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Seminars in SPINE SURGERY

Spinal Care in a Single-Payer System: The Canadian Example

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This article provides a general understanding of the fundamental differences between the Canadian and United States health care systems and how they may relate to spine care. Issues regarding sustainability of either system are beyond the scope of this article. The Canadian perspective is presented in this article. These 2 systems are fundamentally different regarding universality and accessibility of health care coverage and delivery. Comparative studies for a variety of health states, including spinal disorders, do not show significant differences in outcomes between countries for those who are insured. Consequently, the pro's and con's of both systems are variable depending on the perspective taken.
Semin Spine Surg 24:117-122 © 2012 Elsevier Inc. All rights reserved.

KEYWORDS Canada, United States, health care system, spine, surgery, outcomes

The Canadian Health Care System

Where our health care systems are concerned, Canadians view their system's universality with great pride, whereas Americans boast instant gratification. Over the past 2 decades, an increasing number of studies have focused on exactly how the systems function relative to each other. Although it is beyond the scope of this article to present a detailed analysis, we aim to provide a general understanding of the fundamental differences between systems and how they may relate to spine care.

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General Background

The Medical Care Act (Medicare) of 1966 transitioned Canadian health care from a private to a publically funded system.[1] The act instilled the belief that all Canadians should be able to obtain health services of high quality according to their need for such services and irrespective of their ability to pay. This premise remains the primary foundation of Canadian health care. Since the Medicare act, the federal government has been responsible for establishing health care constitution, and the provinces have administered and delivered health care services and health insurance to their citizens. To improve provincial accountability, the Canada Health Act of 1984 established 5 fundamental criteria that had to be met for provinces to receive full federal funding—comprehensiveness, universality, portability, public administration, and accessibility.[1,2] From both public and professional perspectives, achievement of universality and accessibility is a source of significant debate.

Universality

Although universality is perhaps the greatest aspect of the Canadian system, what universality actually entails is subject to interpretation and debate. For example, the utopian definition would denote all individuals covered for all services. The reality is that Canada, and most industrialized countries, falls into 2 broad definitions of universality: all individuals are covered for some services or some individuals are covered for all services. The Canadian definition of universality is

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doi:10.1053/j.semss.2011.11.018

focused on insuring all people for a certain number of services that are deemed medically necessary. In contrast, the United States favors a more pluralistic approach where the majority of coverage is dependent on the individual's ability to pay for services, and thus, not all Americans have consistent health care coverage. Both nations rely largely on private funding to cover medications, and thus, the term "universal coverage" must be considered in appropriate context.

From a spine care perspective, under the context of medically necessary, all medical primary care, emergency room, specialist consultation, diagnostic test and imaging, and associated treatments (including surgery) as prescribed by a physician are covered. Coverage for allied health treatments (eg, physiotherapy or chiropractic care) occurs to varying degrees depending on the province. For example, in 2004-2005, because of budgetary constraints, the Ontario provincial government (representing one-third of the Canadian population) halted public coverage on all chiropractic care and limited public funding for community-based physiotherapy to selected populations (those >65 or <20 years of age; those on disability or social assistance programs; residents of long-term care facilities; and those returning to the community after discharge from an acute-care hospital). Patients with private supplemental health insurance (out-of-pocket or employment benefits), automobile insurance, and workers' compensation continue to be covered for these types of services. Comparatively, an individual in the United States may have insurance that ranges from comprehensive coverage of all medical and allied health services to no coverage other than what they can directly afford out-of-pocket and emergency services that are mandated by law.

Accessibility

Wait times for nonemergent health services are a major issue in Canada,[3-6] and the evidence on the number and lengths of significant wait times has the potential of moving the country closer to a 2-tiered system.[5] It should be noted that any system of health provision, even those funded directly by patients, can expect certain waiting times because of logistical circumstances, medical reasons, and general fluctuations in supply and demand. However, it is general consensus that wait times in Canada are well beyond the normal, expected levels and persist despite increases in health expenditures.[6,7] In 1993, Canadian patients waited on an average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment, a figure that had increased to 18.3 weeks by 2007.[4,7] Further, wait times in Canada are almost double the length that physicians consider clinically reasonable.[7]

Wait times for obtaining advanced diagnostic imaging, such as magnetic resonance imaging (MRI), and surgical services, such as total joint replacement or cataract surgery, have been particularly publicized.[8-10] At the beginning of the new millennium, the federal and provincial governments recognized that Canadians want a sustainable health care system that provides timely access to quality health services. They also identified that reform is essential and supported new public investments targeted to achieve this goal. In 2003, the First Ministers' Accord on Health Care Renewal was struck, and a commitment to achieve meaningful reductions in wait times in priority areas, such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration, was publicly made.[11] Since then, significant, and often dramatic, improvements have been made in accessibility in these 5 top priority areas. Furthermore, new opportunities for improved care in other areas continue to become available. Currently, the largest area of focus is in primary care reform. To date, from a spine perspective, the Accord has resulted in a progressive reduction in the wait times for nonemergent spinal MRI. For example, in Ontario, the mean wait time for an MRI in 2005 was 120 days, with a range of 28-365 days. This time has progressively trended down and is currently at 92 days, with a much narrower range of 58-119 days.[12] It is the opinion of the authors that although the system has improved in many aspects since the 2003 Accord, reform must continue in a wider variety of areas.

Wait times studies pertaining specifically to spine surgery are almost nonexistent; however, it is generally accepted amongst Canadian spine surgeons and relevant associations that the waits are significantly longer for elective spine surgical consultation and surgery in Canada than in the United States.[13-15] For example, as reported by Braybrooke et al[13], the mean wait time from a small cohort of patients accessing primary care health services to surgery for elective posterior lumbar surgery was 310 (±411) days with a median time of 196 days. The large standard deviation is due to the variable clinical presentation of patients, with spinal pathology that necessitates clinical triage and appropriate prioritization of spinal referrals (eg, those with or without neurology). For example, a patient with acute radiculopathy and nonprogressive weakness may access surgical consultation in <6-8 weeks, whereas a patient with back pain only may face waits of 1-2 years before seeing a surgeon. Braybrooke et al[13] reported a negative perception of the impact of waiting; however, this was correlated to only those who had a poor outcome after surgery. The impact of wait times has been extensively investigated for patients undergoing total joint hip and knee replacement.[16-23] Most studies in this population have demonstrated clinical deterioration, as measured by a variety of patient-reported outcome measures, particularly in those who wait >6 months before surgical intervention. Not much information exists regarding the presurgical impact of wait times on patients undergoing elective spine surgery. This issue presents a unique challenge in assessing common degenerative spine disorders amenable to surgical intervention. Unlike the poor natural history of end-stage hip or knee arthritis, the natural history of degenerative spinal disorders can be quite variable.[24-27] Recent work by the first author has attempted to assess this issue in an ongoing prospective spinal wait-times study.[28] Preliminary data on the first 187 enrolled patients with degenerative lumbar conditions (back and or leg symptoms due to disk herniation, stenosis, spondylolisthesis, degenerative disk) have been assessed. The mean wait time, from referral to consultation, for all patients was 6 months (range, 3-18 months). At consult,

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