Delivering on the promise of Medicare

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Among the many roles we play as family doctors is the role of change agents at the level of the health care system.* This involves moving from what the great Ian McWhinney called *the territory,* where we walk with our individual patients, up to the level of *the map,* where system thinkers reside.[1]

While our role in the territory is profoundly important, there is magic in what can be done for the health of our communities if we get the map right. And it has always been my view that, as physicians, we are uniquely positioned to drive system change—for 2 important reasons.

The first is that we understand evidence. We are not afraid of graphs and spreadsheets. Just as we can critically appraise the evidence for and against prostate-specific antigen screening tests, we can understand the data on whether centralized intake for wait lists really works. But that is not all. As front-line clinicians, family physicians see the human effects of big problems on our patients every day. We understand why the promise of Medicare matters to real people. We can function as translators between the territory and the map.

I want to reflect on the ways in which we as family physicians, and as Canadians, can live up to the promise of the map of Canada's most cherished social program: Medicare.

So what exactly is the promise of Medicare? The obvious answer is that the promise is one of living up to our values, specifically the value of equity of access to health care services. Put simply: Canadians believe that access to health care should be based on need rather than ability to pay.

But Medicare binds us together in more ways than just by delivering health outcomes: it strengthens our economy; it improves our social stability; and it gives us an example we can point to of what our nation stands for. From coast to coast, as Canadian Doctors for Medicare have said, it is seen as "the highest expression of Canadians caring for one another."[2]

To me, that is the dual promise of Medicare. To deliver accessible, high-quality services in an equitable way, and to give us something to be proud of.

This means that when we think about improving Medicare, we need to think not only about improving the delivery of health care services—which is hard enough—but also about what is needed to make a social program worthy of iconic status.

That is a high bar to set, but if we choose improvements that are grounded in our values and informed by the best available evidence, I believe we can meet the challenge. I want to share with you 3 big ideas that can help us to fulfil that dual promise, and reflect on how we as family physicians can help to advance them.

Taking stock

Before we get to the big ideas, let's begin by taking stock. I want to look briefly at 3 critical dimensions of Canadian Medicare—cost, quality, and access—and point out some important realities that frame what we need to do.

Cost. We spend a lot of money on health care in Canada, as do all developed nations. In 2013 we spent 11.2% of our gross domestic product on health care services,[3] which puts us in line with other Organisation for Economic Co-operation and Development nations, but still in the top third.

But unlike most of our comparator countries, the proportion of that spending that is *public* is near the bottom. For every dollar we spend on health care in Canada, 70 cents is public. In France that number is 77. In Norway it is 86.[3]

We spend a lot of money on private insurance and out-of-pocket services that are not covered by Medicare, such as prescription medications and dental care—and those numbers are increasing.

Quality. What we spend might not matter so much if we are getting good value for money. And on many measures of health and health care *quality*, we do reasonably well. Canadians report very high levels of satisfaction with the quality of our health care, with 76% of us giving "good" or "very good" ratings to the health care our families receive.[4]

And our health outcomes reinforce that perception. The average Canadian's life expectancy is 81 years, 1 year ahead of the Organisation for Economic Co-operation and Development average, and our infant mortality rates are lower than the average. We rank fourth out of 16 peer countries on mortality due to

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circulatory diseases, which are the number one cause of death in Canada.[5]

But while all of this is terrific, there are areas where quality needs to improve. Last year a Commonwealth Fund survey of 11 countries placed us second to last both for overall health ranking as well as for primary care performance.[6]

One reason we rank so poorly is lack of coordination. Too often, sick Canadians cycle in and out of hospital, receiving treatment from different providers who do not communicate. And nearly half of sicker Canadians report that their most recent visit to an emergency department could have been at their usual place of care had it been available. Food for thought for us as primary care providers.

Access. But of course the controversy in Canada about whether Medicare delivers the goods is not really about quality—it is about *access*. Our system does a terrific job of delivering when people are seriously ill, and most of us are prepared to accept some amount of waiting in a system where we know that everyone has access. But as family physicians, every day we see patients in our offices who are waiting—for specialist appointments, for diagnostic imaging, for surgery, and even to see us.

So in the areas of cost, quality, and access the evidence is clear: while we have much to be proud of, there is clearly work to be done.

