Rethinking Medicare: Response from the Canadian Medical Association

COMMENTARY

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DUNCAN SINCLAIR AND HIS COLLEAGUES (Healthcare*Papers* Vol. 1 No.3) have provided thoughtful reviews of some potential approaches to sustaining publicly funded medicare in Canada. The collection begins with Sinclair's five propositions, briefly:

1. Provide more funding – Sinclair thinks it would most likely come from private sources, and he is concerned about the size of the relative GDP share going to healthcare.

2. Make people aware of the health services they consume through contributions graduated by the tax system, or by an insurance or voucher system.

3. Distinguish need from want through incentives such as capitation payment, thus creating an internal market.

4. Implement system-wide governance within provinces/territories and increase accountability through the use of report cards.

5. Confront rationing – articulate the fundamental principles by which health resources will be allocated.

In addition to either supporting or taking issue with Sinclair's propositions, the commentators set out five additional propositions that come forward in the critiques:

6. Reassess the core values that underlie medicare (Lomas, Kenny, Hodge/Battista, Bear).

7. Establish a commission on the health workforce (Lomas).

8. Regulate/validate health information on the Internet (Lomas).

9. Engage the public in honest dialogue (Bear).

10. Establish a parallel system that can support medicare (Bhimji).

I would like to offer brief comments on these propositions, and then focus on what I see as two major and immediate challenges to medicare that need to be addressed, namely values and governance.

1. For the most part, the commentators are guardedly optimistic about Canada's ability to sustain publicly funded medicare. Lomas cautions that we should not put more money into old ways of doing things, and Segal suggests that we need to bring private funding to the table in a manner that will not compromise medicare. Since publication, First Ministers concluded an agreement in September that will see the federal government invest $23.4 billion in health over the next five years (Canadian Intergovernmental Conference Secretariat 2000). Most would agree that this is a good start. However, there is a need to consider a longer-range planning horizon, as the cost drivers study prepared for Health Ministers this summer makes quite apparent (Provincial and Territorial Ministers of Health 2000).

2. While I think that Sinclair's ideas for using the tax system to engage the citizen in healthcare might hold some promise for new program development such as pharmacare and long-term care, I share Raisa Deber's concern about the notion of promoting an "informed consumer" in relation to health services. In addition to the information asymmetry problem that has been amply documented, it remains the case that those most likely to use health services are least able to afford them. According to Statistics Canada (1999), the 1998/99 National Population Health Survey has shown that "Canadians with low incomes were more likely than those with higher incomes to be very heavy users of physician services, to visit emergency departments, to be admitted to hospital, to take multiple medications and to require health care services."

3. With regard to the use of incentives such as population-based (capitation) funding and the creation of competitive integrated systems, Frank Stronach strongly supports the idea, while others (Segal, Deber, McMurtry) are doubtful. While Sinclair notes that "this approach would require effective gatekeeping by both of the key participants, the user and the provider of every health service," he does not develop how it would apply to the user. This is something that most if not all similar proposals in Canada have failed to come to grips with, in that any direct financial disincentive to patients would most probably run afoul of the Canada Health Act.

4. Most of the commentators (especially Marmor) support greater use of information, and McMurtry goes so far as to propose that accountability be added as a sixth principle to medicare. I agree

with this, and in fact the CMA (2000) has recently adopted a set of guidelines for the assessment of health system performance. With regard to the implementation of system-wide governance within each province and territory, I share the concerns expressed by Segal and Lomas about the need to consider regional diversity. It would be useful to carefully assess the experiments with regionalization over the past decade before embarking on any further reforms of system governance.

5. Segal, Deber and Lomas agree with Sinclair's proposal to articulate fundamental principles of rationing, and there are several references to the international determination of core services. I would suspect, however, that it will be a lot easier to apply these approaches to decision-making about new treatments and programs than it will in cases that might potentially "delist" or "deinsure" some services that may have been publicly insured for decades.

