THE PATH TO HEALTH CARE REFORM
Policy and Politics

THE 2012 CIBC SCHOLAR-IN-RESIDENCE LECTURE
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by André Picard
Foreword by Michael Bloom

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The invitation from Anne Golden to serve as the CIBC Scholar-in-Residence was as surprising as it was flattering. My initial response to her was that this was no doubt the first time the words “scholar” and “journalist” had been used in the same sentence. I am deeply indebted to Anne for taking a chance on me. I hope she doesn’t regret it.

Writing the book was challenging. I loved doing the research, especially on the history of medicare. Taking the time to read and digest reports is a luxury rarely afforded a daily journalist. But I suffered a terrible bout of writer’s block for the first time in 30 years as a journalist. If not for the patience and support of the fine folks at the Conference Board—notably Michael Bloom, Gabriella Prada, and Glen Hodgson—the project would never have been completed, and I am eternally grateful to them for keeping the faith.

Over the past two decades, I have had the privilege of immersing myself in Canada’s health system, and of rubbing elbows with everyone from frightened patients and hard-working nurses on the front lines to health economists and ministers of health. I have attended too many conferences and read too many learned studies to catalogue. The ideas and research in this book are, more than anything, a summary of what I have absorbed over time. Those I have learned from are far too numerous to name individually, but I hope they will recognize themselves and their ideas. The errors and omissions, however, are mine alone.

I don’t expect everyone to agree with my analysis or my conclusions, but I hope my work can help stimulate conversation—adult conversation—and maybe even inspire some solutions.
CONFERENCE BOARD ACKNOWLEDGEMENTS

The Conference Board of Canada is deeply grateful to CIBC for its sustained and farsighted investment in the Scholar-in-Residence Program, which has made this volume possible. CIBC’s generous financial support is underpinning a decade of cutting-edge public policy research. We would also like to thank CPAC for televising the May 2012 Ottawa lecture, a transcript of which forms part of this volume. The broadcast brought the lecture and discussions to a much broader audience of Canadians than could attend the lecture in person.

At the Conference Board, Michael Bloom organized the 2011–12 Scholar-in-Residence Program. We extend our thanks to Anne Golden for inviting our scholar to take part in the Scholar-in-Residence Program, and to Laura Byrne Paquet, who edited this volume.

Above all, we wish to thank our scholar, André Picard, for his original and important contribution to the Canadian public debate on health care reform. We are also most grateful to our Scholar-in-Residence Program lecture moderator, CBC news anchor Heather Hiscox, and to the distinguished panel of experts who responded to Mr. Picard’s lecture: Dr. Philippe Couillard, neurosurgeon and former Quebec minister of health and social services; Dr. Jack Kitts, President and CEO, The Ottawa Hospital; and Judith Shamian, President and CEO, Victorian Order of Nurses.
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THE AUTHOR

André Picard is a journalist and the author of four books. He has been a staff writer and columnist at The Globe and Mail since 1987, where he specializes in writing about health and social policy.

He has received much acclaim for his writing and his dedication to improving health care. He is a six-time nominee for the National Newspaper Awards, Canada’s top journalism prize, and a two-time nominee for the Michener Award for Meritorious Public Service Journalism.

André was named Canada’s first Public Health Hero by the Canadian Public Health Association and a Champion of Mental Health by the Canadian Alliance for Mental Health. He has also received the Centennial Prize of the Pan-American Health Organization, awarded to the top health reporter in the 17 countries of the Americas, and the Queen Elizabeth II Diamond Jubilee Medal for contributions to improving the health of Canadians.

In addition to serving as a Scholar-in-Residence at The Conference Board of Canada, he is a former research fellow at the Atkinson Foundation and a participant in the Governor-General’s Leadership Program.

André holds a bachelor of administration from the University of Ottawa and a bachelor of journalism from Carleton University. He also has an honorary doctorate from the University of Ontario Institute of Technology.
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*by Dr. Michael Bloom*  

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Foreword

by Dr. Michael Bloom
Vice-President, Organizational Effectiveness and Learning, The Conference Board of Canada
Health care reform, the topic of our fifth Scholar-in-Residence’s research, resonates with Canadians everywhere. It is understandable that we should care so much about health care: we care because we all feel connected to it. Even those of us who have not yet used our health care system understand that someday we will, often on multiple occasions.

But our interest goes beyond personal use and private needs. Canadians, with some justification, take pride in our national achievements in health care—in having created one of the most comprehensive systems in the world at a time when few other nations had made such a bold move. Public surveys reveal time and again that we view our health care system as being at the core of our national values. For the majority of us, the system we have constructed is more than a source of great pride; it is a defining element in the character of our country. Our conviction has remained strong and constant for decades—even when we have felt frustrated with some aspects of the system’s performance.

This is our great challenge: We are struggling to “fix” a thing we love as a nation. The tension between our long-standing regard for our health care system and the growing pressure for change explains the tenor of the debate, in which so much emotion is associated with analysis and decision-making. As we move toward the end of the current federal health care-related transfer commitment in 2015, it is becoming more urgent to move beyond the emotion to find sustainable solutions. The key questions before all of us are as follows: What should we do, how should we do it, and how should we pay for it?

This monograph—and the associated responses from our panel of experts—helps us to answer these all-important questions. It is a contribution to the national dialogue and debate on health care that speaks in fresh and vigorous language, and with much-needed candour, about our system. By starting with an open-eyed, non-ideological look at the genesis of the modern health care system from its earliest European roots, André Picard helps us move beyond the mythology of health care to understand what we constructed in previous generations and why. He does so by exploring the often-complex intersection between health policy and health politics over many years. He concludes with
some optimism that “the good ship medicare is not sinking” and that we can “embrace social justice without abandoning fiscal prudence.” Modernization, not dismantling, is at the heart of the change we need. So is universality—within practical limits.

This volume is part of a large series of studies, lectures, and dialogues on issues of great importance to the public policies of Canada and the well-being of our country. Previous scholars have addressed themes of major national importance, including Canadian federalism; the value of a national regulatory regime; cities as engines of innovation; and change in Canada’s North. The associated lectures, held in Ottawa, Toronto, and Whitehorse, have been terrific successes, each engaging hundreds of Canadians in the dialogue.

This book, and the Scholar-in-Residence lecture in which it was first delivered in summary form, were made possible by the generosity of CIBC. On behalf of The Conference Board of Canada, I would like to acknowledge the vital role of CIBC in financially supporting the 10-year Scholar-in-Residence Program. We are grateful to CIBC for its sustained investment in cutting-edge research and analysis of public policy issues.

With its mission of advancing thought leadership for a better Canada, the Conference Board is proud to present this monograph as an important contribution to the health care dialogue in Canada. We hope that its insights will provide leaders, both inside and outside the health care system, with new perspectives to help them move toward the structural reforms that will give us the excellent, affordable, and sustainable system we desire.
Introduction

PRINCIPLES AND GOALS: WHAT ARE WE TRYING TO ACHIEVE?
For the exclusive use of Irfan Dhalla, dhallai@smh.ca, St. Michael's Hospital.
What is the fundamental purpose of medicare? Is it to improve the health of Canadians? Is it to keep health care costs to a minimum? Is it an income redistribution program to ensure low-income families have access to health care? Is it a way of ensuring that health services are distributed fairly across a vast, diverse nation? Is it a health insurance plan like many others but on a grander scale? Is it a de facto nationalization of physician and hospital services? Is it a populist program designed to garner votes? Is it an expensive exercise in nation-building?

We get so caught up in the minutiae of health care delivery and policy-making—such as the political battle about the role of the private sector in the provision of care and the day-to-day disputes about the funding (or not) of various drugs—that we seemingly never step back and ask the most basic question of all: What are we trying to achieve?

If we were building a public health insurance program today from scratch—instead of constantly patching and mending the one we inherited—what would our priorities be? Surely, we would begin with fundamentals.

If we want to transform medicare, not just fiddle with it around the edges as we have done for so long, we need a sense of purpose and purposeful action.

If we want to determine whether our model—a single-payer public insurance program—is the right one for Canada, we need to have goals. Then we have to measure results against those goals, determine whether we have succeeded, and, if we haven’t, figure out how we can improve.

Scrapping medicare and starting over is not realistic, nor is it necessary. We don’t need to throw out the baby with the bathwater. But, to extend the metaphor, we also have to do more than merely change the water; we need to build a better bath.
If we hope to reform medicare, to help it grow and prosper, we need overarching philosophical goals and specific policy goals. The oft-quoted conversation between Alice and the Cheshire Cat in *Alice’s Adventures in Wonderland* comes to mind:

“Would you tell me, please, which way I ought to go from here?”

“That depends a good deal on where you want to get to,” said the Cat.

In short, you can’t get where you’re going unless you know your ultimate destination. It also helps to know where you’ve come from—your history.

When Tommy Douglas began his crusade for what would later become known as medicare, the problem he wanted to address was clear. Many families—particularly farm families—could not afford to pay for even their most basic medical needs, such as treatment of a child with polio. The cost of a hospital stay could bankrupt a family, and private health insurance was unaffordable and offered limited coverage.

Mr. Douglas stated the need for public health insurance bluntly and succinctly: “No one should lose their farm to pay for necessary medical care.”

He set out five key features of a plan that would cover hospital and physician services:

- prepayment, meaning people should pay premiums, in the form of taxes or otherwise;
- universal coverage, meaning access to care would depend solely on need, not ability to pay;
- high-quality service, meaning publicly funded care would be as good as or better than private care;
- public administration, meaning government would oversee the program, like other state-funded services;
- finally, that the “plan be acceptable both to those providing the service and those receiving it,” meaning both premiums paid by recipients of care and payments to providers should be fair.
Medicare was designed to make acute care available and affordable to the masses. There were two simple and straightforward goals: deliver basic medical care to those who were sick, injured, or pregnant; and do not ration care based on ability to pay. The immediate needs were great and real, so no one paid much attention to setting longer term goals, beyond vague plans to later extend public insurance coverage to prescription drugs and homecare.

Yet, from the 1950s to the 1980s, the two key elements that shaped medicare—the delivery of acute care and the financial status of Canadians—changed dramatically. We needed new goals—a new philosophy, even.

A landmark 1974 report, A New Perspective on the Health of Canadians, recognized these fundamental changes and proposed a radical response: dramatically reducing spending on “biomedical health care,” and investing in prevention and health promotion. While the Lalonde report (as it became known, named after then-health and welfare minister Marc Lalonde) was hailed in much of the world—particularly in European countries, which used it as a basis for reform—it was largely ignored at home. Being cautious and being conservative—well-established cultural traits in Canada—did not serve us well in this instance.

Instead of shifting resources to prevention and health promotion, the overriding response in Canada was to do more of the same—to focus on delivery of acute medical care for the masses rather than shift resources to enhancing social welfare programs and preventing health problems. It was politically expedient but a decision that would prove to be a costly mistake and a missed opportunity.

The result was that Mr. Douglas’ approach—appropriate as it was in the 1950s—still found an echo in the Canada Health Act, the 1984 federal legislation often perceived as being the foundation of medicare:
It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

The Canada Health Act also spells out what are often referred to as the five principles of medicare: public administration, comprehensiveness, universality, portability, and accessibility. They are actually the conditions provinces and territories must meet or risk losing federal health transfers. But they are also a good summary of the values underpinning medicare—they express the notion that publicly insured health services should be available to all Canadians regardless of where they live in the country or whether they can pay.

The federal department responsible for the health of Canadians (but not delivery of health services) has an even vaguer statement of purpose:

Health Canada’s goal is for Canada to be among the countries with the healthiest people in the world.... Health Canada is the federal department responsible for helping the people of Canada maintain and improve their health.

Health Canada is committed to improving the lives of all of Canada’s people and to making this country’s population among the healthiest in the world as measured by longevity, lifestyle and effective use of the public health care system.

In other words, in official policy documents we have a penchant for wishful thinking about what we expect from medicare but nothing very concrete. You can tell the goals are insufficient because they are not easily measured.
As the financial pressures have grown, there has been increasing talk about the need to better articulate values and to measure outcomes. However, the political response has been half-hearted at best.

The most detailed goal-setting exercise occurred in 2005, in the wake of the economically devastating SARS outbreak, when the federal, provincial, and territorial health ministers agreed to a set of public health goals.

Carolyn Bennett, then the federal minister of state for public health, and Theresa Oswald, former Manitoba minister for healthy living, guided a process of public consultations that led to the formulation of a unanimously endorsed document. Here is what it said:

**OVERARCHING GOAL**

As a nation, we aspire to a Canada in which every person is as healthy as they can be—physically, mentally, emotionally and spiritually.

**HEALTH GOALS FOR CANADA**

Canada is a country where:

**Basic needs (social and physical environments)**

Our children reach their full potential, growing up happy, healthy, confident and secure.

The air we breathe, the water we drink, the food we eat, and the places we live, work and play are safe and healthy—now and for generations to come.
Belonging and engagement

Each and every person has dignity, a sense of belonging, and contributes to supportive families, friendships and diverse communities.

We keep learning throughout our lives through formal and informal education, relationships with others, and the land.

We participate in and influence the decisions that affect our personal and collective health and well-being.

We work to make the world a healthy place for all people, through leadership, collaboration and knowledge.

Healthy living

Every person receives the support and information they need to make healthy choices.

A system for health

We work to prevent and are prepared to respond to threats to our health and safety through coordinated efforts across the country and around the world.

A strong system for health and social well-being responds to disparities in health status and offers timely, appropriate care.

It is a lovely bit of public health poetry, all Mother Earth and apple pie. That such a list of principles for healthy living and holistic care would be unanimously endorsed is quite amazing. Yet, it is one of the best-kept secrets in Canadian health care—a document that has done nothing but gather dust since the day it was signed.
One cannot help but be reminded of the philosophical riddle: “If a tree falls in the forest and no one is around to hear it, does it make a sound?”

In this case, “If Canada has public health goals and nobody knows about them, do they really exist?”

The short answer is, “No.”

It is telling that when these goals were endorsed at a health ministers’ meeting, media coverage focused exclusively on the adoption of national standards for the maximum length of time patients should wait for treatment in five target areas, including heart surgery and hip replacements.

For years, federal and provincial health ministers have obsessed about surgical wait times and spent billions to shorten wait lists. For the most part, wait times have shrunk in the targeted areas, though there are technical issues with benchmarks and data collection that make a more unequivocal statement impossible.

A report issued by the Health Council of Canada noted that there were “key factors for success” in reducing wait times:

• support from government leaders;
• strong program leadership, with administrative and clinical champions;
• full-time staff dedicated to programs;
• information systems that allow for the creation of centralized lists and make information publicly available;
• a broad, comprehensive approach that acknowledges many large and small changes are required.

As a result of a determined effort, Canadians are no longer waiting as long for angioplasty, hip replacements, and other common surgical procedures. They are getting more care, faster care, and better care.

The point here is that when you fix precise goals and set your mind to achieving them, good things happen. That approach should not be limited to reducing wait times, but should also be applied to improving the health system more generally.
Imagine if the country’s health ministers dedicated themselves to the promises in the public health goals—such as reducing disparities in health—as much as to the promised reductions in wait times.

The “health goals for Canada” have been stated and endorsed. Now there needs to be a next step: establishing specific targets. For example, public health goals could include increasing breastfeeding rates by 5 per cent and reducing the incidence of child injury by 5 per cent within the next two years. (Nunavut, a leader in public health, set and attained these goals.)

When you set priorities, you make a conscious decision that some programs are more important than others, and that has to be backed up with personnel and money.

Reforming health care will require major investments—on the front lines, in public health programs, in health information systems, and in prevention and complementary social welfare programs—that have to be bolstered with strong political leadership.

That leadership must consist of more than signing one’s name to a document and forgetting all about it. But medicare’s history is rife with grandiose promises left unfulfilled.
Section I

THE PATH TO THE PRESENT:
HOW DID WE GET HERE?
An Unhealthy Past
LIFE BEFORE MEDICARE
“Those who don’t know history are destined to repeat it.”

—Edmund Burke

To truly understand the medicare system we have today—and how it developed iconic status—we need to know its origins. If we intend to reform public health insurance and the delivery of health care, we need to know how they evolved.

Canadians, however, are remarkably ignorant about their history, particularly institutional and cultural history.

“Tommy Douglas is the father of medicare” is usually about as much as we can muster by way of explanation, with a passing reference to the Canada Health Act thrown in for good measure. We are so deferential to the status quo that one is often left with the impression that Canadians think the principles of medicare were carved in stone by the hand of God and retrieved from a burning bush by Reverend Douglas. How else can one accept the rarefied status afforded hospitals and physicians in Canadian health care except by believing that it was divinely ordained?

The reality is that the health system we have today is the result of deliberate (though not necessarily well-considered) political and policy choices over decades, if not centuries, coupled with some quirks of history. Combined, they created a unique cultural context.

The first hospital in Canada, Hôtel-Dieu de Québec, was founded in 1639 by Augustinian friars. Three years later, the legendary Jeanne Mance founded Hôtel-Dieu de Montréal, recruiting hospital sisters from the Hospitalières de Saint-Joseph order. For centuries, mendicant friars and nuns offered crude health care services—often little more than prayer and a bed to die in—to the poor, most of whom had been felled by infectious diseases such as smallpox, typhus, and cholera, which were commonplace. As medicine evolved from a vocation to a profession, nuns remained key health care providers and administrators. As late as the 1960s, religious orders still operated many hospitals in Canada, and their innate conservatism and philosophy that providing
health care was a charitable act profoundly influenced health policy. For example, there is no tradition of for-profit hospital care in Canada, and our institutions have always been dour, Spartan facilities.

The provision of medical services developed in parallel but along an entirely different line. Doctors were essentially entrepreneurs who sold health care—poultices, potions, and bloodlettings—as a commodity, mostly to the wealthy. For a long time, quackery prevailed, though science eventually gained the upper hand. In medicine, as in nursing, there was a strong current of social engagement and innovation born of necessity. In 1655, Dr. Étienne Bouchard, a Montréal physician who was troubled by the lack of care available to the working class, offered his services to a set number of families for $1 a year. (Today we call that approach “rostering” and think of it as a modern innovation.) But this kind of offering was the exception, not the rule; access to doctors was spotty and often non-existent in the vast country.

Canada’s first medical school was not established until 1824, at an institution that later became McGill University’s faculty of medicine. It would be 1912 before there were uniform standards for licensing of physicians, and the era of professional medicine began. Being a physician was not necessarily lucrative; doctors were often paid in kind for their services with chickens, wood, potatoes, or IOUs, a practice that continued until the advent of medicare.

The early 20th century was, in fact, a time of dramatic societal upheaval. Canada was still a rural society, but rapid urbanization and new wealth were changing the political landscape. Urban-rural tensions prompted the creation of new political parties, and the rural parties, in particular, emphasized the need for more accessible, affordable health care. Country doctors, though romanticized today, were rare and their services were often prohibitively expensive. At the turn of the century, about one in five children died before age five and many women died in childbirth.

The genesis of publicly funded health care, however, can be found in the response to the First World War. When men enlisted—and they did so in massive numbers—they underwent medical exams. For most, it was the first time in their lives they had been seen by a doctor. The
extent of health problems revealed by these routine physicals was truly shocking: tuberculosis, venereal diseases, and disabilities caused by childhood illnesses were commonplace. The would-be soldiers were not in fighting form, and neither was the nation as a whole. But as unhealthy as the enlistees were before the war, they were, for the most part, far worse after. The First World War was fought in gruesome conditions. During the conflict, almost 57,000 Canadian soldiers died and another 132,500 were seriously wounded, most suffering amputations and severe burns. From the early days of the war, the inability of returning troops to get (or afford) care was a volatile political issue.

In 1917, with forces depleted and volunteers waning, Canada introduced conscription. To get the measure passed in Parliament, the Conservative government of Prime Minister Robert Borden needed the help of Liberals, but the party of Wilfrid Laurier was deeply divided on the issue, largely because the Quebec members of the caucus were vehemently anti-conscription. Pro-conscription Liberals, however, offered their support to the government, with two key conditions: the assurance that veterans would get free medical care and the creation of a federal department of health.

The government was also feeling pressure from powerful interests outside the political realm. At its wartime gathering in 1917, the Canadian Medical Association demanded that the state subsidize medical care for both veterans and infants, arguing that Canada had lost so many young men to war that it could never re-populate itself with a child mortality rate of over 20 per cent.

There were huge disparities in access to health care between cities and rural areas, and between eastern and western parts of the country. In the West, care was so lacking that the Red Cross established outpost hospitals and nursing stations. Doctors, who were private practitioners, had little interest in settling in rural areas, where money was scarce and they essentially had to be on call 24 hours a day, seven days a week. Saskatchewan responded by hiring doctors on salary to work in municipalities; they also created “union hospitals.” These were among Canada’s first publicly funded health services, paid for with a land tax of one cent per acre.
In March 1919, legislation creating the federal Department of Health was adopted. In addition to caring for soldiers and seamen, Ottawa’s role was essentially to collect information on health problems and encourage the provinces to create programs to alleviate them. This encouragement came in the form of money. The department’s first act was to implement cost-sharing programs for treating tuberculosis and venereal diseases, two scourges among returning soldiers.

Veterans of the First World War came to view health care as a right of citizenship and that created expectations in society more generally. Politicians were aware of these sentiments. In 1919, Prime Minister Mackenzie King’s Liberal Party adopted a policy backing a “national sickness plan,” with some cumbersome conditions. These included the support of the provinces, affordability, and limited coverage. In 1919, British Columbia appointed a royal commission to study the idea of public health insurance. There was fierce opposition, especially from doctors. However, the exercise resulted in the mother’s allowance—a small stipend to help ensure children were not malnourished—one of the first broad social programs designed to improve health.

In 1927, J.S. Woodsworth, then of the Independent Labour Party, rose in Parliament to demand state-financed health insurance for the masses. In the libertarian (and libertine) roaring ’20s, the idea gained little traction. Still, a variety of initiatives sprang up around the country. Ontario, for example, created a health insurance plan for hospital and physician services whose premiums were paid in equal measure by employees, employers, and the government.

The Great Depression laid bare the reality that most Canadians could not afford even the most basic health care services. Between 1929 and 1932, per capita income fell by half; farmers, particularly on the parched Prairies, suffered even more. Mr. Woodsworth advocated the nationalization of medical services—essentially, making doctors salaried civil servants. Governments were reluctant to make such a radical move, but they did begin to respond to growing public pressure, especially from rural areas.
In 1934, B.C. unveiled plans for two-pronged public insurance, with different premiums and coverage for urban and rural residents. That same year, the Ontario Medical Association was asked to create a “medical relief” plan for the indigent, paid for by the province. The first year alone, 175,000 people benefited from the plan, which would remain in place until the late 1960s. Alberta went much further; in 1935, it adopted legislation saying the state would provide basic health coverage to all residents. However, universal health care was never implemented because the United Farmers of Alberta Party was defeated.

The battle lines were drawn between two camps. The left of the political spectrum favoured universal health insurance, but the right fiercely opposed “state medicine.” To complicate matters, there were also ongoing federal-provincial tensions over the constitutional division of powers.

Before he became famous for his health work in China, Dr. Norman Bethune headed the Montréal-based Group for the Security of the People’s Health. He was outraged that the two levels of government could not work together to make health care more affordable. “Health is not a question of provincial rights but rather of human rights,” he said. The Canadian Medical Association was more pragmatic but no less insistent on the need for health insurance, specifically for the poor; it insisted that Ottawa and the provinces should share the costs 50/50.

Meanwhile, as health costs increased, private insurance became more commonplace and employee-sponsored plans emerged. Unionized workers in the mining and automobile sectors were the first to negotiate comprehensive health care insurance from their employers, and it also became a perk for executives. New things were being tried in the public realm, too. B.C., for example, created an insurance plan with capitation (meaning doctors were paid a flat annual fee per person for care). The move drew fierce opposition from physicians and failed miserably.

Then came the Second World War, and dramatic economic and social pressures along with it. In the first year of the war, 59 per cent of volunteers failed to pass the initial physical exam, underscoring the poor health status of Canadians. Ian Mackenzie, then the minister
of pensions and national health, became one of the first to push for national—not provincial—health insurance. He argued that Canadians deserved something special in return for the sacrifices they were making to support the war effort. Money was tight, so the idea went nowhere. But the provinces felt more and more pressure from citizens demanding public insurance; the notion that there should be payback for wartime sacrifices became deeply ingrained.

In 1942, Prime Minister William Lyon Mackenzie King signed the Atlantic Charter, which advocated a post-war world free of hunger, unemployment, war, and disease. This utopian vision had a practical effect. After he came back from the signing ceremony, the Prime Minister set up an advisory committee on health insurance. Months later, in Great Britain, Sir William Beveridge published his landmark report calling for a national health service, which had great resonance in Canada and other former colonies.

In 1943, Mackenzie King was presented with a draft health insurance plan and, once the Second World War ended, he acted. He created the Department of National Health and Welfare, significantly expanding the public health role the department had played since the First World War. The Prime Minister also made the provinces an astonishing offer: Ottawa would pay all hospital, medical, pharmaceutical, dental, and home nursing costs if the provinces would consent to a national health insurance plan. But the offer came with a big catch: the provinces had to surrender part of their taxation powers. The provinces resisted, mainly on constitutional grounds, and by 1946 it became clear that national health insurance—or at least a federal health insurance plan—was a pipe dream.

The federal-provincial bickering, however, had a curious effect: It galvanized public opinion. A Gallup poll found that 80 per cent of Canadians wanted a national health insurance plan. Voters didn’t particularly care about constitutional niceties; they wanted affordable health care, and governments got the message. Over the next three
years, several provinces created insurance programs, each with a distinct approach, though they all covered only hospital care. In 1947, Saskatchewan Premier Tommy Douglas unveiled a universal, public health insurance plan funded through general revenues. Alberta took a different tack, mixing private and public insurance, with eligibility based on income; B.C. had an employer-based program with premiums; and Newfoundland offered hospital insurance for a flat rate of $15 per family.

The popularity of the programs was not lost on parliamentarians. By the time the 1949 federal election came around, all the major parties—Progressive Conservative, Liberal, Social Credit, and the Co-operative Commonwealth Federation—supported national health insurance, though they did not agree on the form it should take.

At the time, though, insurance companies were aggressively pushing private insurance as a better option, and they were outmanoeuvring government. In 1950, 1.9 million Canadians had employer-sponsored plans, 900,000 had individual plans, and another 1.4 million depended on government plans. But one-third of the population still had no health insurance. The problem with private insurers was that they practised “cream skimming,” targeting the young and healthy; most plans also had age restrictions and strict limits on coverage, required co-payments, and were expensive. Private health insurance cost about $75 a year, which was a considerable expense, given that half the population earned less than $2,500 annually.

The most outspoken proponent of private insurance was Ontario Premier Leslie Frost. However, when the Premier turned 60, his two individual health insurance policies were cancelled. This fact drew considerable media attention and opened Mr. Frost’s eyes—or, at least, awakened his political survival skills. He became a proponent of public health insurance, though never an enthusiast.

In 1955, Ontario approached Ottawa with a tentative plan for “cost sharing” that was essentially a demand that the federal government transfer more money with no strings attached. During this time of massive infrastructure spending, Ottawa was doling out a lot of health grants to build hospitals. Prime Minister Louis St. Laurent used the
opportunity to make a counter-offer: The federal government would reimburse 50 per cent of hospital and diagnostic costs to any province that offered universal coverage and limited co-payments (also known as user fees). That plan, which remains the basis of the health insurance funding plan we have today, was enacted in 1957 with little fanfare.

Over the next decade, every province fiercely debated the pros and cons of health insurance. Eventually, they all signed on to accept federal money and the conditions that came with it. Gradually, the building blocks of medicare fell into place, but there was never a cohesive or coherent national plan.
Health Care for the Masses

MEDICARE IS BORN
Of all forms of inequality, injustice in health care is the most shocking and inhumane.”
—Dr. Martin Luther King, Jr.

Medicare, as we know it today, was officially born in March 1957, with the adoption of the Hospital Insurance and Diagnostic Services Act. The federal government agreed to fund 50 per cent of hospital care and diagnostic services in exchange for provinces agreeing to some basic standards that would create a semblance of a national program.

It was not exactly a magical moment. There were no fireworks, and no signing ceremony or victory party. It had been a decade since Saskatchewan had introduced a public insurance scheme for hospital care and most provinces had, over time, followed suit. Still, the provinces grumbled about federal intrusion into their jurisdiction. The Canadian Chamber of Commerce denounced the federal legislation as a wasteful socialist scheme—powerful rhetoric during the Cold War—while physicians’ groups vehemently insisted that doctors working in hospitals and offering diagnostic services be paid on a fee-for-service, not salaried, basis.

Despite those hiccups, the public was largely supportive and the provinces that had already embraced public health insurance for hospital care—principally those in the West—were already eyeing expansion. Saskatchewan once again led the way, with Tommy Douglas, in a pre-election promise in 1959, vowing to extend the scope of public health insurance to cover physician services. That move would be significantly more controversial than offering hospital insurance had been, in large part because of opposition from doctors.

“Surely the time has come for us to take this next great forward step and set up a pre-paid medical care program,” Mr. Douglas would thunder during an election campaign that was dominated by the issue. Opponents spent more than $115,000 on advertising opposing
the measure, an astronomical sum at the time. Yet, in the end, the Commonwealth Co-operative Federation won re-election and introduced legislation in 1961.

