PRESERVING MEDICARE AND OPTIMIZING THE CANADIAN HEALTHCARE SYSTEM

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SUMMARY

For over half a century, Medicare has symbolized Canada's commitment to providing equitable care to all its citizens. However, as healthcare becomes more complex, costs have increased and wait times have worsened. Despite decades of government commissions and massive investments to improve the system, persistent challenges have caused physicians and patients alike to advocate for expanding privatization in healthcare, such as introducing parallel private health insurance or more for-profit health facilities.

In this paper we clarify the important issues surrounding privatization of healthcare in Canada. We explain the different aspects of the healthcare system (i.e. financing and delivery) and describe how 'privatization' can be implemented in various forms. Advocates of a parallel private system often point to the underperformance of the public system, and the need for citizens to be able to choose when and where they can access care. Opponents emphasize the harmful and costly effects of introducing a parallel private system, especially in the areas of wait-times, administrative burden, and quality of care.

Moving forward, the CFMS supports these key principles to ensure that Canadians continue to receive the best care possible. The health system must be: 1) equitable and accessible; 2) sustainable and cost-effective; and 3) integrated to provide high-quality care.

The CFMS calls on Canadian governments, at all levels, to reaffirm their commitment to a publicly-funded, universal healthcare system, and to prevent any private measures that may promote a two-tiered and inequitable system. Efforts to make the system more sustainable should focus on expanding Medicare to include National Pharmacare and exploring innovative alternatives within the public system. The CFMS also encourages medical programs to provide medical students with more formal educational exposure to health systems and policy.

BACKGROUND

Canada's publicly-funded, universal health insurance system, commonly known as Medicare, has had a long and difficult, but proud history. The idea of a publicly funded health system was born in Saskatchewan in 1947 when Premier Tommy Douglas introduced the first hospital insurance program in Canada. Efforts to expand public health coverage nationally, however, were stymied by political and ideological divide on healthcare.[1] It was not until 1966 that Lester Pearson's administration expanded health coverage to a national scale, creating Medicare.[2] This plan included thirteen distinct provincial and territorial health insurance programs that covered all medically necessary hospital and physician services for Canadians. The Canada Health Act followed in 1984, outlining specific conditions under which provincial and territorial health insurance plans must comply in order to receive funding through the Canada Health Transfer.[3] These core principles—universality, comprehensiveness, public administration, portability, and accessibility—still stand as pillars of the Canadian healthcare system.[3]

Understanding Health Systems: Putting Canada into Context

Health Systems Financing

Healthcare is funded either publicly or privately (Figure 1). Private payment for health services includes out-of-pocket (OOP) spending, private health insurance, and charitable financial sources. The United States is the only country in the Organisation for Economic Cooperation and Development (OECD) that relies heavily on OOPs and private health insurance to fund its healthcare system.[4]

Publicly-funded systems include social insurance schemes or tax-based financing. Social insurance funding is often used in European systems, such as in Germany and France. Social insurance institutions are heavily regulated by the government, though they operate as third-party insurers and are mandated to set premiums, irrespective of health risk. The current system in Canada is financed through a combination of public sources from taxation and private financing. Only 70% of health services in Canada are funded through the public Medicare insurance plan, which is lower than the OECD average of 72%.[5]

Unlike most OECD countries whose healthcare coverage includes a broad array of health-related services, coverage for the Canadian system is 'deep and narrow.'[6] Medicare is restricted to medically necessary services provided by hospitals and physicians.[7] The remainder of healthcare services, including outpatient medications, dental, and eye care, are funded through a combination of private health insurance, out-of-pocket spending, and public health coverage for special patient populations.

Although Canada's aging population and the rise in annual inflation rates may partially explain increasing healthcare spending trends, the greatest driver of healthcare cost has been the increased consumption of private health services, particularly outpatient prescription medications.[8] The narrow public funding scope of Medicare has resulted in an expensive healthcare system with Canada having the highest total prescription drug expenditure per capita amongst OECD countries, with the exception of the United States.[43]

Health Systems Delivery

To evaluate private and public involvement in healthcare, it is important to consider the distinction between financing and delivery of health services (Figure 1).

