CAN the Queue be Tamed? Medicare meets Dr. Chaouli

A Canadian Tale*

With help from Michael Rachlis, Colleen Flood and others

Fundamentals

- Provinces have jurisdiction over health care in Canada
- The Canada Health Act, federal legislation, governs transfer of payment, or penalty, in return for five principles: universality, accessibility, portability, public administration and medical necessity
- There is **NOT** one Canadian health care system: there are 14 insurance plans (public payment, private non-profit delivery)

"Removing the financial barriers between the provider of health care and the recipient is a minor matter, a matter of law, a matter of taxation. The real problem is how do we reorganize the health delivery system. We have a health delivery system that is lamentably out of date."

Tommy Douglas

"Only through the practice of preventive medicine will we keep the costs from becoming so excessive that the public will decide that Medicare is not in the best interests of the people of the country."

Tommy Douglas

There are three main views of Medicare but none are satisfying to Canadians.

Medicare View #1: Globe and Mail

- We established Medicare when we were young, healthy, and altruistic. The economy was growing fast. It worked pretty well then.
- Now we are old, sick, and the economy is stagnant. Medicare doesn't work very well. Health care costs are going through the roof. The public sector is too inefficient to make it work.
- We now have to ‘be cruel to be kind’. We should allow some privatization of finance and profitization of delivery to ‘save’ Medicare.

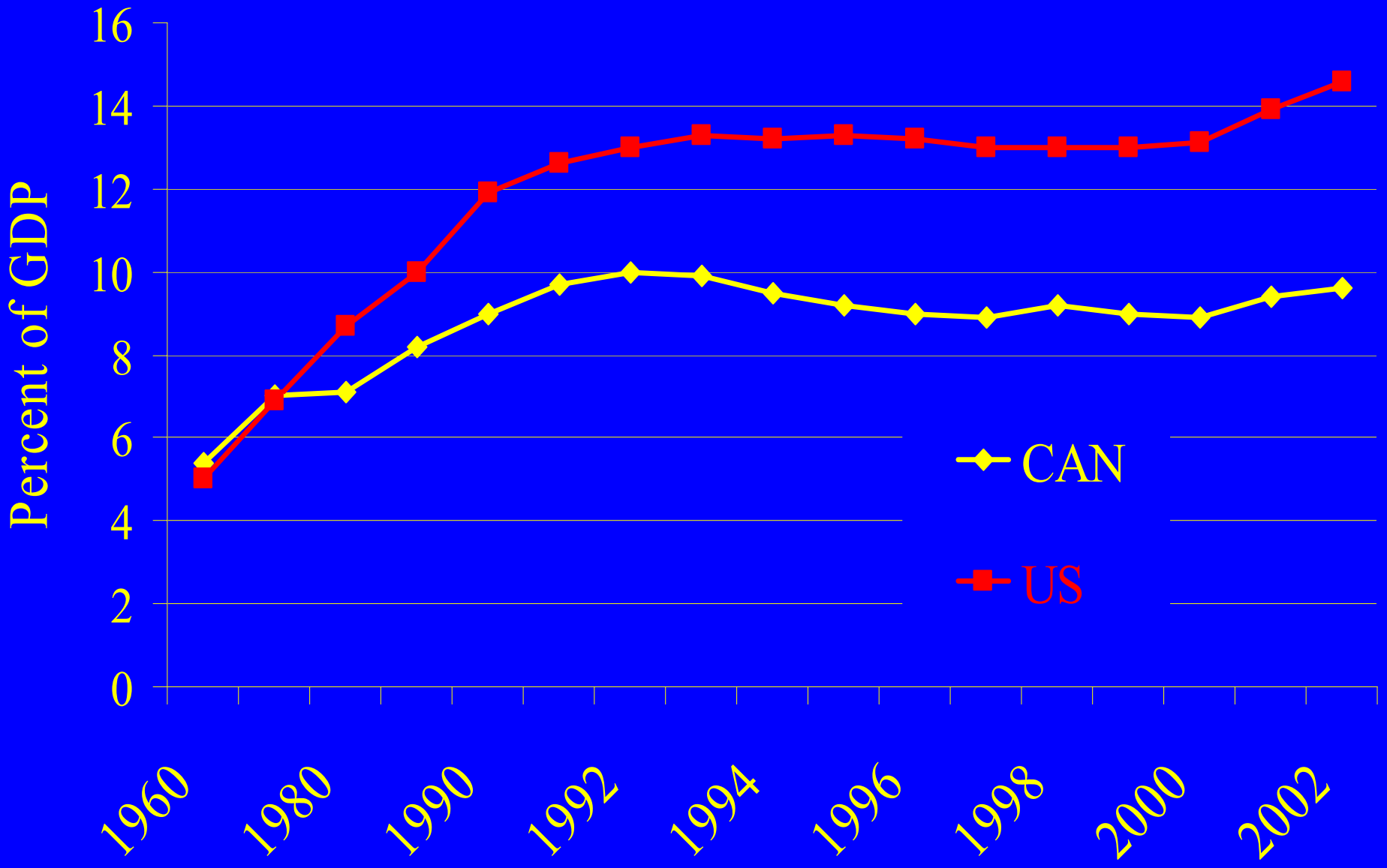
Medicare View #2: Toronto Star

- At the beginning, the federal government paid half the bills and everything worked pretty well.
- The federal government gave up 50-50 cost sharing in 1977, and then hacked funding until 1997. Medicare was starved. This led to service erosion, privatization of finance, and increased use of for-profit delivery.
- Now we need much more federal and provincial money and more federal enforcement of the Canada Health Act to save Medicare.

Medicare View #3: National Post

- Medicare was always a bad idea.
- Health care costs are out of control. But a government run health system is like the Beverly Hillbillies trying to run IBM. Despite the huge costs, services are terrible.
- It's not too late to do the right thing. Let's privatize and profitize as fast as possible. Maybe a dumb, rich American will buy it.

