal care adequately, yet often find themselves going home to elderly spouses or facing charges for care.[22]

" I was home three days after surgery, but dislocated my hip getting out of a chair. I think it was because I was so weak and even though my husband was there, he really didn't really know how to help."

Reports also indicate that both a lack of transportation and the new funding criteria for physiotherapy have resulted in some patients being unable to obtain physician recommended physiotherapy following surgery in a timely manner, or without direct charges of around $25 dollars per visit.

Early discharge from hospital following surgery or treatment has left many families frantically scrambling to buy or rent a long list of expensive supplies and

[22] One 80 year old retired physician from Calgary found himself in just such a position. He chose to pay $100 dollars per day for care and rehabilitation in a long-term care setting, but worries about the people who couldn't afford it or aren't fully advised of what they would be facing after surgery. Another senior wrote " I was home three days after surgery, but dislocated my hip getting out of a chair. I think it was because I was so weak and even though my husband was there, he really didn't really know how to help."

arranging to take days off work to care for a recovering family member. [23]

Care of the Terminally Ill

There have been many strides made in supportive care for dying patients in more appropriate settings, including the comfort of their own home. However, increasingly, admission to an acute care hospital, even near the end, may no longer be presented as an option to patients or families. [24] In the home, patients face direct charges, co-payments and deductibles for the costs of oxygen, equipment and supplies, special nutrition, and drugs to control pain and other symptoms. The charges and co-payments for supplies vary throughout home care programs in Alberta. The drugs, both prescription narcotics and large quantities of over-the-counter drugs, are very expensive. These expenses, which can run anywhere from$5,000 to $50,000 dollars or more during the course of care, are now largely the responsibility of families and/or their employer benefit plans. [25, 26]

> "My wife is dying, but the nurse said she couldn't go to a hospital because it was only for people that will get better."

[23] A sixty three year old Sherwood Park man was thrown from a horse, resulting in many broken bones and internal injuries, particularly to his lung. He spent three weeks in Intensive Care. The day he was transferred to a medical unit, his wife was advised that she would have to take him home the next day - even through he was still in severe pain, on oxygen, unable to use one arm, and unable to walk without assistance. She was given a list of equipment and supplies that she would have to buy or rent and told she would have to get him to physiotherapy every day. The man was self-employed with no extended benefits plan and the couple did not have ready cash for the long list of supplies, or family in the province. The woman was terrified at the thought of her husband coming home in such a condition and had no idea where to shop. She refused, and he spent another two weeks in a rehabilitation setting.

[24] "My wife is dying, but the nurse said she couldn't go to a hospital because it was only for people that will get better." (An Edmonton caller.)

[25] Some families without adequate resources or a generous employer benefit plan must deplete their savings, go into debt, or seek charity from service clubs. As one nurse in the field put it "I continue to be shocked at the high cost of pain control"

[26] A Stony Plain family with a young child diagnosed with cancer was given two day's notice of the need to buy a special pump in order to bring the little girl home from an Edmonton hospital. The first time she had been discharged, the family was given a pump from the hospital. The next time, the mother was told she would have to rent or buy a pump. Because of the uncertainty of the child's condition and the high rental costs she paid $750.00 at the local drugstore. She went on to say that there were many other costs caring for this child at home, and the family was just so grateful they had a good extended benefits plan through an employer. She also said that the finding the money up front had given her many sleepless and tearful nights. Since many such parents up jobs to provide such care at home, many report feeling penalized by having to pay these new expenses which used to be covered in hospital or outpatient care.

Terminally ill patients, now frequently admitted to long-term care facilities, have to pay accommodation charges of around $25 dollars per day for room and board plus charges for laundry service and a number of other items. [27]

According to a palliative care doctor in Edmonton, "85% of patients who died of cancer in Alberta in 1992/93 died in acute care hospitals. In 1995/96 it is expected that 70% of patients who die from cancer will die at home or in a long term care facility."

Chronic Illness

As more and more patients and families are encouraged to become independent and manage daily medical care or treatments themselves in the home, they face stiff charges. For example, parents of chronically ill children are being encouraged (some feel forced) to learn to do procedures at home which were previously done in hospitals, such as changing their child's feeding tube.[28] The only catch is that these tubes, which range from $60 dollars to $300 dollars, then become the family's financial responsibility.

Most people with a chronic disease that flares up from time to time, such as multiple sclerosis, kidney disease, diabetes, or cancer, would rather be able to receive their necessary medical care without having to be admitted to hospital. Their time at home is often important to their family and/or their incomes, and their quality of life. But charges in both home and outpatient settings frequently make it difficult. Although they are willing to pay the money (if they have it), many resent the fact that the public insurance plan doesn't cover them, even though they are saving the plan substantial money by not going to the hospital for treatment.

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[27] A terminally ill elderly man with cancer was transferred from the palliative home care program to a long-term care facility due to the strain on his 88 years old wife and died 3 weeks later. Daily rates of $25.00 were charged to the family plus $38.00 per month for laundry. Because of poor staffing, the family paid someone from a private agency to go in three times a week as well as spending many hours there themselves. A staff person from a private registry advised CACA that requests for private nurses in homes and hospital had gone up "quite a bit."

[28] "A few years ago, feeding tubes were changed in the Emergency for free. Now we have to replace them ourselves and buy it ourselves. The tubes cost $60.00 and we simply don't have the money. We're supposed to change the tube every two months, but now we wait for it to rupture. Every time we need a new tube, it is a fight to get it without paying at the hospital, but what are we supposed to do? I was so upset at the price of a little six inch piece of rubber that I called the U.S. supplier to find out how much the tube cost and if I could get it directly from them. They told me it cost about $10 dollars, but no, I couldn't get it from them. And we've still got lots of other expenses for diapers and other special needs"- (A Calgary mother.)

