

## **Good or Bad? 10 Ideas for Fixing Medicare**

In the raging health care debate, one clear point of agreement among everyone is that Medicare could use some repairs. Some think it is just in need of a bit of tune up, while others want to overhaul the transmission.

And like any repair job, everyone thinks they are exactly the right mechanic for the job. It seems like everyone has an idea for fixing our health care system – from private clinics to new delivery models. How are we to make sense of it all? Which ideas could work, and which will only make matters worse for Canadians looking for reliable health care?

Let's take a look at some of the more common suggestions out there and try to figure out if they are a good idea for improving Medicare or just really bad.

### **Idea #1: Close rural hospitals and create specialist centres in urban areas**

In smaller towns, attracting health professionals, keeping them experienced and ensuring high quality care can be challenging. One solution being proposed by the Alberta government is to close many rural hospitals, and restrict the range of services provided in others.

*“Acute care facilities are not optimally distributed in the province currently, with some facilities providing services redundant with those of nearby facilities. Indeed, almost half of facilities with 20 or fewer beds are within 50 km of another acute care facility.” (McKinsey Report, p. 23)*

In the place of hospitals, small communities would get something called “ambulatory care centres”, increased ambulance service and enhanced telephone health networks. More complex procedures would be centralized in larger hospitals, usually in larger cities.

#### **VERDICT: BAD IDEA**

Because making Albertans travel 50 km or more to access urgent health care means less access to health care. Rural Albertans will get second-class treatment by having to drive, often in dangerous winter conditions, to get health care. While this may save money, it certainly won't make Medicare any stronger.

### **Idea #2: Invest in Community Health Centres and Community-Based Care**

Some people argue the focus on health care needs to be less on the buildings and equipment and more on ensuring there are professionals available to offer care. These advocates suggest moving toward community health centres and community-based care, where health services are offered in a coordinated fashion, with health professionals working as teams, and with access to the resources they need to offer a high level of care.

#### VERDICT: GOOD IDEA

Community-based care allows smaller towns to keep their hospitals by changing how care is delivered, rather than moving it to another location. It also helps by spreading the work around all health professionals, reducing the demand for doctors in small centres.

#### **Idea #3: Encourage the Proliferation of Boutique Medical Clinics**

Last fall, the doors opened on the Copeman Clinic in Calgary, Alberta's first high-end boutique medical clinic. At Copeman Clinic, for an initial fee of \$3,900 and annual payments of \$2,900, patients can get guaranteed quick access to a doctor and an array of diagnostic, assessment and diagnosis services from a team of health professionals. Physician caseloads at the Clinic are one-third to a quarter of standard doctor practices. The Clinic portrays itself as offering "preventative" health services for executives and the wealthy. Supporters say these types of clinics free up other health facilities by taking care of a subset of patients.

#### VERDICT: BAD IDEA

Boutique clinics cater to the wealthy, offering faster and more complete access to health services. A research study released in the fall of 2008 found that these clinics contribute significantly to physician shortages in the public system. They also play fast and loose with the Canada Health Act. "Many of the boutique physician clinics co-mingle medically-necessary with unnecessary services in an attempt to sidestep the Canada Health Act's prohibition on two-tiering." (Mehra, 2008; 47) More of these clinics will mean Cadillac health care for the rich, and broken Pinto health care for the rest of us.

#### **Idea #4: Utilize Nurse Practitioners and Other Health Professionals More Fully**

Many observers point out that doctors are, in many respects, the bottleneck in the health care system. There are too few of them, and their fee-for-service model is restrictive, creating long waits for many procedures and treatments. These observers point to the growing field of Nurse Practitioners – RNs with additional training to allow them to perform many physician functions – and to the emerging awareness that other professionals – social workers, physiotherapists, counselors, dieticians, technicians, speech therapists, etc. – have the capacity to play a greater role in patient care. Many argue care is most effective when these professionals work as a team, offering a coordinated compendium of services to patients. Consequently, their idea is to foster interdisciplinary teams to provide more thorough, more timely care.

#### VERDICT: GOOD IDEA

Patients are not just a collection of maladies. They are complex human beings with an array of issues. The health care they receive should match. While Boutique Clinics are organized in such a wholistic fashion, they cater only to the very rich. A public equivalent would be to adopt such a team approach in a public setting, thereby giving ALL Canadians access to quality care.

#### **Idea #5: Restrict Benefits and Limit Coverage**

We are often told that Medicare can't be everything to everyone. Some argue that we should focus Medicare to only "catastrophic" care, or implement some kind of income testing to target services. As an example, the Alberta government recently announced reforms to the prescription drug program for seniors. Universality has been eliminated, replaced by an income test. Most seniors will pay more for their prescriptions.

**VERDICT: BAD IDEA**

While on the surface it may seem like a good idea to focus benefits to those who most need it as a way to contain costs and maximize benefits, income testing actually serves to undermine a key principle of Medicare. Access to necessary health care regardless of ability to pay is a fundamental component of an efficient health care system. Introducing income tests increases administration costs, increases out-of-pocket costs for average citizens, and sets up a dangerous two-tier sentiment – the deserving and the undeserving.