US and Canada HC $ as % of GDP



Relative Healthcare Expenditures in Canada

In 2002, total health care costs =

$112 billion

Total Public Health costs =

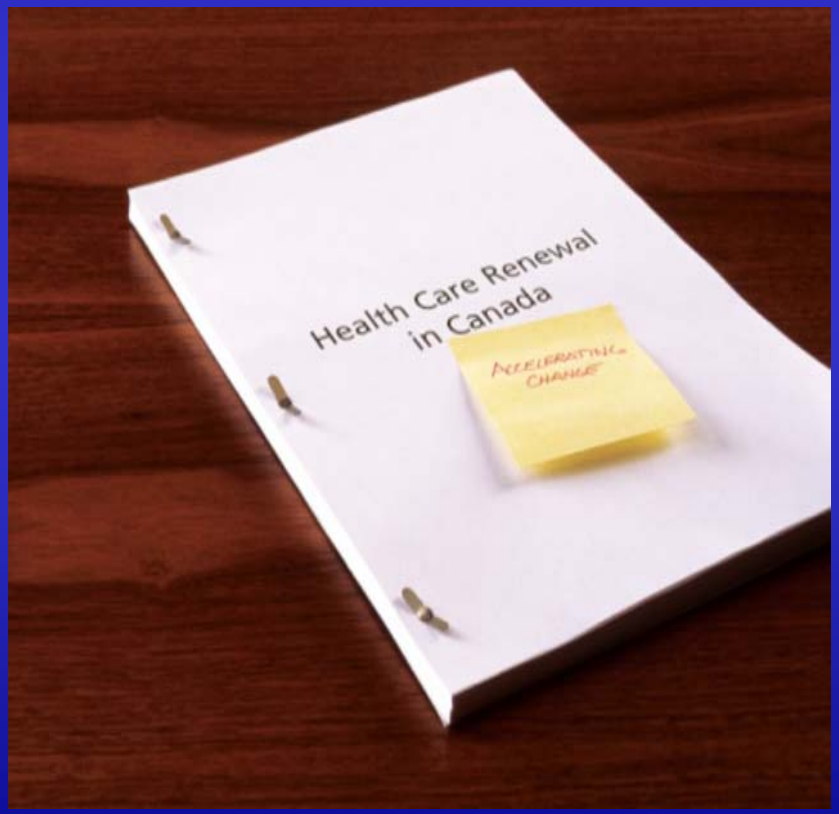
$2 – 2.8 billion

September 2004 FMM Accord: 10 Year Plan to Strengthen Health Care

- First Ministers committed to:
  - achieve meaningful reductions in wait times beginning with priority areas such as cancer, heart, diagnostic imaging, joint replacement and sight restoration by March 31, 2007
  - establish multi-year targets by December 31, 2007
  - establish comparable indicators of access to services by December 31, 2005
  - establish evidence based benchmarks for medically acceptable wait times in 5 areas by December 31, 2005
- Wait Time Reduction Fund established - $5.5 Billion (of the $41 Billion) over 10 years to achieve wait time reductions and augment provincial and territorial initiatives

First Report to Canadians

January 2005



Major Themes:

- Report from Each WG

Also:

- Accelerate the Changes
- Electronic Health Record
- Human Resources
- Primary Care
- Aboriginal & First Nations

The Chaoulli Decision

- Mr. Zeliotis c/o suffering pain and discomfort during the year he waited for a hip replacement
- Dr. Chaoulli wanted to establish a private hospital
- Challenged Quebec's Health Insurance and Hospital Insurance Acts which prohibit private insurance or payment

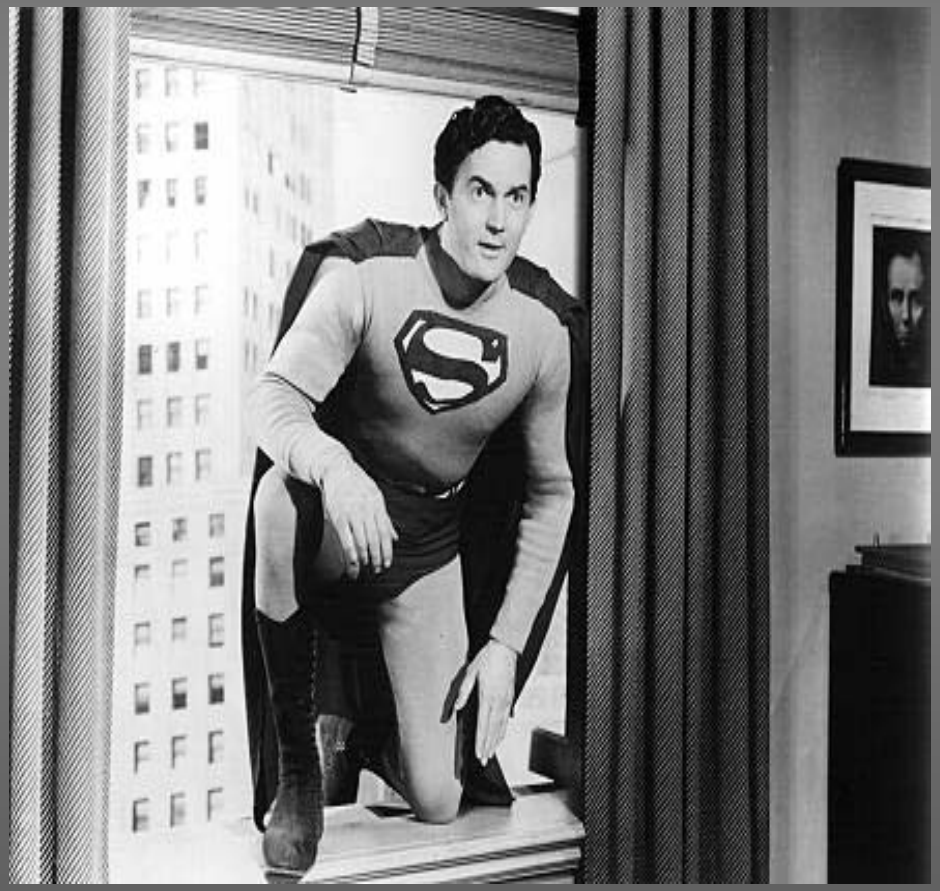
June 9, 2005

- Supreme Court of Canada renders decision on Chaoulli vs Quebec
- 4/3 decision that Quebec Charter of human rights and freedoms violated
- 3/3 = no decision on whether Canadian Charter of Rights and Freedoms violated
- August 4/05 Supreme Court granted partial rehearing and stay (June 2006)

Quebec has three options:

- Improve the management of waiting lists
- Abandon prohibition of private insurance
- Keep prohibition of private insurance by using the notwithstanding device

Diagnosis of a Supreme Court Decision



The Supreme Court decision "has forever changed our health-care landscape". (Ralph Klein, Alberta Premier)

The Supreme Court decision is not an end to Medicare but "an alarm bell" concerning the importance of reducing waiting lists. (Manitoba Premier Gary Doer)

Saskatchewan Premier Lorne Calvert was "disturbed" about the possibility of the Chaoulli decision "opening the door to an Americanized health-care system in Canada".

BC Premier Gordon Campbell suggested that the Supreme Court decision posed an immediate challenge to the federal government and to the Canada Health Act.

