Medicare: Phase Two

A Conference with the Answers.

By GREG FLANAGAN

I ATTENDED A GREAT CONFERENCE in Regina in early May: "SOS Medicare 2: Looking Forward." This was a most exciting, invigorating and informative conference, one of the best I have attended. Over 650 people and more than 40 presenters, including most of the greats in health care, participated. Many academics, analysts, activists and politicians were present; one thing that made this conference so vital and significant, however, was the large number of health-care practitioners participating.

The Canadian Health Coalition, founded at the first SOS Medicare Conference in November 1979 in Ottawa, sponsored this second conference along with 40 other organizations. The original conference addressed the threats to the Canadian medicare system at that time; this one was mounted to address a new threat: growing pressure to undermine Canada's medicare system and move it toward a two-tier or US-style system. I will outline some of the highlights, but can't do justice to the enormous value of each presentation. Fortunately, the entire proceedings can be viewed or ordered in print at www.healthcoalition.ca/SOS2.html.

Spirit of Tommy Douglas

THE SPIRIT OF TOMMY DOUGLAS was certainly present. His daughter, Shirley Douglas, opened the conference by awarding "Spirit of Tommy Douglas" awards to Jim MacDonald, Heather Smith, Roy Romanow and Arnold Relman. She also warned of the grave threats to Canada's health care, reminding us, for example, that Prime Minister Stephen Harper spent years at the helm of the National Citizens Coalition, which was initially founded with the sole purpose of stopping Saskatchewan from achieving public health care.

Video footage was shown of Tommy Douglas's address to the 1979 conference, in which he outlined two phases of medicare. Phase One aimed to remove the financial barriers to receiving medical care. Phase Two was to be much more difficult: reducing costs through group practice, community clinics and other means, thus focusing health care on preventive medicine. Only then would the medicare ideal be achieved: that individuals, free from fear of the financial burden, achieve maximum good health, and that when their good health is diminished they receive remedial action.

The first keynote speaker, Greg Marchildon, is a former executive director of the Romanow Commission. He called on participants to realize Tommy Douglas's vision: "Idealism—dream no little dreams. Prairie pragmatism—work with what you have. Tenacity—act regardless of the means."

Global Comparisons

LESSONS FROM TAIWAN, the UK and the US were discussed in the second session, along with the health-policy implications of trade agreements. The strengths of a single-payer, egalitarian system were contrasted to the inefficiency of the alternative "market" private insurance system in place in the US. It was noted that Canada spends only 52 per cent (~8 per cent of GDP) of what Americans spend (~16 per cent of GDP) per capita on health care, and 45 million Americans are uninsured! We were asked to imagine what Canada might *not* have if it had spent this amount of its GDP. Anyone interested in efficiency should check out the keynote presentation by Uwe Reinhardt. The ridiculous complexity of the US system is truly amazing. "Beware of the US Trojan Horse bearing 'market efficiency,'" he warned.

The panellists contributed to this theme. May Tsung-Mei Cheng outlined the administrative and economic efficiencies of single-payer systems, specifically Taiwan's, which is government-financed and comprehensive, covering drugs, dental, vision and traditional Chinese medicine in addition to hospital and physician services, all for only 6.16 per cent of GDP. As Cheng noted, "good decisions by a single payer have immediate system-wide effects." Alan Maynard, from the UK, called for evidence-based analysis research of outcomes, and gave examples of health-care practices that continue to be done badly. His point is important: we must use evidence to promote what we value. For example, he cited evidence that private insurance co-payments drive out the aged, poor and sick from the system. Is this want we want? Arnold Relman cautioned that the delivery system matters. The US system of profit changes the philosophy and motivation in medicine. "Do not let investors into health-care supply," he admonished. Marcia Angell discussed the drug oligopoly, the sole objective of which is to maximize profits. Prices are unrestricted in the US and profits are huge. These firms argue that large profits are necessary for R&D, but they spend far less than half on R&D what they spend on marketing, creating demand for marginally useful and questionable drugs. Angell beseeched Canada to seek a national pharmacare program. Scott Sinclair brought cautionary tales with regard to the potential for NAFTA to be invoked if private medicine provision continues to increase.