The initial plan was to essentially nationalize medical practice, to put doctors on salary, and to make participation in the plan mandatory. There was fierce resistance from physicians provincially, nationally, and beyond—including the American Medical Association, which feared such an idea could spread south of the border. The government eventually agreed to allow doctors to be paid on a fee-for-service basis but angry physicians still went on strike, determined to quash a compulsory, government-run insurance plan.

July 1, 1962, is often cited as the day medicare was born. On that day, Saskatchewan’s legislation extending public health insurance beyond hospitals to physician services took effect. Virtually every physician in Saskatchewan closed his or her practice, threatening to stay out indefinitely. Initially, the doctors had broad public support. There were dire warnings that physicians would abandon Saskatchewan en masse, resulting in a situation far worse than that prior to medicare. But the provincial government held its ground, bringing in physicians from the U.S. and Britain to operate community clinics.

The strike was one of the most bitter, hard-fought labour disputes in Canadian history. It was also a tactical mistake. Even those who strongly backed physician autonomy and private insurance objected to the public being held hostage. The conservative Financial Post called the doctors’ action an “outrageous assault on organized society.” As doctors cranked up the rhetoric, public support dropped.

The strike lasted 23 days before doctors conceded defeat. The government also compromised, allowing physicians to opt out of the government-run insurance plan and significantly bolstering payments they would receive under the fee schedule. As per the long Canadian tradition in health care, money bought peace. Another important factor contributed to a relatively swift resolution: Public support for medicare was strong.
Saskatchewan’s expansion of public health insurance did not go unnoticed in other jurisdictions. The genie was out of the bottle.

The late 1950s and early 1960s were a time of tremendous scientific and medical progress, and the public was clamouring for better access to health care. Prime Minister John Diefenbaker, facing pressure to do more, made the seminal decision to appoint the Royal Commission on Health Services. It was largely a delaying tactic—one that, in the decades that would follow, would become frustratingly commonplace. However, the inquiry—and the way the government responded to its recommendations—would also profoundly shape medicare.

The Prime Minister turned to his old law school buddy, Saskatchewan Chief Justice Emmett Hall, and gave him a sweeping mandate in June 1961:

... to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada, as the Commissioners believe will ensure that the best possible health care is available to all Canadians ...

Twelve priority issues were identified in the mandate, including the following:

• financing methods;
• current and future requirements for health services personnel and their training;
• current and projected costs of health care services in Canada;
• methods of improving health care service delivery.

The commission—Justice Hall and six others—took three years to produce a report. They held 67 days of public hearings, visited and studied health care systems in several other countries, received submissions from 406 organizations, and commissioned 26 research studies. But the real shocker was the breadth and bluntness of their recommendations.
The Government of Canada, it said, “should take the necessary legislative, organizational decisions to make all the fruits of the health sciences available to our residents without hindrance of any kind.” The commission said there should not only be a public health care plan but it must also be universal, which was defined as meaning “that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors.” It recommended that there be no “means testing” and no user fees, saying using these would be tantamount to “rationing health services on the basis of ability to pay.”

The panel rejected the approach taken by many European countries it had visited, in which the state paid for private insurance coverage, saying that a publicly administered plan would be more efficient and cost-effective. But the commission went much further, saying public insurance should cover prescription drugs, homecare, prosthetics, and even some dental and vision care. The panel said that no citizen should be able to opt out, arguing that “since we do not know which of us may be affected, all should make a contribution to a common fund to assist those who are.” But it also emphasized that, within a public plan, citizens should retain the ability to choose providers and other health care services.

In fact, the report lays out quite clearly what would decades later come to be known as the five principles of medicare: public administration, comprehensiveness, universality, portability, and accessibility. The commission essentially expanded Tommy Douglas’s approach. It embraced a holistic view for creating a healthier society, saying that medical services alone were not sufficient but “must be supplemented by a wide range of other measures concerned with such matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism, and drug addiction.” The commission also stressed that, for public health insurance to remain affordable, there must be a strong dose of individual responsibility. It called for the adoption of the Health Charter, which said Canadians needed to
“observe good health practices and use available health services pru-
dently” and “allocate a reasonable share of … income (by way of taxes 
or premiums or both) for health purposes.”

This was not what was expected from a conservative judge. However, 
Justice Hall would say many times in the subsequent years that he lis-
tened to the evidence and was convinced this was the proper approach.

While the commission was doing its work, there was tremendous 
change on the political front. The Diefenbaker government, which had 
a massive majority, was defeated and replaced by a minority govern-
ment led by Lester B. Pearson, whose Liberals had campaigned on 
the need for comprehensive social programs, including national health 
insurance. They embraced the Hall report—or, at least, its tenor.

The provinces, as always, were a lot less enthusiastic. Ontario 
Premier John Robarts, for example, called medicare a “Machiavellian 
scheme” and a “political fraud.” (However, let’s not forget that he rep-
represented a riding in London, home to Canada’s private insurance giants, 
which stood to be the big losers if public health insurance continued to 
expand.) Alberta still had what was called Manningcare (named after 
Premier Ernest Manning)—essentially, a private health insurance plan 
r

At the time, about 15 million Canadians had health insurance—
either public or private—and 5 million did not, and the inequities were 
growing steadily worse. In 1965, Mr. Pearson called a meeting of first 
ministers to propose a national medicare plan. He got what could best 
be described as a cool reception. So the following year, he moved uni-
laterally and introduced the Medical Care Act. The law would have 
Ottawa pay for approximately half of all hospital and physician ser-

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care), and portable (meaning citizens could be treated in other provinces). The Act established no specific goals and did not require monitoring in return for the federal money.

While some called Justice Emmett Hall—not Tommy Douglas—the father of medicare, it is worth noting that the federal government actually implemented very little of what was proposed in Justice Hall’s report. Instead of implementing a comprehensive public insurance scheme that covered hospital and physician care, along with prescription drugs, vision care, dental care, homecare, and long-term care—an approach that was being implemented across Europe at the time—Ottawa took one small step. It also completely ignored the commission’s warning that medicare would only be affordable in the long term if considerable investment was made in health promotion and related social programs. Little did Canadians know at the time that that scenario would be repeated time and time again: commissions of inquiry making sweeping recommendations and politicians cherry-picking just a few politically expedient measures. It is a cultural trait that has ensured that medicare has never quite lived up to its promise.

Regardless of jurisdictional issues, the program’s shortcomings, and lobbying from vested interests such as hospitals and physicians, all the provinces and territories eventually signed onto the federal program, though it took a long time. In 1971, Quebec became the last province to join medicare and in 1972, Yukon made the program truly national—if you can call a system of transferring funds from one jurisdiction to another a program. The primary motivation for the provinces and territories to sign onto a “national” plan was not patriotism or a desire for equality; it was money. By the early 1970s, all jurisdictions were scrambling for cash because health costs were soaring even faster than galloping inflation.

The 1973 oil crisis and the economic woes it caused strained public finances, leading the federal government to announce that it wanted a new cost-sharing agreement. The provinces and territories, obviously, did not want to give up this lucrative source of financing for health programs, especially not the 50/50 cost sharing. So, in 1975, Pierre Elliott Trudeau’s government announced that it planned to scrap the Hospital
Insurance Diagnostics Act and the Medical Care Act. (The legislation allowed it to do so with five years’ notice.) Essentially, medicare was going to be scrapped as a national program because it was too expensive. At the time, total health spending was $12.2 billion, including $7.3 billion that the provinces spent on hospital and physician services, meaning they were receiving just over $3.6 billion in health transfers from Ottawa.

Abandoning public health insurance entirely would have been political suicide for the federal government, just as losing all federal funding would have been financially disastrous for the provinces. So both sides were ready to compromise—at least behind closed doors, if not in their public statements.

In 1976, Ottawa announced plans to withdraw its long-standing promise to cover 50 per cent of provincial health costs and instead offer provinces block funding for health and education. The approach was formalized the next year with the adoption of the Established Programs Financing Act. The block grants, a combination of cash and tax points, were initially quite generous, and even included an escalator clause tied to the gross domestic product. But there was a clear message between the lines: Medicare was no longer a shared venture, one financed equally by federal and provincial governments. Ottawa had decided to become a minority partner.

Medicare was also undergoing growing pains. Medical and technological advances continued at a furious pace, and so did the expansion of hospital and physician services. Costs were spiralling upward but hospital budgets were being squeezed, and physicians, like other workers, were irked by wage and price controls. After a couple of decades of “free” health care, Canadians were now being slapped with user fees and co-payments.

Another medicare crisis was brewing, so it was time for ... another commission of inquiry.
The *Canada Health Act*

ICON OR PAPER TIGER?
“It is easier to fight for one’s principles than to live up to them.”

—Alfred Adler

When Joe Clark’s Progressive Conservative government took office in May 1979, one of its first acts was to appoint a commission of inquiry to examine how medicare had evolved and what problems needed fixing. The eminent person chosen to lead this exercise was none other than Emmett Hall, principal author of the seminal report a generation earlier. The second Hall Commission, as it came to be known, was a much more streamlined affair than the first; its purpose was also a lot less clear. Still, it travelled across the country holding hearings and received 450 briefs.

In the commission’s report, *Canada’s National-Provincial Health Program for the 1980s*, Justice Hall lambasted the provinces for losing sight of the purpose of medicare; in particular, he railed about practices such as extra-billing and user fees, which he said violated the spirit of medicare and undermined existing legislation:

Canadians understand the full meaning of the Hospital Insurance and Medical Care Acts. They said, through these two Acts, that we, as a society, are aware that the pain of illness, the trauma of surgery, the slow decline to death, are burdens enough for the human being to bear without the added burden of medical or hospital bills penalizing the patient at the moment of vulnerability. The Canadian people determined that they should band together to pay medical bills when they were well and income earning. Health services were no longer to be bought off the shelf and paid for at the checkout stand. Nor was their price to be bargained for at the time they were sought. They were a fundamental need, like education, which Canadians could meet collectively and pay for through taxes.
Mr. Clark’s government had been defeated by the time the report was published, which would normally have doomed the recommendations to irrelevance. However, Liberal health and welfare minister Monique Bégin embraced the idea of banning extra-billing as a way to revitalize medicare and set out to negotiate an end to the practice with the provinces. However, physicians’ groups were adamant that doctors had an inalienable right to demand payment beyond what they received from public insurance plans. There were years of conflict and high drama marked by large numbers of physicians—20 per cent in Ontario and 44 per cent in Alberta—opting out of provincial health plans so they could charge patients the fees they felt they deserved. In 1982, doctors in Ontario and Quebec staged rotating strikes, something that had not been seen for two decades, since the beginnings of medicare.

During this period of unrest, a number of consumer groups were founded, including the Medical Reform Group and the Canadian Health Coalition. Organizations that were traditionally quiet, like the Canadian Nurses Association, also came out strongly against extra-billing, arguing that the public health insurance plan would collapse if patients started paying extra. Battle lines were also drawn in the media, with The Toronto Star lobbying strongly for strengthening public health insurance and its rival The Globe and Mail touting the benefits of a free market.

At the time, though, the government of Pierre Elliot Trudeau was pre-occupied with other issues, such as the National Energy Program and repatriation of the Constitution. Still, Minister Bégin’s staff was busy in the backrooms. In July 1983, the Department of National Health and Welfare published a position paper called Preserving Universal Medicare.

It was a “perfect storm” in public policy—an activist public service, intense media interest, grassroots groups springing up, and groups with a vested interest willing to embrace change—that created a rare opportunity for change to occur.
The timing was also good. The public was getting fed up with the extra-billing dispute and the government was looking for something to bolster its popularity. Polls conducted in that period showed support for medicare hovered around 80 per cent, and opposition to user fees and extra-billing was even higher in virtually every province.

Dr. Bégin had given up negotiating with the provinces and was able to convince her cabinet colleagues that it was time for Ottawa to flex some muscle and introduce legislation. The immediate purpose of the Canada Health Act was to end the extra-billing crisis, so its key provision was a promise to “facilitate reasonable access to health services without financial or other barriers.” This was backed by a strong punitive measure: a dollar-for-dollar reduction in federal transfer payments for any province that allowed extra-billing or user fees.

The legislation, however, was far more sweeping. The government used the opportunity to consolidate years of legislation that formed the legal basis for medicare. The Canada Health Act replaced the federal hospital and medical insurance acts. It consolidated their principles, as well as those found in provincial laws:

- public administration (section 8)—provincially run health insurance plans are managed by a public authority, meaning they answer to the health minister;
- comprehensiveness (section 9)—all services provided by physicians, hospitals, and dentists working in a hospital setting are covered by provincial health insurance;
- universality (section 10)—public health insurance must cover 100 per cent of residents under uniform terms and conditions;
- portability (section 11)—health insurance coverage is guaranteed across provincial and territorial boundaries (in other words, Canadians cannot be left uninsured, even if they move from one province to another).

The Liberal government, in drafting the legislation, also used the opportunity to make an important addition that was not explicitly stated in the law previously, but which echoed the provisions of public health insurance introduced a decade earlier:
• accessibility (section 12)—provinces and territories must ensure that all residents have “reasonable access” to insured health services without financial or other barriers; also, hospitals and physicians must receive “reasonable compensation.”

These characteristics of medicare—public administration, comprehensiveness, universality, portability, and accessibility—have come to be known as the five principles. For many, they are sacred, inalienable principles.

In the *Canada Health Act*, however, they are merely “program criteria”—fairly vague standards that the provinces and territories must meet if they want to receive their full allotment of federal funding.

Let’s not forget that the law was vehemently opposed by physicians, who felt it was a blow to their professional autonomy and limited their ability to be reasonably compensated. Everett Coffin, then president of the Canadian Medical Association, described the law as “a rape of the spirit, if not the legal stipulations, of the Canadian Constitution.” He also said the Act would strip Canadians of fundamental freedoms and lead to the collapse of the health system. It was the type of rhetoric that had not been heard since the Saskatchewan doctors’ strike.

The provinces, for their part, didn’t appreciate being penalized financially for the actions of independent contractors (doctors) and thought it unfair that Ottawa was adding significant new conditions for the transfer of health dollars, especially when it was also significantly reducing those contributions.

Ultimately, though, the public will carried the day. Polls showed massive support for the legislation. The backing of the opposition Progressive Conservatives ensured that the *Canada Health Act* would pass. On April 1, 1984, members of the Liberals, Progressive Conservatives, New Democrats, and Social Credit voted in concert, making the *Canada Health Act* one of the rare bills of importance to pass unanimously. While the vote took place on April Fools’ Day (a coincidence opponents like to highlight), it took effect, symbolically, on Canada Day.
But the fight didn’t end there. The provinces had three years to pass legislation outlawing extra-billing and user fees, and the opposition of physicians had not waned. The solution for most provinces was to buy labour peace—offering significant increases in fee schedules (the agreements that set out how much is paid for individual medical services) and other little perks.

Alberta, where opposition to the new rules was vociferous, increased fees; it also allowed doctors to charge an “extraordinary medical services fee”—essentially, a user fee paid from the public purse—and gave physicians (and patients) the right to opt out of public health insurance. In Ontario, the fight was nasty; while the province offered significant fee hikes, the Ontario Medical Association insisted that the ability to extra-bill and charge user fees remain as a “safety valve.” The dispute culminated in the spring of 1986, when Ontario doctors held “study days,” staged mass rallies, and, eventually, went on strike, resulting in a lack of physician care and, in some instances, closure of hospital emergency rooms. The College of Physicians and Surgeons of Ontario had to step in and warn that doctors who failed to provide essential services would face charges of professional misconduct. The strike lasted 25 days. During that time, public support for the doctors plummeted, making it easy for the province to adopt legislation banning extra-billing.

When all was said and done, however, there was not a party—government, physicians, even the public—that was left unscathed by the implementation of the Canada Health Act.

The lasting political lesson was that governments should tread lightly when trying to change medicare, particularly via legislation. The result is that the Canada Health Act has essentially become the last word—literally and figuratively—in health reform and, as a result, an iconic document.

It is true that the Act articulates, as well as anything does, the philosophical basis for the country’s single-payer system. The Canadian Medical Association’s Canadian Health magazine went so far as to
describe it as a “kind of Canadian Ark of the Covenant.” The problem is that, over time, both supporters and detractors of the legislation have come to attribute to it all manner of powers it does not have.

The reality is that the Act prohibits absolutely nothing. It does not restrict the use of privately delivered care nor prohibit the private ownership of hospitals. It doesn’t even encourage public delivery of care.

The Act does not prohibit physicians from working in for-profit facilities, even if they also work in not-for-profit ones (though there are provincial rules to that effect). Nor does the federal law prohibit the sale of private insurance, even for “medically necessary” care. (Provincial legislation in five provinces does, however.)

The legislation doesn’t even prohibit user fees and extra-billing; there is merely a provision for financial penalties, rarely enforced since the law was adopted. More importantly, the Act gives each province the largely unfettered ability to determine which health services it chooses to insure.

When Ottawa first began toying with the idea of a national medicare scheme in the 1950s, it did so on the understanding that it would provide 50 per cent of the funding. Over time, federal governments backed away from that promise, a process that began before the adoption of the *Canada Health Act* and accelerated markedly afterward.

In fact, in the post-Act era, medicare was no longer about principles; it was about money. And it remains so to this day.
The 1980s were a time of galloping inflation, soaring oil prices, and ballooning government debt. Nowhere was spending rising faster than in health care. To assuage their anger over the ban on extra-billing, doctors were initially given large pay hikes, so nurses demanded the same, as did administrators. New drugs and technologies—particularly in areas that affected huge swaths of the population, such as cancer, cardiovascular disease, and diabetes—drove up hospital costs considerably.

In 1984, shortly after the Canada Health Act was passed, the government of Brian Mulroney was elected and set about getting the country’s financial house in order. Among its cost-cutting initiatives was a freeze in transfer payments to the provinces. The provinces, after years of unrestrained spending, made a sharp shift. They froze or rolled back wages for health professionals such as doctors and nurses, laid off large numbers of people, and slashed other services. (Then, as now, salaries and benefits made up the majority of health care costs.) After years of double-digit annual increases in health care costs, the brakes were slammed on spending from coast to coast. For two years, overall public health spending actually declined. Cuts were generally imposed across the board; there was very little targeting and priority-setting, and no goals other than cut, cut, cut.

The fallout was tremendous. Work was contracted out; full-time employees became casual workers; whole hospital wards were closed. Nurses and support staff in a number of provinces went on strike. Wait lists for care began to grow, and they would become a fixture for years to come.

The financial squeeze triggered an existential crisis. With health spending gobbling up almost 25 per cent of provincial budgets, there were dire warnings that health spending was unsustainable and that it could actually bankrupt governments. Just years after the Canada Health Act, governments were facing the reality of their spending decisions.
Health Act was touted as a guarantee that medicare would survive and flourish, there were grim prognostications about its imminent death. Talk about privatizing services and implementing user fees was ratcheted up. Adding fuel to the fire was the fact that Canada was negotiating a free trade agreement with the United States; nationalist opponents of the deal were convinced that the pact would result in U.S.-style private insurance supplanting Canada’s public insurance plans.

Yet, it was also a heady time in public health. The federal government was convinced that, ultimately, the only way to control health costs was to have a healthier population that had fewer treatment needs. Health Minister Jake Epp had his staff prepare a document entitled Achieving Health for All: A Framework for Health Promotion. It built on the Lalonde report, stressing that, in spite of medicare, Canadians still faced three fundamental challenges: reducing health inequities, bolstering prevention, and managing chronic illness. This discussion, of course, occurred against a grim backdrop: the emergence of one of the worst pandemics in the history of humanity, HIV-AIDS. In Canada, the infection of more than 20,000 hemophiliacs and transfusion recipients with HIV or hepatitis C via tainted blood became a full-blown crisis, overshadowing much of the work being done in health promotion and prevention.

The governmental response to this multi-pronged angst was quintessentially Canadian: study in lieu of action. For a generation, there would be an epidemic of commissions and inquiries, both provincial and federal, most of which were pre-occupied with structural issues.

Quebec appointed the Commission d’enquête sur les services de santé et les services sociaux, chaired by Jean Rochon, which recommended massive decentralization and regionalization, sparking a furious backlash from physicians and hospitals. The Gallant Commission in Nova Scotia stressed the importance of primary care; it also emphasized the need to slash hospitals’ budgets and spend the money instead on community-based care. Alberta’s 1989 Rainbow Report—Our Vision for Health embraced regionalization and primary care as well, but also recommended opening up the health system to private providers and insurers to increase choice and to introduce the discipline of the
free market. Ontario had the Task Force on the Use and Provision of Medical Services, which called for the creation of a network of community care access centres (CCACs) that could provide a continuum of care for patients with chronic illnesses.

Many of these initiatives, however, were lost in the recessionary morass. The government of Ontario premier Bob Rae, for example, is not remembered for CCACs but for “Rae Days”—unpaid days for government employees such as nurses—and for caps on doctors’ incomes.

In this era of uncertainty, think tanks became much bigger players in the health care debate. Groups such as the Fraser Institute and the C. D. Howe Institute published reports condemning the Canada Health Act as a stifling straitjacket for patients and arguing for the widespread privatization of public services to improve access and care. At the other end of the ideological spectrum, the Health Action Lobby (HEAL) demanded that the public system be bolstered and that Ottawa renew its historical commitment to funding half of health costs.

More pragmatic groups—such as the Canadian Medical Association, the Canadian Nurses Association, and the Canadian Hospital Association—focused on drawing attention to the on-the-ground fallout from cuts to health financing. Media outlets were fed a constant torrent of stories about wait times, staff shortages, professional burnout, and lack of equipment and facilities that got the public clamouring for change.

In the 1993 federal election campaign, the Liberals vowed to renew their commitment to medicare. After being elected, Prime Minister Jean Chrétien created the National Forum on Health in a bid to work more cooperatively with the provinces. The forum’s 1997 report, Canada Health Action: Building on the Legacy, called for national homecare and pharmacare programs.

However, those recommendations were never adopted because, in that period, provincial politics took a sharp turn. In Ontario, the Common Sense Revolution of Mike Harris saw dramatic cuts to social welfare programs, which would ultimately have more impact on health than cuts to health care did. In Alberta, Ralph Klein cut even more deeply: Between 1992 and 1995, there were 15,000 layoffs in the health
care sector and per capita health spending fell by more than 15 per cent. (During the same period, Alberta also created health regions, the most important structural change in the province’s health care since the advent of medicare.) Meanwhile, in Quebec, while Premier Lucien Bouchard prepared for another referendum on sovereignty, Ottawa became a convenient scapegoat for all the province’s woes, including health care.

The referendum failed and health care once again supplanted national unity as the number-one political issue. What followed were years of federal-provincial bickering about funding.

Quebec was beset by labour issues, with nurses and other workers striking, and it blamed Ottawa for its problems. The province launched a prominent advertising campaign claiming Ottawa contributed only 10 cents of every health care dollar and Ontario joined in. Alberta took another tack, giving its regional health authorities the power to contract with for-profit providers, seemingly in defiance of the Canada Health Act.

While the Liberal government of Jean Chrétien talked tough, it made a number of concessions to the provinces. It agreed not to proceed with new programs like homecare and pharmacare without provincial agreement, and gave provinces the power to transfer the administration of social programs to their jurisdictions. But money was still a sticking point, particularly since the federal government now had a surplus.

In 2000, Ottawa and the provinces signed the first health accord to supplement transfer payments. Provinces were supposed to use the influx of money to bolster primary care and upgrade hospital infrastructure, but many problems remained, chief among them ever-lengthening wait times for care.

The response, predictably, was yet another round of study. In the first six months of the 21st century, Saskatchewan, Alberta, and Quebec all established provincial task forces or commissions of inquiry to examine the future of medicare.

*Caring for Medicare: Sustaining a Quality System,* the report Ken Fyke prepared for the Saskatchewan government, stressed that improving quality of care was essential to making health care affordable.
He also recommended moving away from the fee-for-service payment model for physicians and creating primary care health teams. In Quebec, Michel Clair made waves by suggesting that health services paid for by public health insurance should be limited and that there should be much greater reliance on public-private partnerships, particularly to improve infrastructure. However, the most sweeping changes were proposed by Don Mazankowski in his report for the Alberta government, *A Framework for Reform: Report of the Premier’s Advisory Council on Health*. He too argued for the delisting of non-essential health services and a greater reliance on private providers but went further, saying Albertans should be able to purchase any diagnostic, surgical, or medical services.

The federal government’s response to all this provincial activity was—you probably guessed it—to launch a national inquiry. In April 2001, Prime Minister Chrétien appointed Roy Romanow, a former premier of Saskatchewan, to head the Commission on the Future of Health Care in Canada. His report, *Building on Values: The Future of Health Care in Canada*, was tabled 18 months later.

Mr. Romanow stressed that Canadians strongly supported the values and principles underlying medicare, and that reforms should be made within a public system. Nevertheless, he suggested a number of changes, including a national homecare program and a catastrophic drug insurance plan. The commissioner also called for significantly more spending, both in the short term—in targeted areas, such Aboriginal people’s health—and in the long term. Specifically, Mr. Romanow said Ottawa should pay at least 25 per cent of health care costs and provide stability with a five-year health accord featuring a significant escalator.

Another national study was taking place in parallel: the Senate Standing Committee on Social Affairs, Science and Technology, led by Michael Kirby. The senators also called for more federal spending, as well as homecare and catastrophic drug insurance programs, but put much more emphasis on wait times, calling for specific wait time guarantees. Mr. Kirby and his colleagues also warned—prophetically—that public frustration could spark legal challenges.
More than half a century after medicare began, the exact same questions were still being debated: How extensive should public health insurance coverage be? What place, if any, do private insurance and for-profit care have?

Overshadowing these philosophical—and sometimes practical—questions was one issue: money.
Is More Study Needed?
“Everything that needs to be said has already been said. But, since no one was listening, everything must be said again.”

—André Gide

The 356-page report of the Romanow Commission placed a lot of emphasis on the core values on which Canada’s health care system is premised—equity, fairness, and solidarity. It also stressed the notion that timely access to medically necessary care is a right of citizenship.

The general themes and recommendations were similar to those featured in inquiries dating back decades, notably:

• medicare requires strong leadership and a health covenant that articulates the values it embodies;
• the health system needs to be more responsive, efficient, and accountable;
• strategic investments are required to address priority concerns such as wait times, and long-term investments are needed to make the system more sustainable.

But the report also featured specific suggestions for dealing with lingering challenges, such as homecare and pharmacare, and for addressing ongoing frustrations, such as wait times and lack of accountability. These suggestions included the following:

• expand and finance homecare, especially for the mentally ill, people just released from hospital, and those in need of palliative care;
• create a catastrophic drug program to cover prescription drug costs above $1,500 a year;
• modernize the Canada Health Act to include the principle of accountability and a dispute resolution mechanism;
• create personal electronic health records for all Canadians;
• develop a comprehensive health human resources plan to deal with the alternating challenges of shortages and gluts of physicians and nurses;
• kick-start primary care reform by removing longstanding barriers such as fee-for-service payments for physicians;
• integrate Aboriginal health services into mainstream medicare;
• improve timely access to care in rural and remote areas;
• reduce wait time benchmarks for diagnostic services;
• publish annual report cards on access, quality, and safety;
• create a Health Council of Canada to watch over medicare.

Again, a lot of these issues were familiar, particularly the talk of modernizing medicare, from access to system management.

The Senate Standing Committee on Social Affairs, Science and Technology, headed by Michael Kirby, also produced a significant body of work, five volumes of background research, and a 371-page final report entitled The Health of Canadians—The Federal Role. The senators rushed to get their report out early, to steal some of the Romanow thunder. But, unsurprisingly, its take on the main issues did not differ much from that of the other study.

Among the highlights, the Kirby report called for the following:
• a catastrophic drug program;
• a beefed-up homecare program;
• a significant investment in palliative care;
• better use of medical technology, particularly electronic medical records;
• a health human resources strategy that would include Ottawa taking over funding of medical schools;
• appointment of a health care commissioner, a sort of ombudsman.

The Kirby report also placed a lot of emphasis on dealing with long wait times, notably through a wait-time guarantee, where out-of-province or out-of-country surgical care would be covered if care was not available promptly in a patient’s home province. The report also focused on the need to make more and better use of private providers.

It is noteworthy that the senators—seven Liberals, three Conservatives, and one independent—unanimously endorsed the recommendations.
Then again, there is not much disagreement, regardless of party affiliation, on the broad outlines of what needs to be done to reform medicare. That’s why the two inquiries, operating independently, came to similar conclusions. This kind of consensus had existed for decades, so unanimity on the broad lines of reform was to be expected.

However, the devil is always in the details. The stumbling block is invariably the fear that change will be disruptive and costly. And the biggest barrier to implementation is always money, beginning with who will pay.

The Romanow report was quite unequivocal on that point: The key to reform was getting Ottawa to cough up more money—not a surprising conclusion, coming from a former premier of Saskatchewan. A little more surprisingly, the Kirby report also said that a new influx of money was needed and should come principally from the federal coffers, with individuals kicking in more, too.

