

Can Medicare Be Saved? Reflections from Alberta



COMMENTARY

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MOST CANADIANS would consider the very question of saving medicare as a threatening prospect. Even more threatening should be the growing consensus that the above question is no longer relevant, that medicare in its current form cannot be saved and that the debate must turn to how our healthcare system should evolve in order to remain sustainable.

First, We Must ask the Right Questions

The notion that our current healthcare system is not sustainable is receiving

considerable attention today in the public domain. A review of recent media reports demonstrates widespread agreement that the issue is grave, but wide disparity of opinion on root causes and key corrective actions.

A number of articles have appeared recently in Canadian newspapers. A May 31 article in *The Globe and Mail* announced, “PM warned of health-care rage,” and quoted Manitoba’s Health Minister David Chomiak, who described the current situation as “the single most important issue we must resolve as a

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nation.” Chomiak recommended “immediate reinstatement of federal funding for healthcare to the 1994-95 level and an appropriate escalator to cover the projected spiralling cost of maintaining the system.”

A June 10 article in *The Globe and Mail* announced, “Health care crisis looms,” and summarized the current costs of the system in absolute terms to be about \$90 billion. The writer went on to project the staggering growth in these numbers absent reform of the system, and emphasized that this growth could be further inflated by \$5 to \$19-billion if improved home-care services and expanded pharmacare were implemented, as is currently being discussed. The writer stressed that this degree of growth would clearly be unsustainable irrespective of whether or not federal transfer payments were restored.

A series of articles in mid-June focused on workforce issues concerning nurses as an important element of our current healthcare crisis, and urged that these be acknowledged and addressed. A host of other reports have identified physician shortages as a key workforce issue. Adding to the discussion in late June, the World Health Organization released its World Health Report which ranked healthcare systems in 191 countries, with Canada in 30th place. More important, this report (WHO 2000) highlighted the absolute lack of correlation between a country’s health expenditures as a percentage of its Gross National Product (GNP) and the health of that country’s population!

In his essay *Aequanimitas* Sir William Osler reminds us that “no quality takes rank with imperturbability,” which he defines as “coolness and presence of mind

under all circumstances, calmness amid storm, clearness of judgment in moments of great peril.” These are important words for us to consider as we contemplate the current state of our cherished Canadian healthcare system and, more so, as we strive to develop a collective vision regarding its restructuring. In this issue of *HealthcarePapers*, Dr. Duncan Sinclair, a respected academic and healthcare reformer, has provided his views on current system stresses. The causes he points to include:

- Continued growth in public expectations compounded by a lack of clarity around need and demand.
- Continued escalation of costs related to technology and knowledge.
- The aging of our population.
- The unacceptability of rationing services.
- System inefficiencies.
- Eroding public confidence, magnified by “perpetual wrangling over who pays.”

Potential solutions identified by Dr. Sinclair include:

- Increased financing of the system.
- Enhancing public involvement in decisions about revenue development and allocation.
- Educating both the public and providers regarding demand versus need.
- Further improving system efficiency.
- Rationing.

While the points raised by Dr. Sinclair are comprehensive and thought-provoking, does his assessment move us forward as we struggle to find a cure for our ailing system – a set of prescriptions that may not be found in the current compendium?

One might argue that Dr. Sinclair's approach is too focused on the here and now, detailing current system stresses and describing the advantages and disadvantages of specific potential solutions that do not appear to be anchored in an overarching strategy or action plan. Is it not reasonable to assume that if medicare is in grave danger, saving it will demand such a strategy first, and specific prioritized actions second?

The Alberta Experience

Recent experience in Alberta may be illuminating, as many of the corrective measures identified by Dr. Sinclair have been implemented in this province. For example, Dr. Sinclair alludes to the advantages of moving toward more integrated healthcare delivery systems. Alberta has demonstrated national leadership in this area, collapsing close to 200 independent hospital boards and administrations into 17 Regional Health Authorities. Each authority or region is responsible for the full continuum of healthcare service, from public health to acute care, to rehabilitation, community-based and long-term care. There are also Provincial Mental Health and Cancer Boards, responsible for managing integrated services within these respective areas.

Through regionalization, Capital Health in Edmonton has become the nation's largest academic integrated healthcare delivery system, and has attracted national attention for its organizational structure, its capacity for innovation, and for its quality of service (Decter 2000; *Maclean's* 1999).

Noteworthy accomplishments of the Capital Health system include reduced administrative costs (currently at 3%, the

lowest of any health administration in Alberta), a focus on illness prevention and public health, interactive relationships with communities and an increased emphasis on accountability and performance management.

While many would argue that this model of healthcare delivery is worth emulating, no one would characterize it as *the* solution to the escalating costs of providing healthcare services. In fact, the Alberta government has recognized and acted on the need for significant reinvestment in the healthcare system in Edmonton (and Alberta) in order to ensure appropriate access to services; furthermore, there is no end in sight for continued growth in service needs and provider and consumer expectations.

