HEALTH CARE REFORM: LOST OPPORTUNITY — Part 2

This is the second in a two-part Atkinson Letter on medicare. On September 11, the federal and provincial governments reached an agreement that will put $21.1 billion more dollars over the next five years into the Canada Health and Social Transfer for health care. It will also give the provinces an additional $2.3 billion in targeted funds. But many experts say that the agreement fails to deal with the most important challenges to medicare—the shift from public to private financing, the long waiting lines, the need for more available and affordable home care, and the need for a national pharmacare program.

Just prior to the First Ministers’ agreement, The National Leadership Roundtable on Health Reform—which brought together a balanced collection of community leaders and policy researchers—presented its own prescription for fixing medicare. The Roundtable was sponsored and organized by the Dialogue on Health Reform and co-sponsored with the University of Toronto’s Department of Health Administration and the Canadian Healthcare Association. This issue of The Atkinson Letter presents the major recommendations of the Roundtable.

1. Shifting the Public-Private Balance in Financing

In 1984, the Canada Health Act was passed by the government of Canada to protect medicare. The Act sets out five principles that the provinces have to meet to receive federal funds: universality, portability, accessibility, public administration and comprehensiveness. At the time the Act was passed, it was expected that all seriously ill people would be treated in hospitals—where all of their care would be covered. In addition to doctor and hospital services, many other services could also be paid for, including: drugs, rehabilitation, recuperation and palliative care.

Since then, new developments in technology and treatment have made it possible for people to be treated at home. When services are moved to the home or community, the provinces no longer have to pay for them. Provincial governments have a real incentive to send people home from hospitals and shift their costs elsewhere.

Similarly, hospitals have off-loaded some of their costs. If someone is sent home, someone else must pay for nursing, drugs, rehabilitation etc. In contrast, sick people soon recognize that the hospital is one of the few places that must treat them “for free”. The resulting pressure can be seen across Canada, as hospital emergency rooms try to cope with patients who might indeed be treated more appropriately and more economically elsewhere if those alternatives existed.

This has undermined health care, since, for the patient, “closer to home” can also mean “out of pocket.” Canada, today, has one of the lowest proportions of public expenditures on health care anywhere in the industrialized world. In fact, services guaranteed under the Canada Health Act are only 45.5% of all services. Provinces may cover other services, but there is a three-fold variation across provinces in the public payment portion of home care and pharmacare. This creates a problem because it means a higher cost burden and, therefore, less access for lower income people in provinces where little public support is provided. The protections provided by the Act against the financial burdens of illness need to be updated:

• the federal government must extend its funding mechanisms to take into
account the changing location of health care, beginning with home care and pharmacare; and,

• mechanisms must be established to review and keep pace with changing delivery realities; while home care and prescription drugs are today’s big needs, new needs may emerge tomorrow.

2. Re-defining Medical Necessity

The Canada Health Act guarantees Canadians that “medically necessary” services will be delivered free of charge. But, “medically necessary” is an ill-defined concept that, in practice, means whatever physicians or hospitals deliver. Fuzzy as the concept is, medical necessity forms the chief dividing line between what government must pay for and what people pay for out of their own pockets or through private insurance.

The shift to community services and revolution in pharmaceuticals have made traditional ideas of medical necessity less helpful than in the past. If we continue to strictly define “medically necessary” as what physicians and hospitals do, then these services will continue to shrink in scope. Rather than looking for new black-and-white definitions of medical necessity, we need a more flexible system that includes:

• a principle that recognizes that there needs to be a seamless continuity of care;
• an obligation to spend public money on a comprehensive range of health needs regardless of where the services are delivered and who is providing them; and,
• the capacity to adapt over time.

3. Easing Waiting Lists

Canadians want their health care system to respond to them according to their needs. This means that equal needs will be treated equally, and unequal needs will be treated differently. People most in need, such as in an emergency situation, ought to be moved to the front of the line. A system that fails to ensure that people get care in the order of relative need or urgency would be viewed by most of us as unfair and a cause for concern.

Waiting for specialists and hospital services has become a major flashpoint in Canada. The spectre of hundreds of cancer patients being bused to border cities for radiation therapy, or patients being turned away from emergency rooms has captured the public interest. In the public’s mind, waiting lists are like a canary in a coal mine—an early warning sign of trouble lurking elsewhere.