In fact, while the recommendations of the two high-profile inquiries were not that different on the delivery side, they masked important philosophical differences on payment. The principal point of contention was on this point: Should more money be invested in publicly funded health insurance or should there be more diversity in funding (that is, more private insurance and out-of-pocket payments)? The Romanow report was seen as representing a left-wing approach of pumping more money into the single-payer system and choking out the private insurance option, while the Kirby report was seen as the right-wing riposte, with greater government investment in the short term but an emphasis on shifting toward a reliance on private insurance.

As always, the debate that followed focused largely on these differences rather than on all the points of commonality. The result was that the ensuing discussion did not focus on values and practical solutions, but on money.

Unlike many other inquiry leaders, both Mr. Romanow and Mr. Kirby costed out their recommendations, calling on Ottawa and the provinces to invest specific dollar amounts in priority areas.
The Romanow report recommended providing an immediate cash infusion of $8.5 billion over two years and then increasing the amount Ottawa transferred to the provinces and territories by $6.5 billion annually, a figure that would come to be known as the “Romanow gap.” There were also repeated and sharp reminders that the federal government had slowly but surely reneged on the commitment it had made when medicare began—to pay for half the costs of medically necessary services.

The Kirby report, released at almost the same time, called for an additional $5 billion a year in federal funding but said the money should be raised through a dedicated health tax, an idea Ottawa rejected but several provinces later embraced. The committee also recognized that Ottawa was not paying its fair share of the national medicare bill.

The federal government was covering somewhere between 20 and 30 per cent of health spending, depending on how the calculations were done. Figuring out how much Ottawa contributed to health care was not easy at all. Over the years, various mechanisms had been used to transfer money from the federal treasury to the provinces, and they had become increasingly convoluted over time.

In the 1950s and 1960s, cash grants and cost sharing were used to encourage the establishment of national programs, including public insurance for hospital and physician services. They gave way, in 1966, to the Canada Assistance Plan (CAP), which attached conditions to federal funding. In 1977, the CAP was bolstered by Established Programs Financing (EPF), a complex mix of cash and tax points. Provinces received 13.5 per cent of personal income tax and 1 per cent of corporate income tax, so that funding of health and education programs grew with the economy. In 1984, extra conditions were attached to health dollars under the provisions of the Canada Health Act.

In 1995, the federal government decided to streamline funding by combining the CAP and EPF in a new program called the Canada Health and Social Transfer (CHST). The CHST, again a combination of cash and tax points, was to be used for health care, post-secondary education, social assistance, and social services, but the federal government
did not specify how the provinces should use the funds. It was not at all clear how much money Ottawa was contributing but, for the premiers, it was clearly not enough.

In 1999, the Liberal government committed an additional $11.5 billion to health care over five years, in large part in response to damning evidence emerging from various provincial inquiries about its shrinking contribution. The next year, 2000, Prime Minister Chrétien sat down with the leaders of the provinces and territories and signed a more formal health accord, the first of many. The 2000 accord was actually a series of bilateral agreements in which the federal government pledged $23.4 billion in additional funding over five years for programs such as early childhood development; the purchase of medical diagnostic and treatment equipment; primary care reform; and the Canada Health Infoway, the agency responsible for introducing electronic health records. In return, the provinces made vague promises of better reporting and accountability.

That brings us to the era of the Romanow report, which gave the provinces and territories ammunition to go back and ask for more money. Not surprisingly, they did, and Ottawa acquiesced. Since the creation of medicare, health spending had never been reduced, save for a very brief period in the early 1990s—and voters had made elected officials of all political stripes pay dearly for that decision. The polls showed the public once again felt their cherished health care was being threatened and they blamed the federal government. Ottawa needed to do something to counter that view, especially with the threat of an election in the air.

In February 2003, a new deal was penned. The First Ministers’ Accord on Health Care Renewal provided $36.8 billion over five years, most of it in cash. Half the money was targeted (though rather vaguely) on the three issues the Romanow commission had identified as the most urgent: primary health care, homecare, and catastrophic drug coverage. There was also a dedicated fund for the purchase of diagnostic and medical equipment; it would later be embroiled in scandal, as it was
used willy-nilly for everything from the purchase of lawnmowers to election-time tax cuts. Ottawa also pledged to bolster care for groups it was responsible for, notably First Nations and Inuit.

A key part of the 2003 accord was a promise to restructure the CHST to clarify how much the federal government was contributing to health care costs. So, in early 2004, the CHST was split in two: the Canada Health Transfer (CHT) for health; and the Canada Social Transfer (CST) for post-secondary education, social assistance, and social services, including early childhood development, early learning, and child care.

A little-discussed aspect of the 2003 accord was the creation of the Health Council of Canada, a national (not federal) agency to promote innovation, principally by serving as a hub for provinces and territories to share information on their reforms and pilot projects. Both Alberta and Quebec refused to participate, a sign that the age-old argument that health was strictly a provincial area of responsibility had not dissipated—not to mention the fact that politicians get nervous when it is suggested that the impact of their policy decisions actually be measured and analyzed.

For many provinces, Ottawa had one role only: to write cheques. And no sooner had the accord been struck than the provinces and territories went looking for more cheques to be written. The Liberal government of Paul Martin was in trouble and, hence, vulnerable to pressure.

The dominant health care story in the media was wait times, in part thanks to a well-orchestrated media campaign by physicians. Canadians were waiting longer and longer for cancer care, for heart surgery, for hip replacements and cataract surgery—procedures required principally by seniors, a demographic no politician could afford to alienate. Ottawa was made the scapegoat.

The federal government had pumped almost $70 billion in new funding into the health system in the previous five years. However, it didn’t feel it was getting any credit; the seemingly insatiable appetite of the provinces and territories was causing a lot of financial and political grief. The federal government needed to make a splash, one that
would both address a primary concern of Canadians—the health of medicare—and show that dividends would come of Ottawa’s efforts to balance the federal budget.

“If money alone could improve our health care system, it surely would have succeeded by now,” Prime Minister Paul Martin told his fellow first ministers at a September 2004 gathering. “Money arguments,” he said, “have obscured more than they have informed. Canadians deserve more than an annual dispute about ‘shares’ and the value of tax points.”

What was needed, Mr. Martin said, was not stop-gap measures but a long-term plan—a “fix for a generation.” That hyperbole would come back to haunt him.

Still, the most important part of a reform package, at least for those sitting around that table, was money. The Prime Minister’s offer featured a lot of it. He promised to do the following:

- fill the Romanow gap with a one-time influx of cash;
- establish a new base for the CHT consistent with the recommendations of the Romanow report;
- provide an annual escalator to ensure predictable and growing federal funding;
- create a fund to kick-start reform.

The lucrative offer would total $41.3 billion over 10 years. That total included setting the yearly cash portion of the CHT at $19 billion (up from $13.5 billion before the deal) with a whopping 6 per cent annual escalator, meaning the CHT would reach $30.3 billion a year by the end of the deal in 2014. Promises made in earlier accords—such as bolstering primary care, homecare, health human resources, and Aboriginal health—were repeated, and the first ministers committed to an ambitious National Pharmaceuticals Strategy (though it fell well short of a national pharmacare plan). The aspect of the accord that garnered the most attention, though, was the $5.5 billion set aside for reducing wait times in five key areas—hip and knee replacement, hip fracture repairs, heart bypass surgery, radiation treatment for cancer, and cataract surgery—the most politically urgent issue for politicians. The only
other monies specifically earmarked were $850 million for Aboriginal health and $500 million for the purchase of new medical equipment. For the most part, the provinces and territories were free to spend the additional money as they saw fit.

However, conscious of criticism of how money from the two previous accords had been spent—and misspent—the government included some accountability measures. The Health Council of Canada was created to monitor progress on the promises, and there was a commitment to two parliamentary reviews, in 2008 and 2011.

When the 2004 accord was signed, there was an unprecedented level of unanimity about what needed to be done and a large new influx of money to get it done. However, there always were—and continued to be—barriers to action.
The Fix for a Generation?
“A goal without a plan is just a wish.”

—Antoine de Saint-Exupery

The 10-Year Plan to Strengthen Health Care identified 10 priorities for health care reform in Canada over the next decade. While almost all the media attention focused on the cash on the table—a whopping $41 billion in new cash transfers—the 2004 health accord had almost all the elements of a blueprint for reform. On paper, this was the culmination of half a century of public inquiries, from the Hall Report to the Romanow Report, because there was now—for the first time—a signed commitment by the first ministers of every province and territory to act on a sweeping number of issues. They vowed, in writing, to bolster health care delivery over the next generation, and Ottawa provided a significant influx of cash, money that was said to be the missing element.

So what happened?

In Canada, we tend to do a poor job of follow-up—of actually measuring progress when new programs are introduced. However, the 2004 health accord actually featured two monitoring measures:

• the establishment of the Health Council of Canada, which was to do periodic reviews;
• a commitment to reviews in 2008 and 2011 by a parliamentary committee, a task that was eventually passed on to a Senate committee.

These reviews did not feature a lot of hard data—generally because the deal included few hard targets—but they nevertheless offered some sense of progress.

The big missing piece from the accord, however, was a timetable. Without deadlines, promises are little more than wishful thinking—things that you may get around to eventually. Ottawa and the provinces got around to implementing a few of their initiatives, but much of the promise of the “fix for a generation” went unfulfilled.
It’s worth examining in some detail each of the promises and actions (or lack thereof) that resulted, because the analysis can provide some good information on the pitfalls of making big, vague promises and on the ways to proceed (or not) with future reform initiatives.

1. REDUCING WAIT TIMES AND IMPROVING ACCESS

The 2004 health accord called for improving wait times by 2007 for procedures in five priority areas: cancer treatment, heart surgery, diagnostic imaging, joint replacements, and sight restoration. To demonstrate progress, the first ministers agreed to establish comparable indicators and evidence-based benchmarks, and then set targets.

Progress to Date

“Have governments actually achieved meaningful reductions in wait times since the accords?” the Health Council of Canada asked in its second major progress report. “The answer is not straightforward.” In other words, there are some indications that wait times have been reduced—in some cases, dramatically—but the task proved a lot more difficult than it appeared at the outset. That is true even though—let’s face it—the areas chosen to improve were glaringly obvious; they were supposed to be the easy ones. Progress has been uneven at best.

It took years to set benchmarks (or targets) for wait times, and there were endless arguments about technical points, such as when one begins measuring the wait. Is it when a general practitioner (GP) refers a patient to a specialist? Is it when a specialist assigns a time for surgery? Some of the benchmarks also lacked good evidence; they were rather arbitrary, and there was no good evidence they improved patient outcomes. There were also concerns about a balloon effect—increases in waits for procedures not deemed political priorities, as limited resources were shifted to the areas of focus. It is also clear that some provinces—the big, wealthy ones—tackled the wait time problem much more aggressively and successfully than others, so one of the unintended consequences was worsening regional disparities.
By 2011, however, the Canadian Institute for Health Information (CIHI) noted pretty good progress in the five target areas. Almost 100 per cent of patients were being treated within the benchmark times for cancer and heart surgery—though it should be noted that many provinces were meeting those targets before the initiative. Similarly, close to 97 per cent of patients were getting diagnostic imaging within the promised time frame, though many argued that the 28-day benchmark was too long for many patients to wait. On cataracts and joint replacements, between 75 and 84 per cent of patients were getting procedures within the benchmarks. So, overall, the record was mixed.

The Health Council of Canada identified seven “key factors for success” that were required to bring down wait times:

- support from government leaders;
- strong program leadership, with administrative and clinical champions;
- full-time staff dedicated to wait time reduction programs;
- information systems that allow for the creation of centralized waiting lists to track wait times locally and provincially;
- publicly available information on waits;
- adequate funding to introduce computerized information systems;
- a broad, comprehensive approach to reducing wait times that recognizes that many large and small changes are required.

In fact, those characteristics are essential for pretty well any reform. Wait times got dedicated funds and the dedication of politicians. But before declaring the wait times initiative a success—or even a partial success—consider this: Reducing wait times did not actually result in any meaningful change to health systems or the way health care is delivered. It simply demonstrated that if you pump enough money into an inefficient system, you can make it appear somewhat less inefficient. Also, nowhere near that much money or effort went into fulfilling the other promises in the accord.
2. STRATEGIC HEALTH HUMAN RESOURCES ACTION PLANS

The 2004 accord said that investments were required to increase the supply of health professionals in Canada, including physicians, nurses, pharmacists, and technologists, and noted that shortages were particularly acute in some parts of the country. The pact called on the provinces to set targets for the training, recruitment, and retention of health professionals by the end of 2005. Ottawa, for its part, pledged to make it easier to recruit internationally trained health care workers, improve the supply of workers in Aboriginal and linguistic minority communities, reduce the financial burden on students, and work on health human resources planning with the provinces and territories.

Progress to Date

In the years following the signing of the 2004 accord, significantly more health workers were hired. That included 12,000 new nurses, 5,000 new physicians, and 500 new pharmacists between 2005 and 2011. (In Canada, there are about 350,000 nurses, 76,000 doctors, and 32,000 pharmacists.) Much of this growth was due to higher graduation rates; university and college class sizes in virtually all health professions grew considerably in the early 2000s, even before the 2004 accord was signed, so it’s not clear there was a causal relationship. However, there is no question that most of the money from the agreement went to pay for increased labour costs. Physicians were the biggest beneficiaries. They not only saw their numbers grow but also saw their professional fees soar; in the years following the 2004 accord, their average gross billing jumped from $231,427 to $307,482.

There is very little evidence that there was any coordinated plan for getting the right mix of health professionals in place to meet the health needs of Canadians. Health Canada published the Pan-Canadian Health Human Resources Strategy but, for the most part, provinces went their own way. There was a multitude of initiatives, federal and provincial, mostly to draw health workers to rural and remote areas, and to attract specialists and sub-specialists. However, the most common strategy was to poach workers from other jurisdictions by ratcheting up wages,
an approach that unions and professional organizations love because it plays into the age-old refrain that the only solution to Canada’s health care woes is more, more, more of the same.

3. HOME CARE

In the 2004 accord, the first ministers acknowledged that homecare (and moving care into the community more broadly) is essential to an integrated, patient-centred health care system. However, they committed to cover only certain, very specific homecare services:
- short-term (up to two weeks) acute homecare after discharge from hospital, especially for people taking intravenous medication;
- short-term acute homecare after discharge from a mental health facility;
- palliative care.

Progress to Date
The accord led to a significant increase in the provision of homecare, particularly for surgery patients. But what the first ministers created was not really a homecare program so much as a way to shift some hospital care to the community. Homecare is being used to discharge sicker patients from hospital more quickly. About 1.8 million Canadians a year now get homecare, at a cost of $5.8 billion. That is significant for a program that, technically, is not considered a “medically necessary” service under the terms of the Canada Health Act. However, for all intents and purposes, it is largely an extension of hospital care.

The promise to provide homecare to mental health patients was not kept at all, while palliative care programs were bolstered only marginally. The reality is that less than one-third of Canadians get decent end-of-life care, and only a fraction of them get palliative care in the home.
The homecare initiative also had some negative unintended consequences. So much emphasis was placed on short-term acute homecare that already-paltry resources for homecare for frail seniors with chronic conditions shrank. This is actually the demographic that needs homecare the most, and it has largely been ignored.

While the homecare initiative got surgery patients out of hospital more quickly—another reason wait times were reduced—it also seemed to have resulted in other patients staying in hospital longer. In the years since the 2004 accord was enacted, the number of “alternate level of care” patients has soared. (These are patients who are “discharged” but who remain in hospital because there is nowhere else to send them.) There are some 7,500 patients living in hospitals on any given day, at a cost of more than $4 billion a year. Over half of them could move back home if homecare services were available (at about one-third of the cost). The balance would be better off in long-term care facilities that have lower overhead and more homey surroundings than hospitals.

One of the failings of the accord was that it did not establish any specific targets for homecare or any reporting requirements. So, little was done, and no effort was made to measure how little was done. Both the Romanow and Kirby reports stressed the need to invest in homecare, identifying it as an area where investment would meet the seemingly contradictory goals of saving money and improving the quality of care. All in all, this was a missed opportunity in an area where there is tremendous need.

4. PRIMARY HEALTH CARE REFORM

In the 2004 accord, the first ministers recycled a promise from the short-lived 2003 accord: that 50 per cent of Canadians would have 24/7 access to multidisciplinary care teams by 2011. They also tried to establish a best practices network and overcome barriers to progress in primary health care reform.
Progress to Date

One of the problems with this goal was there was no good way of measuring whether it had been achieved. Unlike most European countries, where primary care is stressed, Canadians do not necessarily enrol with a specific practice and, even if they do, that is not tracked very well. What we do know, based on survey data, is that 42 per cent of Canadians say they have access to same-day or next-day care. But there is no way of knowing whether that means a walk-in clinic, a GP, or a multidisciplinary team. Further, we know that 44 per cent of Canadians say they have used an emergency room for routine care in the past two years, which suggests they don’t have alternatives. Finally, Statistics Canada data show that some 4 million people do not have a regular primary care provider. So, clearly, this goal has not been met.

Another problem is that the 2004 accord never really defined primary care. Primary health care services should emphasize prevention and health promotion, but the ministers seemed to have emphasized the treatment side—the notion that sick people need a more cost-efficient alternative than the emergency department of a local hospital.

This does not mean there has not been progress. On the contrary, some provinces have made determined efforts to bolster primary care. Ontario, for example, has invested heavily in family health teams, Alberta in primary care networks, and Quebec in family medicine groups. The biggest impediment to primary care reform, however, has been physician remuneration—namely, the tradition of fee-for-service payments. To create multidisciplinary teams, provinces have had to offer significant premiums to doctors. This has proven costly.

After the accord was signed, the provinces created a best practice network, but it was dissolved in 2006 because there was no dedicated funding. This failure is indicative of the reluctance to invest in information sharing. The provinces seem to prefer to work in splendid isolation, busying themselves with reinventing the wheel instead of sharing their successes and failures.
5. ELECTRONIC HEALTH RECORDS AND TELEHEALTH

In the 2004 accord, the first ministers said that electronic health records (EHRs) were essential to health care renewal. They vowed to accelerate the development of EHRs and to bolster telehealth, particularly in rural and remote areas. Ottawa, for its part, invested an additional $100 million in Canada Health Infoway. The goal was to ensure that half of all Canadians had an EHR by the end of 2010.

Progress to Date

In March 2011, the provinces actually met that goal of creating an EHR for at least half of Canadians, but not without some pain and misery, and considerable expense. In fact, the investment in EHRs began well before the 2004 accord and it has continued. In total, $2.1 billion has been invested in Infoway. Judging how worthwhile and successful this investment has been is difficult because the structure is convoluted. The provinces and territories propose projects, and Infoway shares the cost of the required information technology infrastructure. As a result, there is no coordinated national plan, which often gives the impression that little has been achieved.

In fact, about 90 per cent of diagnostic images have now been digitized. Virtually every pharmacy in the country has EHRs, as do about two-thirds of hospitals. However, while over half of Canadians have some sort of EHR, only 37 per cent of primary care physicians use an EHR system, one of the lowest rates in the developed world.

Because systems have been built in a piecemeal fashion, there are also major interoperability issues. Most physicians, hospitals, and pharmacies can’t readily “talk” to each other electronically, even within provinces; when you look at programs outside medicare, such as homecare and long-term care, electronic communication is virtually non-existent. In short, patients are not benefitting from EHRs anywhere near to the extent they should, and there is a lot of frustration among practitioners and administrators.
The reputation of EHRs has also taken a severe beating, overshadowing the work that has been done. Ontario, in particular, was mired in a scandal related to eHealth Ontario’s excessive use of consultants, a problem that scared off a lot of politicians and slowed investments across the country.

In short, Canada remains an EHR laggard internationally and much remains to be done. It is estimated that getting every citizen an EHR could eventually cost upward of $10 billion.

Telehealth, on the other hand, is a much more positive story. It is an area where Canada has become a world leader. Perhaps that is fitting, because the need is great; Canada is a vast country, 90 per cent of which is remote and rural. There are now 5,700 telehealth sites in 1,200 communities, the largest network in the world. But, again, data collection is poor, so beyond the anecdotal tales, there is no real sense of how many patients benefit from telehealth, how much it costs, and how much it has saved.

6. ACCESS TO CARE IN THE NORTH

In the 10-year plan, the first ministers recognized that Canada’s three northern territories face particular health challenges and expenses. The federal government ponied up $150 million over five years: half of it for the Medical Travel Fund to offset the high cost of transporting patients from the North, and the balance to bolster community access. The Territorial Health System Sustainability Initiative (THSSI), as that part of the deal was known, has since been renewed, to extend it to the end of the 2004 accord in 2014.

Progress to Date

There is good anecdotal evidence that the THSSI had an impact on the ground, but the challenges of delivering health care in the Far North are tremendous and the costs enormous. For example, the three territories are home to the majority of residential school survivors, and many of them have sweeping mental health needs. Changes in how care is
delivered—in particular, new technologies and growing specialization—mean that more people than ever must fly south for care, and transport remains, by far, the largest health expense north of 60. It remains an ongoing challenge, too, to attract and retain health professionals in Northern communities, so there is a reliance on very expensive temporary workers. Despite all these demands, the tax base is miniscule. As the Senate committee that reviewed the 2004 accord noted, the territories need stable, predictable funding, and that is going to have to come from Ottawa.

7. THE NATIONAL PHARMACEUTICALS STRATEGY

The most elaborate part of the 2004 accord was the establishment of a National Pharmaceuticals Strategy. To the chagrin of many, the first ministers stopped well short of creating a national pharmacare program, or even a coherent catastrophic drug program. But they did commit to bolstering the availability, affordability, and safety of prescription drugs with the following nine-point strategy:

• develop, assess, and cost options for catastrophic pharmaceutical coverage, especially for those who require expensive drugs for rare disorders;
• establish a common National Drug Formulary;
• accelerate access to breakthrough drugs;
• strengthen evaluation of real-world drug safety and effectiveness;
• pursue purchasing strategies to obtain the best prices for Canadians for drugs and vaccines;
• enhance action to influence the prescribing behaviour of health care professionals;
• broaden the practice of e-prescribing;
• accelerate access to non-patented drugs;
• enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.
The agreement called on health ministers to establish a task force to implement the nine measures and report on their progress by June 2006.

Progress to Date

Given the long list of goals and the aggressive timetable—not to mention the crying need for fair access to drugs—some swift action should have been expected. What we saw instead were baby steps—at best.

Despite having a universal health insurance system, at least on paper, Canada offers a patchwork quilt of access to prescription drugs. There are currently 19 public drug plans (mostly for seniors and those on social assistance) and some 1,000 private drug plans in Canada. About 40 per cent of Canadians have private drug insurance (about half of those have catastrophic coverage), 40 per cent have public drug insurance (with big differences in deductibles and co-payments), and 20 per cent have no coverage and have to pay for drugs out of pocket. When you crunch all the numbers, the bottom line is that some 3 million Canadians don’t have adequate drug coverage, especially for “catastrophic” drug costs.

Every province and territory—save New Brunswick and Yukon—has a catastrophic drug program, but coverage varies widely. Patients with high drug costs can be eligible for relief only after they spend anywhere from 2 per cent to 10 per cent of family income. Ultimately, coverage depends on where people live and where they work. Young people, the self-employed, and middle-income earners in smaller provinces are the most vulnerable.

Consider this example: A person with a $20,000 annual drug bill—not unusual for a cancer patient or someone with a chronic condition, such as rheumatoid arthritis—would pay nothing for prescription medications in the Northwest Territories, roughly $1,500 in Quebec, $8,000 in Saskatchewan, and $20,000 in Prince Edward Island. The National Pharmaceuticals Strategy did little to resolve these injustices. (P.E.I., however, unveiled a catastrophic drug plan in mid-2013.)
The provinces did make some progress on other aspects of the strategy, though. There is now the Common Drug Review, a pan-Canadian process for determining whether new drugs will be listed on provincial formularies. However, there is not a single formulary and provinces have a tendency to opt out of Common Drug Review decisions, undermining the process.

One of the most dramatic public policy moves in recent years has been the provinces’ aggressive effort to cut the price Canadians pay for generic drugs. Prices are fixed at a percentage of the brand name drug’s price, and that percentage has plummeted from 50 per cent to as low as 18 per cent. But, again, moves were made province by province, not in a coordinated fashion. Meanwhile, a bulk drug purchasing strategy, the most obvious way to bring down prices for brand name drugs, has been much talked about but little acted upon. Almost a decade after promising to move forward with the idea, the provinces have, to date, agreed on bulk purchases of only six drugs.

The problem, in a nutshell, is that the National Pharmaceuticals Strategy was a set of vague objectives with no measurable goals. The first ministers got exactly what they planned for: almost nothing.

**8. PREVENTION, PROMOTION, AND PUBLIC HEALTH**

In the 2004 health accord, the first ministers offered up a customary homage to the importance of investing in public health, but there were few concrete commitments. There was a promise to establish a Pan-Canadian Public Health Network to better respond to public health threats, and Ottawa vowed to pump new money into the National Immunization Strategy.

**Progress to Date**

The federal government held up its end of the bargain, spending $600 million on childhood vaccination programs. While it was not a formal part of the agreement, Ottawa also made big investments in the
Canadian Cancer Control Strategy ($250 million over five years) and in the creation of the Mental Health Commission of Canada ($65 million over five years), both major public health initiatives.

The Pan-Canadian Public Health Network was created and it had an impact, particularly in coordinating the response to pandemic H1N1 influenza in 2009. On the health promotion front, however, there were no major initiatives. The reality is that there is no serious Canadian public health strategy that addresses the social determinants of health, such as income, education, and housing. Health disparities—particularly in minority communities such as First Nations, Inuit, and Métis areas—remain one of the principal causes of poor health and inequity, and the 2004 accord did little to address those.

9. HEALTH INNOVATION

In the 10-year plan, the federal government committed to continuing its investments in science, technology, and research in support of health innovations.

Progress to Date
Innovation is the buzzword du jour. It is said, with near-religious zeal, that innovation is the key to reforming health care. But this promise in the 2004 accord was so vague as to be largely meaningless. To be fair, though, Ottawa continued to invest heavily in health research, through funding bodies such as the Canadian Institutes of Health Research and Genome Canada. The focus of that research, however, shifted markedly toward commercialization, supporting projects that would have a financial payoff in the short term. There was very little investment in health care systems research to make the health system safer, more efficient, and more cost-effective.
10. ACCOUNTABILITY AND REPORTING TO CITIZENS

One of the major objectives of the 2004 accord was supposed to be bolstering accountability and providing citizens with much more concrete information on the performance of the health system. The Health Council of Canada was created to report to Canadians on health status and health outcomes, as well as progress on the 10-year plan.

Progress to Date

The Health Council of Canada has done an admirable job, particularly given its limited powers and resources. Specifically, it produced a good body of work highlighting innovative health care projects across the country, in the hope they would be adopted more widely. But when it came to monitoring the implementation of the accord, the council was never able to do much more than observe and comment diplomatically. With the expiration of the 10-year deal in 2014, the Health Council will be disbanded; while there were anguished complaints about that move, the reality is that its disappearance won’t make a whole heck of a lot of difference.

On the accountability and monitoring front, however, there have been a lot of positive developments in the provinces, notably with the creation of quality councils in Saskatchewan, Ontario, and Alberta. The unintended consequence, however, is that the provinces that are investing in these initiatives are improving care, creating ever-greater disparities between these provinces and the laggard jurisdictions.

Data collection and the use of accountability mechanisms are essential to reform; if you want performance to improve, you have to measure it. But systematic measurement of concrete, measurable goals and objectives is still the exception, not the rule, in Canada. Nothing demonstrated that better than the health accord itself, which was long on vague promises and short on specific goals.

All in all, the 2004 health accord moved things along. It provided a little more focused attention on what needed to be fixed in Canada’s health system. However, it is not at all clear that the first ministers got their priorities right. They did what was politically expedient—tackling
wait times—and didn’t really resolve the glaringly unfinished business of medicare, such as ensuring fair access to prescription drugs and homecare. The clear lesson for Ottawa was that it should have been much more specific in its demands.

The 10-Year Plan to Strengthen Health Care saw $41 billion pumped into provincial health insurance plans with only vague promises in return. That money did not buy change; it bought time.

The lesson that should be retained from the health accord process is that, if there is going to be a coherent national medicare system and serious reform, the federal government needs to have a vision and it has to bargain hard. Clearly, though, that lesson was not learned or embraced. Prime Minister Stephen Harper has taken a hands-off approach, arguing that health care is exclusively a provincial jurisdiction. Rather than negotiate a new health accord, he made a unilateral offer. His government maintained the existing CHT and promised an escalator of 6 per cent from 2014 to 2016, followed by increases vaguely tied to inflation that should amount to about 3 per cent a year. In other words, Ottawa has withdrawn completely from the health leadership game, contenting itself with writing cheques.
Section II

FROZEN IN TIME:
THE CANADIAN HEALTH CARE SYSTEM TODAY
How We Compare

WHAT HAVE OTHERS DONE BETTER?
Because of the proximity and overwhelming presence of the United States of America, Canada has a natural tendency to compare itself with its southern neighbour. Nowhere is that truer than in health care.

