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Medicare in BC: Choosing an Evidence-based Future

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ABSTRACT

Health care in Canada is a contentious topic that sparks much debate. Discussions on the future of Medicare pit public and profit-driven health care delivery models against each another, often with wait times at the forefront of the dispute. By examining the current legal challenges in British Columbia, analyzing the peer-reviewed evidence, and exploring various initiatives that decrease wait times without profit motives, we strive to illustrate the importance and feasibility of maintaining all five central pillars of the Canada Health Act: accessibility, universality, comprehensiveness, public administration, and portability.

KEYWORDS: *Medicare, health care, Canada, public sector, private sector*

Canada's health care climate is often portrayed in the media as confused and fraught with critical problems, pitting public and for-profit models against each other. The debate focuses around several key issues: the role of investor-owned, for-profit delivery and private insurance; the most appropriate wait times in a publicly funded health care system; the successes and failures of private financing and profit-driven delivery in health care in other countries; and the alternative nonprofit driven solutions. As medical students we are charged with critically appraising evidence to extract the most accurate information. So what does the evidence reveal? We will look at the court case of *Canadian Independent Medical Clinics Association v. Medical Services Commission of British Columbia* (CIMCA case) and examine peer-reviewed literature to gain an evidence-based perspective on how best to deliver and finance health care in Canada.

In January 2009, the CIMCA and a group of privately owned clinics and surgical facilities, including the for-profit Cambie Surgery Clinic and False Creek Surgical Centre in Vancouver, British Columbia, launched a claim against the B.C. provincial government. They argued that four sections of the B.C. Medicare Protection Act violate the Canadian Charter of Rights and Freedoms by preventing patients from accessing the medical care of their choice and physicians from providing privately funded care for medically necessary services.[1] The Medical Services Commission launched a counterclaim, arguing that the privately owned clinics had engaged in the practice of "illegal extra billing," wherein the clinics bill the patients for medically necessary services exceeding the amount paid by the provincial medical service plan.[2] Section 20 of the Canada Health Act states that if a province allows any physician to charge a patient more than what is provided publically for a medically necessary procedure, the federal government must intervene. Therefore, extra billing may place the province at risk of serious financial penalties.[3] CIMCA maintained that it was unconstitutional to disallow patients to seek privately funded health care in the face of increasing wait times; however, the provincial government believed that CIMCA "intended to cause economic loss to the province."[3]

At issue in the CIMCA case was a model of private health care integration called a parallel public-private system. In this system, patients could pay, either out-of-pocket or through privately held insurance, for faster access to treatments that are normally publicly funded. According to the Romanow report,

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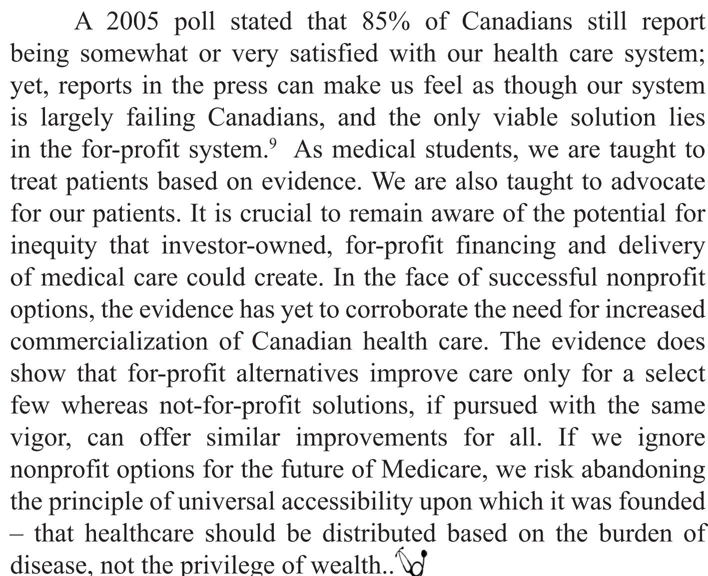
waiting for care is the primary reason Canadians say they would pay for private treatment.[5] Britain has experimented with this system with no success in reducing overall wait times: a 2004 report noted that in areas where there were high levels of private insurance coverage, there were longer-than-average wait lists.[4] In a 2005 Supreme Court case, *Chaoulli v. Quebec*, the Court decided, if wait times in the public system were excessive, prohibiting private medical insurance violated the Quebec Charter of Human Rights and Freedoms.[6] CIMCA argued that the allowance of long wait times is essentially a denial of timely access to medical care and requested that the B.C. Supreme Court use the *Chaoulli* case as precedent for their claim.[3]