Intravenous Therapy

Intravenous therapy is a method of giving powerful and very expensive drugs for serious conditions through an infusion directly into the circulatory system. Although these drugs can be administered into veins in the arm, increasingly this therapy involves a minor surgical procedure to implant a tube in the chest for longer-term therapy or when problems are encountered. Individuals have traditionally been admitted as in-patients.

Over the past two years, patients have been increasingly given the option of receiving intravenous therapy in outpatient departments or at home. [29] This latter option is more appealing to many patients and families, even though they must learn new skills and take a lot of responsibility for the safe management of this treatment. Since a large number of acute- care hospital beds are occupied every year by patients who spend weeks on intravenous therapy for everything from bone infections and pneumonia to transplant treatment, providing this option in an outpatient or home setting has obvious savings for the public hospital system through reduced use of inpatient beds.

But despite this fact, and the significant expense of intravenous drugs and supplies, the Alberta Health Home Intravenous Therapy program, piloted in 1992/93, was designed with a 25% co-payment for supplies and a $5,000 dollar deductible for "catastrophic" out-of-pocket drug costs when patients did not have

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[29] Some reports indicate that in-patient therapy is sometimes not even presented as a option. Some hospitals also charge for intravenous therapy provided in outpatient departments or Emergency rooms. While some Regional contacts have advised us that such charges for outpatient hospital care are not allowed, others stated that it was a directive from "someone in the government". There appears to be a great deal of confusion and an even greater reluctance by administrators to divulge information.

Efforts to both reduce costs and increase patient satisfaction led to the Multiple Sclerosis Clinic in Calgary piloting a number of options. It conducted a study to evaluate the clinic's three programs of Solu-Medrol Intravenous administration: in-patient, out-patient, and home therapy. The treatments costs Medicare about $5000 dollars if the patient is hospitalized for a period of 9-10 days, but patients who receive the therapy in an out-patient department or at home cost the system about $345 dollars, of which the patient pays about $230 dollars. While most patients preferred these alternatives, many had problems with financial arrangements. Comments included "hassle getting money back from Blue Cross", "too expensive to pay up front", "trouble with hospital invoicing", "could not pay because too expensive" and "hard to pay but government does not care".

Some patients also faced problems with transportation and the expense of parking. Six patients from the Home treatment group would have required admission if home treatment were not available because they were too disabled to come to the outpatient department

an employer or government sponsored plan (e.g. Seniors Plan) to pick up the costs. [30] As a consequence of this decision, last year, in the Edmonton area alone, 54 patients had to either be admitted as in-patients or make frequent daily hospital visits because they could not afford to pay for home IV therapy, even though they were good candidates for self-management.

Doctors' Offices

Previously covered physician services such as telephone advice, prescription renewals, and authorization forms are being "unbundled" from set fees and charged directly to patients. Reports ranged from $5 dollars to over $50 dollars. Examples included charges of around $30 dollars for supplies

[30] As well as charging patients 25% of the cost of supplies, these programs may charge daily rental fees for infusion pumps at home. Included in the Guidelines are directions that "clients without third party supplemental health insurance will be encouraged to join a plan."

A 74 year old woman from rural Alberta wrote: "I was admitted to a regional hospital recently for five and a half weeks for treatment for a painful bone infection requiring intravenous therapy. Because I was relatively independent I didn't notice the delays that may have caused problems for other patients. However, within the first 10 days of therapy the veins in my hand had been used up and the site of the infection was inflamed so I now had two hands that were almost useless. A tube had to be inserted in my chest into a vein, but the doctor had difficulties because of old mastectomy scars. While all these things were happening, Home Care were persistently trying to persuade me to have the IV therapy in my own home. Of course, I wanted to be home but I was worried if I could manage, and no one I asked could tell me how much it would cost. The doctor said it was expensive, the head nurse said "Blue Cross will pay", the Home Care worker said "Blue Cross would cover some of the cost. Some said it could cost up to $200 dollars per day. I was anxious and confused, and my doctor, bless his heart, sensing my distress, had me stay at the hospital until cured. When I got out of hospital, I was curious and went to see my pharmacist. I was told that as well as paying for a portion of the supplies, I would have had to pay drug costs of around $60 dollars per day for 10 days, although Blue Cross would pay about 2/3 of that. While it was a far cry from $200 dollars a day, still it would have been a hardship for me, even so. So give patients who don't need intensive care an incentive to go on home care. Pay the $20 dollars! "

An Edmonton woman had a serious bone infection and has required intravenous therapy for over a year. Because of drug resistance she now requires medication that cost $867.00 per week. A combination of her Blue Cross coverage and her husband's employee benefit plan pays for the drugs. Twice, the computer failed to accept the claim, she has had to put the $867.00 on her VISA before the pharmacy could give her the drug. Last year her co-payment for supplies came to $900 dollars. She is worried about what would happen if her husband lost his job because the home IV therapy program has made such a difference in her quality of life and her. It has also enabled her to do some free-lance work and help bring in income for the family.

From April 1,1994 to March 31, 1995, 318 patients were accepted to the Edmonton Home IV program with an average length of stay of 17 days. A number of patients had repeat therapy and some are on long-term therapy. The average cost per day for clients (drugs and supplies only) was $73.00 per day. During this past year, program partners (area hospitals and health units) have absorbed almost $4,000 dollars worth of bad debts. Dollar contributions by third party plans amounted to about $141,000 dollars, and patients paid $40,000 dollars in out-of pocket charges.

for the removal of a pre-cancerous mole, to $5.00 for having a blood sample taken. More than half the individuals who identified these charges stated that they had received the same services in the past at no charge. [31]

A letter sent to all doctors from the Alberta Medical Association in the summer of 1995 advised them that they could be missing charging for a number of items they were now entitled to charge for. The list included cancellation within 24 hours of appointment, long-distance calls for referral appointments, photocopying, telephone prescription renewals, reviewing medical records for release, telephoning lab tests and advice by telephone. It also included removal of benign skin lesions, newborn circumcision, non-medically required removal of warts, third party forms including absence from work/school and pregnancy leave, and depending on the situation, lab or X-ray services and medical supplies and devices. The letter said these decisions had been made in consultation with Alberta Health and the College of Physicians and Surgeons.

