Article in New York Times 1993


The New York Times

Now Patients Are Paying Amid Canadian Cutbacks

Spending Outstrips the Government's Resources

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Now Patients Are Paying Amid Canadian Cutbacks

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This winter Fred Holmes took his two children, Monica, 15, and David, 13, both of whom had colds, to a medical laboratory to have their throats swabbed. A few weeks later he received two bills, each for $19.80.

Never before under Canada's 27-year-old universal health insurance system did Mr. Holmes have to reach into his own pockets to pay for such a common medical service. But bills like that are the wave of the future.

Like the United States, Canada, with a radically different system in which the Government uses tax money to pay most medical bills and regulates hospital budgets and doctors' fees, faces exploding medical costs. One response has been to get individuals and employers to pick up more of the tab -- like laboratory fees for some common procedures. Spending Growing Fast

Canadians are proud of a system that generally provides good medical care to all its citizens at a lower cost than in the United States -- averaging 1,915 American dollars

per person in 1991, the latest year for which figures are available, compared with $2,868 in the United States. But spending in recent years has grown nearly as fast as in the United States, and is outstripping the ability of the public sector to pay.

Despite new efforts to control costs, from cutbacks in covered services to caps on doctors' fees and hospital budgets, "revenues in the public sector are not increasing fast enough," said Bill Tholl, director of health policy at the Canadian Medical Association.

Aggravating the financial distress has been Canada's most painful recession since the Great Depression, which has compressed tax receipts and cut federal transfer payments to the 10 provinces and 2 territories, which actually run the health system for 27 million Canadians. A Major Reassessment

The Federal Government used to pay half of the health system costs. Now it is down to 30 percent. As a result, the provinces have been forced into ever larger deficits to finance health care, which consumes about a third of their total spending. These deficits mean more money owed to domestic and foreign lenders, who buy provincial bonds.

As the Clinton Administration prepares to overhaul the American health care system to include 37 million Americans now uninsured and to stem rising costs, the Canadian system -- which gives everyone, rich or poor, equal access to doctors and hospitals -- is going through a major reassessment of its own.

No one wants to dismantle the most popular Canadian social program. But there is talk of changing some of the ground rules. Fees Are Debated

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For example, fees have been widely discussed, even though they would contravene the Canada Health Act of 1984, which reaffirmed the fundamental principles of universal access to comprehensive care, unimpeded by financial barriers. One of the provincial Premiers, Frank McKenna, a Liberal Party member from New Brunswick, has suggested that wealthier Canadians would be willing to pay fees to insure that the poorest Canadians continue to get free health care.

"I don't believe there's another nation in the world that has such an open-ended system of health care where they simply give the dollars out, no matter what the amount, to health-care providers and recipients, without asking for some modest deductible in return for those who can afford to pay it," he said last year.

Quebec's Ministry of Health has already proposed a user fee of $5 each time a patient uses an emergency room, but has not yet adopted it. Still, it does require a $2 service charge per prescription for those over 65 who normally get prescriptions free. A ceiling limits the fees to $100 a year.

While opinion surveys show that more than half of Canadians would support patient fees as the best way to control health costs, opponents have successfully resisted, arguing that the practice would polarize rich and poor and require cumbersome administrative machinery.

Reducing covered services, another approach to shifting the burden to users, has made greater headway. The Ontario Health Insurance Plan, as Mr. Holmes found, has reduced fees to commercial laboratories and allows them to bill patients directly.
How Costs Are Cut

Ontario, which insures 10 million people or nearly 40 percent of Canada's population, has cut costs in these other ways:

*Stopping payment for certain services in connection with employment, insurance, pensions, legal proceedings, recreation and education. For example, if a doctor writes a letter in support of a disability claim, the claimant pays for that service. Or if a worker needs a physical to get a job, he must pay for the examination.

