

**THE FISCAL AND HEALTH CARE EFFECTS
OF ONTARIO'S POLICY OF DE-LISTING CHIROPRACTIC CARE***

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EXECUTIVE SUMMARY

1. The proposed de-listing of chiropractic will impose a net fiscal burden of at least \$107 million on the Government of Ontario. While government will save \$93 million in direct payments to chiropractors, the province will incur at least \$200 million in additional health care expenditures as patients shift from chiropractic care to other fully funded health care. Delisting of chiropractic services does not make any fiscal sense.
2. The delisting of chiropractic will have other adverse effects on the health care system:
 - it increase the queues and waiting times for medical care,
 - expenditures on drugs will increase
 - the use of emergency care in hospitals will rise
 - it marginalizes chiropractic and inhibits its integration in the transformation of primary care
 - the indirect costs to society of neuromusculoskeletal disorders and injuries will rise
 - it imposes a heavier regressive financial burden on the low and middle income groups
 - it seriously worsens accessibility to care to the very groups who have the highest incidence of the disorders and injuries chiropractors treat.
3. The decision to delist chiropractic services is not evidence-based. Most studies show that chiropractic is more effective, safer and less expensive than other care. Critics question whether the evidence is conclusive, but very few claim superiority for other care. There is no scientific, clinical, nor economic reason for de-listing chiropractic.
4. Patients with neuromusculoskeletal conditions and injuries invariably express greater satisfaction with chiropractic than other therapies and care. The public consistently supports greater insurance coverage for chiropractic under provincial Medicare plans. As such, the decision to delist chiropractic services is contrary to public preferences and the public demand for greater choice.
5. There is not a single positive effect of the de-listing policy for the public, for the health care system, businesses, or the government's fiscal situation.

INTRODUCTION

The Government of Ontario revealed several radical and unexpected health policy changes in its budget announced on May 18, 2004. While, the Liberal Party had previously strongly opposed health care premiums and committed to no tax increases, the budget contains a sizeable increase in taxes in the form of a health premium. Further, the burden of the premium is not fully progressive.

Completely unexpected was the de-listing of chiropractic, optometry and physiotherapy services. Indeed, Ontario is the first jurisdiction in Canada to completely de-list chiropractic care and may well be the first in the world to do so. (In B.C. government funding is still available for persons with incomes of less than \$24,000 per year; for a total of 10 visits annually at \$23 per visit to chiropractors, naturopaths, podiatrists, massage therapists and physiotherapists).

This paper identifies the probable effects of de-listing chiropractic care in Ontario, demonstrating that the decision was not evidence-based. The analysis illustrates that the resulting impacts of the decision are contrary to the purported fiscal and health care objectives of the Liberal Government of Ontario.

More specifically, it will be shown that the de-listing of chiropractic care will impose an additional fiscal burden on the Government of Ontario, quite contrary to the stated expectation of savings. While the fiscal position of the Government of Ontario has been put forward as the rationale for the elimination of funding for these health care services, de-listing will worsen the fiscal position of the Government. The “savings” from the policy is neither positive, nor zero, but rather negative. The Government of Ontario would be spending a significantly greater amount for the care that will shift from chiropractors to other fully funded health care than the reduction in payment to chiropractors. As a result, although government has suggested that delisting will allow government to “improve cancer care and cardiac care, home care and long-term care,” the province will actually have less money to devote to these important services.

In addition, the de-listing of chiropractic services will have other significant negative consequences on the stated health care objectives of the Government.

THREE IMMEDIATE FISCALLY RELEVANT EFFECTS OF THE POLICY OF DE-LISTING CHIROPRACTIC CARE

The Globe and Mail (May 19, 2004, page A9A) has reported that “removing these three services from the Liberal government’s ballooning health care tab will save it \$47 million in 2004 and the \$157 million on an annual basis in the future, according to Finance Department

officials”. Of the projected \$157 million in savings in 2005 and onwards, close to \$100 million of these savings would be from de-listing chiropractic, i.e. by far the largest component of the expected savings. The lower figure of \$47 million for this year (2004) is simply accounted for by a partial year since the de-listing policy is to begin sometime in the fall of 2004.

