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MLI

True North In Canadian Public Policy

Straight Talk

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Straight Talk: With Brett Belchetz

For the latest instalment of *Straight Talk*, MLI discusses medicare reform with Dr. Brett Belchetz, an ER physician who battles with the inefficiencies of Canada's medical system while treating patients on the front lines of health care delivery.

Brett Belchetz is a practising emergency room physician in Toronto, and a former management consultant with McKinsey and Company. He obtained his undergraduate degree in Statistical Sciences from the University of Western Ontario and his Doctor of Medicine degree from the University of Toronto.

Dr. Belchetz has been published multiple times in the *National Post*, *The Toronto Sun*, and *The Huffington Post*. He appears regularly as an on-air health and medical expert for *Sun News Network*, and for CTV's *The Marilyn Denis Show*.

MLI: Should Canadians be worried about their health care system?

Belchetz: They shouldn't be happy, and let me give you just one example. The Commonwealth Fund, a US-based think tank, recently compared the health systems of 11 of the most developed industrialized countries in the world. It was a really interesting survey because they looked at a number of dimensions, including patient outcomes, accessibility to care, cost of care – pretty much every dimension that people would think is important in terms of an effective health care system. Canada scored second last.

The only country that performed worse than Canada was the United States. What was particularly interesting – and this is what is of concern to Canadians – is that the United States has a system that is all private care. Canada has the system that is the most public. But all of the other nine developed nations in the study have blended systems that are more of a mix of private and public care. And it's of concern that we are the second-worst performing of these countries, and we are totally bucking the trends of health care systems that seem to be performing much better.

The other thing that was concerning was, they looked at the cost per capita of running the health care system and while we were second last in the world, we certainly weren't second last in terms of cost. Our system costs about $4500 per person per annum and the United Kingdom's system, which is the number one performing system in the world I believe, is only around $3400 or so. So, countries that are doing far, far better than us are doing it far more cheaply and with a system that blends private and public, which is something that we have been completely unwilling to do in this country for a long time.

MLI: Were you surprised by these findings?

Belchetz: Well, I wasn't. As somebody who works in the system I can tell you there are a number of issues with it. Costs are out of control; there is rampant abuse of the system; accessibility to care is poor; our wait times are getting worse over time, not getting better; the availability of specialist care, surgeries, and all sorts of things have continually gone downhill, and in fact because of a lack of funding for certain specialities we actually have unemployed physicians in our country for specialities where people are waiting months and months for procedures. There's a major imbalance in our system between the supply of health care and the demand for health care. So, when I hear that our health care system is both inefficient and not delivering care effectively, it's certainly not a surprise to me as a front line worker at all.

MLI: You don't often hear about a problem of unemployed physicians. Many Canadians fear a medical brain drain.

Belchetz: From a personal perspective, I know many colleagues who have finished surgical training programs, radiology training programs, and who don't have jobs – they cannot find work in their field. This is something that should never be happening, but I know people who have trained for many, many years across specialties where I know there is a shortage and they can't get a job. I can talk about plastic surgeons I know who can't get jobs. Ear, nose, and throat surgeons who can't get jobs. Radiologists who can't get jobs. Neurosurgeons who can't get jobs. Cardiac surgeons who can't get jobs. Across every one of these specialties, all of which are in demand, where there are wait lists for the procedures, I can tell you that I know doctors who can't get work.

We need more data on this. I'm basing this on my observations. But, what I can say is that this is one of those things that should, in a properly economically-balanced system, be able to be solved through fluctuating prices. If, for instance, geography was the factor that caused people to be unemployed, in a normal supply-demand equation then the price paid for the services provided in the regions that people

don't want to serve would go up. Unfortunately, because our system has set pricing for all of health care, there's no ability for the price to vary and therefore, there's no way to really persuade people who don't want to work in a certain geographical area to actually go out there for a higher salary.

MLI: How do you see the problems with Canada's system in your day-to-day practice? What are you seeing there that needs to be fixed in Canadian medicine?

Belchetz: Well, I think there are a number of things that we need to address. First of all, I would say that the lack of access to tests and short supply of specialty consultation are certainly big challenges to medical care here. Things like routine diagnostic colonoscopies can be a struggle to get. Things like access to MRIs and CT scans, again, can be a huge struggle to get. Access to specialty consultations and things like consultations with neurologists and other types of surgeons/specialists, that can be a struggle. So, when as a clinician working on the front lines you are not able to get patients access to the correct diagnosis and the correct treatment in a timely manner, certainly that compromises the outcome.

