AN OUNCE OF PREVENTION...

For-profit healthcare has taken another bold leap forward. Ironically, the public model could learn from the Copeman Centre.

By GREG FLANAGAN

The new Copeman Healthcare Centre in Calgary's Beltline, which offers government-insured services for a yearly fee starting at $3,900.

ACCORDING TO FOUNDER OF MEDICARE TOMMY Douglas's original vision, healthcare in Canada "should be designed to keep people well—because in the long run it's cheaper to keep people well than to patch them up after they're sick." Indeed, the first phase of Medicare (1960s–present) saw the removal of financial barriers to health, accomplished by instituting a single payer (the government) and removing charges to users for medically necessary services. Designated services were made universally available to all citizens based on need, not ability to pay. Although it was a remarkable achievement, many people now characterize Medicare as not a health system, but one that treats sickness.

The second phase (phase two) of Medicare, anticipated by Douglas, will emphasize health through prevention of illness and the maintenance of healthy lifestyles. This "new" approach to health is to be primarily delivered through community health centres, where teams of healthcare professionals—including doctors, nurses, mental health professionals, kinesiologists, physiotherapists, nutritionists, dietitians, social workers and educators—provide primary healthcare, wellness promotion and community development programs. The objective of these health centres is to promote healthy living, healthy aging and healthy dying.

Alberta already has a number of clinics that use the title "community health centre." The most recent is the Sheldon M. Chumir Health Centre, which delivers accessible, community-based healthcare to Calgary's inner city. When fully operational, the Chumir Centre will offer a broad range of services: outpatient mental health support (to help people with mental illness live in the community); an urgent-care centre, wound-care clinics and diagnostic imaging; a community health program; a sexually-transmitted-disease clinic; a harm reduction team (to provide wellness education and healthy living support). This will improve access to healthcare for those who have limited mobility or who find it difficult to travel beyond the inner city, and may prevent unnecessary hospital admissions—or at least help reduce the likelihood of hospitalization. However, this clinic is more a hospital substitute (there were four hospitals in the area prior to the 1990s) than true phase two Medicare.

We've also seen innovation in the form of primary care networks (PCNs); trilateral, formal agreements between the Alberta Medical Association, the regional health authorities (soon to be amalgamated) and Alberta Health & Wellness. In a PCN, family physicians coordinate primary care services for patients in a specific geographic area. The daily operations of a PCN are primarily within the control of the physicians through a lead doctor. The leader may engage the services of a business manager to administer the network, and may establish a triage system to route patients directly to other healthcare providers (such as a nurse practitioner or therapist). The goals of a PCN include increasing the proportion of Albertans with ready access to primary care; providing coordinated 24-hour, seven-day-per-week access to appropriate primary care services; increasing the emphasis on health promotion, and disease and injury prevention; improving the care of medically complex and chronically ill patients; and improving coordination among services.

A PCN has the flexibility to develop programs and provide services in a way that works locally, and it's expected that each network will be unique in the way it operates. However, networks are generally meant to build on the strengths and resources that currently exist, with only some extra start-up funds. They're expected to deliver specific primary care services, improve access, increase capacity through the more intensive use of existing resources and facilities and "innovate"—that is, find better, different and special ways to provide healthcare to their patient population. In addition to providing all of the regular primary care services more efficiently, they're expected to provide access to laboratory and diagnostic imaging and also to coordinate home care, emergency room services, long-term care, secondary care and public health. All this with essentially the same resources as before—namely people who are already exhausted!

So we know what needs to be done to complete phase two of Tommy Douglas's vision for Medicare: integrate health services and focus on health, well-being and prevention. However, community health centres are rare, and primary care networks are more theoretical than real at this point. Meanwhile, 13 per cent of Albertans can't find a doctor. Add to this the reality of doctors closing offices in our cities because they can't afford rent increases; walk-in clinics reducing their hours due to a shortage of doctors; and hospital emergency rooms backlogged because people have nowhere else to turn. Far more numerous public community health facilities are needed to implement PCNs. These need professional managers to attend to business and coordinate networks, so salaried physicians and other health professionals can attend to medicine.

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CLEARLY, THE PUBLIC SYSTEM IS NOT RESPONDING fast enough to Albertans' desire for a better approach to healthcare provision. While the public system struggles to implement phase two initiatives—lacking adequate government funding—the private model has moved quickly and quietly to try to fill the void.

In late 2007, an exclusive Vancouver health clinic announced it would open a clinic in Calgary. The Copeman Healthcare Centre professes to offer "the new standard of healthcare." Its

PHOTO: SUZY THOMPSON

Members of Friends of Medicare confront Dr. Copeman in Calgary. FoM claims the Copeman Centre violates the Canada Health Act.

website continues: "[Copeman] provides world-class screening and disease prevention programs that are combined with the general care of physicians to provide people with a complete healthcare service. …At the Copeman Healthcare Centre, you will never walk away feeling like you've been rushed. We give you all of the time and attention that you deserve." Copeman also promises "timely" access, collaborative care, "world-class" prevention, early disease detection, integrated mental health and specialist services (including kinesiologists, registered dietitians and psychologists)… all under one roof… for an all-inclusive fee of $3,900.

