



Blueprint Response

I think most physicians recognize that there are serious issues confronting our health care system, as there have been in the past, and that hard work will be required to resolve them.

On Sunday, Canadian Doctors for Medicare joined Roy Romanow in hosting a celebration of the 25th Anniversary of the *Canada Health Act*, a bold piece of legislation that addressed what was then a serious challenge to the wellbeing of our health care system.

I appreciate the need to take bold steps to address new challenges now, and Canadian Doctors for Medicare would like to commend our Canadian Medical Association President on the hard work and long travels that went into the development of this Blueprint.

However, though his hard work is commendable, it certainly appears there is hard work still to be done.

In architecture, the virtue of a blueprint is it spells out all the details. Every inch of every aspect of the plan is in the blueprints. That tells you when some minor miscalculation means that something won't quite fit the way you planned. The plan our current Canadian Medical Association President has provided is more like a sketch. There are many ideas in it, some of them are good ideas, but many of them are so loosely described that it's hard to be sure if they fit in our current context, and hard to see the impact they will have.

There are some ideas in the Blueprint that obviously need to be adopted. On behalf of the Canadian Medical Association, Dr. Ouellet suggests measures to address the shortage of medical professionals and the need for action here is clear. We have, by all international standards, a shortage of doctors and other health care professionals and the system cannot work if it is under-staffed. There is an equally pressing need for our health care system to address homecare, community care and Pharmacare. There is widespread agreement in the medical profession and in the public that movement on these issues is needed.

However, in other areas, we should be very careful about moving forward with such a loose sketch, where the implications are less well known and the issues less well defined. We should be especially careful since many of the ideas are cherry-picked from European health systems where the context is very different.

It is worth noting, for example, that none of the European countries visited by Dr. Ouellet have the same shortage of medical professionals that we have. Nevertheless, Dr. Ouellet suggests increased competition between hospitals in our system. I think most of us know

intuitively that competition in the context of a shortage has a very different impact from competition where there is a surplus. Ignoring that difference in context can have dire consequences. Failing to precisely define how we will address those differences is risky at best. Moving forward before we have done so is ill advised.

Furthermore, a brief review of foreign cases can overlook details of significance. Though Dr. Ouellet and some managers of the UK's National Health Service have praised the role of competition in the UK medical system, British Medical Association Chair Hamish Meldrum has said that "we should be encouraging all parts of the service to work together and not compete with each other. There is no evidence that competition has driven up quality of care." Adopting these models without fully understanding their impact is not advisable. We should heed the advice of our physician colleagues who have lived through these changes in the UK and show caution. Similar problems affect many areas of the Blueprint. Dr. Ouellet argues for activity-based funding. This type of mechanism has worked well in some instances—for example to clear surgical backlogs. But this kind of mechanism can, in other instances, have a very different impact. Activity based funding has, for example, been used for diagnostic imaging in Ontario, and the wait lists have hardly budged, and there are indications that these changes have increased the number of unnecessary procedures. In the UK, where this kind of funding mechanism has been recently introduced on a large scale, costs have risen sharply and adverse impacts have been recorded. Some UK doctors report hospitals pressing them to increase referrals to drive up revenue, and some researchers suggest that some doctors are cherry-picking patients to gain credit for priority procedures without giving ready access to the patients with the most challenging needs.

It's easy to appreciate why Dr. Ouellet would look to Europe for guidance. We all know what Canadians think of American-style health care. If you think, as Dr. Ouellet says in the Blueprint, that Canadians are demanding "fundamental change" in their health care system, American examples will prove unwelcome and Europe is an obvious alternative source of data. However, the evidence is that Canadians are not seeking "fundamental change". Just this July a Harris-Decima Poll showed 70% think the system is working well and in particular, only 1 in 8 thinks we need more private care. There are many other polls, described in the materials circulated on Sunday, that show the trend is consistent and reliable, Canadians want the current health care system improved, not transformed.

Most medical professionals agree with the public on this matter. We know that our health care system needs to grow, change and improve. But making those changes should not mean that we abandon what we value about our system and make wholesale shifts to foreign models that might not work in Canada. No such changes should even be contemplated unless they show clear evidence that they will result in better care. To date, evidence-based approaches tend to point physicians toward accessible, universal, not-for-profit care and there is a significant burden of proof on those who make any other claim.

Our health care system was founded on innovations made right here in Saskatchewan. Wait times, the current lightning rod for controversy, are coming down in individual jurisdictions across the country because Canadian policymakers and health care

professionals are taking innovative steps to improve on what we have, instead of trying to start from scratch.

Canadian Doctors for Medicare believes that the way forward is to innovate within Medicare. Earlier this week we presented the Alternative Delivery Tool Kit, to help governments, medical professionals and the public assess new service delivery options to determine their impact on accessibility and on the strength of our health care system.

Tomorrow we will present new tools to help health care professionals pursue progressive health care reform. But our focus will be on Made in Canada solutions that reflect our real context and proven approaches in Canadian settings.

Building a better Medicare system should be based on a detailed and realistic understanding of the Canadian experience. Sketches for change should be seen for what they are - untested ideas that may or may not withstand scrutiny. Blueprints on the other hand can only be drawn up with a thorough understanding of the best available evidence and should reflect the values of those who must live with the consequences of what is built. Canadians want the right care, in the right place, at the right time. They are closer than most in achieving that. Casting aside the achievements of the last 30 years in favour of untried models may have consequences that are unanticipated, counterproductive and inequitable. This is neither timely nor wise.

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