*Ending coverage of electrolysis, used for the removal of unwanted hair, sometimes the result of a hormonal disorder, and reviewing coverage of 40 other items including psychoanalysis, vasectomies, newborn circumcision, in vitro fertilization and chiropractic, podiatric and osteopathic services.

*Increasing patient payments for drug prescriptions covered by the Ontario Drug Benefit Plan, which chiefly serves people over 65.

"At one time Government could afford to be comprehensive, covering all medical services," said Dr. David Peachey, director of professional affairs for the Ontario Medical Association. "Now we need to re-examine what the Government will pay for." A Cap on Spending

Pat Rich, managing editor of The Medical Post, which follows health politics for the country's 40,000 doctors, said the provinces were determined to keep health spending from rising above the current one-third of their total expenditures.

Mainly by curbing hospital budgets and doctors' fees, Ontario has capped spending on health care at $16.9 billion this fiscal year, ending March 31, up only 2 percent over last year, against average increases of 11.2 percent in the 1980's. Hospitals are held to an overall 1 percent increase.

Colin Goodfellow, vice president of the Hospital Council of Metropolitan Toronto, said hospitals had been "surprised" by the required austerity, but added, "Nobody jumped up and down and screamed." He said there was a recognition that "we can sustain quality service with this level of funding."

Still, the hiving off of benefits signals a narrower scope for the basic medical care promised under Canada's insurance system. Analysts see growing use of private insurance to cover what is being taken off the provincial plans. Blue Cross organizations in each of the provinces, for example, are now offering plans for individuals that incorporate the delisted services, according to Mr. Holmes, a health benefits analyst at the Toronto consulting concern of William M. Mercer Ltd. . The Priorities New Procedures Reduce the Delays

For years, Government limits on medical spending have led to waiting lists for certain costly nonemergency procedures. In some provinces patients have had to

wait as long as 18 months for hip replacement surgery, 12 months for cataract surgery, 3 to 6 months for elective coronary bypass surgery. In British Columbia the situation became so acute a few years back that the Government arranged to send 200 patients to Seattle to reduce the backlog.

Yet many doctors and health economists here insist the waiting has not been as serious as critics say. In the United States, they note, rationing also exists, but it is rationing by price, keeping many from getting basic health care.

Canadian analysts say that despite the financial constraints, practitioners have worked out new standards for assessing patient priority that have eased the problems. For example, cardiovascular surgeons in Ontario now have a registry for all potential heart patients. A result has been a reallocation of caseloads based on need and surgeon availability.

The registry, combined with a recent 10 percent expansion in open-heart surgery capacity, has largely eliminated delays in the province, practitioners reported. New heart surgery capacity has also come on stream in British Columbia. The Problem Zone

"The first thing to keep in mind," said C. David Naylor, chief of the Institute for Clinical Evaluative Sciences, "is that anyone needing urgent service gets it. The problem arises in the zone between where it is an urgent need and where it is safe and convenient to wait."

According to a 1991 survey by Statistics Canada, 95 percent of all Canadians reported receiving the care they needed within 24 hours.

Dr. Naylor, whose institute is an academic research center that studies the Ontario health system, insisted that "some kind of queuing system is necessary if you want to run a service efficiently."

"The alternative," he said, "is excess capacity, which is not a very efficient way to run a service."

World-class research is conducted in Canada, but Canadian hospitals and institutes cannot always afford the high technology products developed in the United States. For example, not many Canadian hospitals have $1 million to buy a nuclear magnetic resonance imaging machine, and there are long waits for the available machines. But generally, once a procedure proves worthwhile, it is adopted in Canada.

Hospitals in Canada are private, voluntary, nonprofit corporations run by professional administrators and reporting to community trustees. Yet they are also state-dependent contractors that must answer in part to the provincial health ministry. Hospitals as Entrepreneurs

Peter Ellis, chief executive officer of the Sunnybrook Health Science Center, one of the biggest hospitals in Toronto, said: "In the last three years we have received funding way below our actual increase in costs. So we've had to become increasingly aggressive."