"My husband had to pay for anesthetic for removal of moles on the back of his hand. But we were told they were pre-cancerous and had to be removed so we had no choice."

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[31] "I've been on the same medication for years. My doctor doesn't do telephone renewals anymore. It forces me to take time off work and go to his office. I think he just want the price of an office visit." Someone else wrote: "Of course I'll pay $10 dollars. It saves me half a day off work, but why should I be made to pay. But if I complain, he'll make me go in."

"I'm disabled and need to get yearly authorizations to drive. But being disabled, I also don't have a lot of income. It seems unfair that other people who are probably more dangerous on the road shouldn't have to pay this fee."

One older Calgary woman suffering from complications from total hip replacement surgery called Home Care for help. She was advised that she would need to make an appointment and get a letter from her orthopedic specialist (for which she would have to pay $50.00) in order to have Home Care. She no transportation and the soonest appointment was three months.

An irate principal from Wetaskiwin faxed CACA a copy of a recent letter from the Alberta Medical Association to schools indicating that either the school or the parent would have to pay for any information or reports requested by the school. He sees this as a major problem due to increased mainstreaming of handicapped children, and the school's need for medical direction. He also pointed out that parents of these children often have low incomes because of the need for a full time caregiver so cannot afford these fees. Given that he is often asked to fill out forms as a "professional courtesy", he wondered if he should be reciprocating "in kind."

With the closure of the lab in his doctor's office building, a patient was offered to have his blood specimen collected and transported at a cost of $5.00. "Why, if reducing the number of labs saved so much money, is the cost of collection not covered?"

"My husband had to pay for anesthetic for removal of moles on the back of his hand. But we were told they were pre-cancerous and had to be removed so we had no choice." Another caller indicated a $30 dollar charge for dressing supplies and sutures for the same surgery.

5. New Hospital Fees

Hospitals are being just as entrepreneurial, sometimes charging for outpatient drug therapies or Emergency room visits, invoicing patients for supplies related to treatments, asking chronically ill patients to bring in their own special supplies when they come for treatment, or charging for safer or better options for care. Patients are also now finding they have to pay for previously covered surgical preparation or rehabilitation relating to an episode of illness or otherwise insured treatment. [32] In many cases traditional in-patient or outpatient treatments are being replaced by expensive new drugs which fall on the patient to pay. A member of the Schizophrenia Society indicated that it is not unusual to find pensioners with incomes of $800 dollars/month paying large drug bills for grown children who cannot maintain gainful employment because of their condition. A new technique to replace hysterectomies carries with it the need for expensive drug therapy prior to treatment. There are many examples.

7. Announced De-insurance of Medical Services

The announced de-insurance of a number of previously covered services and the lack of clear Alberta Health policies on these changes (e.g. eye exams, removal of warts, physiotherapy) has resulted in the de facto de-insurance of even more than was intended.

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[32] A young man from Calgary called: "I went in for day surgery on my arm. When I woke up I had on a sling, but again no one told me that I'd be billed for it. Later I got the invoice at home."

A woman from northern Alberta said: "The Emergency Department up here has been charging $5.00 for a visit for over a year. Since there is only one doctor and he keeps his office open only two days a week, if you need to see him, you go to the Emergency Department. My ear was blocked and I couldn't hear, so I didn't want to wait five days. It wasn't a problem for me to pay the five dollars, but I wonder if they are allowed to do that."

"Our child needs a special kind of surgically implanted feeding tube which has to be changed in day surgery at the hospital. About two or three years ago, the hospital said it would no longer pay for the tube. The cost at that time was $227 dollars. Last year it went up to $295 and just recently it went up to $300 dollars. But many times it only lasts three months. We still have to take the child to the hospital because a doctor has to put in this kind of tube."

A Westlock mom, with a five year old who needed a kidney X-ray, found herself reading a consent form in a Calgary X-ray department. In it, she was asked if she wanted to pay $42.50 extra for a safer dye with less side effects. As she put it "What choice did I have? What would you do if it was your child?" At the Grey Nun's Hospital in Edmonton, all patients are routinely presented with this choice and charges range from $60 dollars to $120 dollars depending on the amount of dye used. At the University hospital, patients fill out a form. Then, depending on past experiences, the type of patient, and the type of test (because the rate of infusion of the dye varies by type of test and affects the intensity of side effects) the radiologist determines the best type of dye to use, and there is no patient charge.

The lack of clear policies restricts access to medical services through fear of charges for which an individual cannot plan in advance. For example, because there is no way for consumers to determine before they go for an eye exam if the exam will be covered, some put off necessary and appropriate visits.[33]

The new narrow and highly subjective criteria for eligibility for publicly paid physiotherapy (based on patient impact, risk of delay, and potential value of treatment), has resulted in many people being forced to pay for necessary and physician recommended therapies or face long waits. This lack of clarity has also prevented private insurance carriers from being able to cover the costs of some physiotherapy treatments. Recently physiotherapists, the government and insurance carriers have developed a cut-off point for determining private and public coverage, but CACA has been advised that because of the subjective nature of the criteria, problems continue. Furthermore, patients with chronic conditions often end up with lower ratings on this scale, yet these individuals often do not have access to private supplemental coverage.