Legal versus Political Implications of Chaoulli:

- Take a Valium?
- Quebec now has the same regulatory environment as NB, NL, & SK
  - virtually no for-profit care in these provinces
- There will be little impact in some other provinces
  - limits of private insurance
  - restrictions on extra billing

Colleen Flood's Four False Conclusions

- The public sector "monopoly" in Canada causes waiting lists;
- Freedom to purchase private insurance will reduce the burden on the public system;
- Freedom to purchase private insurance will allow many "ordinary" Quebeckers access to timely treatment; and
- According to international experience, allowing a private insurance regime will have no detrimental effect on the public system.

False Conclusion 4: International Experience Shows that Allowing Two-tier Will Have No Detrimental Effect On The Public System

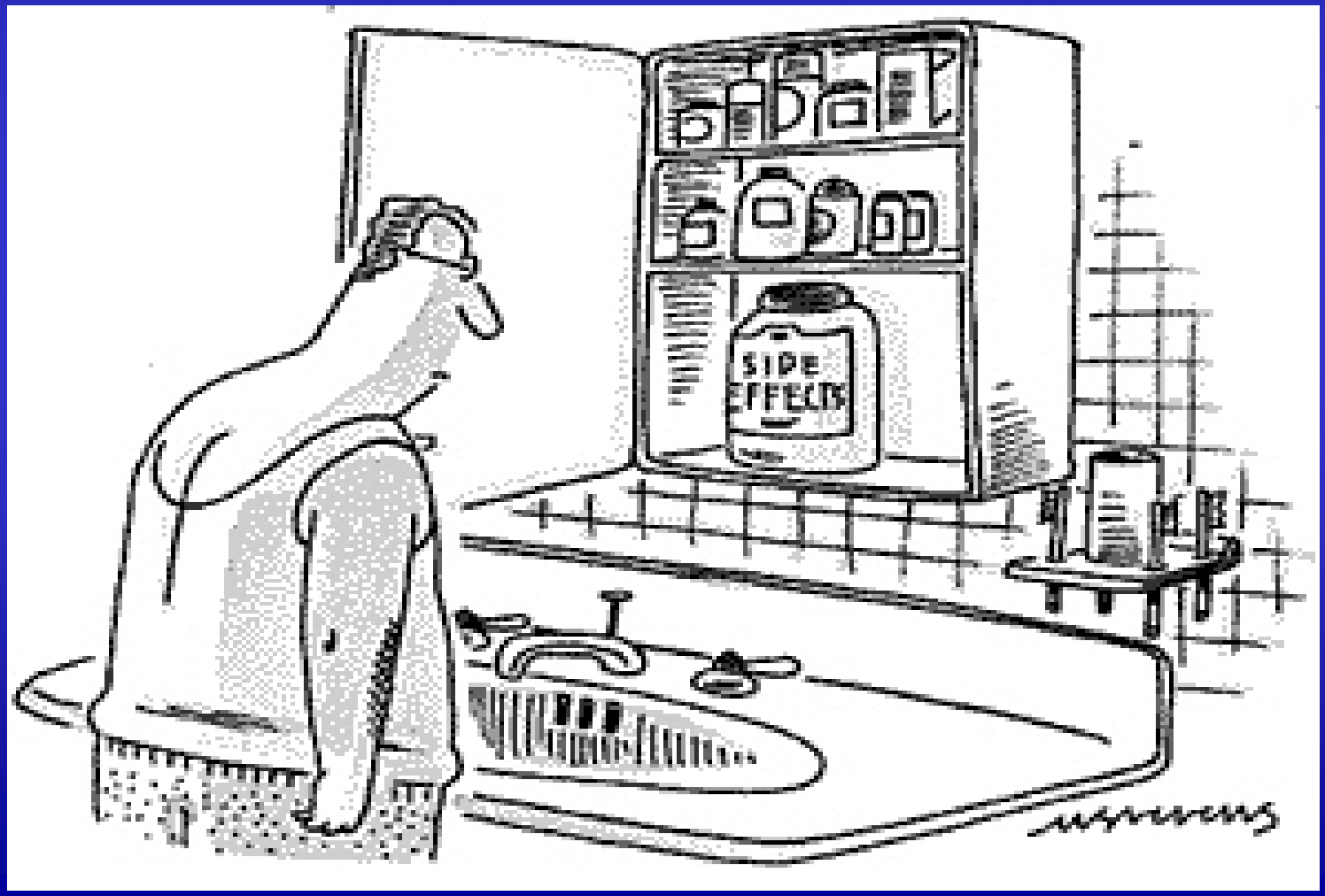
- It is a fundamental error to classify all health care systems with a private sector as two-tier as would be allowed post *Chaoulli*.
- European systems not two-tier but group-based
  - The Netherlands
  - Germany
- There is little or no role for duplicate insurance, ie a two-tier *Chaoulli* system in European countries (with the notable exception of the UK)
- To achieve the "superior" European model, social insurance premiums would have to replace taxes as the source of Medicare funding.

Two-Tier Systems similar to that mandated by Chaoulli – New Zealand and UK Models

- Private insurance **duplicates** coverage of certain publicly provided services;
- Physicians work in both the public and private sectors; and
- Waiting lists in both countries are much longer than those within Canada (although recently waiting times have improved in the UK).

This strongly refutes the linkage made by the majority between long waiting lists and Canada's public monopoly on insurance.

The Court Ignores the Side-Effects of Systems with More Private Financing and Less Waiting



Two Possible Conclusions

- The majority was not aware of the (magnitude of) income-disparities associated with private insurance; or

- The majority determined that although only wealthy Canadians will benefit from private insurance, poorer Canadians will not suffer more than they do at present OR, at least, there is no conclusive evidence that they will suffer more.

Calculations

- If 10% of specialist capacity is diverted from the public to the private sector, we estimate that median wait times in the public sector would increase as follows:
  - hip replacements would increase from 126 days to 146 days;
  - knee replacements would increase from 177 days to 205 days;
  - cataract surgery would increase from 80 days to 93 days; and
  - CABG would increase from 17 days to 20 days

