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Conference on the future of health care financing and delivery in Quebec – October 18, 2000

Le Choix privé universel: Une vision de la santé offrant la qualité, l'accès et le choix à tous les Canadiens

M. MICHEL KELLY-GAGNON:

So we're going to move immediately to our next presentation. Nos deux (2) prochains conférenciers ont rédigé l'étude *Liberté de Choix Universelle: Une vision de santé offrant la qualité, l'accès et le choix à tous les Canadiens* qui a été publiée il y a quelques semaines par l'Institut économique de Montréal.

Il faut comprendre que nos recherches ne sont pas le fruit d'une politique éditoriale, c'est-à-dire qu'il y a certains membres, même à la limite, à l'intérieur de notre propre conseil d'administration qui pouvaient ne pas être d'accord, d'autres qui étaient d'accord, mais une chose était certaine, c'est qu'on trouvait le texte intéressant et si vous en avez pas de copie, je vous invite à vous en procurer ou à le voir sur notre site Web.

There's a full text version of their study on our Web site which is www.iedm.org, facile, so it's the same Institut économique de Montréal, you just take each first letter and then point ORG.

So Dr. Coffey a enseigné longtemps la... à la Faculté de médecine de l'Université de McGill, il fut président de l'Association médicale du Québec.

Il a de plus, fait partie du Conseil de l'association médicale canadienne et de son groupe de travail sur le financement des services médicaux au Canada.

Il a participé à plusieurs panels d'experts, autant au niveau national qu'international au sujet de la réforme des soins de santé.

He is also one of the early supporter of the institute and we are grateful for that. Le docteur Jacques Chaoulli est médecin de famille, chercheur en éducation médicale et militant engagé dans la lutte pour l'amélioration des soins de santé.

Il s'est fait connaître du public québécois par des batailles judiciaires très médiatisées dont une grève de la faim et il s'oppose... ce qu'il considère être des traitements inacceptables aux patients.

Et I want to point out that neither the presentation of today or the publication is in relation to these legal battles where we have no opinion for or against but we thought that Mr. Chaoulli had interesting things to say and that's why he's here.

Alors, nous allons commencer et chaque conférencier va bénéficier de quinze (15) minutes, je vais être particulièrement cruel dans l'application de l'échéancier.

DR. JACQUES CHAOULLI:

Bonjour, messieurs, dames. Alors, on va commencer directement. Il y a deux (2) mots qui ont été prononcés par notre précédent conférencier, c'est les mots "liberté et créativité".

Alors, effectivement, c'est un... ce sont des mots qui résonnent particulièrement à nos oreilles pour les raisons que chacun sait ici.

Alors, je voudrais juste confirmer les... les gains de productivité en Suède par une étude de l'OCDE datant de mil neuf cent quatre-vingt-seize (1996) qui est indiquée dans la publication que nous avons publiée à la référence numéro 12 à la page 28, la référence de l'OCDE qui indique que le nombre d'interventions pratiques a effectivement beaucoup augmenté et les listes d'attente ont été très notablement raccourcies, donc, c'est confirmé par les experts de l'OCDE.

Maintenant, dans d'autres pays, avec un financement mixte de public privé dans les services médicalement requis, l'OCDE a observé qu'il n'y a pas de problème de liste d'attente.

Et on va commencer avec le... la Belgique dans le... en mil neuf cent quatre-vingt-douze (1992) où il n'est pas signalé qu'il y ait de longues listes d'attente à l'hôpital selon les experts de l'OCDE.

Également, en Allemagne, dans la même étude, il ne semble pas y avoir de listes d'attente dans les hôpitaux.

Et également, en France, il est rare que les patients français doivent attendre pour obtenir un rendez-vous de leur médecin, généraliste ou spécialiste ou pour être admis dans un hôpital.

Alors, ce sont des pays qui ont effectivement un financement mixte public privé comme en Suède. La Suède, bien évidemment, comme on l'a entendu tout à l'heure, a un financement privé qui est très réduit, ce qui nous démontre à nous, Canadiens, que un service... un système privé parallèle n'a pas menacé l'intégrité et la viabilité du régime public universel suédois. C'est intéressant de le noter.

Ensuite, le rapport de l'OMS 2000 qui est disponible sur internet montre des éléments très intéressants.

C'est que on pourrait se demander au Canada si l'introduction d'un système privé, financement privé allait détruire notre régime public et les valeurs canadiennes auxquelles on est attachés.