To further discuss the CIMCA case we must critically examine the true length of wait times in Canada and whether the addition of private funding of medical care is a desirable solution. A common misconception is that many specialties routinely experience unacceptable wait times. In 2005, health ministers across Canada set safe and acceptable benchmark wait times based on clinical evidence.[7] The Canadian Institute for Health Information conducted a study indicating that the percentage of patients receiving treatment within wait time benchmarks was very high for most procedures (i.e. 95% for cancer radiation treatment), but for a small number of other procedures, particularly in orthopædics, the percentage was lower (i.e. 71% for knee replacement).[7] The existence of excessive wait times for a small percentage of procedures has been used as representative of our entire system to argue for a commercialized solution.[7]

While wait times are not as significant as we are sometimes meant to believe, this is not to say that they not worth addressing. Patients must go through many steps in accessing health care, each contributing to wait times: from the family doctor's referral to a specialist, to appointments for diagnostic testing, and to the eventual treatment. Other variables, including missed appointments by the patients themselves, may cause additional waits. While many believe that the management of wait lists is efficient, some patients may wait years to see a specific surgeon when they could have seen another surgeon in much less time.[7,8]

In response to this issue, successful public options for reducing orthopædic surgery wait times have been explored. The Alberta Hip and Knee Replacement Project, for example, was created to address the issue of orthopædic wait times. It was a collaborative effort on the part of the government, local regional health boards, Alberta Bone and Joint Health Institute, and orthopædic surgeons to create a single site for the assessment, diagnosis, and treatment of hip and knee injuries. An interdisciplinary team was formed to assess patients' need for surgery and eventual outcomes. These measures were found to greatly reduce the number of last-minute cancellations.[8] The team sought to standardize many aspects of patient care, including operating equipment, follow-up procedures, and evidence-based practices. This saved operating room setup time and cut costs by allowing bulk equipment ordering. Overall, this initiative reduced wait times from General Practitioner referral to first surgical consult by 80% and total wait times by 41%. Length of hospital stay also decreased by 30% due to increased continuity in post-operative care.[8]

Another example of a successful publicly funded initiative to reduce wait times is the Richmond Hip and Knee Pilot Project. A collaborative effort within the public health sector, this project organized two operating rooms with standardized equipment and procedures dedicated to hip and knee surgeries. The specialization of these rooms allowed for quick and effective operations, and surgeons were able to increase the number of joint replacements per day from six to eight. This initiative decreased median wait times from 20 months to five, and decreased the waitlist total by 27%. The average length of hospital stay was also reduced by 25%.[8]



A 2005 poll stated that 85% of Canadians still report being somewhat or very satisfied with our health care system; yet, reports in the press can make us feel as though our system is largely failing Canadians, and the only viable solution lies in the for-profit system.[9] As medical students, we are taught to treat patients based on evidence. We are also taught to advocate for our patients. It is crucial to remain aware of the potential for inequity that investor-owned, for-profit financing and delivery of medical care could create. In the face of successful nonprofit options, the evidence has yet to corroborate the need for increased commercialization of Canadian health care. The evidence does show that for-profit alternatives improve care only for a select few whereas not-for-profit solutions, if pursued with the same vigor, can offer similar improvements for all. If we ignore nonprofit options for the future of Medicare, we risk abandoning the principle of universal accessibility upon which it was founded – that healthcare should be distributed based on the burden of disease, not the privilege of wealth..

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