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Health Care Guarantees under Canada's Medicare Plan

by John Have

Waiting lists for some medical procedures have become the norm in most public health insurance plans in the Western world. Aging populations, availability of many new and effective medical procedures along with patient expectations has demand increasing faster than the capacity growth of medical resources.

During the recent Canadian federal election, the two main political parties both promised health care guarantees, as to maximum wait times, for five key medical procedures (cancer care, cardiac care, sight restoration, diagnostic imaging and joint replacements).

Canadian Medicare

The federal government provides partial funding and oversight of the overall Canadian Medicare plan under the Canada Health Act. Each province has developed its own Medicare plan that must cover at least core medically necessary physician and hospital procedures on a reasonable access basis. Those core services must be entirely publicly funded and patients are not allowed to pay directly for them. This prohibition is felt to be necessary to protect the public plan by avoiding shifting of health care resources to private care.

A central concept in the Health Act is that relative medical necessity, rather than ability to pay, should determine access to the health care system.

Most physicians operate out of small private clinics and are paid on a per-service basis based on fixed and negotiated provincial fee schedules. And with very few exceptions, Canadian hospitals are public and operate primarily on preset annual budgets. Usually, no private clinics are allowed to compete for core services provided by hospitals.

This effectively means that the public Medicare plan has a monopoly on the delivery of core medical services. However, with that monopoly position comes accountability and performance—the key issues in the recent Chaoulli Supreme Court case.

Chaoulli Supreme Court Decision[1]

Dr. Chaoulli and his patient Mr. Zeliotis launched a legal challenge against the Canadian and Quebec governments after Mr. Zeliotis was forced to spend a year on a waiting list for a hip replacement in 1997 because he was prevented from paying directly to get faster service. His doctor, Dr. Chaoulli, had also long argued for the right to set up his own private medical business. Failing to get relief in lower courts, they asked the Supreme Court of Canada to hear their case, and in 2004 their case was heard.

Chaoulli argued that Quebec's ban on buying private health insurance to cover, or for Mr. Zeliotis to pay for directly, services insured under the Quebec Hospital and Health Insurance Acts ran afoul of the Canadian Charter of Rights and Freedoms as well as the Quebec Charter. Quebec's and Canada's attorney generals argued that such violations were justified under the charters since both charters place limitations on those same rights for the common good and public order of all its citizens in a free and democratic society.

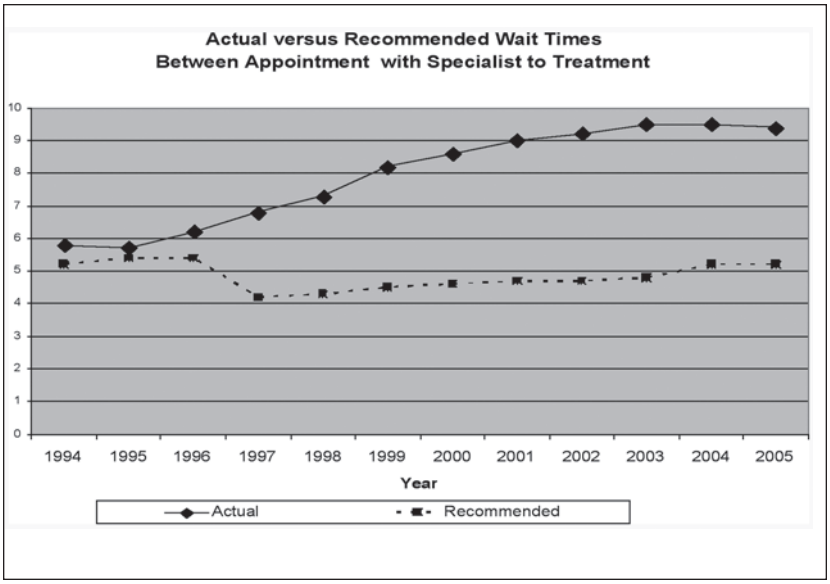
In the summer of 2005, the Supreme Court found that the prohibition against private health insurance violated Mr. Zeliotis's right to life and to personal security under the Quebec Charter.

