Canada: Public and Private Health Care

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The Canadian public health care system and privately sponsored group health care programs have enjoyed a complementary relationship for many years. The public system has provided full access to basic health care, while private plans have stepped in to cover the cost of supplementary services for their plan members. However, this relationship is changing. As provincial governments struggle to hold the line on spending, and private plans find themselves shouldering a growing share of health care costs, privately sponsored group health care arrangements are beginning to redefine their role and take a more active approach to managing their plans.

PUBLIC HEALTH CARE

Canada is recognized as a pioneer and leader in developing and providing quality health care coverage to its residents. Next to the United States, Canada spends more money on health care than any other country in the world*. The Canadian Health Forum reports that the cost of health care in Canada is paid primarily from public funds (about 70-75%), with the balance paid by the private sector.

The Canada Health Act ensures that all residents of Canada have equal and affordable access to high quality hospital and physician services. The Act requires that all Canadian provinces and territories adhere to five major criteria in providing health care insurance to residents in return for transfer payments from the federal government. These five criteria are as follows:

Public administration. The administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority.

Comprehensiveness. All medically necessary services provided by hospitals and doctors must be insured.

Universality. Every insured person in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions.

Portability. Coverage for insured services must be maintained when an insured person changes address, travels within Canada or travels outside the country.

Accessibility. Reasonable access for every insured person to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

PRIVATE HEALTH CARE

Privately sponsored Canadian health care programs existed before the enactment of the Canada Health Act in 1984, the Medical Care Act of 1968 or even the Hospital Insurance and Diagnostic Services Act of 1957. However, most of today's privately sponsored health care programs have evolved around the benefits provided under the public health care system. In fact, it is illegal for any private health care insurer or provider to reimburse an expense that would otherwise be an insured item under the provincial health care insurance programs. The way the two systems interface is shown in Table 1 overleaf.

Many working and retired Canadians and their families have access to privately sponsored group health care coverage provided through an employment or association arrangement. More often than not, the intent of this coverage is to enhance or supplement health care coverage available under the provincial plans. Thus, most privately sponsored health care plans are referred to as "supplemental" or "extended" health care plans.

These supplemental plans provide coverage for such items as prescription drugs (when ineligible under the public plans), ambulance services, private-duty nursing, paramedical treatments (e.g., treatment by a psychologist, chiropractor or massage therapist), and miscellaneous medical services and supplies such as crutches, wheelchairs and blood glucose monitors. Many plans also include coverage for out-of-Canada emergency medical treatment, vision care (glasses or contact lenses) and dental treatment (cleanings, fillings, crowns, bridges and orthodontics).

PUBLIC AND PRIVATE HEALTH CARE RELATIONSHIP

The relationship between the public health care system (often considered first payer of medical expenses) and group private health care plans (often considered a supplemental health care source) has worked well in the

* 9.3% of gross domestic product in 2000, according to Statistics Canada

TABLE 1 **What Costs are Covered under the Public and Private Group Health Care Systems**

	Public health care	*Private group health care*
Hospitalization	Cost of standard ward room rate	Cost up to semi-private or private ward room rate
Physician services	Cost of general practitioners and specialists	Uninsurable
Drugs	Cost of drugs while in hospital. In some provinces, cost of drugs outside hospital after annual deductible is satisfied and/or some portion of costs for seniors and welfare recipients	Cost of drugs that are not insured under public health care system
Nursing care	Cost of hospital nursing	Cost of private home nursing
Paramedical practitioners	Cost per visit up to specified annual maximum	Extra billing and costs in excess of public annual maximums

past, despite the absence of any kind of formal working relationship or partnership. Indeed, any attempt to coordinate the efforts of the 10 provinces and three territories (the administrators of public health care) with the thousands of group health care plan sponsors and hundreds of insurers, providers, administrators and consultants, would present a very daunting (not to mention politically risky) task for the country's leaders.

CHALLENGING TIMES

Even the enviable Canadian health care system is not immune to the kinds of pressures facing public and private health care sponsors throughout the world. Health care costs have skyrocketed, the population is aging, and the Canadian insurance market has gone through significant restructuring. Technology has changed everything, from the way benefits are being delivered to people, to the speed at which new, very expensive drugs are being developed and brought to market.

From a national perspective, Canada's current public health care delivery system cannot keep up with the demand. Waiting lists are long and people are getting impatient. To alleviate the pressure, some Canadian provinces have allowed private medical clinics to offer specialized treatment for those who can afford to pay. Advocates of the Canada Health Act are crying foul. They say these provinces are not complying with the five criteria and should not be eligible to receive federal cash transfer payments.

