

The Future of Health Care in New Brunswick: An Interview with Dr. Dennis Furlong

Jane Jenkins

Abstract

Dr. Dennis Furlong is uniquely positioned to weigh in on current debates about the future of health care in New Brunswick given his decades-long career as a family physician, president of provincial medical societies, and government minister. In this interview, Furlong outlines his prescription for a sustainable health care system: a proposal to increase accountability among both providers and patients thereby reducing overuse (and misuse) of an overwhelmed and financially strained system to make it affordable and viable in the long term.

Résumé

Dennis Furlong est la personne tout indiquée pour intervenir dans les débats actuels portant sur l'avenir des soins de santé au Nouveau-Brunswick étant donné sa carrière de plusieurs décennies en tant que médecin de famille, président des sociétés médicales provinciales et ministre du gouvernement. Dans la présente entrevue, M. Furlong expose les grandes lignes de ce que serait son ordonnance pour un système de soins de santé durable : accroître la responsabilité des fournisseurs et des patients, ce qui réduirait la surutilisation (et l'utilisation abusive) d'un système saturé et aux ressources financières très limitées afin de le rendre abordable et viable à long terme.

Introduction

Universal and comprehensive health care for all citizens regardless of medical history or income is a defining feature of the Canadian identity. In recent years, however, as the health care system faces a staggering array of challenges, its long-term viability is being called into question. Statistics about overcrowded emergency rooms, long wait times for surgeries, physician shortages, and budget shortfalls fuel debates about the long-term sustainability of the health care system. And arguments about how to reform the system punctuate most discussions of political, economic, public policy, and social justice issues.

In New Brunswick, health care spending amounts to about 40 percent of the province's total budget—higher than the national average—with projections that it will continue to rise. In spring 2013, Premier David Alward's Conservative government attempted to curb these escalating costs and fight the provincial deficit by capping fees for physician services, cutting health care jobs, and finding efficiencies in the system, but the angry, even fearful response to his government's strategies highlights both the seriousness of the health care issues currently facing the province and the need for solutions.

Dr. Dennis Furlong's thirty-seven years of service in the New Brunswick health care system has provided him with unique insights into all aspects of the system from the perspectives of patients,

physicians, advocacy groups, and government. His decades-long career as a family physician, with a large rural practice in the Dalhousie region, has been augmented by service to provincial health agencies and organizations, including president of the New Brunswick Medical Society and Minister of Health and Wellness in Bernard Lord's Conservative government from 1999–2001. He continues to be involved in provincial health care matters, serving as chair in 2011 of the provincial committee on health services. In 2012, Dr. Furlong was awarded the Canadian Medical Association's prestigious Sir Charles Tupper Award for Political Action in acknowledgement of his long-term efforts to educate government and policy makers on public health issues.

Dr. Furlong presented proposals for health care reform in his 2004 book, *Medicare Myths: 50 Myths We've Endured about the Canadian Health Care System*. He maintains that the solution to preventing the complete collapse of health care systems and the governments overseeing them, both nationally and provincially, is to reduce patient use of health services. This, he argues, would require bold steps, including rewriting the Canada Health Act to allow implementation of a payment structure requiring patients to pay a prorated deductible for services. He feels that the stampede of patients that currently overwhelms doctors' offices and emergency rooms would subside if patients carried some of the financial responsibility for their own health care. In the end, Furlong's prescription for a sustainable and affordable health care system is to increase accountability (at all levels, but especially among consumers) in order to reduce use. Any reform of the health care system will not be easy; while some economists and policy makers may disagree with Furlong's proposals, the need for dialogue on this important issue is clear.

Dr. Furlong sat down with me in early July 2013 for a discussion of the future of health care in New Brunswick. In addition to detailing his plan for a prorated deductible payment structure that would both defray costs as well as utilization, Dr. Furlong voiced his concerns about salaried forms of remuneration for physicians, and the need to shift health-care thinking from a focus on illness to a focus on wellness. This interview has been edited and condensed from our discussion.

The Sustainability Issue

Jane Jenkins: You write in the opening pages of *Medicare Myths* that universal health care has become a defining feature of the Canadian identity and this is certainly widely acknowledged. Currently, one of the key concerns regarding universal health care in Canada is whether it will be financially sustainable into the future, at both the national and provincial levels. You stated in an interview with CBC in August 2010: "If we don't control health care costs we won't be able to control provincial solvency." Do you still think that we won't be able to maintain provincial financial solvency without controlling escalating health care costs?