Increased Transportation Costs

Transportation costs associated with accessing appropriate and insured medical care has the potential to become a major expense for both families and employers as services are consolidated. Ambulance rides in the city run over $200 dollars per trip, a ride from Westlock just over an hour from Edmonton is $800 dollars, and longer distances run into thousands of dollars. Public payment for ambulance services in Alberta only covers seniors and those on social assistance. Specialized care is now available only at some hospitals within regions and many hospitals have closed, reduced services, or changed the services provided. A number of callers to CACA have stated that they have no idea of where they are supposed to go when they run into problems. Nor do they usually have the ability to self-diagnose the type of care needed in order to go to the appropriate location. However, only patients admitted as in-patients have their ambulance expenses covered by the public insurance system according to the *Alberta Hospitals Act*. Patients who are assessed and/or treated in an Emergency department but then transferred elsewhere must pay their own ambulance or transportation costs. The high cost of ambulance service is already a major issue for both consumers and health care providers. This area will need to be carefully monitored and addressed.

[33] A woman in a new home-based business relates on how the cost of an eye exam and confusion over coverage resulted in her not getting her eyes checked when she should have. "My eyes had been causing me some problems, but I knew I needed new contacts too, so I just put off going to see my eye doctor so I wouldn't have to pay twice for an exam. Now, it turns out I've done some permanent damage to my eyes. It's not that I couldn't have found the money. But with all my money going into trying to get my business going right now, I just didn't put it as a top priority. You know how it is, the kids and business often come before your own needs."

The increased use of outpatient departments and day treatment has also led to strain on families and disabled or handicapped transportation systems (DATS). Individuals who rely on DATS report that they often can no longer use this system for regular social outings because of the demand for transportation for medical care. Yet this social contact is very important to their overall health, well being, and their ability to live outside an institution.

Higher Costs for Private Care

Examples of higher costs for private care include paying to jump the public queue for heavily advertised cataract surgery and MRI diagnostic clinics and payment for routine adult eye exams, which were de-listed last year. According to survey of seven urban settings in Alberta undertaken by the Consumers' Association six months following the de-listing of eye exams, the price had jumped an average of 30%. The highest prices were found in the cities with the fewest providers.

Last year the Alberta Health Care Insurance Plan paid out almost $9 million dollars to physicians in private surgical facilities, almost two-thirds of that in the city of Calgary. These surgical suites also charge large facility fees directly to patients. A 1994 survey by CACA found facility fee charges for cataract surgery ranged from $800- $1275 dollars on top of the $701 dollars paid by Alberta Health for surgeon and anesthetist fees. Theoretically these charges are to cover overhead costs in private facilities, but they are 2-2 1/2 times the per case costs of $488.09 ($342.65 in direct costs and $145.44 indirect costs) at the publicly funded Wetaskiwin Hospital, 60 kilometers south of Edmonton. This hospital is part of a national program for tracking hospital costs. Stony Plain Hospital figures showed $369.90 per case, although some general overhead costs were not included in this calculation. Although Edmonton and Calgary eye surgeons did about the same number of cataract surgeries last year, 50% of the surgeries in Calgary were done in private surgical suites, while in Edmonton only about 2% were done in private suites. It is difficult to say whether Calgary patients are simply choosing to go to certain surgeons who limit their hours of practice in the public sector, or if they felt they had no choice.[34]

Even the increased reliance on private fund-raising by hospitals and programs to pay for services and equipment is a much less efficient method of either raising or distributing funds for healthcare. It also takes away charitable dollars from traditional charities such as the Emergency Youth Shelter or the United Way that have historically played an important role in supporting the general health of the population.

[34] The Consumers' Association 1994 "Access to Cataract Surgery" Survey of Waiting Times found reasonable waits for surgery in public hospitals for all ophthalmologists, except those who had active private surgical suites and charged extra fees in such settings.

To date, the Alberta government has been very supportive of a strong role for the private sector both inside and outside of the public insurance plan, despite the absence of any visible cost and quality analysis - or any legislation or regulation to protect consumers.

More Reliance on Private Insurance to Fill the Gaps

A recent survey by the Population Laboratory at the University of Alberta found that only 63% of Albertans have supplemental health insurance. Of that number, 48% did not believe it would protect them from future health cuts.

Currently Alberta Blue Cross, a private non-profit company, which has a contract with Alberta Health to administer government subsidized supplemental insurance programs for special populations such as Seniors, is actively marketing a number of new private supplemental policies. Most of these policies require an individual assessment and rating prior to approval. Although a CACA representative was advised by phone that some programs have a 30% rejection rate, Alberta Blue Cross and other private insurance companies have refused to provide any statistics in writing on rejection rates or denial of claims in writing. This information is considered confidential.

The real problem with increased reliance on private health insurance, is that health insurance works just like house and car insurance! The more claims on a policy, the more the premiums go up, and the greater the risk of the insurance company canceling coverage or refusing to renew. And just like car and house insurance, there can be difficulties trying to get reimbursement for claims.

Alberta Health does sponsor a community-rated supplemental policy for individuals and families through Blue Cross, primarily for drug and ambulance coverage. Community-rated plans are different than ordinary individual plans because they have no restrictions on people with a history of illness and everyone pays the same premium. This plan is used primarily by Albertans who cannot obtain ordinary private health insurance due to frequent claims or pre-existing conditions. As a result, premiums tend to rise more quickly for the people who can usually least afford it. Premiums for this government sponsored plan have climbed from $100 dollars per year in 1990 to $492 dollars in 1995. There is a waiting period for benefits unless an individual is transferring from another plan. Coverage is limited and there are co-payments of 30% for drugs up to a maximum of $25 dollars for each prescription. Alberta Blue Cross is also offering new wrap-around policies to make up for decreased government coverage in health, dental, and vision care for seniors. Today's seniors face new charges ranging from $22 dollars to $33 dollars per month if they choose to purchase such policies.