We take much self-righteous succour in the belief that the big, bad U.S. has a health system that is distinctly worse than our own. The number of uninsured Americans exceeds, by far, the entire population of Canada. Health care bills are the number one cause of bankruptcy in the U.S., a phenomenon that is essentially unknown in Canada. Health care spending is, per capita, about 50 per cent higher in the U.S. There are a few reasons for this, including the profit-driven tendency to overtreat those who do have health insurance and the excess decentralization that makes the system very expensive to administer. In Canadian hospitals, the smug saying goes, they don’t check your credit rating before they check your pulse. Moreover, our population health measures—from childhood mortality to life expectancy—rank better than those in the U.S., virtually across the board.

No wonder we love medicare—it provides quality care equitably to all, regardless of race, creed, age, or income.

But this jingoism is delusional. Medicare does provide a slight advantage that contributes to population health, but other factors matter a lot more to health than medical care does. They include income, education, housing, and the environment—factors that require investment in social programs and some redistributive taxation. The only thing more dysfunctional than the U.S. health system is its social safety net. Also, the quality, accessibility, and affordability of health care in the U.S. vary greatly, spanning the very best to the very worst. In Canada, we have embraced equity, but too often at the price of comfortable mediocrity.

“The first wealth is health.”

—Ralph Waldo Emerson
If we want to take a true measure of the Canadian health system, the U.S. is the worst possible comparator. It is an outlier. The American health system—which isn’t even a system, because it lacks any sort of organization or principles—is an experiment in the commodification of health care gone wildly amok.

Compared to the blind man, the one-eyed man has great vision. To gauge the relative success of the Canadian model of health care financing and delivery, we need to look to other countries with universal health systems, such as European countries. When we do so, the reflection is far more humbling.

In addition, if we are going to undertake reform—transformation even—we need to know the full range of options. We have to move beyond the tiresome caricature of a debate that holds “it’s our way or the American way.” The choice is not between the sputtering status quo and the outright untenable. There are other models, and we should look to them for inspiration and guidance as we set out to reform medicare.

There are essentially four ways of delivering and paying for health care, with many permutations. Let’s take a quick look at them.

**THE BEVERIDGE MODEL**

This model is named after William Beveridge, who introduced Britain’s National Health Service in the post-Second World War period. In it, health care is financed through tax revenues and provided to citizens by government, much like highways and firefighting services.

Governments own many, but not all, hospitals and clinics. In some instances, doctors are state employees, but there are also private providers who work for the state on contract. These systems often have low per capita costs because the single payer, government, controls providers’ fees.

Among the jurisdictions using the Beveridge plan or versions of it are the United Kingdom (though it should be noted that it has moved away from this approach considerably in recent years), New Zealand,
Spain, and several Scandinavian countries. Cuba uses the Beveridge model to its fullest extent; it is the only place where the government controls the entire health system.

**THE BISMARCK MODEL**

This model is named for 19th-century Prussian chancellor Otto von Bismarck, who is credited with inventing the welfare state while leading Germany’s unification. In this insurance system, employees and employers usually use payroll deductions to fund the insurers, which are known as “sickness funds.”

While insurers are private, the provision of insurance is strictly regulated and must cover all citizens. Doctors and hospitals tend to be private providers who sell their services to insurers. The system might seem complex; Germany alone has some 240 separate funds. However, strict regulation lets governments manage costs to the same degree as a single-payer system does.

As well as Germany, countries using the Bismarck model include Switzerland, the Netherlands, Belgium, France, several Latin American countries, and Japan.

**THE NATIONAL HEALTH INSURANCE MODEL**

Aspects of both the Bismarck and Beveridge models are blended in this system. Under it, every citizen funds a government-run insurance program through taxes. That program pays private providers, which generally offer services on a not-for-profit basis. The principal benefit of this approach is that it is administratively simple and cheap.

The single payer often has great clout—at least in theory—to bargain for low prices, whether for the mass purchase of prescription drugs or for physicians’ services. To keep costs manageable, governments using this system restrict the range of covered services or make their peace with long waiting times.
Canada’s medicare is the classic national health insurance system, although the fact that it operates as 14 separate systems undermines some of the theoretical benefits. Some other industrialized countries, such as Taiwan and South Korea, have adopted this approach.

**THE OUT-OF-POCKET MODEL**

Only about a quarter of the world’s countries have highly organized health care systems and some form of universal health insurance. In most countries, inequity in access to health care is the norm. The wealthy get treated; the poor may mortgage their future to get care, live with untreated chronic illnesses, or simply die.

In much of the developing world—especially the rural areas of China, Southeast Asia, Africa, and South America—people have no access to a doctor or, if they do, they are hard-pressed to pay for one. They depend on merchants selling dubious pharmaceuticals at the market, the local healer, or, if they’re lucky, a nurse at a Spartan clinic. In these market-driven systems, not only does wealth equal health, but wealth also determines access to health care.

In fact, wealthy countries are almost the only ones with wide-ranging and universal health care systems. Of the 25 wealthiest countries in the world, 24 have universal health care systems—the only exception being the U.S.

In some ways, citizens of these countries are the least in need of universal health care, though there are significant disparities within wealthy countries. However, there is a growing recognition that basic health care—like basic education—is essential to population health and economic growth. That’s why a country such as Rwanda, which was ravaged by genocide, has made a universal health system the cornerstone of its rebuilding. Even countries such as India—which faces countless social and political challenges—are making great strides toward providing basic health care to all.
There is a lot of mythology and misinformation about what a universal system is. The most common misconception is that “universal” means “socialist” or “state run.” Every universal health care system in the world—with the exception of those in Cuba and North Korea—has a mix of public and private health insurance, and private and public delivery of care. And, within each of the models—Bismarck, Beveridge, and national insurance—there are tremendous variations. There is no single magic formula that works best. Rather, every country needs to develop a health care system that is appropriate to its political, economic, and cultural context.

What is clear, too, is that every country struggles with the same issues that Canada does—notably, how to ensure equitable access to care while containing health costs. For the most part, however, other countries—especially those in Europe—have been more successful in implementing reform, achieving near-universal coverage of their citizens, and keeping costs reasonable.

Take, for example, the Netherlands, which the Organisation for Economic Co-operation and Development recently deemed to have the best overall health care system and which is often cited as a model for health reform.

Like most Western countries, the Netherlands introduced a host of social programs in the post-war years, including a state-run health insurance program for low- and middle-income citizens; higher income individuals were expected to purchase private insurance. While coverage was close to universal, there were growing disparities over time, and mounting public dissatisfaction with the quality and efficiency of the state-run plan.

In 2006, the Netherlands undertook massive health care reform, making health insurance mandatory for all. Instead of expanding the state-run insurance program, the government abolished it. Citizens had to purchase insurance from private providers, with the state providing subsidies on a sliding scale based on income. The result is that roughly the same two-thirds of the population had health insurance funded by government, but they had greater choice.
Insurers, however, do not operate in a free market but in a highly regulated one; in particular, they cannot refuse coverage to any individual, regardless of their health status. This avoids the problem of companies cherry-picking healthy, inexpensive clients and dumping costly ones to maximize profits, as they do in unregulated markets. At the same time, though, the Dutch government provides higher subsidies for people who are sicker.

While this private insurance scheme with risk adjustment has attracted a lot of attention, it is often forgotten that the Netherlands made significant changes on the delivery side as well. In particular, the country invested heavily in a primary care model. In addition to having mandatory health insurance, every citizen must also register with a general practitioner (GP), who coordinates all his or her care. GPs, who are salaried, serve a gatekeeper function; one of their roles is to keep health costs down. (Most specialists are also salaried, and those who work on a fee-for-service basis have a salary cap.) For the Dutch, same-day physician appointments are the norm and emergency waits are short, thanks to a network of urgent care clinics. However, the flip side is that access to specialists is limited and waits for elective procedures can be long, though not nearly as long as they are in Canada. It also needs to be underlined that the delivery of health care, a mix of private and public services, is also highly regulated.

Despite the rather radical change in approach—one that was supposed to bring some private sector discipline and efficiencies to the health insurance system—in the end, the savings were minimal. The Netherlands continues to have among the highest per capita health costs in the world. Let’s not forget, though, that the Dutch still pay less per capita than Canadians for health care, and the services covered are far more extensive—in addition to physician and hospital care, insurance covers prescription drugs, homecare, and dental care. Despite reform, the financing of health insurance remains complex. Citizens pay private insurance premiums averaging $1,750 (which may or may not be subsidized), as well as a health tax of 7.5 per cent of their wages (to a maximum of $3,775 a year), along with a payroll tax to cover homecare and long-term care.
On the plus side, there is some evidence that the Dutch are among the most informed and cost-aware insurance clients, in large part because they are called upon annually to choose their insurance provider. In the early years of reform, 1 in 4 citizens switched plans, but it is now 1 in 20, showing the system has achieved some stability.

While health care reform was quite radical in the Netherlands, the process was not quick; a national commission started studying the state of the health care system in 1996, but its recommendations weren’t implemented until 2006. Unlike the case in Canada, however, there was follow-through, despite changes of government. The reasons for this are largely cultural. The Dutch take great pride in their social services, and when the health system was perceived to be floundering, there was tremendous public pressure to fix it. When the inquiry started, it was not a stalling tactic; on the contrary, the expectation was that the government would act fully on its findings.

The Dutch experience provides some important lessons. First and foremost, reform is complex and multi-faceted, and it cannot occur overnight. You cannot change the insurance funding system fundamentally without making equally substantive changes to the delivery system. It’s a striking example, too, of the fact that the process can be—and almost certainly will be—humbling. One of the primary motivations for reform was to cut costs, and that didn’t really pan out. Still, in the end, the Netherlands ended up with a more effective and efficient health care system, one offering better access and more equitable coverage, and that was ultimately the goal.

If Canada hopes to do the same, we need to dispense with the simplistic bromide that our health system is better than that in the U.S. and take some strong medicine in the form of critical comparisons with other countries that are leaders in health reform—be they the Netherlands, France, Sweden, or even India.
What Are the Barriers to Reform?
The only constant in health care is change—or so goes the cliché. While that may be true in medicine, where there have been tremendous advances in surgical techniques, drugs, and technology over the years, it is certainly not the case with the structures used to deliver that medical care to the masses.

There is no question that we deliver better care than we did when medicare was born. In fact, medical care is constantly improving. But access to and appropriateness of care are not what they should be, and the efficiency and cost-effectiveness of the system leave much to be desired. That is because the administrative structure for delivering care, from payment methods to priority-setting, has not kept pace with what’s happening in the laboratory and on the front lines. Rather, the building blocks of the system have remained frozen in time. Modernization is desperately needed.

So what are the impediments to change?

Lack of information is certainly not the problem. The never-ending series of inquiries and analyses that have been done in Canada over the years have laid out the problems and solutions fairly clearly. In short, they have all recommended that we move away from the emphasis on curative medicine and institutional care to a system that places far more emphasis on community-based prevention and primary care. On the payment side, the oft-repeated recommendation is to focus expenditures from the public purse on the necessities, and leave the extras to be covered by private insurance or out-of-pocket payments. There has also been a lot of collective nodding of heads in response to these sensible, middle-of-the-road alternatives. But there has been far too little real action on the implementation side.

The tendency, then, is to conclude that the fundamental problem is a lack of leadership in general and a lack of political leadership in particular. “If only politicians had a little backbone,” goes the refrain, “we
could fix medicare.” Ironically, politicians themselves are the leading proponents of this theory—especially when they are howling from the opposition benches.

However, saying we lack leadership is too simplistic. It is disingenuous to suggest that all it takes is a snap of the fingers by a strong-willed politician to implement wide-ranging health reform. There are, in fact, multiple hurdles to overcome, and the complexity of the task should not be understated. By failing to recognize and acknowledge how numerous and large these challenges really are, we have left our political leaders, no matter how well-intentioned, impotent.

The barriers are constitutional, legislative, political, ideological, economic, and practical. Together, they create a culture of fear—a fear of acting that has left us with unsatisfying incrementalism instead of the real reform that we know, deep down, is necessary.

So let’s examine each of the big barriers in more depth.

CONSTITUTIONAL

Health is a provincial responsibility. It says so in the Constitution. It’s why we don’t have a truly national health care system and why those who would like to create a truly national medicare program have their hands tied. That is the commonly accepted wisdom, yet this is another example of mythology overriding reality.

Constitutionally, health care is a shared responsibility. Provinces have jurisdiction over delivery of health services to citizens in their area, but this in no way implies Ottawa has no role. On the contrary, the federal government plays a key role in health care delivery, including providing care for Aboriginal people, refugees, and members of the Canadian Forces and the Royal Canadian Mounted Police. In fact, when you add up its direct constituents, Ottawa runs the fifth-largest health system in the country. In addition, it is responsible for public health, drug regulation, food safety, international health, and health research, among other areas—via large departments such as Health Canada and the Public Health Agency of Canada, and independent bodies that are
funded federally, such as the Canadian Institutes of Health Research. Not to mention the fact that Ottawa funds three of the largest private health insurance programs in the country: for federal public servants, members of the Canadian Forces, and status Indians and Inuit. The budget of Health Canada exceeds that of most provincial health ministries and Ottawa provides about 25 per cent of all the money the provinces use to provide health care.

In short, the federal government is, arguably, the single most important player in the health system, even when it tries to take a hands-off approach to health (like the government of Stephen Harper). What is true is that Canada will never—barring an unlikely constitutional amendment and a major philosophical shift—have a federal health system. But it can, and should, have a national system—one in which all the players in the federation agree to some common goals and standards. There is no constitutional barrier to Ottawa creating national standards for health care delivery, nor to it placing conditions on the money it provides to the provinces and territories. In fact, traditionally, that is precisely the role the federal government has played, and citizens and most first ministers have encouraged it to play. The federal government has the power and the duty to create a semblance of fairness so that Canadians receive more or less the same health care coverage from coast to coast to coast, just as it had a duty (not a constitutional obligation) to build a unifying national railway.

That being said, the provinces have often responded to federal initiatives in health care by railing against violations of this area of “exclusive provincial jurisdiction.” But rarely, if ever, do they challenge those “incursions” in court. The politically motivated lament is essentially code for “give us more money.” Throughout history, provinces have always been happy to set aside their sacred constitutional principles when there is cash on the table. This is not a problem in itself; it is part of the cut and thrust of a federation. The problem is that this arrangement has never been formalized—though it almost was in the late 1950s, when Louis Saint-Laurent’s government offered to trade taxation powers for greater jurisdiction over health. Less cynically, the provinces also recognize that having similar health standards
across the country is politically beneficial. With Ottawa shirking its moral—if not legal—responsibilities, they are making efforts to attenuate growing disparities by adopting common policies via the Council of the Federation. In short, the Constitution is not a barrier to health reform. Rather, it has long been a convenient excuse for inaction, all too often invoked.

**LEGISLATIVE**

The *Canada Health Act* was designed to put an end to extra-billing, the practice among some physicians of demanding extra payments for basic services. In addition to closing the loophole that allowed this practice to arise, Ottawa used the opportunity to consolidate some general principles found in disparate health laws that had accumulated over the years—notably the notion that universality, comprehensiveness, portability, accessibility, and public administration were the hallmarks of medicare. The law gives Ottawa the power to claw money back if the provinces fail to heed these principles. In the public consciousness—or, more precisely, in the public discourse of interest groups—the *Canada Health Act* does much more, however. It outlaws the provision of private health care, obliges Ottawa to generously fund health care, and creates a Canadian identity. The reality is that the law outlaws nothing. What it says is that if a province wishes to take a different approach from common practice—to allow private clinics to charge for services that could be seen as essential, such as hip surgery, for example—Ottawa could withhold some health dollars from that province. The law is rarely enforced, in part because violations are poorly defined, but it is nevertheless a huge impediment to reform.

The belief that, under medicare, rules surrounding the financing and delivery of health care are carved in stone has led to stagnation. Anyone who dares suggest any reform that can be viewed as offending the “sacred principles” of the *Canada Health Act* is seen as a traitor. The real penalty is not financial, but the risk of public disapproval.
Never has a relatively straightforward piece of legislation been imbued with such mythical powers. The *Canada Health Act*, which was intended to “facilitate reasonable access to health services without financial or other barriers,” has itself become a major barrier to reform. The law has become a velvet handcuff, promoting the status quo and discouraging innovation. The law itself is not an impediment to reform, but the perpetuation of the mythology about the *Canada Health Act* certainly is.

**POLITICAL**

The legendary Newfoundland premier Joey Smallwood once said, “I’ve never had a conversation about health care that didn’t lose me votes.” That view, that a dire political price will be paid for attempting reform, is widespread. It helps explain why health care consistently ranks as the number one concern of Canadians but the issue is virtually absent from the political discourse, even at election time. The consensus, though largely unstated, is that there is little incentive for politically bold leadership.

In addition to this fearfulness, the structure and traditions of the Canadian political system help ensure that the health system remains the same. In the four-year political cycle, there are two years to undertake initiatives and then two more to shore them up and prepare for the next electoral battle. However, the fundamental changes required to reform the health system will have to be implemented over a much longer time period. Practically, that means that the politician putting his or her neck out has a good chance of getting a lot of the grief and very little of the credit for reforms, even if they are effective (or, more importantly, seen to be effective.)

The other difficulty is that health is seen as so important—with the polls and voter feedback serving as constant reminders—that politicians feel a need to micromanage the system. There is little doubt that a health system overseen by professional managers would make significant changes, if not for the political interference. European systems,
which have been far more effective at adapting to changing demographics and consumer demands, place a lot more power in their bureaucracies, while politicians provide the broader vision. (They also don’t see public administration as an anathema.) That’s why countries like the Netherlands and Sweden—which, in theory, face as many barriers to change as Canada does—can undertake fundamental reforms over many years and despite changes of government.

In Canada, the vision and the clearly stated goals to give it life are absent. There is also a notable lack of stability: Ministers of health change as if in a revolving door, as do deputy ministers of health.

VESTED INTERESTS

The most powerful force in Canadian health care is inertia. Why? Because those with the most power and influence are doing pretty well and, if the system changes fundamentally (as it should), they stand to lose the most, at least in the short term. While everyone in the system talks a good game—and, for the most part, their proposals for change are more well-intentioned than self-serving—the bottom line for most interest groups, unions, and individual practitioners is this: Change is essential, and we support it wholeheartedly, as long as we don’t lose any power or money. The priority is not reform; it’s turf protection. The economic footprint of health care is large: more than $200 billion in spending and 1.1 million workers. If you want to know which groups pose the biggest barriers to change, you need to follow the money.

The best way to do so is to visualize health spending as a pie chart. Three big slices account for over 60 per cent of the pie: hospitals (30 per cent), drugs (16 per cent), and physician services (15 per cent). This is where the power rests and the resistance to change is concentrated. Hospitals don’t want to cede patients to homecare, many physicians don’t want to see nurse practitioners absorb some of their work, and makers of brand-name pharmaceuticals don’t want drug plans paying for similar generics instead. These are natural reactions; nobody—individuals or institutions—wants to give up power, prestige, and
money. The result is that the shifts that need to happen to modernize care are occurring, but at a fairly glacial pace. For that to change, more deliberate policy measures and, to a certain extent, incentives for change are needed.

Health care spending is usually broken down into major categories such as hospitals, physician services, drugs, and other institutional care. But there is another way to slice the health care spending pie that is rarely considered. Almost 70 per cent of all health dollars go to labour. This is not, in itself, a bad thing. After all, good care depends on good people, and it should be hands-on. But despite spending some $140 billion on health workers, Canada does not have a coherent health human resources strategy. There is a constant refrain of shortages in every area—nurses, physicians, technologists, occupational therapists—but little effort is made to coordinate care.

One of the keys to reform is getting various health professions to break out of their silos and work together to fashion a coherent labour policy. There is plenty of work—and plenty of cash—to go around, but it needs to be apportioned differently and more smartly.

MONEY

Money is also a big impediment to change—not because we lack health dollars, but because we’re all too willing to pump more money into the health system to do more of the same. Health spending has risen from $12 billion in 1975 to $200 billion today in current dollars. In constant 1997 dollars—meaning adjusted for inflation—costs have still risen from $36 billion to $142 billion in that period. The cost of delivering care doubles every decade and health care technology is always changing. However, when all is said and done, the care delivered (and the way it is delivered) has not changed that dramatically.

There have been, over the years, repeated attempts to “buy change.” The most notable example was the 2004 health accord, which saw Ottawa transfer an additional $41 billion to the provinces in what promised to be the “fix for a generation.” What did Canadians get for
that massive investment? Almost a decade later, the answer is: not very much. The money didn’t buy change; it bought labour peace. Almost all the money went to hiring additional workers—12,000 nurses and 5,000 doctors in the last five years alone—and to offering significant wage hikes.

Worse yet, there is rarely, if ever, discussion of whether Canadians are actually getting value for the money they spend on health care. The system is costly, but is it cost-effective? We simply don’t know, though there is a fair bit of evidence it is not. After all, Canada has one of the most expensive health care systems in the world but also one of the least inclusive and universal.

FEAR

Every one of the impediments listed—and there are many other smaller ones not explicitly mentioned—has the same fuel: fear.

Canadians are profoundly conservative (small c). There are few things that they fear more than change. When discussion of health reform arises, there are rarely, if ever, inspiring words about the power of innovation or excitement about the limitless possibilities of medicare. No, when these discussions take place, it is always against a backdrop of fear. Canadians are, for the most part, believers in the axiom, “Better the devil you know than the one you don’t.”

They are willing to tolerate the queues, the waits, the inefficiencies, and the waste they know full well exist in Canadian health care for one reason alone: because they fear that if things change, they will get worse.

Where do they get this idea? They get it from interest groups, who cry wolf constantly. These groups have cowed the public into subservience, into fearful acceptance of the status quo.

So, what do we get? Inertia, with a built-in cost escalator.
Foot-dragging, lack of direction, legislative paralysis, lack of control over the workforce, poor return on investment, fear of change: That’s no way to run a $200-billion-a-year business. There are big barriers to change or, stated more bluntly, formidable excuses for inaction. But every one of those issues should be—and is—resolvable.

Without clear goals, a mandate, and stable administration, there will never be effective health care reform. We also need to learn to say “no” to inertia, and to demand and expect continuous improvement.

That’s where politicians, policy-makers, health professionals, and consumer groups should be investing their energy: in daring to dream of a better medicare. That is the show of leadership we need to break down the barriers to reform.
National Issue, Provincial Authority
“Courage is what it takes to stand up and speak; courage is also what it takes to sit down and listen.”

—Winston Churchill

There is not really a national health care system in Canada. Rather, there are 14 publicly funded and decentralized systems to deliver care—10 provincial, 3 territorial, and 1 federal—supplemented by a lot of privately financed services.

Public funding comes from both federal and provincial governments, and this has been a source of some tension and confusion since well before the advent of medicare. While the constitutional division of powers is clear (sort of), the financial responsibilities of each level of government are not.

It is often said that health care delivery is strictly a provincial responsibility, but that is an oversimplification. In fact, under the Constitution Act, 1867, there are health matters that fall under federal and provincial jurisdiction. In short, it is a shared responsibility. Section 92 of the Constitution grants provinces primary jurisdiction over health care delivery. Provinces are responsible for property and civil rights, so they have the power to regulate businesses, including the private and public provision of health insurance, and the training and licensing of health care providers. Further, the Constitution grants them the authority to establish and regulate asylums and hospitals, with the exception of marine hospitals (which we now call veterans’ hospitals).

However, section 91 of the Constitution Act also makes the federal government responsible for delivering health care to some groups of people, including the military, militia, and naval services; First Nations and Inuit (a court ruling extended this to Métis as well); and federal inmates. Under section 95, the federal government also has jurisdiction over immigrants and refugees. When all those citizens who are dependent on Ottawa for health care are gathered under one umbrella, the federal government becomes the fifth-largest provider of health care.
services in the country—bigger than most provinces and territories. (However, federally, there is not a single insurance plan, as there is in the provinces.)

Because Ottawa has criminal law powers under the Constitution, it is also responsible for regulating potential health hazards. These include food and drugs, medical devices, tobacco, pest control products, and industrial and consumer products. That role has grown increasingly important over the years. It has also become more blurred, because determining whether treatments—from surgery to prescription drugs—are safe is often enmeshed with figuring out whether they are cost-effective and worth financing.

Finally, the Constitution gives the federal government jurisdiction over public health, which is defined as “the science and art of promoting health, preventing disease, prolonging life and improving the quality of life through the organized efforts of society.” The “peace, order and good government” powers granted the federal government also mean that Ottawa can override provincial powers in a public health emergency, such as a pandemic.

These legal niceties are important, but we need to keep them in context. When the powers were divvied up in the Constitution Act, 1867, no one could have imagined, in their wildest dreams, just how important health care would become—or how pervasive government would become in our lives, for that matter. At the time, the federal government had control over what were probably considered the most important health powers—overseeing quarantine and taking care of soldiers. In the 19th century, there was no health system to speak of, and provinces had the power to oversee commercial acts, including sale of goods and services by doctors and quacks alike (at the time, the distinction was not always clear). There was no deliberate choice to decentralize control of what would become, arguably, the most important government service: health care. We should not forget that when academics and politicians speak haughtily of exclusive jurisdiction and the sacred division of powers. Health care delivery is largely a provincial responsibility because of an accident of history.
Beyond the basic parameters set out in the Constitution, the practical division of powers and sharing of responsibilities in health care have been worked out over time, largely by mutual agreement between Ottawa and the provinces. When necessary, disputes have been settled amicably, or by the courts. In fact, Ottawa had virtually nothing to do with health care until the First World War, and the devastating influenza pandemic that followed, when it created the first federal department of health. The provinces did not resist that move; on the contrary, they welcomed it because of the devastating impact of the Spanish flu. Over the next decades, the provinces approached Ottawa with increasing frequency, mostly looking for cash to expand health programs. And let’s not forget that the Constitution is silent on that all-important question: Who should pay for health care?

Despite the constitutional division of powers, the federal, provincial, and territorial governments have a long history of collaboration. Until the 1950s, there were very few major disputes and, since then, there has been a lot more political rhetoric than actual power struggles.

What developed over time is something that is not spelled out in the Constitution but that is an obvious need in a vast country: a commitment to ensuring a modicum of equity and fairness in the health services available to Canadians in different regions. In other words, Ottawa’s role became to create a semblance of a national system beyond provincial and territorial boundaries. The way to do that most easily was with money, supplemented by legislation. Federal laws have never been intrusive or heavy-handed; the tradition has been to set out standards that provinces have to meet to get money, to entice them to buy into national programs.

That approach is central to what has become the country’s iconic health legislation, the *Canada Health Act*. While it gives Ottawa no real powers (aside from the ability to withhold money from the provinces), it spells out pretty clearly some basic, unifying principles: public administration, comprehensiveness, universality, portability, and accessibility.

To ensure that provinces and territories live up to those principles—and ultimately to ensure that care offered is roughly similar across the country—Ottawa dangles some pretty significant dollars in front
of them, in the form of the Canada Health Transfer (CHT) and other equalization payments. The federal government currently transfers just over $30 billion a year to the provinces and territories in the form of cash and tax points. Still, the current formula and the existing level of investment are not enough to completely even out considerable regional differences in demographics and health care costs. Consider that health care accounts for 13.2 per cent of GDP in Nova Scotia, compared with 7.6 per cent of GDP in Alberta.

While the cash transfers from Ottawa to the provinces and territories are significant, the reality is that the federal government has, over time, gradually reneged on its role in financing health care. Medicare became a national program because the federal government vowed to cover half the costs of medically necessary services incurred by the provinces. However, since 1977, it has gradually backed away from that promise, supplanting the straightforward 50/50 deal with a series of complex funding formulas that mixed health funding with money for other social programs and that became confounded with other equalization programs. The bottom line, though, is that Ottawa now covers only 20 per cent of publicly funded health expenses. The federal government should not be a minority partner in the single most important social program in the country. It is passing the buck instead of passing on the bucks.

Regardless of the size of the transfers, Ottawa should not content itself with merely writing cheques. No one is suggesting it should be blindly dumping more money into medicare with no strings attached. In fact, the whole system of federal transfers and equalization needs a pretty fundamental revamping. In the meantime, the least the federal government could do is place some clear conditions on the CHT to promote reform. While there has been a lot of talk about “buying change” with federal money, particularly the huge whacks of cash in the 2004 accord, accountability measures were virtually non-existent and a lot of the targeted money did not go where Ottawa intended. Federal money should befunneled to specific areas where inequities exist, the most obvious example being prescription drug funding.
catastrophic drug plan could be financed with a very small investment from Ottawa. It is that kind of incentive that helped create the medicare system we have today.

Financing—what is financed and how it is financed—should also be a collaborative process. Federal-provincial-territorial collaboration is essential to sound fiscal management of the health care system, as well as to ensuring equity among regions. Ottawa unilaterally imposed the most recent funding deal on the provinces and territories—quite shocking in a field of shared responsibility. The only reason more of a fuss was not made is that the federal government bought silence with a ridiculously generous 6 per cent escalator clause on the CHT, at least for a few years. But all that did was delay a needed political debate and necessary reforms.

The Constitution is not a real impediment to reform; it is an excuse. Ideology is also an important factor. The hands-off-health-care attitude of the current government reflects a dogmatic belief in decentralization, one that holds that the federal government has few responsibilities other than national defence, international relations, and the economy. Virtually everything else is perceived as the sole responsibility of the provinces and territories. This “fundamentalist” reading of the Constitution means Ottawa has virtually withdrawn from any leadership role in health care.