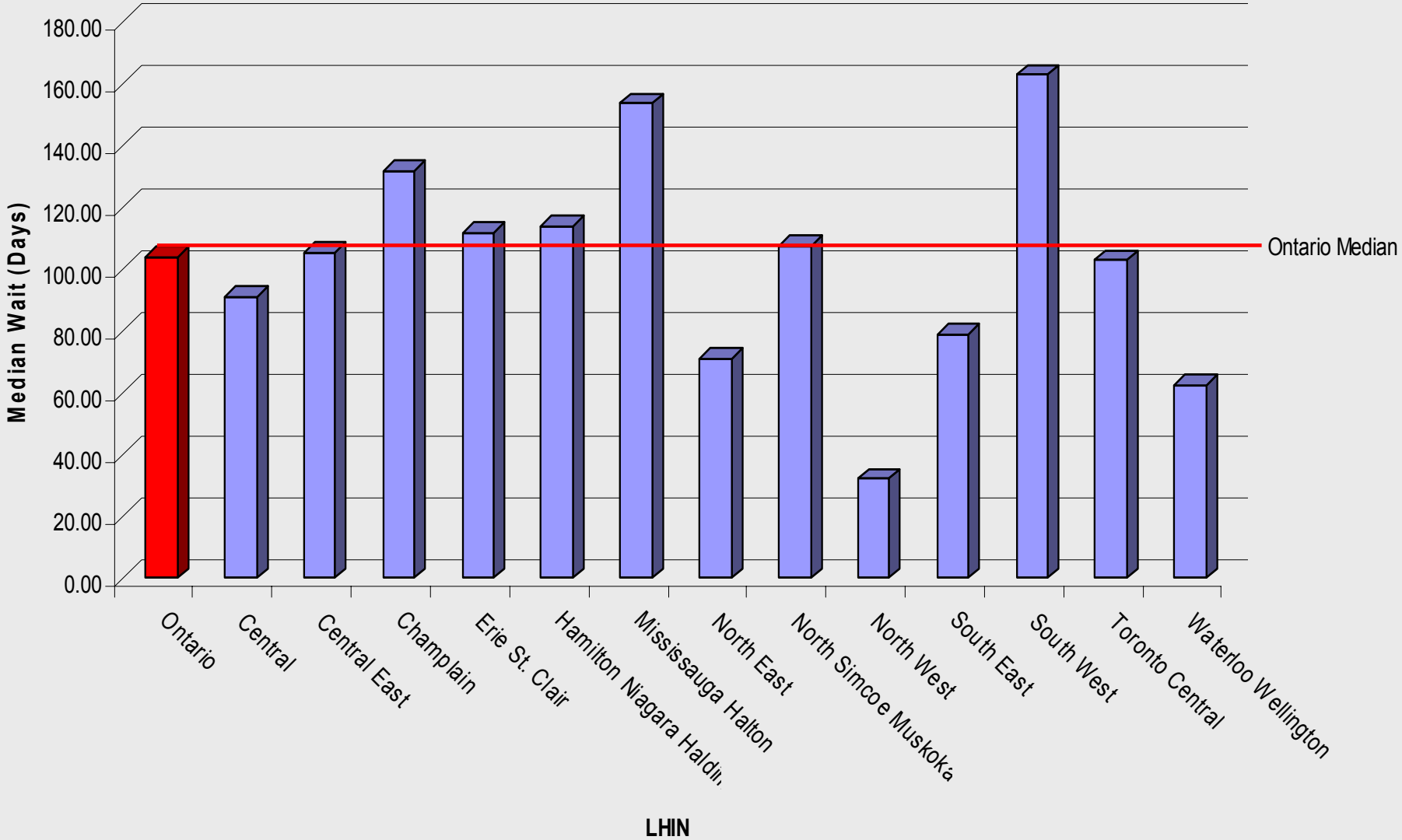
Michael Rachlis's Fourth Way: Two Big Quality Problems

- Queueing
- Primary health care reform

“I have a good doctor and we’re good friends. And we both laugh when we look at the system. He sends me off to see somebody to get some tests at the other end of town. I go over there and then come back, and they send the reports to him and he looks at them and sends me off some place else for some tests and they come back. Then he says that I had better see a specialist. And before I’m finished I’ve spent within a month, six days going to six different people and another six days going to have six different kinds of tests, all of which I could have had in a single clinic.”

Tommy Douglas

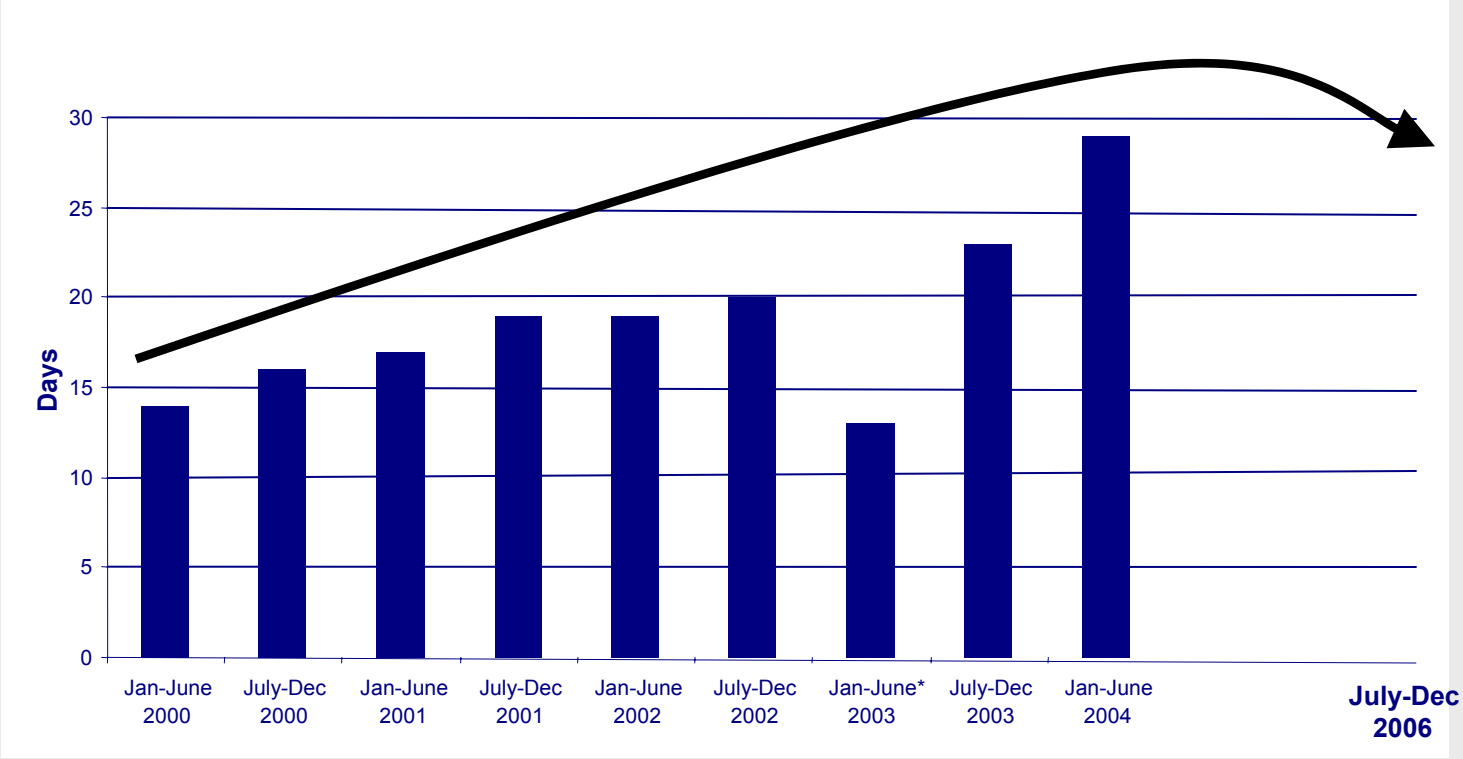
Hip Replacement Surgery Wait Time by LHIN (July 2005)



