Medicare reform

Some thoughts on medicare

Bob Rae

This is the sixth in a series of essays in which notable Canadians give their perspectives on the future of medicare. In the next issue Lloyd Axworthy and Jerry Spiegel consider the Canadian health care system as a global public good.

If access to quality health care is, as opinion polls keep telling us, the top political priority for Canadians, then our governments need to find a way to ensure that health care funding is guaranteed at an appropriate level without being subject to each new political whim. Over the last 10 years governments have changed spending patterns, have tried to tie funding to outcomes rather than allocating money unquestioningly, and still face the reality that a serious injection of new money into the health care system is required. All the while, the provincial and federal governments have fought with one another about who should be paying for what.

The "hospital and doctor" system is, by and large, insured by government. But care for elderly people is shared between government, private insurers and individuals. Home care is also a shared expense, but more and more of the burden is now falling on families. Drug costs, which were relatively small in the early years of medicare, are rising sharply, and government is paying a diminishing share of the bill. In the meantime, we are facing serious shortages and urban–rural disparities in our workforce of nurses and physicians, while many foreign-trained physicians are refused the opportunity to fill in the gap.

Manpower issues are at the core of our current problems with waiting lists and unacceptable delays in the provision of needed care. We need to allow more doctors educated outside of the country to practise here. We also need to make sure that nurse practitioners and others are allowed to do the work they've been trained to do. We need to train more professionals, and to stop turning the tap on and off again.

We do need stability in governance and funding. The role of government as payer and insurer needs to be clearly established in legislation that will resolve the disputes between the federal government and the provinces. Health care providers and institutions need to be able to escape the tyranny of an annual, last-minute, doling-out of funds. Our health care systems need stronger and more professional management mandated to respond to broad government policy. Accountability for the day-to-day operation of the system needs to be strengthened. We need to establish properly funded health care commissions at the federal and provincial levels to ensure standards of care, plan more effectively over the longer term, and undertake the regional and local reforms that are necessary.

We need a national drug plan to protect Canadians from the catastrophic costs of therapies that are increasingly seen as essential to medical care. I am immodest enough to think that the Ontario Trillium Plan, initiated in 1994, could serve as a basis for such a plan: it is not "free," yet it deals with a serious problem for many people. Many Canadians do not have access to any such plan and are facing serious financial difficulties as a result — or, even worse, are denying themselves necessary treatment because they simply cannot afford it. Moreover, because drugs are provided free to patients in hospital, there is a perverse incentive to keep people in hospital to allow them to receive drug therapy.

A national pharmacare plan would increase the clout of governments in their dealings with the drug industry. It would also eliminate the administrative costs involved in having 10 provinces run separate drug plans. The whole system could be linked to the income tax system, thereby ensuring that the maximum benefit would go to those who need it most.

It is important to be clear in our minds about the difference between the assurance of general access to a quality system and the need for greater imagination and entrepreneurship in the way that services are actually provided. The principle of universal access, the basis of the "medicare contract" that Canadians have come to expect, means making sure that no one is denied first-class treatment on the basis of income. It also requires agreement about which services to insure. But the manner in which services are actually provided involves a different set of concerns. The debate about how to deliver services most efficiently, with the lowest overhead and the maximum benefit to the client, is a debate that should be fuelled by facts more than by ideology.

To conclude, then, we need to encourage reforms that increase funding, ensure a stronger element of accountability and better management, deal with the absence of strong

support for home care and pharmaceuticals, and do all of these things in a practical way. It is a tall order, but it must be done, precisely because of my first point: this is too important to the Canadian people for us not to succeed.

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Competing interests: Mr. Rae is a partner in a law firm that acts for a number of companies with an interest in the health care field, as well as governments and professionals.

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Articles to date in this series

Lewis S. The bog, the fog, the future: 5 strategies for renewing federalism in health care. *CMAJ* 2002;166(11): 1421-2.

Maxwell J. Bringing values into health care reform. *CMAJ* 2002;166(12):1543-4.

Suzuki D. Expanding the health care debate. *CMAJ* 2002; 166(13):1678-9.

Bégin M. Renewing medicare. *CMAJ* 2002;167(1):46-7.

Wynne-Jones T. Whose health? Who cares? *CMAJ* 2002; 167(2):156-7.

Occasional essay

Patenting of genetic material: Are the benefits to society being realized?

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Patents represent a contract between an inventor and society. By granting time-limited market exclusivity, patents create the potential for inventors to generate high returns on successful innovations. In exchange, the inventor provides a complete description of the invention so that others may build on the technology to create improvements or other breakthrough discoveries. Patent protection of intellectual property is particularly important to inventors in the biotechnology field because of the relatively high fixed cost of research and the ease with which discoveries may be copied. By attracting investment capital for research, patent protection increases the pace of innovation, thus benefiting society.

To qualify for a patent, the invention must be deemed useful, novel and not obvious. The utility criterion requires that a clear application is known. Novelty means that the invention has not been described before in the literature. The criterion of non-obviousness demands creativity on the part of the inventor. For example, the courts in the United Kingdom have ruled, on the grounds of obviousness, that Pfizer's patent on the use of the entire drug class of phosphodiesterase-5 inhibitors for erectile dysfunction was invalid because the knowledge was already in the public domain when the patent was issued.[1]

Although contentious in principle, patenting of life forms is now well established in law. The landmark case identifying the patentability of life forms occurred in 1980, when the US Supreme Court ruled in a 5–4 decision that the genetic modification of a bacterium to break down oil spills was consistent with "a new composition of matter" as defined in the Patent Act of 1793.[2] This decision did not directly address the patentability of genes; however, the courts eventually reasoned that, if whole organisms were patentable, then their components would also be eligible for patent protection. Subsequently, the patenting of isolated gene sequences (but not the human genome) was permitted by the American and European patent offices, provided the applicant could demonstrate utility of the gene sequence. The Canadian Intellectual Property Office has recognized the patentability of isolated genetic sequences, and the status of patents for higher life forms (e.g., the Harvard oncomouse) is currently before the Supreme Court.[3] The Canadian Biotechnology Advisory Council has recently recommended that higher life forms (i.e., plants,