INSURANCE BUREAU OF CANADA

BUREAU D'ASSURANCE DU CANADA

Restoring confidence

Submission to:

The Commission on the Future of Health Care in Canada

and

The Standing Senate Committee on Social Affairs, Science and Technology

September 2001

THE INSURANCE BUREAU OF CANADA

Canadians in all walks of life depend on insurance coverage for their cars, homes and businesses to protect themselves against unintentional loss. Property and casualty (P&C) insurance plays a vital role in supporting a strong dynamic economy by providing greater peace of mind with respect to many of the risks involved in modern life. The P&C insurance industry also works to improve the quality of life in our communities by promoting loss prevention, safer roads, crime prevention, improved building codes, and co-ordinated preparation for coping with disasters.

The Insurance Bureau of Canada (IBC) is the national trade association representing the private general insurance industry. Members account for roughly 90 percent of the non-government, non-life insurance business in Canada. The P&C insurance industry is one of the largest employers in Canada, providing some 100,000 jobs. In 2000 the industry paid more than $14.7 billion in claims, including rehabilitation expenses to those injured in road incidents and other circumstances, replacement of stolen goods, and repairs to damaged homes and vehicles.

Direct involvement in the health system as the major purchaser of medical and rehabilitation services for people injured in motor vehicle crashes and other fault-based events drives the insurance industry's interest in health care and its future in Canada. Covering more than 15 million vehicles, automobile insurance is the largest single class of property and casualty insurance in Canada; since all provinces require every motor vehicle to be insured, there can be no occurrence of a motor vehicle incident resulting in injury to individuals that does not bring the involvement of an insurer. The broad scope of health-related activity – from injury prevention, to funding of services delivered in public settings, to responsibility for injury rehabilitation delivered largely by private providers, to paying compensation for lost wages – all of these contribute to P&C insurers' unique perspective on health care in Canada.

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Executive summary

Private insurers spend more than a billion dollars a year on health care for individuals injured in motor vehicle crashes and other fault-based events such as slipping on an icy walkway. The largest portion of these expenditures go to the payment for rehabilitation services for automobile crash victims either under provincial no-fault requirements or pursuant to court awards under the tort system. Automobile insurers also provide direct funding of provincial health insurance plan services through insurance health levies. In 2001 the value of the health levies was $173 million, representing a 300 percent increase from $43 million five years ago. In addition, property and casualty insurers pay substantial sums for the medical and rehabilitation expenses of individuals injured in a wide range of fault-based incidents that can occur at home or on commercial premises. Finally, corporate and payroll taxes – amounting to more than $3.6 billion – are paid by the P&C insurance industry to the federal and provincial governments and constitute a further substantial contribution to the funding of health care in Canada.

Each year, more than 225,000 people are injured by motor vehicles. As the major funder of the health services required by these individuals and others injured in fault-based events, insurers confront challenges that are quite similar to the core issues faced by provincial governments and workers compensation systems in meeting their ongoing health care responsibilities:

- Employing injury prevention strategies to reduce the need for treatment services
- Assuring access to timely and appropriate care for injured individuals
- Achieving the best possible health outcomes
- Preventing insurers' expenditures on health care claims from exceeding the resources available to pay these costs
- Reducing over-utilization of insurer funded health services and, in some cases, fraud by providers or users.

Injuries bring very large pressures on health system resources and substantial costs to society. Each year injuries from all sources are responsible for about 1.7 million days of hospital care – including approximately 200,000 days attributable to injuries from motor vehicles. But the impact of injuries on acute care resources is only part of the whole picture. Injured people usually require rehabilitation services to restore their functional capacity and help them regain quality of life at work and in the community. IBC estimates that, in Canada each year, more than $3.4 billion is expended on rehabilitation services by provincial health insurance plans, workers compensation programs and private insurers. When viewed from the perspective of the total direct and indirect costs to society, the burden of injuries multiplies to $14 billion per year, according to a recent analysis from Health Canada – and in this respect is exceeded only by cardiovascular disease, musculoskeletal conditions and cancer.

Despite the substantial costs attributable to injuries and rehabilitation services, neither has received the attention deserved from health policy decision-makers. As a result, in Canada today there is no national priority, as exists in other countries, on reducing the

incidence of injuries. And for the same reason, rehabilitation in Canada today exhibits some of the most serious examples of poor system performance: fragmentation; lack of service standards and quality control; differential access to care; insufficient accountability for health outcomes; and uncontrolled cost escalation, to name a few.

Prefacing the property and casualty insurance industry's specific proposals for responding to the issues raised in this document, three key system-wide elements are identified as fundamental to achieving a stable future health system that can continue to meet Canadians' expectations for high quality and appropriate care. These are:

- While the principles in the *Canada Health Act* are expected to continue to guide decision-making on health policy throughout the country, these principles will be augmented through increased focus on improving efficiency, effectiveness and individual provider/user accountability in the use of health system resources.

- There will be an ongoing role for both public and private funding of health services, and future health system planning (including standards setting, data collection and analysis, and cost constraint measures) will encompass both components of the system.

- As broad consensus is achieved on initiatives to promote sustainability within the context of our value-driven system (e.g. more integrated delivery of health care with less reliance on fee-for-service funding; a health information privacy framework that supports effective management of care), there will be the commitment from governments to move from discussion to action in a timely manner.

In our specific proposals, the insurance industry has deliberately avoided attempting an exhaustive prescription for "fixing" the national health care system. Instead, the proposals address the specific concerns that come out of insurers' experience in dealing with the health care and rehabilitation needs of injured people, as well as insurers' responsibility for maintaining affordable insurance premium costs.

Summary of recommendations

(1) Launch a permanent national effort on injury prevention

(2) Establish a comprehensive framework for improving delivery and accountability of rehabilitation health services

(3) Improve management of health care data by:
(i) undertaking comprehensive data collection on rehabilitation, and
(ii) implementing the legislative framework for facilitating data sharing among health providers

(4) Increase support for evidence-based rehabilitation research

(5) Improve primary health care through more integrated service delivery and reduced reliance on fee-for-service funding

(6) Make available to consumers clear and useable information on health system performance and on the cost of their personal use of health services

(7) Establish a national target relating the combined total of health spending from public and private sources to the size of the economy.