That is, at best, unfortunate. It can fairly be called an abdication of responsibility. At the very least, Ottawa could lead by example, setting out to create the best health insurance and health delivery system for the population for which it is responsible. The federally funded insurance program for Aboriginal people could very well be a model for all of Canada: It provides coverage well beyond hospital and physician services, including prescription drugs, homecare, and dental care, and it does so for a relatively modest cost. But on the delivery side, Ottawa has a dismal record: There are serious accessibility and quality issues, and much of the provision of care is contracted out without good accountability measures.
Regardless of whether one agrees with it or not, Ottawa’s hands-off attitude toward health care is a legitimate political position, and the provinces and territories have to deal with it. Instead of simply bemoaning the federal government’s position while cashing their federal cheques, they could take this golden opportunity to say: “We have common interests and, despite Ottawa’s indifference, we’re going to create a truly national health care system.”

But they have done nothing of the sort. The provinces and territories have failed to work effectively together, to share best practices, or to unite in their common interest. More than anything, they have tended to work at cross-purposes, poaching health care workers from each other’s jurisdictions and driving up labour costs tremendously in the process.

There are some promising examples of cooperation through the newly bolstered Council of the Federation, but they are mostly baby steps.

There are many examples of successful national (not federal) models that could be used to improve health care and stem the growing inequities, including the following:

- the Canadian Institute for Health Information, which collects and analyzes data with the goal of improving health care delivery and efficiency;
- the Canadian Agency for Drugs and Technologies in Health, an agency that assesses new drugs and technologies to ensure sound purchasing decisions—a task that includes overseeing the Common Drug Review;
- the Health Council of Canada, which, in addition to monitoring the implementation of the 2004 health accord, highlights health innovations.

However, these are all information-sharing approaches. There is not yet enough common management of the health system, but there is an excellent model for taking this next step. Canadian Blood Services (CBS), an agency that oversees the collection and distribution of blood products, has an integrated management model. It was born of necessity, in response to the horrific tainted blood scandal and the need to
restore confidence in the blood system. CBS took a disgraced, decentralized, dysfunctional network of 16 blood centres and transformed them into a singular, streamlined system with national standards. The provinces essentially own and manage CBS; they appoint the board members (including members of the public) but it operates independently, at arm’s length. Practically, this means CBS has a single purchasing plan for drugs, common standards that ensure safety and equity of care across the country, and transparency in financing and accountability measures. It answers to all the provinces, with oversight from federal regulators.

In short, CBS has created a national health care delivery model that retains provincial control. This is what Canadians should expect on a grander scale—a multi-jurisdictional, federated health care system. There is no constitutional barrier to using this approach, and many benefits to be derived from doing so. It’s a concrete demonstration that transformation is possible.
The Third Rail

WHAT IS THE ROLE OF THE PRIVATE SECTOR?
“When I use a word it means just what I choose it to mean—neither more nor less.”
—Humpty Dumpty

Nothing inflames passions and sows confusion in the ongoing debate about the future of Canadian health care more than the so-called public-private debate.

One camp holds that for medicare to provide care to all, it must remain a purely public, “values-based” system and resist the entreaties of greedy profit-mongers; the other argues that opening up the system to competition will bring market discipline that will make all the health system’s woes disappear.

But it’s a false dichotomy and the “debate”—more accurately described as exchanges of dogma—is circular, tiresome, and paralyzing. The fear of “privatization” is one of the greatest impediments to reform.

First, we need to get the terminology right. What do we mean by “private” and “public” health care? Second, once we have clearly defined the terms, we need to figure out why we would opt for private over public, or vice versa. Is one approach cheaper than the other? Does opting for one approach improve access or ensure better quality of care? That’s the kind of pragmatic public-private debate we need—one that is informed and has a purpose.

Let’s start with language. In Canada, “private” tends to be an inflammatory term. Why? Because, for many, “private” is synonymous with “for-profit,” and the notion of profiting from the sick and dying is perceived as distasteful and unethical. But there is actually very little private, for-profit care in Canada—at least not in the traditional sense of the term, where large corporations listed on the stock exchange run health conglomerates. The private care we have tends to be provided by individuals or small groups who incorporate for tax reasons, and companies that contract with publicly administered bodies and institutions.
But why is it necessarily wrong for an individual or company to make a profit selling health care services, when we accept they can do so for selling food, housing, or other basic necessities? It comes back to mythology: this notion that medicare is somehow a sacred program; that it is “values-based,” not “profit-driven.” That kind of rhetoric, which sets up a false dichotomy on an issue that is far from black and white, stands in the way of frank analysis and discussion.

In Canada, we have both private and public provision of health care, as well as private and public funding of care. It’s important to make the distinction between service delivery and payment. We need to recognize too that, in both cases, there are not two distinct camps—private and public—but rather a public-private continuum.

Most care is privately provided, through a mix of private not-for-profit and private for-profit providers. Very few health services are actually delivered publicly—meaning by public employees. Sometimes, it’s not entirely clear whether services should be classified as private or public.

Take physicians: They are, for the most part, independent contractors, which makes them private, for-profit providers. Physicians are essentially small businesses, even if there are no cash transactions in their offices. Their payments are negotiated centrally between professional associations and ministries of health (similar to the collective bargaining process) and paid almost exclusively from the public purse. Doctors do very well by this process, with their average billings exceeding $350,000 a year. This is gross income, but the average overhead is 26 per cent, meaning there is still a generous profit, or take-home pay.

In fact, health workers are paid very well in Canada, and appropriately so. But it is no coincidence that the most vocal promoters of the notion that any privatization will spell the death of medicare are unions. What unions fear is the loss of their monopoly—the ability to negotiate labour contracts centrally with the provinces—which gives them tremendous clout. Conversely, there are entrepreneurs who would love to operate non-union facilities, for the flexibility they would provide. Because health workers are highly specialized, non-union shops tend to pay as well or better than unionized ones, but they don’t have a lot of
the constraining rules. For example, under many union contracts, only nurses can supervise other nurses. These are not insignificant issues, but what we need to do is separate discussions about labour practices from the larger debate about the benefits and drawbacks of private and public provision of care.

Managing labour issues is the single biggest challenge in Canadian hospitals. There can be, within a single institution, dozens of labour contracts in place. Alongside the unionized workers, there are fee-for-service doctors, non-unionized salaried employees, volunteers, and countless outside providers.

And how do we classify hospitals—as public or private? Technically at least, most are charitable institutions, meaning they are private, not-for-profit providers. But their employees are a mix of private contractors (from physicians to caterers) and salaried employees (from nurses to administrators), almost all paid by a third party (government), and their operations depend on funding from ministries of health (government), private insurance (private), and charitable foundations (private, not-for-profit). Then there is homecare, a mix of for-profit and not-for-profit companies that compete head to head; and pharmacists, who can be entrepreneurs who own their own stores, employees of private companies, or hospital employees. Then there are strictly private businesses, such as parking lot owners and makers of drugs and devices, which sell their services for a profit. Finally, there are employees on the public payroll, most of them working in ministries of health and public health units.

All told, roughly 70 per cent of health services are provided by “private” workers and companies. So, in that sense, the health system is barely public at all. The delivery of health services, however, is subject to a lot of regulation, and that is the key to ensuring that the health care system works in the public interest. That, rather than the classification of workers into private or public categories, is what should matter.

When it comes to financing, there is also a mixture of public and private payment for services, but the public side dominates. Overall, 70 per cent of health care fees are paid from the public purse, while 30 per cent are paid privately, either with private insurance or out of
pocket. To put it in raw numbers, in 2011, public spending totalled $140 billion and private spending totalled $60 billion ($25 billion of which came from private insurers and $35 billion that was paid out of pocket). But the system-wide split masks some great variations in the private-public mix across sectors.

Under our medicare system, the financing of physician and hospital services is almost 100 per cent public, meaning it is paid by provincial, taxpayer-funded insurance plans. Those two areas alone account for almost half of all health spending in Canada. Drug costs are paid 40 per cent from the public purse and 60 per cent privately, largely through employer-sponsored drug insurance plans. Dental care is almost 100 per cent privately funded, except in Quebec, where dental care for children is state-funded.

The perception is that having a provincial health card entitles Canadians to “free” health care. The reality is that 22 million Canadians have private health insurance to supplement public insurance. One in every nine health dollars actually comes from private insurance. This includes $12 billion for prescription drugs; $6.3 billion for dental care; $1.2 billion for hospital services not covered by medicare, such as semi-private rooms; $1 billion for health professionals, such as physiotherapists and psychologists; $800 million for vision care; and $115 million for equipment, such as wheelchairs. Canadians even spend a tiny amount ($7.5 million) on private physician care. In most provinces, physicians cannot bill for care privately if they bill provincial insurance plans, but they can opt out entirely. Ironically, the principal clients of private clinics and services are workers’ compensation programs, which want their patients (many of them unionized) fast tracked so they can get back to work quickly. Governments are also, increasingly, contracting work out to private clinics, further blurring the private-public lines.

While Canadians tend to get worked up about the privatization of care—real and perceived—the reality is that all universal health care systems, like Canada’s, depend primarily on the private sector to deliver care, and pay for it with a variety of private and public payment schemes.
The question is not whether there should be private and public methods of delivery and payment, but rather what mix of methods and level of regulation should be used to ensure quality health care is available, affordable, and accessible to the masses.

While medicare is largely perceived to be “socialist”—or state-funded—the truth is that Canadians invest far fewer public dollars in health care than most countries with universal health systems. Across Europe, the norm is about 80 per cent public funding and 20 per cent private. European countries are also perceived to have far more private, for-profit health care, which is not accurate either.

The distinguishing feature—or, more precisely, anachronism—in Canada’s system is its bifurcated payment method, under which we publicly pay 100 per cent of the costs of hospital and physician care, and varying percentages of costs in other areas, such as drugs and homecare. In most European countries, coverage is far more extensive—it includes prescription drugs, homecare, and dentistry—but less comprehensive, meaning it rarely covers 100 per cent of any one service, even physician and hospital care. Most people will purchase private insurance to cover those additional costs. Unlike Canadians, very few citizens in other countries pay for health services out of pocket.

“There seems to be confusion about the legitimate role of the private sector in the health system,” the OECD said in a 2010 report. That’s quite an understatement.

One of the most common misconceptions is that private health care is illegal in Canada. It is a popular political talking point to say that the Canada Health Act (CHA) outlaws private health care. In fact, federal law outlaws nothing. It says health care must be publicly administered but is silent on the way care is provided—and even how it is financed. What the CHA says is that if provinces allow private payments for “medically necessary” services (defined as hospital and physician care), specifically in the form of user fees or extra-billing on top of what public insurance pays, then federal transfers can be clawed back an equivalent amount. In theory, it’s a dissuasive measure, but it’s rarely enforced. First of all, there is little need for extra-billing; fees negotiated with physicians are generous, often to a fault. There are also a lot
of grey areas. For example, a private clinic can bill for standard medical treatments and it can, legally, also charge extra for all manner of tests and frills, such as nutritional planning. So if it adds an additional fee for “managing” a patient’s care, is that extra-billing?

Currently, legislation in five provinces outlaws the sale of private insurance for “medically necessary” care. Until 2005, it was six provinces, but the Supreme Court of Canada struck down Quebec’s law in the much-discussed Chaoulli decision. The court, however, said private insurance should be considered only as a last resort, if waits in the public system are unreasonable. There are legal challenges to provincial laws in Ontario, Alberta, and B.C. that are likely to reduce legal restrictions. What remains to be seen, however, is whether a viable market will emerge for private insurance that covers “medically necessary” care. That will likely not occur until there is more clarity about what public insurance plans cover and do not cover.

In the meantime, there is a small but lucrative market for “medically necessary” services such as hip transplants for patients willing to pay out of pocket. This is where the “two-tier” rhetoric gets cranked up. Of course, some important ethical and societal points should be considered: Should people be able to get care more promptly (or “jump the queue,” to use the common parlance) just because they are wealthier? Opponents argue that allowing that offends the principles of equity and fairness that are central to medicare. But proponents counter that allowing the wealthy to pay will ultimately benefit the public system because it will free up a spot in the queue. That is only true if there is additional capacity, meaning that a surgeon is not replacing publicly paid procedures with privately paid ones.

This issue is not unique to Canada. However, it does not cause the gnashing of teeth in Europe and elsewhere that it does here. In most countries, there is parallel provision of some services—mostly surgery—but with strict regulation. For example, a surgeon will be permitted to perform X number of hip replacements in a private, for-profit clinic but not until she has done Y number of hip replacements at the publicly funded hospital. In other cases, the issue is moot because patients have insurance that they can use anywhere. Most important of
all, most countries don’t have the long waits that exist in Canada, so the queue-jumping notion is largely irrelevant. For the most part, their “two-tier” systems do not allow faster access to care but do provide frills, such as better food.

Waits are, without a doubt, a major issue in this country, but they are an organizational issue. Long waits do not, as some argue, provide a social licence to throw the doors open to private, for-profit care. The courts have been quite clear on this point, and politicians and policymakers should be as well. However, we should not be blindly opposed to using private providers, even for medically necessary care, either individually or collectively—as long as there are conditions, such as the hip replacement example above.

We should turn to the private sector if the services provided are of equal quality (private and public institutions need the same rules and regulations), if they are the same price or cheaper, if they are faster, and if the public option has been exhausted. A sound regulatory and accountability framework is the key.

The reality is that the advantage that private clinics offer rarely relates to the magic of the market but, rather, to specialization and flexibility. Specialized clinics can be efficient in the public system but they are underused, and they are constrained by rules that often exist in unionized workplaces. Contracting out to private providers in a publicly funded health system is acceptable as long as the aforementioned conditions are met and the purpose is clear. What we need to avoid is so-called cream-skimming, where all the profitable procedures are left to the private sector and all the complex, expensive care is left to the public system. Allowing this would create the false illusion that publicly administered care is inefficient and expensive.

We have to be careful, as well, not to become so consumed with these debates that we lose sight of what matters ultimately—caring for patients. When people are in need, they don’t especially care who will be providing the service, where it will be provided, and what the contractual details are. What is important, above all, is the quality of care, and that has to be paramount in all funding decisions.
What is important for individuals, too, is the total cost of health services, not whether they are paid with public insurance (taxes), with private insurance, or out of pocket. One of the main reasons we have a public health insurance program is that the pooling of resources is supposed to keep costs down. That benefit can be offset if there are a lot of additional private insurance and out-of-pocket costs, which there are in Canada.

When it comes to per capita health costs, we fare poorly. According to the Organisation for Economic Co-operation and Development, the average per capita cost across 34 OECD countries was $3,270 in 2010. That is well below Canada’s cost of $4,445 per capita. To be fair, the OECD includes some countries where the cost of delivering care is much lower, such as Turkey and Chile. But even next to comparable countries, such as France ($3,975), the U.K. ($3,435) and Japan ($3,035), Canada’s overall health care costs are high.

There are a couple of obvious reasons for this. As mentioned on several occasions, we under-invest in public health care. That means insurance costs for services not deemed “medically necessary”—such as drugs, homecare, and dental services—are high. Of that $4,445 per capita spending on health, Canadian spend about $555 each on private insurance and $780 out of pocket, in addition to the $3,110 they pay in taxes to fund the public portion of health care.

There is no either-or in the public-private debate. It’s about getting the mix right, in delivery and in payment, with sound regulation and strict accountability.

Do we have it right now? It certainly seems not.
Paying the Piper

IS MEDICARE SUSTAINABLE?
“We need to defend the interests of those whom we’ve never met and never will.”

—Jeffrey D. Sachs

Medicare is unsustainable.

That phrase has been repeated so many times as to become accepted common wisdom. After all, health spending is already gobbling up 40 per cent of provincial revenues, and it will soon account for 50 or 60 per cent of public spending, if not more. Plotted on a graph, it’s a trend line that health economists gloomily refer to as the “straight line of death.”

Why is this happening? Why is health spending putting us on the fast track to bankruptcy? Because the population is aging, we’re all obese, drugs costs are out of control, technology costs are soaring, the tax base is shrinking, younger consumers are becoming more demanding, and so on.

The same old dire warnings have been trotted out since Otto von Bismarck created the first universal health care system in 1883. This cynicism is unhelpful, counter-productive, and dated. Instead of throwing up our hands in despair, we need to roll up our sleeves and get to the task at hand: creating an effective, affordable means of delivering health care to the masses.

There is no magic formula for doing so. It will require innovation, imagination, and, above all, some tough choices. We need to embrace openness, consider new options, and be willing to challenge so-called accepted wisdom and shake off our entrenched cultural quirks, such as fear and conservatism.

The starting point should not be a fatalistic statement: “The health care system is unsustainable.” Rather, it should be a challenging question: “How do we make the health care system sustainable?”

That, in turn, should lead to some even more basic questions, such as these: “What is the purpose of the health care system? What do we mean by sustainability? What exactly do we want to sustain? Once that
is established, how do we do so? And how do we do so while ensuring we meet the health care needs of the population and are fiscally responsible?"

The reason we have a publicly funded health care system is, quite simply, to spread risk over a large population. We pay it forward. Health care is expensive; it always has been and always will be. But the vast majority of people do not need health care services at any given time. The solution is to pool money—by paying taxes or premiums—over a long period and then dip into that pool when we need to pay for care. In Canada, this model has served us well; it has been used on a small scale for centuries and on a grand scale for over half a century. But both the scope and cost of care have risen steadily. That raises the prospect that there may not be enough money in the pool for those who need it in the future or, conversely, that keeping the pool topped up will place too much of a burden on taxpayers.

Currently, about 70 per cent of Canadians pay as much (or less) in taxes that go to health funding than they consume in health services over a lifetime. (The average lifetime health cost for a Canadian is $220,000, and roughly 7 per cent of all the taxes we pay go to finance health care.) The other 30 per cent will draw from the insurance pool. Superficially, that may seem like a bad deal for the majority, but it’s not. First, pooling keeps costs down, so everyone benefits; more importantly, though, no one knows when they will be on the wrong side of the gurney, when they will need a lot of health care.

Concerns that the pool will run dry or that taxpayers won’t be able to replenish it are very real, for individuals and for society as a whole. But do they necessarily imply that medicare is unsustainable?

The Oxford English Dictionary defines “sustainability” as “keeping something going continuously.” But, in health care, is that really what sustainability means—continuing to do what we’re doing now for the foreseeable future? It’s actually a pretty sad notion—to want to keep doing the same old thing, to keep treading water. It’s a very Dilbert-like ambition. And it’s one of the principal reasons Canada has the Dilbert of health care systems, one that plods along. The only obvious goal we have in Canadian health care is to do the same thing as we did last year.
And the only clearly measurable outcome we have is how much money we spend from year to year. Sustainability should not be defined as sustaining the status quo.

Still, there is no question that health care—a universal health care system, even—is something that, as a society, we want to “keep going,” for reasons of economics and social justice. If we’re going to have a health care system, then of course we want it to be sustainable; it would be absurd to suggest otherwise.

The real question, though, is what exactly we want to sustain. Again, there is broad consensus on the fundamentals. What Canadians like about medicare—regardless of their political affiliation—is the values it embodies, such as fairness, equity, and compassion. What we want to sustain, above all, are those values. However, there is more than one way to skin that cat.

The basic principle of medicare is that medically necessary care should be available to all, regardless of ability to pay. Does that mean that all care every Canadian desires must be provided “free of charge” at all times? Of course not. That is unrealistic and unsustainable. There are practical, ethical, and financial limits to the care that a state-funded insurance program can and should provide. While ensuring that essential care is available to everyone, we also have to ensure that the overall cost of providing that service is affordable. To sustain a universal health care system, we need to make care affordable not only for individuals but for society as a whole.

The challenge, of course, is establishing limits or, stated more bluntly, saying “no.” That word does not appear to be in the lexicon of Canadian politicians and policy-makers, at least not when it comes to health care. On the rare occasions when Canadian public insurance plans do say “no” to funding new services or drugs—or delist ones that have been covered previously—they tend to do so willy-nilly. There is a lack of explanation and transparency. Saying “no” is not enough; we have to learn to say “yes” to the right services—those that provide real benefit and a good return on investment (in the form of health outcomes, not profit).
There are various categories of health services: essential, desirable, and frills (for lack of a better word). A universal system should provide, and fund, the essentials and, where it is affordable, the desirables. The frills can be paid with private insurance or out of pocket. Drawing those lines is the key to keeping medicare affordable and sustainable.

But how do you make those distinctions? Many smart people and smart organizations have struggled with that question for many years, in Canada and elsewhere. No one has come up with the perfect solution, but many have come up with sound principles and various mechanisms to apply them.

First and foremost, you pay only for what works and provides value for money. You pay for what is essential. The U.S. Institute of Medicine (IOM) has done what is probably the most extensive examination of the thorny question, “What is essential?” The IOM stresses that the determination requires a delicate balancing act but that getting it right is essential to ensuring both affordability and fairness. If the services deemed essential are defined too narrowly, health insurance can become meaningless because it does not cover real needs; if they are defined too broadly, then coverage becomes too expensive.

In a 300-page report published in 2011, the IOM set out 10 broad areas that should be covered by health insurance plans (in the U.S., these are mandated by law):

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and addiction services;
- prescription drugs;
- rehabilitative services and devices;
- laboratory services;
- preventive and wellness services, and chronic disease management; and
- pediatric services, including oral and vision care.
The panel, however, did not outline what precisely should be covered in each of these areas. Rather, it said there needs to be a framework to determine what is essential and what is not. It stressed, too, that decisions should be evidence-based, and focus on effectiveness, cost-effectiveness, and value.

Various agencies around the world—such as the National Institute for Health and Care Excellence (NICE) in the U.K., and the Canadian Agency for Drugs and Technologies in Health (CADTH) and the Institute for Clinical Evaluative Sciences (ICES) in Canada—already do this kind of analysis. In fact, Canada is a world leader in assessing health services, particularly when it comes to drugs and new technologies. But the techniques and information are rarely used in the day-to-day administration of the health care system. Rather than depend on dispassionate calculations, we too often make funding decisions based on lobbying and anecdotes.

In Canada, the decision on what is medically necessary is largely left—by default—to physicians. This is problematic, because the priority of physicians (quite rightly) is to treat specific patients; they rarely consider how those decisions affect the total pool of health dollars, and they are even more rarely called upon to do so.

Physicians, understandably, are not fans of limiting the availability of services or payments for services. They balk at the notion that a bureaucratic process can be allowed to overrule their clinical judgment. But the reality is that there is little evidence that many of the services that physicians routinely recommend are effective. There is too much reliance on tradition and not enough on evidence. (And let’s be clear here that no one is suggesting that physicians and other health professionals blindly follow guidelines or that they be programmed robotically. Medicine is as much art as science, but clinical practice must be evidence-informed, and decisions cannot be made with complete disregard for cost and cost-effectiveness.)

Since health dollars are not unlimited, it is also necessary to consider trade-offs. That has to be done at a societal level, not an individual one. Imagine for a moment that there is a drug that can—according to research—extend the life of a 60-year-old cancer patient by three
months, but at a cost of $50,000. That same amount of money can pay for a liver transplant for a young mother that will allow her to live another 20 years, or it can buy lifesaving vaccines for 1,000 babies. How do you make those gut-wrenching choices?

You don’t make them individually. You make them systematically, and you make that system a key component of the funding process. The IOM, in its report, acknowledged that there is pressure to try to fund everything, an approach that is unrealistic. The panel suggested that decision-makers use a grocery shopping metaphor to help them determine which services should be deemed essential: “One option is to go shopping, fill up your cart with the groceries you want, and then find out what it costs. The other option is to walk into the store with a firm idea of what you can spend and to fill the cart carefully, with only enough food to fit within your budget.”

In other words, governments should not have a stagnant, carved-in-stone list of what is covered and what is not covered, but rather should make ongoing decisions using an evidence-driven, transparent, and apolitical process.

There is much talk in health care about bending the cost curve. The economics are not complex: cost equals price times volume, so you have to cut costs (with innovation and efficiency), reduce volumes (by focusing on effective, necessary interventions), or do both.

Collectively, ensuring affordability and sustainability must be seen as the cost of offering health services without unduly restricting other government (or collective) programs. Individually, Canadians need to consider the total cost of their health spending, not just the government portion.

It is a mistake to assume that sustainability is strictly a financial issue. The Conference Board of Canada recognized this fact in the definition it crafted:

Sustainable health and health care is the appropriate balance between the cultural, social, and economic environments present within a complex system that is designed to meet the health and health care needs of
individuals and the population (from health promotion and disease prevention to restoring health and supporting end of life) and that leads to optimal health and health care outcomes without compromising the outcomes and ability of future generations to meet their own health and health care needs.

This approach is inspired by the famed Brundtland Report, which defined sustainable development as “development that meets the needs of the present without compromising the ability of future generations to meet their own needs.”

What we need to be clear on is what we want to deliver and why—our health goals. Then we should focus on delivering health services to the masses in a way that will achieve these goals effectively, cost efficiently, and equitably.

That’s what we want to sustain—a system that ensures that everyone has essential health care.

What we should be striving to sustain is a system that embraces innovation and best practices, and that is constantly improving. We should be doing so with purpose, and deliberately.

But in Canada, our tradition has been to sustain the status quo. Sustainability is not about continuing to do what we do now. It’s about doing it better and smarter.
The Economic Footprint
When we talk about health care in Canada, it is all too often in Chicken-Littlesque terms: The aging population will bankrupt us, drug costs are out of control, health care is gorging such a large proportion of provincial budgets that there’s no money left for anything else, and so on.

Come budget time, dour finance ministers will invariably pull out a graph showing health spending over time—featuring a dark line jutting menacingly upward, especially on the “projected” part of the graph. It is an iconic image some health economists refer to mockingly as the “straight line of death.” The message is clear: We are doomed. Health care spending is a bottomless pit where tax dollars go to die. But there’s a flip side to the dire equation, a counterpoint to the overheated, one-sided rhetoric. Health spending is not strictly an expense; it is also an investment—in the health of individuals and the health of a nation. There is a payback that we neglect at our peril.

The health sector is an economic driver, a generator of wealth, a source of good-paying jobs, and a stabilizer in times of economic upheaval. Universal health care is also a tremendous benefit not only to individuals, but also to employers and the economy in general.

We spend upward of $200 billion a year in Canada on health care services—$140 billion from the public treasury and $60 billion from private sources. The principal reason that health care spending is inexorably rising is that we are using more health services. The second is that there have been technological advances and improvements in care. We are living longer and better than people ever have in history, in part because of better health care. This is hardly a waste of money.

No one is arguing we should not be spending anything on health care. That would be foolhardy. There is very little, if any, opposition to universal health care. The economic benefits of providing essential health care to everyone are undeniable. There are, of course, debates on how much we should be spending and how we should be financing the
provision of health care, but those are different issues. Instead of dire warnings about the unsustainability of health care spending, we should be focusing on how to get the best bang for the health care buck.

In strictly economic terms, health care spending is a good thing—though we have to be careful not to take that idea to an absurd degree, as has happened in the U.S. Health care spending has outpaced economic growth for three decades, which is a bit concerning. But there is not a lot of evidence that, in Canada, our spending has been profligate. Our investments in health care have also served as ballast in tough economic times.

In Canada, the health care sector is about the same size as the manufacturing sector, accounting for over 10 per cent of gross domestic product. Health care plays an even more important role in poor parts of the country: it accounts for 13.2 per cent of GDP in Nova Scotia, for example, compared with 7.6 per cent in Alberta. The health care sector is also much less volatile than manufacturing or resource-based industries are, providing much-needed stability in the economy.

Let’s not forget that health care is a labour-intensive sector. About two-thirds of all health care spending goes to wages. Nationwide, the health care sector employs 1 in every 11 workers, accounting for 1.6 million direct jobs and another 500,000 indirect jobs.

Total compensation for health care workers is more than $127 billion annually, just shy of $60,000 per direct or indirect job. Health care workers pay a lot of taxes. Health care institutions also pay taxes on goods and services. Overall, the health care sector generates $30.6 billion in tax revenues annually. (That is, coincidentally, almost identical to the amount Ottawa transfers to the provinces each year for health care.) Put another way, for every $5 in public spending on health care, governments get back at least $1 in taxes. The sector is a key part of the tax base, federally, provincially, and municipally.

Hospitals are landmarks in communities; they are also economic motors, especially in smaller centres. The 1,200 hospitals across the country are often among the largest employers in their cities and towns,
and the other 93,000 ambulatory care centres—the dentists’ offices, optometrists, community health centres, and so on that we tend to take for granted—stabilize the tax base in addition to providing key services.

It has become self-evident to Canadians, through repetition if nothing else, that health care is costly. We hear it said repeatedly that health care accounts for 40 to 50 per cent of all program spending by provinces. But that is not the most useful figure. If you want to bring down the proportion of health care spending, the quickest way to do so is by jacking up investments in other areas, such as education, roads, and so on. In fact, one of the principal reasons that health costs have “soared” is that governments have cut spending in other areas, particularly in social services. In many cases, that proves to be a false economy, because citizens who fall through the social safety net invariably require more health care.

The other important issue we rarely discuss in Canada is the cost of health care for individuals. Because we don’t pay health insurance premiums, it is hard to determine how many of our tax dollars go to health. The Canadian Institute for Health Information crunched those numbers and found that Canadians pay between 5.8 and 7.5 per cent of their income for their publicly funded health insurance. Because we have a progressive tax system—meaning the higher your income, the higher your tax rate—the dollar amounts vary. So, for example, if you earn $17,500 annually, you pay $1,020 a year for health services; if you make $114,000, you pay $8,650 for those same services. Those are quite reasonable amounts.