Alberta has also been an innovator in healthcare delivery through a number of other initiatives. The "Wellnet" project has explored the manner in which contemporary information technology can be utilized to improve information management, efficiency and patient care. Alberta has been one of the first provinces to complete detailed physician and healthcare worker resource plans, and to use these as the basis for planning increases in health science faculty enrollments. A number of physicians in Alberta are already paid through "alternative payment plans," and there is a well-functioning process in place allowing additional physician groups to be considered for this payment mechanism. The Ministry of Health and Wellness in Alberta has recently completed an extensive stakeholder consultation process to better understand how improved alignment of incentives with system goals can be achieved among healthcare

providers. Again, while these initiatives all have merit, they are not necessarily effective at cost containment. Several are actually associated with increased costs.

The government of Alberta has also taken a national leadership position by advocating for some element of “privatization” of healthcare and introducing Bill 11, the Health Care Protection Act. This legislation enhances the government’s ability to regulate private sector clinics, defines the role of these clinics within the system and permits overnight stays in private surgical facilities. This initiative, while provoking a healthy national debate, has been met with some confusion and uncertainty. This initiative may be better understood if it could be seen as one of many steps within an overall health reform strategy.

What might such a strategy entail? I would suggest that key elements would include the following sequential steps:

- A. Galvanize public support for change through a process of aligned and apolitical public discourse.
- B. Revisit/reaffirm the values that should be preserved within Canada’s public healthcare system.
- C. In light of the above, assess current system weaknesses and future major drivers of change.
- D. Within a defined timeline, set a new course of action.

A. Aligned and Honest Public Discourse

A requisite step in forming an effective blueprint for the restructuring of our healthcare system is honest communication with the public. The general public have a higher level of awareness regarding vital public issues than they are given

credit for. Our healthcare system will not be rescued if politicians, healthcare administrators and others in informed positions continue to deny to the public that it must evolve.

The public need to be advised, in unambiguous fact-laden terms, that the current system is unsustainable. The public must hear this from every level of government, and from the leaders of their healthcare institutions. There must be no question that fundamental and profound change is necessary.

The public must be prompted to look beyond any notion that restoration of federal funding alone will be a significant corrective action. I suspect the public already knows the truth and wants to hear that truth spoken in a clear and factual manner. Honest public discourse of this nature, uniform in tone and content, will ultimately lead to galvanized public support for change.

B. Revisiting/Reaffirming Values

Canada’s healthcare system is value laden. The principles born of these values (accessibility, universality, portability, comprehensiveness and public administration) are enshrined in the Canada Health Act. The public healthcare system in Canada grew in stages in the post-war years and culminated in legislation in 1966. The structure of this system combines public health insurance for individuals with government funding of publicly administered healthcare organizations and was intended to protect Canadians from the potentially devastating financial effects of illness. It did not presume a future of educated, informed people who want to use their knowledge to make decisions and choices.

Canadian society is much different now than in 1966, and the values important to the citizenry may be quite different now. In beginning the process of rethinking medicare, is it not essential to establish a mechanism through which the values and principles that underpin medicare are carefully reviewed for continued relevance? Dr. Sinclair alludes to this need to re-examine values in his conclusion, but the requirement for this process should be made explicit.

C. Current State Assessment; "Future Shock"

The current literature (scientific, pseudo-scientific, public domain) is replete with opinions regarding the flaws in our current healthcare system. Some articles target specific issues (roles of providers, inadequate private sector participation), while others take a more all-embracing view describing a litany of system ills.

This collective body of opinion and thought, as currently arrayed, does little to aid in the development of a prioritized, data-driven list of issues and opportunities. Now is the time for all levels of government to collaboratively identify a group of apolitical, representative and knowledgeable opinion leaders in healthcare and charge them with the responsibility of undertaking an objective evidence-based assessment of our system. This table-setting exercise would then serve to prepare us for the design and implementation of change.

Such a group should be charged with the responsibility of identifying the major forces of change that will impact our healthcare system, and assessing the risks and opportunities associated with them. After all, never has mankind experienced

an age in which the shock waves of change are so incessant.

In healthcare, these changes will both magnify current system imperfections and lead to new system stresses that in some instances will be so profound as to be scarcely imaginable. In *Four Strong Winds: Understanding the Growing Challenges to Health Care*, author Michael Dexter identifies paradigm shifts in health policy, the consumer revolution, the technological transformation of health-services delivery and global competitive economic pressures as four important forces of change. Would other experts agree? What level of detail is required to sufficiently understand the sub-elements within each of these major change categories? What other forces should be considered? How should each of these be prioritized?

Even a superficial assessment of the dramatic changes our healthcare system is facing indicates a need for comprehensive long-term planning – changes driven by advances such as the genomic revolution, the development of artificial intelligence, the cloning of human beings or body parts, the transformation of communication. Such advances – and their effects – should cause us to consider the various forces of change, and the possible futures they bring with them.