Big ideas

In scanning the policy environment, I see 3 big ideas out there that would truly raise the bar for the health of Canadians in the next decade and help us address the challenges of cost, quality, and access. They are not my own ideas. But they are well formulated, they are based on good evidence, and, in my view, they meet the key tests for delivering on the promise of Medicare. They would improve equity of health outcomes. And they are worthy of an iconic program. These are big ideas that have the power to excite people about what it means to be Canadian.

And so, with gratitude to the innovative thinkers who continue to develop new ways to improve our system, I want to dedicate these 3 big ideas to 3 Canadian patients, because I think it is important that we remember who we are in this for.

1. Twenty drugs to save a nation. I am sad to say we do not only need to look south of the border to find health care that is inequitable, costly, and inefficient. An honest assessment of our approach to paying for prescription medications in Canada reveals a sorry state of affairs.

At the time that Medicare was developed in the 1950s and 1960s, the bulk of health care was provided by physicians and in hospitals. That meant that our public health care system covered nearly all drugs, as medicines were, back then, largely provided through and in hospitals.

Today our systems are rapidly transforming to meet the needs of an aging population that is living longer with chronic disease. And one of the mainstays of treating many chronic diseases is prescription drugs.

Canada is the only developed country with universal health insurance that does not include prescription drugs. Our drug coverage today is managed through a dizzying patchwork of private and public payers working at odds with one another, and not in the interest of patients.

That patchwork has meant profound regional inequality: A patient with congestive heart failure might face out-of-pocket costs for prescriptions varying between $74 and $1332 depending on which province she calls home—or $0 if she has good private coverage.

And it has meant inequity across income levels, too. The shameful reality is that 1 in 10 Canadians does not fill prescriptions or take medication as prescribed because they simply cannot afford to.[7] You and I know these patients well because we see them every day.

So I am dedicating idea number 1 to a long-standing patient in my own practice, who we will call Ahmed. Ahmed is a taxi driver of South Asian heritage. He lives in downtown Toronto, Ont, with his wife and 3 beautiful kids, and he works long shifts behind the wheel, in spite of his university education and his perfect English.

Like so many taxi drivers, his genetic heritage and sedentary job have predisposed him to his current medical problems of diabetes, hypertension, and dyslipidemia. Although he and his wife are careful in their spending, he simply cannot support his family and pay for his medically necessary medications. And even if he could afford the deductible for Ontario's catastrophic drug plan, he cannot figure out how to navigate it.

So sometimes I do not see Ahmed for long periods of time, and when that happens I know it is because he is not taking his medication and does not want to disappoint me. I worry, as he does, about the complications he might experience in the coming decades, some of which could be devastating, such as coronary artery disease, visual impairment, and renal failure because he cannot both feed his family and buy his needed medicine.

The most obvious way to fix this problem would be to extend our public drug plans to all Canadians, just as we have done for physician and hospital care. But if we cannot summon the political will right now to cover all prescription medications, let's focus first on those with the biggest bang for the buck.

Let's choose 20 drugs—or 50, or 100—that are commonly used to control chronic disease like asthma,

diabetes, and hypertension. If we can agree nationally to go in together on public coverage for these medications, we can cover them for everyone, including Ahmed.

And, if we did this, we would actually end up spending *less* publicly than we currently do. There are 2 key reasons for this.

First, you may not realize that in Canada we pay much higher prices than many other health systems pay for their drugs, in particular generic drugs. If we could negotiate prices like those paid in other developed countries, we could easily cover the cost of 20 drugs to save a nation within our current public budgets.

For example, in Ontario we currently pay 31 cents a pill for atorvastatin. In New Zealand the price for the exact same pill is 2.6 cents. The price for 10 mg of ramipril is 19 cents here compared with a mere 6 cents in the publicly financed Veterans Health Administration in the United States.[8]

If we bargained more effectively, the prices we pay even for those drugs we already buy publicly—like for all seniors in many provinces—would go down.

Second, other systems achieve these huge savings by bulk buying their prescription drugs on a large scale. Just as we all know it is cheaper to buy toilet paper in bulk than 2 rolls at a time, it is similarly less expensive to buy our drugs together than separately. Between our public plans and private plans, right now we have literally dozens of purchasers in Canada. We would do much better with just one.

We all need to make it clear to our elected officials that we want to see it moved to the top of the priority list. If the family physicians of Canada were to throw our collective weight behind the movement for national pharmacare, even just for 20 drugs, I think we could have considerable influence.