In a publicly funded system, examples of public delivery include the Public Health Agency of Canada, Veterans Affairs hospitals, and clinics in the United States. Privately delivered care can be further subdivided into not-for-profit and for-profit institutions. In not-for-profits, any surplus revenue is returned to the public, while in for-profits, surplus revenue is retained by investors. In Canada, not-for-profits include most hospitals and doctors, and for-profits include privately-owned medical labs and walk-in clinics. Examples of privately funded services that are publicly delivered include non-medical services, such as private rooms in public hospitals. Privately delivered not-for-profit services include some homecare and nursing homes, while for-profit services include cosmetic surgery and some long-term care facilities.

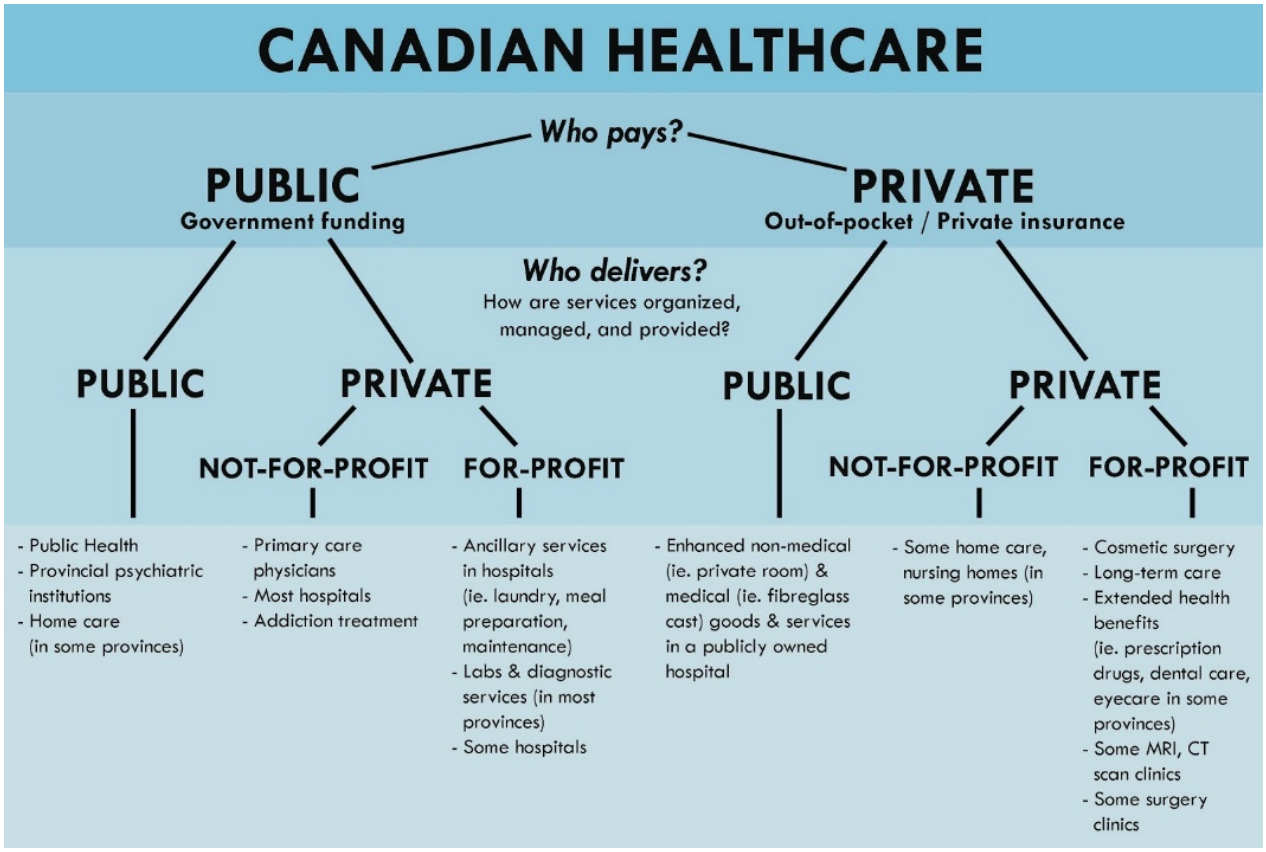

Figure 1. Financing and delivery of healthcare services in Canada.[15]