6. I agree strongly with the need to revisit core values and will come back to this.

7. Lomas's suggestion for high-profile attention to the workforce is long overdue. In our pre-budget submission in 1999, the CMA called on the federal government to establish a national centre for health workforce research. Most jurisdictions are now dealing with critical shortages of nurses and physicians that are a clear result of lack of foresight and planning in decision-making. The health sector workforce studies that are being supported by Human Resources Development Canada are a promising start, but it will take a concentrated effort to firmly establish a longer-term planning horizon encompassing all health disciplines and which has buy-in from all key stakeholders. It would be important for such a planning body to have an institutional framework with tenure such that it is not interrupted by changes in government.

8. As more Canadians become connected to the Internet they will increasingly use it to seek health information. The World Health Organization (2000) has recently proposed the adoption of a ".health" top level domain to assist citizens in finding their way through an estimated 10,000 health sites on the Internet. Certainly patients and providers would like to have assurances that they are accessing reliable and up-to-date information.

9. I support Bear's call for public discourse and will address this below under governance.

10. Canada is probably the only industrialized country that does not permit privately funded health services to compete for the provision of what are typically considered as core services (i.e., hospital and physician services). Nonetheless, I think that the research evidence on whether such private systems can support the public system is very thin. The CMA continues to advocate that public funding must be sufficient to cover core services.

I believe two key, linked challenges that are before Canadians in the short term

are, first, to establish the vision and values for a sustainable medicare program and, second, to sort out the governance of our healthcare system.

Vision and Values

In the simple dictionary sense, a value is something to which we attach great importance. In the social sciences, however, values play a role in shaping society and its institutions. In his new book *Health Care in the New Millennium*, Ian Morrison (2000) states that "values are important determinants of health policy and health management." Some idea of the role that values play may be seen in the contrast that Morrison draws between the healthcare values in the United States versus those of other countries with universal health systems, including most of Europe for example.

Comparative Healthcare Values

Countries with Universal Systems	United States
Universality	Pluralism and choice
Equity	Individual accountability
Acceptance of the role of government	Ambivalence toward government
Skepticism about markets and competition	Progress innovation and new technology
Global budgets	Volunteerism and communitarianism
Rationing	Paranoia about monopoly
Technology assessment and innovation control	Competition

In Canada, medicare has been defined by five principles that taken together embody the value of solidarity – the sense that we are all in the same lifeboat. Over the years the five program criteria (principles) of the Canada Health Act (CHA) have been effective in preserving the publicly funded character of hospital and physician services. According to the most recent estimates from the Canadian Institute for Health Information (CIHI 1999), almost 99% of physician expenditures and 92% of hospital expenditures are publicly funded. In contrast, categories such as drugs and other health professionals are 68% and 90% privately funded respectively.

Over the past decade, however, hospitals have represented a declining share of total health expenditures, dropping from 40% in 1989 to an estimated 32% in 1999. CIHI now estimates that more is now spent on drugs than physicians. One of the reasons behind the declining share of hospital expenditures is that the delivery of healthcare has expanded beyond physicians' offices and in-patient beds. Between 1986 and 1996 the hospitalization rate has declined by one-quarter and the rate of days used by one-third. There has been an increased burden on the patient and his or her family in terms of out-of-pocket expenditure and informal caregiving. Statistics Canada has reported that, on average, households spent close to $300 more (in constant dollars) on healthcare in 1998 than they did in 1978 (Chaplin and Earl 2000). While virtually all jurisdictions have introduced public programs to expand coverage of the continuum of care, they are not covered by the five CHA criteria, and there is wide variability across jurisdictions.

In his commentary, Lomas poses three questions that outline some of the value questions Canadians will face:

- How will we make decisions on highly effective therapies that are very expensive?

- What criteria should be used to determine public, private or cost-shared funding for services? and
- What are the boundaries between home care funded under universal medicare and social support funded through means-tested welfare?

