

*still*  
It's about **access!**

CMA policy  
statement

# Medicare Plus



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CANADIAN  
MEDICAL  
ASSOCIATION

# It's still about access!

## Medicare Plus

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CMA Policy Statement

July 2007

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# Foreword

This consolidated policy statement summarizes the deliberations of the Canadian Medical Association (CMA) on the public–private interface in the funding and delivery of health care that began at General Council (GC) in Edmonton, Alta., in 2005. It should be read in concert with the discussion paper *It's about access: informing the debate on*

*public and private health care* (cma.ca). The discussion paper served as the basis for further debate at GC in Charlottetown, PEI, in 2006. The resolutions adopted at GC in 2005 and 2006 form the basis of the documents in this statement, and they were ratified as CMA policy by the Board of Directors in May 2007.

# Medicare plus: toward a sustainable publicly funded health care system in Canada

Medicare is now 40 years old in Canada, and by all accounts it continues to be highly valued by Canadians. However, there is evidence suggesting that in its present state, Medicare will not be able to effectively deliver timely access to high-quality care that reflects the needs of our changing health care landscape. To sustain Canada's health care system for the next generation, changes need to be made to bring about a new vision for Medicare. The CMA identifies this future vision as "Medicare Plus." This policy statement expresses the views of the Canadian Medical Association (CMA) at the present time and reflects, in the CMA's opinion, a future vision of Medicare that respects the current Canadian values, legislative frameworks and commitments from government.

Three key steps must be undertaken to implement this vision:

1. The current Medicare program must be shored up to deliver timely access to care.
2. A guarantee that provides individual recourse to timely treatment must be put in place.
3. The basket of services must be expanded along the continuum of care through a variety of means.

## Shoring up the current program

The public system must commit to timely access to care according to relative need for all necessary hospital and medical services. Governments have made a good start by providing for a stable funding base and by making strategic investments in medical equipment and health information technology. They have begun to deliver on their 2004 wait-time commitments by establishing national benchmarks in 2005 and by agreeing to implement a wait-time guarantee in at least 1 of the 5 priority areas by 2010. However, the job is far from finished. Governments have yet to set out the timelines for achieving their benchmarks, and there are many other procedural areas beyond the initial 5 for which benchmarks need to be established. Moreover, the benchmark approach now needs to be expanded beyond the specialist-patient decision to treat to include access to primary care and specialist consultation.

Delivering on timely access will not be achievable without an adequate supply of doctors, nurses and other health care professionals. Canada must adopt a pan-Canadian planning approach to health human resources with a goal of national self-sufficiency that engages key stakeholders on an early, meaningful and ongoing basis. Just as the 1966 *Health Resources Fund Act* was instrumental in expanding the health education and research infrastructure in the 1960s and 70s, further federal and provincial-territorial investments are critical now, in light of the recent expansion of medicine, nursing and other health professional enrolment and the establishment of new health disciplines. Considerable further investment is also required in health information technology. While the establishment of the Canadian Institutes for Health Research has been a positive step, further investment is necessary, particularly in the area of knowledge transfer — from bench to bedside.

## Care guarantees

It is essential to implement a means of guaranteeing that Canadians can obtain timely access to care. As the Supreme Court found in the Chaoulli decision, the *Canada Health Act* and provincial-territorial health insurance legislation provide for a virtual monopoly for public health insurance, which "on the evidence, results in delays in treatment that adversely affect the citizen's security of the person," hence it does not conform to the principles of fundamental justice. The CMA has called for a Canada Health Access Fund that would provide for a means of individual recourse to patients facing waits that exceed benchmark thresholds. When the wait time is exceeded the patient and their physician would be able to seek timely treatment where it is available, ideally close to home, but potentially in another city, another province-territory or country. The \$612 million Patient Wait Times Guarantee Trust established in the 2007 budget is a step in this direction. To the extent that the current public infrastructure constrains capacity, governments should consider contracting publicly funded services to the private sector.