Dennis Furlong: No, we won't, and we're there now in New Brunswick, almost. Public health care is a cardinal expression of social justice and also an expression of the redistribution of wealth. The societies that are most peaceful on earth are the ones that redistribute their wealth as equally as they can, and Canada, I think, does a marvellous job of that redistribution of wealth. I think that if we do not watch what's happening in public health care then we will mitigate against all our other departments. For instance, as early as ten years ago, 100 percent of all new dollars in the government that I worked in went into health, and I should qualify "health" every time I say it, because health care today means illness. What I mean is that it's not a health care system, it's an illness care system. That has to be manifestly expressed by everybody because the health care system deals with illness pretty much after it appears. There is a small component—about 6 percent—of our system that deals

with preventative health, such as immunization, baby care, and public health. But an illness care system mitigates against the solvency of provinces. I can say this empirically because I've been in the system a long while—about forty years at every level—at the advocacy level with the Council for the Disabled and the New Brunswick Lung Association, and also as Minister of Health at the government level. I also have a very large rural practice and I deal with all aspects of health care in it. All this has given me a fair idea of all the components of what is necessary to make a health care system work.

Jane Jenkins: Before we move on to what you think would make it work, I'd like to challenge you on the notion that health care costs are so out of control that they run the risk of bankrupting provincial governments. There are some economists and public policy people who would argue that point. For instance, an article published in *Canadian Public Policy* in 2006, "Does Health-Care Spending Crowd Out Other Provincial Government Expenditures," draws the conclusion that it does not.¹ The argument is that publically funded spending on core health care amounts to only 43 percent of all health care spending, and that the rest of funding comes from either a blended private-public structure or a wholly private funding structure, for extended services such as dental and vision care. The argument is that these private systems are driving up costs because of the high administrative costs associated with running them. In this view, publically funded care is not out of control. How do you respond to this argument?

Dennis Furlong: I'd have to disagree. Within the last twenty-four months we've heard all of the ministers of health in Canada in concert at their annual meetings say that health care costs are unbearable. We have heard all the federal ministers and provincial ministers of finance in concert at their provincial meetings say health care costs are out of control. We have heard the last Auditor General say the same thing before she left her job. We've heard the general government establishments right across the country in the form of the premiers of Canada say health care costs are out of control and unsustainable. So the word on sustainability is not my coin, it's the coin of everybody who's running government, and I'm not sure how health care economists can look at the numbers and say that it's manageable because it's not manageable right now. I would challenge any health care economist to go back and look at individual provincial debts, and I would guess that at least 80 percent of provincial debts across this country are summations of deficits in health care. There's no question in my mind and there's no question in the minds of the ministers of health, ministers of finance, and the premiers of this country that it is unsustainable.

Jane Jenkins: One of the solutions you've suggested to fix the health care system is to shift attention away from illness to health. How do you see such a shift enhancing sustainability?

Dennis Furlong: In July, a report came out projecting that by 2020 health care costs in New Brunswick would be about \$4.3 billion.² Well, as early as ten years ago it was 1 billion. So we've quadrupled it in twenty years. No other budget in government has done that. If all of this spending meant better health then why don't we have better health? We do not. Actually, we've spent \$100 billion more in Canadian health care, or illness care, in the last ten years. Spending has grown from \$100 billion to \$210 billion, yet the population demographics for wellness are actually worse now than they were ten years ago despite all that spending. And they were worse ten years ago than they were ten years before that. So if all this spending was worthwhile then why isn't our population's health better?

Our longevity is better but not because of the illness system but because of many other things that people don't think about like central heating, better nutrition, immunization, seatbelts, helmets, sanding roads and sidewalks, and, of course, intervention of the health care system at certain ages with well-baby clinics, for instance. All of these factors have had a huge effect on longevity. So we can't say that the reason we're living longer is because of the illness care system, because it's actually due to public health, such as clean water, safe food, and a control of contagion. We have to understand and define the problem before we try to put in place a solution. What I have been seeing for thirty years is government after government in Canada trying to control spending by squeezing supply, and that just doesn't work. It hasn't worked in the past, and yet we've just embarked upon that approach in New Brunswick, an approach that says: let's squeeze the supply and utilization will decline. This is a way of thinking that assumes that if you control the number of physicians in the country you can control the spending in health care, that if you control the number of beds in hospital you control spending, that if you control the number of people who are supplying then you control utilization, but this is a premise that doesn't work.

Jane Jenkins: Do you think Premier Alward used this premise when he recently put a spending cap of \$425 million on physician fees in New Brunswick?