Introduction

Property and casualty insurance and the Canadian health system

Each year in Canada, more than 225,000 people are injured in motor vehicles. As large as that number is, it has been estimated that close to six times more people suffer injuries from other sources, such as falls and sports mishaps.[1] A significant portion of these people seek the services of professional medical and rehabilitation service providers.

Insurers have a strong interest in the factors affecting the health outcomes of those involved in motor vehicle accidents, as well as in the wellbeing of all Canadians who may suffer from unintentional injuries. This means that insurers also have a firm stake in the effectiveness and efficiency of the health system, as well as in the application of prevention strategies to reduce the incidence and severity of unintentional injuries.

Central to this submission is our belief that effective and appropriate health care should be available to Canadians when they need it. Unfortunately, for rehabilitation services, which is the area of health care where insurers have most experience, there is currently no guarantee that this expectation will be met. The inability of Canada's rehabilitation "sector" to perform at the high level of outcome standards, operational efficiency and accountability expected of other parts of the health system is a source of very significant costs. These costs are social as well as economic; they affect individuals, families, employers and communities, as well as the health system itself.

This submission will address the P&C insurance industry's concerns regarding the future of Canadian health care in four sections:

- The effect of injuries on the health system and society
- Key elements of a vision for Canada's public health system
- The case for a priority focus on rehabilitation
- Recommendations for action

[1] Inferred from National Trauma Registry statistics on injuries causing hospitalizations

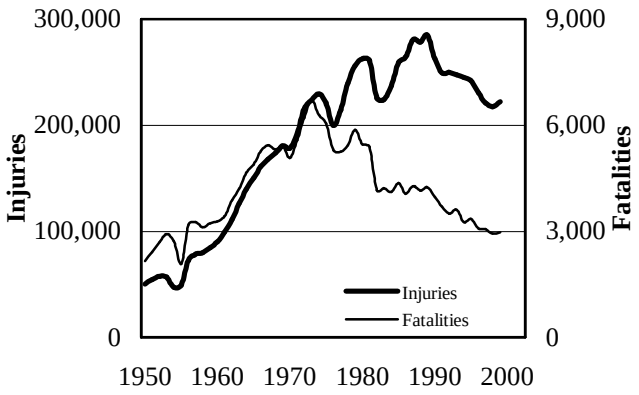
Snapshot of the annual incidence of injuries

Injuries bring very large pressures on health system resources and substantial costs to society. Some sense of the dimensions of injuries as an issue for health care and for public policy generally can be seen from a selection of statistics on the prevalence of injuries and their impact on utilization of the health system:

- According to the most recent data from the Canadian Institute on Health Information's (CIHI) National Trauma Registry, the number of hospital admissions from injuries of all types was approximately 102,000 in 1997/98, or 7 percent of all admissions in Canada. With an average length of stay of 9 days, injuries were responsible for a total 1,738,778 days of hospital care. Injuries from motor vehicle crashes accounted for more than 200,000 hospital days and an average length of stay of 7 days.

- The latest available data from Transport Canada reveals that approximately 225,000 people were injured in 1999 as a result of a motor vehicle incident. This resulted in 29,319 hospitalizations of crash victims lasting one or more days. Motor vehicle incidents were the second largest source (15 percent) of hospitalizations from injury. By contrast, unintentional falls were responsible for 54 percent of injury hospitalizations.

Road traffic injuries and fatalities



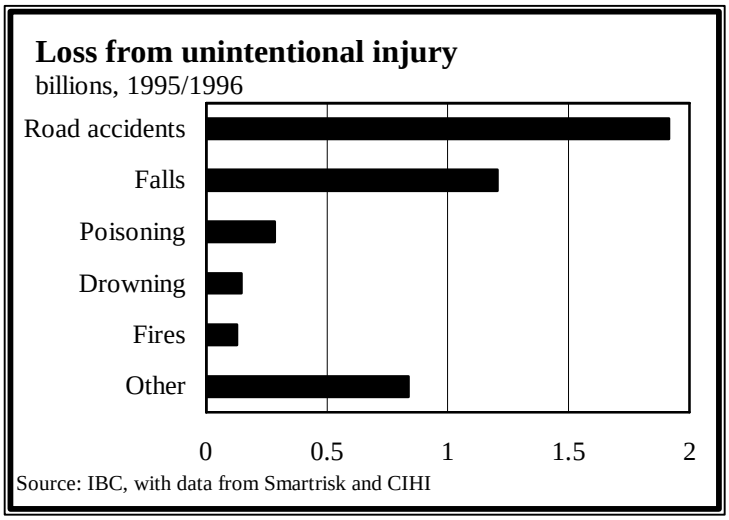
Source: IBC, with data from Transport Canada

- CIHI's data relates only to injuries that result in at least one night's stay in a hospital, and, at present, there does not exist a national source of information on injuries that do not require overnight hospital care. (For example, hospital emergency room visits from injuries are not included in the hospitalization data). However, it is known that the vast majority of people who seek assistance for injury from health care providers are never admitted to hospital. In the case of individuals injured by automobiles, insurance companies estimate that between eighty and ninety per cent of medical claims relate to soft tissue injuries where treatment may be provided by a physician and/or by other regulated or non-regulated health service providers. Although not always requiring acute care, these kinds of injuries can often lead to extensive treatment and affect individuals' productivity, lifestyle and wellbeing over a long duration.

The burden of injuries on the health system and society

In recent years, health care researchers have become increasingly attracted to studying injuries in order to lay the groundwork for increased public awareness and more focused and effective public policy to address the injury problem in all its dimensions. An initial effort of injury research in Canada has focussed on documenting the total costs to the country from injuries. For this purpose, the major costs are divided into the direct costs of providing health services to treat the injury and the indirect costs that relate to the individual's loss of ability to perform the major life activities such as working, child rearing and so forth. The findings arrived at through these analyses are notable, both for their sheer size and for the messages they carry about the need to address the prevention and effective care of traumatic injuries as a central element of health care:

- In 1997, Health Canada reported that injuries cause $14 billion[2] in total direct and indirect costs to society. Total costs from injuries are exceeded only by cardiovascular diseases, musculoskeletal diseases, and cancer.



- Studies into the costs of injuries, whether carried out in Canada or other jurisdictions, consistently show that the direct medical costs of treating injuries are typically outweighed by the indirect costs, such as lost earnings. This was confirmed by the Health Canada study cited above. Both private insurers and workers' compensation boards experience high disability payment costs.

