Intelligence MEMOS

From: Don Drummond and Duncan Sinclair

To: Canada's Ministers of Health

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Re: FIXING MEDICARE

Medicare, our label for Canada's cherished health system, is failing.

First, the Canada Health Act is misnamed. It is not about health; it's about publicly funded insurance against some of the cost of treating ill health. Ensuring good health plays a very quiet second fiddle.

Second, the Act fails tests against its five famous principles.

With respect to universality and portability, Medicare comes out pretty well.

Accessibility, added in 1985 to prohibit "extra billing," removed ability to pay as a barrier to universal access to insured services. Such access does remain rationed but is based on assessment of the urgency of need and service availability. But it is by no means equal universally or to services of equivalent quality.

The principle of public administration applies solely to governance and management of the insurance plan by Canada's provincial and territorial governments. It disallows coverage by private-sector insurers of the services covered by Medicare. It does not apply to the administration (organization and running) of healthcare services themselves. These critical functions are left to individual and institutional healthcare providers. The resultant "field of silos" fails as a coherent system.

While officially comprehensive, Medicare fails badly in covering the entire range of services a person may require both to prevent and treat ill-health. It is far from comprehensive.

In 1961, when first implemented in Saskatchewan, in addition to hospital and physician services, it did cover some prescription drugs and a few other aspects of non-medical out-of-hospital care such as dental, chiropractic, and optometric care. The "basket" of covered services has shrunk ever since.

The re-inclusion of prescription drugs under some form of pharmacare is one of today's hot discussion items. But many mental health and addiction services are also not within Medicare's basket, an exclusion urgently deserving remediation.

The same applies in spades to the range of health-related services needed by Canada's tsunami of elderly people to age well, particularly those with the chronic diseases characteristic of old age, conditions not curable but manageable with long-term support and care, most of it non-medical.

When the population was much younger, the repair of acute diseases and conditions rightly claimed priority. But Medicare has failed to adjust its focus to serve the ongoing need of Canada's now much larger, fast growing older population for continuing support and care of their good health as well as restorative services for their illnesses and disabilities.

What else? Think about the definition of what are considered publicly insured, "medically necessary" healthcare services. Are prescription drugs not medically necessary? What about home care, rehabilitation or dentistry, et cetera? What's right about emergency hospital admission for a family bread-winner with tooth-abcess sepsis, a consequence of the inability to pay privately for a dentist or for prescribed antibiotics?

Many services not necessarily prescribed or provided by physicians or routinely accessed in hospitals are essential for health optimization.

This means exacerbations of an elderly person's chronic illness are insured under Medicare, but, ironically, the far lesser cost of services to prevent such exacerbations are not. Accepting the adage that the role of the physician is to prevent illness when possible and treat it when necessary, the exclusion of preventive services from coverage, whether by physicians or other providers of healthcare services, makes no sense.

It's long past time to discuss and decide how best to remedy these failings and achieve Medicare's prime purpose: optimizing the health of Canadians.

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