Trend of Wait Times

A Case Study of cancer surgery access for colorectal cancer in Ontario

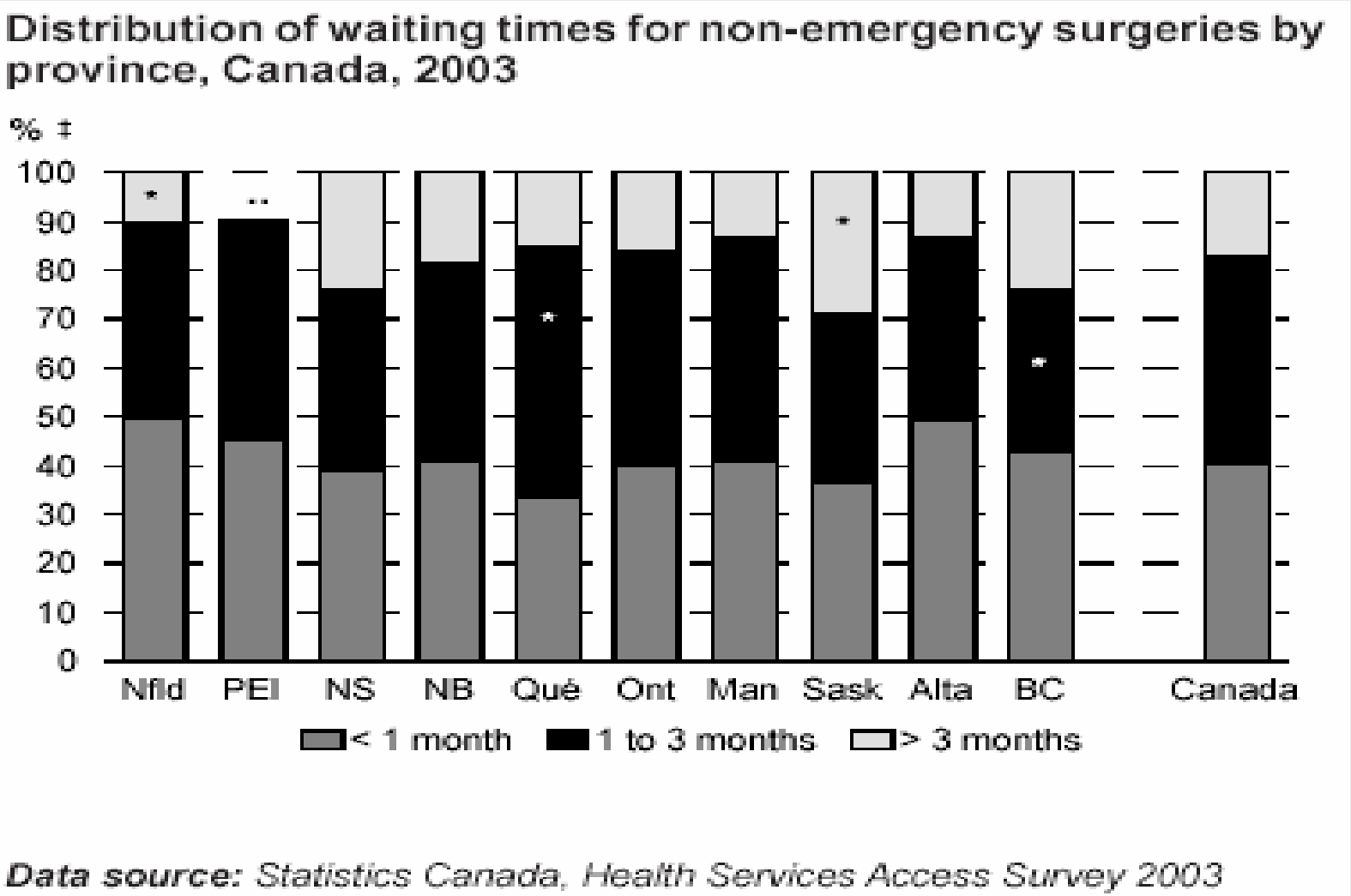
*(*Measuring days from patient's consult with specialist until actual surgery)



Median interval in days using OHIP data

(*note Jan-June 2003 drop due to SARS restrictions on ORs)

Between 10% (NFLD) and 29% (SK) of those who waited for non-emergency surgery reported waits longer than 3 months