- While the occurrence of diseases such as cancer and cardiovascular disease rises with age, most injuries (the exception being falls) are far more common among individuals in their most productive years. In the case of injuries from motor vehicles, 42 percent of hospital admissions involve individuals aged 15 to 35, while another 34 percent are people between 35 and 64 years old. Indeed, automobile crashes are the leading cause of death for Canadians between the ages of 14 and 24.

In a 1999 study carried out by the aptly-named SmartRisk/*Sauve-Qui-Pense*, the authors ask the question "Why examine the economic burden of injury?"[3] Canada's insurers endorse their answer to the question, which reads as follows:

[2] *Economic Burden of Illness in Canada*, Health Canada, 1997. The estimate was based on 1993 data.
[3] *The Economic Burden of Unintentional Injury in Canada*, SmartRisk/*Sauve-Qui-Pense*, 1998.

"The epidemiological information suggests that there are substantial costs incurred from unintentional injury. Not only from the perspective that already scarce health care resources are required to treat, care for, and rehabilitate injured persons, but also from the high number of productive years of life lost due to premature death and long-term disability. No less important are the costs … experienced by injured persons and their families and friends."

Key elements of a vision for Canada's public health care system

Setting the Context

For most of the two decades following the establishment of universal health care in Canada, private insurers played a limited role in the health care system. The statutory primacy of the public system coupled with the greater reliance on hospital-based care during this period (for acute care, recuperation, and rehabilitation) helped to confine insurers' payer role largely to the realm of extended and supplementary services and payer of last resort. Overall, insurers during that period saw themselves as passive payers of a limited range of health services that were not covered by provincial health insurance plans.

Over the past 10 to 15 years this situation has changed significantly all across the country. This is the result of several factors. Budget pressures have prompted hospitals everywhere to push ever-larger portions of the recuperation and rehabilitation services that injured people need into the community and, increasingly, out from under the protection of the Canada Health Act principles. Meanwhile, changes to provincial automobile insurance legislation and related developments have directed the insurance industry to take over a great deal more of the responsibility for paying the medical and rehabilitation costs incurred by injured crash victims. The predictable consequence of these changes has been to dramatically increase both the absolute and relative amounts of insurance claims expenditures on medical/health treatments. With this has come a growing sense within the industry that the traditional role of "passive payer" is not compatible with current needs to know (i) that the resources expended on treatments are leading to positive health outcomes; and (ii) that health costs remain affordable within a framework of insurance premium prices that are acceptable to our customers.

As increasingly important payers for health services, insurers today confront challenges that are in many ways analogous to the core issues faced by provincial governments and workers compensation systems in meeting their ongoing health care responsibilities. As a result, the insurance community's vision of the policy directions needed to achieve cost-effective management of insurers' health care obligations contains key elements relating to the management of the health system as a whole. These are described below. The subsequent section of this submission will address specific concerns related to the provision of rehabilitation services.

Three Critical Elements of a Sustainable Health Care System

A. Balancing the core values underlying health care

The principles established in the *Canada Health Act* are a unique statement of the values underlying our current system. In light of the broad public consensus on these principles, the insurance industry accepts that the Canadian public wants them to continue to underlie national health policy in the years ahead. We also believe that they provide broad scope for innovation in meeting the health care challenges of our time.

At the same time, we see as regrettable the fact that the concepts of "efficiency", "effectiveness", and "user/provider accountability" were not embedded with the foundational values of our health system. This needs to be addressed as we look to creating the conditions for sustainability.

The absence of efficiency and effectiveness from the original value framework for health care in Canada may be one of the reasons why our universal health system has historically not placed sufficient emphasis on evaluating health outcomes; why performance indicators have not been routinely used to measure the effectiveness of components of the system; and why evidence has often not been demanded as the basis for resource allocation, treatment options and other important processes. This began to change with the growth of concern about the pressures to continuously increase health system capacity. Still, a legacy of low valuation, even mistrust, of the efficiency and effectiveness concepts as applied to health care continues.

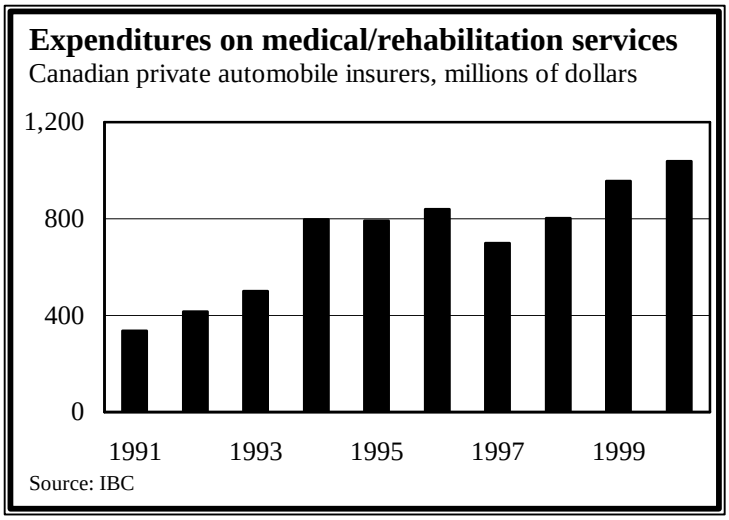
Similarly, the limited prominence accorded to user/provider accountability for the efficient use of health resources has, in our view, contributed to current fears that the system may be becoming unsustainable. The health system needs to be seen as an asset from which every Canadian benefits, and, because of this, every Canadian needs to share in the vigilance that it is not used inappropriately, inefficiently or fraudulently. Too often, however, this is not the case. Because health services, whether paid for by a provincial health insurance plan or an insurer, usually come to individuals as "free goods", there may not be the incentive to use the service only to the extent that it is needed. Insurance files provide evidence that a significant number of claims involve excessive, duplicative, or, in some cases, non-existent services.[4]

Improving the flow of information to the public about health system performance and costs is a key strategy for raising appreciation of the connection between efficiency, effectiveness, and individual accountability, on the one hand, and ensuring the sustainability of health care, on the other. There is, in addition, sound evidence of the need for the major funders of health care to work together to develop specific mechanisms to strengthen individual accountability for the proper use of health system resources, regardless of who is providing payment.