Dennis Furlong: It's a concept that they're trying, but it's not only physician fees that are being limited. Physician spending is a small issue inside the whole big picture, which is an austerity mode, imposed from the top to try to reduce spending.

Jane Jenkins: Will finding efficiencies in the health care system solve the problems it faces?

Dennis Furlong: Yes, that's possible to do. It's hard to do, but it's possible to do. But the big-picture issue is that the basic structure of what we're doing right now has become unaffordable because of the nature of the Canada Health Act and how we operate from one province to another. Sustainability is all about affordability and affordability is all about utilization. Utilization is all about accountability and right now there is none in the system, either at the provider level or at the consumer level. If you look at the triangle of insured, provider, and insurer, there is no accountability. Not at the level of the providers (the physicians and nurses) and not at the level of the consumer either. It'd be a mistake to assume that everyone who comes into the health care system for a service needs to be there because that's not true. My inclination is that about 20 percent of what we do in the system is useless and doesn't do anything for anybody except incur a fee.

Insurance Model of Health Care

Jane Jenkins: So you're suggesting that the health care system is unsustainable in part because people are overusing it and, therefore, misusing it?

Dennis Furlong: Exactly. And for the past fifty years every new initiative governments have made in health care has been on the supply side, emphasizing illness care. That's what we've done and we've spent \$100 billion a year extra in the last ten years and it has made no difference. So supply-side initiatives have not worked. We need to look at utilization instead. We need to do something there. We have to have some accountability and responsibility among both consumers and providers. Right now, when patients walk in their doctor's door there is no cost. It's carte blanche for patients and it's carte blanche for doctors and all other health care providers. If the insurance industry did that it would collapse in no time, but the insurance industry requires participation in costs by

consumers, which puts accountability into the system and controls utilization. In the health care system, there is no control of utilization in any way. And the concept of top-down control of supply doesn't work. It has failed repeatedly in this country.

Jane Jenkins: But how can you control utilization of health care in New Brunswick when it has an aging population as well as rates of obesity, smoking, and cancer that are far higher than national averages? With these kinds of conditions, how do you control utilization of services?

Dennis Furlong: That's a poignant question. Education is important. But what we really need is prorated patient participation in health care costs. We should be looking at restructuring the Canada Health Act to install some insurance principles in the program. There has to be a prorated deductible that is related to income with no financial barriers of any sort, so people would not have to provide any money as they go in the doctor's door. So, for instance, if my annual deductible was \$1,000, I would have to pay the first \$1,000 that I consume and it would come off my tax bill at the end of the year. And there would be no barrier to access. If I faced a \$250,000 coronary event I would pay my \$1,000 deductible and the government would pay the other \$249,000, but that would put some accountability at the consumer level.

Jane Jenkins: How would this system be administered?

Dennis Furlong: It will need very little administration in my estimation, but it will need a lot of actuarial work up front. There would have to be income assessments and assessments of family size, which would require defining "family."

Jane Jenkins: Some might suggest that your recommendation of a prorated patient insurance model would not help to reduce health costs because of the increased administrative costs to run that kind of deductible insurance program. In countries like the United States, which does have a kind of insurance model, health costs have escalated because of the huge administrative costs that go along with that model.

Dennis Furlong: Yes, your comment is in one way correct and in another way not. It's very hard to compare the United States to Canada. In many ways, the difference between Canada and the United States—well, besides the forty-ninth parallel and guns—is that in Canada we *provide* health care, and Canadian physicians and Canadian nurses are generally interested in patients. I firmly believe that in the United States they *sell* health care. It's a different thing altogether. It's a business, not a calling. It's a business, and physicians there are hired by health corporations. If they don't generate work, they're fired. It's an industry. *We have a better product.* The costs in Canada are around \$4,000 per capita. The costs in the United States, despite 50–55 million people with no insurance whatsoever, are around \$8,000 per capita—double. So it's very hard to compare the health industry in the United States to Canada. But they have an administrative component, which is about 30–35 percent. I know a group of five orthopedic surgeons in Maine, with about twenty-five to thirty or forty different insurers, and every one of the insurers is different on certain things. None of that exists in Canada, and Canada's overall administrative costs, as I've said publicly, are far less than the United States, maybe around 15 percent. And while there is some efficiency to achieve there, I don't think that's where we're going to save money. Should it be done? Yes, but would we expect to control overall spending by finding administrative efficiencies? Probably not. I think the answers are

in utilization and how to make patients responsible for what they consume in the health care system. Right now, they're not.

