

CCPA-MB

FAST FACTS



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Health Care Panic Leads to Bad Diagnoses, Harmful Prescriptions

Everybody take a deep breath. The current debate about the future of health care is taking place in an atmosphere of fear and panic — precisely the emotions that will lead to bad decision making. The over-reaction is fueled by such prominent figures such as Alberta's Ralph Klein when they declare that medicare is about to "hit the wall." That is simply not true.

It is true that health spending has risen sharply in the past five years. In part, however, this increase is simply catch-up for under-funding during the early 1990s, and so current trends are not evidence that the system is heading full-speed into unsustainability.

In general the Canadian health system is one of the best in the world; it will remain so only if we resist responding to the hysteria by gutting or selling it off. A more responsible approach would be to identify the central challenges, including the costs that are driving health spending, and address them accordingly.

Pharmaceuticals

From 1987 to 1996, the cost of prescriptions in Canada rose 93% compared to an increase of all consumer prices of 23%. Drug costs grew proportionately faster than any other

item on the nation's health bill, from 9% of total health expenditures in 1984 to 12.7% in 1994 and over 14% by 1996. In Manitoba, drugs costs paid by the Pharmacare program rose 40% in just two years (1998-2000).

In effect, we gave away health care resources in exchange for increased profits for pharmaceuticals companies.

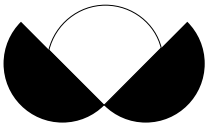
Many of the new drugs coming on the market are no improvement on the old, and are incompletely evaluated. Some are simply an older drug with minor modification brought onto the market to gain another 20 years of patent protection for the company (for example see Glaxo-Wellcome's FloVent substituted for Beclaven at twice the cost).

The ideal response to this is at the federal level in the form of a national drug coverage program, a repeal of the over-generous patent protections extended to the drug companies by Brian Mulroney, bulk buying, an improved review process, a Crown corporation producing generic drugs and de-listing of drugs deemed to be ineffective or

too expensive.

Thus the major provincial response ought to be in alliance with the other provinces to bring about these changes at the national level. It might also be possible to bring about a similar scheme on a regional basis failing Federal cooperation.

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Ageing Population

The ageing population is a gradual phenomenon that on its own does not come close to explaining a sudden rise in spending. And to the extent that this demographic shift does account for a proportion of the upward cost pressures, it is because of the way that the existing system responds to it, rather than the phenomenon *per se*.

Ageing is chronic, and our health care system is set up to deal with acute care. While the Manitoba government deserves congratulations for its initial steps toward changing this, the elderly are still too often being cared for in acute care hospital beds instead of in personal care homes or with an array of home care support services. The latter is far less expensive, as well as being a more appropriate form of care for the elderly.

Doctors

Doctors' fees and salaries combined now account for about two-thirds of total health care expenditures in Manitoba. There is no easy or quick response to this cost driver. One long-term possibility is a salaried system for physicians. Another is a delivery system in which other health care professionals, working with physicians in teams, perform many of the diagnostic, counselling and treatment functions now the exclusive prerogative of the physician. There are studies and pilot projects that demonstrate that this is not only possible, and less expensive, but also a more effective form of patient care. Privatization is touted as a response to this difficulty, but private provision does not deflate physician remuneration (the opposite in many instances).

Hospital costs have remained fairly constant. Even so there are savings and improved care that could be realized over the long term by moving to a system that relies less on acute care and more on primary and community care, early diagnosis, health promotion and prevention. A comprehensive network of community health clinics, utilizing professional teams, total patient care, research into environmental health, and health promotion could be the primary link and referral source to the acute care system of hospitals.

Similarly, health care reform must take into account the broader determinants of health. Low-income people disproportionately enter the health care system at the acute care stage. In other words, in the most expensive way possible. Reduced inequality, new housing and job creation initiatives, better child care, and improved environmental health all must be feature in an effective, long-term strategy to reduce the stresses on the health care system.

Hysteria about the state of the health care system is leading too many politicians in exactly the wrong direction: privatization. This would do nothing to address the real, immediate cost pressures. Climbing drug costs illustrate how those sectors

of health care that are in *private* hands are the ones that are driving up health care costs. Why would we contemplate more privatization when it is the private sector that is already a major part of the problem?

In the longer term, a major part of sustainable health care reform must include a move from acute care to community and preventative care. Yet privatization works against this: for the private sector, the lucrative areas are all acute care, including drugs, surgery, and hospitals.

Gary Doer has pledged to tell the other premiers at their conference this weekend that a publicly funded, universal health care system is the best and most sustainable in the long run. If he is successful in making the case for Manitoba's seven priorities, his will be a vital contribution in a climate of exaggerated fears.

—Peter Hudson

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