Other private insurance companies, primarily Canadian subsidiaries of major U.S firms are moving into Alberta as well. They are offering a variety of very expensive policies to increasingly fearful consumers.[35]

Yet there is no real consumer protection legislation or regulation of the health insurance industry in Alberta or Canada. There is no requirement by the province of Alberta to approve a policy before it is sold. There is no approval requirement at the Federal level either. Most existing regulation deals only with solvency issues. Companies can say anything they want about the ability of a policy to provide services. The only protection a consumer has is from an industry organization called the Canadian Health and Life Insurance Association, with a mandate to champion to interests of its insurance company members. Membership is voluntary and it has no regulatory authority. There is no agency with any effective authority to deal with fair marketplace practices or consumer complaints.

"The addition of such riders [for new home care and long term care insurance policies] can drive monthly premiums up to $80 for someone aged 40 and $342 for someone aged 60."

Paying for healthcare through private insurance also means paying up to 40 cents of every dollar for administration costs and profit. This is why many large employers in both Canada and the U.S. prefer to carry the risk of "self-insuring" or paying the costs directly. This is also why so many small companies in the United States thoroughly check out the health history of any potential employee and their immediate family prior to hiring.

[35] A large international insurance company (AFLAC) is aggressively marketing a very expensive and complicated home care and long-term care policy to Alberta seniors at present. Premiums for future $40 dollar/ per day coverage are $31 dollars per month for someone aged forty, and $119 dollars per month for someone sixty years of age. There are *maximum benefits allowed to be claimed* and optional riders for inflation protection, equipment rental, and removal of the maximum benefit. The addition of such riders can drive monthly premiums up to $80 dollars for someone aged 40 and $342 for someone aged 60. According to the Winnipeg Free Press "G-W [Great West Life Assurance Company] chief executive officer Ray McFeetors told the company's annual meeting yesterday that G-W Life will begin selling home care insurance products under an agreement with the American Life Assurance Corporation of Canada (AFLAC). . . 1995 was another good year for G-W Life's holding company G-W Lifeco . ("G- W Life jumps into home care", Winnipeg Free Press, April 25tth, 1996)

Another company, American Medical Security, is taking advantage of Canadians' growing fear of being unable to get timely surgery within the public system. They are offering a special Canada/America Healthcare Plan. This plan covers medical treatment in the United States for Canadian residents on an Approved Surgical/Procedural Waiting List when treatment is not expected to be available earlier than 45 days from the date the individual's name is placed on the list. Premiums, depending on age, range from $59.35 to $171.65 each month. However, the limitations on this policy make it almost a certainty that it will rarely be used.

7. OTHER EMERGING ISSUES

Variations in Coverage across Alberta

Although there have always been differences in public insurance coverage because of the local availability of a service, there are now major differences in **what** medically necessary services are insured, and the extent of that coverage. Treatments previously covered in hospital settings are now subject to a variety of co-payment arrangements and deductibles in outpatient and home care settings. Terms of coverage vary widely across the province.

Perhaps one the best examples of these variations is public coverage of the costs of intravenous therapy. Intravenous therapy can be provided to individuals as in-patients, as outpatients, or in patients' homes through a Home Care program. While this expensive therapy is always fully insured when provided as an in-patient, it depends on which hospital one goes to whether or not it is fully insured as an outpatient. For example, patients pay the full costs of the intravenous drugs in one hospital's outpatient department, but don't pay at another hospital twenty kilometres down the road. The third option of Home Care leaves patients having to pay all intravenous drug expenses plus additional charges for equipment and supplies.

"For example, patients pay the full costs of the intravenous drugs in one hospital's outpatient department, but don't pay at another hospital twenty kilometres down the road."

CACA has been advised that some Regional Health Authorities in Alberta have looked at covering the cost of home intravenous therapy. According to Alberta Health, this decision is now up to each Health Authority. However, there is a twist. If even one RHA covers the costs of this therapy in the home, private insurance companies will consider it "publicly insured and medically necessary" and refuse to provide coverage anywhere else in Alberta. After all, private insurance companies and employer benefit plans don't want to pay any more claims than they have to, and the headaches and paperwork involved in keeping track of what is publicly insured in all seventeen regions could be an accounting nightmare. Besides, intravenous therapy is a common and very expensive treatment.

It will be interesting to see what will happen if Alberta Health continues to allow such discrepancies in publicly insured medical services, particularly when the Department brings in an already announced population-based funding formula.

For example, if outpatient and home intravenous therapy is not insured the Capital Region Health Authority, but insured a few kilometers away in the Aspen Region, will Albertans cross-border shop? Will the Headwaters Health Authority cover the cost of outpatient intravenous or home therapy for patients visiting from the Crossroads Region? Or will Albertans' new "smart cards" make sure that the specific terms of service (complete coverage, no coverage, deductibles and co-payments) for treatments provided to patients in their home region apply in all other regions as well? Will patients who need this therapy on a long-term basis be motivated to move or prevented from moving? Will they be faced with a waiting period for coverage if they do change their place of residence? Perhaps they will move to Vancouver and live with friends or relatives in order to take advantage of the complete coverage for home intravenous therapy in B.C.

Increasing Reliance on Premium Revenue for Public Funding

The increased reliance on rising premiums as a method of funding health care in the province of Alberta was identified as a problem by some individuals, particularly low income families or self-employed individuals struggling to start or maintain a small business. Many also stated their unhappiness with the fact that they were paying "higher and higher premiums but getting less and less coverage." Alberta is only one of two provinces in Canada (the other is B.C.) charging premiums. Most other provinces pay for healthcare primarily through general revenue. Alberta Health Care premiums have risen rapidly over the past few years, from a family rate of $474 dollars per year in 1990 to $816 dollars in 1995. Partial subsidies are only available for adjusted taxable balances below $12, 620 dollars for families and $7,500 dollars for singles.