In essence, no public, social or health program can have a monopoly unless the government is prepared to deliver. And secondly, if it can't

perform, it can't limit a person's right to solve the problem with that person's own money. While the decision was specific to the province of Quebec, political practicality means that it really applies across Canada.

Wait Times for Medical Procedures

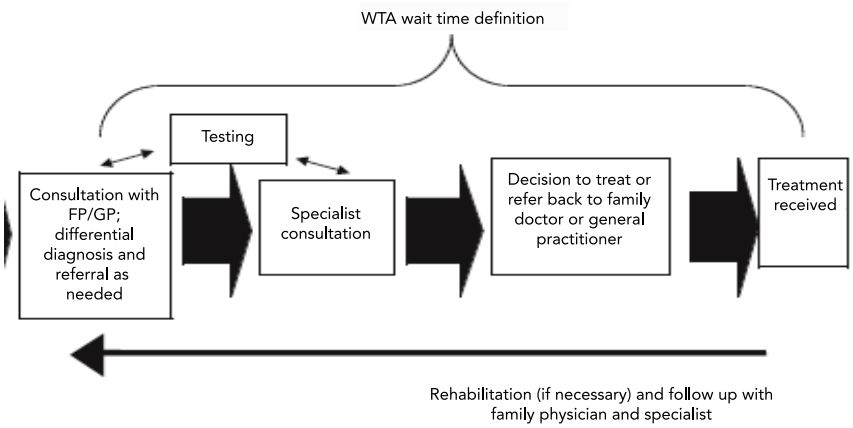
Even before Chaoulli, wait times had been identified as a serious problem in Canada as seen in the accompanying chart taken from a 2005 Fraser Institute report.[2]



At the September 2004 First Ministers Conference (prime minister together with all provincial premiers), reducing wait times was identified as a Medicare priority. Since then, a number of initiatives and studies have been launched to recommend wait time benchmarks. However, in order to set benchmarks one needs to define wait times.

When does a wait time begin? The Wait Time Alliance (WTA)[3] has recommended that wait time be defined as shown in the chart to the right. The WTA is comprised of the Canadian Medical Association (CMA) along with Canadian medical specialists associations.

Others, typically governments, start the wait time clock once a specialist has made a recommendation for a specific medical treatment. This choice is easier to track and measure because one just links the last specialist appointment with the procedure.



The WTA concluded in its 2005 report[2] that wait time benchmarks must:

- be fair, equitable and transparent from a patient's perspective,
- be based on best available medical evidence along with clinical consensus,
- be dynamic and evolve to recognize new technologies,
- recognize different needs and capacities by province,
- be sustainable and not be achieved at the expense of reduced access to other health care services.

The WTA developed wait time benchmarks according to three urgency categories:

- **Emergency** – immediate danger to life, limb or organ,
- **Urgent** – situation that is unstable and has potential to deteriorate quickly into emergency admission to a hospital,
- **Scheduled (or elective)** – situation with minimal pain, dysfunction or disability.

While the clinical evidence on wait times is still quite limited, the WTA recommended benchmarks for radiology, nuclear medicine, joint replacement, cancer care and cardiac care. The emergency wait times are all within 24 hours.

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Factors Affecting Wait Times