In an effort to resolve the issue, Jean Chrétien, Canada's Prime Minister, recently appointed former Saskatchewan Premier Roy Romanow to lead a commission on health care (Saskatchewan is the birthplace of universal health care in Canada). Romanow's commission has begun its fact-finding mission with a mandate to identify the long-term challenges of maintaining a public, universal health care system in Canada and to recommend policies and programs to balance health maintenance with care and treatment. The report will be presented in November 2002.

HEALTH CARE COSTS

Based on information adapted from Statistics Canada (see Figure 1 opposite), in 1996 Canada spent C$75.2 billion* on health care expenditures. That number grew by 26% to C$95.1 billion for 2000. Annual health care inflation over the past five years has averaged 6% versus typical annual inflation levels that range from 1.5% to 2.5%. Insurers of private health care plans are typically applying overall annual inflation factors of 12-18% to keep up with rising costs.

PRESCRIPTION DRUG TRENDS

Prescription drug costs alone have increased from C$4.4 billion in 1985 to C$15 billion in 2000 and the trend is expected to continue in the future. New, better and more expensive drugs are making it to market faster than ever before, thanks to advances in biotechnology. Canada's insurance market is using what appears to be a baseline annual trend factor of 15% for drug expenses, with the opportunity to adjust it upward based on a private group's actual drug claims experience.

In a five-year review of prescription drug transactions (1996-2000), BCE Emergis Assure Health, the largest provider of pay-direct drug services to privately sponsored health care plans in Canada, found the following developments:

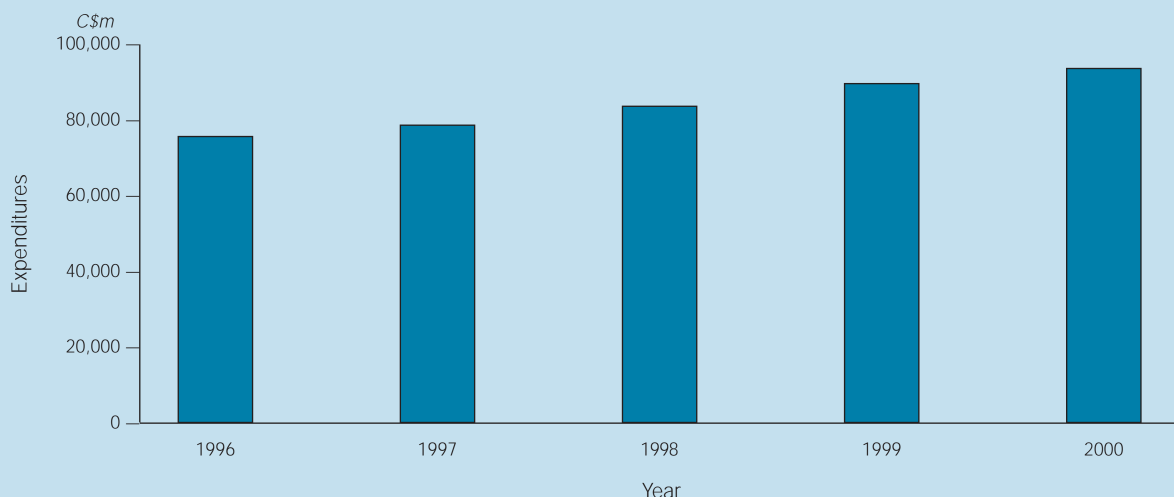
Costs. Average eligible drug costs increased by 19% from 1996 to 2000.

Utilization. Utilization increased by 45% from 1996 to 2000 (even after adjusting for a shift in customer base).

* £1 = C$2.27; €1 = C$1.41; US$1 = C$1.59 as at 16 November 2001

FIGURE 1

Canadian Health Care Expenditures (1996-2000)



NOTE: Health care expenditures include spending by federal, provincial and local governments, workers' compensation boards and the private sector.

Source: Adapted from Statistics Canada data

Expensive treatments. Five percent of members accounted for approximately 30% of total drug costs, suggesting, along with several other statistics, that new medications are having a significant impact on overall drug costs.

AGING OF THE POPULATION

The fact that the Canadian population is aging only compounds the impact of drug developments on overall health care costs, especially when prescription drug expenses typically represent 65-75% of overall private group health care costs. The BCE study shows that the average monthly cost of prescription drugs for members between the ages of 50 and 59 is 50% higher than the cost for members between the ages of 40 and 49.