[4] The Canadian Coalition Against Insurance Fraud has recently carried out a research study to determine the incidence of fraud in personal injury insurance claims in Canada. The findings of that study will be reported in detail in the Coalition's submission to this Commission.

B. Preserving a positive role for private funding in Canada's health care system

The property and casualty insurance industry provides very significant funding to what are generally viewed as the "public" and "private" segments of the health system. While the insurance industry is sensitive to the public debate about the role of private funding, we believe our own experience testifies to the value that private funds can bring to health care. Our experience also carries lessons about how to take advantage of the presence of private funding while avoiding some potential difficulties.



The simplest indicator of the value of private involvement in health care is the additional funds that it brings to the system. Nationally, CIHI reports that, for the year 2000, funding from private sources was $27.5 billion or about 30 percent of total health spending. Clearly, private funding of this magnitude is significantly expanding the capacity of our health system. It is thereby enhancing the system's ability to deliver on the values underlying health delivery in Canada and the associated public expectations. Yet another important and positive impact of private involvement in paying for health services is the proliferation of competition that it engenders among services, providers and agencies – which can only improve the range of choices available to users and ultimately the level of consumer satisfaction.

The presence of private sources of funds is a strength in our system. At the same time, insurers' experience bears witness to the problems that can arise when the existence of multiple funders of health care is permitted to translate into discrete silos of care and different standards of care, based on the source of funding. To illustrate, providers and consumers often cite evidence pointing to differential access to rehabilitation services depending upon who is paying for the care. This is not a new phenomenon, but it appears to be a growing trend. According to a group of researchers from Ontario's Institute for Work and Health, the point was graphically illustrated during a visit to a physiotherapy clinic. This is what they saw:

> "In the clinic was a reception desk divided into two parts. A wall divided the clinic space. On the right was a so-called "Schedule 5 clinic" where physiotherapy services are paid for by OHIP, and on the left was the "private clinic" where the services must be paid for by the client or the client's insurer.
>
> "The clinic owners said that for professional and ethical reasons, they insisted that there not be *too much of a difference* (emphasis added) between the care provided on each side of the wall. Consequently, similar pieces of equipment were found on both sides, though in greater number on the "private" side. The clinic owner emphasized that the fees paid by OHIP were not really

> adequate to provide the kind of care that was being provided on the "private" side. Presumably (though the clinic owner did not explicitly state this), the fee structure means that in this clinic there is an effective subsidization of the "Schedule 5" OHIP side by the "private" side."[5]

Scenes like this one are inconsistent with the spirit, if not the letter, of the *Canada Health Act* principles, and with our proposed additional principles of efficiency and effectiveness.

They are also entirely avoidable. However, preventing these consequences requires the people who plan and make policy decisions for the health system to not treat privately funded services and treatments as though they are outside the nation's health system. Similarly, it is not productive for major funders, such as insurers and workers compensation authorities, to have virtually no role in overall planning and evaluation processes for the sectors in which they have most involvement, although this is currently the case.

If it is agreed that timely and appropriate treatment is no less important for a teenager who breaks his neck diving into shallow water than it is for a stroke victim, or than it is for a motor vehicle accident victim who has suffered a brain injury, then it should not be impossible to find agreement on organizing the health system such that these individuals benefit from the same quality of care, whoever is paying the cost.

For the entire history of universal health care in Canada, private sources have played a significant part in the funding of our health system. This is not likely to change, nor should it. However, realizing the full potential of private funds to benefit health care in a value-driven system will require different and more inclusive planning and decision-making processes than currently exist.

C. Committing to action

IBC does not subscribe to the "crisis" language used by some to describe the current state of the Canadian health care system. In part, this is because we believe that over the past thirty years Canada has achieved a fundamentally sound model for meeting the health care needs of our population. There exists in Canada today a wealth of experience in managing an ever more complex health system that has had to change and adjust through dramatic demographic changes, the emergence of new diseases and increased incidence of others, and through broad swings in the strength of the economy. The tradition of excellence among the nation's health professionals is known world-wide, and we continue to stand at the highest levels in international comparisons of population health, such as life expectancy and infant/child mortality. Another vitally important strength of Canada's health system is found in the broad, often passionate, support it commands with the public.

In addition, the insurance community is aware that the problems and challenges to our health system are really no different from those faced by almost every country.

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[5] *Rehabilitation Services Inventory and Quality Project*, Phase I Report, Institute for Work and Health, 1995.

Everywhere the pressures for more and better health care push up against the ability of nations to pay for more and better. Within a range, the factors feeding the pressures are similar or the same: population age bulges among the young or old; technology and innovation in treatments; rising drug costs; and a growing scarcity of skilled health personnel, to name the most prominent ones. While the issues needing to be addressed in ensuring sustainable health care systems are certainly serious and difficult, the presence in Canada of abundant expertise in managing health care and the broad popular consensus on the values underlying our system place us in a position that is better than most for dealing with them effectively.

Over the past decade or so, a great deal of research has been carried out in Canada, exploring ways to achieve more cost-effective and sustainable health care. Through study after study, the themes of what needs to be improved on in our system have been remarkably consistent, as have the remedies proposed. Among the most frequently echoed recommendations are the following:

- There is need for a great deal more attention to *prevention, health education and public health* to develop the partnership with the users of the system in helping to maximize population health and, in turn, to have a major impact in keeping costs from escalating to an unmanageable level.

- The *primary care* system needs to change to achieve more efficient and consumer-focused delivery of first order services, to reduce reliance on fee-for-service funding, to lessen opportunities for service redundancy and to remove utilization pressure from high cost secondary care deliverers.

- The investment needs to be made in implementing an *information infrastructure* supported by *up-to-date personal health information rules*, to realize the quality and productivity goals of more integrated health care

- There needs to be sufficient commitment from government and academic institutions to *research* on the evidence basis for care modalities and the timely transfer of research knowledge within the health care system.

- There is a need to institutionalize *collaboration and information sharing* among funders and providers to provide better care in accordance with best practices; to reduce duplication and inefficiency; and to plan for the effective allocation of health human and financial resources.

Like the vast majority of other stakeholders consulted in the previous studies that produced them, insurers support these directions. However, after noting the consistency among the remedies proposed for sustainability and improved health outcomes, it is with a sense of considerable frustration that we also remark the very limited progress achieved anywhere in Canada on most of the major recommendations. The apparent preference among governments for study over action has produced little progress on ensuring that the health system is sustainable. The time to act on what is already known about how to improve and preserve a national health system is now overdue.