The expected savings identified by Government reflect the direct reduction in payments to chiropractors. However, the Government has only de-listed chiropractic care; they have not de-listed the range of neuromusculoskeletal (NMS) conditions and injuries chiropractors treat. The Government will cease paying for care delivered by chiropractors but will continue to pay for treatment of the very same conditions if the patient obtains the care from other fully funded health care providers. Many who suffer from NMS conditions and injuries will choose to visit medical doctors, hospitals, and emergency rooms rather than pay an additional out-of-pocket cost to visit their chiropractor. As such, any analysis of the fiscal impact of decision to delist chiropractic services must take into the account the fact that many patients will “substitute”, at a significant cost to government, fully funded care from other practitioners rather than pay more to visit their chiropractor. Once this is acknowledged, two additional economic and financial factors come into play, further modifying the “expected savings”. First, and very significantly, for the Government of Ontario the average cost of visits to medical doctors is very much higher than the cost of chiropractic visits. Government pays the full fee for medical visits, while its fee for chiropractic visits is quite low (\$9.65 for second and subsequent visits up to a ceiling of \$150 per year). So payments to medical doctors is very much more costly to the Government of Ontario on a per visit basis than for chiropractors.

Secondly, payments to medical doctors for their fees are a small fraction of the overall health care costs generated by medical doctors managing NMS conditions and injuries. Visits to medical doctors are much more likely to entail additional costs for a variety of diagnostic tests including several types of imaging, referrals to specialists such as neurologists, orthopaedists and physiatrists (physical medicine and rehabilitation), a range of drugs, and for a considerable number of patients, hospitalization. Most of these additional costs must be covered by the Government of Ontario. In the case of drugs, private insurance held by individual patients will no doubt bear a significant portion of the expenditure on drugs. However, for most other services the burden will fall mainly on the Government.

The fiscal effects of these three factors, specifically, switching or substitution, higher fees for visits to medical doctors, and additional health care expenditures consequent to the medical visits will occur immediately upon the implementation of the de-listing policy.

There are other adverse economic and health system effects that also need to be considered for a fuller understanding of the overall impact of de-listing. These effects will be discussed later in the paper. The three immediate or short-run effects alone will lead to an increase in expenditure for the Government of Ontario that is much greater than the approximately \$93 million it now pays for chiropractic care.

SWITCHING FROM CHIROPRACTIC TO MEDICAL CARE (Substitution)

The de-listing of chiropractic care by the Government of Ontario obviously implies a very large increase in the out-of-pocket costs of chiropractic visits to patients, even if the profession keeps the overall fee for a visit at the current level. The OHIP payment for the second and subsequent visit to chiropractors is \$9.65. For first visits to chiropractors, OHIP pays \$11.75 and \$8.00 per x-ray film. Patients pay about \$60 for the initial visit plus \$8.00 per x-ray film. The cost of first visits will therefore increase by \$11.75 + \$8 per x-ray film. The high cost of first visits has been recognized as a barrier to chiropractic utilization. It will now become a bigger barrier, particularly to those who have no extended health insurance coverage. The OHIP coverage of chiropractic had an annual limit of \$150. This constraint affects a minority of chiropractic patients.

While there is regional variation, the cost of a subsequent chiropractic visit for an adult is, on average, \$30; \$9.65 paid by OHIP with a patient co-payment of \$20.35. If fees remain unchanged, delisting will increase average patient fees by almost 50%. However, chiropractors typically have reduced fees for seniors, students, and those in need. For those patients the increase in fees will be as much as 100%. In this analysis, the overall increase in the out-of-pocket costs of chiropractic care to patients is assumed to be 50%. This is, of course, a conservative figure since higher estimates of the increase in price would yield even more dramatic effects of the de-listing policy.

Such a steep increase in price is bound to influence patients' care-seeking behaviour, and hence the overall utilization of chiropractic and substitute or competing professional care. For many NMS conditions and injuries, chiropractic patients may visit medical doctors, physiotherapists, acupuncturists and massage therapists. The latter two professions are

quantitatively far less significant than the professions of physiotherapy and medicine. Since non-hospital based physiotherapy is being de-listed as well, and hence will also become more costly to patients, the bulk of the shifting or switching that will occur will result in an increase in the use of medical doctors for NMS conditions and injuries. Under Medicare, the out-of-pocket cost to the patient of a visit to a medical doctor is zero, since the fee is paid directly by OHIP.