Thinking back to the CHA principles of medicare, it seems to me that we need to address the following questions:

- Do the values and principles embodied in the CHA need to be applied more broadly (e.g., in terms of the continuum of care)?
- Is there a need to apply some additional values/principles to medicare?
- Have the core values of Canadians shifted in relation to those embodied in medicare?

Canadian experience of the past few years suggests that there may be more values/principles in play than may have been the case some years ago. For example, the report of the provincial/territorial Ministerial Council on Social Policy Reform and Renewal sets out 15 principles along four themes, namely that social programs must:

- be accessible and serve the basic needs of all Canadians;
- reflect individual and collective responsibility;
- be affordable, effective and accountable; and
- be flexible, responsive and reasonably comparable across Canada.

More recently a diverse group of participants at a 1999 Alberta Health Summit identified 14 basic values and principles for the health system.

Alberta Health Summit '99
Basic Values and Principles

• Access	• Information
• Accountable	• Choices
• Affordable and sustainable	• Cooperation
• Adequately funded	• Team Work
• Publicly funded and administered	• Balance
• Consistent with the CHA	• Adaptable
• Standards	• Coordinated

The CMA (2000) has just published a report on its Futures project that has identified a set of value statements with respect to societal values, healthcare system values and values in medicine.

Elsewhere, the re-examination of core values and principles in relation to healthcare is taking place internationally. In its 1999 World Health Report, the World Health Organization discussed "new universalism," which includes the following design features:

- Membership is defined to include the entire population (i.e., it is compulsory).
- Universal coverage means coverage for all, not coverage of everything.
- Provider payment is not made by the patient at the time he or she uses the health service.
- Services may be offered by providers of all types (WHO 1999).

In summary, I am inclined to agree with Clement Bezold of the Institute for Alternative Futures who has said that "vision is values projected into the future." If this is the case, this underscores the need for a wide-ranging dialogue among a representative group of Canadians with a view to developing consensus on the fundamental values and

principles that should define medicare in light of the transformed delivery system.

Governance

The challenge to the governance of Canada's healthcare system is reflected in a definition provided by Gilles Paquet of the University of Ottawa – "Governance is the process of effective coordination when power and knowledge are distributed." In Canada, there are at least three axes along which power and knowledge are distributed:

- between the federal/provincial/territorial and regional authority/municipal levels of government/administration;
- along the east-west array of provinces and territories; and
- among a range of stakeholders, including governments, non-governmental associations (NGOs) and citizens.

There has been a profound imbalance among these axes over the past decade; it seems that at any given time it is difficult to achieve concerted direction on more than one of them. For much of the past decade, the tension between the federal/provincial/territorial governments in relation to healthcare has been very pronounced. For example, the provinces and territories did not generally participate in the National Forum on Health. Conversely, when the provincial/territorial Health Ministers produced their 1997 Renewed Vision for Canada's Health System (Conference of Provincial/Territorial Ministers of Health 1997), the report received very little attention at the national level.

While there has been progress along this front, as evidenced by the February 1999 Social Union Framework Agreement (Canadian Intergovernmental Conference Secretariat 1999) and the September 2000 health accord reached by First Ministers this highlights a second problem. In general, governments have discounted the role that NGOs and citizens might play in policy-making and in promoting policy among their members. The recent Federal/Provincial/Territorial agreements have been negotiated by government officials behind closed doors, and yet it is the providers and patients who are expected to implement and live with the results. To highlight one problem that this has caused, we are now facing an acute shortage of physicians in many places across Canada due, in part, to a unilateral decision by Health Ministers in January 1992 to reduce undergraduate medical enrolment by 10%.

If we are to achieve a vision for a sustainable medicare program in the challenging decades ahead, it will be critical to resolve the imbalance along these axes. Governments must begin to work collaboratively with other stakeholders, including citizens, as they have among themselves over the past few years. The population must be engaged in a deliberative dialogue process that will enable Canadians to understand the challenges before us, identify options and make choices that are congruent with our values.

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