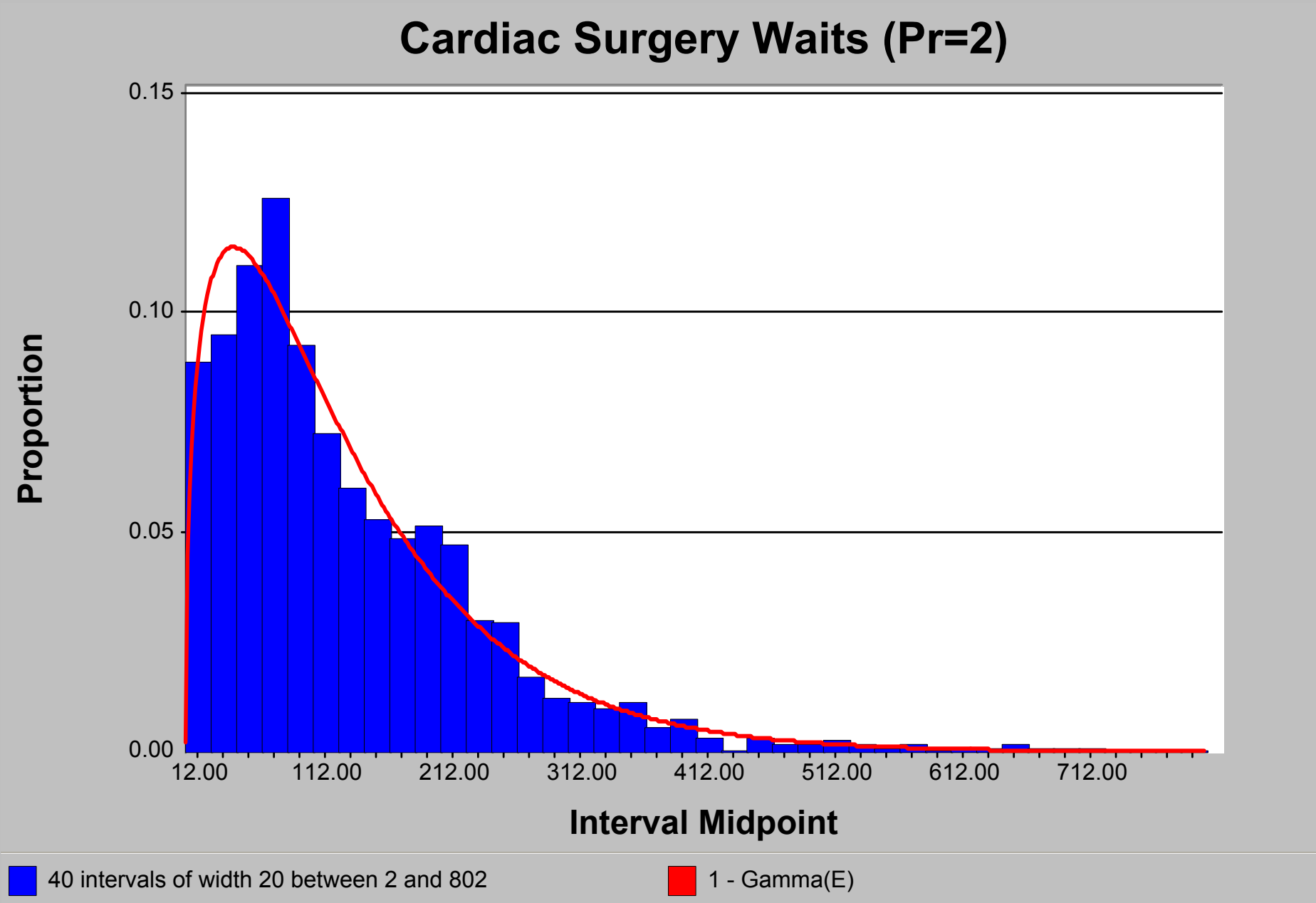
Working Group on Wait Times & Access

The First Report

1. Waiting can harm people
2. Simplify the steps in what is a complex journey
3. Comprehensiveness … target first if you must, but then …
4. Make information freely available to patients & managers
5. Evaluate outcomes
6. Align the financial (and other) incentives to keeping productivity high and waits short
7. Get serious about capacity

Another Year of Waiting for Wait Times

- More players working on wait lists:
  - Wait Times Alliance
  - 2nd Taming of the Queue conference
  - Individual provincial governments
  - CIHI conference
  - Federal government appointee
  - In the meantime, have waits improved ?


Cardiac Surgery Waits (Pr=2)
0.15
0.10
0.05
0.00
Proportion
12.00
112.00
212.00
312.00
412.00
512.00
612.00
712.00
Interval Midpoint
40 intervals of width 20 between 2 and 802
1 - Gamma(E)

How the Numbers Work

- Median Waits are always shorter than the Average.
- Average Waits are always shorter than the 90th Percentile.
- Percentile Times tell us a lot about the tail.
- The Average tells us only a little about the tail.
- The Median is the worst because it tells us *nothing at all* about the tail.
- There is **ALWAYS** a tail.

Two Great Ways to Make Waiting Times Look Good

1. Quote waiting times for ALL cases (emergency and booked categories together)

2. Always quote *median* waiting times

HCC: Ten Steps to a Common Framework for Reporting on Wait Times

- Let's agree on definitions (when waiting starts, and what's in, what's out)
- Let's define a common waiting dataset
- Let's agree to report on the *tail* of the wait time distribution. That means percentiles instead of median times
- Let's agree not to mix different priority levels

Why Primary Health Care Reform?

Primary Health Care is the Key to Better System Management

- Key factor for access
- Key factor for secondary prevention –
  ie enhancing the health of those with chronic disease
- Key part of the health system which deals with primary prevention –
  ie the prevention of the occurrence of disease

Examples*

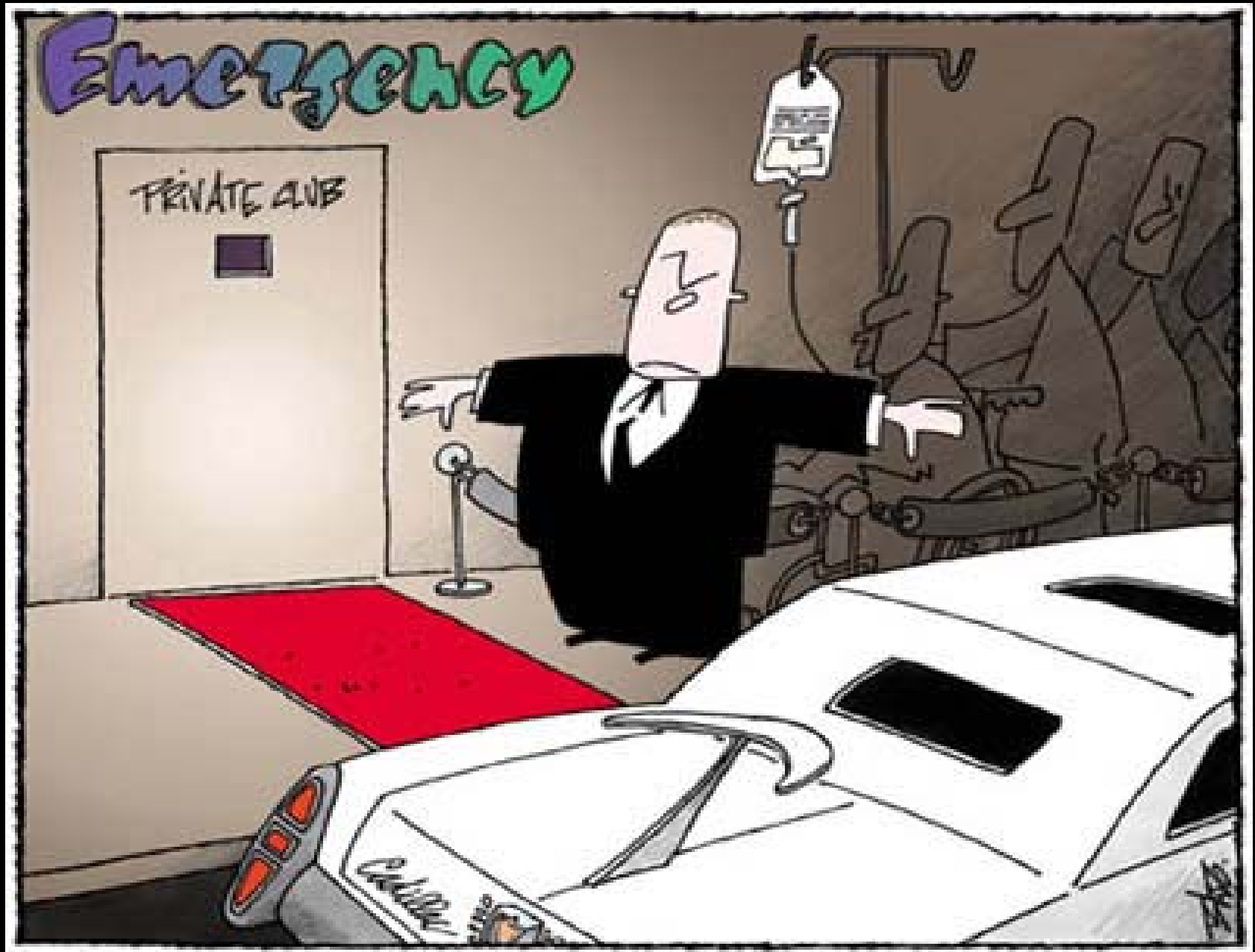
- The Hamilton HSO Mental Health Program increased access for mental health patients by 900% while *decreasing* referrals to the psychiatry outpatients' clinic by *70%.*