The expected “savings” to the Government of Ontario of about \$93 million to \$100 million in 2005 claimed by officials in the Finance Department assumes that chiropractic patients will not switch to medical doctors. This is grossly unrealistic. Consumers make price-quality trade-offs and a 50% increase in the “price” (i.e. out-of-pocket costs) to patients will compel many chiropractic patients to seek care from medical doctors. In technical economic language, the demand curve for chiropractic care is not vertical and totally irresponsive to the price of visits. If it were, it would mean that chiropractic care was absolutely essential. If so, chiropractors could charge whatever they wish, and patients’ demand for their services would be independent of insurance coverage. Both ideas are ridiculous. Patient utilization of chiropractic care, and in fact other health care services, have been shown to be price sensitive.

Chiropractic services are described by government officials as “less critical services” (Globe and Mail, May 18, 2004, page A9A). However, in Ontario musculoskeletal disorders and injuries are shown to be the second most costly categories of health problems in economic burden of illness studies. Musculoskeletal disorders are also among the most important reasons for activity limitations and short-term disability. They rank first in prevalence of chronic health problems and first as a cause of long-term disability. Musculoskeletal disorders rank first as a reason for consultation with a health professional in Ontario, and rank second as a reason for the use of prescription and non-prescription drugs (Health Canada, 1998). Furthermore, approximately 95% of chiropractic practice in Ontario involves the management of patients with neuromusculoskeletal disorders and injuries (Manga and Angus, 1998, 1).

The important question then is: how large a shift, or substitution, from chiropractors to medicine can we reasonably expect?

Many patients do not have extended private insurance coverage for chiropractic care, and those who do, invariably face quantitative limits of say \$300 to \$500 per year. Thus, even in the highly unlikely event that such private extended coverage remains unaltered in the face of the elimination of government, many chiropractic patients will be facing a very large increase in the cost of care.

It is estimated that 45 to 55% of the population in Ontario has some chiropractic coverage under a private health insurance plan – usually through a health benefit plan offered at their place of employment. However, it is estimated that only about 5% of the population has insurance coverage that provides funding as of the first visit, or first dollar. The majority of coverage is only available after the OHIP funding of \$150 has been exhausted, and because only about 25% of patients reach the OHIP maximum, this coverage is rarely used and is therefore not a significant cost to the employers or sponsor of a health benefit plan. If chiropractic care is de-listed then any private chiropractic coverage will be a significant cost to employers, so we can expect insurers to immediately move to limit their liability as they did in British Columbia.

In the language of economics, the statistic used to estimate the magnitude of any reduction in chiropractic visits is the price elasticity of demand. For example, if the price elasticity of demand is negative one (-1.0) then a 10% increase in price (the cost of chiropractic care to patients) will result in a 10% decrease in the number of chiropractic visits. Unfortunately, the price elasticity of demand for chiropractic services in Ontario is not available. However, we do know with certainty that it is not zero (the assumption that underlies the estimate of Government savings of \$100 million). We also know that the greater the availability of substitutes (i.e. other professional care) the larger is the value of the price elasticity of demand for chiropractic. In one of the rare economic studies ever done on the price elasticity of chiropractic care, Shekelle et al (1996) estimated the figure to be almost -2.0. That is, in their study they discovered that when chiropractic price per visit increased by 25%, the expenditure on chiropractic care dropped by 50%. This is a US study and refers to a period some 20 years ago. It may, therefore, not reflect the situation in Ontario but it does suggest a high price elasticity of demand. We also know that a related concept called the cross-price elasticity of demand for chiropractic care is very high (Shekelle et al, 1996). This statistic indicates how large an increase in demand in medical care would occur in response to an increase in the price of chiropractic care. The high cross-price elasticity of demand implies that medicine and chiropractic are relatively close substitutes as far as patients' decisions to seek care are concerned. Unfortunately, specific cross-price elasticities are also not available for Ontario.