Failing the enactment of a publicly funded safety valve, the Chaoulli decision has established that patients cannot be denied a private sector insurance and treatment option. The Quebec government has since made provisions in its legislation to comply with the decision, however it has so narrowly circumscribed the terms and conditions under which private insurance contracts might be offered and delivered that it is highly unlikely private coverage will be offered. Nonetheless the Chaoulli decision put governments on notice, as evidenced by their progress on benchmarks and reduced wait times. Governments may be further stimulated by the fact that a case similar to Chaoulli has been filed in Alberta and another is about to be filed in Ontario.

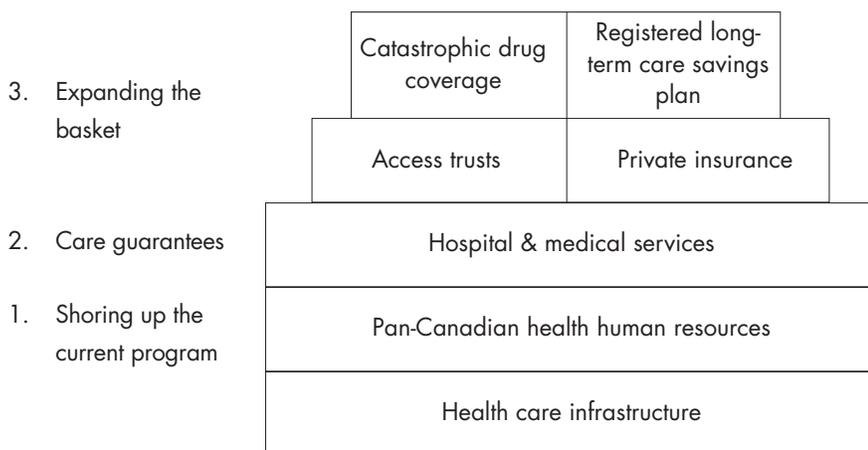
### Expanding the basket

Medicare must be modernized to reflect the current reality of the delivery of care. In 1975, just after Medicare was fully adopted, hospital and physician expenditures represented 60% of total health expenditures; as of 2006, this share has dropped by almost one-third to 43%. Over the past 2 decades, prescription drugs as a proportion of total health spending have doubled from 7% in 1986 to an estimated 14.2% in 2006. While a majority of Canadians have prescription drug coverage from either private or public plans, it is estimated that some 3.5 million are either uninsured or underinsured for prescription drug costs. Looking ahead, we can expect to continue to see a mix of public and private plans and out-of-pocket payments (e.g., co-payments) and greater use of tax policy. This is the experience of most

European and other industrialized countries. In Canada and internationally, the prospects for additional health programs funded on a first-dollar basis out of general taxation revenues are slim. However, there is a clear consensus as reflected in the Romanow and Kirby reports on the need for catastrophic prescription drug coverage and a growing concern about how to address the issue of very costly “orphan” drugs for rare diseases and expensive treatments for common diseases such as breast cancer. In 2003, first ministers committed to having catastrophic drug coverage in place by the end of 2005–06, and while this is one of the elements of the National Pharmaceutical Strategy, little collective action has taken place beyond further study. Similarly a 2003 commitment by first ministers to first-dollar coverage for a basket of short-term acute home care, community mental health and end-of-life care services remains unmet.

The issue of long-term care (LTC) of the elderly looms on the horizon as the first cohort of the baby boom generation turns 65 in 2011. Indeed hospitals are already feeling the pinch of a lack of alternative level of care beds. International experience suggests that LTC cannot nor should not be financed on the same pay-as-you-go basis as medical–hospital insurance. Germany has implemented a social insurance approach to pre-funding LTC. In its 2007 budget, the federal government introduced a Registered Disability Savings Plan (RDSP) to help parents of children with a severe disability to ensure their children’s future financial security by investing after-tax income on which the investment income will accumulate tax-free. Consideration should be given to implementing a similar program for LTC.