- Sault Ste Marie decreased hospital re-admissions from heart failure by 65% with better home care

* Rachlis, M Prescription for Excellence at www.michaelrachlis.com

Barriers to PHC Reform

- Canadian primary medical care is primitive.
- Poor links with regional health authorities, secondary and tertiary care, and community health and social services.
- Reforms tend to focus on family doctors vs interdisciplinary care.
- The provinces are “co-managing” the system with provincial medical associations.



TWO-TIER HEALTH CARE

Canadian Medical Association Responds

- August 17, 2005 CMA rejects a motion endorsing single tier health care.
- August 18, 2005 64% of delegates endorsed a motion calling for the introduction of private health insurance to pay for services when "timely access to care cannot be provided in the public health care system".
- Delegates endorsed motion that health care should be provided on the basis of need, not the ability to pay.

Motions not historic, but **consistent**!

STUDENT MEDICAL REFORM GROUP PETITION Campaign

Download petition > .pdf file

Medical Reform Group

On-line petition is now available! Click here

Canadian medical students: Supporting publicly funded & accessible medicine

"We, the undersigned Canadian medical students, recognizing our future role as physicians and our duty to be advocates for our patients, urge the Canadian Medical Association (CMA) to support publicly funded and accessible medicine. We were disappointed to see CMA delegates vote on August 17, 2005 in support of allowing private health insurance and private-sector health services."

CMA Petition: click here to continue [English].

AMC Pétition: ici pour des détails [Français]..

MRG RELATED NEWS

April 2004 - The solution to our health-care funding problem is innovation, and it's already working brilliantly in some parts of Canada
by Michael Rachlis
> Read Globe&Mail Article

March 2004 - Private Payment: The Zombie of Health Care
by: Gordon Guyatt
> Read Globe&Mail Article

May 6, 2004 - Don't confuse private delivery with private funding
by: Andre Picard
> read Globe and Mail Article

MRG WATCH

- For-Profit Delivery Watch
- Pharma Watch
- Ontario - Private MRI Watch

MRG NEWS

- Hospital Cost Comparison
- Administrative Costs: U.S. vs Canada [NEJM 2003]
- Effect of Socioeconomic Status or Perceptions of 1st & 2nd Year Me Students
- Drug Regulation in Canada: Miraç or Oasis?
- Winter 2005 MRG Newsletter is Out!

MRG LINKS

- MRG Professional Group
- Canadian Health Coalition
- Ontario Health Coalition
- P3 Watch
- Physicians for Global Survival
- Canadian Federation of Medical Students
- World Health Organization
- Sunsih

Fix

Medicare

Don't Privatize it !

Medicare need not greed

www.medicare.ca

Crowder Challenges Dosanjh To Visit For-Profit Clinic 10-Minute Drive From Office

Mon 28 Nov 2005

OTTAWA – NDP Health Critic Jean Crowder (Nanaimo-Cowichan) volleyed back at Ujjal Dosanjh today – inviting him to go tour an example of health privatization right under his nose.

"Last week, and this is just one example of what's happening under the Liberal's watch, the Copeman Clinic opened in Vancouver, a 'members-only' for-profit clinic for people able to pay a $1,200 initiation fee plus $2,300 a year for no-waiting access to doctors," said Crowder.

"Copeman has said he's planning to roll out 37 clinics across the country over the next year. The Vancouver clinic is only a 10-minute drive from Mr. Dosanjh's office in Vancouver, so if the Health Minister refuses to admit the growth of for-profit health care taking place under his government's watch, maybe he should take a drive over and see for himself."

This fall, the NDP put forward proposals to end the growth of for-profit medicine across the country. But the Health Minister refused to acknowledge that there was even a problem.

In a speech in Vancouver this weekend, and in a letter on his ministerial letterhead posted recently on the Liberal election website, Dosanjh denied Canada faces a health privatization issue.

Harper Pledges Patient Wait Times Guarantee

02 December 2005

Plan Upholds Principles of Canada Health Act; Rejects Private Parallel System

This morning in Winnipeg, Stephen Harper and health critic Steven Fletcher announced that a Conservative government will work with provinces to develop a Health Care Guarantee that ensures patients receive essential medical treatment within clinically acceptable waiting times.

"There will be no private, parallel system," Mr. Harper said. "We can, and will, achieve better results for patients and maintain the essentials of our system of public health insurance while maintaining our universal public health care system."

From: Canadian Independent Medical Clinics Association (CIMCA) [mailto:zoltan@cimca.ca]
Sent: Thursday, December 08, 2005 12:01 PM
To: Rosana Pellizzari
Subject: Documentary on Canadian Healthcare Tonight at 9:00 on CBC

Dear Dr. Rosana Pellizzari:

I thought you would be interested to learn about this documentary on the current state of Canadian health care televised tonight at 9:00 pm on CBC.

MEDICARE SCHMEDICARE
Thursday, December 8, at 9pm on CBC-TV's "Passionate Eye"
(Repeating Monday, December 12, at 10pm ET/PT on CBC Newsworld)

"Is one tier Medicare a myth? Have we been saluting its founder, the 'Greatest Canadian' Tommy Douglas as an emperor who really has no clothes?

As the country heads toward an election in which our health care system promises to be an emotional issue, Medicare Schmedicare takes the highly unorthodox stance that two tier health care is already here and thriving. Medicare Schmedicare offers viewers an inside look at private health care clinics across Canada - where $1,250 can get you immediate access to a doctor.