D. Turning Information into Action

Data, information and enlightened opinion are of little value until they can be sculpted into knowledge and action. Even if all levels of government were to agree on the need for healthcare reform and communicated openly about that need; and even if a knowledgeable group of individuals met their mandate of

providing us with a comprehensive, value-based current state assessment of our system and a parallel assessment of the impact of the most important forces of change, how would these data, this information and these opinions be translated into an action plan?

There is a growing consensus that a public, apolitical discussion forum is required, a forum supported by information concerning current system weaknesses and important future trends, involving the public and other key stakeholders, managed by individuals with the requisite commitment and skills.

Evidence of this growing consensus abounds. In Saskatchewan, Premier Romanow has announced The Commission on Medicare, which will “identify challenges facing medicare, outline potential solutions and engage the public and health care providers in a discussion of new ideas.” Alberta engaged in an extensive consultation process in developing the Rainbow Report prior to regionalization, and is currently establishing a Utilization Commission with a broad mandate to examine the healthcare system. The Conference Board of Canada has also signalled an interest in playing a leadership role in helping to search out new directions for our beleaguered healthcare system.

While these initiatives or expressions of interest are to be welcomed, does the path toward positive change not require a national approach? Is such an approach, the basis of which would be honestly communicated to the public, not an absolute prerequisite to the development of an action plan for change? Is it not time for a Royal Commission on this national issue?

Conclusion: Further Reflections from Alberta

Reform of our healthcare system is required; this is a given. This is not to say it will meet with everyone’s acceptance. As historian Barbara Tuchman says: “Men will not believe what does not fit in with their plans or suit their pre-arrangements.”

In this paper, an argument is made that this reform would best occur in the context of an open admission by all levels of government that the current system is non-sustainable. Further, reassessing the validity of current values and principles inherent in medicare, along with an informed current state assessment and exposition of the major forces of change that will torque it, and a properly supported stakeholder consultation/public debate regarding preferred future directions are all necessary and needed.

As a healthcare administrator who works in the province of Alberta, I have my own views regarding the strategy that should inform consideration of required reforms. An essential element of the overarching strategy should involve tailoring the “new” healthcare system so that it genuflects to the emerging power of the consumer. This paradigm would be the lens through which all potential reforms are examined.

Never has the consumer of healthcare services been so demanding of information and influence; never has he or she had as much ability to acquire that knowledge or exert that influence. In this age of genomic revolution, of “new ethics,” of unlimited possibility bridled by limited resources, one view is that the consumer as a driver of policy and change will reign as never before.

Two simple examples from Alberta are illustrative. Regionalization, or integration of healthcare services as has been accomplished here, is considered by many to be the health-system organizational model of the future. However, the implementation of this model has not been without its challenges. Why so? As Decter (2000) points out, “The reality of modern health systems is that, most often, only the patient has an integrated view of his or her care.” He further comments: “Any vision of care integration that ignores the patient, or treats him or her as a passive recipient, is sterile and will not work.”

Perhaps the regionalization process in Alberta has been impacted by the new reality of consumer needs and expectations, leading to some tension. In the Capital Health Region based in Edmonton, this consumer tension is beginning to be understood. The organization is increasingly driven by the notion of consumer involvement, and increasingly oriented to the utilization of contemporary communication and e-health strategies to promote and capitalize upon that involvement. Dr. Sinclair, in his provocative article, references the importance of involving the public in different ways in the reform movement. In Alberta, this is already becoming a reality.

The debate over Bill 11 may be another Alberta example of a bold initiative that is in alignment with the growing role of the new consumer. As described above, medicare combines both public health insurance and funding of a public healthcare system. It was initiated at a time when the public was not as knowledgeable about health matters, sought information predominantly from

providers and was not in a position to make informed choices.

Today, the public is well informed, has extensive access to health information (there are over 20,000 health-related websites), and is increasingly insistent on being able to make decisions and choices regarding health care.

There may no longer be a strong rationale for enveloping both health insurance and health system funding in a single entity – medicare. A strong case might be made for unbundling the insurance component from the health-system provider component, permitting options, healthy competition and choice. If viewed in this way, Bill 11 could be seen as empowering, and as deserving of serious consideration.

These two illustrations from Alberta may be viewed as modest examples of the importance of focusing upon the consumer as healthcare reform proceeds. However, I believe that the power of this approach is just beginning to be recognized, let alone taken full advantage of. Indeed, there may be virtue in realigning the “Four Strong Winds” of change referenced by Michael Decter, so that the opportunities associated with paradigm shifts in health policy, the technological transformation of health services delivery and global competitive economic pressures are each considered predominantly and strategically through the lens of the new consumerism.

This is indeed a time of great change that calls for the imperturbability, the clearness of judgment, described by Osler. It is also a time for optimism. Peter Schwartz, in his book *The Art of the Long View* (1991), observes that one word for optimism in Japanese is *Rakkanteki*.

It means having enough challenges to give life meaning, and implies acceptance of problems as challenges to be met. A suitable word, one might suggest, to describe the attitude that will be required of those involved in “the saving of medicare.”

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