Alternatives North

RESPONSE TO THE SUPPLEMENTAL HEALTH BENEFITS PAPER – A CONVERSATION WITH NORTHERNERS

Prepared by

Alternatives North

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Background

Alternatives North is a territorial social justice coalition based in Yellowknife. Its membership includes church, labour, women, anti-poverty and environmental organizations as well as individual citizens.

This critique is in response to the GNWT's discussion paper on supplemental health benefits released in March 2010.

Outline of Document

In its document, the GNWT reviews the current programs for supplemental health insurance in the NWT for non-Métis and non-Aboriginal residents. Currently, the program offers benefits to northerners with specified conditions, to those 60 years of age and over and to those on income assistance. Supplemental health benefits include prescription drugs, medical equipment and supplies, limited dental and vision care and ambulance and medical travel. The document presents an overview of the rising costs of the program, the number, location and income level of users, the conditions associated with claims and the types of claims that are most common. It also discusses employment based insurance coverage. It suggests the use of co-payments as a method for partially financing the program.

The overall cost for supplemental health benefits for seniors, people with specified medical conditions and indigent populations was $6,190,637 in 2008/09. Program costs have increased at the annual rate of 6.3% for the last five years while cost of living annual growth has been 2.2%.

In a presentation made after the release of the document, the GNWT released tables that suggest starting a co-payment at net income levels of $30,000 or $50,000.

Comments

Health Services

The GNWT's supplemental health benefits discussion paper begins with a description of Insured Health Services as described by the *Canada Health Act*. Erroneously the paper asserts that these services are "free". On the contrary, Insured Health Services are paid for out of tax dollars and are a highly regarded Canadian social program. They include lab and x-ray tests, drugs given in hospital, standard hospital room and nursing services, radio therapy and occupational therapy and physiotherapy at approved locations.

Of note, the NWT receives funding under the Canada Health and Social transfer. This funding is not tied to the provision of insured services only.

The use of the word 'supplemental' to describe the benefits covered might suggest they are secondary in importance. However, practitioners and users recognize the key role pharmaceuticals, glasses, dental care and medical supplies and equipment such as walkers and dressings can play.

Though they are not strictly covered by the *Canada Health Act*, it was always the intention of Tommy Douglas, the founder of Medicare, to widen the scope of services covered.

Cost of the Programs

The supplemental health insurance program takes up approximately 1.9% of the overall health and social services main estimates for 2009/2010 ($324,982,000).[1] The GNWT states that the program must be changed because its costs are unsustainable. It does not state what presumably lower level or percentage of expenses would be sustainable. It does not link the deemed 'unsustainability' to any analysis of the GNWT's future financial position, nor consider the likelihood of increased revenues. Projections of increased costs must be married to predictions of future resources if the rationale of unsustainability is to be justified.

Number of Claimants

The document notes that the number of users is rising. The number of claimants in the specified conditions category has had an average annual growth rate of 1.2%. The number of claimants in the seniors' category has shown an average annual growth rate of 8.3% over the last five years. The increase in the number of senior users also reflects an increase in the number of seniors who are staying in the north. This is surely a goal that the NWT wants to support since the GNWT has repeatedly stated its interest in increasing our population. There is the obvious benefit of the transfer payments we receive that are based on our population. Has the GNWT done a cost-benefit analysis of the costs of losing transfer payments versus anticipated savings from co-payments? Given that this is a time when our population base is shrinking, it would appear misguided to make benefits more difficult to obtain, probably worsening the trend of a decreasing population. The appeal of universal access applies to all populations.

[1] Budget Address 2010-2011; Fiscal Review, Summary of Operations Expenditures by Department.

Lack of Coverage

The document rightly notes that there are individuals and families living in the NWT who do not have access to NWT funded supplemental health benefits, nor to employment-based insurance programs. Neither the number of people involved nor the amount of money they spend on supplemental health insurance is known, though this analysis is essential. The document states the GNWT is interested in making supplemental health benefits available to all northerners. Alternatives North agrees with this goal. The document does not present any estimation of the cost of making the supplemental health program accessible to people who do not have coverage.