"Alberta is only one of two provinces charging premiums. Health Care premiums have risen rapidly over the past few years, from a family rate of $474 dollars per year in 1990 to $816 dollars in 1995."

While premiums have the benefit of being seen as a dedicated tax, they are also a flat tax. This creates a disproportionate burden for lower income earners. Lower income families or individuals therefore pay a much higher portion of their income for the health care system than higher income families. However, another point came through during CACA interviews with consumers. This was primarily pointed out by people, with both sufficient savings and good employer benefit plans, who had recently faced major medical expenses. They expressed the view that since they were paying for benefits through the public plan, they

[36] Alberta Health's "Three Year Business Plan" shows a further planned increase in premium revenues of $243.7 million dollars between 1993/94 and 1997/98.

felt it was wrong to force them to rely on private insurance and savings simply because they could afford it. As Canadians, they paid for health insurance through taxes and premiums, and they felt the insurance plan they paid for should cover them. Similar feelings were expressed about being asked for donations to support hospitals, having to ask for charity to cover medical expenses, and means testing. Many individuals also felt it was unacceptable that health care providers so often assumed that they would automatically have the money to pay. They felt it put them in a compromised position. "After all, if medical treatment is necessary, you'll find the money", but that didn't make it easy to find the money immediately, and it didn't mean that it might not be a problem because of temporary circumstances."

Finally, although the status and impact of the new Third Party Liability amendments to the *Hospital Act* in Alberta are unclear at this point, these amendments also reflect a shift to increased reliance on premiums and private sources for payment of healthcare expenses. Through increased litigation for a wide variety of possible new "wrong-doings" which create a need for medical care, home and auto insurance premiums could rise substantially. Depending on the regulations and how they are applied, this could turn our essentially "no fault" health care insurance plan into one where a major component of expenses for healthcare will be costly court proceedings and the exercise of assigning blame as it is in the U.S. While assigning blame and costs for an individual's use of medical services may be emotionally rewarding for some, it ads extra administration costs everyone has to pay.

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Barriers to Necessary Medical Care

` All the new charges and expenses facing Albertans as a consequence of changes in coverage have resulted in many families being left stranded in difficult situations due to unexpected charges. Although many with major extra medical expenses did have supplemental insurance, the delay in reimbursement caused significant problems. Reports indicate that healthcare providers are also increasingly insisting on money *before* providing a service. Individuals simply don't get the service or product until they pay. Even long-term care institutions are now billing in advance.

Modest income families report having to choose between making their mortgage payment on time - or paying for intravenous treatment; paying this month's utility bill - or for a long list of supplies to bring a sick spouse home from the hospital. It is also creating "job lock", where individuals feel they can't change jobs because of their reliance on an employer benefit plan.

Some Alberta families even find themselves having to go asking for charity from a local service club in order to pay for equipment and incredibly expensive pain control medications to ease the pain of a dying family member at home. This is not an easy thing for people to do. And they don't feel they should be put in this position. "Dealing with ill health is enough of a problem."

Even worse off are those families with already reduced incomes because a wage earner develops a chronic condition that limits his/her ability to maintain a decent income, or those who have children or other family members with chronic conditions requiring a full-time caregiver. While there are some provincial programs and special funds to draw upon for help, the head of one parent support group said she was finding that families with newly diagnosed medical problems weren't having the contact with social workers and programs which they used to have in the hospital. As a result, some were missing out on the limited help available.

Seniors are also being particularly hard hit, especially those who have carefully planned their retirement on an expected level of benefits, and who have no options for bringing in income other than selling their assets. Yet most seniors' assets are tied up in their homes. Now a number of seniors are finding that new and rising expenses for medical care are shrinking their monthly incomes and savings. This is forcing them to give up many of their social contacts just to make ends meet - or do without. Between 1993/94 and 1994/95 Alberta seniors have experienced new charges for healthcare premiums, increases in drug co-payments requirements from 20% to 30% with a $25.00 cap per prescription, an increase in the co-payment of personal support in home-care, increased daily rates in long-term care, etc. According to a 1990 Statistics Canada Survey 56.8 percent of seniors in Alberta (not living in collective dwellings) had incomes below $15,000 dollars.

Standards of Care

Contact with Albertans indicated a concern with standards of care, particularly from those who had used the healthcare system intermittently over the past decade. However, comments were both positive and negative and varied throughout regions and institutions. There were, on average, an equal number of positive and negative comments, often from the same individuals. For example, some expressed satisfaction with their surgery, but had a miserable

and frightening time in the hospital. Others found their care in hospital excellent, but had complications from surgery and problems managing at home. Some were grateful for the option of Home Care, but found the expenses overwhelming. A young woman was glad she'd been so quickly diagnosed-which had saved her life, but found lying in the hallway on a stretcher for three days almost unbearable. Dealing with all the responsibilities and instructions for care of tubes and dressings after surgery (when they were still feeling sick and frightened) was an "awful' experience for a number of callers, but they really liked the home care nurse.

Low levels of staffing, and the inconsistent skill or knowledge level of the various caregivers in institutions appeared to be more of a problem in urban hospitals than in rural hospitals. However, there was not an adequate sample of responses to determine if it was just a matter of institutional differences or geographic location. Certainly, there some pretty appalling stories, as well as praise for certain doctors, nurses, and other health care workers, who had "gone out of their way to help". A few reported feeling "unsafe" during their hospital stay. A number of people interviewed reported taking time off work and spending long hours with friends and relatives who had been hospitalized because of the difficulty getting a call button answered or help to go to the bathroom. Some felt that they were expected to carry too much of the load for medical care in the hospital and at home, especially when they weren't really confident they were doing the right things. Long waits for certain tests or surgeries, and difficulties getting specialist medical care were mentioned. So was the stress level of staff.