### Medicare Plus



In summary, we must first ensure that the current Medicare system is on sustainable footing for future generations. Second, Canadians must have a measure of certainty that not only will they receive quality care, but they will receive it in a timely fashion. Third, recognizing the boundaries of our current Medicare program, we must address the terms and conditions under which Canadians will be able to access the broader continuum of care. Finally, it must be recognized that the health policy land-

scape is not static, a fact of which governments are aware. For example, in its 2007 budget, Quebec announced that former health minister Claude Castonguay will chair a task force to address sustainable health funding. In addition, British Columbia has been holding a “Conversation on Health” with its citizens that will wrap up in the fall of 2007. As the debate on the future of Medicare changes over time, the CMA’s policy will continue to be redeveloped and redefined.

## **Policy summary: managing the public–private interface to improve access to quality health care (2007)**

### **Background**

The CMA supports the concept of a strong publicly funded health care system where access to medical care is based on need and not on the ability to pay. Health care services in Canada have historically been funded and delivered by a mix of the public and private sectors. At the present time, approximately 70% of health expenditures are publicly funded from general tax revenues; the remaining 30% are privately funded either through private insurance or out-of-pocket payment. The public–private interface occurs in two key areas: the private delivery of publicly funded services, and the delivery of privately funded services in publicly owned facilities.

Drawing on the key issues raised in the CMA’s June 2006 discussion paper, *It’s About Access*, this policy summary sets out guidelines for decision-making and policy development for managing the public–private interface within Canada’s health care system to optimize timely access to high-quality care.

### **Policy principles**

The following principles provide a framework for guiding future strategies for managing the public–private interface.

1. **Timely access:** Canadians should have timely access to medically necessary care and individual recourse should wait times be unreasonably long.
2. **Equity:** Access to medically necessary care must be based on need and not on ability to pay.
3. **Choice:** Canadians should have choice of physician and physicians should have choice with respect to their practice environment.
4. **Comprehensiveness:** Canadians should have access to a full spectrum of medically necessary care.
5. **Clinical autonomy:** Any care model should respect the autonomous decision-making within the patient–physician relationship. Physicians must be free to advocate on behalf of their patients.
6. **Quality:** The public and private health care sectors must be held to the same high-quality standards and be independently monitored. To ensure professional accountability, any facility providing medical services must be subject to medical supervision.
7. **Professional responsibility:** The medical profession has a responsibility to promote the strongest possible health care system that best meets patients’ needs. Both public and private sectors have a responsibility to train the next generation of health professionals and to advance knowledge through teaching and research.
8. **Transparency:** Decisions affecting the mix of public–private funding and delivery must be made through an open and transparent process. Providers faced with potential conflicts of interest have a duty to recognize and disclose them and to resolve them in the best interest of patients.

9. **Accountability:** The public and private health sectors should be held to the same high accountability standards including clinical outcomes, full cost accounting and value-for-money.
10. **Efficiency:** The public and private sectors should be structured to optimize the use of human and all other resources.

### **Public-private interface issues**

In light of the foregoing principles, the CMA has identified several key issues where improved management of the public-private interface could lead to better access to high-quality health care services for Canadians.

#### **Implementing a wait-time care guarantee**

Canadians face increasingly long wait times for necessary medical care, frequently beyond recommended maximum wait times. In the 2004 first ministers' agreement, wait-time benchmarks were established for 5 priority areas in the publicly funded system: cardiac care, cancer care, diagnostic imaging, joint replacement and sight restoration. When care is not delivered within benchmarks, there is no effective "safety valve" to provide recourse. Patients are forced to wait for care in Canada or seek it within the private sector or in other jurisdictions at their own expense.