The Problem with Co-Payments

The document suggests that the practice of requiring a co-payment for people above a certain income level be instituted. The tables provided suggest a net income threshold of $30,000 or $50,000 (increasing with number of children). The co-payment amount would be progressive in nature, starting at 20% and increasing to 60%. There is no yearly ceiling level or cap on the summative amount of contribution on the part the claimant.

The problem with co-payments or premiums is that they place a burden for funding a program on a specific sector – that is, people with health problems and chronic conditions already needing to access the service. Social and health programs are fairest and most successful when paid for by everyone through a progressive tax system. If we limit who pays, we place more financial burden on them. We don't plan or choose when we are going to be sick or become disabled or give birth to children with disabilities or chronic conditions. And as stated before, internationally and in Canada's own history, the evidence clearly shows that programs that are not universal soon lose a critical overall public support.

The prime example of this was the national family allowance program established in 1945 as part of the government's attempt to support families and keep Canadians out of poverty. This program provided support to Canadian families with children for four decades until it was abolished in 1992. Although it did not keep up with the cost of living and in the end was not providing significant amounts of funding, its abolition still had an important impact. McQuaig observed that cancelling this program moved us away from a European 'social support' approach to an American 'targeted' approach.

> "The reason targeted programs don't work, according to many analysts, is that it is difficult to maintain political support among the population for programs that only benefit a small portion of society. On the other hand, if taxpayers feel that a program offers important

> benefits for themselves and their family members, they are more willing to support it – even pay more taxes to maintain."[2]

The *National Child Tax Benefit* is a distant imitation of this program. It has repeatedly been attacked by arguments over who 'deserves' to receive it and when it should be clawed back from recipients because they are receiving other support.

Bob Evans, an economist who specialises in health care issues, raises an equity argument against the imposition of co-payments in the health system when he observes, "The introduction of user charges shifts part of the cost burden from those who pay taxes to those who use care."[3] Why should the cost of insuring more people under the program fall to users and not to the general population? It is essentially a tax on the sick. We pay taxes for other services we are not using (or maybe have never used) – schools, police, fire fighters, etc. But who would want to be without these services? Collectively we decide these services are important to everyone in the community and so we fund them. In fact, the main beneficiaries of the implementation of co-payments are the healthy and the wealthy that don't pay enough taxes to fund universal coverage.

> "When such costs are shared by everyone, they are affordable…. When we all protect each other, all of us are protected. When some of us are excluded from the burden of taxation or from the protection of universal programs, whether we are wealthy or poor, the social fabric unravels and none of us is safe."[4]

Michael McBane, executive director of the Canadian Health Coalition says: "If it is not universal, it will be inferior."

In previous work Alternatives North noted that the tax system is the best method for ensuring that "the cost of social and health programs is borne by those who can afford to pay"[5]. The tax system is progressive and as it is already established, it does not require another system for means testing.

And Canadians, including northerners are prepared to pay for better health care services.

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2 The Wealthy Banker's Wife, Linda McQuaig, Penguin Books, Toronto, Canada, 1993
3 Who are the Zombie Masters, and What Do They Want? Robert Evans, Health Policy Research Unit, Centre for Health Services and Policy Research, 1993.
4 Tax on the Sick: A Violation of a Social Contract, Lynda Sommerville, 2008.
5 Improving Access to Health Care in the NWT, A critique of the proposed GNWT Supplementary Health Benefits for NWT Residents, February 2009

> "Canadians consistently rate public health care above tax cuts but governments across the country have instead focused on tax cuts at the expense of health care affordability."[6]

Income Levels

As per GNWT tables, co-payments would be based on pre-identified net income thresholds of $30,000 or $50,000 with increasing thresholds depending on the number of children. The establishment of income ceilings after which co-payments will be required is arbitrary at best. The $30,000 threshold is drastically too low and unacceptable.