Filmed in private clinics in Montreal, Vancouver, and Toronto Medicare Schmedicare jumps into the Medicare debate-outlining the various health services that have become privatized in Canada. It compares the waiting times for patients who opt for private services versus those who anxiously line up with their health cards.

Medicare Schmedicare was written and directed by Gemini award-winning filmmaker Robert Duncan and produced by Carolyn Schmidt for International Documentary Television in association with the CBC."

Warm regards,

Zoltan Nagy
Executive Vice-President
Canadian Independent Medical Clinics Association
Tel: 604.688.6364
zoltan@cimca.ca
www.cimca.ca

CIMCA | ACMIC

Canadian Independent Medical Clinics Association
Association des Cliniques Médicales Indépendantes Canadiennes

Improving Canadian Healthcare for All.

Healthcare Summit: Legal, Economic and Medical Issues

Fairmont Hotel Vancouver – *Vancouver, British Columbia*
November 11 - 12, 2005

Limited Space. Register Today!

"Yet another pivotal moment in Canadian history is shaping up to take place at the venerable Hotel Vancouver this fall."
Matt Borsellino, The Medical Post, July 19, 2005

This National conference will bring together over 25 experts in the fields of law, health, finance and insurance, economics, medicine, and politics. The goal of the conference is to help Canadian governments (federal and provincial), and those involved in the health sector in Canada, develop a practical blueprint for beneficial reform and recommend changes that conform to the guidelines of the recent Supreme Court of Canada decision. [more details]

Title Sponsor:
BLAKE, CASSELS & GRAYDON LLP

The Canadian Independent Medical Clinics Association (CIMCA) has been formed to provide representation for independent health care providers and their supporters and to promote improved access to high quality and timely health care for all Canadians. We believe this to be the first time that such an association has been established in Canada.

Join CIMCA Today!
Receive 5 -10% discount on all CIMCA organized summits and conventions.

Let Them Eat Cake:
Poor and Hungry In Ontario

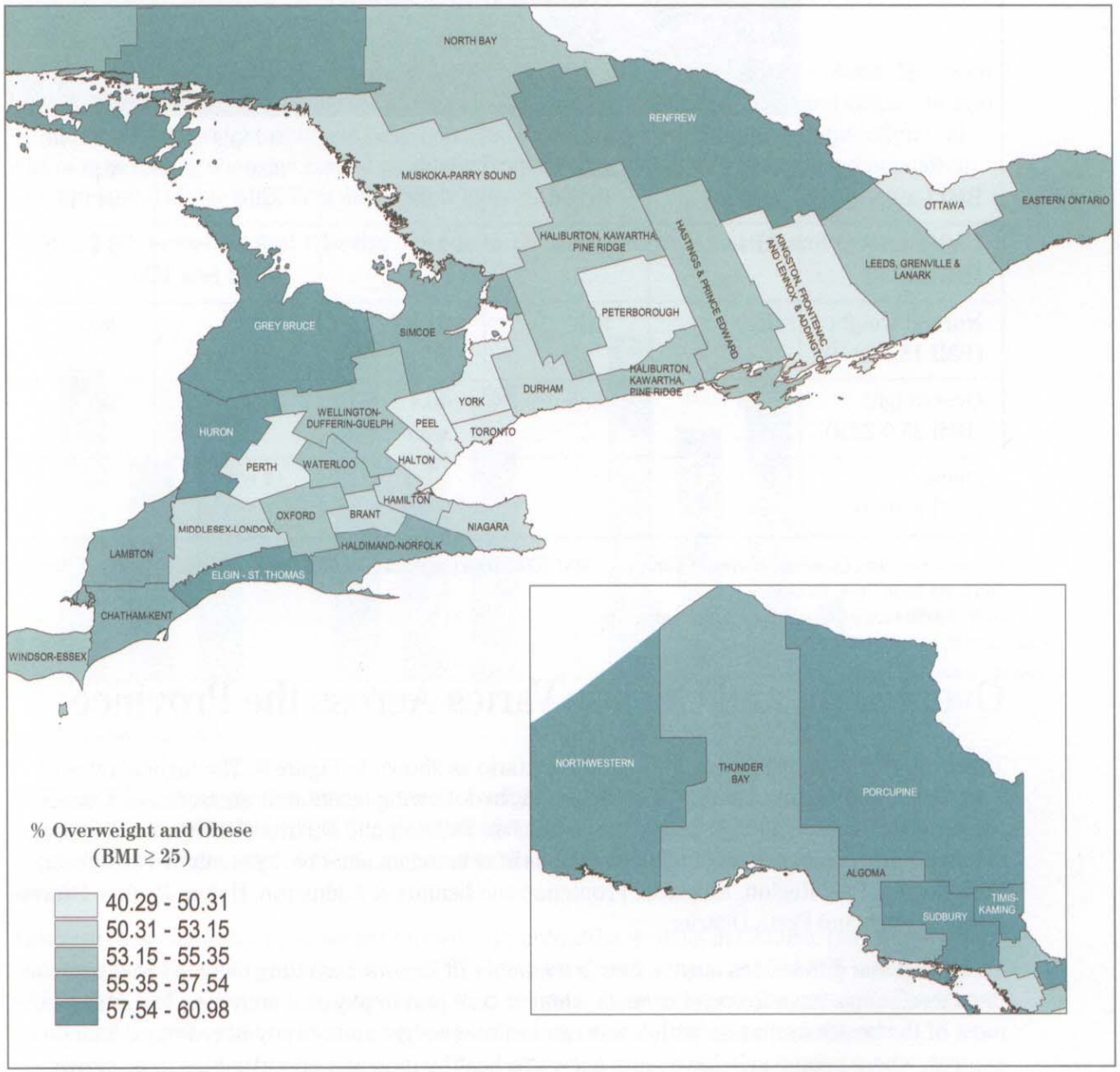
Strong Language*

Use strong language. Health disparities are the number one health problem in the country and health care alone is powerless to overcome them. The health disparity between groups in Canadian society and the impact of the gap must be reported and highlighted. This is a difficult message to get across in the current environment where the public is preoccupied with funding for health care. But it needs to be done.

Health Council of Canada

January 2005

Figure 3: Distribution of Overweight and Obesity Among Ontario Adults Age 20-64 by Health Unit



Data Source: *Canadian Community Health Survey (CCHS) 2000, Ages 20-64*

"Before I operate, I want you to know you're in my parking space."

Summary

- The hard facts of disparities are not embedded in the public consciousness
- The health sector alone has some capacity to reduce disparities by making key programs more effective and responsive
- It has a major role to play in communication, reporting, and advocacy
- Disparities are not inevitable - we can progress
- We have much to learn from European reports and experiences

Courage my friends.
'Tis not too late to
make a better world!

Tommy Douglas