Getting to the future: the special case of rehabilitation

Unintentional injuries cost Canadians billions of dollars every year, yet they persist as a predominantly hidden epidemic. Injuries have less identity and recognition in health policy in Canada as compared to other health issues.[6]

These words, adapted from the introduction to a recent study of injury costs, apply equally to the rehabilitation component of health services. Never in Canada has rehabilitation been treated as part of the mainstream of planning and resource allocation for health care. As a result, rehabilitation exhibits some of the most serious examples of poor system performance: lack of service standards; differential access to care; insufficient accountability for health outcomes; and uncontrolled cost escalation, to name a few.

> *"Stakeholders identified a number of issues affecting neurotrauma survivors, such as: limited access to support services early in the injury, difficulty obtaining early and intensive rehabilitation services following discharge from acute care…rising costs for health supplies and independent living equipment; insufficient and inconsistent provision of home care services across health regions…restrictive eligibility requirements for programs and services…benefits based on the cause of the injury or financial status rather than assessed need…limited control over the services they receive."* From "Report on Community Rehabilitation of Neurotrauma Survivors and their Families", Alberta Centre for Injury Control and Research, 1999

What is rehabilitation?

The World Health Organization defines rehabilitation as follows:

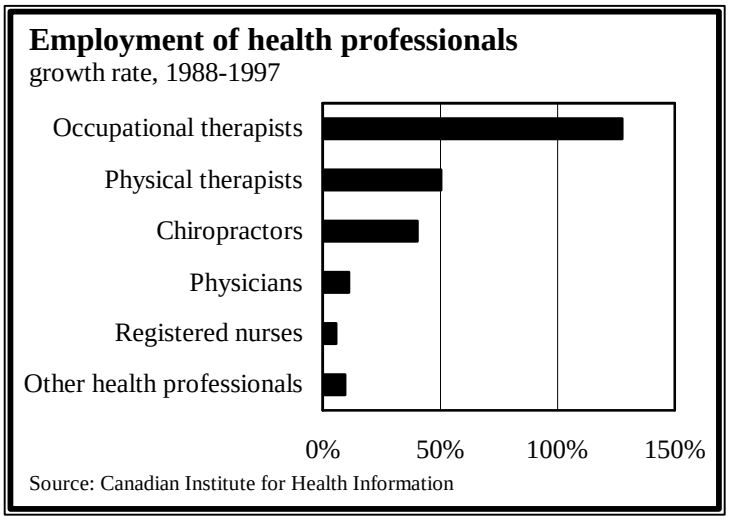
Rehabilitation is a goal-oriented and often time-limited process, which enables individuals with impairments, activity limitations and participation restrictions to identify and reach their optimal physical, mental and/or social functional level through a client-focused partnership with family, providers and the community. Rehabilitation focuses on abilities and aims to facilitate independence and social integration.

This definition helps to illustrate the vital nature of rehabilitation as a class of health services. On the one hand, it suggests that the real value of rehabilitation is its role in helping individuals to achieve an optimal level of function and independence. To accomplish this, rehabilitation addresses all spheres of life including mobility, communication, activities of daily living, leisure and spiritual and emotional concerns. On the other hand, the broad focus of rehabilitation translates to a multiplicity of practice settings and modes of treatment. Rehabilitation is delivered through general and specialty hospitals, on an in-patient and out-patient basis, as well as through family physicians, privately owned clinics, community health clinics, schools and long-term care facilities. At the front-line level, a broad spectrum of regulated and unregulated health care professionals is involved in the provision of rehabilitation services.

[6] Adapted from the introductory paragraphs of *The Economic Burden of Unintentional Injury in Canada*

At present, a national database for rehabilitation services does not exist.[7] Consequently, it is difficult to convey more than a rough picture of the "rehabilitation sector".

A unique feature of rehabilitation is that there is a multiplicity of individuals and organizations that pay for services. Indeed, given the complexity of the payer system, it has proved difficult to put together information on how much is being expended, by whom and for what services. Some notion of the magnitude of the national rehabilitation effort can be inferred from Ontario information indicating that, in 1999, automobile insurers spent approximately $650 million on rehabilitation services[8], the Workers Safety and Insurance Board spent about $111 million on rehabilitation of injured workers, and the Ontario Ministry of Health and Long Term Care allocated a little more than $600 million to rehabilitation. Assuming that the Ontario amounts are about 40 percent of rehabilitation expenditures nationally[9], the total for Canada is here estimated at more than $3.4 billion.



The data on health providers working in rehabilitation is also far from comprehensive. CIHI's registry of health professionals reports that in the three top health professions associated with rehabilitation – chiropractic, occupational therapy and physiotherapy – there were 16,063 registered professionals in 1988 and, by 1997, this number had risen by more than 64 percent to 26,386. (By contrast, the number of physicians and registered nurses increased during the same period by 11 percent and 6 percent, respectively.) In addition, there are many other types of health providers involved in delivering rehabilitation service in a number of treatment streams – including psychologists, massage therapists, naturopaths, acupuncturists, kinesiologists and others. There are indications that the number of practitioners in these groups has also been growing rapidly in recent years. However, the absence of systematic data collection in this area makes it impossible to know the overall rate of growth of the professional rehabilitation community or the degree to which their combined services and costs represent unmeasured components of the total health system.

[7] CIHI's recent effort to substantially improve upon existing data in this area is limited to rehabilitation services delivered by hospitals.
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[8] This figure does not include the rehabilitation component of personal liability claims. The latter is currently not identified separately in the insurance data.

[9] In fact, Ontario's share of total health expenditures in 1999 was approximately 39%.

Growth pressures on Canada's rehabilitation services

The need for rehabilitation may come after an injury suffered at work, in an automobile or any other location. It can also come following a disease event such as a stroke or heart attack, or a musculoskeletal condition such as a joint replacement.

In the case of injuries, the first section of this submission provided a snapshot, drawn from the most recent – but incomplete – data available, of the number of individuals who each year suffer injuries that will require them to seek some type of rehabilitation service: more than 100,000 injured people admitted annually to hospital and 80 to 90 percent of automobile crash injury claims requiring rehabilitation services delivered outside the hospital are major, albeit partial, indicators of the demand.