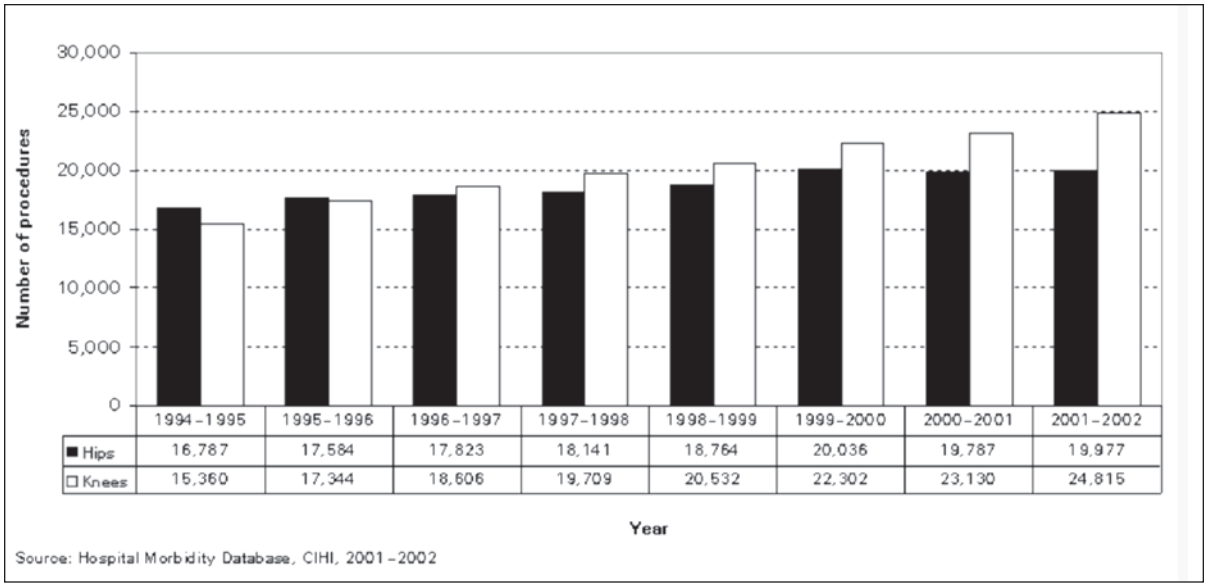
According to the Institute for Clinical Evaluation Sciences (ICES)[4] in its second 2005 report, measuring wait times can be tricky, particularly for one patient, because many factors may affect wait times for a surgical procedure or diagnostic exams that are unrelated to the efficiency of a particular hospital, a particular surgeon, or the availability of resources. At this point in time, there is no way to capture all of these potential factors in the information that hospitals are currently measuring. Although these factors (see below) may have significant impact on the wait time for an individual patient, overall wait times are still a good reflection of the current situation for a typical patient at that hospital.

- **Patient Choice –** a patient with a non-life threatening condition may choose to delay treatment for personal or family reasons to a more convenient time.
- **Patient Condition –** treatment may be delayed until a patient's condition improves sufficiently that surgery or an exam can be performed.
- **Follow-up Care –** a patient with an existing condition may be pre-booked for a follow-up treatment or exam a long time in advance.
- **Treatment Complexity –** specific resources may be required for a patient with special requirements, resulting in a delay until these can be scheduled.

Joint Replacements

In order to understand the magnitude of the wait time issue, I will now focus on total hip and knee replacements—the source of the Chaoulli decision. Here, the number of completed joint replacements has increased significantly over the last few years (see chart below), but is still not fast enough to keep up with demand.

Chart 1: Number of Total Hip and Knee Replacement Procedures Performed in Canada (1994-1995 to 2001-2002)



	1994-1995	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002
■ Hips	16,787	17,584	17,823	18,141	18,764	20,036	19,787	19,977
□ Knees	15,360	17,344	18,606	19,709	20,532	22,302	23,130	24,815

Table 1: Number and Distribution of Total Hip Replacement Procedures by Age Group and Sex in Canada (2001-2002 compared to 1994-1995)

	Males			Females		
Age Group	1994-1995	2001-2002	7-year % change	1994-1995	2001-2002	7-year % change
<45 years	489	553	13.1%	475	484	1.9%
45-54 years	716	1,055	47.3%	630	943	49.7%
55-64 years	1,609	1,753	8.9%	1,659	1,966	18.5%
65-74 years	2,475	2,789	13.1%	3,746	3,748	0.1%
75-84 years	1,470	1,976	34.4%	2,798	3,547	26.8%
85+ years	194	315	62.4%	526	839	59.5%
Total	**6,953**	**8,450**	**21.5%**	**9,834**	**11,527**	**17.2%**

Source: Hospital Morbidity Database, CIHI

Table 2: Number and Distribution of Total Knee Replacement Procedures by Age Group and Sex in Canada (2001-2002 compared to 1994-1995)

	Males			Females		
Age Group	1994-1995	2001-2002	7-year % change	1994-1995	2001-2002	7-year % change
<45 years	104	136	30.8%	155	206	32.9%
45-54 years	282	648	129.8%	397	1,067	168.8%
55-64 years	1,292	2,181	68.8%	1,684	3,030	79.9%
65-74 years	2,754	4,008	45.5%	4,170	5,884	41.1%
75-84 years	1,564	2,559	63.6%	2,597	4,321	66.4%
85+ years	117	261	123.1%	244	514	110.7%
Total	**6,113**	**9,793**	**60.2%**	**9,247**	**15,022**	**62.5%**