The universal health care system is particularly beneficial for the poor. In Canada, we often hear horror stories from the U.S, where some 40 million people do not have health insurance and where medical bills are the leading cause of personal bankruptcy. The CIHI data help us understand how this is possible. They show that, on average, lower income Canadians consume health care services equivalent to 24 per cent of their income, compared with 2.9 per cent for higher income Canadians. Medicare is a redistributive social program in addition to a health insurance plan. Having publicly funded health care is equivalent to an 18.3 per cent boost in income for the country’s poorest citizens.
and results in an income loss of 4.6 per cent for the wealthiest. For middle-income Canadians, it is pretty well a wash, the equivalent of a modest 2 per cent gain in income. But the pooling of resources means that everyone benefits economically. Essentially, what the numbers tell us is that publicly funded health care makes Canada more equal, more fair. Medicare offers benefits not only on a micro scale, but on a macro level as well.

Canada’s political leaders like to brag that Canada weathered the global recession a lot better than many other countries, particularly the U.S., because of sound fiscal management and a well-regulated banking sector. What they too often neglect to mention is the role of the health care sector, and the universal health insurance program in particular, in this equation.

In a report published by The Conference Board of Canada, a telling graphic shows the shrinkage of the economy from 2007 to 2012 and, alongside it, the slow and steady growth of the health care sector during the same period. You can clearly see an offsetting effect. The message here is clear: Universal health care helps make Canada recession resistant. In the U.S., the opposite effect actually occurred. When the recession hit, job losses meant people lost their health insurance. Business in the health care sector slowed considerably, leading to layoffs and cutbacks—a vicious circle.

It is a reminder that it is not spending alone that has an economic benefit. The universal nature of the medicare system is important. In countries such as Canada with universal health care systems, the health insurance system provides a great advantage for citizens and employers.

First of all, ensuring everyone has access to essential care makes people healthier. (So, too, do many other redistributive social programs, but the discussion here is about health care services.) That means, among other things, that they can participate more actively in society, in ways ranging from volunteering to working.

Also, when employers alone provide health benefits, many people are left out in the cold. Such a system also reduces the mobility of the workforce. (This is a big problem in the U.S. in particular.) Having large, publicly funded health insurance plans brings down costs. That
is a great benefit to employers, especially in an export economy. For example, it costs about $2,000 less to build a car in Canada than it does in the U.S., strictly because of lower health insurance costs. In a competitive international economy, those kinds of savings matter, and they translate into jobs.

Universal health insurance also matters a lot in a service economy, where employers offering low-wage jobs often cannot afford (or choose not) to provide health insurance to their workers. Health insurance contributes greatly to a more stable and productive workforce. It reduces absenteeism and encourages people to deal with health problems early, before they reach a crisis point.

Investments in health research—billions of dollars annually in Canada alone—are also economic drivers, and an important source of innovation and technological advancement.

Of course, none of this suggests we should mindlessly shovel more money into health care. Opportunity costs have to be taken into account. Can the money we spend on health care provide a better return—economic, social, or otherwise—if we invest it elsewhere? We should be making every effort to deliver health care more efficiently and cost effectively, not to advocate spending for the sake of spending.

However, as we talk of health care reform in the years to come, and as the rhetoric about our “unsustainable” health system heats up, let’s not lose sight of the fact that the $200 billion Canadians spend each year on health care is not just shovelled into a big black pit.

It’s actually good medicine for the country’s economy, especially when the economy is ailing.
Section III

HEALTH CARE REFORM: WHAT NEEDS TO CHANGE?
The Path Forward

STRUCTURAL REFORM
“If we want things to stay the same, things will have to change.”

—Giuseppe Tomasi di Lampedusa

In Canada, we have excellent care, in large part because of the quality of health care providers, and state-of-the-art equipment and infrastructure. There are also few real limits on spending, so there is no skimping on medical interventions. But we are able to deliver quality care in spite of the system, not because of it. Constantly using square pegs to fill round holes is inefficient and expensive.

As mentioned throughout this book, Canada’s publicly funded health care system was designed and structured to deliver acute care to a young population. The near-exclusive emphasis on hospitals and physician care was appropriate when medicare was born; it was, after all, an era of great medical advances and boundless promise, and more care invariably meant better care.

“A few decades ago, cutting-edge medicine was all going to be technical, reliant on ever-bigger, better, and more expensive gizmos,” says Dr. John Haggie, former president of the Canadian Medical Association. “What we're looking at now is the era of low-intensity health care—not the big glamorous investments, not the multi-million-dollar machines and the very expensive procedures, but small incremental amounts of money invested in community points of care, where it makes a difference.”

In other words, we live in a very different world today. We need a health care system designed to deliver chronic care to an aging population. The “journey of care” does not last a few days any more; it often lasts years. Technology and drugs are important, but they should not take precedence over hands-on care and good old-fashioned caring. Over time, we have focused so heavily on increasing the quantity and sophistication of care that we have lost sight of the basics—namely, that we are treating people, not just bodies harbouring a collection of diseases and conditions. One of the greatest medical challenges we face today is resisting overtreatment—the use of expensive, intrusive technologies.
that provide only marginal gain to the patient. The excesses of medical care have, paradoxically, become one of the leading causes of premature mortality. They have also become an enormous expense.

After getting the quantity and quality of care right, the next biggest challenge is figuring out how it should be delivered. The principal complaint of patients in today’s health care system is the lack of good old-fashioned customer service. Ultimately, that’s what patient-centred care is all about: listening to patients and their families, and adjusting to their needs and their daily realities.

The Canadian health care system needs to be modernized. Practically, we need to turn the way we deliver health care on its head, placing the emphasis on primary care (multidisciplinary clinics) instead of on tertiary care (hospitals). We need to put the “care” back into “health care.”

That philosophy has to be embraced at the bedside, but also at the policy and planning levels. It means viewing health care as a system—one with specific population health goals, care plans for individuals, and accountability for both.

Currently, we don’t have a cohesive health system. We have a collection of services that are offered to the public under the rubric of a public health insurance program—in 14 different jurisdictions, no less. These services are rarely offered in an organized, coherent, or purposeful manner. We can do so much better.

“Real improvement comes from changing systems, not from change within systems,” says Donald Berwick, the former CEO of the Institute for Healthcare Improvement. We have spent far too long fiddling while medicare burns.

Fixing—or, more precisely, creating—a coherent health care system is not a constitutional issue, nor is it a political or financial one. It’s not even a medical issue. It’s an engineering issue. We have all the pieces in place to create a superb health care system; we just have to put them together differently.
Most of our problems, from wait times to soaring costs, have their roots in antiquated processes of care. We are hamstrung by structural inefficiencies—a situation that has been likened to an out-of-control ride in a wheelbarrow at 100 kilometres per hour. What we need instead is a vehicle—a structure—that can deliver a more comfortable ride.

There is no one magic bullet for reform. Rather, a number of initiatives need to be undertaken simultaneously. The recommendations that follow would require significant change on many fronts. But they should not be viewed as overwhelming or impossible. On the contrary, a lot of these changes are already underway. What we need to do now is pick up the pace and coordinate. We need to move from incremental changes to purposeful reform—the difference being that change is a single act, while reform is a process.

**PRIMARY CARE**

One of the fundamental structural problems in Canada’s health care system is the lack of a clearly identified front door. Put another way, there are few places where patients can routinely go to access the care they need promptly and efficiently, and very few people responsible for tracking them throughout the health care “journey” that is modern life. With few exceptions, there is no place Canadians can call their medical home, which the College of Family Physicians of Canada defines as a “central hub for timely provision and coordination of a comprehensive menu of health and medical services patients need.”

Traditionally, we have depended on family physicians to serve as that home base. Almost 30 million Canadians have a link to a family doctor, however tenuous, but roughly 4 million others have none. Still, even for those with a regular doctor, prompt appointments are hard to come by and same-day access—the gold standard—is a rarity. Doctors, who have rosters of 2,000-plus patients, no longer know each by name. Few practitioners visit their patients in hospital or nursing homes any more, never mind at home.
So, when medical help is required, it tends to be catch as catch can. The de facto entry point into the system all too often becomes the emergency room (where patching and dispatching, and long waits, are the norm) or walk-in clinics (tremendous money wasters that specialize in passing the buck back to emergency rooms or family doctors).

Using these inappropriate points of access is the equivalent of entering your home by clambering up the fire escape or crawling in through a basement window, only to find that the door to the main floor is locked and you have to start over again. It’s a terribly inefficient and expensive way to deliver health care.

Among other things, when there is no front door, there is no real gatekeeper. However, with the proliferation of ever-more-expensive drugs and technologies, the gatekeeper function has become more important than ever.

Primary health reform has been talked about for decades. In fact, with the publication of the Lalonde report, a groundbreaking document prepared by then-health minister Marc Lalonde in 1974, Canada became a world leader in the concept of primary care (but, sadly, not in the practice of it). Every one of the dozens of health inquiries since has dedicated a good chunk of its recommendations to the need for primary care reform. In the 2004 health accord, the provinces received $800 million to bolster primary care, but that news was overshadowed by the politically motivated focus on reducing surgical wait times, where billions were invested to produce modest results. The good news is that there has been a lot of progress of late on the notion that every Canadian should have a clearly identifiable primary care provider for preventive care, sickness care, and some quarterbacking and follow-up when a patient needs acute care.

In the 21st century, primary care can’t be provided by a single physician, à la Marcus Welby. Today’s patients require episodic, acute care on occasion, but mostly they need chronic care. Consider that 81 per cent of people over the age of 65 have at least one chronic health condition, such as heart disease or diabetes. And this is not an issue exclusive to the elderly: by age 50, over half of Canadians are living with a chronic health condition. They don’t need intensive care, but they do
need monitoring and advice to avoid complications. This kind of care can’t be provided by a solo physician; it is health care best delivered by teams of people with specialized functions, such as a dietician, occupational therapist, pharmacist, nurse, and so on.

Thankfully, in recent years, there has been a significant shift to providing primary care using interdisciplinary teams. Alberta has primary care networks, Ontario has family health teams, Quebec has family medicine groups, and most other provinces have variations on these names with similar philosophies. We shouldn’t forget, either, that excellent primary care has been offered for decades by local community services centres (CLSCs) in Quebec and community health centres in Ontario; however, these pioneering initiatives have always been chronically underfunded. The process of primary care reform needs to be accelerated and valued.

Ensuring that every Canadian has a medical home doesn’t necessarily require spending more money. It means shifting resources from acute care hospitals to community-based primary care practices.

**PHARMACARE**

Medicare was created in response to an untenable situation. Families were being bankrupted by hospital and physician bills, and patients were going without treatment—even for life-threatening conditions—for lack of money.

Today, an eerily similar situation exists with prescription drugs. People with conditions such as cancer (particularly if they are treated outside hospital), multiple sclerosis, and rheumatoid arthritis can face crushing out-of-pocket expenses and go without necessary care for lack of money.

As happened before medicare evolved, programs have sprung up piecemeal to deal with the most egregious situations. Back in the day, physicians would take payments in kind from cash-strapped patients and religious hospitals offered charitable care to the desperate. Then government programs were created, giving way to provincial insurance...
plans and, finally, to a cohesive national system of medicare (more or less), with Ottawa kicking in money to ensure people in have-not provinces did not have second-rate access to care.

As prescription drugs have become a key component of the medical toolbox, the same pattern has repeated itself. Drugs were offered at no cost to “indigents,” then to seniors (who, prior to income supplements, often lived in poverty), and then to those on various forms of social assistance. Many provinces and territories have responded to public pressure and created catastrophic drug plans to bail out folks whose drug costs gobble up an inordinate portion of family income.

It is widely accepted that people can be called upon to contribute to their drug costs and that the state steps in only when these costs become “catastrophic”—a term defined as anywhere between 2 and 20 per cent of income, depending on the province and income level. But millions of Canadians remain uninsured and under-insured for essential care in the form of prescription drugs.

There is a basic unfairness in the wide provincial variations. A patient requiring a $20,000 drug treatment for cancer will pay nothing out of pocket in Nunavut, $3,000 in B.C., and $20,000 in P.E.I. The situation is unjust and untenable; it offends the principles of medicare and the values it embodies.

So what is the solution?

It requires levelling the playing field. That means introducing some national standards for coverage. Interestingly, the federal, provincial, and territorial governments have agreed to do so—in theory, if not in practice. The National Pharmaceuticals Strategy was adopted in 2004. It spells out the blueprint for managing drug costs, including the following:

- establishing a national formulary, a process that has begun with the creation of the Common Drug Review;
- implementing drug pricing and purchasing strategies to obtain the best prices for drugs and vaccines (some provinces have acted to cut generic prices and there is bulk purchasing, but only for a handful of drugs);
• strengthening the evaluation of real-world drug safety and effectiveness (stated plainly, we pay for a lot of drugs that don’t work, and that has to change);
• using e-prescribing technology to reduce waste and help avoid dangerous adverse reactions;
• improving the prescribing behaviour of health professionals (no one likes to talk about it, but there is a lot of inappropriate prescribing going on—expensive drugs are used when cheaper ones work fine—along with over-prescribing and under-prescribing of treatments for various conditions).

This strategy was supposed to pave the way for a national pharmacare program. Why that didn’t happen is not entirely clear, though like many other reform initiatives over the years, pharmacare has become enmeshed in federal-provincial bickering. And, of course, there is fear—principally, fear of the cost.

But estimates of how much a national pharmacare program would cost—or save—vary dramatically. According to one study, a national pharmacare program could cost governments as much as $5 billion more a year, because drug use would increase and private drug plans would dump their most expensive clients onto public plans. But another study estimated that pharmacare could save governments and consumers up to $10.7 billion a year in prescription drug costs. (The total prescription drug bill is more than $25 billion a year.)

Those multi-billion-dollar variations depend on devilish details, such as limitations on drugs included in the formulary, the aggressiveness of bulk purchasing negotiations, the willingness to accept trade-offs (such as makers of brand-name drugs cutting jobs if sales of generics undercut their revenues), and the regulation of private plans.

A drug plan need not pay for everything, but it needs to cover the essentials; to be rooted in policies that are fair to individuals, employers, and suppliers; and, of course, to be affordable. Again, these issues have all been tackled in other jurisdictions. A decent drug plan—an extension of medicare—is achievable.
In fact, one province has had universal pharmacare since 1996. In Quebec, it is mandatory for all citizens to have prescription drug insurance—purchased either from private companies or from the provincial health insurance program. Those who cannot afford the premiums are subsidized. The program has proved costly; the net cost to the treasury rose from $531 million in 1996 to $1.8 billion in 2010, despite sharp rises in premiums for the public plan. However, Quebec, which is home to the head offices of many brand-name drug companies, makes little effort to use cheaper generic drugs. (This is not meant to single out Big Pharma for criticism; Canada as a whole has pandered to the generic drug industry, and as a result we have some of the highest generic prices in the world.) Quebec’s plan also has quite lax regulations, which have allowed private drug plans to dump expensive patients into the public one. (In most European countries, which have similar models of mandatory drug insurance, private insurance companies are not allowed to refuse clients and the state pays premiums to private plans, rather than administering a separate public plan.)

The lesson from Quebec is that, yes, a universal drug insurance program is costly. But it is only unaffordable if we continue to spend thoughtlessly, the way we do now. The keys to a viable pharmacare program are sound regulation and an insistence on effectiveness and value for money. Canada has, for too long, tried to attract pharmaceutical jobs by having poor drug pricing regulations. That is bad economic policy and a poor way of creating jobs.

Finally, when we discuss pharmacare, we should not be talking solely about how much it would cost to make essential prescription drugs available to all, but how we can make it affordable for individuals and society as a whole.

In Canada, we have been mulling over the notion of pharmacare—and its variations, such as catastrophic drug coverage—for over half a century. The philosophical and moral arguments for pharmacare are powerful and compelling, and the economic ones are stronger still.
Instead of dragging their feet on this issue and prolonging the injustice for many Canadians, our political leaders and policy-makers need to put their noses to the grindstone and implement a series of measures that will make catastrophic drug insurance feasible, affordable, and sustainable.

HOMECARE

If we want to offer 21st-century care, we need to treat people where they live: in the community. That begins with primary care, where the goal should be a network of community-based clinics that offer wellness advice, treatment of minor ailments, and even some urgent care. This, of course, does not eliminate the need for emergency departments and hospitals. A significant number of people suffer traumatic injuries; have medical emergencies, such as heart attacks or strokes; or require surgery and complex care for conditions such as cancer. These people need the services of hospitals and specialized clinics, but these institutions should be reserved for the sickest of the sick. They are not a place to warehouse relatively stable patients with chronic health conditions. There are thousands of Canadians—most of them frail seniors—who are living in hospitals by default because they have nowhere else to go. Many thousands more end up in nursing homes and long-term care facilities when they could, with a little support, remain in their homes and in the community. Again, there is a need for institutional care—for example, for people with advanced dementia—but it should always be the last resort.

If you want to minimize institutional care, you need to design the health care system and adopt policies to reflect this philosophy. Then you need to invest in homecare or, more precisely, community care. Not everyone can or should be getting medical or nursing care in their own home, but they don’t necessarily need to be in sprawling institutions, either. There should be a full range of options to supplement homecare, such as day programs, respite care, and small group homes, along with
investments in rehabilitation that, made smartly, can delay institutional care. Again, the reports of countless inquiries have advocated shifting our focus from acute care to chronic care.

The homecare sector has experienced enormous growth in the last couple of decades, but the expansion has occurred in a rather hap-hazard fashion. Roughly 1 million Canadians benefit from publicly funded homecare services annually and half as many again—another 500,000—access homecare services not funded by government, paying for them either with private insurance or out of pocket. It is not clear how many more people could benefit from access to homecare, but there is little doubt there is an unmet need.

As with prescription drugs, there are growing inequities in access from province to province; the proportion of seniors who have had state-funded homecare ranges from 18 per cent in Newfoundland and Labrador to 29 per cent in British Columbia. These variances undermine some basic principles of medicare—namely, that essential care should be publicly funded, and that access to care should be universal and reasonably similar across the country.

Organized homecare, whether funded publicly or privately, is just the tip of the iceberg. Most homecare is provided informally by spouses and family members. Roughly 2.1 million Canadians are providing care to loved ones at any given time. For many it is a full-time job, one that lasts for years.

While the growth in the homecare sector is, on the surface, a good thing, several fundamental problems need to be rectified. Government-funded homecare services are used, principally, on a short-term basis. They are a way of assisting patients who are convalescing, usually from surgery. This has allowed a significant expansion of same-day surgery, and shortened or eliminated a lot of hospital stays.

But the real homecare need lies elsewhere, in providing care to people with chronic conditions that allows them to stay out of hospital and remain active members of their community.

The research on the financial benefits of investing in homecare is unequivocal. Equivalent care can be provided at home for 40 to 75 per cent less than it costs in hospital. And virtually no medical care offered
to stable patients in hospital cannot be provided as readily at home, including help for patients recovering from surgery, care for ventilator-dependent patients, and palliative care. In addition, homecare reduces readmission rates to hospital, as well as infections, and patients greatly prefer it.

So, again, we need to ask the basic question: “If all the evidence points to the benefits of investing in homecare, why haven’t we bought in?” The barriers to reform here are the same as those elsewhere in the system: Vested interests—namely, hospitals—stand to lose if resources are shifted, and many care providers don’t want the inconvenience of delivering care in the community. (Our system is designed around the needs of care providers, not patients, and the lack of homecare is one of the most glaring examples of that fact.) But the predominant obstacle stalling the expansion of homecare is the fear that it will be costly. In Canada, we always assume that new programs will add costs; shifting resources is considered nearly impossible, largely because our health care system is so siloed. In addition, there is an assumption that, if a large public homecare program were created, demand would surge because family caregivers would abandon their commitments.

There is actually no evidence from other jurisdictions with comprehensive homecare programs that this would occur. Currently, in Canada and elsewhere, family, friends, and community groups provide about 75 to 85 per cent of homecare. While the media and many researchers have focused on the drawbacks of caregiving—emotional and physical strain, stress, and depression—a recent report from the Institute for Research on Public Policy notes that most caregivers also enjoy caring for others and derive great satisfaction from it. In fact, many who provide care for seniors don’t even consider their efforts to be work or see themselves as caregivers. These data undermine the assumption that massive numbers of people are going to demand homecare or institutional care as the population grows older.
The principal purpose of an organized community care system is to help people remain in their homes for as long as possible, which is what many of them want. That is the essence of patient-centred care: discerning the desires and needs of patients, and adjusting the system (not vice versa, as is currently the case).

A secondary benefit of community-based care is financial. Getting people out of institutions and providing supports in the community reduces the cost to publicly funded health insurance plans; it also reduces the financial burden on caregivers and families. What we must avoid is deinstitutionalizing patients without creating supports, as was done when psychiatric institutions were closed in decades past. The key to successful community care is helping caregivers continue to provide the support they now offer willingly. The rules and regulations—and the non-system that exists today in most Canadian provinces—offer exactly the opposite: They leave people burned out, desperate, and bitter.

Caregivers can rely on some modest tax measures for help; for instance, they can claim compassionate care leave under Employment Insurance. In many communities, respite care—such as adult daycare, temporary nursing home beds, and sitter services—is available. However, in most instances, someone must already be receiving formal care before their caregiver is eligible for respite care.

“Those who are doing such a good job that the recipient does not need formal services are, by definition, not considered for support,” says Dr. Neena Chappell, the Canada research chair in social gerontology and a professor in the Centre on Aging of the University of Victoria, who has studied this question extensively.

The health care needs of Canadians have changed fundamentally since the advent of medicare, due to everything from demographic shifts to medical advances. We created a health care system at the height of the Baby Boom but, in over half a century since, we have done virtually nothing to understand or prepare for the subsequent changes. It’s not too late, but there is a lot of catching up to do, and we have to do it quickly.
COORDINATION

In discussions of the shortcomings of the Canadian health care system, one issue comes up time and time again: the lack of coordination. There are many pieces to the health care delivery and funding puzzle, but there seems to be little attention paid to how they fit together within regions, within provinces and territories, and among jurisdictions. This is true whether we examine the system from the perspective of the patient, the provider, or the administrator.

The “journey” of care, no matter how short or how long, should be seamless. Yet, regardless of which door patients use to enter the health care system—a family doctor, an emergency department, a hospital, homecare, or a nursing home—there is little continuity in their care. There are two principal reasons for this disjointedness: Patients lack a “medical home” and most still are without an electronic health record. If someone has a heart attack and ends up in the ER, or is prescribed antibiotics at a walk-in clinic, or gets to see a specialist, the family doctor is unlikely to know, as is the pharmacist, just as the hospital is unlikely to know the person’s medical history or current medication regime when the patient is wheeled in. This situation is not new but, as people live longer with multiple chronic conditions, is it becoming increasingly important to resolve.

We have the ability and the technology to do this; we just haven’t made it a priority. Continuity of care has to be a priority, because it is during the transitions—from the family doctor to the specialist, from the ER to the ward, from hospital to home and back again—that all the bad things happen. These bad things are the everyday stuff of nightmares in Canada’s health care system: long waits, lost paperwork that means tests must be redone, dangerous drug interactions, deadly infections, debilitating falls, and so on. Not all of these problems are entirely avoidable in a complex system such as health care, but coordination would certainly help.

Ensuring that every patient has a medical home is the starting point. Having a single, accessible record of their care is the next. Canada is a laggard when it comes to electronic health records.
The many silos in health care have also been a huge impediment to modernization, via information technology (IT) or otherwise. Many practitioners and health care institutions (and even departments within those institutions) purchase IT systems separately, with little or no consultation with key partners such as pharmacies, and the result is little compatibility. And while lots of money has been invested to catch up, through the national Infoway agency, this effort has often been hampered by political bickering and a lack of buy-in on the front lines.

The root of many of these problems is a poor administrative structure. Canada’s health care system has many managers but very little management. You see that most glaringly in the huge variations in practice and outcomes across the country and even from one institution to the next. No corporation, no coherent system, would tolerate these kinds of inefficiencies. That they persist, however, is not surprising; when you don’t have stated goals or accountability, you are highly unlikely to get good results.

When medicare began, management of the public insurance plan was pretty straightforward. Individual hospitals, and later physicians, submitted monthly bills for the services they provided and, after cursory review, they were paid. As the provision of services expanded, so too did the complexity of payment. Governments negotiated annual budgets with hospitals and fee schedules with associations representing physicians (one province’s fee schedule now weighs in at a staggering 800 pages).

In addition to establishing overall health care budgets (which were routinely surpassed), the federal and provincial governments also developed the habit of announcing specific program funds for infrastructure projects and all manner of programs and services that individuals and associations had lobbied for, from breast cancer screening to drugs to treat rare disorders. The coordination was left to ministries of health, populated by bureaucrats who had little power and who struggled to deal with a constant barrage of conflicting demands.
As health care services and budgets grew, health ministries expanded and specialized. They also became balkanized along functional lines, such as medical, hospital, nursing home, mental health, public health, and homecare. Each service had its division within the ministry, with little communication and coordination among them.

The answer was to regroup and to create geographic regions of a more manageable size, in the hope that would make it easier to coordinate care and adapt it to local needs. Almost every province eventually adopted some form of regionalization, though the theoretical benefit—to be able to move money between programs (for example, to take hospital money and use it instead for homecare)—never really played out. The reason is that provinces never imbued regions with real power. In many cases, the large institutions in each region—hospitals—continued to dominate and influence policy. Over the years, regionalization has become a political hot potato and its original purpose, coordination, has seemingly been forgotten.

There has also been a lack of cooperation between Ottawa and the provinces and territories. There has been little animosity—aside from the occasional flare-up, usually when provincial governments demand more money from the federal government—but a puzzling lack of working together for a common cause. Why, for example, does each province have a separate drug formulary? Why do they each have a separate fee schedule for payments to physicians? Reinventing the wheel is a perverse way of demonstrating independence.

One area where cooperation and coordination is desperately needed—on a couple of levels—is health human resources. There is a constant barrage of claims of “shortages”—of doctors, of nurses, of pharmacists—but it’s a mug’s game. The number of health care workers is higher than it has ever been, both in absolute numbers and per capita. Wages have soared because provinces poach health care workers from each other. Meanwhile, none of the chronic problems we have—such as access, wait times, and so on—are really improving. That’s because we are merely throwing more (very expensive) bodies into doing more of the same thing, no matter how inefficiently.
Another important issue is ensuring that all health care professionals work to their full scope of practice. Right now, many health care workers routinely do work for which they are grossly overqualified. We have also taken the idea of specialization to absurd lengths, especially in medicine. In Canada, we have a 50/50 split between GPs and specialists; in many European countries, the split is 70/30, because they have recognized that primary care is best delivered by generalists, not specialists.

Changing these wasteful approaches to human resources requires policies to break down protectionist barriers that professions have created to guard their turf. It also requires investing in support staff, like secretaries, janitors, IT specialists, quality control managers, and so on, to ensure that doctors, nurses, and other front-line workers don’t spend so much time pushing around paper.

The status quo is not working. If we want better health care, we have to do things differently, to ensure that patients have access to the right care, at the right time, from the right professional.

Coordination is required, above all, to ensure quality. And quality of care has to be the overriding goal of reform.

PREVENTION

Beyond improving the delivery of sickness care, Canada needs to invest in prevention and health promotion. Right now, only 6.5 per cent of health spending goes into public health measures, such as vaccination and smoking cessation, even though the return on investment is much greater than that for many (if not most) medical treatments. We short-change prevention because we tend to place too much emphasis on the health of individuals and too little on the health of the population as a whole.

There needs to be recognition, too, that the measures that have the greatest influence on health are not medical interventions, but the socio-economic determinants of health. The single most important thing we
can do to ensure someone is healthy is give him or her a good education. Education equals employment and that equals income. And money is, by far, the best drug we have.

We often hear how European countries spend less on health care than Canada does but have better health outcomes. The reason is that they spend more—and more purposefully—on social programs that contribute to a healthy citizenry: early childhood education, housing, social welfare, job creation programs, and so on.

Not too long ago, we had a federal department of health and welfare. When it became Health Canada, we seemed to have abandoned the all-important welfare part of the equation.

We need to break down the barriers not only within the sickness care system, but also between health care and other social services. That is where continuity and coordination are dismally lacking.

Take patients undergoing cancer treatment. In Canada, they will get state-of-the-art care; no expense is spared. But what many of these patients need beyond surgery and chemotherapy are practical things: daycare for their children, decent public transit to get to appointments, Employment Insurance benefits to ensure they have an income during treatment, and so on.

That thinking has to extend to the general population as well, with the goal of keeping people healthier. It is well-established that illness (and the cost of providing care) follows a social gradient: the lower a person’s socio-economic position, the worse their health. We cannot lose sight of the fact that medicare is not only an insurance program; it is also an income redistribution program. We cannot forget, either, that a sickness care system, no matter how good, is not all that is required to ensure good health—for individuals or for a nation.
The Path Forward

AFFORDABLE CARE
“There are many ways of going forward but only one way of standing still.”

