10 Measures to Court-Proof Medicare
by Steven Lewis

Like it or not, the Supreme Court has issued a stern rebuke and formidable challenge to those who fund, govern, and deliver care under Medicare. Citizens who feel abused by the system can claim a violation of their Charter rights and go to court to seek a remedy. This is a monumental shift in the dynamics of health care policy, financing, and organization. Up to now, the health care wars were political—if the system wasn't (allegedly) doing its job, fight it out democratically, on the hustings and in the media. Increasingly we may expect that they will be legal. This is particularly ominous because it gives the enemies of Medicare the chance at victories they could never achieve politically. The Supreme Court, narrowly, has decided that it will overrule long-standing public policy if it decides that in even one case, a patient has fallen in the cracks of an imperfect system. The strongly-worded dissenting judgment held that the courts are in no position to micro-manage health care, and have no warrant to second-guess public policy.

Governments, obviously, would agree with the 3 dissenting judges. Before governments assumed judicial restraint would prevail; now they will have to earn it. How can governments court-proof Medicare knowing that even the best system will occasionally fail?

Here are 10 actions governments should take to improve Medicare's performance:

1. Educate more health care workers than the system needs, not fewer. A modest over-supply creates a safety valve and a stable work force; a modest under-supply can be a catastrophe in a system that is not fast on its feet. Scarcity breeds growing wait times, tilts bargaining power heavily in favour of providers, leads to bidding wars among jurisdictions that drive up costs without adding service, and tempts Canada to raid personnel from developing nations. It is not terribly costly to educate most health care personnel. Physicians are expensive, but even if we trained 1000 more each year than we need, the price tag would be about a quarter of a billion dollars—adding a paltry .3% to public spending. European countries have for years produced a surplus, with an estimated 100,000 unemployed in 1995[1]. Recent unemployment rate estimates are 3-4% in Sweden, 7-8% in Greece, 5-10% in Spain, and as high as 20% in Italy[2]. No one wants involuntary unemployment, but it can create competition for quality, alleviate shortages in under-serviced areas, and impose some semblance of market discipline on wages and salaries. At the very least, governments should develop models to project the costs and consequences of switching from a "just enough" approach to HHR to a "just a little too much."
2. Clear away the barriers to all health care professionals fully using all of their knowledge and skills. Stultifying rules and turf protection stand in the way of both efficiency and job satisfaction. Doctors are doing what nurses can ably do[3]. Highly educated, high-priced surgeons are performing routine, high-volume procedures that technicians perform elsewhere—notably cataract surgery—while their advanced knowledge and cognitive skills are underused. Primary health care reform is by many accounts moving at a glacial pace[4], and even more discouragingly, ambitious, comprehensive models[5] have been diluted into physician-extender compromises. The result is a sub-optimal use of skills and often demoralized personnel.
3. Make it less attractive for scarce providers to abandon the public system. The firewall between the public and the private system should be thick. Follow the lead of those provinces, and countries like Sweden with policies that prohibit providers from practicing in both camps.
4. Guarantee that the needs of public system patients do not take a back seat to those with private insurance. If public hospitals are to be made available to privately insured patients, it should be on a discretionary basis, and only when there is unused capacity. The price should be high so that public patients benefit from the revenues generated. And all governments should be vigilant to ensure that private sector diagnosis does not lead to queue-jumping for public service—in short, ensuring that Alberta's legislation is observed in practice.
5. Create a strong financial incentive for health science students to commit to practicing in the public system. For those willing to commit to, say, ten years minimum in the public system, tuition fees should be low. For those who want the option to go private, tuition should reflect the actual cost of their education, as many schools now charge international students. For medical students this decision could be the difference between $10,000[6] annually and $50,000 a year[7]. Public policy should not exclude students who intend to practice in the private system, but nor should it subsidize them.

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6. Manage, monitor, and fix wait time issues, not just for hot button diagnostic and surgical procedures, but for the entire system. Access matters—polls suggest that it matters more than quality and cost. The system must be fair, and be seen to be fair; at present, for many, it is neither. Huge numbers of patients are served in a very timely fashion[8 9 10]. But the Canadian tradition of cottage-industry medicine has all-too-often extended to waiting lists and wait times. The result—too many patients waiting too long, and now, Chaoulli. Follow Saskatchewan's lead and create a province-wide wait list management system—no more uncoordinated lists kept in individual physicians' offices and untransparent prioritization processes. Sooner than later there will have to be agreed-upon indicators of need and reasonable thresholds for intervention[11] to ensure that reduced wait times do not lead to unwarranted increases in utilization.
7. Take a long, hard look at all of the financial incentives in the system—they are at the root of much inefficiency and are impediments to change. Tie funding to both organizational innovation and performance standards. Create real incentives to speed up the adoption of comprehensive primary health care, with appropriate roles for nurse practitioners, therapists, pharmacists, and others. Make it financially less rewarding for doctors to practice isolated, volume-oriented medicine. For organizations, some policies should be mandatory elements of performance agreements and contracts—for example, the implementation of comprehensive wait time management systems and strategies for quality improvement.
8. Refine the art and science of value-for-money auditing and reporting in health care. It is important to inform the public of when diminishing returns have set in, and where the system is comparatively efficient or not. It is sobering to learn that internationally, there is no correlation between per capita health spending and life expectancy beyond about $600 to $800 US a year, while Canada spends about $3300[12]. Canadians may make a democratic choice to increase health care spending, but they at least should know what the return on investment is likely to be.
9. Expand high-quality community services such as home care. If Canada is to avoid huge expenditures on long term residential care, a growing elderly population—and younger disabled people—must have access to an excellent home care system that is as integral to medicare as hospitals. Private home care—often delivered by for-profit companies to those able and willing to pay—cannot do the job adequately. Home care budgets have risen in the past decade, but they are not commensurate with community needs. A strong home care system that serves all on the basis of need will make Medicare more sustainable, and just.
10. Get serious about prevention and health promotion. The creation of the Canadian Public Health Agency is encouraging but not nearly enough. Canada needs a truly integrated health policy that increases investments in the social determinants of health. Many chronic diseases (which are expensive to treat) are preventable. We have yet to fully maximize the impact of home care. The best health care in the world is a far less effective and efficient approach to good health than good housing, good nutrition, exercise, a decent income, and meaningful work. Investments in these areas are especially vital to improved aboriginal health.

The federal government has a strong role to play in financing the system, coordinating efforts to measure and report on performance, enhancing public health and health promotion, supporting research and evaluation, and seeding innovation. It should also respond vigorously to Auditor General Sheila Fraser's observation that enforcement of the Canada Health Act has been too lax.

Governments can improve the fairness and efficiency of Medicare without breaking the bank. There is no shortage of money for health care, and there is a good deal of avoidable error and waste. Now is the time to speed up the pace of vital reforms so that neither citizens nor the courts have reason to seek alternatives to the public system. The best defence is a good offence: great performance is a far stronger bulwark against privatization than legal argument or even favourable high court decisions. Canada has dragged its feet on real change for decades. We can get far better access and quality if we do the right thing. Now is the time.