Jane Jenkins: But wouldn't New Brunswickers feel that yet again they will be the ones burdened with rescuing a system that is in free fall and is the fault of the government? If you remember the cynicism and resentment of all New Brunswickers when car insurance rates increased, wouldn't there be a similar response to your insurance model for health care?

Dennis Furlong: Roy Romanow [Chair of the 2002 Royal Commission on the Future of Health Care in Canada] asked Canadians if they would be willing to pay a little bit more to keep the system, and about 80 percent said they would prefer to pay a little bit more to keep it. That's a reality out there. If you prorate the payments people would make based on income, then those who have marginal income may pay very little. Those with a better income would pay more. There are many people who have adequate resources to be able to pay part of their health care up to a limit. Everything beyond their deductible would be covered by government. My message is not that there should be more money put into the system, but that there should be less utilization of the system by consumers. If people had to pay a deductible, they would think twice about asking for health services.

Controlling Costs of Prescription Drugs and Physicians

Jane Jenkins: I suppose the fear of moving to an insurance model for health care would be the loss of the essential feature of Canadian health care: that universal health care is a right of citizenship, a public good. The insurance model you describe focuses attention on the consumer, but isn't there a different way to reduce health care spending by focusing attention on the providers of health care and imposing targeted reductions in the payment structures for physicians as well as for prescription drugs? How would you view a shift away from the fee-for-service structure to a structure of salaried payments for health care providers?

Dennis Furlong: Let me talk first on the issue of prescription drugs. There's no question that about five or six years ago the cost of prescription drugs in Canada surpassed the cost of physicians. And drug costs are growing at about 9 percent a year. Right now, drug costs average about \$1,000 per capita in Canada or about \$34–35 billion a year. That's huge, but some of the drugs are so good that we've emptied our operating rooms for such conditions as gastric ulceration or ulcerating peptic ulcers disease. Thirty-five years ago these conditions would have required surgery. And in the same way, we've emptied our mental health institutions because of the hugely successful anti-psychotic drugs. The anti-hypertensive drugs that we have today compared to thirty-five years ago have not eliminated stroke but have vastly reduced the number of strokes in our society. There's no question that some drugs are very successful, but they are also very expensive and the research pharmaceutical industry has been driving costs, almost hellishly. Canada is doing a better job than the United States at controlling these costs with provinces now starting to think about collective buying of generic drugs, for instance, but they're still very expensive. So, yes, they're very valuable but I ask you: where is the accountability when the research pharmaceutical industry develops a drug and sets its price at \$100,000 a year? The question arises: how do you put some accountability in the system?

Jane Jenkins: How might governments reduce the high costs of drugs rather than focusing on reducing patient utilization of drugs?

Dennis Furlong: I believe that, generally, governments are now taking on the pharmaceutical industries because drugs have become so expensive. But on the consumption side it's a different ball game because people think there's a pill to cure everything. There is an expectation at the level of the consumer that there's some chemical therapeutic that will do everything. Doctors have to deal with that on a daily basis. But the utilization of drugs versus their provision by the research industry are two different issues.

Now, concerning your question about fee for service versus salaried positions for health care providers: having had the perspective of thirty-five years I know that most of the blame for rising health care costs is put on the fee-for-service payment structure. The response in the early 1980s was that governments cut 10 percent of medical school seats to reduce the number of practising physicians. This made a huge difference in the provision of care and moved the average age of physicians up quite a bit, and it's affecting us today because a lot of people are long in the tooth in this business now. Cutting the number of doctors graduating from medical school was not good and another example that we can't control demand by eliminating supply. But the concept at the time was that fee for service was bad and that salaried doctors were good.

Like everything else this was partly right and partly wrong. So, for instance, when we needed neurosurgery here in New Brunswick thirty years ago it was hard to get anybody, so the government put them on salary plus an incentive. If you're going to get one you have to be competitive or you're not going to have them. In New Brunswick now we don't have as many physicians on salary as Newfoundland and Labrador. That area is so rural that if physicians were not on salary they wouldn't go there. That's because they have to be there twenty-four hours a day and wouldn't generate much on fee for service. In urban areas, however, what government is noticing now is that physicians in salaried positions don't see an adequate volume of patients. I think that being on salary leads physicians to lose their motivation. The fee-for-service physicians see around twenty to thirty patients per day starting at 8:30 in the morning and finishing at four or five o'clock in the afternoon, while salaried physicians are only seeing six, seven, or eight patients. So which is better health care, who knows?