Another thing I am seeing that is a big problem is rampant abuse of the system which is being allowed. So, for instance, I've had patients with chronic abdominal pain who don't like the diagnosis that they have, who will have 14 CT scans of their abdomen done in one year and OHIP, the Ontario Health Insurance Program, pays for every single one of them. The cost to the system of each of those CT scans is $1000. I fully support everybody's right to a full diagnosis, but after the first or second scan that simply confirms the initial diagnosis, there's a problem. The fact that we are not somehow clamping down on that extra $12,000 in costs, and are allowing a patient, with absolutely no restriction, to incur that kind of cost on a system that is resource-constrained is not appropriate.

Similarly, patients will see their family doctor for a cold, and not like the diagnosis of "cold" because they wanted antibiotics. Then, the next day they will see a walk-in clinic, again asking for antibiotics, and when they don't get any antibiotics from the walk-in clinic, then they come to see me in the emergency room on day three. The accumulative costs of those three visits is extreme. Some studies have estimated just walking through the door of the emergency room and registering as a patient can cost the system $300 to $400. So, the fact that somebody has already seen two physicians and been given the same diagnosis and now proceeds with absolutely no change in symptomatology and has a third visit where they receive the exact same diagnosis – that's a problem.

I don't know the exact way to address it, but this kind of thing is costing the system tremendous amounts of money and we need to do something to prevent the rampant abuse of the system that happens when the price for access to care is zero.

Another example of abuse that seems quite common is when people come in seeking narcotic prescriptions. Some people come to our emergency room 20, 30, 40, 50 times even in one year because they know that they might get what they want eventually. Because there's no consequence to them from those visits, there was no cost to them whatsoever, they are willing to make those 25 extra visits in order to get what they're looking for. If there was some price to the emergency room visit, even a nominal user fee for access, people would be less willing to come in for things that clearly are not what the system was designed to provide.

MLI: This kind of frankness is unusual. Are your opinions common, do you think, among your colleagues?

Belchetz: I would say that what I'm talking about is probably not an uncommon experience for people in emergency medicine. I think the willingness to talk about it is probably more uncommon. I think as physicians we're very afraid to in any way criticize the behaviours of our patients. The reason why I'm willing to speak frankly about it is because I think it's important overall for the health of all of my patients for us to have a system that's sustainable. When we have a system that truly is in a dire financial circumstance, where we can't afford basic procedures, when we can't afford an MRI for someone who desperately needs it, when somebody who has presented and wasted tens of thousands of dollars on unnecessary testing and that prevents cancer care for other patients, I believe that's an issue that needs to be addressed. So, for me, what I'm always looking to do is to see when we are wasting money and how it is harming others, because this isn't a harmless behaviour. It's not something that we can look at in isolation; something that we can just allow to happen without considering what it's doing in terms of limiting care for others.

MLI: If the distribution of resources is one of the big problems, as you have written recently in the *National Post*, what reforms would help make the Canadian system more efficient?

Belchetz: Spending on health care is out of all control. Health care budgets eat up approximately 40 percent of the total spending of all of our provinces. It's a tremendous portion of everything that we spend. It is such an enormous amount of money that even small amounts of change could effect major improvements in our society, so that's number one.

Number two, the proportion of our economy that is dedicated to health care is massively increasing over time. So, if you look back in the 1970s, we only spent about 7.5 percent of our GDP on health care and that's up to almost 12 percent now. That's a tremendous rate of growth. That's only going to get worse as our population ages and that's something that we need to address sooner rather than later before our health care system bankrupts us all.

When I talk about the "war on economics" in Canada's health system, I'm talking about the fact that we now have a health care system that ignores all rules of supply and demand because what we've done is create almost what I would call a communist system within a capitalist country. By *communist* I mean a system whereby there is no flexibility of price, which allows no flexibility of supply and demand. Anybody who has studied basic economics knows that as the price of any good goes down the demand for that good tends to increase to the point where if the price is zero, demand is infinite. Conversely, the rules of supply and demand also say that as the price of any good goes up there tends to be more of that good supplied by people who produce that good. Unfortunately, what we've done in Canada is we've created a communist system where we've set in place price control. So, the price to patients for care is zero, patients are not allowed by law to pay any money for health care, and prices that are paid to suppliers are set at very specific levels that are not allowed to be changed at all. What that has created is a system where demand has skyrocketed, as we've seen in the incredible growth in health care expenses. There is no amount of health care that we can supply that is ever enough to meet demand, that is ever enough to curb the wait lists that we always see.