Et qu'est-ce qu'on voit? C'est que au chapitre de l'équité dans la contribution financière, ce qui est au coeur de nos valeurs canadiennes, et bien, on voit que des pays qui sont classés mieux que le Canada ont un système privé parallèle qui fonctionne en parallèle avec un système public universel, comme le Japon, la Norvège, et caetera, et que le Canada est au dix-septième rang, donc, il est moins bien classé tout en ayant un monopole qui interdit la liberté de choisir.

Par conséquent, on peut en tirer la conclusion qu'il n'y a aucun rapport parce que il y a des pays qui ont aussi un système privé parallèle et qui sont moins bien classés que le Canada.

Autrement dit, on peut pas en tirer la conclusion qu'un système privé parallèle aurait pour

conséquence de détruire l'équité dans notre système.

Une autre analyse de l'OMS du même rapport deux mille (2000) montre que au chapitre de la réactivité qui est un nouveau paramètre étudié par l'OMS, en gros, c'est la... l'accessibilité et la dignité, le respect des patients, il y a plusieurs facteurs qui sont là-dedans et là aussi, on voit qu'il y a des pays qui sont mieux classés que le Canada, comme le Danemark, l'Allemagne, le Japon, ont un meilleur score que nous, que le Canada, alors qu'eux, ils ont un financement mixte public privé et que, également, il y a d'autres pays qui sont moins bien classés.

Donc, encore une fois, on peut pas en tirer de conclusion sur l'introduction d'un système privé sur ces paramètres.

Par ailleurs, le fait que des assureurs privés excluent les personnes trop âgées ou trop malades, c'est aussi une préoccupation que nous avons beaucoup au Canada et alors, il est très intéressant à noter que dans l'État de New York, qui est notre voisin, le département de... d'État, d'État de New York a proposé une loi en mil neuf cent quatre-vingt-seize (1996) pour interdire aux assureurs privés justement de faire ces sélections-là basées sur l'âge ou la condition des malades.

Et il y a d'autres pays qui l'ont fait, comme l'Irlande et de nombreux pays en Europe de l'Ouest qui ont réglementé pour protéger les intérêts. Alors, c'est le gouvernement, bien entendu, qui doit faire cela. Et ça se fait même aux États-Unis, ce qui est très intéressant pour considérer qu'au Canada, un gouvernement responsable pourrait très bien le faire également.

Ensuite, dans la présentation, je voudrais vous dire que... en fait, dans l'OCDE, il y a vingt-cinq (25) pays avec un accès universel et un système mixte public privé pour le financement, quelle que soit la taille du financement, peu importe, mais il y est là.

Et les seuls pays de l'OCDE qui n'ont pas d'accès universel, c'est les États-Unis, la Turquie et le Mexique.

Alors, je voudrais montrer l'acétate suivant qui est une étude de l'OCDE... pardon, c'est l'acétate numéro 1, d'un rapport de l'OCDE qui indique que... qui souligne le fait que le Canada est le seul pays de l'OCDE à interdire les assurances privées volontaires et que la possibilité de souscrire à une assurance volontaire est apparue comme une liberté importante de... pour tous les pays de l'OCDE, sauf le Canada.

Ensuite, on peut passer à l'acétate suivant. Certaines personnes disent qu'il ne faut pas laisser entrer les compagnies privées dans les services médicaux parce qu'il y a des compagnies malhonnêtes et que ils font des fraudes.

À cet égard, ce qu'on ne peut dire, c'est que dans une société libre et démocratique, un gouvernement responsable réglemente et exerce un contrôle sur une activité, mais ne l'interdit pas.

Il s'agit plutôt... cette position-là, il s'agit plutôt d'une position idéologique qui est opposée à toute idée de profit dans la santé.

La Suède n'a pas ce problème-là, il y a des hôpitaux privés qui fonctionnent contracting out, certes, ou privés complètement commercial en parallèle, ils n'ont pas ce problème, ils ont résolu ce problème idéologique dans les années quatre-vingt ('80) quand ils ont ouvert le système, à la fin des années quatre-vingt ('80).

Et opposé... la position idéologique qui est opposée à l'idée de... du fait qu'une... qu'un patient, en raison de pouvoir payer, va avoir de meilleurs soins qu'une autre personne dans le secteur public.