My wife and I visited the Vancouver Copeman Centre in May. We wanted to see what it was like and how it was different from public clinics. Then-general manager Susan Rafter took us on a tour. Rafter said Copeman supports Tommy Douglas's perspective that healthcare has to expand beyond care for the sick into preventive health, with good health and well-being paramount. She reiterated their goals (as stated on their website): "In the short term, the company hopes to demonstrate that such programs can not only achieve its primary objective of making people's lives better, but that it can reduce the demand for more costly medical interventions," and "In the long term, [we] hope to use the information we gather to create low-cost, high-value programs for people of all walks of life, leveraging technology and the often underestimated talents of non-physician health workers."

Rafter, and the other staff I met at the Copeman clinic, seemed sincere in their wish to provide the kind of integrated, preventive and health-focused care that phase two Medicare is all about. However, given their fees, this kind of healthcare is clearly not affordable or accessible to all Albertans. A fee of $3,900 for the first year and $2,900/year or $250/month for continuing membership (Copeman currently includes members' children younger than 22 for free) is not within everyone's means. Phase two healthcare it may be—Medicare it definitely is not.

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DOESN'T CHARGING A FEE VIOLATE THE CANADA Health Act? A Health Canada webpage defines "extra billing" as "the billing for an insured health service rendered to an insured person by a medical practitioner… in an amount in addition to any amount paid or to be paid for that service by the healthcare insurance plan of a province or territory. For example, if a physician were to charge patients any amount for an office visit that is insured by the provincial or territorial health insurance plan, the amount charged would constitute extra-billing. Extra-billing is seen as a barrier or impediment for people seeking medical care, and is therefore contrary

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to the accessibility criterion."

The British Columbia Medical Services Commission spent a long time evaluating Copeman's fees. Initially, Copeman proposed a $1,200 initiation fee (for baseline assessment) in addition to a yearly membership fee. On the advice of the commission, Copeman "eliminated" this fee by rolling it into the first year's annual fee. As well, on the BCMSC's advice, Copeman changed some promotional material. Subsequently, in November 2007, the commission decided that Copeman is not in contravention of the Canada Health Act. According to the Copeman website, their fees "are strictly for non-insured health services and… do not guarantee access to insured services."

The Copeman Healthcare Centre opened in Calgary in September near the corner of 5th St and 12th Ave SW—a block west of the Chumir Centre. It includes a large medical and preventive care facility, an exercise and rehabilitation centre, a neuroscience component and a preventive cardiology clinic. Copeman has hired doctors and administrative staff and has advertised for clients. The company also plans to build and operate facilities in a number of Canadian cities, including Edmonton. Alberta Health & Wellness has not opposed the Copeman clinic's arrival in Alberta.

Let's be clear. The people behind Copeman are entrepreneurs. They're running a for-profit business in healthcare. Their approach, and the ruling that it does not contravene any Canadian laws, has serious implications for public healthcare.

Alberta currently has a shortage of doctors. Private, for-profit clinics like Copeman's will draw even more doctors away from traditional practice. For example, my wife's doctor left her practice early this year because she couldn't afford her increased rent. She signed on with Copeman. She believes in taking time with her patients and couldn't afford this "luxury" with the increased costs of her practice. At Copeman, doctors are salaried and will have a maximum of 500 patients, seeing 10–12 a day. The current average in Alberta is approximately 1,100 registered clients per general practitioner. In practice, this number may be much larger when part-time physicians, and doctors serving in administration, are considered in the numbers.

The medically necessary services performed at Copeman will be billed to Alberta Health & Wellness. In addition to the revenues it receives from Medicare, Copeman will bring in an additional $1.5-million per physician per year in fees (assuming a 500:1 patient to doctor ratio). Copeman's healthcare approach may generate greater Medicare costs to the public system even as they collect member fees. And if Copeman's extra fees actually reflect the costs of providing integrative healthcare, the per capita healthcare budget in Alberta would have to almost double to provide a similar level of public healthcare—at least in the short run.

The average Medicare cost per capita in Alberta is just over $3,000. However, healthcare costs vary considerably across age groups. Costs for infants under 1 year old average $9,000. Expenditures drop significantly through childhood and adolescence. After age 20 and through to age 44, average expenditures rise to approximately $2,000 and from 44–54 increase to the average of $3,000, rise above the average after age 55 and become significantly higher for seniors (aged 65 and greater).

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ONE HUNDRED YEARS AGO, CANADA WAS A YOUNG country with a low average age. Most healthcare was for acute problems. Many of the diseases that killed our ancestors are now preventable or treatable, so life expectancy is now over 80. Michael Rachlis, a prominent health researcher and medical doctor, summarizes what has changed: "Today, our main health problems are chronic diseases in an aging population."