—Franklin D. Roosevelt

If we are to fundamentally reform the health system, fixing the structural issues is only part of the equation. All the changes have to be made with the aim, first and foremost, of improving care. But that’s the easy part, relatively speaking.

When politicians and policy-makers start getting serious about changing, they almost always get hung up on the financing question. But the aim should be to make the health system sustainable, financially and otherwise. There are many who doubt that is possible or, more precisely, say it’s impossible because it threatens the imperfect, yet comfortable, status quo.

To say that medicare is unaffordable, or unsustainable, is hollow rhetoric. It’s a cop-out. People need health care services and we need to, collectively, figure out how to ensure that everyone gets essential health care in the most efficient, affordable way possible.

Every sector of society has a role to play in this quest: government, business, unions, not-for-profits, employees, patients, and other citizens. Together, we need to come to a consensus on how to best pay for medicare and for health care needs more broadly. So far, the only consensus is that what we’re doing now is not ideal—we’re not getting a big enough bang for our health care buck. Despite enormous investments of public money, supplemented with considerable private money, too many people are still falling through the cracks.

On the financing front, there are really just two broad issues that need to be tackled:

- determine what we will pay for from the public purse—what is “medically necessary,” in the terminology of the Canada Health Act—which will, in turn, establish the public-private split;
- figure out the method (or methods) we will use to pay for these services from the public purse—whether we will use taxes alone or taxes combined with user fees.
In other words, we need to figure out how much we will pay for, then how we will do so. For far too long, we’ve put no real limits on coverage and spent a lot of time agonizing over the fact that this is costly. Then, every few years, when there are economic challenges, we try to slam the brakes on overall spending without ever tackling the root causes.

If reform is going to be real and sustained, we need not only to set our priorities for service provision but also to set clear parameters for funding. We need to tackle the two central questions—“What will we pay for?” and “How will we pay for it?”—simultaneously.

Let’s begin with the latter because, regardless of what we decide to cover under publicly funded health insurance, we will need to finance those costs.

In Canada, we have traditionally paid for medicare from general tax revenues. The average Canadian, over a lifetime, consumes roughly $220,000 in health care services. The money raised to pay those costs from the public purse comes from a variety of sources. Personal income taxes account for 49 per cent of health spending, sales taxes for 16 per cent, and corporate income taxes for 14 per cent; the balance comes from a variety of other tax measures. In other words, funding of health insurance depends largely on so-called progressive taxation, meaning the more you earn, the more you pay, regardless of the health services you use. Unlike many countries, Canada does not require user fees or co-payments to any appreciable degree; these fees are verboten for “medically necessary” care (hospital and physician services) but used to varying degrees in prescription drug and dental insurance plans. In recent years, provinces have turned increasingly to more targeted health premiums, but these cover only a small fraction of health care spending, so they are a bit misleading.

There are a variety of ways to fund health care. Other countries, particularly in Europe, fund health care through payroll taxes, the way Canada funds Employment Insurance and the Canada Pension Plan, though usually supplemented from general tax revenues. Some, such as Singapore, have medical savings plans, much like a RRSP, which citizens pay into while they are young and healthy, and then draw
down later in life when they need more health care. Other countries, such as the Netherlands, require citizens to purchase private insurance and subsidize those who cannot afford it. In some countries, the public treasury also raises considerable revenues by charging user fees and co-payments.

Services that are not covered by public health insurance plans—those not deemed “medically necessary”—are covered by private insurance and out-of-pocket payments. Generally, private insurance premiums are deducted directly from an employee’s paycheque, and employers match them to varying degrees. In Canada, that is currently the case for most prescription drug insurance and for supplemental health benefits, such as dental care, semi-private rooms, psychological services, and physiotherapy. Many of these plans also require co-payments. The problem is that fewer than half of Canadian workers have any private health insurance, and the number is shrinking as self-employment and part-time work become more common. Employers are also feeling the pinch of rising costs and increasingly restricting coverage. The challenge, of course, is getting the public-private mix right so that everyone gets necessary care at no cost, while an element of choice is maintained.

When considering how to pay for state-funded health care, we should eliminate nothing from consideration, but we need to heed culture and tradition. For example, switching to a payroll model of funding would be a dramatic and disruptive change with no obvious benefits. The whole issue of user fees also merits some discussion because it is raised time and time again, to the point where it’s often referred to as the “zombie” of medicare.

The first question we need to ask is: “What is the purpose of having user fees (or health deductibles or co-payments, or whatever other euphemism is chosen)?” Is it to raise revenue? Is it to act as a financial disincentive to unnecessary care? Is it to create awareness—to serve as a reminder that health care is not “free”?

User fees would certainly raise revenue, but likely not as much as proponents imagine. First of all, you can’t have user fees for low-income citizens without undermining the central tenet of medicare: access to care regardless of ability to pay. Means tests are cumbersome
and they cost money. In fact, a practical argument against implementing user fees in Canada is that collecting the money would prove costly. Most Canadian health care providers do not currently have the infrastructure or staff to collect fees. The situation is very different in European countries, where dealing with payments from private insurance and individuals is already the norm.

There are, of course, ways around this. Quebec, for example, proposed legislation that would oblige citizens to declare on their provincial tax return how many times they visited a physician, and each consultation would be assigned a $25 value. There would also be an additional fee if patients sought treatment from an “inappropriate” provider—say, if they went to an emergency room instead of a community health clinic for a non-urgent problem like a rash. The Quebec approach, however, went down in flames because it was totally impractical. For example, there is no easy way for tax officials to verify medical records, nor should there be. The move also sparked an angry public backlash, something that has occurred every time a province has proposed user fees. This is yet another reminder that history and culture matter in formulating health policy.

The Canada Health Act was created specifically in response to the Ontario “user fee crisis” in the early 1980s. The law does not ban user fees, but it allows Ottawa to claw back money from any province that allows its providers to charge additional fees for physician or hospital services. (Quebec, by the way, argued that it was imposing a tax, not a user fee, so it would not be subject to penalties.)

Canadians believe strongly, for better or worse, that basic health care services should be “free,” and challenging that belief could be politically costly and distract from other reform measures. The question then becomes, “Would it be worth it?” Would the savings that result from imposing user fees make the fight worthwhile? If we are to embrace transformative change in the health care system, do we want the distraction and the added bureaucracy of user fees? And, most important of all, do user fees make public health care more affordable? (That should ultimately be the goal.)
All the evidence suggests that the answer to those questions is “No.” The notion that paying a few extra dollars—anything from $10 to $25 has been proposed over the years—will dissuade people from going to the doctor for minor ailments is a good one in theory, but it doesn’t really work in practice. First, despite some apocryphal tales, there is little evidence that Canadians use health care services frivolously. Too many patients end up in ER because of the inadequacy of primary care, not because they enjoy waiting in a dank hospital for 10 hours. Second, the only people who will be discouraged from visiting a doctor because of the perception it may cost money are the poor—meaning the elderly, people with chronic illness, and those with mental health problems. They will invariably end up sicker as a result. User fees, if applied universally, are a punitive tax on the poor and the sick; they are regressive and counterproductive. As a result, those who cannot afford user fees would have to be exempted from paying them. The net result is that people who can afford the fees pay them, which is in no way dissuasive. (If you want the wealthy to pay more for health services, there are easier ways to do it.)

The final argument used to promote user fees is that they raise awareness of the cost of health care services. Again, it is the wrong approach to a laudable goal. Paying $25 for a visit that may cost anywhere from $40 to $4,000 (depending on the time required and the procedures and tests done) is in no way informative. If education is your goal, a better approach would be some form of shadow billing—actually providing patients with detailed statements outlining the cost of the services they received. Again, a costly bureaucratic infrastructure would be required. The reality, too, is that the Canadian health care system does a terrible job of tracking costs down to the patient level. We know, for example, how much a physician can bill for a specific service and how much individual tests cost, but little or no effort is made to factor in overhead costs or to provide cumulative totals. This approach has been tried in the past, notably in Alberta, which for a brief period provided patients with annual statements of the cost of the health care services they used. While this shadow billing was purely for informational purposes, it was poorly received. Many patients felt they were being “blamed” for
having incurred health care costs, which they had paid for with their tax dollars. There were concerns, too, that the process was setting the stage for the private provision of services—that, in the future, citizens would actually be billed for their care. As a result of the pushback, the initiative was scrapped.

However, if we want to contain costs and to know whether we’re getting value for our health dollars, the starting point is knowing exactly what it costs to deliver care. Currently, our health data are largely collected on a macro level: We know how much is spent on hospitals and on physician services overall, but we don’t really have a good sense of how much specific cases cost. Say, for example, that a senior is prescribed blood pressure medication by a GP but doesn’t fill the prescription. She then faints at home, falling and breaking a hip, and spends a week in hospital. There, she acquires an infection that requires three more days of treatment. Those kinds of micro data are key to understanding how to spend health dollars more wisely—in this case, they show the value of doing follow-up calls after prescribing medications.

All of this is to say that investing in data collection is essential. Done properly, it will have an important impact on policy-making and make a lot of people uncomfortable. If we’re going to have patient-centred health care, data should be available to patients as well as practitioners and policy-makers; transparency must be the norm.

Health care is not a commodity like many others. The number of providers is quite limited, creating a monopoly—or, at best, an oligopoly—market. People needing care cannot always shop around, either, so there is no competitive marketplace to speak of. The tough question here is this one: “Is it justifiable or ethically acceptable to deny access to additional care to those who want to pay for it?” This is currently happening in Canada and it’s troublesome. Allowing people to purchase health services over and above what is covered by a publicly funded health system will not automatically create a destructive “two-tier system.” (That “two-tier” terminology is largely meaningless and overused, but it makes politicians cower in fear.)
The key, as in everything in health care, is balancing competing interests. Giving people a right to choose is important but it does not override other goals, such as equity, accessibility, and fairness. To find a fair middle ground, you need strict regulation and oversight. Almost all universal health systems strictly regulate prices, and they often ration care. The best and easiest way to do that is within a publicly administered system. The challenge again is striking the right balance: to regulate, but not to the point where you stifle innovation.

Now it’s time to consider the other essential element in the funding equation: determining what you fund. A publicly funded system should not try to be all-encompassing. It cannot cover all things for all people all the time. Rather, it should cover the basics—and in a wealthy country like Canada, “basic” is fairly broadly defined. You pay for what works, meaning it eases suffering and prolongs life, but it also has to be affordable. Privately offered services provide the rest. Ideally, these services should be constantly gnawing at the edges of the public system, pushing it to do more and do better.

We need to recognize that the appetite for health care services is virtually infinite, and that new products and services will continue to be made available at a dizzying, relentless pace. Setting arbitrary limits, such as capping new health care spending at 2 per cent, may work temporarily, but it is doomed to failure in the long term. So we need to equip ourselves with tools to judge the appropriateness and cost-effectiveness of products and services, and we need to learn to say “no” to offerings that are not up to snuff. The hope is that, in doing so, we will be able to rein in costs—to “bend the cost curve,” in the parlance of health economists.

What we have to stop doing is what we’ve been doing for over half a century, since the advent of medicare: simply shovelling more money into the processes we’re using now, allowing spending to gallop upward faster than inflation and population growth combined, with no clear improvement in outcomes.

Hopefully, by now, we have made the case for stating unequivocally that Canada’s current, bifurcated model of funding health care is outdated and dysfunctional. Medicare, in the form of provincial
health insurance plans, is supposed to cover “medically necessary” care. However, defining the “essentials” as “all hospital and physician services” is an outdated notion. Some hospital and physician services are not essential and should not be covered by public insurance. At the same time, some prescription drugs, homecare, long-term care, psychological services, and dental care should be deemed essential and covered by medicare.

In short, the challenge is simultaneously expanding the breadth of medicare coverage while limiting the depth of coverage.

The goal is universality for *necessary* care.

How much would that cost? It’s not entirely clear. Costs to the public treasury may increase, they may stay the same, or they could even decrease. It would really depend on what’s in the medicare “basket of services.” Right now, that basket is ill-defined, so the first step is to bring some clarity and transparency to the decision-making process. There are some clear principles that need to be applied.

First and foremost, you pay for what works—meaning the intervention extends life, avoids or reduces disability, or prevents or treats illness. Decisions have to be evidence-based or at least evidence-informed. It is surprising how much of the treatment we deliver in modern health care systems lacks good evidence. We are always eager to add new treatments, but we need to put as much effort into eliminating redundant or ineffective ones.

Innovation should improve care and reduce costs. For example, when new technology reduced the time required for cataract surgery from two hours to 15 minutes, the fee for doing that operation should have been reduced; instead, ophthalmologists got rich and taxpayers got taken for a ride. We have to remember, too, that new is not always better. Many new interventions, from drugs to surgical techniques, are touted as essential when they simply offer marginal improvements at a much higher cost. Wishful thinking is not sufficient to justify funding.

The interventions covered by public plans must not only be medically effective but also cost-effective. For example, should a public health care plan fund a cancer drug that costs $50,000 and extends survival, on average, by only three weeks? Where funds are limited, this
is not justifiable, economically or ethically. There is a lot of overtreatment, particularly at the end of life. Should we, for example, give a 95-year-old with terminal cancer a hip replacement? That money would be better spent on decent palliative care.

No one is suggesting these decisions are easy. They’re not. But they’re necessary.

Can efficiency gains alone resolve all the financial challenges facing medicare? Probably not, but they are definitely a good starting point. Consider that the Institute of Medicine estimates that fully one-third of health care spending is wasted on redundancies, and on procedures and medications that provide no benefit. Some will dismiss that number, saying it applies only in the U.S.; however, while there is no question that the American system lends itself to waste and overtreatment, the Canadian system is not immune to these issues. While the profit motive is not necessarily driving a lot of interventions, the way it does in the U.S., Canada’s overdependence on fee-for-service payments encourages volume more than efficiency. There are also very few checks and balances in the Canadian system, which is the downside of not aiming to maximize profits.

These decisions cannot be left to physicians alone, with no regard to the way resources—such as money, surgical time, and hospital beds—could be better used. These difficult decisions need to be depoliticized, so they can be made based on evidence and clinical evaluation. Rationing occurs in every health system; the key is to do it as fairly and openly as possible.

When you limit what medicare covers, there will, of course, be types of care that citizens want that public insurance does not cover. Within reason, citizens should have the right to make those choices. That means we need a complementary private insurance system.

Thankfully, we already have one—or at least the semblance of one. About 23.2 million Canadians have private health insurance, which principally covers drugs and supplementary health care, such as semi-private rooms, medical transport, and mobility devices. Another
13.2 million have dental insurance, and 10.6 million citizens have disability insurance. They pay just under $30 billion in premiums for this coverage, most of it through employee-sponsored plans.

Most provinces also have programs to ensure that low-income citizens who cannot afford private insurance—seniors, and those receiving social assistance or disability payments—get services that medicare does not currently cover, like prescription drugs, vision care, and dental care. But there are large and often irrational variations in coverage from province to province, and even within provinces. Those who suffer most under the current approach are low-wage workers and the self-employed, who often don’t have supplementary health insurance through work; this is one of the fastest-growing demographic groups, so this issue needs to be tackled.

One of the most worrisome trends is the steady rise in out-of-pocket health care expenses—spending on items that are covered by neither public nor private insurance. About 1.4 million Canadians spend over 10 per cent of their income on health care expenses, well above the level that is generally considered “catastrophic” (usually 3 to 5 per cent of income). Some of this spending is for pretty routine purchases, such as Aspirin and vitamins, and some is for frills such as massage. But when expenses reach catastrophic levels, they are often for things such as cancer medications and psychological services, and that is troublesome. If all basic coverage was incorporated into medicare, that would remove many of the complications that currently exist and make medicare more universal and equitable.

Once it is clear what medicare covers, the private insurance part of the equation will work itself out, as it always has. In the 1950s and 1960s, Canada moved from a system where private insurance paid for most health care services to one where public insurance dominated. There was a lot of resistance, from politicians, from business, from physicians, and even from some taxpayers. That’s why it took 15 years for all provinces and territories to sign on, meaning they had to accept some basic rules (such as not having user fees) in exchange for federal money. But insurance companies adjusted, focusing on filling the gaps
in medicare, such as prescription drug insurance and dental insurance. As medicare shifts its focus, private industry will do the same. It will see opportunity and exploit it—in the true, positive sense of that term.

From a public policy perspective, the real question is how to finance public insurance programs—how to provide sufficient funds to meet the health care needs of the population without choking off every other public initiative. Currently, the public treasury pays $140 billion annually for health care—$3,640 per capita. Despite all our gnashing of teeth about out-of-control health care spending, that is actually lower than the per capita figure in many other developed countries. The catch is that Canada’s public health insurance actually covers significantly less than that in most countries. In Canada, 70 per cent of total health care spending comes from public funds; in Sweden, it’s 85 per cent.

We actually need to invest more in the public health insurance system, to better take advantage of the benefits of a mass insurance plan. At the same time, we have to be clearer about where we are spending our public dollars and why.
Conclusion

A CALL TO ACTION
“An ounce of action is worth a ton of theory.”
—Friedrich Engels

As someone who has written about health care policy in Canada for over two decades—someone who appreciates all the good medicare does but, like many Canadians, is frustrated by its shortcomings—I believe that the solution to our health care woes begins with a single word.

It is a question: “How?”

When I set out to write this monograph for The Conference Board of Canada, my ultimate goal was to provide a credible answer to the dreaded question: “How do we reform our health care system?”

It is a haunting question because it is, alternately, simple and seemingly impossible to answer.

Simple because the question has been answered countless times: Royal commissions have been convened and learned reports have been written. Wise women and men have diagnosed the problem and prescribed a solution. Promises have been made. Pilot projects have been conducted. Actions have been taken.

Impossible because “How?” is not a single question but a seemingly endless series of questions, and we seem a little too content to answer only the easy ones. The result is that recommendations never seem to be fully implemented, successful pilot projects rarely get scaled up, and promises never seem to be fulfilled: The grand plans always seem to get whittled down to half measures. The prescription is forgotten; the treatment, if it begins, is never completed.

Why?

The status quo reigns because it is easy and comfortable. Yet we know the status quo is not good enough. Why do we tolerate mediocrity when we know it is intolerable?

How can it be that we haven’t done more and done it sooner?

As a journalist, I write regularly about problems in the Canadian health care system: the long waits, the lack of drug coverage, the purported shortages, the soaring costs, and so on. I also write about
solutions, such as innovations that improve patient care and save money. It often seems as though medicare is engaged in a losing battle, a Sisyphean exercise of bailing out a sinking ship with a bucket full of holes.

But even that analogy isn’t quite right. We tend to overstate the problems in our health care system and forget all the great care that is provided. The good ship medicare is not sinking; it’s merely adrift. It needs to get back on course before it hits rocky shoals.

There always seem to be more new problems than new solutions. Or perhaps it’s just our Canadian inferiority complex that makes us more likely to accept our failings than embrace our successes.

It has long been my feeling that we have all the solutions we need to fix medicare. We have many islands of excellence in a sea of mediocrity. Why have they not been embraced and put in place on a grander scale? How can that be that, in the communications era, there is so little shared learning?

In Canada, we like to profess our love for medicare. We say things like, “Medicare is what defines us as Canadians.” We describe public health insurance as our most valuable social program, and that’s why we tolerate the fact that it gobbles up close to half of provincial budgets.

But if we truly value medicare, why is it adrift? Why is it a victim of benign neglect? Why do we tolerate just-good-enough care rather than striving for excellence? If we truly want to preserve medicare, it must change. And we must demand change.

But how? Where do we begin?

We need to be guided by an overarching philosophy, a vision. We have that already: a philosophy that holds that no one should be denied essential health care, regardless of ability to pay. Most Canadians also share a belief that everyone should get equitable (not equal) access to care, regardless of where they live in the country. That is, in a nutshell, what the five “principles” of medicare—universality, accessibility, comprehensiveness, portability, and public administration—are designed to say.
Yet we don’t articulate that basic vision or those fundamental principles nearly often enough. Instead, we tend to get caught up in an endless debate about how to modify the current system, an argument that tends to be dominated by two partisan camps.

One holds that medicare has been a failure, that the system we have now is “unsustainable,” and that we need to build something new. That “something” is invariably a system with a lot more private care and private insurance, where individuals get more choice—largely based on their financial means—but those who cannot afford care get help from the state and/or charitable groups. This camp believes market discipline is going to resolve all our problems, from wait times to the shortage of nursing home beds.

The other holds that medicare is a grand achievement that needs to be worshipped and that we need more of the same. If we are going to provide health care to all, then everyone must pay part of a collective insurance scheme through progressive taxation, and all can access services, regardless of ability to pay. This camp holds that most, if not all, the problems we have with medicare are due to the fact that nasty profiteers have infiltrated the system and undermined the purity of this great moral enterprise. We need more public investment and less offloading to the private sector to get back on track.

Both sides ultimately want the same thing: universal health care. But they have significantly different beliefs about how to get there, principally because they don’t agree on the definitions of basic health care or equity.

These dichotomous positions have poisoned the debate—or, more precisely, made it impossible to actually have a debate—about reforming medicare.

I believe that we agree on the fundamental goal or vision—universality—and that the way to achieve it lies somewhere between the two extremes.

Canada, like virtually every country with a universal health system, has a mixed private-public system. We have health care providers and institutions affiliated with the public system and with the private system; we have public health insurance and private health insurance.
The challenge is getting the mix right—a mix that ensures everyone has access to necessary health care and that care is provided as effectively and cost efficiently as possible.

But how? How do we get the mix right?

There is no magic formula. It’s about choices, about trade-offs, and about compromise. It’s also about respecting our culture and traditions, but not being handcuffed by them. It’s about embracing social justice without abandoning fiscal prudence. All developed countries have faced the same struggles as Canada has in trying to provide health care to their citizens as fairly and efficiently as possible, and they have all taken slightly different approaches. Canada’s only real distinguishing feature is a reluctance to act. We have been far too willing to listen to those with a vested interest, from the throw-the-baby-out-with-the-bathwater types who hope to cash in on sweeping privatization to those who want nothing to change because they are so comfortably ensconced.

The more I tried to figure out how our current challenges emerged and the more I searched for practical solutions, the more I found myself delving into the past. It is said that those who don’t know their history are doomed to repeat it. So, too, are those who mythologize and demonize their history—and in Canada we do plenty of both. That’s why this monograph features a lot of history. It’s important to understand how we came to have the health care system we have today, warts and all.

It’s equally important to recognize that our health care system has a lot of good traits. One reason we have not been compelled to act is that, despite all our complaints, we have it pretty good in Canada. When we really need care, we get it and, while wait times get a lot of attention, waits aren’t that bad most of the time. The same goes for spending; our health care system is expensive, but we’re a rich country and we can afford it. While we complain about how health care is gobbling up an increasingly large part of public spending, we have also implemented massive tax cuts in recent years.
Our health care system does not need to be dismantled and rebuilt from scratch. It needs to be modernized. Medicare has changed a lot over time. It’s just not evolving as quickly as it should, for a host of reasons: mythology, vested interests, lack of political leadership, fear, and others.

How are we going to overcome those very real obstacles to change? How indeed? That is perhaps the single biggest challenge. If the health care system is going to be reformed, there are going to be winners and losers. Those who stand to gain the most from reform are patients; creating a patient-centred system needs to become a priority. Those who stand to lose the most are principally health professionals—specifically, the organizations that represent them, from unions to professional organizations. They have a lot of power right now, and they’re not going to give it up without a fight.

Still, there is broad consensus that the status quo is not good enough. What we have to make clear is that there are no romantic, sweep-you-off-your-feet solutions.

The calls to “privatize” or to “embrace Canadian values” are not very helpful. They’re little more than political posturing.

Equally unhelpful are cynical conclusions such as “medicare is unsustainable,” or naive proclamations that all the system needs is more money, more doctors, more access to drugs. More, more, more is not a recipe for a healthy health care system.

The challenge we have is a big one. We need to find a way to provide essential health care services to all Canadians, without exception. We need that to be affordable. We’re not succeeding so well right now, on either count—or not as well as we should. We need reform, and we need it urgently.

But how do we fix the flaws? How, how, how?

First, we need to commit, or re-commit, to universal health care. All Canadians should have access to essential health care, regardless of their income, age, or where they live. A broad, publicly funded health insurance program is a sound investment, for both economic and moral reasons. But there have to be limits, and they need to be clear. The financing of medicare will never be easy, and there will never be
unanimity, but we can live with that as long as the decision-making process is clear. What’s in and what’s out of the publicly funded basket of services? That’s an essential question that every country with a universal health insurance program struggles with.

If there is a formula for reform, it is this: plan, invest, measure, repeat. There is no single magical solution. We need a portfolio of measures. The good news is that the solutions are known, and many changes are already under way.

We need to reconcile all the contradictions that exist in Canadian health care today. Our system is one of the most expensive in the world but one of the least efficient. We have no real limits on what medicare covers, yet it covers far less than most other universal health plans do. We have a wealth of innovative pilot projects, but we are painfully slow to scale them up.

In fact, one of the big impediments to reform is that we almost never scale up innovations. Rather, we routinely kill successful pilot projects and then we start new ones. If we want innovation-driven reform, we have to commit to ongoing project funding. We have to make initiatives that work—meaning they improve patient outcomes and cost less—the standard of care and eliminate the obsolete programs. The approach we take to reform in Canada is planting new seeds each year, instead of nurturing and growing seedlings until they become mature trees. We have too many academic exercises and not enough practical ones. In short, as has been mentioned numerous times already, we have the solutions—many, if not most, of them gathering dust in studies and reports. Implementation is where we need to put our energy and our money.

So where to start? How do we set priorities? Well, we focus on where the needs are greatest—in other words, on the shortcomings that are undermining universal, accessible, equitable, cost-effective care.

When you look dispassionately at the state of the Canadian health system and you compare it with systems in other countries that are providing better, cheaper, and more equitable care, it becomes fairly obvious that five key areas need to be addressed:
• Drugs: Canadians desperately need more equitable drug insurance, meaning some form of pharmacare to cover essential drugs or catastrophic drug insurance.

• Primary care: In a world where chronic disease dominates, we need to make primary care the focus.

• Community care: As much as possible, we need to get patients out of hospitals and treat them in the community. Ideally, that means providing homecare to those who need it; alternately, it means offering home-like institutional care. Hospitals are important, but they should be for short-term acute care.

• Social determinants: We have to stop pretending that health is merely a medical issue. Health and health costs are profoundly influenced by levels of education, income, access to housing, and environmental factors. We need to take a whole-of-government approach to health.

• Quality: “Safe and prompt” must be the guiding principles for care delivery. For the most part, this is an engineering and administrative problem, not a medical one.

So how do we pay for all this?

We have a terrible knee-jerk habit in Canada of assuming the solution to everything is more—more money, more bodies, more programs. I am not suggesting we spend more money on health care, particularly public money. Nor am I suggesting that we blindly dump services to lessen the burden on the public treasury, leaving citizens to purchase private insurance or pay out of pocket. What matters ultimately is the total cost of health services to the individual. Everyone should be able to access all essential services, regardless of ability to pay.

Just as there are many measures to implement to improve the delivery of health care, there are several challenges to tackle on the financing side. Once you determine which services are essential, you must focus on ensuring they are delivered in the most cost-effective manner, and then on paying for them in the most cost-effective manner.
Our approach to financing health care—at least the costs of hospital and physician services—has long been a single-payer insurance program. There is no question that that is administratively efficient and that the simplest approach would be to extend this model to other areas, particularly prescription drugs and homecare. This would shift some costs to the public treasury and away from individuals and employers, but it would not necessarily increase overall costs. (Drug spending, in particular, could be reduced substantially through better organization.)

But we don’t have to be bound to this approach. Rather, we should look to other universal health care systems and the ways they fund their programs. In most European countries, significantly more of the health care bill is paid from the public purse—80 per cent or more, compared with 70 per cent in Canada. But those countries also routinely apply user fees; this is done not so much to raise revenues as to remind people that there is a cost to health care—that it’s not “free.”

Similarly, there can be different financing methods for different programs. It doesn’t have to be one size fits all. Quebec, for example, has a universal drug plan that is financed through a mixture of private and public insurance; it is mandatory to have insurance, and those who can’t afford private plans are part of the public plan. This is not an ideal approach but, again, it is one that several countries use.

Funding new programs is the most problematic issue of all, which is why our investment in homecare has lagged despite tremendous need and demand. Japan decided to finance homecare through the national pension plan, the logic being that older citizens are the main people who need homecare. That approach would work well with the Canada Pension Plan, if premiums were increased significantly, particularly because centralized financing would help address the reality that the poorest provinces are also those with the oldest populations.

We have to formally scrap our bifurcated funding model, where physicians and hospital services are 100 per cent publicly funded and everything else is funded higgledy-piggledy, instead of just tiptoeing around it. The point here is that we need to innovate on the financing side as much—if not more—than on the delivery side.
We also have to find a way to settle the never-ending debate about the need to privatize services. As mentioned repeatedly, we have a mixed public-private system, as does every other country with a universal health care system. What we lack are clear rules—or a philosophy—about when public or private funding is appropriate. I would suggest that, given Canada’s history, the default position is that health services should be publicly funded and publicly delivered (or, more accurately, privately delivered by non-profits). That has been the norm for a long time and it is a fairly efficient approach. However, we should not dismiss out of hand the contribution that private, for-profit providers can play.