Jane Jenkins: You're suggesting that salaried physicians see fewer patients per day?

Dennis Furlong: The problem that the government has noted and that the minister [Minister of Health Ted Fleming] has just described is that we have a number of primary care physicians on salary, and the minister says they don't see any volume of patients. If people are waiting too long to see a salaried primary care physician and they're not waiting to get in to see a fee-for-service physician, that's a problem. Right now they're looking at the numbers to see why it is that fee-for-service family doctors working here in Fredericton will see twenty to twenty-five patients, or even thirty on a big day, while salaried physicians are seeing only six, eight, ten, or twelve patients a day.

Jane Jenkins: Do you think those comparisons are accurate?

Dennis Furlong: I know government is looking at it. They're trying to figure out what's good and what's bad now, because if you have a practice size that's eight hundred or a thousand patients, we wouldn't have enough family doctors in this country. We would need double the number of physicians to deal with all the patients. So the question arises: how do you service the population of Canada? If you train a physician who goes out into the system of public health care and limits

practice size to seven hundred patients and works only from nine to five, four days a week, it's not sustainable. There are 168 hours in the week and primary health care has to cover all of them, and if it can't, there's a big problem. This is why the emergency rooms are full. A Nova Scotia study was very clear: 80 percent—about four out of five people—in the ER do not belong there but should be in a doctor's office. But if primary care is available only for 30 to 35 hours out of 168 hours a week, then what's your first clue that patients are all going to be in the ERs? There is no other place to go except perhaps a walk-in clinic, but they offer "McDonald's" medicine. They don't do blood tests, for example, because they don't want to have any obligations to the patient. This becomes very expensive since there is no follow-up and no continuity.

Jane Jenkins: I want to switch gears a bit here and ask you about the requirement that health care in New Brunswick be offered in both official languages. Do you see this as an additional financial challenge for the province?

Dennis Furlong: First of all, we're not the only province that deals with two languages. Many deal with two, three, or even four different languages. About 250,000 immigrants arrive in Canada every year, and in Ontario where most of them go there is multilingual provision of health care. It's a component of health care everywhere in Canada because we're so cosmopolitan, but I don't think it is an issue. I think it's something we work with. I live in a francophone area, where everyone is bilingual. I have never seen anybody come in and say they want to go to either a French or English hospital. They just want to go to the best place.

Jane Jenkins: Let me ask you about this issue in a different way. The two health networks in New Brunswick, the francophone Vitalité and the anglophone Horizon, have very different economic annual reports. The Vitalité network had a deficit of over \$9 million last year while the Horizon network had a surplus of \$2.5 million. How do you explain that difference?

Dennis Furlong: That is difficult to explain right off the cuff, but these kinds of numbers are a small percentage of the overall \$2.3 billion budget, so it's very marginal either way. Part of the reason they've had a fairly good year is because there are no human-resource pressures this year. This will be different next year and the year after when contracts are up for negotiation. But the question of overall costs of public health care in Canada is very clear. In New Brunswick, in another seven years, health care costs will be at \$4.5 billion. When I was in government ten years ago the budget for the whole province was \$5 billion. So if anyone says there's no problem, what they mean is that there's no problem if you choose to ignore it. The way out of this problem, in my view, is focusing on health and wellness to reduce utilization.

Jane Jenkins: I'm not sure New Brunswickers will approve of your insurance model.

Dennis Furlong: Collectively, nobody in Canada will agree until they are presented with fiscal collapse and provincial governments that become functionally bankrupt like Greece or Spain or Ireland. It can happen here. People think it will never happen, but it can happen here. It happened in New Zealand about thirty years ago. And it didn't happen slowly. It happened almost like a tsunami, not like a glacier. My projection is that some provinces will not be able to pay before others. When governments can't pay their bills then we will have huge problems. What we've done to date is borrow to pay our bills, and I think the health care system right now is terminal. The Canada Health Act is outdated and needs to be restructured so that we can have a sustainable Canadian system that

provides quality health care equally to the people who need it and doesn't serve the people who don't need it. Simple as that.

Endnotes

¹ Stuart Landon et al. "Does Health-Care Spending Crowd Out Other Provincial Government Expenditures?" *Canadian Public Policy* 32.2 (2006): 121–141.

² "Actuaries' Expertise Could Cut New Brunswick's Health Care Costs," *News Wire* 2 July 2013, <http://www.newswire.ca/en/story/1193017/actuaries-expertise-could-cut-new-brunswick-s-health-care-costs>