We can, however, make educated estimates of the approximate value of the desired price-elasticity of demand for chiropractic care. The de-listing policy in Ontario would create a very similar situation to what is now the case in Quebec and the four Atlantic provinces. Let us refer to these five provinces as the “never-listed” provinces. The chiropractic utilization rate in

Ontario is 11.2% whereas in the never-listed provinces it is much lower, as shown in Table 1 below. The chiropractic utilization rate in Newfoundland and Nova Scotia is just 3.5%, and it is 3.8% and 4.3% in P.E.I. and New Brunswick respectively. Quebec's rate is 9.2%, surprisingly high in comparison to the Atlantic provinces. This may reflect the evidence that people in Quebec have always been far more willing to use alternative and complementary therapies and professions than the rest of Canada (So, 1997). By contrast, Ontario's rate of 11.2 is surprisingly low compared to the Western provinces. Much of the difference is probably due to the greater burden of chiropractic care to patients in Ontario, since the governments of the Western provinces pay for a larger proportion of chiropractic fees than Ontario (Kapsalis, 2000, 24). If the utilization rate of Ontario fell to the weighted average of the never-listed provinces of 7.8, it would mean a drop of 30%. This is a very conservative estimate since Quebec's utilization is unusually high. If Ontario's utilization rate drops to the weighted average of the Atlantic provinces, the decrease would be almost 60%. In this analysis the drop of 30% is assumed to yield conservative estimates of the effects of delisting of chiropractic services. Ontario's visit rate is 12.4 per patient is 1.37 times the weighted visit-rate (average visits in Table 1) of the never-listed provinces. Thus, one can expect a decrease of 41.2% (30% decrease x 1.37) in the total number of chiropractic visits in Ontario, assuming that Ontario becomes like the weighted average of the never-listed provinces (where the weighting is done by provincial population).

If the overall price increase resulting from de-listing is 50% (a conservative estimate) and the corresponding decrease in chiropractic visits is 41.2%, the implied price-elasticity of demand is -0.82 (i.e. $-41.2 \div 50$). This represents a very conservative estimate, as it is less than half of the aforementioned estimate of -2.0. As well, the existence of substitute professional care normally suggests higher price elasticity of demand. At the very least, an elasticity of -0.82 does not appear to a gross overestimate. It implies that the overall reduction in chiropractic visits from the de-listing policy would be 5,124,356 (using the total visits calculated from Table 1 which refers to the fiscal year 2000/01). That is, 5,124,356 is $0.412 \times 1,003,045 \times 12.4$.

How would this shift or switching from chiropractic to medicine take place? There are essentially five forms of this switching. One would be the reluctance of medical patients to switch to chiropractors. Many chiropractic patients have previously consulted a medical doctor for the same complaint. A second form of the switching is patients leaving chiropractors for medical doctors as they become unwilling or unable to pay the new increased cost of chiropractic care (of about 50%). The third form is "new" patients deciding on the caregivers for

their NMS conditions or injuries. Fewer would choose a chiropractor as the higher costs act as a deterrent. This decrease in new patients, of course, translates into a much larger loss in the number of visits. An additional complication in estimating the amount of switching that may occur is the fact that about 10% to 25% of chiropractic patients visit medical doctors for the same episode of NMS condition or injury. This dual medical-chiropractic care is often not coordinated. Such patients are more likely to drop chiropractic care because of the increase in chiropractic fees of about 50%. But this phenomenon of dual-use patients also suggests that patients who hitherto obtained care only from chiropractors may now begin to use medical doctors to moderate the cost of chiropractic care. In other words, the de-listing policy may encourage chiropractic-only patients to become dual-chiropractic-medical patients, thus further shifting chiropractic visits to medicine and increasing costs. While this is likely to happen, it is, of course, difficult to develop quantitative estimates of this shifting or switching. Finally medical doctors may become less willing to refer their patients to chiropractors. Instead, and especially for poor and low income population group, medical doctors may direct their care to “free” care covered by OHIP.