Medicare *Is* Sustainable

IN THE THIRD SESSION, Robert Evans made the critical point that sustainability relates to whether the people of

a nation can afford a given level of services. The relevant ratios are: debt to GDP, health-care expenditure to GDP, and health-care expenditure to real dollar expenditure per capita. Canada is in the best fiscal shape of all the G8 nations. Our debt-to-GDP ratio peaked in the early 1990s and has steadily declined. Our health-care-expenditure-to-GDP ratio was climbing steadily, in step with that of the US, before medicare was introduced. Subsequently, though, it has been more in line with European and other developed nations (~8 per cent) while the US ratio has continued upward and is currently at about 16 per cent.

The widely reported steady climb (what Evans termed the "Klein line") in health care as a percentage of total government expenditures does not necessarily mean health-care expenditures are growing. Other government expenditures have been falling and tax cuts are undermining total budget revenue. And although it is true that total health care is rising in per capita real dollars, the costs of government universal programs are relatively steady. It is the dramatic increase in privately funded drug costs that is primarily responsible for this increase. Evans underlined that none of this analysis tells us whether we are spending too much or too little, nor whether we are spending it efficiently.

What Needs to Be Done

SESSION FOUR MOVED THE DISCUSSION more to the heart of the matter: the future necessary reforms to medicare—pharmacare, home care and primary care. Michael Rachlis made an excellent summary of the changes needed to fulfill the dream of Phase Two medicare: publicly funded universal services without user payments; integration of health care delivery through local regions; comprehensive care including physicians, hospitals, diagnostic services and dentistry; group practice involving teams of doctors, nurses and social workers; democratic community governance; locally elected health boards.

The extremely important field of the social determinants of health was introduced in session five by several notable speakers, including Monique Bégin.

A proper discussion of this perspective would require a major article in itself. Suffice it to say here that an individual's health depends on a host of social, environmental and equity factors that can be affected by public policy. We need greater synthesis and integration of all social policy, with equity at the forefront.

In the final session, Roy Romanow, chair of the Commission on the Future of Health Care in Canada, gave a passionate call for action. Five years ago, the commission's final report articulated Tommy Douglas's vision for the future of health care in Canada this way: "We must transform our health-care 'system' from one in which a multitude of participants, working in silos, focus primarily on managing illness, to one

Linda Silas, Monique Bégin, Shirley Douglas and Kathleen Connors at the SOS Medicare 2 Conference in Regina.

in which they work collaboratively to deliver a seamless, integrated array of services to Canadians, from prevention and promotion to primary care, to hospital, community, mental health, home and end-of-life care."

Romanow noted that at least 85 per cent of Canadians value greatly our egalitarian health care system. We need to get going on this program.

He emphasized that universal health care is not just about efficiency; it is central to our national narrative of fairness and compassion. We need to capture the moral and political strength to build a progressive nation.

Summary

THIS CONFERENCE WAS EXTREMELY IMPORTANT for at least four reasons. It called for renewed solidarity against those looking to undermine the considerable success of Canadian Medicare. It debunked the myth of out-of-control and unsustainable spending on health care in Canada. It re-emphasized the need for integration of health services and a focus on health, well-being and prevention, rather than the current emphasis on the treatment of sickness. And it confirmed that the knowledge is in place—it's time to get on with the program of reform; many Phase Two experiments are already in place across the nation.

The conference theme can be summarized in the words of Bruce Campbell: "Protect it, expand it, renew it, but do not neglect or dismantle it." ■

Greg Flanagan will assess Alberta's health care using the Phase Two framework in the November 2008 issue of Alberta Views.

PHOTO COURTESY OF UNITED NURSES OF ALBERTA