Challenges to Medicare

Medicare has faced multiple Charter challenges since it was first signed into law in 1985.[10] The most significant challenge was *Chaoulli v. Quebec*, where the Supreme Court of Canada recognized the right to purchase private health insurance in cases where the public system is unable to provide for the patients' needs.[11] Recently a Charter challenge was initiated by Dr. Brian Day against the B.C. Medicare Protection Act, who claims that it limits Canadians' right to purchase health services.[12] He argues that doctors and clinics should be able to directly bill patients for medical services and other associated services.[12] An important aspect of this challenge involves extra-billing and double-billing. Extra-billing involves charging more for a service than the fee outlined by the province's payment schedule, while double-billing involves charging both patients and the province's insurance plan for the same health service. These billing practices have the potential to create a system where an individual's access to essential health services is not based on their need, but rather their ability to pay.[1] Canadian provinces have all enacted laws to protect their public health insurance plans and prohibit or limit extra-billing and double-billing for health services.[12]

Supporters of a two-tier system see the introduction of privatized healthcare as long overdue for a system plagued with excessive wait-times and uncontrolled costs. Since *Chaoulli v. Quebec*, the number and size of private clinics in Canada has grown substantially, albeit

quietly, in recent years. It is estimated that there are over 300 private not-for-profit and for-profit clinics in operation in Quebec, 66 in BC, and 60 in Alberta.[13] Though the extent of privatization remains limited, many see this as the beginning of Medicare's slow unraveling, with the vision of a system that treats individuals according to need being replaced by one that treats individuals based on ability to pay.

Arguments for a parallel private system

Despite decades of government initiatives to improve timely access to care, wait times in Canada remain about two to three times longer than in other OECD countries with universally-funded public health systems.[14] About 25% of Canadians report waiting over four hours in the emergency department, compared to 1% in the Netherlands and 4% in the UK.[14] Unnecessary delays in access to care can result in significant negative consequences for patients and their loved ones, who often experience prolonged suffering, disease complications, and deteriorating health.[14] Some have argued that avoidable mortality increases significantly for every one-week increase in wait times for elective cardiovascular surgeries.[15] Increased wait times also incur extra costs to the system by reducing productivity and tax revenues, and by requiring patients to undergo monitoring and temporizing interventions until they receive definitive care.[15]

Given the relative underperformance of the Canadian healthcare system, proponents of a parallel private payment scheme argue that patients have the right to choose where and when they spend their money on health. They equate healthcare services as any other good (such as clothes, cars, and food) which should be paid for freely with minimal government interference and rationing. Medical tourism, in which Canadians travel abroad to receive care, is a key example of patients already exercising this right. However, this is an expensive and inefficient way to access health, and it poses potential risks for Canadians who are compelled to choose this option. Proponents of a parallel private system argue that these risks could be avoided and better managed if medically necessary services could be privately purchased in Canada.

Arguments against a parallel private system

a. Wait times

Wait times constitute the main challenge in Medicare's ability to deliver equitable access. These are persistently long in orthopaedic surgeries, medical imaging, cataract removals, and emergency room visits.[16] Governments' failure to address this satisfactorily has led to renewed interest in promoting private payment for medically necessary services. Proponents of this private funding strategy suggest that this would relieve wait lists in the publicly funded system. However, the evidence shows that decreased wait times are limited to those who can afford to pay for health services, at the expense of increased wait times in the public system.[16] As the case in Australia illustrates, introducing privately funded care in a generally public system results in increased median wait times in the public

sector.[17] Furthermore, in Quebec, wait times for hip, knee, and cataract services in the public system have not improved, despite the *Chaoulli* decision to permit private health insurance.[18,19]

