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The Liberals' health plan: senseless, shortsighted

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Seth Klein, the BC Director of the Canadian Centre for Policy Alternatives, recently spoke to the Canadian College of Health Care Executives, BC Lower Mainland Chapter about health care policy in British Columbia. In his presentation, he outlined the weaknesses in the government's reform approaches. The following are some excerpts from his presentation.

here is a false economy underlying much of the current round of health care reform in BC, and that is that many of these cuts (I'm sorry, 'changes') don't actually control or save costs. They simply shift costs onto individuals, families and in some cases employers.

According to recent estimates by the Ministry of Health, about 13 per cent of acute care patients are only there because of a lack of long-term, rehab or community services. Therefore, the decision to decrease the number of long-term care beds, and to merely maintain current funding for home support, will mean more pressure on the acute care system, which as you all know, is already under great stress. Given demographic trends, there is a clear need for more long-term beds. 'Assisted living' spaces, while desirable, are no substitute. Assisted living is appropriate for some at some stages, but cannot replace long-term care.

Given this, the plans tabled by the health regions on April 23rd to reduce the number of acute care beds are simply not realistic, particularly given the fact that the number of acute care beds available in BC has already dropped by almost 40 per cent over the past 10 years (well in excess of what was recommended by the Seatton Commission in 1991, and without the needed commensurate investment in community care). BC now spends less per capita on hospitals than any province except Saskatchewan, and the latest cuts haven't even started.

Another example: With increased contracting-out of various services will likely come a decrease in quality. Lower wages are associated with poorer training and higher staff turnover. Estimated cost-savings from contracting-out rarely include the costs of administering and supervising contracts, which continues to be borne by the public system. And what is saved in lower wages generally goes to the shareholders of the private firm offering the service, leaving no real net savings to the public.

Other challenges stem from broader public policy changes.

For example: The Liberal tax cuts.

It needs to be said that, to the extent that much of the current dislocation, disruption and downsizing in the health care system is driven by an alleged need to cut government costs – this fiscal imperative is a self-inflicted crisis. None of this hardship needed to happen. It is almost entirely the product of the reckless tax cuts delivered last summer – a public policy choice with very real consequences. The Liberals campaigned on the promise that tax cuts would generate so much economic activity that they would pay for themselves, and no spending cuts would be needed. Even the government's own budget shows that the tax cuts won't come close to paying for themselves.

In its early days in office, the government blew a hole of over $2 billion in the provincial budget. The spending cuts and the health care freeze are merely about paying for those tax cuts. They are the other shoe dropping. This is important context for the debate on health care reform.

Bad health reform idea No.1: User fees.
The basic false premise behind this idea is that if people are charged a modest fee for service, frivolous usage will decrease and a new income stream will open, thereby saving the overall system money.

The core problems with the idea are:

1) Doctors have much more influence over usage than patients do.

2) The theory behind use-fees is that, under the law of supply and demand, consumption will decrease when the price increases. The problem is that we consume health care not because we want it, but because we need it.

3) The research indicates that patients are poorly equipped to tell the difference between necessary and unnecessary treatment.

4) The research on user fees shows that those who are primarily sensitive to user fees are the poor, and when they face user fees may avoid needed as well as unneeded care. If, however, one tries to build into the system a threshold to exempt low-income people, the added administrative costs wipe out any hoped-for savings.

Consider this simple fact: it is that part of the health care system that is fully public hospitals where spending has remained most stable. There has been no change in spending on hospitals relative to GDP since the 1970s. In contrast the part of the health care system that has experienced the greatest increase in costs is drugs, which is largely private, and where large user fees are the norm.

Bad health reform idea No. 2: Privatization, or for-profit delivery
This approach fails the tests of both efficiency and equity. It fails the efficiency test because so much money is lost to administration, duplication of service, marketing, fragmentation and the loss of system-wide co-ordination, and, of course, to profits.

Privatization also fails the test of equity, not only because low-income people cannot afford insurance, or because those with precarious employment do not have employer plans, but also because those with chronic, or, increasingly, genetically-predisposed problems, will face prohibitive premium costs.

So what about the Alberta model? That is, public funding but private delivery. What's wrong with private delivery if the funding stays public?

There are many things the private sector does well. It makes exciting computer games, produces food and clothing, builds homes, services appliances, and it makes a pretty good donut. But the private sector doesn't do health care well and the research evidence on this from around the world is unequivocal.

A key difficulty with all these private options is that with health care, unlike with conventional commodities, there exists an imbalance of information.

If you have a splitting and persistent headache and you go to see your doctor, and she says, "you need an MRI," who are you to argue? How do you know a strong painkiller won't do the trick? The imbalance of information means we are incredibly dependent on doctors to control costs.

What happens if that doctor making the diagnosis is working at a private hospital? Inevitably, the doctor is in a conflict of interest. Why? Because the best interest of the patient and the public system may be at odds with the interests of the institutional shareholders who own the hospital and want a high rate of return, it means prescribing the most expensive form of treatment so long as the public is picking up the tab which drives up health care costs.

The key is that private hospitals are inevitably less efficient than public ones. Here's why:

Say we have $100 in public health dollars. If that is directed towards private hospital, right off the top there are institutional investors who demand 15 per cent rates of return (The profits.) Investors also demand growth of about 15 per cent annually, leading to more built-in pressure to drive up costs. Then there is the fact that private sector top executives generally command salaries much higher than the public sector. Then there are the private costs of marketing, processing claims, corporate expansion and take-over strategies and lo and behold if you're lucky, the $100 you stated with is now only $70. What's more, while you might have been able to care for three people with the original $100, now you only have enough to care for two, leading to growth of waiting lists.

Bad health reform idea No. 3: P3s (Public-Private Partnerships)
At its root, the issue with P3s is simply about who holds debt. Any time a capital project is to be undertaken, the money almost always must be borrowed. But governments, mainly because of the success of groups like the Fraser Institute, fear taking on debt. With P3s, they leave that task to a private firm, and then they simply lease back the services on an annual operating basis. The private firm takes on the debt, and the debt stays off the government's books.

The government is still paying for the capital costs, however, only the financing costs are built into the annual rents. The irony is that private firms always face higher financing costs than governments do.

But beyond the issue of money, there are issues of accountability. In the event of a problem with the project or services, who is responsible the public authority, or the private firm? And to whom will the private firm feel its principle responsibility the public or its shareholders?

The experience with the Private Finance Initiative in Britain is telling. According to the British Medical Journal and other reputable British publications, P3s in Britain have been plagued by shoddy construction standards and huge cost over-runs, which have siphoned funds away from patient care services. The Journal also noted that costs for these private facilities are 18 to 64 per cent higher than conventional public hospitals.

Bad health reform idea No. 4: Medical Savings Accounts
This is similar to the private voucher system the Fraser Institute and others proposed for education. It involves some or mostly public funding and then individuals are free to shop around to various providers. Private advocates like it, because it opens the door to unlimited private delivery, with the associated profit potential. But it raises many questions. In particular, what happens to people whose health care requirements exceed the money available in their MSA accounts? It is an approach that discriminates against the sick and old and poor who face high health costs. This approach is also incredibly and unnecessarily complicated. It is a case of the cure being far worse than the ailment.

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