Professional nursing care in home care settings was universally valued and highly praised by all contacts. However, a number of individuals commented on the less skilled workers who often lacked social or nursing skills. Frustration was also expressed with the sheer numbers of people and "strange faces" they had to deal with coming into their homes. Long-term care was identified by a number of callers as having deteriorated significantly over the past two years, particularly "since the nurses left", yet family members were reluctant to complain for fear of reprisals, and because "nothing ever changes". In all settings there were frequent complaints of too many different faces and inconsistent information and expectations.

One trend that began to emerge is the apparent lack of flexibility when individual circumstances are less than ideal. For example, complications from surgery or childbirth, side-effects from anesthetic, lack of help at home, or lack of finances to cover costs for home care, did not seem to affect planned discharge from hospital from the perspective of a number of individuals.

Keeping Track from the Consumer Perspective

During the early stages of our research this fall CACA developed a number of both written and telephone surveys for particular groups of patients who, with some degree of regularity, rely on the public healthcare system. We did this with the assistance of an umbrella organization of family-support groups from Calgary, and a professional in the field. Much of the type of data we were looking for has been historically obtained through personal interviews in peoples' homes, which CACA simply did not have the financial resources to support. With the help of this umbrella group, The Parents of Chronically Ill Children, we trialed survey after survey.

While we obtained some of the information we were looking for, subsequent conversations often revealed more pertinent data than was gathered on the survey. Individuals coping with chronic illness are busy people with little time for surveys. However, we continued to work together to try and find a better method. The result has been probably the most satisfying outcome of the past three months of work. It is the beginning of a "reporting network" of a number of individuals from family support groups in all of the seventeen regions of Alberta, and a design for an incredibly simplified set of questions which appears to get at the relevant information very quickly. Other family and disease-support organizations have now expressed an interest in recruiting members, and sharing the information collected. CACA believes that this will prove to be an invaluable source of information for future healthcare planning as it becomes more developed.

One of the biggest roadblocks CACA has encountered in exposing the problems brought on by recent healthcare reforms has been the understandable reluctance of families to expose their own personal health and financial information publicly, and the often greater reluctance of public officials and health care administrators to provide data. We would like to thank those individuals who found the time and the courage to speak out and share their information and thoughts with our organization during these past few months.

9. CONCLUSIONS & RECOMMENDATIONS

Health Reform has gone awry in Alberta. While there have been a number of successes in increasing the efficiency and coordination of care within the public system, failure to ensure that coverage for care follows the patient to alternative settings has created new problems and new costs.

Just because the site of care changes does not mean that an individual's need for that care changes. Shifting the site of insured services should not result in decreased coverage. This not only creates a demand for higher-cost and insured hospital services, but it reduces the flexibility of provinces and regions to achieve cost savings through alternative modes of delivery and local solutions.

Both provincial governments and the federal government must be responsible and accountable for protecting the public interest, and ensuring access to safe, effective and affordable healthcare. Both have a responsibility to provide stewardship in the wise use of public resources. Both must be accountable to Canadians for complying with the principles of the *Canada Health Act*.

These principles will be the key to successful reform. Albertans and Canadians cannot afford to "throw out the baby with the bath water" by throwing out the criteria for the public health plan or eroding the comprehensiveness of coverage. (See Appendix A) The human and financial costs of increased reliance on private insurance and individual payment, instead of increased efficiencies within the public plan, will make today's challenges pale by comparison. Whether through general taxation, private insurance premiums, credit, savings in the bank, or higher prices for goods and services because of the added costs of employer benefit plans, consumers ultimately pay the bill for healthcare. The central issue in healthcare reform must be how to provide all Alberta consumers with compassionate and effective medical care when needed, and how to get the best value for our healthcare dollars.

Given the unique nature of the need for medical care and the well-documented experiences of other countries with parallel public and private healthcare systems, *Canadian governments need to resist the urge to subsidize, or regulate to the advantage of, an already protected and lucrative private healthcare and health insurance sector.* Governments have a responsibility to ensure that private sector involvement in the Canadian healthcare system occurs under rules that protect the larger public interest.

RECOMMENDATIONS

- **That the Principles of the *Canada Health Act* guide and direct healthcare reform initiatives in Alberta.** The principles of the *Canada Health Act* provide guidelines for sound economic as well as social policy. Although many people mistakenly assume that these guidelines are the cause of rising healthcare costs, they are actually the key to effective healthcare reform and cost containment for healthcare services.

- **That coverage for insured services within the public plan follow the patient when care is moved to alternative settings.** There should be no financial disincentives for patients to choose lower cost options such as outpatient therapy and Home Care, or to take increased responsibility for self-management. Such financial disincentives drive patients into higher cost options such as in-hospital treatment. Only by providing for this increased flexibility in coverage will new, more efficient, and more patient-friendly options be free to develop.

- **That the Government of Alberta be responsible and accountable for maintaining province-wide standards for coverage which continue to provide portability both within the province, across Canada, and outside the country.** In order to ensure province-wide standards, the provincial government should provide adequate financial support, expertise, direction, and coordination for the Regional Health Authorities to carry out their responsibilities. While the Regional Health Authorities have the ability to effectively identify local needs and coordinate care in their areas, many programs and responsibilities require provincial administration in order to be effective. The Minister of Health has a fiduciary responsibility to be accountable for both the wise use of public dollars and the health of Albertans.

- **That a Consumers' Advisory Panel be created to support the new Alberta Health Council in its mandate to monitor the outcome of healthcare reforms.** This Consumer Panel should include representation from broad spectrum consumer groups such as the Consumers' Association of Canada and the Alberta Council on Aging as well as specific disease or family-support groups. There should also be representation from employer groups, who act on behalf of their workers. A specified amount of funding should be available for membership surveys on relevant issues and for a specified number of questions on the quarterly population survey done by the Population Laboratory at the U of A. Results of these surveys must be publicly available upon request.