Quelqu'un qui paierait en privé aurait un meilleur soin que dans le secteur public, on considère... certains considèrent que il s'agit là d'une... d'une chose inacceptable, intolérable, ce qui constitue une position, encore une fois, de nature idéologique.

On peut la respecter, on peut la discuter, mais c'est cela. Alors, le... le profit dans la santé et un système de santé privé parallèle, est-ce que cela constitue des menaces contre les valeurs canadiennes fondamentales auxquelles nous sommes attachés et est-ce que alors, il faudrait empêcher tout financement privé dans les services médicalement requis?

La Suède a tourné la page à la fin des années quatre-vingt ('80) en ouvrant le système, ce qui a permis en Suède, grâce à cette ouverture, à cette souplesse et cette absence de rigidité idéologique, de permettre que des compagnies privées viennent, fassent des profits et donnent des meilleurs services pour tout le monde.

C'est cela que on doit retenir aussi de la présentation tout à l'heure parce que l'objectif, c'est donner des meilleurs services à tout le monde.

Mais pour cela, il faut avoir résolu un barrage auquel nous faisons face ici au Canada qui est de nature idéologique.

Et le rapport OMS 2000 montre que dans les années quatre-vingt ('80), la Chine, la Chine communiste a relégalisé la pratique libérale des professions de la santé et que le jeu de la concurrence heurte les obstacles parfois considérables, comme l'interdiction officielle de l'exercice privé qui est encore en vigueur à Cuba et chacun sait que Cuba est un régime de nature marxiste.

Alors, l'interdiction est officielle à Cuba, oui, et qu'en est-il au Canada? Eh bien, au Canada, l'interdiction n'est pas officielle, elle est déguisée, c'est-à-dire que la loi permet des médecins privés, mais la loi interdit également les assurances privées de manière à ce qu'à toute fin pratique, il n'y en a pas de système privé parallèle, sauf quelques médecins en... en clinique qui peuvent faire de la pratique privée.

Mais ce qui ne constitue aucune menace, entre guillemets, aux principes idéologiques qui sont défendus ici.

Alors, je terminerai en disant que le philosophe français Pascal avait dit: "Il faut choisir".

Eh bien, permettez-moi de terminer sur cette note et de vous dire que, messieurs et mesdames, le moment est venu, je crois, au Canada, pour chacun d'entre nous de choisir notre camp idéologique, de régler ce problème-là initial sans lequel il n'y aura aucune possibilité, à mon avis, d'aller de l'avant et de suivre les autres exemples que nous fournissent les pays du monde entier. Je vous remercie.

M. MICHEL KELLY-GAGNON:

So we're going to pass immediately to the presentation of Dr. Coffey since both presentations are inter-related and then, afterwards, when we have the... when we open to the floor, you'll have the occasion to ask your questions to whoever you'd like to ask.

DR. EDWIN COFFEY:

Bonjour, mesdames et messieurs et... I'm going to take you on a very rapid voyage. This voyage is not economically oriented, I don't have a lot of figures and percentages because the concept that we're trying to evolve and develop is one how do we... how do we handle the problems that we have, can we utilize some of the good features and add to them and perhaps move in a direction that will see some improvements in our ability to better finance, ensure and provide a good quality

health care to the citizens in a reasonable time and at a reasonable cost, of course.

Now, this is just to show you the present system and I've put the term Medicare that we informally call it, that is a form of universal public choice.

In other words, most of the major decisions are made at the level of governments, bureaucrats, politicians and lower levels.

A very few of the very important choices are made by the individual patients or in terms of people who are consuming services when they're buying insurance and so on.

The flow of money, as you can see, essentially goes through taxes from the consumers to governments, you can't see the other line, Hélène, if you can move that, in... from governments, the... the flow of money comes down to the providers, providers, at this time, consist of physicians, hospitals and clinics.

And the... it's a pretty tight circuit, it's a single payer, essentially a single payer system. Now, the next slide.

Now, this is just to... no, I'm sorry, Number 6, Number 6, they're all in order. This is to again indicate and David Gratzer referred to this, this is one of the more recent surveys done by the Commonwealth fund and a Harvard group which we consider to be quite a good... a good group to refer to.

And in nineteen ninety-eight (1998), they surveyed, among five (5) countries, they did Canada, the adult population and they asked them, "What do you think about the Canadian health care system in general and are there any changes that should be made?"

Twenty percent (20%) said that there are some features about the system but we need some minor changes.