A safety valve is needed to enable Canadians to obtain required care where wait-time guarantees cannot be met. Ideally, Canadians would never have to use the safety valve, but its inclusion in Canadian health policy would help restore confidence in the public health system and focus governments upon meeting commitments to provide timely access to care. The Patient Wait Times Guarantee Trust announced in the 2007 federal budget is a positive first step.

The CMA recommends that:

- Governments work with the CMA and other medical organizations to establish clinically appropriate wait-time benchmarks for all major diagnostic, therapeutic, surgical and emergency services.
- Where wait-time benchmarks can be established, governments implement them nationally.
- If national wait-time benchmarks are not met, Canadians should be entitled to a publicly funded safety valve whereby the government would reimburse payment for treatment, travel and other appropriate costs if

the service is provided outside the home jurisdiction or within the private sector.

- When access to timely care cannot be provided in the publicly funded system, Canadians should be able to use private health insurance to reimburse the cost of care obtained in the private sector. Private insurance contracts are now permissible in Quebec for hip replacement and cataract surgery, with the stipulation that the insurer must fund all aspects of the treatment including rehabilitation. At present, it is not clear how this could work in practice in terms of risk rating of either the patient or on the performance of the public system.
- In the interest of providing timely care within the publicly funded system, governments must ensure that Canada has sufficient health professionals and infrastructure to meet need.

#### **Improving performance measurement, quality assurance and accountability in the public-private interface**

It is essential that the health care system be accountable to Canadians, in particular with respect to the roles and responsibilities of different levels of government and their delegated agents, such as regional health authorities and specialty boards. Accountability becomes all the more pressing as public-private collaboration expands.

There may be a growing role for the private sector in the delivery of publicly funded health care provided that it delivers services in a cost-effective manner. As with the public sector, any private sector involvement in health care must be patient-centred as well as transparent and accountable. Health care services in both sectors must be delivered to the same high standards of quality. To achieve this, solid means of quality assurance must be in place to ensure that value-for-money is being received where public funds are used to contract for service delivery in public and private settings and to monitor the impact of privately funded services on the public system.

There are currently a number of data gaps that need attention. For example, there is a lack of formal comparative studies of the cost-effectiveness and quality of public and private delivery in Canada based on primary data; there is confusion surrounding the monitoring of quality for uninsured services; and there is uncertainty about the extent of voluntary accreditation of health care facilities in the public and private sectors.

The CMA recommends that:

- Governments establish uniform requirements and regulation where appropriate for measuring quality of care in both public and private settings, including:
  - a) collection of data on process and outcomes of care;
  - b) reporting of such data on all publicly insured services to regulatory bodies;
  - c) accreditation standards for both public and private service delivery equivalent to those of the Canadian Council on Health Services Accreditation; and
  - d) protection of health information privacy.
- Governments and regional health authorities that enter into public–private partnerships do so through an open and transparent tendering process.
- Where governments include public–private delivery mechanisms to expand system capacity, they do so with regulation to evaluate quality and cost-effectiveness.
- Governments conduct ongoing evaluation of the quality and cost-effectiveness of public–private delivery options.

### **Defining the public health care system and the basket of publicly insured services**

The delineation of publicly insured services is a fundamental policy issue for governments, health care providers and patients. The publicly funded health system cannot be expected to meet all needs for all patients; choices must be made and trade-offs negotiated. However, decisions about the basket of insured services have typically been ad hoc and made behind closed doors. The system has also been slow to respond to emerging technologies and shifts in the delivery of care.

At the present time the national medicare basket includes hospital and medical services. The provinces–territories also fund additional services at their discretion (e.g., seniors' drug coverage, home care). While this widens the scope of public coverage, it creates disparities in access across jurisdictions, and Canada is often referred to as a “patchwork quilt” in this regard.

The CMA recommends that:

- There should be ongoing periodic monitoring and reporting of the comparability of Canadians' access to a full range of medically necessary health services across the country.