While the waits for some forms of care have increased, others have improved. But the public perception that waiting lists are, on the whole, growing, creates anxiety and erodes confidence in our health care system. Both the reality and the perception are a problem. Solutions have to speak to public perception, inadequate resources, and poor management of access and delivery. Better access and shorter waiting lists are necessary to strengthen public confidence in our health care system.

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While this may sound like a simple problem, the situation is actually quite complex. To begin with, most waiting lists are kept by individual physicians. With the exception of some cancer registries and cardiac care networks, there is astonishingly little coordination of waiting list information among physicians across sites and across specialty care areas. Whether or not it is appropriate for a patient to be on a list is largely the decision of an individual physician. There are no agreed upon rules for when a patient should be put on a list. The result is physicians differ on their decisions on when and who to place on a list. Sometimes wait lists may be inflated by an individual physician because longer lists show that he or she is in greater demand and so, must be good.

Possible solutions for reducing waiting lists and time include:

• developing comprehensive information systems with coordination mechanisms across sectors of care;
• more funding for certain problematic areas of care;
• but, in cases where the core problem is management rather than resources; simply increasing funds is not enough, and could be counter-productive;
• in some specialty care areas, investments in care providers and technology;
• aggressive management with continuous monitoring and audits of wait list information; and,
• government funders becoming involved in not only funding list reductions, but also funding development of management mechanisms spanning activities across hospitals and regions.

It should be noted that creating a second, private tier of health care, would not reduce waiting lists. Making it possible for people to “queue jump” does not reduce public waiting lists. There is more than enough evidence of this in studies conducted in Australia, the U.K., New Zealand and even the United States. The very presence of a private tier requires, from an economic point of view, the perception of problems and waits in the public system.

4. Investing in Information

Better and more timely information must become the bedrock of our health care system. We need it so we can accurately judge the system’s performance, and so we can separate fact from fiction and reduce the time wasted debating misinformation or out-of-date information. Information systems are the necessary tools for efficient and effective planning and reform. Valid and reliable information is needed to support policy decision-making as well as clinical practice, and to improve the confidence and involvement of consumers. At the moment, much of the data that is available is old or out of date.

Consumers need to be able to easily find information such as:
• what benchmarks have been established for a given intervention in a specific condition;
• what the basis is for current guidelines for the intervention;
• whether and to what extent waiting might affect the prognosis;
• how the length of the current list compares to the total population receiving or requiring the care;
• current rate of “coming off” the list for the particular intervention, and alternatives available; and,
• suggestions that consumers could discuss with caregivers for managing the condition while waiting.

For this to happen:
• non-partisan brokers, such as the Canadian Institute for Health Information (CIHI) are essential; and,
• information networks need to be broad-based, linking decision-makers and consumers.

Evidence has to continue to be gathered and applied in a coherent way in order to be useful to decision makers. For example, conditions such as cancer and many others are not one disease, but many different diseases in different stages of progress. Ongoing research is needed to establish scientific benchmarks for waiting times.

The recent announcement by First Ministers (http://www.scics.gc.ca/cinfo00/80003807_e.html) is a helpful step in targeting funds to this sector.

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5. National Standards for Home Care

In the last two decades, we have seen a tidal wave of change sweeping across most components of the Canadian health care system and coming to rest upon the shores of the home and community care sector. This period of dramatic change is having an enormous affect
on care recipients, their families and friends and in-home service providers.

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There are many reasons why home care spending is growing: more people are eligible, access is easier, technology is changing, the health system is being restructured, and the population is getting older and living longer. But a large motivating factor appears to be the common belief that government can save money by steering care away from institutions and toward the community.

The need for home care will become a major issue for all Canadians as the baby boomers age, as average life expectancy rises, as health-care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of “informal” caregiving by family members.

Home care spending is already growing faster than any other health spending. If past trends continue, total home care expenditures, whether privately or publicly financed, will reach $3.4 billion in 2000-01. The amount of money that Canadians have to pay out-of-pocket is large— with Canadians facing significant financial barriers to accessing in-home services.

There is a need for some form of national standard to promote a basic range of services in the home that is comparable for all Canadians, and that is based on an understanding of where home care is effective and where it is not. The First Ministers have a range of options at hand, as do the Health Ministers, including:

• new federal legislation to create common goals and regulatory mechanisms for achieving them; and,

• a common statement of First Ministers to show their commitment to a base of home care coverage.

Funding for such an expansion of services covered by medicare poses challenges. Options for meeting this challenge include:

• a national standard for home care supported by either a cash floor or a commonly agreed upon basket of services.