Fifty-six percent (56%) said that there are some major problems and fundamental changes are needed, twenty-three percent (23%) said that a complete rebuilding of the system is needed. Next.

Now, in this... this year in July, that same group at Harvard and the Commonwealth fund did the same questionnaire, this time directed at two (2) types of physicians, the generalists, the general practitioners primarily and the specialists.

And the results of this are very interesting. First of all... and I think the important thing in this slide is that seventy-two percent (72%) of the general physicians said that fundamental changes are needed, four percent (4%) complete rebuilding. Next one.

When they went to the specialists, a much higher number suggested eighty-four percent (84%) that fundamental changes were needed, four percent (4%) for rebuilding.

So just keep going. As a result of this, it's quite apparent that major changes of some nature seem to be required in the system.

And other observations, now, you can take these, some people aren't very happy with the world health order figures, but in any case, Canada does not come in the top ten (10) as far as overall performance and these are very recent, this was the World Health Organization two thousand (2000).

We're Number 30 in overall performance. European countries with parallel public and private systems generally rank higher than we do.

And the parallel systems in Europe have generally avoided the problems that have afflicted our system, such as wait list, lack of modern technology, et caetera. Next.

Now, one of our difficulties, of course, is the prohibition in Canada by the provincial legislation of a parallel public system, a parallel private system with the public.

And this, of course, is contrary to other countries and it has prevented us from doing very important research in health system financing.

We don't have control studies, for instance, for Medicare, it's a great system, we love it, it gets Number 1 rating when you do surveys, but on the... we really don't have a Canadian made control study to support that and we... I think we dearly need some comparative studies done in Canada by Canadian researchers and health system financing.

Next. So, concluding on... on those approaches, we... we do have to test, we have to test different ways of - just keep going - different ways of ensuring financing and delivering health services.

The study that Dr. Chaoulli and I did for the Montreal Economic Institute concluded that yes, a new approach was needed, we sort of named this Universal Private Choice or Medicare Plus and you'll see the reason for that as we go along.

The principles on which we... we sort of designed our approach, I'll run through these very quickly and you may or may not agree with them but I think you'll find them, some of them are quite favourable.

First of all, government funded core health insurance, Medicare, should be available for all residents to cover the following categories of services: medical hospital, laboratory, diagnostic and drugs, et caetera.

In other words, Medicare should stay. We think there are good features about Medicare, there is some features that are less favourable but for the moment, it would be such a radical see change to ever suggest eliminating Medicare, I think that's totally impractical and since there are some good features, administratively and clinically, we should continue with that as a basic core service.

Patient cost sharing may be required for those above certain income levels. Now, of course, people say, "Oh, you want user fees", well, now, when we think of it, most European countries have always had some kind of patient participation, not by the people in very low levels of income but by enlarge a lot of... a lot of the population has contributed a bit towards their services, good features and bad features but nevertheless, it's a fact.

The other principle, no one will be denied access to core medical and hospital services because of financial difficulty.

Now, I think that's something we're very emphatic about and that should be reassuring to people who get nervous when you start to talk about any kind of change or reform in the current system.

Patients and consumers may opt out of selective categories of Medicare services and obtain a refundable tax credit or voucher that must be applied to an alternative health plan or insurance to cover these services.

Now, that's an opting out privilege but, now this is very important, but tax or premium eligible patients are not permitted to opt out of tax or premium obligations.

In other words, it's not opting out of the... the solidarity concept, we think everyone should share the

costs of publicly funded health care.

But we think that it would be very interesting to, at least, test opting out of the benefits according to certain categories, for instance, hospital services as one or physician services or laboratory services or drugs.

And either of those, selectively, could be... come back to the patient, as a consumer, marked very specifically to be used for alternative... alternative insurance or health plans, whatever might evolve.

Patients and providers are free to act to make vital decisions and to exercise responsibility in all matters of health care and health insurance.

In other words, individual freedom in health care matters.

Property and contract rights are respected, intellectual property. Patients and physicians should have choices as to the health care setting, the mode of delivery, the type of... the location of your practise and the method of health care financing.

Again, freedom of individuals like all other professions, whether they're teaching, education, lawyers, accountants, engineers, et caetera.

The market process... and this is sort of a philosophic thing, but the market process is a discovery procedure and a generator of information and knowledge for both consumer and provider of health services.

