Carry Medicare Forward

Cut the clichés, let's get creative: If we were designing medicare afresh, we could make it better and more sustainable if users paid a portion

By WILLIAM ROBSON

The debate over reforming publicly funded health care in Canada can be reasoned and constructive. Too often, it is vehement, uninformed and sterile. Defenders of the status quo wrap themselves in the flag and insist that only much more money can keep us off a slippery slope to a two-tier, US-style disaster. Would-be reformers lash out, condemning the current system for real and imagined failings, often discrediting themselves and their ideas in the process.

Vehemence and ignorance — on display when Canadians tell pollsters they venerate the five principles of the Canada Health Act, but are unable to say what the five principles are — are particularly unhelpful now. Sensible, practical suggestions for improvement are in the air, but they'll do no good if we can't hear them above the deafening roar of entrenched opinion.

Let's turn the volume down and clear our heads with an act of imagination. What if, through some accident of history, Canada had not put its current system of hospital and doctor insurance in place a generation ago?

Suppose we were designing it now, and the Canada Health Act and the familiar provincial machinery for delivering services did not exist ... would we use our fresh start to recreate them in their current forms?

In some cases, the answer is certainly yes. The universality that the *Canada Health Act* describes would be a feature of the new system. Ensuring coverage for all responds to concerns about fairness and an adequate safety net, and also permits the pooling of risk (which makes health insurance work when people face very different health prospects).

Portability of benefits across the country, another principle of the *Canada Health Act*, would also be a feature of the new system — Canadians don't want to worry about losing coverage when they step across a provincial border.

We'd also allow individual entrepreneurs to provide services as family doctors and specialists in the publicly funded system; we'd permit non-government and even for-profit organizations to supply equipment, drugs and many kinds of services to the publicly funded system. In this respect as well, our new setup would resemble the one we now have.

In other cases, however, we might use our fresh start to do things differently.

In using public funds to pay doctors and hospitals, we would probably not recreate the straight fee-for-service payments and institutional grants we now have. We might pay family doctors on the basis of the number of patients enrolled in their practices, to make maintaining health as financially rewarding as treating sickness.

We might tie hospital funding more closely to services delivered, encouraging administrators to focus more on running the shop and less on lobbying governments. We might even give family doctors control of some of the funds that flow to specialists, hospitals, labs and drug companies. This would put the search for greater cost-effectiveness in the hands of experts on the front lines, rather than bureaucrats in health ministries.

The *Canada Health Act* now insists that (except for the little-noticed "second tier" of workers' compensation) all public funds for doctor and hospital treatments must flow through one provincial, monopoly insurance plan. I

doubt that we'd insist on that — now that we have decades of experience with government monopolies in Canada and evidence from competing insurance plans in other countries to draw on.

Instead, we might permit alternatives. We might insist that all plans provide basic coverage to all comers, but let the plans compete on quality. Supporters and critics alike of Canadian medicare bemoan the inability of today's administrators to say what we get for what we spend on different treatments; in our new world, the better-performing plans would tell us much more of what we want to know.

Here's another controversial idea. If we could start afresh, I doubt that we'd refuse to let our system charge patients for doctor or hospital services, yet make patients pay entirely out of pocket for often complementary treatments such as drugs.

Other countries don't do this, and for good reason. If we imitated successful schemes from elsewhere, we would extend the coverage of our publicly funded insurance, but we would also add deductibles or co-payments for many services. We could even go the rest of the world one better, collecting those charges through personal income tax at the end of the year, scaling the payments to the ability to pay, and ensuring that nobody would refrain from seeking treatment because of an up-front charge.

That would preserve the accessibility the *Canada Health Act* demands, while encouraging smarter use of health resources by patients and providers alike.

If we could redesign our publicly funded health system now, I hope we would have the wisdom to take one further step.

When today's doctor and hospital insurance plans took shape, their designers assumed — if they thought about it at all — that a steady flow of young workers into a fast-growing economy would generate ample tax revenue for decades to come.

Now, however, we know that the baby boomers had far fewer children than their parents. As a result, there are relatively few taxpayers funding the public system just as aging boomers are beginning to draw more heavily on it.

Our pension plans have already responded to that prospect, moving from almost pure pay-as-you-go programs to advanced funding. But our health systems make no provision for the future; indeed, many of medicare's defenders deny such cost pressures exist, even as they suggest a 43-percent hike in the GST to cover them!

A foresighted alternative wouldn't just impose new taxes to pay for today's spending. It would also set something aside for tomorrow, when demands may outrun the capacity of today's children to pay.

Unfortunately, Canadians do not have the luxury of designing a publicly funded health system from scratch. The nationalist slogans, the vested interests, the indiscriminate critics and the *Canada Health Act* already exist.

But we can turn down the volume. In quieter moments, defenders of the status quo might note that, although many countries have looked at Canadian health care for ideas about reforming their own systems, not one has imitated our model. Meanwhile, medicare critics should temper their condemnations, and acknowledge that much of what we do makes sense.

Better yet, we can clear our heads by comparing the system we have with the one we would create if we could start afresh. In some respects, publicly-funded health care in our new world would be much like what already exists. In other ways, it would be much better.

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