Another factor is that, because there's no flexibility in the price of supply, we see issues like communities that are unable to have surgeons or no ability to get physicians to work more hours. There's no extra money in the pot that can allow us to fund more care. So, I believe that if we could introduce some form of price into health care – and I'm not talking full capitalistic price, the way it would be in the United States – but at least some form of user access fee into our system that would at least curb demand, and

we could recruit extra supplies of medical care to address shortages. We could bring our system much closer to a supply and demand equilibrium where the amount of health care that is supplied is much closer to the amount of health care that is demanded; whereas right now, we have a massive, massive excess of demand over supply and that leads to the huge wait list that we see right now.

If we introduce some form of fee we eliminate a lot of the unnecessary visits. So, the people that right now would come five times for a cold might only come once to get their diagnosis, or the person that consumes 20 CT scans of their abdomen in a year because they don't like their diagnosis of abdominal pain might not continue to seek further CAT scans once they've had one or two. So, what we can do is at least curb some of the most flagrant abuses of the system and put a ceiling on the demand, which at this point has absolutely no ceiling on it whatsoever.

There are many out there who would argue that the problem with this is it prevents people of lesser means from seeking diagnosis in care, but that's not been the experience in a lot of the other countries that have co-payment. If you look at the Commonwealth Fund study, a lot of the countries out there have requirements for some form of payment for all health care services even in their public systems and that has not hurt access to care in all of those countries. For their least advantaged citizens, they have schemes whereby people can be reimbursed for what are considered legitimate medical visits. So, there are many examples we can draw from rather than saying, "This is an impossibility and it will lead to diminished levels of care for those of lesser means". What we can do is actually look at how other countries achieved co-payment, achieved some form of user access fee without hurting access to care, and I think we can very easily emulate what they have done successfully.

MLI: Do you think that kind of reform is possible under the *Canada Health Act*?

Belchetz: Unfortunately not. The *Canada Health Act*, which was legislated in 1984, states that it is not allowed for anybody to charge for medically necessary services. The minute any province allows any medical care provider to charge for medically necessary services, the *Canada Health Act* allows the federal government to withdraw funding from that province. So, it's really a noose around the neck of our entire health care system. It prevents any innovation, it prevents any attempt to change the model that we have right now, and it really locks us into being the only developed nation in the world that has a fully public health care system with absolutely no private option whatsoever to at least release some of the pressure off of demand that we see, and to also open up extra avenues of supply. So, I think the very first thing that has to happen – if we're going to start trying to innovate in health care and try to open up our system to some of the better ideas that we've seen work very well in other countries – is to repeal the *Canada Health Act* or at least modify it in an extensive manner that allows us to innovate in a way that up until now we haven't been able to do.

MLI: Isn't that heresy?

Belchetz: Unfortunately, in Canada it has been for decades. It has been political suicide for any politician to even speak about private health care of any kind or charging for health care in any way, and certainly to talk about rolling back the *Canada Health Act*, which in many respects is almost looked upon as if it's a biblical act. The truth of the matter is the *Canada Health Act* is not that old. The *Canada Health Act* is an experiment; it's been here for the last 30 years and that is it. Canada did very well in terms of health outcomes before the *Canada Health Act* came into existence and, in fact, what the *Canada Health Act* has led to is ballooning waiting lists, ballooning expenses, and worsening care. Before the *Canada Health Act* we were certainly not the second worst of the developed nations in the world when we were ranked in terms of our health care system, so when we look at this mandated system of zero pricing, it has done nothing other than worsen outcomes.

So, we need to be realistic and we need to start saying, instead of only looking at the United States when we talk about repealing the *Canada Health Act* and saying we will become like the United States, which is the worst performing health care system in the world, we need to look at countries like the European nations, all of whom have blended systems of private and public care and all of whom do better than we do. We need to actually look at the best examples in the world and forget this idea that the *Canada Health Act* is a law that can never be repealed, and we need to say there is something out there that's working far better than what we're doing, and repealing this law allows us to innovate and to copy that.