- In keeping with the CMA's 1994 document *Core and Comprehensive Health Services: A Framework for Decision-making*, there is a need to define a set of nationally comparable, publicly funded core services. The nature of these services should be continually assessed in an evidence-based and transparent manner. The mode of delivery for these services should be at the discretion of local jurisdictions and may involve both the public and private sectors.
- Government health insurance plans should give adequate notice when services are to be delisted.

### **Transparency and accountability in the regulation of physician activity within the public–private interface**

The ability of physicians to choose whether or not to participate in the public health insurance plan has been a key feature of Medicare since its inception. Physicians are willing to accept reasonable limits on their ability to opt in or out of the public health plan to ensure that adequate access to medical services is maintained. To achieve this, an effective regulatory framework is required to govern the intersection of public and private health care and there must be concerted effort on the part of stakeholders to investigate the implications of and opportunities to minimize conflicts of interest. When considering options for the delivery of publicly insured services by the private sector, it is critical that the integrity of the public system is maintained and that Medicare remain the cornerstone of Canadian health care.

The reality for many physicians is that they must concurrently deal with multiple payers — patients covered by provincial–territorial health insurance plans, injured workers covered by workers' compensation boards and various groups of individuals covered by third-party insurers. Whatever the funding arrangement, the following fundamental characteristics of the physician–patient relationship cannot be altered:

- Patients should be able to choose their physician.
- Physicians must have freedom to advocate on behalf of their patients.
- Physicians should be allowed to have choice in their practice environments, including the right to opt out of the publicly funded system.
- It is the duty of providers to recognize and disclose potential conflicts of interest and to resolve them in the best interests of patients. The CMA will work with its divisions and affiliates to develop a code of conduct for

physicians who provide services in the private sphere and for those who provide services in both sectors.

The CMA recommends that:

- Governments should allow physicians to have choice in their practice environments, including the right to opt out of the public health insurance program provided that patient access to publicly funded care is not compromised. This is presently permitted in all jurisdictions except Ontario.
- Governments should examine practice arrangements where physicians are able to work in both the public and private sectors so as to maximize the availability of medical services, particularly in situations where there are budget constraints resulting in inefficient use of health human resources and physical infrastructure.
- Governments should remove bans preventing physicians from opting out or preventing them from practising in both the public and private sectors where it can be shown that this would improve access to services for the entire population, increase the capacity of the health care system and reduce wait times.

### **Medical education and training**

Physicians collectively have a responsibility to train future generations. Looking ahead, we may expect to see a continued trend toward the delivery of diagnostic, medical and surgical procedures in specialized facilities that are privately owned and operated. From the standpoint of medical education and training, this raises two issues. First, a significant number of the current complement of clinical teachers may perform an increasing proportion of their work in such facil-

ities, which may have implications for public teaching hospitals. Second, to the extent that the delivery of services may migrate from teaching hospitals to specialized facilities, this may potentially limit the education and training exposure of medical residents.

The CMA recommends that:

- Physicians must be appropriately trained for the scope of practice in which they are engaged, whether in the public or private sector.
- Medical trainees need exposure to all types of practice arrangements across the public–private interface.
- Medical trainees need exposure to all areas of clinical medicine, including those areas predominately delivered by either the public or private sectors.
- Governments that choose to contract out services to private delivery must ensure that training opportunities include exposure to both sectors.
- The CMA, in partnership with medical student organizations, will promote education about the public–private interface and health care funding and delivery issues.

### **Conclusion**

Canada's health care system is the product of a long-standing partnership between public and private funding and delivery. The interaction between both sectors will continue to be an important dimension of Medicare that must be carefully managed. The framework of decision-making principles and recommendations set out in this policy will hopefully enhance debate among stakeholders and the public about future directions for how to best manage the public–private interface.

# Glossary

## **First-dollar coverage**

100% public coverage with no point-of-service charges.

## **Insured service**

Under the *Canada Health Act* (CHA), insured health care services are medically necessary hospital services, physician services and surgical–dental services provided to insured persons.

