

### **SESSION III:**

**Michael Hatfield:** [revised by the author on November 21, 2003]

I am going to begin by providing a brief history of Canada's publicly-funded health insurance system because it sets the necessary context for discussing how we treated health related expenditures in our measure. Beginning in the late 1950's hospital insurance became covered by publicly funded single payer plans in each of the provinces and territories in Canada and that process was completed, I believe in 1961. One province Saskatchewan had that kind of system beginning in the mid 1940's and then in the mid to later sixties, all the provinces and territories became covered for doctors visit bills. If you go to your doctor and whatever bill he charges you for your visit, that is now also paid by a publicly funded system. So, as you would expect this covers a large part of peoples' health-related expenditures in Canada. Those expenditures are paid through the tax system as one of the founders of the system Justice Emmet Hall stated the basis of the system "is that we all band together to pay for these services when we are well and earning incomes so that we are not called upon to pay when we are not well and cannot earn incomes."

However, there is still a very large part of health- related expenditures that are not covered by these plans. Prescription drugs for instance; if you receive them outside of the hospital setting are not universally covered. They are partially covered in some plans, most notably usually for seniors; dental care is not covered except in some plans for some children of certain ages, vision care is usually not covered. There are some other things, those services provided by non- traditional health practitioners, such as Chiropractors, acupuncturists and so on, are generally not covered by the health insurance programs. Therefore, as I say, even though we do have a single payer health system, this doesn't get us around the types of problems that the people in the National Academy of Sciences had to struggle with. It does make those problems smaller and as the group that I worked on was developing this measure we paused several times to give thanks that we were doing this in Canada, and not in the United States but we still wind up with the same kind of issues that Patricia Ruggles discussed so ably in the last presentation this morning. If you are going to account for the health care expenditures that people make out of pocket, you essentially have two choices. One is, you can add those expenditures to the threshold. The second choice is you can deduct them from

income before you compare the income to the threshold for the other goods and services. We chose the second method and we followed the example of the National Academy of Sciences in this respect.

I guess there were two reasons why we did that. One was that we were primarily concerned not to bias the results in such a way that people who could not afford all the other items that we did expressly deal with in our basket, people who could not afford to purchase those items because they were making large expenditures on health-related spending; we wanted to make sure that we would identify them. The second reason we did not try to determine how much people should be spending on these out of pocket expenditures that are not covered by our single player plans is that, as in the USA, they are very lumpy. They are not as high in dollar terms but they are very lumpy. There are some people who pay a lot and a big percentage of their income on these and they account for a very large share of total expenditures. Some people pay nothing, if their health is good during the year. Others still, pay small amounts because they have coverage through their employer or they purchase coverage privately or whatever. So in the face of this we said basically, we are not pretending that we are taking account here of what people should be paying to cover their minimum needs for health related expenditures that are not covered by the public plans. All we are saying is hopefully we are identifying most of the people whose health related expenditures, out of pocket are such that they cannot afford to buy the other goods and services in the basket. So I just want to make all that clear. Sylvie did a fantastic job of explaining this in general terms but that was the one part that we kind of agreed between ourselves that I would take on my presentation. So, that's the rationale behind the decisions that we made.

I remember reading at one point that the National Academy of Sciences people have said, if you had a single payer health plan system, this problem essentially disappear. Actually that's not quite true, I wish that were the case, but since not all health related expenses are covered by these plans it is not the case. In fact about 25%, at last count of health-related expenses in Canada are not covered by the public plans, so this is still an issue that you have to deal with in a measure of this type. Interestingly though because of the way that these expenditures are covered in Canada, subtracting these from people's incomes does not push up the low income rate for the way that it does in the United States. Take the elderly, for instance. Using our measure,

the elderly have very low low-income rates. And the reason for that is, is because most of their really severe expenditures are covered by the public plans whether or not the supplemental plans in the provinces go beyond what is required to get Federal financial support. The provincial plans do tend to target groups like the disabled and the elderly who are most at risk of being thrown into poverty by these expenses and cover aids for low-income persons with disabilities or high prescription drug bills. In fact, the people who do in fact pay high out- of-pocket expenses tend to be people who also have fairly considerable money resources, so they are paying for things like expensive health coverage for their seven months spent in Florida during the year or whatever, so they are not so much of a concern for a low income or poverty measure.

The other thing in the text on which I want to expand on a little bit in my presentation is that there remains a problem even after you have decided conceptually what you want to do. The problem is that you can't always exactly implement your concept, because the data just are not fine tuned enough to allow you to do that. What we found very early on our exercise was that what we needed a large sample of people who told us the details of their income and their expenditure on the same survey, so we didn't have to impute any of this. Well, such a database doesn't exist in Canada. I don't think it will ever exist anywhere. If it did exist you would have, as Bill said, you will have a 5% response rate because the interview will take seven hours. So we had to impute a lot of this data. Some of things we imputed we didn't want to impute. That means that we didn't catch all the things we wanted to catch. For instance we use the medical expenses people claim on their income tax forms. Those medical expenses include some things that are not authorized by health professionals which is the standard that we conceptually set. But we were unable to fully implement it because it just wasn't possible to separate out those expenditures which were recommended by health professionals and met some test of necessity and those which were purely discretionary and voluntary, for instance, as I say, purchasing out of country health insurance to take a long trip. So the good thing about it is that in our situation the dollar amounts were not so large that we had to be fearful, we were injecting a major bias into our system by including this. As I say, most of the people who are claiming these types of medical expenses also had fairly high incomes in the first place. So, even after deducting those expenses from their income they weren't anywhere near our thresholds.

The other thing is and this is with reference to the statement that was made this morning about the Latin American countries and trying to move from a system of essentially measuring food cost and then extrapolating from that. It certainly think it is an important thing to move on to other categories of expenditures because as living standards improve and as your own data show, the proportions spent on food or even food, clothing and shelter start to shift to other things. We are finding that our other categories which in your measure is a fairly small residual category, in most of our urban centers accounts for about 25% of the cost of the basket. I just did a couple of quick calculations. If you look into our first report and look at the threshold levels for the 48 geographical areas for which we estimated the cost of the basket for the reference family, you will find that in most of them the other categories winds up being about 25% of the total threshold amount in the basket. And it obviously, as I said, does not include health expenses. It does not include child care expenses because we are dealing with both of those in the same way they were dealt with by the NAS; that is subtracting them from income. As an aside, the child care expenditures are better estimated because the information you get from the tax files on that is much closer to what we were trying to measure than the information on the health related expenditures is.

As I said, that's kind of an historical and contextual exposition of our experience in dealing with these issues. I must say that it returning to my historian academic roots, it is quite interesting that health related expenditures are implicitly linked with the history of poverty measures right from the beginning. Rowntree set up his measure to determine how many people in the city of York, England, lacked the resources to maintain their physical health. That was the whole basis of his basket and as we get into better data and a deeper understanding of the causes and the consequences of poverty, health and poverty remain closely related. We know that poor health is one of the chief causes of poverty. It is also one of the chief consequences of poverty and getting an understanding of how those things inter-relate, I think it is key for policy makers to understand what effect their health policies are having not only on peoples' ability to consume but also what effect they are having on peoples' ability to participate as workers, as citizens and in every other way in the community,

This is my roundabout way of saying, I think what you are trying to do here is extremely important and all of us are who are coming here from Canada, are very

honored to participate in this because we do recognize how important that work is not only as researchers trying to understand poverty and health better but also as policy makers or at least as advisers of policy makers, in my case, about what policies really are effective in making a difference in those outcomes.