Providers and consumers may participate in free market competition and experience both the risks and the benefits of such.

Now, health care decisions are better determined by private choices of patients as consumers who have access to free markets than by the public choices of bureaucrats and politicians whose decisions are made within the political process.

Now, if you think about it, politicians make their decisions on matters of health care that are very dear to us and what their interests are may be quite different than our interests, take the upcoming election. Next.

Individuals which... who lose their freedom in matters of health care, they do... they do risk losing their freedom in health... in matters of health care when governments often are influenced by political interests and who resort to the expediency of undirected health legislation whereby the liberty of some is not equally respected under legislation.

Again, we won't delay on... and we can just keep... keep moving, we can skip this next one because I want to get to the other one.

Now, patients are best informed and represented by a member owned, non-government mutual purchasing agency or coop that speaks for sufficient members to give it financial clout in negotiating effectively with insurers and health plans for insurance packages or plans that best meet the individual needs of the members.

And this has to do with the... with the concept of group purchasing and we'll see that as we come up with our final slide.

This then shows you a flow under the proposed universal private choice or Medicare Plus, it shows how the money would flow from the consumers as tax payers to governments, up on the left, and

from governments, most of that would flow down to... to the providers, flow down on the side to the providers, physicians, hospitals, insurers, clinics, health plans or alliances of doctors and hospitals that might evolve with... within this freer system.

Some of that money would be refundable tax credits or vouchers and would come back to the patients who are consumers who would then be able to invest in medical savings plans to... like the RRSP, very similar to that and they would use this money for routine costs, having an X-ray, going to a clinic, having an annual check-up.

And there would be a threshold, perhaps two thousand dollars ($2,000.00), one thousand dollars ($1,000.00) a year maximum.

But if you use a medical savings plan, you must buy a catastrophic health insurance and this insurance would be a high deductible low premium, that would ensure that nobody would sort of use all their medical savings and then say, "Well, what do I do now, I have to go into a hospital for a heart transplant".

Well, there's always that safety net of the catastrophic insurance which would not be very expensive.

And the... while we're... while we're here, the health purchasing agency, down on the left, this is a group, purchasing group owned by the members, ten thousand (10,000) people can form an agency and this body will negotiate with insurance companies, health plans, alliances of doctors, hospitals and laboratories who might provide services to... to this agency for the consumers.

And the... the important thing is that they would gather information so the patients, when they made a decision on purchasing a plan, they would be fully informed and there would be no question about trying to soft sell a patient in a low price that was not going to have quality or access.

Employers, of course, will continue... would continue to either they pay... they would contribute to payroll taxes and they would also be able to contribute premiums to the providers on behalf of their employees in buying into these other health plans and so on. Next.

No, I will skip... there was another slide in French but I think we better move on. Okay, this... this then is... is a summary of what... what I've been trying to tell you.

Universal Private Choice is based on the following political assumptions. First, that legislation, current legislation that... that now prohibit access to private health insurance for medically required services and that prevent private medical services in hospitals, that this legislation would be revised and secondly, that the necessary enabling legislation to allow and accommodate things like medical savings accounts and so on, that these... these areas would be also revised in the legislation.

Now, universal private choice allows for an optional non-binding referendum on the proposed policy direction that we would suggest.

A proposal that retains universal Medicare but allows for fundamental changes in the present system as called for by a majority of adult Canadians and physicians.

In other words, a referendum, we think, would be a very good way to start the ball rolling, to get a... to see if the opinion of the population is the same as we have presented earlier in the surveys.

And now, we would retain Medicare and in a modified form to cover core services that are cost-effective of proven value and try to make them readily accessible.

Now, this plan frees up the innovative competitive capacities of all and the services of patients, it

eliminates government monopoly in financing, planning and coordination of services, it takes advantage of market competition, it puts purchasing power voluntarily in the hands of all consumers of health services, rich and poor, and that's very important, nobody is excluded, encourage... encourage his patients, participation in the market for health insurance and services and assists them in making informed choices among various health insurance options. Next.

It allows for a voluntary shifting away from the predominance of government in health care financing and monopolistic control of health insurance as payer, insurer and provider and finally, it allows for voluntary shifting towards a pluralistic and a mixed approach in financing insurance and providing health insurance and health services mainly controlled by the patient as consumer. Thank you.