The interaction between private and public markets becomes more apparent with increasing private sector activity within healthcare. In a parallel system, physicians may choose how they split their time between both systems. Physicians who decide to spend more time working within the private health sector compromise access to care for patients waiting in the public health system.[17] Further, physicians in the more lucrative private sector have an incentive to maintain longer wait times in the public sector to encourage patients to seek earlier care through private payment.[17,20-22] A study found that the practice decisions of ophthalmologists in Canada affected the wait times of their patients. The median wait times of ophthalmologists that only operated in the public sector was 7-8 weeks for cataract removal. For surgeons operating in both systems, the public patients' wait times were 15-20 weeks.[23]

b. Administrative costs

Current evidence demonstrates that administrative costs in the private health sector are higher than those in the public sector.[24] Moreover, countries that have transitioned to more market-based payment systems, such as the UK, report higher administrative costs, with little to no benefits in patient outcomes or efficiency.[25,26] At the extreme end is the United States, where there is no universal public health system. Administrative costs in the United States contribute to up to 25% of total hospital spending—double the costs in Canada.[25] Their multi-payer health insurance system also results in highly complex, inefficient, and expensive physician and hospital billing systems.[25] The annual cost of total time spent by physicians, administrative staff, and nurses on administrative tasks is four times higher in the US compared to Canada (whose administrative work is often not compensated).[27] In contrast, single-payer health systems where hospitals receive global annual operating budgets and direct government funding, as in Canada, have the lowest administrative costs.[25]

Finally, introducing a parallel system would incur hidden public costs. Private clinics often specialize in minor surgeries and elective care, while the public system is left to handle complex cases and emergency care for both private and public system users.[28] These result in a very low potential for cost shifting, as private users still use the public system for more expensive services.

Broadening the scope of Medicare to include other important health services, such as National Pharmacare, would be key milestones in ensuring a healthcare system that is financially sustainable and cost-effective. In contrast, expanding private financing in healthcare would introduce administrative inefficiencies and would create added costs to the system.[29]

c. Quality of care and patient outcomes

There is little evidence that introducing a private, for-profit funding and delivery scheme is the right approach in addressing these challenges. In fact, the evidence so far is discouraging. Patients treated at private for-profit hospitals have a higher risk of death compared to those in private not-for-profit hospitals.[30,31] For-profit nursing facilities have inferior quality and outcomes compared to not-for-profit facilities, as measured by staff-to-resident ratio, use of physical restraints, pressure ulcers, and regulatory attainment.[32] Furthermore, for-profit providers may be more likely to perform procedures inappropriately[33] or perform procedures that are not evidence-based.[34]

On the other hand, there are multiple examples of innovative programs that have improved healthcare delivery within our public system. The Alberta Bone and Joint Institute successfully reduced wait times for knee and hip surgeries from 11 months to 11 weeks,[35] reduced length of hospital stay by 30%, and increased patient satisfaction.[36] They did so by centralizing patient intake, designating operating rooms and staff, and using multi-disciplinary teams such as physiotherapists and dieticians to customize patient care.[36] Modifying physician reimbursement schemes such as in community health centres and family health teams designed to help reach marginalized populations—who are among the most frequent users of the healthcare system—can result in fewer visits to hospital emergency departments.[37] The Champlain Collaboration Space, "BASE" (Building Access to Specialists through e-Consultation) Project in Ontario links family doctors and nurse practitioners to specialists in over 60 different disciplines, eliminating formal wait times, reducing costs, and improving convenience for patients. This has lowered unnecessary face-to-face referrals, while facilitating better communication and dialogue across physicians.[38]

These innovations show that significant improvements in the healthcare system could be made within the context of Medicare, without resorting to parallel private health models.

PRINCIPLES

Given the current challenges that affect the Canadian healthcare system, we believe that introducing a parallel private system would aggravate inequity, increase costs, and lower quality of care.

1. **Canadian patients deserve a healthcare system that is equitable and accessible**

A public healthcare system should aim to provide equitable access to care for all its citizens, regardless of economic status. The Canada Health Act states, "the primary objective of the Canadian healthcare policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."[39] Equity is a key pillar of our healthcare system that should not be compromised.

The finite number of health human resources—including physicians, nurses, and laboratory and imaging technicians—ought to be judiciously distributed to serve all Canadians, and to ensure fair access to healthcare based on need, and not the ability to pay.