We now run into a second difficulty in the analysis. How do we translate a reduction of more than 5.1 million chiropractic visits to increased visits to medical doctors? It cannot be assumed that the loss of chiropractic visits translates into an equal gain in visits to medical doctors. The latter do not see patients as frequently as chiropractors do. A reasonable or a good estimate is that medical doctors see patients only one-third (1/3) as frequently as chiropractors in Ontario for similar conditions. Based on this assumption, the increase in medical visits is 1,281,089 ($5,124,356 \div 4$). Alternatively, since the utilization rate may drop by 30% (to the weighted average of the never-listed provinces), a switching of 300,913 chiropractic patients to medical doctors is implied.

Almost all patients visit a medical doctor at least twice for NMS conditions and injuries. As well, many patients have a recurrence or a new episode of care within a year (Shekelle et al, 1995). So, for such patients a minimum of 4 medical visits is reasonable and the average may well be 5 or 6 visits per year. A significant number (around 10%) will be referred to specialists. Thus, an average number of medical visits of 4 represents a reasonable and conservative figure to work with. The actual average rate may well be higher and is not likely to be lower than 4. A recently published study of trends in care for back pain in the United States, by Feuerstein et al (2004), empirically supports the “educated guess” of 4 visits per patient used in this analysis. If

the average number of visits (including referrals) of medical patients is 4 then the switching implies an additional 1,203,654 visits to medical doctors. Since these figures are described as ‘educated guesses’ we will work with the round figure of 1,250,000 medical visits as reflecting the likely effect of switching. The rounded figure of 1,250,000 is between the two estimates of 1,281,089 and 1,203, 654.

TABLE 1

Percentage of population using chiropractic services, and mean number of visits to a chiropractor during previous year, by province, Canadian household population aged 18 or older, 2000/01			
	% using chiropractor	Estimated number of people using chiropractor	Mean number of visits among people who visited chiropractor
CANADA	11.6	2,715,914	9.8
Newfoundland	3.5	14,459	9.7
Prince Edward Island	3.8	3,923	8.0
Nova Scotia	3.5	24,668	8.8
New Brunswick	4.3	24,584	8.0
Québec	9.2	521,477	8.1
Ontario	11.2	1,003,045	12.4
Manitoba	18.5	151,010	8.6
Saskatchewan	14.3	102,817	8.7
Alberta	17.7	392,235	9.0
British Columbia	15.2	472,449	7.9
Yukon	9.6	2,123	3.6
Northwest Territories	9.3	2,598	5.2
Nunavut	3.3	524	3.4

Source: Canadian Community Health Survey, Statistics Canada, 2000/01. Statistics Canada, Ottawa, 2004.

How much will these visits cost the Government of Ontario? Since specialist fees vary from family practitioners’ fees it is difficult to know precisely what overall average figure should

be used to cost out these ‘switched’ visits. The overall figure for OHIP fee paid to medical doctors can, however, be estimated. These are the fees listed on the MOHLTC Website:

	<u>\$</u>
1. GP intermediate assessment	28.50
2. Neurology	
a. Consultation	125.00
b. Repeat consultation	73.85
c. Medical specific assessment	57.10
d. Medical specific repeat assessment	41.15
3. Orthopedics	
a. Consultation	56.15
b. Repeat consultation	44.95
c. Special surgical consultation	112.35
4. Physical Medicine and Rehab (physiatrist)	
a. Consultation	125.00
b. Repeat consultation	73.85
c. Medical specific assessment	57.10
d. Medical specific repeat assessment	41.15

We do not really know the proportion of specialist and family practice visits. In this paper the average medical fee used is \$36 per visit. It, of course, could be higher. The \$36 figure was calculated under the following assumptions: (a) that 90% of medical visits for NMS conditions and injuries are to general practitioners (b) that the specialist consultation rates are physical medicine (3.5%), neurology (3.5%) and orthopaedics (3%). If the use of specialists is higher than that assumed here, lets say to 20% and not 10%, the average medical fee would be around \$41, and all of the estimate of costs developed in this report would be about 14% higher.

Thus, the cost to the Government of Ontario for medical fees alone - and not the total financial burden of switching - would be about \$45 million (i.e. 1,250,000 visits times \$36 per visit). It is thus very important to recognize that the Government of Ontario’s expectations of “savings” need to be examined. The analysis conducted thus far provides clear demonstration that the estimated savings of \$93 million to \$100 million are clearly inaccurate.

