CCPA-MB

FAST FACTS

Canadian Centre for Policy Alternatives-Mb • 309-323 Portage Ave. • Winnipeg, MB • Canada R3B 2C1
ph: (204) 943-9962 • fax: (204) 943-9978 • ccpamb@mb.sympatico.ca • www.policyalternatives.ca/mb

September 17, 2002

Medically Necessary, Economically Possible

The question of which treatments, procedures, or equipment are "medically necessary" — and therefore should be covered by medicare — is medically and philosophically complex. And eventually any decision as to what is deemed "necessary" must be measured against what is economically feasible. However, working without an honest and accurate assessment of economic reality does not make the task of answering that question any easier—instead, it only artificially limits our choices.

Currently a lot of what passes for thinking about what is medical necessary is nothing more than going over which services to de-list in order, we are told, to make up for shortages of technology on the one hand and the need for user fees, MSAs, and for-profit medicine on the other hand — all because health care spending is out of control and we can no longer afford the system we so cherished.

There is much more economic room to move than medicare opponents would have us believe.

In reality, health care spending is not out of control. And, while we always have to make choices with respect to how to spend our health care dollars, our room to manoeuvre is as great as ever. In order to make informed, humane, and responsible decisions about what is medically necessary—and take advantage as much as we sit fit of that room to manoeuvre — we need to understand what is driving our health care costs up and the revenue we spend on it down.

Costs

For 20 years Canada has spent approximately 9% of GDP on health care—and the situation is no different now. There is no crisis; or, if there is, it is a "crisis" we have dealt with for a generation.

Let us consider where costs have grown. One of the major problems with deciding how well the Canadian system is doing is that we need to be clear as to what it has been set up to do and what it has not been set up to do. The Canadian health system is mandated to control three subsectors: hospitals, physicians and administration — *not* other subsectors such as dental care, pharmaceuticals, long-term care, medical devices, and so forth.

According to the Canadian Institute for Health Information, the share of total expenditure spent on hospitals is forecast to have fallen from just over 45% in 1976 to around 31.5% in 2001, a drop of 13.7%. The share of total health expenditure on physician services has declined gradually over the past decade, from 15.4% in 1991 to a projected 13.5% in 2001.

Expenditures have not increased when it comes to the publicly controlled hospitals, administration and physicians. In fact these costs have been stable or even fallen for thirty years.

Drugs: A Real Cost Driver

So where have costs increased? Significantly, drugs. The deregulation of Canada's drug industry has led to spectacular increases in the costs that were once among the lowest in the industrialized world.

From 9% in 1984 the share of total health expendi-

ture spent on drugs is forecast to have been 15.2% in 2001. We spend more on drugs now then we do on doctors. Are these drugs worth it?

Advocates suggest they are worth what we spend on them because they pay for themselves by saving on hospital and physician costs. As well, some argue that without large profits, drug companies would have no incentive to undertake the research necessary to develop new drugs.

A recent research report tells us why these arguments are not supported by the facts. The National Institute for Health Care Management (NIHCM) in the United States reported in May of 2002 that, after analyzing the Food and Drug Administration's approved 1035 new drug applications for a twelve year period from 1989 to 2000, it concluded that in 85% of the cases the new drugs do not provide significant improvement over currently marketed therapies. According to the NIHCM, brand manufacturers have flooded the market with product line extensions (known as "evergreening" in the industry) in response to perverse incentives related to changes in patent laws and advertising regulations that do not serve the consumer or public interest. The disparity between spending on these drugs and their clinical value means less money available for other more useful medical interventions. There are billions to be had here for additional medical interventions.

In Canada, successive Tory and Liberal administrations rewrote patent laws, extending the period of patent protection and restricting access to lower priced generic drugs. The extension of patent protection was justified on the grounds that we needed to encourage the multinational drug companies to do more of their research and development in Canada. In other words the cost of higher drugs would be offset by the multinationals willingness to increase Canada's role in the knowledge economy. The problem with this strategy is that if these new drugs drive costs up without improving our health or saving resources, it is the equivalent of paying people to dig holes and fill them in again. If anything is out of control, it is the health expenditures that the health system pays for but over which it has no control.

Revenues

We cannot judge sustainability on the cost side alone. Our public health care system is funded through taxes. Under the program carried out by then-Finance Minister Paul Martin through much of the 1990s, program spending and income taxes fell — in some cases to the lowest level in fifty years. Yet at the same time the federal government supported the argument that medicare is in crisis. Provincial governments followed suit. Alberta, for example, has cut Health spending as a proportion of GDP to the lowest level of all the provinces, while complaining the loudest about the unsustainability of the program.

This approach of cutting taxes and then pleading funding crisis has consequences that go beyond simply being unable to provide Canadians with the quality of health care for which poll after poll shows they are willing to pay. Public health care offers Canada a distinct competitive advantage. The attendant huge savings on employee health insurance is a key incentive for auto manufacturers, among others, to locate plants in this country. That advantage is being eroded; according to analysis prepared by the consulting firm KPMG, if we continue to reduce our taxes, there will be no money for our health care system that provides an advantage to our economy by making health care cheaper than the American system.

If we stop wasting our health dollars and giving away tax revenue without good reason, we can have more technology if we think it is necessary, we can shorten our surgical waiting times if that is necessary—but what is absolutely necessary is that we don't destroy our cherished universal health care system first.

—Robert Chernomas

Robert Chernomas is a health economist at the University of Manitoba and a Canadian Centre for Policy Alternatives-Manitoba Research Associate.

CCPA-MB *FAST* FACTS

are produced and distributed by fax on a regular basis.

They can be reproduced as an OpEd or opinion piece without obtaining further permission, provided they are not edited, and credit is given.

If you would like to receive the *FAST* FACTS, please contact the CCPA-MB to begin your free subscription.

Canadian Centre for Policy Alternatives-Mb
309-323 Portage Ave.
Winnipeg, MB
Canada R3B 2C1
ph: (204) 943-9962
fax: (204) 943-9978
ccpamb@mb.sympatico.ca
www.policyalternatives.ca/mb