2. Doing more with less. Reforming our public insurance to include medicines is something our public officials can do. But as front-line health care providers, we need to roll up our sleeves to work on idea number 2, a concept I am calling *doing more with less.*

Doing more with less is about improving access and reducing waits for health care by reorganizing the way services are delivered to people. It is not a single policy that can be implemented by passing a law. It represents a shift in our thinking, away from the presumption that the answer to our challenges in health care is always more—more money in the system, more doctors, more tests and procedures—an approach that has plagued the health care system for too long.

Instead, we need to take the resources available to us and start using them more intelligently. This means that where we struggle with access problems, we do not immediately try to train more doctors or buy more scanners. Instead we ask 2 thoughtful questions:

- Will everyone on the waiting list actually benefit from this intervention?
- Where is the bottleneck causing the wait and can we organize care better to improve the flow of patients through the system without spending more?

The question of whether the test or treatment will actually benefit the patient is one we all struggle with as primary care providers. To illustrate this principle, I want to tell you about a patient we will call Sam who came under the care of a cardiologist colleague of mine. Sam was a perfectly healthy man in his 60s. He did not smoke, drink, or take any medications, and in fact he was a world-ranked athlete in a competitive sport. As part of his compensation package at a fancy firm in downtown Toronto he went every year for an executive physical at a private clinic.

One year, in spite of the fact that he felt perfectly well, he was subjected to an exercise stress test "just in case." Some incidental potential abnormalities were identified. He ended up with an angiogram. Happily, the angiogram confirmed that Sam did not have coronary artery disease. But not before he suffered a stroke on the table, a known complication of the procedure that occurs in 1 in every 1000 cases. This healthy athlete will never play his sport again because he is paralyzed on one side of his body *as a direct result of a completely unnecessary and inappropriate test*.

When I tell Sam's story to friends and families outside the medical profession, I watch them struggle with the question, "But what if they had found something?" and wonder if the risks are not still worth it to pick up that 1 cancer or undiagnosed heart condition. But that is exactly the point. We need to stop thinking only about benefits and start talking about harm. As family physicians, we have a huge role to play in that conversation.

Millions of Canadians are harmed every year by inappropriate, wasteful, and harmful tests and prescriptions. And many of these are ordered with a stroke of the pen or the keyboard by well-meaning family doctors like us.

It is for this reason that, as many of you know, Canadian physicians—including family physicians—are following the lead of our American colleagues and have launched the national campaign Choosing Wisely Canada. As part of this campaign, our national specialty associations have acted to create "Top 5" lists of things physicians and patients should question. Choosing Wisely is one promising initiative, and other groups are beginning to do work on the same theme.

Mammography for young women, prostate-specific antigen testing for men not at risk, drugs meeting the Beers criteria for our elderly patients—we need to acknowledge as a profession that even good tests and drugs, when used on the wrong people or at the wrong interval, really harm people. And we need to start to wrestle with a culture change that does more

than just lay the responsibility on patients who read something on the Internet and ask for a given test or procedure. Instead we need to acknowledge the many complex reasons why we make those little choices in our own practices every day to tick that box or prescribe that antibiotic.

The second question we ask when we try to do more with less is whether the bottleneck causing the wait can be alleviated using creative approaches. What does that entail exactly?

We do more with less when we run our practices differently to give our patients the access they need without sacrificing quality.

Today, only 47% of Canadian family doctors report that their patients can get same day or next-day appointments.[9] But increasing numbers among us are turning to approaches like advanced access scheduling, group visits, telephone and e-mail visits, and of course working in teams with other skilled health care providers to improve both access and quality of care for our patients.

It is important to remember that the innovations we need in our system might not be high tech and sophisticated, and they might not always involve more. They can be as simple as a single telephone number when there used to be many, or as obvious as better use of teams so that surgeons are not the rate-limiting ingredient in access to care. As family doctors, we can individually make changes in our own practices that help the system to do more with less. Each of us could start tomorrow.

3. Basic income. This brings me to the last big idea, and to a patient in my practice we will call Leslie. Leslie suffers from severe asthma. She takes multiple puffers, has been on and off prednisone many times, has multiple specialists, and has been seen many times in her local emergency department.

Leslie's asthma started when the social housing unit she lives in had a flood. Mold grew inside the walls of the building, and Leslie's health began to deteriorate. She took photos of the mold and brought them to her landlord. Her doctors, including me, wrote letters of support begging them to find her another unit or another building to move into.