For purposes of developing its own estimates the Government of Ontario should consider the following simple equation.

$$\Delta MFC = S \times M.F.$$

where

ΔMFC = the incremental cost to the Government of Ontario for medical fees alone

S = the number of visits that would shift or switch over to medical doctors

M.F = average medical fee per visit to medical doctors

To summarize, ΔMFC is \$45 million, S is 1,250,000, and M.F is \$36.

THE FULLER FINANCIAL BURDEN OF THE DE-LISTING POLICY TO THE GOVERNMENT OF ONTARIO

The additional costs from switching or substitution of chiropractic care to medical care of \$45 million is NOT the whole of the financial burden to the Government of Ontario. In a Report commissioned by the Government of Ontario it was stated that:

“There are also very important economic efficiency arguments that favour the greater use of chiropractors in the management of LBP. Chiropractic therapy is almost wholly hands-on care. There is a minimal use of auxiliary services, no use of drugs, and little hospitalization. Payments to chiropractors for services they provide is 80% or more of the total cost of care. For physician management of LBP the proportions are virtually reversed. Prescription drugs, laboratory tests, referrals to specialists, and hospital in-patient care lead to a four or five fold increase in total health care costs of the physician’s own billing for medical services.” (Manga et al, 1993, 80).

In a later report commissioned by the Ontario Chiropractic Association, Manga and Angus (1998), using a Health Canada (1998) study on the burden of illness, found that “medical care” (as defined in the Health Canada report) constituted 29% of the total direct health care costs of NMS conditions and injuries. This figure of 29% is calculated from Table 20 of Manga and Angus (1998, 57) showing the direct health care costs by diagnostic category for Ontario for the year 1998. While not “a four or five” fold increase - figures that were generated from many jurisdictions and mainly the USA - it is still a noteworthy 3.3 times the cost of medical fees estimated in the previous section. Since many of the costs of pharmaceuticals associated with NMS conditions are not borne by government, the 3.3 figure needs to be adjusted downwards. However, the “medical care” category in Manga and Angus overstates somewhat the medical fee burden referred to and estimated above. In other words, the ratio of 3.3 understates the extra health care costs generated by the medical visits. (The drug costs which the Government is not

liable for overstates the ratio). Globally, medical fees account for about 22% of the total cost of care, suggesting a ratio of over 4. However, it is difficult to establish a most “reasonable” figure for NMS conditions and injuries. In light of the difficulties - which the Government of Ontario should be able to resolve - the estimate used here is the 3.3 figure derived as described above. Using the 3.3 figure the direct health care cost of switching is thus \$193.5 million or in round numbers \$200 million. The latter estimate is simply derived by the following equation.

$$\Delta\text{MFC} \times [1 + \text{Inc Health Cost Ratio}] = \text{Total Burden to the Government of Ontario}$$

where ΔMFC is as calculated above, and

Inc Health Cost Ratio = the incremental or additional health care costs generated by patients visiting medical doctors over and above the medical fees; these costs are a burden to the Government of Ontario.

Again, the Government of Ontario can and should develop its own incremental health care cost ratio. It should be noted that even if the ratio was estimated to be only 2 (i.e. an overly conservative estimate) it would triple the medical fee costs to the Government of Ontario.

One might rightly wonder what the lowest conceivable estimate of the financial burden to the Government of Ontario might be from the policy of de-listing chiropractic?

It is difficult to think of a price elasticity of demand as low as -0.5, but let us assume that it could conceivably be that low. This implies a reduction of just 2.8 million chiropractic visits and an increase in medical visits of just over 700,000. This would cost the Government of Ontario about \$25.2 million dollars in medical fees alone. With the incremental health cost ratio of 3.3 the overall incremental burden of direct health care costs to the Government of Ontario would be about \$108.4 million, that is, more than the total cost of payments to chiropractors resulting from the de-listing policy.