Neither way, it is important that the federal government play an active role in shaping a national role in home care. (Since the First Ministers did not take action in this area, some form of federal or national review of medicare may be required to achieve this objective.)

6. Pharmacare and a National Insurance Program

The increasing costs of drugs and the increased burden on provincial governments, employers and consumers suggest the need for a national pharmacare program.

Standards and regulations for the pharmaceuticals industry fall within federal jurisdiction. The chief role of the provinces has been in the setting of drug formularies (i.e. list of approved drugs) for payment by the provincial drug plans.

Given the nature of the industry and of the product itself, this is an area where it would make sense for the federal government to take a lead role, not only in setting standards and providing funds, but in assuming the role of national insurer for pharmaceuticals. This would offer many benefits, including: the standard availability of pharmaceuticals across the country; and, the elimination of inefficiencies associated with the creation, negotiation, and administration of different, parallel formularies from province to province.

The National Forum on Health (a former advisory body to the federal government), in a similar vein called for a national pharmacare program. The complexities of such an undertaking would be considerable. But rather than ignoring it and doing nothing, the federal government should begin now to:

• establish linked federal-provincial organizations or institutions for identifying the contours of such a program and the means of implementing it.
Excerpts from the National Leadership Roundtable’s Report

On the shift to private financing...
“Hospitals are 90% publicly funded, but private expenditures on capital and other institutional costs are rising. As for spending on drugs and non-physician professionals, private payments account for, respectively, 70% (including non-prescription drugs) and 90%.”

On which services are “medically necessary”...
“It was generally agreed that listing individual health-care services as either in or out of the public scheme on the basis of ‘medical necessity’ is too rigid an approach. What is needed is an ongoing process for reviewing services to be publicly covered as delivery realities change. The details of such a process would need to be determined, but its core features should include access to up-to-date information about health care delivery realities, the flexibility to respond to them appropriately, and the capacity to determine best practices.”

On waiting lists...
“Fear attaches to some conditions more than others. No one would argue that waiting a long time for cancer radiation is a good thing. Nonetheless, many concerns arise because people do not know whether they are waiting too long and fear they might be. It would be valuable for all concerned to invest in informing people, as much as knowledge permits, whether they are compromising their outcomes by waiting the length of time typical for a given intervention and condition. One means could be to establish ongoing communication, via such mechanisms as Web sites or dial-in-lines that could provide information.”

On home care...
“Many Canadians do not know what home care is available to them. Our so-called ‘national health system’ and ‘social safety net’ are assumptions that have a limited basis in reality, notwithstanding rhetoric at home and elsewhere. Furthermore, standards in home care are highly uneven from province to province. Ontario’s retirement homes are a case in point. While other provinces require retirement homes to be licensed, Ontario leaves care services in them entirely unregulated, except insofar as professional licensing applies to some providers.”

Would You Like To Know More?
We encourage readers to learn more about the recommendations of The National Leadership Roundtable on Health Reform. The Roundtable’s full report and background papers prepared for the Roundtable are available at the Web site of the Dialogue on Health Reform at www.utoronto.ca/hlthadmndhr/
Speaking of Reforming Medicare...

“With the announcement that the first ministers were getting together to talk about health, it seemed that the issue of private versus public could not be avoided. But it was. And this is too bad. Because if public, universal medicare is to survive, then it has to be expanded into the areas that people use—including home care and drugs. That requires not only federal money. It requires something more difficult: a federal government willing to act, one willing not only to expand national medicare but to enforce its rules.”

— Thomas Walkom
The Toronto Star
September 12, 2000

“Another area that bears attention is the wide variation in home care spending among the provinces. If all Canadians are to have access to the same services regardless of where they live in the country, it will take more equitable funding arrangements. Wide inter-provincial variations in home care funding highlight opportunities for federal and provincial initiatives to address potential inequalities in access to home care services. Of course, implicit in this is the belief that uniform access to home care funding irrespective of where Canadians live is appropriate; that national standards be developed outlining the range of publicly-insured professional and homemaking services; that common eligibility conditions be designed for in-home service provision; and, that common servicing plans be devised once the eligibility is determined.”

— Peter C. Coyte
“Home Care in Canada: Passing the Buck”

“There is simply no rational way that a political process can define medical necessity. It's a local, circumstantial, judgmental, moving decision that can only be made by well-motivated doctors and informed patients.”

— Arnold Relman
MD, Harvard Medical School