Earlier this year, the Canadian Institute of Actuaries submitted a paper to the Standing Senate Committee on Social Affairs, Science and Technology. One of the conclusions outlined in the paper, entitled "Health Care In Canada: The Impact of Population Aging," is that age is but one factor that is driving the rising cost of health care. The paper makes references to an additional actuarial study that concluded, ". . . at ages over 65 health care expenditure in a year (HCE) depends on remaining lifetime, but not on calendar age."

Another critical influence on health care costs in Canada has been the introduction of new accounting legislation for non-pension post-retirement liabilities, such as retiree health care insurance. Before 2000, most companies used a pay-as-you-go method for funding post-retirement health care costs. With the introduction of the new rules in January 2000, companies were required to book significant future post-retirement health care liabilities. Once again, with an aging population, those liabilities, along with the annual cost of post-retirement benefits, are expected to increase significantly.

DE-INSURING PUBLIC HEALTH CARE COVERAGES

One of the more important trends contributing to private plan costs involves a concerted effort by the provinces to offload or de-insure various health care expenses, as the following three examples demonstrate:

- In Quebec, legislation was introduced in 1996 requiring any employer that offers employee benefits to provide prescription drug benefits to all employees, subject to mandated minimums.
- In Alberta, the provincial government recently approved the opening of a private clinic providing user-pay MRI* services. Before 2000, these services were only available through the public system.
- Several years ago, the province of Ontario discontinued paying for out-of-country prescription drugs that were administered in hospital. In 2001, the cost of physicians administering physical therapy was also de-insured in Ontario.

De-insuring these and other public health care expenses has contributed to the sharp increase experienced by most (if not all) private group plan health care sponsors. However, some industry experts believe that the most significant factor in transferring costs from the public to the private sector is not so much in de-insuring health expenses, but in the changing manner in which the public system delivers benefits. For example, medical authorities are on record as saying that in an effort to manage costs, where medically appropriate, hospital stays are being shortened (or, in some cases, dispensed with altogether). Discharging someone from the hospital early or providing out-patient treatment

* magnetic resonance imaging

certainly saves the system money, but it also means the public sector has been successful in transferring the financial liability to the private sector. The prescription drug that was to be administered to the patient in hospital is now being prescribed to the patient on his/her way out of the hospital door, only to be submitted as an expense under a private group health care plan.

THE CHANGING RELATIONSHIP

Historically, the private group health care sector has taken its cues from the public health care system. More often than not, private plan sponsors have filled the breach when public plans have changed policy, have reduced covered expenses, or have de-insured previously covered medical expenses altogether. In exchange for accepting this transferred health care liability, privately sponsored health care plans have largely avoided restrictive legislation or adverse tax consequences. Once again, this is changing. Bill 33 in Quebec requires prescription drug coverage if benefits of any kind are extended to members. Recent changes to the Alberta Insurance Act require disability plans covering Alberta residents to be insured if they provide benefits of more than two years' duration (with certain very restrictive exemptions). This poses a serious challenge for many self-insured disability plan sponsors, especially national plans with only a small number of Alberta members.

With costs continually on the increase, emerging legislation and a public system that seems intent on passing the buck, Canadian plan sponsors are beginning to realize that a passive approach may not be the most effective management strategy. They are also beginning to realize that group benefit plans (including health care) are a significant component of overall compensation, and should be positioned to reflect this reality.

ACTIVE PRIVATE HEALTH CARE PLAN MANAGEMENT

A history of passively following the lead of the public health care system is no longer the norm in Canada. Canadian employers and plan sponsors are not waiting for the public health care system to make its next move so that they can respond. Some of the interventions that plan sponsors are undertaking to create a more active approach to managing health care and other benefits include the following:

Aligning benefits with business strategy. More and more, plan sponsors are reviewing their benefit programs and reassessing their role as either plan facilitator or plan guarantor. Their goal is to determine how well the plan design aligns with the business objectives of the organization. This process may involve a wholesale redesign of employee benefits, such as the introduction of a flexible benefits program, or it may simply mean some fine-tuning.