With respect to the other diagnostic categories that may involve specific rehabilitation needs, there is currently not even the level of data that is available on injuries to indicate the size of the demand for rehabilitation that these conditions generate. What is known, however, is that two of the major precipitating conditions for rehabilitation needs are among those whose prevalence and cost are so dominant: cardiovascular disease and musculoskeletal conditions.

Looking to the future, there are strong indications that pressures to increase the existing capacity of rehabilitation services will be significant. For instance, the National Trauma Registry reports that in 1998/99 the national average age for injury admissions to hospital was 49 years. Injury admissions for people over the age of 65 accounted for 35 percent of all injury admissions. This group was responsible for almost 64 percent of hospital days from injuries, indicating that not only is the incidence of injury higher in the older population, but also the injuries incurred are more severe and difficult to recover from.

There is also evidence that even today the capacity to provide needed rehabilitation services has not been keeping up with the demand. An example is found in the waiting lists for rehabilitation services that were recently published by the *Regroupement des establissements de readaptation en deficience physique de Montreal*. As of March 31, 2001, 9,391 people were waiting to receive rehabilitation services in Quebec. A similar finding of deficient capacity was made by the Chronic Care Role Study, conducted for the Ontario Ministry of Health, which looked at waiting lists in acute care hospitals and found that 84 per cent of the people on lists were waiting for long term care or rehabilitation. At any point in time an average of 328 patients were reported to be occupying hospital beds inappropriately because of the unavailability of suitable rehabilitation services.

Problem issues in rehabilitation

In our attempt to describe rehabilitation in Canada, some of the serious problems affecting the sector have been alluded to. Here, we present views on the major issues in rehabilitation that demand attention from public policy. The issues we have identified emerge from the experience of insurers in working with injured people and their health providers to achieve optimal recovery, functionality, and quality of life.

✍ *Fragmentation of the rehabilitation sector and impact on quality and continuity of care:*

Fragmentation of services is frequently cited as a problem throughout the health system that produces adverse consequences for patient care as well as for cost containment. In rehabilitation, it is particularly pronounced because of the presence of multiple funding sources. At the provincial level, there are typically no forums for the major funders and providers to share information, plan and develop mutually compatible policies. As a result, the walls of the silos *within* rehabilitation can seem particularly thick to the people needing services.

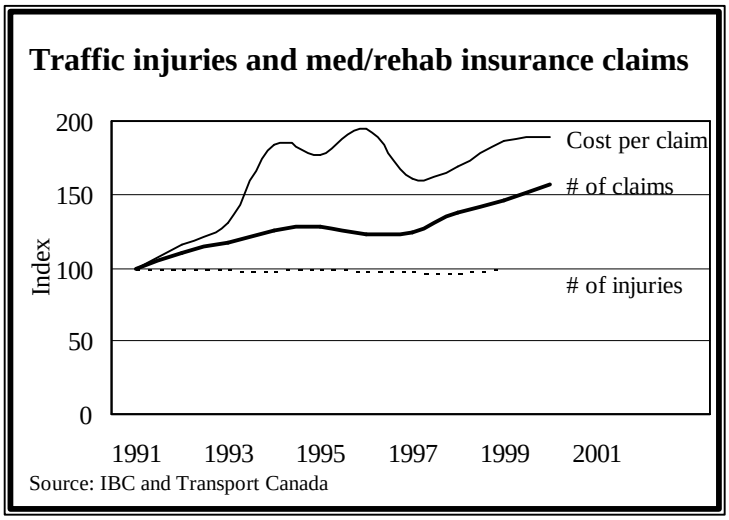
For an individual trying to recuperate from a serious injury, the fragmentation of rehabilitation services can mean that the plan of care is interrupted as she moves from an institutional setting to community based care. It can mean that she has to endure a long wait for treatment or cannot receive appropriate treatment because the service is not available in the funding stream she happens to be eligible for. In rehabilitation, where early intervention and continuity of care are usually critical to optimizing the health outcome, these are very serious symptoms of performance failure. Moreover, many insurers have observed that the fragmentation of services can present patients with a confusing array of choices, and lead to duplication or redundancy or the choice of an ineffective treatment. Nor can patients always rely on providers to ensure that care is based on the patient's best health interests. For, as described in a recent report to a physiotherapists' organization, fragmentation of the field can promote "load-shifting" whereby providers attempt to minimize their costs by transferring patients to other providers in both private and public sectors.[10]

✍ *Uncertainty surrounding the limits of provincial health insurance plans for rehabilitation and of the role/accountability of provincial ministries of health regarding the large portion of rehabilitation services that are not funded by government:*

Health care restructuring across the country and changes in provincial lists of insured health care services have resulted in an increasing proportion of rehabilitation services being privately funded. As some rehabilitation services continue to be provided by provincial health plans, however, it is often unclear how those resources are accessed or if the patient's care is covered under private or public health insurance. For the individual, this uncertainty adds to the difficulties of trying to navigate the system. Most importantly, it can be disruptive to the patient's recovery.

[10] Cummins R. "Paymasters in Revolt: The Environment for Physiotherapy in Ontario. Prepared for the College of Physiotherapists of Ontario", January 19, 1996.

At the system level, once responsibility for a stream of treatment leaves the publicly funded segment, there often is no one to monitor the transferred activities. There is no organized data gathering, no way of determining who may be falling between the cracks, no systematic problem identification, and no sector-wide planning. As well, government concern for the cost of services largely disappears once it is assumed that costs will be paid by insurance or by individuals. Whereas the provinces have aggressively pursued strategies to contain cost escalation of the publicly insured services through, for example, compensation policies and efficiency measures, these governments have made available few, if any, mechanisms to those seeking to bring cost discipline to privately funded rehabilitation services.



Effective rehabilitation is an important matter of population health. In a value-driven health system, issues such as access, quality of care, consistency of outcomes, and cost-effectiveness are equally important to patient well-being and affordability wherever the service is delivered and regardless of who is paying. However, the absence of an oversight function encompassing the entire rehabilitation sector ensures that the reality falls far short of this ideal.