Source: Hospital Morbidity Database, CIHI

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Chart 1: Obesity rates, by age group, household population aged 18 or older, Canada excluding territories (1978, 1979 and 2004)

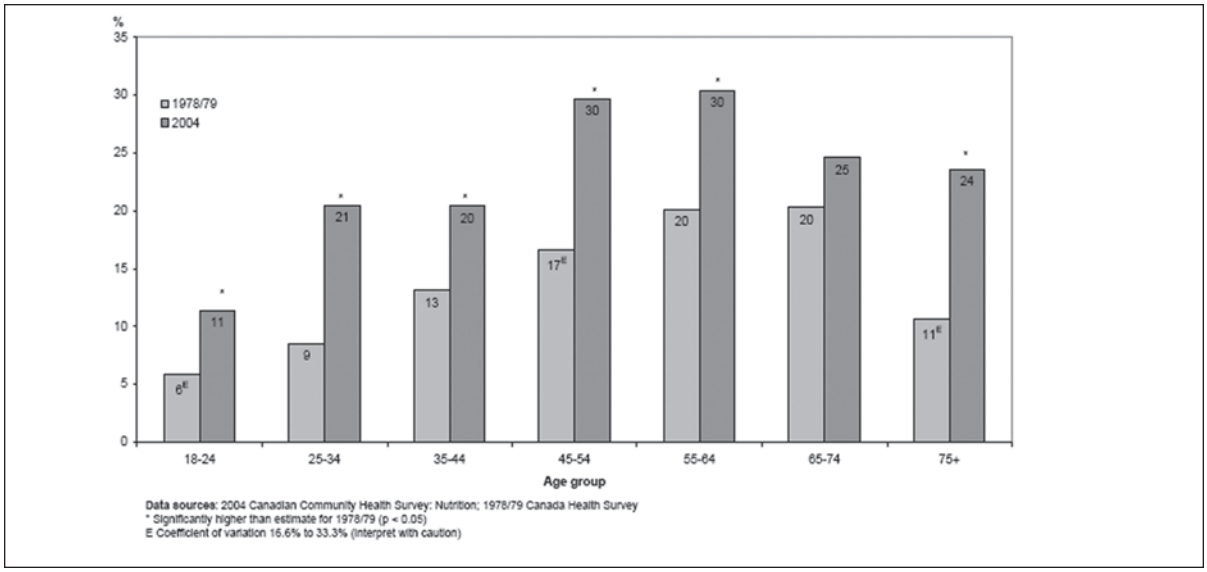
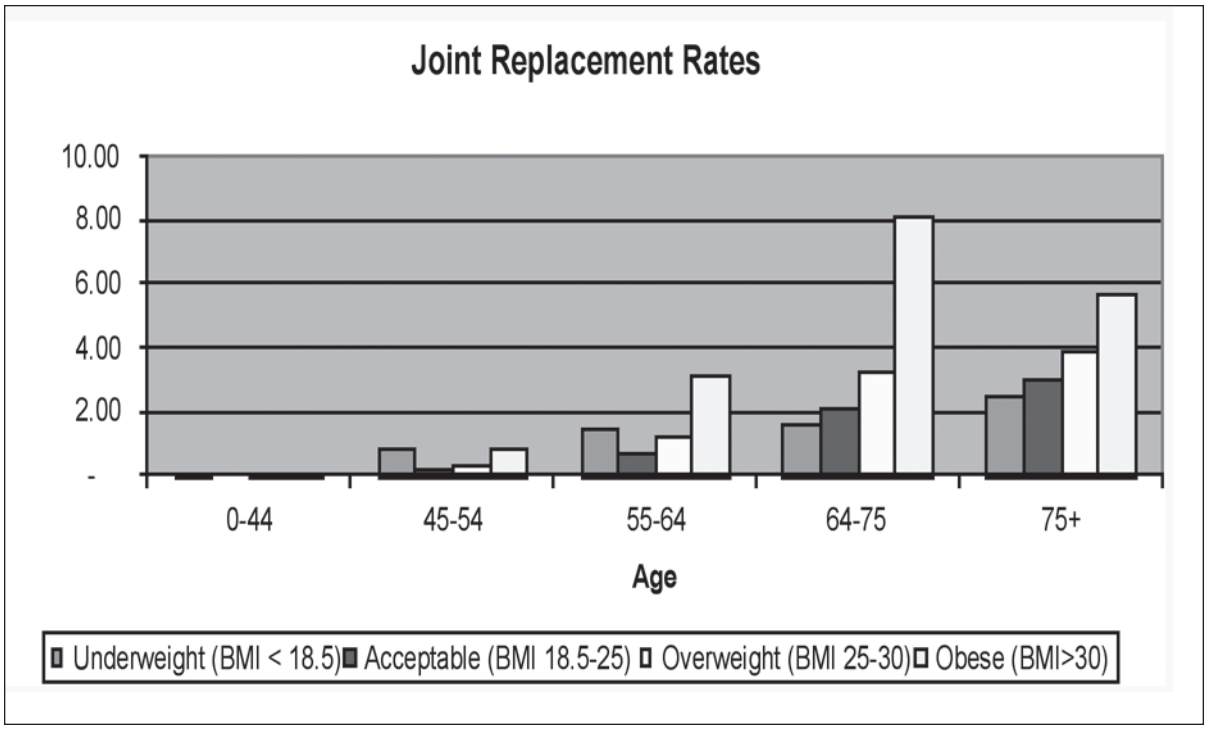


