Dr. Jeffrey Brock, MDCM and Evan Savelson

Medicare -The Vital Issues

Dr. Jeffrey Brock and Evan Savelson are the principals of MedExtra, a Canadian company, playing a central role in facilitating healthcare and providing healthcare information for the public. MedExtra facilitates access to services, ranging from diagnostic testing and everyday needs to the management of life threatening and critical illnesses.

Chaoulli or not the reality in Medicare is that waiting times will continue to increase and resources, both technological and human, will continue to be scarce. As baby boomers age, the deterioration of Canadian healthcare will accelerate and the gap between Canada and other G8 countries will widen.

The continued deterioration of the Canadian healthcare system has obvious implications on every individual Canadian rich or poor. And one of the most serious effects is on the corporate sector.

In addition to the direct costs of illness to operations, employers are subject to the often hidden indirect costs of medical problems as well. An absent employee costs more than simply their replacements' salary. Each individual within a corporation creates unique, often irreplaceable value that goes straight to the bottom line.

A sustainable healthcare system is imperative to the Canadian national identity we espouse.

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The shortage of physicians and nurses is one of the more visible problems in our healthcare system. Artificially low compensation resulting from ceilings on annual earnings, and inadequate resources have served to drive medical professionals to other more welcoming jurisdictions.

These professionals are mobile and in demand throughout the G8 countries and have been leaving Canada for years. It is estimated that there are now more than 8,000 Canadian physicians (total practicing physicians ~50,000[1]) practicing in the US[2] with physician emigration having increased 68% in 2001 according to one study[3]. Other studies have conclusively shown that we experience a recurring annual net loss of physicians[4]. Currently Canada has about 210 physicians per 100,000 population (average for OECD[5] members is 289/100,000 population) this ranks 25th out of the 30 member states of the OECD[6] . It is estimated that 2500 medical graduates a year are required to maintain current levels of care . Our medical schools are only producing 2200[7].

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[1] PTM 2004
[2] Exodus! Movement of the Doctors - Dr. Sydney Smith - Tech Central Station
[3] Ibid
[4] ISUMA Volume 1 N° 2 o Autumn 2000 o ISSN 1492-0611 - Morris L. Barer and William A. Webber
[5] The Organization for Economic Co-operation and Development (OECD) is an international organization of those developed countries that accept the principles of representative democracy and a free market economy.
[6] OECD Report 2003

The most obvious effect of this imbalance is that over 3.6 million Canadians or 15% of the population have no access to a family doctor.

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Why care? There are many reasons to disregard these issues - you may be healthy, you may be wealthy, you may have the deluxe executive physical package with access to the best specialists, you may have US healthcare insurance, your brother in law may be a physician, maybe you donate thousands of dollars to hospitals.

Why care? It is simple - Canada's success as a prosperous country depends on a cost effective efficient healthcare system.

The solutions demand provincial and national leadership, vision and foresight.
Physicians, nurses and other healthcare provider must be retained by increasing compensation, improving available technology and working conditions. The loss of healthcare professionals from poorer provinces to Ontario, Alberta and British Columbia must be prevented. Provincial medical licensing bodies, physician unions and provincial governments must work together to develop a pan-Canadian model for physician and nurse reimbursement. These same bodies must develop a streamlined, yet diligent plan for rapid integration of foreign medical graduates and practitioners into active medical practice.

Integrating Nurse Practitioners, Physician Assistants and Technologists into the practice of medicine will free up valuable physician time to provide more complex patient care.

Currently there are more than 60,000 physician assistants in the United States[8] working in all specialties. Over 20% work in rural or underserved areas[9]. PA's are qualified and licensed to carry out some 80 percent of the duties usually performed by primary care physicians[10].

In 2003, approximately 192 million patient visits were made to PA's with approximately 236 million medications prescribed or recommended[11] . The numbers are growing in the UK, Western Europe, India and China[12] as well.

Augmenting the number of physicians and reducing the more delegable demands on their time will increase access to and quality of care.

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As an added economic bonus, more, specially trained medical professionals would be employed to work at a lower cost base. For example, a technician taking a blood pressure instead of a nurse or physician costs less and is an added taxpayer.

Increased case volume hones the expertise of the practitioners while lowering costs by improving efficiency and generating economies of scale. Quebec has successfully reduced waiting times for cataract surgery by designating and funding high volume cataract centres. This model should be applied across specialties throughout Canada.

Thousands of physician entrepreneurs have invested in clinic space, equipment, technology and human resources to provide efficient, cost effective healthcare to millions of Canadians while being reimbursed entirely by provincial healthcare plans. These privately owned clinics, providing the majority of primary care to Canadians, represent a lower cost alternative to overburdened Emergency Rooms for all basic care.

Ontario and Quebec have recognized this and are leading the way in the establishment and funding of extended hours family care clinics.

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[7] The Canadian Medical Association
[8] University of the Sciences in Philadelphia
[9] The American Academy Of Physician Assistants - Submission to The Department Of Health And Human Services Task Force On Drug Importation May 2004
[10] Physician assistant / clinical coordinator: 'One life at a time' - Mike Moore
[11] Ibid
[12] Physician Assistants in the United States - DE Mittman, James F Cawley, William H Fenn

The five criteria of the Canada Health Act are:

1) Public administration: the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;

2) Comprehensiveness: all medically necessary services provided by hospitals and doctors must be insured;

3) Universality: all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;

4) Portability: coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and

5) Accessibility: reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

Commonly misperceived, a government monopoly on the provision of healthcare is not a part of Canadian Medicare. Why is it that the list of medical services permitted outside public institutions is limited in large part to primary care, specialty consults and basic diagnostic imaging? Does it really make sense that the majority of ambulatory diagnostic testing and day surgery is within the confines of hospitals?

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Clearly more complex procedures belong in the hospital. Moving non-complex procedures outside of the tertiary care hospital centers can alleviate a substantial burden on resources. This will permit these hospitals to increase procedures and reduce waiting times.

Public-private partnerships either in existing hospitals or free standing diagnostics centers would enable greater access to non-complex procedures with reduced capital investment by governments. The physician/entrepreneur could provide all diagnostic imaging and many day surgeries in private clinics with reimbursement entirely by provincial healthcare plans. This would greatly increase hospital-based resources available for the more serious cases requiring complex treatment, while maintaining a single payer, one tier health care system.

Provincial licensing bodies would continue to control standards of care, and the quality of care would improve as physicians have increased, specialized caseloads.

Clearly, spending on new technology is part of the solution.

Transferring costly capital investments to private entrepreneurs will enable increased spending where it is sorely needed: Increase funding directly to care. Increase care availability. Reduce waiting lists.

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Provincial treasuries unencumbered by massive capital equipment expenditures could invest instead in support staff, technicians and hospital infrastructure to augment accessibility to hospital services for more complex cases.

We remain at a critical juncture. With an aging population, waiting lists continue to increase despite billions of dollars of new investment. New and more expensive pharmaceuticals and technology are introduced each year.

We need to see beyond the rhetoric of the prevailing discussions on healthcare. If we circumvent the galvanizing and divisive debate we can focus on core problems. The real issues for discussion are: How can we improve access to healthcare? How we can make more care available to more people?

As a nation we could learn a lot from the example of the US enterprise, Kinko's, which grew to its formidable size by cultivating best practices from each outlet and applying them enterprise wide. We have before us the opportunity to examine the best healthcare management practices from coast to coast and revitalize Medicare for future generations thus restoring our position as a role model to other nations. ■