✍ *Absence of data on the rehabilitation sector, including utilization of services by providers and users*

The fact that national funding and utilization data for rehabilitation services are not collected on a regular basis is symptomatic of the generally low valuation that is placed on this part of the health sector. Several initiatives are under way to find out more about rehabilitation, two of the most promising of which are being led by IBC in Ontario and CIHI at the national level to develop standardized invoices for use by rehabilitation providers, as well as a related data warehousing capacity. Still, we are not aware of any plans to begin to collect systematic, ongoing data on who is working in the sector as a whole, what the structure of the private portions of the industry is, overall capacity, utilization and so forth. As in every other part of the health system, having good, comprehensive data is critical to being able to ensure that the people needing rehabilitation services are being treated effectively.

✍ *Insufficient research on treatment outcomes and outcome measures*

Although research is being done in rehabilitation services, this sector – rapidly growing in size and importance – is traditionally relatively under-funded for research. This is illustrated in the observation by SmartRisk/*Sauve-Qui-Pense* that although injuries are the cause of 7% of the hospitalizations that occur annually in Canada, rehabilitation commands only 1% of the research dollars available for health-related research in Canada. In addition, as there is no inventory of the rehabilitation-related research that is

being done, it is difficult to determine what research is going on where, and when results are likely to be available. For the same reason, the findings from research cannot be counted on to be known by rehabilitation practitioners, administrators and funders.

The people using rehabilitation and those funding it have the same interest in pursuing treatment strategies that deliver optimal health outcomes as quickly as possible. For this to happen there needs to be a great deal more research on issues such as the evaluation of alternative treatments for commonly encountered disabilities, outcome measures that are appropriate for rehabilitation, and injury prevention.

✍ *Absence of consensus guidelines on best practices in treatment for common conditions requiring rehabilitation services.*

One of the best ways of ensuring the dissemination of results of research is through the development of consensus guidelines. However, as distinct from other significant health conditions, there are few examples of widely used treatment protocols in rehabilitation, with probably the best known being the tool developed by the 1995 Quebec Task Force on Whiplash Disorders.

The many practitioners and practice settings involved in treating similar disabilities heighten the need for best practices guidelines in rehabilitation. Consensus guidelines are a necessary catalyst to improving standards in the delivery of rehabilitation services, to reducing unnecessary costs in the public and private rehabilitation segments and to eliminating duplication of rehabilitation service utilization.

✍ *Inconsistent quality assurance*

The absence of consistent evaluation processes being applied across the rehabilitation sector leaves patients and payers with little reason for confidence that they are not at some risk for uneven or incompetent treatment. Undoubtedly, the vast majority of providers are competent, and practice knowledgeably and in accordance with the standards of their profession. When the provider is a member of a regulated profession, there is generally a requirement for participation in some kind of continuing competence activities. However, this is not the case for unregulated providers, nor is there usually any requirement for health agencies – whether publicly or privately funded -- to engage in quality assurance. As a result, often "word of mouth" is the only means available to a consumer to learn where the quality of care is highest and where quality may be problematic.

✍ *Shortages of rehabilitation professionals and the absence of human resource planning that takes into account the needs of the entire spectrum of rehabilitation services*

Yet another important symptom of fragmentation in rehabilitation is the growing inequity in the rates of pay within the sector, and particularly between the public and privately funded components. The concerns that this phenomenon raises are twofold: first, that scarce human rehabilitation resources will migrate to situations where the pay is highest; and, second, a high cost structure is being built into the privately funded portion of rehabilitation, without there being mechanisms for moderating this cost escalation.

Recommendations

The property and casualty insurance industry's recommendations to the Commission are not intended to be an exhaustive prescription for "fixing" the national health care system. Instead, they are directed to the specific issues and concerns discussed in this paper, that come out of insurers' extensive experience in dealing with the needs of injury victims.

The major theme running through our recommendations is the need for stronger tools for strengthening performance and accountability – for improved health outcomes, more efficient use of resources, and better protection of the public – in all parts of the health system, and, in particular, the rehabilitation sector. We also intend our recommendations to convey optimism that Canada's health system *can* change in ways that reflect the requirements of sustainability, while substantially improving achievement of the values and goals that Canadians look for in the health system.

Recommendation (1)
Launch a permanent national effort on injury prevention

Injuries are exacting an enormous, but largely avoidable, toll on Canada's society and economy. We need to do more to prevent injuries

The automobile insurance industry has for many years recognized that better designed vehicles, improved road safety, and capable drivers will reduce the number of motor vehicle accidents and the severity of bodily injuries. The industry supported mandatory vehicle seatbelts in the 1960s, campaigns against drinking and driving in the 1970s and 1980s, and championed road safety initiatives and graduated licensing in the 1990s. While these and complementary efforts by other organizations and governments have paid off in the trend to lower injury and death rates from motor vehicle crashes over the past thirty years, the number of automobile incidents resulting in bodily injuries remains high and costly in the broadest sense.

Numerous studies have concluded that *the single most effective way to reduce the cost of injuries is through effective injury prevention programs.* These findings have produced significant public policy responses in a number of countries. Canada needs to follow their lead in establishing a permanent priority effort targeted at injury prevention. The goal of this effort should be nothing short of creating a *culture of safety* that is shared by all Canadians in every part of the country.

Federal government leadership of the injury prevention initiative will help to ensure a national scope and consistency of effort. But the program must also enlist the long-term commitment of the provincial governments, worker safety and compensation organizations, health agencies, consumer product manufacturers and the insurance industry. Specific, measurable injury prevention goals need to be set and annual reports issued on the progress realized in meeting the goals. Finally, a variety of tools -- ranging from public education measures to legislative/regulatory action to incentive/disincentive

mechanisms for injury prevention – need to be developed to promote safety in all dimensions of life.

Recommendation (2)
Establish a comprehensive framework for improving delivery and accountability of rehabilitation health services

The problems of fragmentation, low performance accountability and absence of cost containment tools in rehabilitation are symptomatic of the relative neglect that these services have suffered from policy makers across the country. This needs to end with the establishment of new mechanisms charged with overseeing the rehabilitation sector and achieving a higher standard of public accountability for its health outcomes and more efficient use of its resources.