Chart 2: Joint Replacement Rates – By Age and BMI Index – Stats Canada 2004



According to the Fraser Institute[2], the median wait time to see an orthopaedic specialist has increased from four weeks in 1980 to 12.5 weeks in 2005. In addition, the median wait time for the operation has increased from eight weeks to 30 weeks. In total, wait time has increased from 12 weeks to 42.5 weeks, compared with a median acceptable wait time of about 20 weeks.

Increases in number of hip and knee replacements are caused by a number of factors aside from an increasing and aging population:

- Availability of new and improved medical technology, thereby increasing number of effective procedures. The large increases in procedures in age groups 45-54 and over age 75 bear this out (see Tables 1 and 2).
- Significant increases in Canadians' average body mass index (BMI) (see Chart 1) since, aside from age, the need for joint replacements is highly correlated with someone's BMI (see Charts 2 and 3).
- Increasing patient awareness and expectation.

The WTA recommended wait time benchmarks according to a severity rating that can be applied on a universal and objective basis by assigning a priority score to each patient within a patient wait list. Emergency cases (see categories define above) would be treated within 24 hours while urgent cases would be treated within 30 to 90 days, depending on whether the situation could deteriorate quickly or the patient just has some pain and disability but is unlikely to deteriorate. Scheduled (elective) wait time benchmarks were set at three months for consultation plus six months for treatment.

In setting those wait time benchmarks, the WTA[2] reviewed similar benchmarks in other public health care plans in the Sweden, New Zealand, Finland, Spain, Australia and United Kingdom.

Next Steps

With the Canadian federal election over, it is now time to implement the promised health care guarantees. In essence, maximum wait times would be set for the five medical procedure categories identified above. Once those wait times are exceeded, Medicare would pay all expenses, including travel, for the patient to have the medical procedure performed immediately in another province or country, if necessary.

At time of writing this article, Quebec, Alberta and British Columbia all have proposals for public comment and the federal government is developing its own position. Key issues are funding of the guarantees and the possibility of allowing private specialty clinics to perform joint replacements, normally only permitted in hospitals, thereby avoiding the extra costs of sending patients outside Canada for treatment.

References

1 Chaoulli v. Quebec (Attorney General) 2005 SCC 35.

2 Waiting Your Turn: Hospital Waiting Lists in Canada, 15th Edition. Fraser Institute, October 2005.

3 It's about time! Achieving benchmarks and best practices in wait time management, Canadian Medical Association, August 2005.

4 Access to Health Services in Ontario—ICES Atlas, Institute of Clinical Evaluation Services, April 2005.

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