He was referring in part to energetic entrepreneurship, the bolstering of revenues by pushing ancillary businesses, from car parking, the cafeteria and the variety store to an on-site conference center. But hospitals are also being pushed into greater efficiency and less wasteful care.

Sunnybrook gets 70 percent of its funds from the Government, against 77 percent five years ago, but thanks to its entrepreneurship, combined with contributions of private foundations and new management techniques it has shown surpluses the last two years. The Physicians With More Doctors, More Services

Beyond the unavoidable price of new medical technology, the explosion in Canadian health costs has been encouraged, many analysts say, by an oversupply of doctors and the fee-for-service system that rewards them for seeing more patients and doing more procedures.

In 1964 there was one doctor for every 800 people in Canada; today there is one for every 450. Growth has been almost comparable in the United States, where in 1965 the ratio was one for every 720 persons compared with one for 411 now. The World Health Organization recommends one for every 600.

In Canada there is evidence that the doctors create their own demand, without necessarily improving the quality of care the population receives. At the encouragement of the Ontario Ministry of Health, the University of Toronto has just announced a 30 percent reduction in enrollment at its medical school, the country's largest. Medical schools in other provinces have also announced cutbacks.

Ontario's Deputy Health Minister, Michael Decter, says that each new doctor who goes into practice costs the province $500,000 a year. "If you continue to have too many physicians, it limits the resources you have for other areas of health care," he added.

Doctors are paid according to a fee schedule negotiated like a labor agreement between each provincial government and the provincial medical association. The latest increase is 1.75 percent, which is less than the rate of inflation. Incomes at U.S. Levels

Ontario doctors went on strike for 25 days in 1986 over a demand to be allowed to make supplementary charges. They lost the strike and had to back down. Now the doctors sit with the Government on a Joint Management Committee that tries to reach consensus. If the two sides cannot agree on fees, the doctors have now agreed to a process of mediation and independent binding arbitration.

After weighing the higher costs in the United States, including malpractice insurance premiums, which are 10 times stiffer, incomes of Canadian doctors are close to American levels. The specialists generally do better in the United States than Canada.

After treating a patient, the doctor bills the provincial health authority according to the fee schedule. For example, if a doctor in this province makes a house call from 5 P.M. to midnight and on weekends he may bill for $71. In Quebec, a simple

consultation by a general practitioner costs the Quebec insurance plan $13.80; $50.80 for a complete examination.

The vast majority of doctors -- an estimated 80 percent -- work under the fee-for-service system, as opposed to salaries. But critics say this system creates incentives for doctors to provide more services than may be needed.

Some fee schedules implicitly recognize this by building in their own disincentives. For instance, the Ontario doctor whose house calls constitute more than 20 percent of his billings will collect only $41.50 for that weekend call, instead of $71. Fees drop for doctors earning more than $400,000, a situation affecting 870, or 5 percent, of the province's physicians. A Shift to Clinics

Also keeping costs up is the tendency for hospital stays to be long, at least longer than in the United States. For example, maternity cases average three and a half to four days, compared with two days in many hospitals in the United States. But Canadian hospital managers say they face the same pressures as American counterparts to reduce lengths of stays.

In its own efforts to cut costs, British Columbia is moving dramatically to shift services away from hospitals to outpatient clinics, public-health programs and home care. But the program means closing hospitals, which is not popular either with doctors or the general public.

Despite its current convulsions, Canada's health system remains very popular. Polls regularly show it is supported by 85 to 90 percent of the population. But with rising expectations on the part of the patient, ever more costly technologies and an aging population, more strains and more change are unavoidable.

Echoing a general sentiment, Robert Evans, a health economist at the University of British Columbia, said, "The message must be that business as usual is not sustainable in the new economic environment."

A version of this article appears in print on March 7, 1993, Section 1, Page 1 of the National edition with the headline: The Bill Comes Due: Canada's Health Care Costs -- A special report.; Now Patients Are Paying Amid Canadian Cutbacks.