MLI: And yet, you often hear about Cadillac care at US hospitals and clinics.

Belchetz: Well, there are two dimensions where the Commonwealth Fund really indicted the United States health care system. Dimension number one is cost. Their average cost per care is extraordinary. They are by far the most expensive health care system in the world. The second is care. Access to care is completely unfair and disproportionate in the United States. So, those people who are of greater means certainly have unlimited access to, I agree, Cadillac care. But, other than the wealthiest part of society, and not just the poor, many people have absolutely no access to care whatsoever. Even people of the middle class who are on insurance plans tend to have quite poor access to care. We hear many stories of people who, once they have become ill, find their insurance coverage all of a sudden rolled back or denied, or people cannot obtain insurance at all because they are ill, despite having some amount of money to pay for insurance. What you end up having in the United States is awful access to care and awful treatment once you have become ill, unless you have great wealth. So, what the Commonwealth Fund found was that the majority of Americans are actually receiving terrible treatment.

MLI: So, if the United States is at the bottom of the Commonwealth Fund report, how effective is the charge of "US-style health care" in Canada?

Belchetz: You know, I think it's a very effective charge for those people who are looking to derail any attempt to fix our health care system. So, everybody here knows, I think, through all of the media that we see, that the United States has terrible health outcomes. We know that people who are of lesser means in the United States are treated horrifically by that health care system, so it's a very easy charge to pull out when anybody talks about charging for any type of care here. It's a very effective way to shut that debate down quickly. However, what people are not exposed to here is the European example, I guess, because it's across an ocean. We are not seeing all of the stories that come out of those countries where patients are routinely charged for health care. Every one of those countries has a public care system just like ours, but they also have a very effective private care system and we're not hearing the stories that those counties have very effectively blended those two systems and created incredibly great health outcomes and have done far better on the Commonwealth study than we have. So, you ask how effective is the charge of US-style health care at, I guess, shutting down our health care debate? It's very effective. It's an incredible tool because people don't know the alternatives that are further away than the United States.

MLI: Do you think the health care debate has neglected the needs of the patient?

Belchetz: I think to a great extent people have been caught up in dogma rather than thinking about what's best for the patient. There's an addiction to the idea of free-for-all health care rather than health care that is good for people. What we should want is health care that creates the best outcomes for our citizens. We look at ourselves as being slightly more enlightened than the United States, but our dialogue is just as poor as theirs. In the United States, if anybody talks about any role for government in health care, the debate is automatically shut down – socialized health care will never be allowed in the

United States. Here in Canada, we look at that and we say, "That's dark ages. How can you be so closed-minded to not allow the idea of government-funded health care?" And I would say we are similarly closed-minded because here in Canada when anybody talks about charging for health care – all of a sudden it's US-style health care; let's shut down the debate. So, I think, we need to stop looking at ourselves as being an enlightened country that's open to debate and realize that so far we haven't been.

MLI: How would you advise policy-makers, then, to sell the idea of reform?

Belchetz: Well, I think we need to start educating people about the other systems that are out there in the world. I think there's an amazing lack of knowledge around Canada about just how well private health care systems have complemented public health care systems in other parts of the world and I think we need to educate people both about the fact that outcomes for everybody have gotten better under those systems and that there's been no limitation of access to care for people of lesser means. So, I think the debate starts with educating people to say stop looking at the United States. The UK system, Swiss system, Swedish system: let's look at the phenomenal outcomes that all of these people have achieved by allowing some amount of private health care into their systems. I think once people have their eyes opened a little bit here, we will start to realize that in fact our system and the US system are not the only options in the world and that allowing private care into our system is not a poison pill that leads directly to being the United States.

MLI: How do these other countries balance public and private health care?