## **Insured person**

Under the CHA, insured persons are eligible residents of a province, but do not include those who may be covered by other federal or provincial legislation. Persons not covered by the CHA include serving members of the Canadian forces and Royal Canadian Mounted Police, inmates of federal penitentiaries and people covered by provincial workers' compensation.

## **Opting out or in**

Refers to whether a physician has chosen to give up his or her right to bill the public health insurance plan and take up practice in the private sector. Although there are differences in terminology (e.g., “non-participation,” “non-enrolment,” “practising outside the act,” “not subject to the agreement”), every provincial plan except Ontario's permits physicians to opt out.

## **Private delivery**

Private delivery of health care is carried out by health care provider organizations that are not agencies of government or otherwise directly accountable to government and health care providers who are not employees of such agencies or public servants. This can range from self-employed health care professionals (e.g., physicians) to small, medium and large organizations that may be for-profit or not-for-profit.

## **Private funding**

Private funding of health care includes health insurance claims paid by private health insurance firms (including the cost of administration), out-of-pocket expenditures on health goods and services by individuals and households, non-patient revenues received by health care institutions (donations, investment income), private spending on health-

related capital and equipment and privately funded health research.

## **Private health insurance**

Various forms of private health insurance coverage are found in different countries:

- *Primary private health insurance*: Private insurance that represents the only available access to basic health cover because individuals do not have public health insurance. This could be because there is no public health insurance, individuals are not eligible to coverage under public health insurance (principal cover), or they are entitled to public coverage but have chosen to opt out of such coverage (substitute cover).
- *Duplicate (parallel) private health insurance*: Private insurance that offers coverage for health services already included under public health insurance. Duplicate health insurance can be marketed as an option to the public sector because, while it offers access to the same medical services as the public scheme, it also offers access to different providers or levels of service. It does not exempt individuals from contributing to public health insurance. (Available in Australia.)
- *Complementary primary health insurance*: Private insurance whose coverage complements that of publicly insured services or services within principal/substitute health insurance. It is intended to pay only a proportion of qualifying care costs, by covering all or part of the residual costs not otherwise reimbursed (e.g., co-payments). (Available in France.)
- *Supplementary private health insurance*: Private health insurance that covers additional health services not covered by the public scheme. Depending on the country, it may include services that are not covered by the public system, such as luxury care, elective care, long-term care, dental care, pharmaceuticals, rehabilitation, alternative or complementary medicine, etc., or superior hotel and amenity hospital services (even when other portions of the service, such as the medical component, are covered by the public system). (Available in Canada.)

**Public delivery**

Public delivery is delivery of a service either directly by government or by regional health authorities or through a not-for-profit charitable organization, often with community governance, that is directly accountable to government through statute or regulation (e.g., public hospitals act).

**Public funding**

Public funding of health care includes health expenditures by federal, provincial and municipal governments, as well as workers' compensation boards.

**Public-private interface**

Any instance where there is a mix between public and private sectors with regard to the funding or delivery of health services.

**Public-private partnership**

A cooperative venture between the public and private sectors, built on the expertise of each partner, to capitalize or deliver health services in a way that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards.

**Social insurance**

Social insurance (often referred as the Bismarck model

after the German chancellor who initiated this approach) provides health care coverage through non-profit insurance or sickness funds financed by employer-employee contributions. Although it may be mandated by the state, the program is not government run. This model is found in Germany and several other European countries.

**User charges**

Direct charges to patients for insured services under a province's or territory's health insurance plan that are not payable, directly or indirectly, by the health insurance plan.

**Wait-time benchmark**

Health system performance goals that reflect a broad medical consensus on reasonable wait times for health services delivered to patients.

**Wait time**

There are multiple wait times involved in a health care episode, beginning with the wait to see a family physician. The patient's wait for specialty care begins when he or she receives a differential diagnosis from the family physician-general practitioner and it is decided that the patient requires diagnostic testing or clinical intervention or both.