**Idea #6: Expand Medicare to Include Pharmaceuticals, Homecare and Dental Care**

A longstanding call from some quarters has been to finish the job and extend Medicare coverage to include a Pharmacare and Dental Care plan, plus universalizing homecare. The argument is that offering a single payer for acute care has succeeded in both increasing access and decreasing costs. Adopting the same model for what are today very expensive parts of our health care system has the potential to achieve similar gains.

**VERDICT: GOOD IDEA**

Prescription drug purchase is the fastest growing cost in Canada's health care system. Tens of thousands of Albertans cannot afford to access proper dental care. Homecare is spotty and inconsistent from community to community. All three parts of our health care system are not working as they should. Including them in Medicare would lower costs, increase access and ensure equity. They would also increase opportunities for coordinating care to provide more effective delivery.

**Idea #7: Allow Private Clinics to Access Public Funds**

One solution proposed to the question of how to increase access is to allow for-profit, private clinics (that usually charge patients directly) to work within the public system, billing the government for services provided at their clinic. Proponents argue this saves money and reduces waiting times, as the government does not have to invest in costly infrastructure, and the private clinic is more likely to stay up-to-date with technology and techniques. A recent study found that there are 130 private clinics operating in Canada, and the vast majority take both public and private funds.

**VERDICT: BAD IDEA**

This proposal neglects the fact that there is a limited number of health professionals in Canada, and that the growth of private clinics only draws doctors, nurses and technicians from public facilities – which means waiting times are not shortened. More importantly when examining the costs of governments paying for-profit operators to deliver health care “researchers found health spending was higher and increased faster in communities served by for-profit hospitals compared to non-profit communities.” (CHSRF, 2004) Funneling money to private clinics serves only to pad the wallets of their owners – it doesn’t reduce waiting lists or use public money effectively.

### **Idea #8: Buy Back Private Clinics**

The Manitoba NDP government in the past few years has been slowly and quietly buying up private clinics and returning them to the public fold. Plus it has prohibited private clinics from both billing publicly and privately. In 2001, they bought the Pan-Am private clinic, which now operates as a public facility with no extra fees. The number of procedures out of this state-of-the-art clinic has more than doubled since it entered public hands.

Due to its policies, Manitoba has only 2 for-profit clinics (who have so far refused to sell to the government), compared to Alberta’s 31.

#### **VERDICT: GOOD IDEA**

Using tax dollars to ensure that health care is publicly delivered is not popular in these neo-conservative times, but the results speak for themselves. Studies have shown that following public purchase the quality of care goes up, costs go down, and more capacity is created in the system

### **Idea #9: Give Health Care Money to Individuals to Choose Their Health Care**

An idea that regularly re-surfaces is the concept of individual health accounts – sometimes called Medical Savings Accounts (MSAs). This is the model where instead of paying for health services directly, the government provides money to every person, who then can use that money as they see fit. Under this model the government would continue to pay for “catastrophic” care, but other services could be moved to an individual-pay account. MSAs could also be used to pay premiums for private health insurance. There are rumours the Alberta government intends on establishing a supplementary health fund Albertans can use to purchase insurance for non-insured services.

This model is seen as a way to increase individual choice and autonomy, while managing costs for the government. It also finds a way for Albertans to purchase health insurance independent of their workplace, as only a small percentage of workers have workplace insurance plans.

#### **VERDICT: BAD IDEA**

This concept essentially adopts the RRSP approach to pensions, which, as the recent downturn demonstrates, has serious flaws. By not guaranteeing an outcome but only an input, the plan

cannot assure people that health care will be there when they need it. You can save for years, only to find that when you need it – there still isn't enough in the account. Just as important is the MSA model inserts private insurance into our Medicare system, allowing a wedge for these companies to expand their business. It is only a small step to give them the job of managing the entire health care system – HMO-style.

### **Idea #10: Move to the Second Stage of Medicare**

Noted health care policy expert, Dr. Michael Rachlis, has recently suggested the time has come to implement the second stage of Medicare. As Dr. Rachlis explains it, the original vision held by Tommy Douglas was of a more comprehensive programme, both in what is covered and how it envisioned health and how it delivered health care. Political realities (the doctors' strike, opposition from other provinces) forced Douglas to put off the second stage.

Rachlis is arguing we need to re-structure health care delivery and our approach to illness and health. It, of course, means including dental and pharmaceutical care, but it means more than that. Some of the elements include moving away from fee-for-service and shifting toward coordinated, community-based care, more direct democratic control over health care and, most importantly a focus on keeping people well.

#### **VERDICT: GOOD IDEA**

Effective ways to keep people healthy are obviously worth considering, but shifting how we deliver health care will also address doubts about Medicare's sustainability. In Tommy Douglas' own words: "All these programs should be designed to keep people well – because in the long run it's cheaper to keep people well than to be patching them up after they are sick." (Douglas, 1984) In the end, Mr. Douglas's vision may be the best way to contain costs AND ensure good health care for Canadians.

Just like going to a mechanic, Canadians need to be wary of the promises made about fixing Medicare. We need to do our homework before choosing a policy path so that we choose the right mechanic with the right tools.