It took her, and us, 2 years to get the system to respond. During that period of time, her physical and mental health deteriorated. She became depressed. Her relationship fell apart. She wasn't able to hold down a steady job. She gained weight and her blood pressure worsened because she could not exercise owing to her breathing problems.

As my colleague Dr Ryan Meili would say, Leslie is not sick with asthma. She is sick with poverty. She is sick with a lack of access to appropriate housing, decent food, and the basic human dignity that comes along with being able to make the choices we all want to make to stay healthy.

This third idea is a proposal that can be explained without even a passing reference to health care. Yet, acting on it would do more to improve health than any single other policy we could support.

Decades of studies have demonstrated that, as important as health care is, the social determinants of health, like those that led to Leslie's illness, have a much more powerful effect on the most meaningful outcomes.

Low-income Canadians die younger and suffer more illnesses than Canadians with higher incomes, regardless of age, sex, race, and place of residence. No wonder Dr Gary Bloch from St Michael's Hospital in Toronto often quotes his patient who once told him "Doc, if you really want to make me better, get me more money."

And that is idea number 3: a basic income to bring all Canadians up to a decent standard of living.

Basic income is a well developed approach to reducing poverty by using the tax system. It is pretty simple. Every year you file your taxes. If you fall below a certain level, you get topped up to a level sufficient to meet basic needs. It is an alternative to existing costly and bureaucratic social assistance programs that would virtually eliminate poverty in Canada.

As Senator Hugh Segal has pointed out, this is not a radical policy. In 1975, in Ontario, we had a poverty rate among seniors of 35%, most of whom were women. The Davis government implemented a tax-based seniors' income top-up that then spread across the country and formed the basis of our current Old Age Security program. In 3 years the poverty rate among seniors went from 35% to 3%.[10] There are very few social policy decisions in our lifetimes that have had this kind of effect.

And there is pretty good evidence that a broader population-based basic income policy improves health. In Dauphin, Man, in the 1970s, a basic income supplement offered to all the eligible residents in a small town reduced hospitalization, particularly for admissions related to mental illness, accidents, and injuries.[11]

Part of what makes basic income tick is not simply the money in people's pockets. Income security also means that even those families that never collect a penny know that if they were to fall on hard times they would not lose everything, and this has positive health effects on the whole community.

In fact, basic income is very much like Medicare or any insurance policy. We all pay in. We all hope we will not have to use it. But if we do, there is no humiliating process of having to prove our worthiness in order to have our medical bills covered or put food on the table for our kids.

The same principles that led us to establish universal health insurance underpin basic income: administrative simplicity; risk pooling; and the belief that access to

some basic things should be automatic—a right of citizenship rather than an act of charity.

Given that the Manitoba experiment was nearly 40 years ago, it has been suggested by many experts that a series of pilots should take place across the country to figure out how to design the program for a 21st century Canada.

I am sure each of you could tell me a story of one of your own patients who is similar to Leslie, someone for whom our medical model can only do so much. I believe that collectively as family doctors we should do all we can to support a rigorous evaluation of basic income as a health intervention.

Thinking bigger

Each of you undoubtedly has strong views about what we should do to improve health for our patients, and there are hundreds of good ideas where these 3 came from. But I do think that the test for whether we focus on a particular solution should be the one I articulated at the outset: namely, that solutions should actually reinforce the value of equity and that they should be worthy of the enormous importance we place on our most cherished social program.

And when we set out to design those solutions, we should do so based on the best available evidence, unapologetically devoting time, energy, and resources to study the effects of our interventions in health care systems to learn whether they actually work.

As family doctors we are used to acting as advocates for our patients. Our relationship with them over time enables us to speak to the complex factors affecting their health, and our role as their "medical home" positions us to advance their interests within the health system. I want to challenge us to think bigger than that.

It is too easy to get caught in the trap of regarding the health system as a fixed reality outside our control, or as something to defend our patients from rather than engage with for the common good.

We have the skills to marshal the evidence and a deep understanding of the human side of health care policy. This positions us perfectly to drive system change for the better. So no more tinkering around the edges. Twenty drugs to save a nation. Doing more with less. Basic income. If we start moving to do these 3 things, we will see substantial improvements in the health of Canadians—Canadians like Ahmed, Sam, and Leslie, like you and me.

We need to take action worthy of Medicare. Let's go get started. We have a promise to keep.

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Competing interests

None declared

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