Chronic diseases cannot be cured but often can be prevented. Our current healthcare system does not emphasize disease prevention and promotion of healthy lifestyles. As Rachlis says, "Some of these problems could be ameliorated if clients had access to a high-functioning team of professionals instead of the more typical focus on one doctor."

This is where Copeman and phase two Medicare come together. Both argue for comprehensive and integrative preventive healthcare. Living healthily through exercise, good nutrition and weight control may prevent most current age-related chronic diseases. This is the professed belief of the Copeman Centre, the expectation of the proponents of phase two Medicare, and the hope of health ministries everywhere.

Seniors (those age 65 and older) now comprise 10 per cent of the population in Alberta. This percentage will rise to 15 per cent in the next 10 years and 20 per cent over the next 20 years. Healthcare use rises with age. If nothing changes in the delivery of healthcare, the increase in the proportion of the population in the senior group will mean expenditures on healthcare will increase faster than the population at large and faster than expenditures in the rest of the public sector. Using the current cost projections based on estimated age-related costs, a doubling of the seniors cohort would raise the average cost 30 per cent, from $3,000 to $4,000 per capita in 20

PHOTOS: SUZY THOMPSON

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years. However, if seniors' healthcare needs diminish through "healthy aging," cost escalations could be reduced or avoided altogether.

Can we afford the investment in the short term for better health? The Alberta government is obsessed with the affordability or sustainability of the publicly funded part of the health system. The Alberta Health & Wellness Business Plan 2008–11 states: "Alberta's publicly funded health system has grown steadily over the last 50 years. The range of services and benefits covered by the system and the rate of cost escalation jeopardize the continued viability and affordability of the system. The ministry's budget now represents more than one-third of all provincial program spending. As new healthcare needs and expectations emerge, the cost of meeting them threatens the ability of the province to address and fund its other obligations and priorities. In the health system context, sustainability is about finding the right balance between the needs of Albertans and our funding capacity. However we describe it, there is no question that long-term sustainability is a major challenge of Alberta's publicly funded health system."

Reducing public expenditure on health will not make the costs go away. It will shift costs to private, personal out-of-pocket expenses (for those who can afford it) and private insurance (for those who have it). And it will push costs onto families, increasing stress on caregivers, increasing workplace absenteeism and reducing productivity and GDP.

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HEALTHCARE SHOULD BE PROVIDED PUBLICLY for both equity and efficiency reasons. An extensive literature supports the tenet that the most efficient and equitable way to deliver healthcare is through the principles of Medicare. The real political question should be how much we need to spend to assure healthy Albertans now and for the future.

Alberta can easily afford spending on public healthcare. In gross domestic product (GDP) terms, Alberta public healthcare spending is low by any comparison—approximately 4 per cent, a fraction of the Canadian average. Alberta has posted 12 straight budget surpluses in the billions of dollars. With no provincial sales tax and low income taxes, we have exceptional tax room if we wished to use it. The Ralph Klein era (1993–2006) saw the diminishing of the public-sector share of the economy from 21 per cent of GDP in the early 1990s to 12.5 per cent in 2007. This is a phenomenal reduction in the public sector. None of these statistics tells us whether we are spending too much or too little on healthcare, nor whether we're spending it efficiently. It does tell us, however, that healthcare spending in Alberta is very much affordable and sustainable.

Klein's efforts resulted in increased inefficiencies in healthcare, overextended healthcare workers and demolished or privatized public assets (including the implosion of Calgary's General Hospital in 1997 and the sale of the Holy Cross Hospital to private interests in 1998). Will the Stelmach era be different? This year's Alberta Health & Wellness budget announced a 9 per cent increase in spending that will "address population growth pressures and workforce challenges and, at the same time, support the improved efficiency of health system services and operations." The Health & Wellness budget will grow to $13.2-billion in 2008–09, up $1.1-billion, or 9.1 per cent, over last year. Additionally, the 2008–11 capital plan will support $3.3-billion in health commitments, an increase of $294-million over the previous plan. Of this increase, $151-million is designated for capital maintenance and renewal projects, including construction of more than 600 new and 200 replacement long-term care beds. The government also needs to address ways to promote and improve health in a cost-effective way.

If the Copeman approach is good healthcare, we need to implement it publicly. Most Albertans can't afford fees for a Copeman-style, for-profit practice—even if it provides better healthcare. Copeman as a for-profit healthcare venture raises concerns about an eventual two-tier health model in which the rich receive a far higher standard of care than middle- and low-income Albertans. However, Copeman has at least served to clearly demonstrate to the Alberta government what it should do: build more comprehensive community health facilities, hire the managers, medical practitioners and other professionals needed to implement the primary care network model in this way, an approach people understand. That Copeman can set up a profitable practice of integrative and preventive health means people want this approach and don't see it happening in the public sector. If we'd even partially developed this health centre model years ago, Copeman would likely not have had an opportunity to enter the healthcare field in Alberta.

Healthcare spending is a public choice, and we've a right, even a duty, to discuss how much is appropriate. Truly, we've no excuse to build anything less than the best healthcare model we can—nothing else is so important. ■

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