M. MICHEL KELLY-GAGNON:

Je vais... je vais inviter le docteur Chaoulli à se joindre à l'avant ici, peut-être, docteur Coffey, vous pourriez rester à l'avant et vous partager le micro selon les questions qui seront données.

Donc, même concept, on... nous allons donner priorité à ceux qui ont pas déjà eu l'occasion de poser des questions, donc, j'ai une... il y avait madame et ensuite, monsieur. Voilà.

MRS. ELIZABETH KRACCO:

Hi! My name is Elizabeth Kracco, I'm a medical student at McGill University. I have two (2) parts to my question.

Perhaps I misunderstood but I'm confused as to how you would ensure a system where the premiums would be sufficiently low and the deductible sufficiently high considering that that's counter to the profit motive of any private insurance company. So that's part one (1).

And part two (2) is I was wondering if you studied the impact of the free trade agreements on this proposal considering that under the current free trade agreements, a private hospital in Canada would be fair game for, let's say, an American or a Mexican company to own.

DR. EDWIN COFFEY:

The answer to the first one, how do you establish a market price, of course, is to allow the markets to exercise their capacity to exchange and compete.

And at the moment, of course, that's illegal so we have no ideas how... how well this would... this would operate and that's why I emphasized the importance of legalizing and experimenting research in health system financing in Canada.

We need research badly. Johan has presented the... the concept of the internal, sort of a managed market within a publicly funded system in Sweden.

Now, even that would be a step forward for us. And I think a lot of people might go for that. But our... our impression is that we should not just restrict ourselves to an internal market but we should also allow our freer market where there are multiple providers of services and multiple insurers competing and as... as I say, there will be successes and there will be failures but the informed consumer, helped by his... his health purchasing agency, that he essentially owns as a member, that will give him some confidence that he's getting the best possible price quality and access.

DR. JACQUES CHAOULLI:

I'd just like to add to his answer about NAFTA, that... to answer directly to your question, yes, because of NAFTA, you will have an influx of private capital to Canada in order to establish private

facilities and (inaudible) private facilities and your concern might be what about to be flooded by the Americans' interests and the Americans coming here and dictate to us how we should run our Canadian health care system.

And the answer to that is very simple, is that the provincial governments, they have the authority, the power to control any entry of outsiders or private providers from wherever they come and to limit the number of both private hospitals, private facilities and private doctors, non-participating doctors. So this is a matter of regulation.

UNIDENTIFIED VOICE:

Ed, as you know, I support a freedom of choice, an alternative to what we have now but I have a serious question about the... the way you've constructed the... your plan and that is; is there not a possible negative feedback in that the government, seeing themselves taken off the hook for a certain amount of... of responsibility, would, in fact, decrease the amounts allocated to the health care system and let your insurers take over and in fact, that could lead to a deterioration of services under the health care plan, under the public health care plan?

DR. EDWIN COFFEY:

The concept, at the moment, would be that, for instance, in a... if you had the refundable tax credit, if someone elected to opt out of one of the categories of services like physician services, let's say, to start with, one would probably recommend that the per capita public expenditure on physician services would be used as a guideline for the... the refund, in other words, if there's... I think it's eighteen hundred dollars ($1,800.00) a year or seventeen hundred (1,700) spent in Quebec on physician services, so theoretically, that could be refunded to the patient to then go out and either invest that in medical savings account or... or purchase traditional health insurance or perhaps by then, doctors at the Royal Victoria and Westmount Square and Montreal General would form an alliance with the laboratory and say, "We're going to come up with a high quality health plan for downtown Montrealers".

And that seventeen hundred dollars ($1,700.00) might very well by that all the physician services from that alliance for the year.

And it would be totally funded by government but the... the consumer would have the money in hand with the purchasing, the group purchasing agency which would assure that they would be getting the quality and the price that was best for them.

UNIDENTIFIED VOICE:

I think I'm next. I'd like to just suggest a couple of anecdotes before getting to my question. The speaker this morning talked about having more rational demand, we see in the prescription situation in Quebec that when the people were charged for their prescription, they stopped taking their medication and it led to the long range increase cost.

On the second incident, when you talked about contracts within a public system, we've seen an example in contracting out things like laboratory tests.

Now, the private companies took all the... easy profit making enterprises and left the difficult expensive ones to the public service.

You talked about group purchasing and for example, just recently among teachers, dental plans, the... the retired teachers were thrown out of the plan because the premiums were too high so the other ones were kept but the other ones were thrown out.