What assumptions do we need to make to yield a net savings of say \$50,000,000 from the current amount budgeted for chiropractic? This analysis demonstrates that an exceedingly low estimate of the switching rate and/or incremental health cost ratio is necessary in order to demonstrate a situation that yields any significant savings. The most incredible, of course, is a switching rate of zero (0). It is only this assumption that can generate a savings of about \$100 million, and even this is questionable in the long term as will be argued later in the report. What then is the point of de-listing chiropractic?

This analysis demonstrates that delisting of chiropractic services is bad fiscal policy; it will create additional costs that will be borne by the government. The Government of Ontario is reducing payments to chiropractors by approximately \$100 million, only to spend approximately \$200 million for the same NMS conditions and injuries. It is important to note that this will not be a long-term implication, as some have suggested. Rather, it would occur very quickly.

The analysis above still does not present the entire picture of the effects of the de-listing. There are yet other adverse consequences that must be considered. Incidentally, if Ontario's utilization rate drops to the level of the Atlantic Provinces, the total burden to the Government of Ontario is in the order of \$400 million. While that may be too pessimistic, the forecast decrease to a utilization rate of 7.8 may be too optimistic. The overall burden is thus most likely to be between \$200 to \$400 million.

WAITING TIMES

Governments throughout Canada are concerned about the long queues and waiting lists to obtain medical care. The funding of chiropractic coverage has enhanced access to other health care services because it represents an alternative to care offered by scarce medical resources (particularly physicians). The shifting of chiropractic patients to medicine (and of course similarly from optometrists and physiotherapists) will simply worsen the problem. Waiting times for both acute and chronic conditions will increase, as more patients visit busy family physicians and use overcrowded emergency departments and other hospital services. Delisting of chiropractic services will increase access problems in the health care system.

DRUG EXPENDITURES

The cost of drugs is the fastest growing component of health care expenditure. Yet the Government of Ontario, surprisingly, had nothing or little in the budget to control these costs. Worse, the de-listing policy adds to the problem of rapidly rising costs of drugs, since medical doctors rely heavily on drug-based therapies for NMS conditions and injuries.. While the Government is not financially responsible for all of the increased drug costs, it nevertheless is the burden on the economy generally and businesses and the health care sector specifically. One can only hope that the Government adopts a larger societal view on the costs of its de-listing policy. But even if it stubbornly wishes to take a very narrow and myopic view of the effects of the policy, it still does not make any financial sense as shown above.

EMERGENCY CARE

Longer waiting times to see medical doctors, and a much higher cost to patients of accessing chiropractic care will no doubt result in an increase in patients with acute NMS conditions and injuries visiting emergency units in Ontario hospitals. Use of emergency care is very costly. Similarly, the impact of increased volume on already overburdened emergency departments and hospitals is significant in terms of additional costs and delayed care. This incremental cost is difficult to quantify and therefore is not added to the \$200 million figure derived above. However, this is a very important impact from both a fiscal and health policy perspective that must be considered.

EFFECTIVENESS, SAFETY AND PATIENT PREFERENCE

There is a large body of literature demonstrating that chiropractic care is safe and effective for musculoskeletal conditions, especially for low back pain, which constitute the largest portion of all the conditions chiropractors treat. Patients themselves must believe that chiropractic is an effective therapeutic modality for their conditions (Bigos et al, 1994). After all, they have to pay about \$20 to \$37 per visit (and even much more for first visits) to chiropractors and do not incur such co-payment for a visit to medical doctors. Every study on patient satisfaction shows a very high score for chiropractic care. In every public opinion poll in Canada over the past decade, the public would prefer to see a greater coverage of chiropractic under provincial Medicare plans, the very antithesis of the de-listing policy.

DE-LISTING IS A REGRESSIVE BURDEN ON PATIENTS

The upper income groups, the well-educated and those in certain occupations have private insurance coverage for chiropractic care. Most in the middle and lower income groups and the working poor don't. A uniform increase in the cost of care is regressive. It harms mostly the poor and lower-middle income groups. It worsens the existing inaccessibility of chiropractic care to the very population groups who have a higher than average incidence of NMS conditions and injuries (Manga and Angus, 1998). Many of them do not have a regular medical doctor either, and are, therefore, more likely to obtain care from emergency units in Ontario hospitals.