IBC recommends that a Rehabilitation Effectiveness Council be established in each province to bring together the major funders of rehabilitation to address the issues and concerns related to service delivery in every province. We foresee the following elements forming the mandate for the Rehabilitation Effectiveness Councils:

- Articulate a vision for rehabilitation.
- Coordinate consistent data collection on rehabilitation in the province within a national data collection framework.
- Share information on utilization trends, best practices and research needs.
- Monitor the key aspects of performance in rehabilitation, including the capacity to meet demand, consistency of standards of care across the system, access, pertinent human resources issues, and costs.
- Identify patterns of inappropriate and over-utilization of rehabilitation services and respond with measures to enforce providers' and users' accountability for the proper use of system resources.
- Identify strategies and tools to enhance the cost-effectiveness of rehabilitation services, and
- Provide input into health planning insofar as it affects rehabilitation.

Recommendation (3)
Improve management of health care data by:
(i) undertaking comprehensive data collection on rehabilitation, and
(ii) implementing the legislative framework to facilitate data sharing among health providers

Existing public policy on health data management is negatively affecting the potential to improve the rehabilitation sector's performance in two ways. On the one hand, the absence of a comprehensive national database on rehabilitation confounds effective monitoring and planning for the sector. On the other hand, in rehabilitation the multidisciplinary nature of care makes it particularly critical for providers to be able to access pertinent patient information across the professional and service agency silos – yet

in many Canadian jurisdictions, this is made difficult by existing laws governing personal health information.

There are various initiatives under way to enhance the information base for rehabilitation. The work of IBC and the professional rehabilitation community in Ontario, with support from the Financial Services Commission of Ontario, to develop a standard invoice is an important example of this. So too is the agreement among the country's workers compensation organizations to work together to standardize data collection based on the ICD-10 system. The recent announcement by the Canadian Institute for Health Information of the launch of a national reporting system for adult in-patients receiving rehabilitation services is also positive.

At the same time, it is still unclear whether or how these data collection projects may come together. A single and comprehensive national rehabilitation database is needed to encompass the continuum of rehabilitation services from hospital care through community-based treatment programs to long term care.

Regarding the issue of provider access to personal health information, rehabilitation shares with other components of the health system the need for rules that permit a variety of regulated health professionals to easily access patient data. This is key to being able to effectively manage a plan of care, without unnecessary duplication of services and inadvertent errors of omission and commission. Providing a legislative environment that supports and facilitates this kind of information flow is, therefore, an essential – and urgently needed – part of the infrastructure for sustainable health care.

Recommendation (4)
Increase support for evidence-based rehabilitation research

The insurance industry was disappointed that when the National Institutes of Health Research were established in 2000 there was no National Institute for Rehabilitation Research. It is time to correct that omission with the establishment of a national organization with the mandate to focus on linking and supporting researchers pursuing the common goal of improving the effectiveness of rehabilitation services. In light of the wide diversity of practitioners and practice settings involved in rehabilitation, an important component of this organization's activities will be to mount a broad program for knowledge transfer.

More than three and a half billion dollars per year is spent by provincial health ministries, workers compensation organizations and insurers on rehabilitation services. We believe that Canada's research effort for injuries and rehabilitation should be proportionate to their contribution to the total costs of disease and injuries. Establishing this goal for supporting research on rehabilitation makes economic sense. It also offers the best hope to the many thousands of people for whom the burden of injury is a daily, personal experience.

Recommendation (5)
Improve primary health care through more integrated service delivery and reduced reliance on fee-for-service funding

Most of the authoritative recent studies of the health system have identified the need for significant changes to the primary care system in Canada. The reasons cited relate to quality and continuity of care objectives and to the recognition that fee-for-service is a flawed and expensive method of funding health services. Yet, despite many calls for these reforms, very little has in fact changed in the way primary health care is delivered and funded. So, for patients and their families, finding out how to navigate the system remains one of the most awesome challenges of recovery and rehabilitation. Similarly, fee-for-service remains the dominant mode of paying for primary health services.

Integrated health service delivery is a far better care model for injury victims, whose rehabilitation needs may include physical and occupational therapy, drug therapy, long-term care, mental health services and more. Equally important is the opportunity, provided by moving from fee-for-service to alternative payment plans, to build in specific mechanisms for accountability and quality control. For insurers, the experience of managing health claims in a context where payment is almost always on a fee-for-service basis testifies to the absence or weakness of such safeguards in this environment. This must change.

Recommendation (6)
Make available to consumers clear and useable information on health system performance and on the cost of their personal use of health services

Thirty million Canadians are the true owners of our health care system. As individual users, they need to have the information and the knowledge to make informed choices about their health care. As custodians of the system, they need regular, factual information as to its cost, capacity, and performance.

At present, most information on system performance is targeted to decision-makers and providers, but is rarely of practical use to consumers. For example, the hospital report card program, initiated by the Ontario Hospital Association, does not yet offer users clear, comparative information on where a particular procedure is being performed with greatest success or how the incidence and severity of medical errors compares among institutions. On another level, there are probably few Canadians who have a realistic sense of their own actual and potential contribution to the cost of providing universal health care. Should they wish to find out, the information is unavailable or inaccessible.

Consumers should be provided with specific information on the cost of their personal health services utilization.[11] They also need access to a great deal more information than is currently available on the performance of publicly and privately funded health care delivery agencies. These measures should be developed through a cooperative process

[11] Broad public support for this concept was demonstrated in a national poll conducted by IBC in 2000. Eighty percent of respondents supported the provision of information on the cost of health services paid for by their insurance companies.

that is led by the federal and provincial health ministries. They will be important ingredients in enlisting consumer commitment to informed and responsible use of the health care system.

Recommendation (7)
Establish a national target for relating the combined total of health spending from public and private sources to the size of the economy

Canada's health system is, among other things, an economic asset that contributes to the competitiveness of Canadian goods and services. But here, as in every other country, the cost of health care must also be continually managed to ensure that it does not prevent the pursuit of other social and economic priorities.

National health spending should support two objectives. On the one hand, as an open economy, Canada must accept the discipline of maintaining a relationship between health spending and economic growth that is not out of line with the experience of our major trading partners. On the other hand, the level of the country's health expenditures should support evidence on the health care needs of our population and the core values of our health system. These two objectives can be met through a process of consultation between the federal and provincial governments to arrive at an explicit target for the combined total of health spending from public and private sources in relation to the size of the economy.

The insurance community believes that a national health spending target, arrived at in this way, will be a catalyst for better informed public expectations about the health system. It will also be a meaningful tool to enable longer-term commitments to funding levels by the federal and provincial government and to support them in meeting the ongoing challenge of sustainability.