2. **Canadians deserve a sustainable and cost-effective healthcare system**

There are growing concerns that Canada's healthcare system is fiscally unsustainable, compromising timely access and quality of services.[14] Although total health spending as a percentage of GDP in Canada has remained on par with most OECD countries, public and private health expenditures have increased in the last several years. Healthcare costs have risen faster than any other government program and currently makes up 42-45% of provincial program spending. This strain on provincial budgets has compromised governments' abilities to manage their other responsibilities, including education, public transit, and housing. Furthermore, Canada's aging population presents its own challenges to the sustainability of Medicare. Older patients contribute to 50% of hospital costs and 44% of the total costs of Medicare nationally. To meet the growing health needs of the Canadian population, the healthcare system must optimize its financial and functional performance and reduce its impact on other essential government programs.[6]

3. **The healthcare system must provide integrated and high quality care for all Canadians**

Advances in medicine and health technologies continue to accelerate at a dizzying pace. Our health system needs to be able to adapt to the constant flux of medical knowledge, the drive to use cutting-edge sophisticated diagnostic instruments, the increasing reliance on health informatics, and the need for an interdisciplinary approach to manage chronic conditions. As such, it is imperative that our system has the capacity to integrate and adapt to this complexity, in order to provide high quality care. These challenges can be addressed without dismantling Medicare. Scaling up effective innovative delivery models and utilizing the full continuum of care across health disciplines would address these current healthcare challenges.

RECOMMENDATIONS

1. **Canada's Federal, Provincial, and Territorial governments should renew their commitment to a publicly-financed, universal, single-payer healthcare system.**

International examples and literature (as discussed previously) have demonstrated that private solutions would not necessarily mitigate the issues within our current system, and not-for-profit delivery has been shown to provide safer and better quality healthcare. Federal, Provincial, and Territorial governments should commit to the principles of our

current system and be stricter in enforcing those principles, including banning double coverage.

2. **Canada's governments should enforce the ban on double billing and extra billing.**

Double billing involves physicians charging both the government and the patient for the same health service, while extra-billing involves charging more for a service than the fee outlined by the province's payment schedule. Both these practices create unnecessary cost burden on patients, limits their access to healthcare, and are not in keeping with the principles of our universal, healthcare system.

3. **Federal, Provincial, and Territorial governments should work together to expand Medicare include prescription drug coverage.**

Rather than turning to private funding solutions, a better alternative for reducing the financial burden on our healthcare system and improving patient outcomes would be expanding Medicare to cover prescription drugs. Currently, 1 in 10 Canadians cannot afford their prescription drugs.[40] A National Pharmacare plan would address the needs of these Canadians, and lower total drug spending by an estimated $7.3 billion, with minimal increases in public health budgets.[41] Combining the purchasing power of multiple drug plans into one system, while allowing free-market competition between drug manufacturers, would ensure more affordable drug pricing in Canada.[42]

4. **Local and Provincial healthcare authorities should collaborate with groups such as Wait Time Alliance and Choosing Wisely Canada.**

These groups offer unique strategies to strengthen the public healthcare system by exploring alternatives that would alleviate wait times, prevent unnecessary procedures, and improve health outcomes for patients.

5. **Healthcare professionals should engage in discussions with government bodies and policy experts about ways in which we can improve the public system.**

Those at the front lines of patient care might best understand how to pursue practical solutions for challenges such as wait times and expansion of Medicare. Healthcare professionals should be consulted more heavily and included in conversations moving forward.

6. **The Association of the Faculties of Medicine of Canada and local undergraduate medical education faculty members should ensure medical students receive adequate exposure to health systems, policy, planning, and financing throughout their medical training.**

Current medical school curricula touch upon the history and realities of our current systems to various degrees at different schools, but students in all healthcare professions would benefit from more thorough education on the advantages and shortcomings of our current system. The next generation of health professionals must fully understand the intricacies of financing and delivering Medicare in order to preserve it, as well as to develop new and innovative solutions for future challenges.

7. **The Canadian government should carefully consider the implications of implementing private funding measures as an alternative option within healthcare.**

Privately financed and for-profit delivery systems have been touted as being a simple solution to save money and time for all involved. However, the introduction of such systems can have many unintended consequences ranging from increased costs and inequity, reduced quality, and minimal effects in improving patient outcomes. At present, we can only predict such outcomes based on international examples and small examples within a Canadian context; we cannot accurately assess the full range of outcomes, positive or negative. If such a drastic change is to be implemented, further research needs to be conducted to better our understanding of other such implications, and more detailed study should be pursued prior to committing to such a change in our healthcare system.

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