INDIRECT COSTS

Manga and Angus (1998) argued that the indirect costs associated with NMS conditions and injuries are very significantly lower for chiropractic than other care. One reason for this is that the person-day loss from work is lower for patients of chiropractic. A large number of studies internationally confirm this finding. This has implications for the cost of the workers' compensation system in Ontario, and ultimately the cost to Ontario businesses and their international competitiveness. The increased cost to Ontario businesses of insuring chiropractic care will further impact upon their competitive position. Ultimately, this will also have an adverse impact on the fiscal position of the Government of Ontario.

MARGINALIZATION OF CHIROPRACTIC

Study after study, many commissioned by governments, have called for the integration of chiropractic into the wider health care system. In fact, integration of chiropractic and other health providers into multidisciplinary teams is a key component of primary care renewal advocated in Ontario and all other provinces. The integration of chiropractic is already happening in many countries, including Canada. However, de-listing in Ontario will inhibit this integration and will marginalize chiropractic. Delisting will create disincentives and barriers to chiropractors and physicians working together for the good of their mutual patients. The very idea of de-listing “announces” to the public that chiropractic is not worthy of public funding. When a patient with back pain visits a medical doctor, it is, ipso facto, medically necessary. If the patient had chosen to visit to a chiropractor for the same condition, it is deemed not “medically necessary” and not covered by OHIP. Given the accepted effectiveness and efficiency of chiropractors in treating these problems – evidenced clearly in Ontario by the Workplace Safety and Insurance Board Program of Care for Acute Low Back Injury – this makes no sense.

The Government of Ontario should consider the following: since chiropractic is effective, safe, inexpensive and has great patient satisfaction, what is the justification for eliminating funding? Using the funds for other important purposes is not an appropriate justification given the fact that costs will actually increase as a result of delisting. In fact, evidence shows that it would be fiscally responsible to significantly increase the utilization of chiropractic services for NMS conditions and injuries, thus saving the Government significant sums (Manga and Angus, 1998).

CONCLUDING COMMENTS

This analysis clearly suggests that the Government of Ontario could not have based its decision to de-list chiropractic on evidence or analysis. Rather, the decision appears to have been solely a reaction to a genuine fiscal crisis. However, it is wrong and miscalculated because delisting will not improve the fiscal predicament of the Government; it worsens it. It also has other negative health care effects on waiting times, use of emergency care and drug expenditures. It also goes against both patient and public preferences. Not surprisingly, there are indications that the majority of the public is against the de-listing of chiropractic services. The de-listing policy is also contrary to previous studies commissioned by the Government of Ontario. Manga et al (1993) recommended greater coverage and an expanded rate for chiropractic. The Wells report (1994) reviewed this study, confirmed its findings and re-affirmed its principal recommendations. There have been no public studies or reports in Ontario recommending the de-listing of chiropractic (or physiotherapy and optometry). Delisting also increases the indirect costs associated with the conditions chiropractors typically treat. Finally, delisting also marginalizes chiropractic rather than integrate it in the larger health care system. Indeed, there is not a single clearly positive effect one could cite for the proposed policy.

It is economically illogical to eliminate cost-effective care and replace it with costlier care that is already scarce. Indeed, there is a moral and economic obligation on the government to promote cost-effective and accessible care. This would compel the enhancement of chiropractic coverage (Manga and Angus, 1998), not the announced delisting..

The Government of Ontario must reconsider the decision to delist chiropractic services. It is a costly error but one that it still has time to avoid. Indeed, the aggregate payment to chiropractic is 0.033% of Ontario's health care expenditure; that is, one-third of one percent. Chiropractic expenditures under OHIP are one-eighth of one percent of the total Ontario budget. Given this, it must be asked what budgetary problem can be meaningfully addressed with this sum. Expenditures on all three delisted services together still amounts to less than six tenths of one percent of health care expenditures. In contrast, spending on pharmaceuticals accounts for 15 percent or more of total health care expenditures. The Government of Ontario must re-think this decision. There is no shortage of good health care reform ideas and hardly any studies recommended the de-listing of chiropractic, physiotherapy and optometry.

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