- **That there be province-wide public hearings on any new limits to the public health insurance plan.** Only through such a process can the Alberta government be assured of both adequately informed decisions and support for their initiatives. There must be notice well in advance and hearings held across the province. Any changes to insured services in the public plan need to be well advertised and clearly explained.

- **That an independent committee, reporting to the Legislature, be appointed to examine the issue of health care premiums and the reason for the 28% rise in the number of individuals who have opted-out of the provincial Medicare insurance plan between 1993/94 and 1994/95.** The Alberta Health Care Insurance Plan is governed by the *Canada Health Care Act* which requires each province to provide insurance for 100% of the population. Although the total numbers are not significant, CACA is concerned that rising premiums may be forcing more people out. This Committee or Commission should also investigate and report on alternative tax systems to support public healthcare funding.

- **That the Standing Policy Committee on the Restructuring of Healthcare investigate and make recommendations to protect the public interest from anti-competitive activities in the healthcare industry in Alberta.** Healthcare professionals and provincial governments in Canada have had little experience with general rules of marketplace conduct being applied to the healthcare industry. Alberta needs some clear and well thought out rules and regulations to protect the public interest and individual consumers from anti-competitive activities if the trend to increased privatization is to continue. Consultations should include, among others, the Federal and Provincial Justice Departments, local and national health care economists, the Health Law Institute, Consumer Groups, the Federal Bureau of Competition, and international experts in the field.

- **That the visibility of the cost and risks/benefits of tests and treatments to both consumers and providers of services be increased.** Without this visibility of the cost of various tests, treatments, drugs, supplies and services, it is difficult for consumers and providers to play a responsible role in the stewardship of finite resources, or to place a value on available options. Options to increase visibility of costs include statements being provided at point of service, average prices being identified on lab forms, requisitions, etc. Sources of reliable third party information need to be developed and supported.

- **Should Alberta continue to shift to increased reliance on private insurance and private markets for healthcare, there should be no further changes until appropriate statutes, regulations, and staffing of appropriate offices occur in order to adequately protect consumers.** New private markets in healthcare should not be created until there is adequate protection in place for consumers. This includes rules governing advertising, disclosure, contracts, payments, and redress. All major privatization initiatives should also be required to undergo a thorough and publicly disclosed cost and benefit analysis.

- **That the Federal Government actively support the Principles of the *Canada Health Act* through on-going, adequate, and dedicated financing.** Only through such support will Albertans and all Canadians be able to retain a viable and valuable healthcare system. The Federal Government also has a responsibility to monitor the activities in the various provinces and intervene when necessary.

Appendix A

EROSION OF THE GUIDING PRINCIPLES OF THE CANADA HEALTH ACT

1. Decreasing Universality:

Not all Albertans are being equally covered for the same treatments or medical needs. This is pushing more patients out of the public insurance pool and into paying privately - either in direct charges over and above the usual and customary fee or through third party payers. Such activities reduce the ability of the public plan to effectively negotiate prices for specific services and control overall costs. Since providers are attracted to spend more of their time in frequently higher paying private settings, this in turn reduces the ability of other patients to access them within the public system, ultimately decreasing real choice for consumers.

2. Decreasing Comprehensiveness:

Previously fully insured medical services have been completely de-insured, or partially de-insured by the public plan through a variety of subtle changes, as well as through specific announcements by the Ministry of Health. These include changing the location of fully insured in-patient hospital care to out-patient departments, long-term care facilities, free-standing clinics, and patients' homes; the "unbundling" of charges for treatment related supplies and services by doctors and hospitals. It also includes replacing traditional therapies or hospital stays with new very expensive drugs paid for by patients and policy changes in public health coverage which create confusion and restrict access through fear of charges or discriminatory criteria. This reduction in the comprehensiveness of fully insured services reduces the ability of provinces and regions to reduce costs through adaptable solutions for their unique settings.

3. Decreasing Accessibility:

New charges and user fees are creating hardship and barriers to necessary care for a number of Albertans. When patients are faced with up-front or excessive costs for care they often find themselves delaying or not following up with medically recommended treatment or going into debt. Those individuals with chronic conditions, seniors with limited incomes, and the terminally ill are being particularly hard hit by both new financial barriers to care or decreased access to certain services; yet these are often the groups with the least financial and social resources due to their reduced earning capacity. They are the least likely to be able to obtain private coverage due to the insurance industry's practice of adverse selection. Decreased access to skilled professionals,

specific tests, procedures, and surgeries in some regions or settings are also creating both hardship and safety concerns.

4. Decreasing Public Administration:

An increased reliance on multiple payers through a combination of user fees, deductibles, employer benefit plans and private insurance increases the expense of healthcare through the loss of bulk purchasing power and higher administrative costs. Fear of inadequate coverage and a lack of financial security and safety have led to an influx of poorly understood private insurance policies being aggressively marketed. This increases overall health spending without providing significant value. The increased reliance on private sector contractors to manage programs as well as deliver care has the potential to both decrease standards, increase long-term costs, and affect availability of services. This is particularly true when the public system becomes dependent on private monopoly suppliers and a lack of anti-competitive regulation in the healthcare industry. This reliance on investment driven corporations in the U.S. has been shown to reduce the responsiveness of the service delivery level to the needs of the insureds.

5. Decreasing Portability:

The provincial government has reduced the portability of the public health insurance plan and the mobility of Albertans traveling outside of the country through reduction in out-of-country coverage. These restrictions, as well as the prohibitive cost of private out-of-country insurance is now curtailing the travel of many low and middle income seniors, who previously traveled to warmer climates in the U.S. during the harsh western winter months. Major differences in coverage between provinces could restrict the job mobility of Canadian families and businesses at a time when all provinces are actively working on an agreement to resolve internal trade barriers. Of even greater concern, is growing evidence of decreased portability of benefits among various RHAs in Alberta.