The document does not indicate how income levels would be determined. The use of the prior's years income tax documents as a basis for determining income level is one method of establishing income level. However, the data obtained from this does not necessarily reflect the current situation. Retirement, illness and loss of employment are examples of factors that could greatly change an individual's income level. Accommodating such factors, although fair and justified, would be problematic and expensive to manage. Failing to do so would not be acceptable. Furthermore, going through income testing can be a humiliating and demeaning experience for people.

Significant extra administrative costs would be required to determine actual income levels. Claimants on income assistance already undergo income testing. However, the total number of claimants who would now require income testing is 3,101 (not including new claimants). There is no estimation of the administrative cost of obtaining this information. As the situation of our American neighbours shows us so clearly, the administrative costs of making financial transactions a precondition for receiving health care places us at risk of putting more energy into managing the financial system than delivering care.

Moreover, income level is only one factor to consider in determining ability to pay. Unequal access to family income, debt level, housing situation, community of residence and child care expenses are among the other factors that need attention.

Impact on Patients and Practitioners

Obtaining co-payments will put more stress on both patients and service providers. What will be involved in registering for the program and having your income level screened? Will factors such as illiteracy or isolation make it more difficult for patients to gain access? Do you consider the cost of living in the community where it is paid?

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6 Changing the Landscape in the Health Care Affordability Debate, Medicare Facts, Myths and Problems. Diana Gibson, Lorimer Press, 2007.

What if people are not able to pay or refuse to pay? Will treatment be withheld until the co-payment is made? Will this result in inefficiency and extra appointments because the treatment could not be provided on the initial visit? Will conditions worsen for those who don't get treatment and ultimately require more intensive emergency department or hospital based treatment? There are many factors that would need to be considered before we go down that road.

A study in Québec that reviewed the impact of a new drug coverage policy that required co-payments by seniors confirms our concern about the impact of cost-sharing. "In our study, increased cost-sharing for prescription drugs in elderly persons and welfare recipients was followed by reductions in use of essential drugs and a higher rate of serious adverse events and ED visits associated with these reductions."[7]

Standard of Coverage

The government document states that the NWT is more generous in its provision of supplemental health benefits than other regions of Canada. The problem here lies with the lower standards of the other regions, not with our level of coverage. Reduction of the level of benefits to the inadequate levels of other jurisdictions should not be a principle of NWT program policy. Doing so is nothing more than a race to the bottom.

The Role of Pharmaceuticals

The document outlines that the purchase of pharmaceuticals is the most frequent claim made by all categories of claimant (1432 out of 3907 claims for seniors). No actual costing of these claims is presented. Given that pharmaceuticals are a main driver behind the rising costs of health care overall (averaging 15% price inflation in each of the last 10 years), it is crucial to examine methods for curbing the costs of pharmaceuticals.

The GNWT has already established the use of a formulary of accepted prescription medications, a useful means of controlling drug costs. Another cost saving method to explore further is bulk purchasing. We note that at a recent Western Premiers conference there was agreement to begin development of a provincial-territorial joint purchase consortium aimed at reducing drug costs. This is a positive development. Rather than complacently accepting that the cost of drugs is uncontrollable (at the expense of other important services), all options should be explored to reduce the costs of medications.

[7] Adverse events associated with prescription drug cost-sharing among poor and elderly persons. JAMA, 2001, May 9: 285 (18);2328-0

Final Recommendations

Northerners have a strong tradition of helping each other out and taking care of our seniors. Changes to the supplemental health benefits program should reflect both of these values. Therefore Alternatives North supports:

1. universal supplemental health benefits coverage for NWT residents funded out of revenues from progressive taxation, not through co-payments;

2. simplification of the program description materials and of the registration process; and,

3. implementation of a drug purchasing program to decrease the cost of pharmaceuticals.

If the GNWT proceeds with the concept of income thresholds, it should choose the $50,000 option (or higher) and set a cap for yearly contributions by claimants for any supplemental health benefits.