Heightening employee perception. What do plan members view as important? Do they have any idea of the cost of health care and other benefits? More often than not, plan sponsors do not know the answers to such questions. Plan members are an invaluable source of information and input. It is often said that a well-communicated but poorly designed benefits program will receive higher marks from members than a poorly communicated but well-designed benefits program. Plan sponsors need not overspend, enhancing or adding benefits. In fact, successful plan sponsors may seek to increase member appreciation of the health care plan while maintaining, or even lowering, current health care expenditures. Educating members so that they become "smart consumers" rather than simply "users" can have an exponential financial impact on health care plans. Plan sponsors are beginning to learn that it is acceptable to relinquish control of the health care budget when members have a personal, vested financial interest in the outcome of their own individual benefit choices and expenses.

COST CONTROL AND COST CONTAINMENT

Once a plan sponsor has identified its strategy for health care benefits, and member input has been collected and processed, it is appropriate to consider how best to deal with rising health care costs.

Some plan sponsors may determine that health care cost increases are simply beyond their control. Others, who have undertaken a review of their business and benefit objectives, may have determined that health care cost increases are part of the cost of doing business, and represent a valued component of compensation. The reality is, however, that most plan sponsors are genuinely concerned about costs. Below are some of the strategies that Canadian private health care sponsors are currently employing to achieve cost control or cost containment.

Cost Control

A significant number of defined benefit pension plans have been converted to a defined contribution basis in Canada over the past 10 years. A similar strategy is being adopted by many private group health care plans. Establishing a threshold of financial commitment or liability has enabled many plan sponsors to avoid future cost increases. However, unless the delivery of health care benefits is changed in conjunction with introducing the defined contribution approach (such as the introduction of flex plans), the move will only succeed in transferring the ultimate future financial liability of the health care plan from sponsor to member.

On a less grandiose scale, many private group health care plan sponsors are introducing cost control measures such as prescription drug dispensing fee caps and other internal annual maximums. Another form of cost control might be to freeze all benefits under the private plan at a given point in order to avoid the potential of inheriting more de-insured health care expenses from the public health care system.

Cost Containment

The notion that a plan sponsor can change the environment within the private group health care plan to the extent that costs are contained, and thus more manageable, is a different and, perhaps, more challenging approach than simple cost control measures. There are, effectively, two ways in which cost containment is achieved:

Plan design. Health care benefits can be constructed to influence behaviour, promote "smart shopping," and separate the "wants" from the "needs."

Education. A properly designed cost containment initiative needs to be supported with the appropriate

amount and level of communication. Technology has made the task of communicating what might otherwise be considered a complex program much easier.

Of course, the funding level of a health care program is the cornerstone of any cost containment initiative. Most flexible benefit programs have elements of cost containment built into the framework of the program.

Other examples of cost containment initiatives include the following:

Post-retirement health care redesign. The financial impact of revising health care benefits for future retirees is a priority for many Canadian plan sponsors. In some cases, millions of dollars in future liability can be saved through a post-retirement health care redesign. For both cultural and legal reasons, however, post-retirement plan redesign projects often do not impact those who are currently retired or close to retirement age.

Managed prescription drug formularies. In order to avoid or control the cost of emerging prescription drugs under privately sponsored health care programs, some plan sponsors have turned to managed prescription drug formularies. A managed formulary sets out to define a list of drugs eligible for reimbursement under a private health care plan. New drugs, which are often very expensive, are not automatically added to the list, giving plan sponsors some control over eligible prescription drug expenses. Of course, for every prescription drug plan that is deemed ineligible, the plan sponsor may open itself up to criticism and the possibility of a human rights challenge.

Cost sharing. This is one of the oldest methods of containing costs and also the most difficult to communicate or "sell" to plan members. That said, many plan sponsors have no choice but to increase cost sharing on health care premiums by introducing or increasing annual plan deductibles, or lowering plan reimbursement. With non-pension benefit plan costs creeping into the double digits as a percentage of annual income, some plan sponsors are going even further and adopting a user-pay approach whereby the level of cost sharing is determined by how much the plan is used.

CONCLUSION

The relationship between the public health care system and private health care plan sponsors is changing. What was once a civil, passive synergy, on the model of universal health care operating shoulder to shoulder with the private sector, has become an uncoordinated scramble to offload, reduce and avoid the effects of rising health care costs.

While awaiting the release of the Romanow commission report on public health care in 2002, sponsors of private health care programs in Canada need to ask if they are prepared for what the future holds. The option of tendering their program to the shrinking, demutualized Canadian insurance market will not solve these cost problems. If private health care plan sponsors really want to take a proactive approach to cost control, the process must begin with managing their programs so that they have a fighting chance in the face of spiraling health care costs. Ω