So my question to bring all the three (3) together is what controls do your system have that would prevent the exclusions of this... of the old, the... for example, in a group plan, what happens if you have a large concentration of black people, for example, and the risk of sickle cell anaemia, are they going to be included in the group plan or not?

So what controls exist to prevent exclusions along all these various lines?

DR. EDWIN COFFEY:

I think that's... that's a very good thing to be concerned about. The people who have worked most with this concept of group purchasing or health purchasing coops, Allen Anthovin who's an economist at Stanford who worked with the federal employees' benefit plan in a federal American plan as well as a California state employees' group and is now in Europe consulting with governments, the Netherlands and England with the same concept.

He has said that to answer your question, first of all, an open enrolment period would always be held, maybe two (2) months a year where everyone, regardless of their risk, whether they were in severe congestive heart failure, a severe diabetic, everybody would be insurable in that window each year, that was his... his criteria.

To avoid the creaming, in other words, just take all the healthy people that aren't sick, of course, that makes a lot of money for insurance companies.

So how do you adjust for that? He has suggested and they have actually implemented this in some of the jurisdictions whereby the government regulation has required that all groups buying health insurance must contribute a small percentage, I think it's two percent (2%) of all the premiums collected, to a pool of money which is then redistributed for the companies that are creaming and making a lot of profits on well people and moving some of their... some of the money or their profits over to the group who are looking after the high risk population.

And that seems to be one way of equalizing the... the risk problem that you're suggesting. Now, it's obviously... no one here has any experience because we have not been able to... to test that.

But in the other jurisdictions, that's... that's the current thinking. There is a way of doing it.

UNIDENTIFIED VOICE:

One other thing though, if I may, in all of the discussions (inaudible) we don't talk about prevention (inaudible) long run, surely, a question of prevention is (inaudible) even more important because that's... it could eliminate a lot of costs. How does your plan work on...

DR. EDWIN COFFEY:

That's where the health purchasing agency comes in which is an information agency and an educator, not only of consumers but of the providers, the insurance company or the alliances or hospitals.

It goes and says, "Look, we know that everybody should stop smoking, drop drinking, don't take drugs and so on and we want a plan that if our clients will not smoke, they won't abuse drugs and so on, we want the best price that you can give us".

In other words, by forcing the insurance groups to lower their prices for... for a consumer group who is willing to... to lower their risk and that's preventive health care.

So you use again market forces, group purchasing, they suggest there should be at least ten

thousand (10,000) people in a health purchasing agency.

For instance, if the... the Association of Accountants of Quebec or the Quebec Medical Association took their membership as a group and formed a purchasing agency, they could leave this kind of results out in the market with competing providers of insurance and health plans.

MR. APANTHAUS STANILIS:

Hi! my name is Apanthaus Stanilis, I'm also a second year medical student at McGill and I'm going to play a bit of a devil's advocate here, like always, you know, it's in the long standing traditions of these debates.

You mentioned there was a couple of (inaudible) that mentioned about freedom... getting more choice for your dollar and that's all fine and dandy but it seems to be you're saying, "As long as you can afford to have an opinion on the matter".

Now, for the poor involved, how does this model or any other model give them more options in terms of can I have, you know, can I get my care at a private institution or can I get it at a public institution?

DR. EDWIN COFFEY:

You noticed that the title of the concept is "Universal Private... Universal Private Choice", everyone has private choice, there are no exclusions.

And the way you enable that is that, first of all, Medicare stays, Medicare is here, universal program, we carry on, we have a Medicare card and I would think that if this kind of concept were, you know, further developed and implemented, the vast majority of people would stay with Medicare, I would probably, for a year or so and see how things went.

But so that everybody will get at least the choice they have now but it might very well become apparent when other competing groups come in to play and start offering a lot of different services that would be more appealing even to the lower income group, they would say, "Ah, I'm going to opt out of the government plan for hospital services and physician services and maybe even laboratory services and put all of that refund or voucher into the plan that's being offered by the Royal Vic, Montreal General laboratory, radiology alliance.

There are high quality physicians, good facilities with the new super hospital and what better care can I have?

And yet, I'm in a very low income position, maybe even a non-taxable position. So that, you know, theoretically, that could answer your question, everybody is equal in this system.

M. MICHEL KELLY-GAGNON:

So we're going to move along immediately... well, thank you to both speakers and to the floor for very good questions.