Belchetz: When you look at the European nations and Australia, what you end up seeing is that there's an extremely large role for the government. Their federal governments pay for a huge percentage of health care expenses; however, side-by-side there are fully private health care options. There are hospitals that are run fully by private industry and paid for fully out of the private purse. So, those particular options are not paid for out of the public purse at all, which is actually a great thing because it takes some of the weight off of the public health care system. For instance, if one-quarter of the people in Canada with appendicitis had the means on their own to pay for the procedure, that's a huge savings for our public health care system. Similarly, if 25 percent of the people who wanted an MRI were willing to pay for it out of their own pocket, again, that's a huge savings given that the cost of each MRI our public health care system has to pay for is thousands of dollars. So, that's just one of the benefits of allowing a complementary private health care system to exist alongside our public system.

MLI: What does Canada's health system do well?

Belchetz: We have a system whereby we take excellent care of those people who have serious illnesses and need help. I have never seen in our system patients, for instance, who are suffering from terrible things like a heart attack who don't get great treatment. I've never seen somebody who is a victim of a trauma who isn't getting amazing care in a trauma centre whether they have insurance or not. So, we do a lot of things well in terms of making sure that some of the worst illnesses and the worst accidental injuries get well taken care of. There's also no fear anywhere in our system that somebody who has no means is going to be turned away for any reason whatsoever. I think people feel very safe in our country to go about their lives knowing that they're going to be taken care of. So, that's excellent. I don't think introducing some form of private care will take away from that assurance at all. I think we can build safeguards into any blended system that still say it doesn't matter who you are; it doesn't matter what means you have; it doesn't matter what you're coming in with, you will still be taken care of. I still think we can have assurances that that will exist no matter how we blend public and private care in our system.

MLI: We have some big decisions to make in the future.

Belchetz: Yes, consider the fact that drug coverage is not universal here, so the truth of the matter is some of the other countries that are in the Commonwealth Fund study actually offer more public coverage in key areas. We always think of Canada's system as being universal coverage, where everything is free, but people are left to pay for their own medication outside of hospital. We have a system that is so bankrupted by allowing universal visits to the doctor and universal visits to the hospital that for those people who are truly ill, medications aren't covered at all. A lot of people I see – actually I have great experience working in an area of town that is not a wealthy area – there are many people I see who can't afford to fill the prescriptions I write for them. Some of the blended private/public systems in Europe, although there may be a small user fee to see the doctor and there may be some other fees that we don't have here, a lot of them provide drug coverage as part of their overall health insurance program. When you include things like dental care, things like medical prescription costs, those systems actually become far more equitable to the patient and far more affordable than our own, where people have no access to dental care without money and no access to prescriptions without money.

Dental care is a big one. I frequently see people in the emergency room with dental problems and they come to the hospital because there's no coverage under OHIP for them to see the dentist. Unfortunately I'm not a dentist and I don't have dental training so there is very little that I can do for them. I have seen people who have lost most of their teeth because they cannot afford to see a dentist, and that doesn't exist in a lot of these systems in Europe where they have blended private and public coverage, but the public coverage includes dental care.

So, I think we've been very myopic. We have basically said, to the expense of everything else, let's have unlimited physician visits, let's forget about dental care, let's forget about prescription drug coverage. I think it makes a lot more sense to be a little bit more limiting on the physician visits and hospital visits, but give much more broad coverage to somebody's overall health.

RECOMMENDATIONS:

MLI has drawn three recommendations from its discussion with Dr. Belchetz:

1) Repeal the *Canada Health Act* and begin to allow those who can pay for their own care to do so and relieve pressure on the system.

2) Implement user fees to reduce abuse of resources and deliver price signals to increase supply and reduce demand, while preserving access for patients of limited means.

3) Stop concentrating on the poorly performing US system and look to better-performing systems in Europe and elsewhere for policy ideas.

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As the author Brian Lee Crowley has set out, there is a strong argument that the 21st Century could well be the Canadian Century.

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PETER NICHOLSON, FORMER SENIOR POLICY ADVISOR TO PRIME MINISTER PAUL MARTIN

I saw your paper on Senate reform [Beyond Scandal and Patronage] and liked it very much. It was a remarkable and coherent insight – so lacking in this partisan and anger-driven, data-free, a historical debate – and very welcome.

SENATOR HUGH SEGAL, NOVEMBER 25, 2013

Very much enjoyed your presentation this morning. It was first-rate and an excellent way of presenting the options which Canada faces during this period of "choice"... Best regards and keep up the good work.

PRESTON MANNING, PRESIDENT AND CEO, MANNING CENTRE FOR BUILDING DEMOCRACY