I would argue that politicians and policy-makers don’t have a social licence to privatize health care service delivery on a large scale. Rather, there should be preconditions for abandoning the public/not-for-profit option in favour of the for-profit one. Private delivery and private insurance should be employed only if they ensure faster, cheaper care and the public option has been exhausted. Privatization should not be a first step but a last resort.

We need to meet all these challenges to ensure we deliver health care more fairly, efficiently, and cost effectively.

To do so, we need leadership. It is often said that what is required to begin health care transformation is a spark—a burning platform that engages the public and forces politicians and policy-makers to act. I don’t agree. I think we have too many burning platforms and they pull us every which way. We spend so much time fighting fires that we never deal with the larger structural issues.

The kind of leader we need in Canadian health care is one who is willing to step back from the daily fray and address the big picture. We don’t need a bombastic saviour making grand promises. We’ve had too many of those and, since Tommy Douglas, few have followed through on the rhetoric. Our discussion about medicare features too much hubristic mythology and too little humble realism.
What we need at this time is a uniquely Canadian style of leadership—conciliatory and cooperative. That ranges from individual citizens taking more responsibility for their health to vested interests putting some water in their wine and political leaders implementing the solutions they know are required.

For far too long, we have fallen into the trap of always talking about the need for action but not actually acting.

How can we break that logjam? How can we actually kick-start reform?

In short, we need less talk and more action.
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CONCLUSION: A CALL TO ACTION


Transcript of the Lecture
The CIBC Scholar-in-Residence lecture was held in Ottawa, Ontario, in May 2012. CBC news anchor Heather Hiscox moderated the event, which attracted a capacity crowd of 400 people. The audience heard from Scholar-in-Residence André Picard and three prominent experts who provided responses to Mr. Picard’s lecture: Dr. Philippe Couillard, neurosurgeon and former Quebec minister of health and social services; Dr. Jack Kitts, President and CEO, The Ottawa Hospital; and Judith Shamian, President and CEO, Victorian Order of Nurses.

Anne Golden:
Good evening, all. Welcome. What a fabulous turnout! Four hundred Canadians are here to discuss a public policy issue—health care. I think that’s fantastic. Maybe it’s because there are no Canadian teams left in the playoffs.

Tonight’s Scholar-in-Residence lecture is closely linked to a major research project at the Conference Board on the future of health care in Canada. It’s called the Canadian Alliance for Sustainable Health Care, and the acronym we use is CASHC. And its mission is to contribute to building a common vision of sustainable health care among the key stakeholders to identify the policies, strategies, and practices that will contribute to a transformation of our health care system into one that is top quality, and also sustainable and affordable for the long term.

We’ve just released our report today—The Canadian Health Care Debate: A Survey and Assessment of Key Studies. We looked at the top 17 or 18 studies done in the last decade and a half or so. You can download a free copy of this from our website and we actually put a card in your kit to make it easy for you. It’s fascinating to read and I think André may make reference to it. Stay tuned for further research as we progress toward recommendations on how to ensure that Canada’s health care system is effective and affordable.
Also in your kit is information on our October summit on sustainable health and health care. I urge you to register; if you register this summer, you get the early-bird rate. It’s going to be a great event that actually gives you the chance to hear the latest research—that’s what we do at these summits—and to give your input into the deliberations.

Now, to tonight’s program which, by the way, is being taped by CPAC, to be aired on Saturday morning. I have to tell you how thrilled I was when André Picard, Canada’s award-winning health journalist, accepted our invitation to serve as our fifth CIBC Scholar-in-Residence. And tonight in the presence of this very impressive audience—not just in size but also in prestige—André will present his findings to date on, and this is the title of the study, “The Path to Health Care Reform: Policy and Politics.” I’ve had a chance to hear André discuss his analysis as it evolved; let me say, you’re about to hear a fascinating lecture.

Our distinguished panellists—Dr. Philippe Couillard, Dr. Jack Kitts, and Dr. Judith Shamian—will respond. Our moderator, Heather Hiscox, will introduce André and the panellists in a few moments, after I invite her to the podium. But, first, a word from our sponsor. I want to acknowledge the pivotal role of CIBC in making tonight’s lecture possible; in fact, making the whole 10-year program possible at The Conference Board of Canada. I think it’s a tribute—and I’m going to invite CIBC’s David McGown to the podium in a minute—I think it’s a tribute to CIBC that it has chosen to make investing in cutting-edge research and analysis on public policy issues a priority.

We are also gratified by the confidence that CIBC has in us, in the Conference Board, to bring issues of national importance to broad and influential Canadian audiences. So let me now invite David McGown, Vice-President, Government, Regulatory and Public Affairs at CIBC—by the way, because I know him personally, I can tell you that he gives a lot of his own personal time and energy to public policy issues, for instance through the Couchiching Institute on Public Affairs—to say a few words. David.
David McGown:
Thank you very much. Ladies and gentlemen, let me say it’s a thrill to be here. Anne, thank you so much for that kind introduction. On behalf of CIBC, I just want to say what a pleasure and honour it is to be in this room with the panel, with André and, indeed, with each and every one of you. Since Anne first approached CIBC—I think it was 2005 first. I’m looking for that right word … Anne is a very persuasive fundraiser. And I don’t know very many men, women, business executives, or government officials who have ever said “no” to Anne, and seven years ago I don’t think anyone at CIBC could have said “no.” But our 10-year and $1-million commitment to the Scholar-in-Residence program indeed not only recognizes the faith that we have in the Conference Board, but also is a demonstration of how CIBC actually wants to create the basis for positive change and progress in public policy.

And throughout the six years that the Conference Board has been running the CIBC Scholar-in-Residence program, we’ve seen incredibly diligent work from some of Canada’s finest academics. That work has dealt with federalism, with the uncertain world of regulation, with cities, Canada’s North, and now health care. And all of us at CIBC commend the dedication and vision that those scholars have shown in improving our collective future. It’s because of initiatives like these that the Conference Board is able to dedicate resources and time to exploring critical issues of public policy.

Now, Anne mentioned the health care initiative—the Canadian Alliance for Sustainable Health Care. I want to commend the work that the Conference Board has undertaken in this field, because they’ve set their sights broadly to help unravel the challenges of health care in Canada. My own interests are maybe a little less broad at one level; health care can always, or can sometimes, be reduced to the dollars and the cents. My own interest in this field was piqued when Tom Clark, not the journalist but the academic, wrote an essay on the Kingston Conference of 1960 and Janice Mackinnon, Roy Romanow’s former finance minister, wrote a seminal piece called The Arithmetic of Health Care a few years ago for the IRPP. And in both cases, these pieces reflected the fact that health care is not a sacred cow in Canada: health
care in and of itself does not define who we are as Canadians. But what should define us is how we collectively ensure that our health care system—or, in fact, the health care system that we all want—is financially sustainable over time. And this is where the research and analysis that André has done is going to help provide the kind of vital insight we need for our health care system and at least one view on how to create a financially sustainable future.

Frequently, as I think most of us in this room recognize, the energy that’s expended on the health care debate creates heat and not light. André’s core skill lies in his ability to shed light on complex matters. He is recognized throughout Canada for his innovative research and reporting on our health care system. As the public health care reporter at the Globe, he has written extensively on this topic—and I know that I, like all of you, are looking forward to his comments this evening. He advocates for a health care system that’s universal and fundamental and, at CIBC, I would say we add a voice to ensure that that universal and sustainable system is financially sustainable over the course of this time.

So, on behalf of CIBC, I’d like to commend André Picard and The Conference Board of Canada for their dedication to improving and shining light on Canada’s health care system. We’re thrilled to be funding this year’s research and to help fund, in the next few years, other new, cutting-edge research in Canada. Thank you everyone for being here this evening and I look forward to your comments.

Anne:
Thanks so much David and I’m so thrilled that you personally could be here to represent CIBC. I think most of you will recognize our moderator, Heather Hiscox. Heather is in her seventh season as morning anchor and host of “CBC News Now,” a job at which she starts her day at the incredible hour of 2:30 a.m.! So, no more complaining. Before moving into the studio, she worked for three years as a reporter for CBC’s “The National.” During this time, Heather worked extensively at the CBC’s bureaus in Washington and London, and was part of CBC’s coverage team at four consecutive Olympic Games. And, of course, she’s going
to lead the team over to London, England, in July, which will be her fifth. Heather began her broadcasting career in 1982 at the age of 17, working as a disc jockey in her home town of Owen Sound, Ontario. Since then, she’s been nominated for three Gemini awards, including for best anchor and for best host/interviewer. How lucky are we to have her tonight. Heather, thank you.

**Heather Hiscox:**

Thank you so much for that kind introduction and for inviting me to be part of such a distinguished event. And thank you for letting me stay out and play at the grown-up hours, because I didn’t realize there were two six o’clocks on the clock—it’s very exciting! I’m going to enjoy every minute. Let me add my good evening to you, ladies and gentlemen, and my welcome to the CIBC Scholar-in-Residence lecture. Like you, I am eager to hear André Picard’s insights on the path to health care reform.

I’m here as your moderator on André’s recommendation, for which I’m very grateful. I’m a tremendous admirer of his. We’ve covered stories together and worked together on a couple of events, and he knows I take a particular interest in health care for several different reasons. The first is my family background. In the interest of full and complete disclosure, I am the daughter of an ophthalmologist and the wife of a cardiac surgeon. So discussions of health care service have been as common as food for supper, if you know what I’m saying.

Second, I have volunteered within the health care sector, specifically the area of medical research, for the past 15 years. I’ve been proud to be an advisory board member at the Montreal Neurological Institute. The third and primary reason is my work as a CBC journalist. Health care figures prominently in our news coverage. Unfortunately, all too often it’s when the system breaks down. Examples spring readily to mind: the Royal Columbian hospital in March of 2011 having to use its Tim Horton’s outlet as an overflow ward. The breast cancer patient being denied the drug Herceptin because her tumour was smaller than guidelines permitted. Surgeons and patients from Ontario and Alberta flying to Vancouver to do surgery in a private facility because access to elective surgical care in their home province was so poor. The woman
showing up at “Emerge” for a urinary tract infection because she had nowhere else to go—like nearly four and a half million Canadians, she is unable to find a family doctor.

When we run stories like those, viewers always express keen interest and strong reaction, ranging from disbelief to dismay. Canadians are concerned about what is happening with their beloved health care system, and I use the word “beloved” intentionally. The principles of free, equitable, and universal are sacrosanct to many Canadians. David says they should not be—perhaps, but I think to many they are. A triumph of value; it’s a part of the very essence of who they are. In fact, poll Canadians on national identity; even today, more than half define themselves by the characteristic of free health care.

In 2004, when CBC Television asked viewers to choose the greatest Canadian, who won? Not Terry Fox, not Pierre Trudeau, not Alexander Graham Bell, not even Don Cherry. It was, of course, Tommy Douglas, the father of medicare. And yet the system that is the source of so much pride is struggling. Many analysts have pointed out medicare was designed chiefly to deliver acute care by physicians in a hospital setting. But 50 years have passed and the system remains frozen in time with structures and processes that no longer suit the modern context. The system doesn’t reflect the fact, for example, that most patients today have multiple chronic conditions and could be better treated in the community.

But homecare and other community supports have not emerged to take the place of the hospital.

It doesn’t take into account, as well, the demographic and fiscal pressures of an aging population and ever advancing, ever more costly, technology. To quote from one of André’s previous speeches, “You can’t deliver 21st-century care with a 1950s system.”

There’s a stack of reports that is bearing that out. For example, the most recent data from the Organisation for Economic Co-operation and Development found that Canada is one of the biggest spenders among industrialized countries with universal health care. Canada had the sixth-highest spending—both per capita and at just under 12 per cent of GDP. Canada nevertheless lagged behind most member nations
and ranked poorly on many key indicators, including access to medical technologies such as MRIs, wait times for medically necessary surgeries and procedures, the number of practising physicians per 1,000 population, and the number of acute care beds per 1,000 population.

The OECD picture was one of waits, lineups, shortages—an inefficient system bursting at the seams. A recent Senate committee report put it this way: “When compared internationally, Canada is no longer seen as a model of innovation in health care delivery and financing.” No wonder Canadians are frustrated. No wonder an Environics’ poll last year told us Canadians’ view of the health care system depends on their level of engagement with it. Those who use it more tend to like it less.

So why not, to borrow from Nike, “Just do it”? Just fix it. Why has there not been any real systematic transformation of the health care system over these past 50 years? In part, it’s because what a recent Health Action Lobby report found. I quote: “Governments are unable or unwilling to initiate a conversation. Health care is an instrument of politics. It’s a perennial top election issue for Canadians. Politicians know it and know they can be elected or re-elected by pandering and promising, for example, more doctors and more nurses. It’s political grist to invoke the mantra of medicare: it’s political suicide to suggest change or even a public discussion.”

As the University of Toronto’s president, Dr. David Naylor, once said to the Globe’s Jeffrey Simpson, “Health care is the third rail of Canadian politics.” In other words, it’s as lethal as the electrical rail in a subway; better to evade the issue entirely. My husband likes to put it another way. “It would be easier to change the Ten Commandments than to cut the Health Act.” He says it quite often at home. And yet health care reform is suddenly back on the table again, and it is Ottawa that has forced the issue this time.

Last December, Finance Minister Jim Flaherty announced a new non-negotiable arrangement for long-term funding. Federal transfer payments will continue to grow by 6 per cent annually until 2016–17. After that, increases will be tied to growth plus inflation—never falling below 3 per cent. The unexpected unilateral move has sparked a fierce new debate. Some say the federal government is stepping back and
reducing its role to writing cheques. Now they say there will be no one to protect the national interest, and Canadians will soon see a patchwork of services and standards and a deterioration of quality.

Others counter that this is an opportunity to allow the provinces to experiment and innovate in a way they have not before, and to share their learning with the goal of introducing meaningful, sustainable reform. What is certain is that there must be real debate away from the political arena among clear thinkers willing to take the long view and to develop a framework for cost-effective, efficient health care—a system that responds to the medical needs of all Canadians. Clear thinkers, like those you’re going to hear tonight: our panelists in just a few minutes, but, first, our guest lecturer, this year’s CIBC Scholar-in-Residence at The Conference Board of Canada. Let me introduce him to you now.

André Picard has been writing about the Canadian health care system for a couple of decades now and I dare say many of you have at least one of his bestselling books on your shelves at home. And I’m equally certain you never miss his pieces in The Globe and Mail. André is a reporter and a columnist with the Globe and his work has received much acclaim and many awards. Among them, a National Newspaper award as Canada’s top newspaper columnist; the Michener Award for Meritorious Public Service Journalism; and, just last year, the Hy Solomon Award for Public Policy.

In his acceptance speech for that award, André told his audience: “I plan to become increasingly cantankerous and obnoxious on behalf of the Canadian public, which is demanding that our leaders embrace and implement health care reform.” André, I suspect that this is a crowd that would welcome that, so let it rip. Be your Mister Cantankerous self. Ladies and gentlemen, Mr. André Picard.

**ANDRÉ PICARD SPEAKS**

Heather:

Ladies and gentlemen, the brilliant André Picard. Wonderful. Thank you for that insightful, coherent picture; for even making us laugh as we examine a very serious issue—but also for pushing us to consider what
have been, to this point, unpopular options, unexamined questions. So, no doubt, André has you thinking and perhaps even asking some questions of your own.

I’d like to draw your attention to the question card in your program today. We’re going to be opening the floor to you a little bit later on in our evening together and, as you’ll notice on either side of our auditorium, we have some of our staff and volunteers collecting your questions. So if anything that André said prompted a question for you, you can certainly submit it in written form or we do have two microphones that we’ll also be opening to you a little bit later on. Just a little bit of a heads-up to give you some advance warning if you’d like to participate in our discussion tonight.

What you’re going to hear next may well prompt further questions, so let’s bring on the next phase. We have invited three distinguished health care experts to respond to André’s lecture and to offer their own insights into health care reform. We’ve given 10 minutes to each of them individually and then we’re going to group together for a round-table discussion following that.

Our first guest tonight is Dr. Philippe Couillard, who’s an independent health care consultant. From 2003 to 2008, he was Quebec’s minister of health and social services. Prior to that, he was head of the Department of Neurosurgery at Saint Luc Hospital, a co-founder of the Department of Neurosurgery in Dhahran in Saudi Arabia, and a professor at the University of Sherbrooke Faculty of Medicine. Then, jumping forward, since 2008, he’s been a partner in Persistence Capital Partners, which focuses on investment in the health field. He also teaches health care governance at McGill University, sits on the security intelligence review committee, and is a member of the preview council. Ladies and gentlemen, Dr. Philippe Couillard.

**Dr. Philippe Couillard:**
Merci, Heather. Good evening, I’m very happy to be here with you tonight. André, in my view, is the most thoughtful and certainly often courageous public writer we have on the health care sector in our country. So, great job again tonight, André. I would agree with basically all
he says, so maybe I should stop there and move to the next panellist. I don’t think what concerns Canadians is that we spend too much on health care; I think what concerns them is the value we get out of the funding we put in health care, the money we put in health care. And I thought that I would start by looking at the origins—we could say the genesis—of the system which was an appropriate word for this public service, as André said, that has taken on quasi-biblical proportions. And if I can stay in the religious analogy sector, I would say that what we have in Canada is—I’ve called it misplaced secularization. We’ve secularized the system rather than the values and the principles that lie underneath the system, which should be protected at all costs. This system should always evolve because society always changes and needs to have a different system of public services. But for health care for some reason, we cannot even start doing this in a very significant way.

André has described the origin of part of the problem—that is a massive concentration of public funding in hospital and medical services. And it was okay then, as he said, for young, affluent societies—but it is not connected to our days and challenges. And the consequences are numerous. First, health care is not following needs outside the walls of the hospital. If you still today get an acute problem, you will get excellent care and most of the time it will be timely. But if your mother has Alzheimer’s disease, for example, another chronic condition that happens and must be managed outside the hospital, it’s a totally different story.

So, because of this bifurcated—I like your description, André, I would quote if you allow me to—so, many times the OECD has described the non-medicare part of our system, which is basically what we don’t cover with medicare; they call it a non-medicare part of Canada’s health care system as basically a U.S. kind of system. And if you look at it carefully, it’s entirely true. It’s a system that is based on out-of-pocket payment and private insurance, if you get private insurance. And it’s not something we see in other countries, like in Europe where they have a much broader coverage, but also thinner, which is a very different option from what we’ve been doing here.
This concentration on physicians and hospitals has also crystallized inequity, and there is much more inequity in Canada’s health care than most Canadians realize. The Commonwealth Fund recently published a study of heavy users of the health care system—people with multiple chronic conditions. It showed that, strangely, and to the surprise of many Canadians, the average Canadian citizen pays more privately out of pocket every year than the average Western European citizen.

If you look, for example, at the OECD figures, and compare, for example, Canada with France, you will notice that there is much more out-of-pocket payment in Canada than in France. And France has user fees, private insurance, and private surgical clinics that operate on people with public funding. So it’s not only a question of public-private, or this general way of approaching the system; it’s the way we define coverage from day one.

So we have allowed a kind of balkanization of coverage, the best example again being coverage of prescription drugs in various provinces of this country. And, of course—and I say this as a Quebecker as well—it’s true that it is good that provinces have their own way and that they have some autonomy in providing their public services. But maybe we could leave health care out of this. And even as a Quebecker, I would say this is a more appropriate discussion if you talk about culture or these types of issues. If you talk about health care needs, I don’t see why the barriers need to be as strict as they are sometimes.

The second legacy we have, following the concentration of funding in the medical and hospital world, is the unique status of our physicians. I always call this a “Faustian bargain”—the people in the room who know opera, and I’m sure most of you do, know what happens to Faust. He basically gave his soul for a day’s pleasure and somebody later comes and collects his soul again. So when we had the introduction of medicare in Canada, the medical profession as a whole was not that enthusiastic about the idea. As you know, we had to deal with the medical strikes in Quebec and Saskatchewan, and the final deal was the government allowed physicians, uniquely among OECD countries, to
remain free entrepreneurs even if they act in publicly funded hospitals. And to this day, this is a fundamental tension and the origin of great difficulty in managing the system.

Now I’m not saying that we should transform physicians into salaried employees of the state; I don’t think this is desirable, either. But, again, we should look at other models. And one model I have in mind is actually from the United States. Because it is true that the U.S. is not the best health care system—if there is such a thing in the world—by far. But there’s also jewels of excellence in the U.S., like the Kaiser organization for example, which has a very innovative and very creative partnership between the medical profession and the insurance plan, which is based on shared accountability, and this is what we need.

There is also, I would say, in the public discourse, faulty interpretation of our relatively good population health results. With the exception of child mortality, in which we have been sleeping for a few years if you look at the figures—I would say that this is something we should look closely at. So having these good results at the population level, long life expectancy, etc., it’s not proof of the excellence of the health care system because we know that the health care system itself determines roughly 25 to 30 per cent of the health status of our population. Other factors, and the way we deal with health determinants and social determinants of health, are much more powerful in what we achieve in terms of population health.

In addition, and I won’t spend too much time on this, André has rightly underlined the somewhat toxic nature of the public-private discussion. I think it’s based on the misunderstanding—sometimes voluntary, sometimes not—of the distinction between financing and delivery. And it’s a very strange conversation. I remember I was, a few years ago, on a panel on the public-private divide in health care in Canada—typical Canadian discussion, bad public, good private, and vice versa. In the audience, there was the CEO of a large university hospital in France, and he came to me after the panel and told me, “I don’t understand your conversation here. Why are you talking about these things the way you do? In our country, citizens get the choice of choosing for a variety of conditions of private or public provider, but the state pays. And the state
determines the price. So they compete for public funding to the benefit of the patient.” He said, “You have to explain this to me.” I didn’t have enough time, so I suggested he come back another year.

There’s another angle to the discussion I’d like to bring. I call it the discounted value, and it follows my comments on population health. The discounted value of the individual experience of the patient with the system—it’s as if it’s not that important. So we have these good population health results but we don’t need to talk too much about this. Rather, we keep discussing issues like funding, volumes of production, and the end result of this, which is wait times, instead of going to the core of what we should do with the system—which is better health care and better quality for patients.

Patient experience—you know it’s not folklore; it’s not a side issue. In many good health care organizations in the world, it’s a well-documented, well-studied notion, often now used for evaluation and decision-making by excellent organizations. I mentioned Kaiser and there are many others now. And it’s more than asking you as a patient if you’re happy or not with their services. People say, “Oh, you mean being asked if I’m happy or satisfied with the services.” It goes much deeper than that. And there are now standardized ways of going after this and asking people about the care they are receiving.

One question that I like particularly because I have been hospitalized, and people in my family have been hospitalized, I would ask you the same question. Has it ever happened to you, in your room at the hospital, that people were talking about you as if you were not there? So that’s a typical question that good standardized questionnaires on patient experience bring. And people get penalized and rewarded following the results to these questionnaires and results are made public, which is an important thing.

What I have learned from my experience with the private sector has been, in particular, that service organizations—and, basically, the health care system is a service organization—based on cost containment and rationing usually will fail, even from the business point of view versus the organization that would value quality as the core mission. And by quality, when we discuss health care, we talk about clinical quality, and
of course access, timely access, safety—very important issue—efficiency, and again patient experience. But the important thing is that we try evaluating the outcome and the results not from the system’s point of view, but from the patient’s perspective and point of view.

This sounds very simplistic, I know, but I’ve been struggling with this for many years. How many times have you heard a politician, I may have heard these words myself when I was in office, “I’m going to create a patient-centred health care system.” Then, fortunately, no journalist asks, “What exactly do you mean by this?” They go to another question. It’s hard to define but, again, if you come back to patient experience and the patient perspective and making the most of your decisions and policy choices, you’ll understand what it means. Because if quality is there, it’s true also that lack of quality is very expensive.

I agree also with André’s recommendations, of course with a slight twist. I think more than funding, we have a problem with payment. When I say payment, I mean how we pay people and organizations, what we reward them for, and what we don’t reward them for. I would say if I want to summarize it again and maybe in a simplistic way, we don’t pay enough for what we need, and we pay too much for what we don’t need. And that’s the centre of some of our problems with providers. And this is true for institutions and individual providers, and new models exist and they’re starting to come up in our in country—in Ontario and B.C., particularly.

I think we have to be worried of apparently easy solutions, like activity-based funding for hospitals. I think it’s a good trend, but it should be really looked at carefully. Because if you think about it, it’s fee for service applied to hospitals. In an era where we want to move the system and integrate missions in the hospital and outside the hospitals, if we get the massive incentives to bring the funding again back in the hospital with this new way of funding, we may have very different results than we anticipated.

I say only this regarding the Canada Health Act: that André is entirely right; it doesn’t prevent us from doing anything that we need to do. All that we’re going to discuss tonight I would predict, even before the end of the discussion can be made and accomplished with
the Canada Health Act as written today. It just needs to be read maybe more carefully. I would finally say—and again I congratulate the Conference Board on bringing this forum together—that from my experience in public office, I would say there’s very little room for politicians in office to discuss health care in a deep way.

And I think one role that you can play and this organization can play is to create and define a zone of safety for public officials and decision-makers to engage in certain discussions—touch certain subjects like public, private insurance; like what equity means; what equality means etc.—without being immediately crucified the next morning. And I think this…I can tell you from experience, this is a reality and it needs to change, otherwise we’re always going to stop the discussion even before it starts. So I didn’t want to take too much time because I think the most valuable time of this evening is engaging with you later tonight. Thank you, and again, André, thank you.

Heather:
Dr. Philip Couillard, thank you so much. Much for our discussion, indeed, to come a little bit later on. But let me introduce you now to our second guest panellist, Dr. Jack Kitts. He’ll be familiar to you, I’m sure. He’s the president and CEO of the Ottawa Hospital; has been since 2002. He graduated from the Faculty of Medicine at the University of Ottawa, did his internship at the University of Toronto, and for three years served as a medical officer in the Canadian Armed Forces.

In 1988, he joined the Department of Anesthesiology at the former Ottawa Civic, eventually becoming the department’s chief. He became associate professor of anesthesia at the University of Ottawa in 1996 and he has completed an MBA there as well. Last year, he received the Canadian Society of Physician Executives Award for Excellence in medical leadership. We look to him now for some leading ideas. Please welcome Dr. Jack Kitts.
Dr. Jack Kitts:
Thank you very much, Heather. Let me begin by congratulating André for delivering such a very thoughtful and insightful account of where we’ve been, where we are, and where we need to be. I also want to commend André for challenging all of us in the room in a call to action. Having listened carefully, and having had the advantage of reading his speech yesterday, I can confidently state that I agree with almost everything he has said today. So my comments will focus on my own observations and experiences as a front-line physician, a department head, and a hospital CEO in our health care system over the past 25 years. I don’t think I was that CEO that you had that debate on.

So I want to begin by stating that today in most centres across Canada, if you are severely injured or seriously ill, you will be treated at the front of the line and receive appropriate, timely, accessible, and safe care—but only if you’re in urgent need of care. In fact, the care you will receive then is world-class. For everything else, as André indicated, we have a problem, and we know we can do better. André states that there are many barriers that must be overcome before we can realize a better health care system—one that all Canadians can once again be proud of.

One of those barriers is that most Canadians still do not know, or perhaps they just refuse to accept, that our system is no longer able to provide the kind of health care that Canadians have cherished and grown to expect. I believe that we as a society are too tolerant of the mediocrity when it comes to health care. We find ways to understand and accept that our system doesn’t really have sufficient capacity, it’s inefficient, and we accept that our doctors and nurses are too busy to provide that timely and safe care. In fact, many patients are grateful to have just received the treatment and are less concerned whether the experience was acceptable or whether it was actually safe.

We have known for the past decade, beginning with the Romanow and Kirby reports, what we need to do. And in 2003–04, a federal provincial health accord was signed and a 10-year plan to transform health care for the ages was approved. This was promoted as a blueprint to transform our ailing health system and reclaim our status as one of the premier health systems in the world. And I have no doubt that
successful implementation of that accord and all its themes would have led to a much higher quality health system by 2014. But, as André suggested, there are a number of significant barriers to a successful health care transformation. However, André is not deterred by these barriers and challenges, and recommends that we move forward by focusing and acting on five key themes: primary care, drugs, homecare, social determinants of health, and quality.

Interestingly, these key themes were also identified in the 2003–04 accords as essential for health care improvements. There have been some improvements over the past decade, but most would agree that we will fall far short of the mark anticipated for 2014. So why should we believe that we would overcome the hurdles and succeed this time around? Now I know some of you know me here, and I’ve been accused of wearing rose-coloured glasses. And I am passionate about our health care system.

But I don’t spend a lot of time debating whether the system is gobbling up too much of our tax dollars and is not sustainable, or whether we’re actually spending enough money—we’re simply not getting value for the money. And I don’t spend time in that argument because if either or both are true, we have to change, and we know from highly successful businesses and organizations that there is a proven process for a successful change.

First, we must accept the case for change: We need to recognize that there is a burning platform. As André recommended, we have to change the reality that most Canadians are ill-informed, perhaps deluded, that the medicare that once defined us as Canadians is better, faster, and cheaper than anywhere else in the world. It’s not. This is a myth, and it has to be busted. André says that reform will not come in the form of rapture; I agree.

Reform will come with strong leadership and a clear vision. André says that medicare is devoid of vision. Again, I agree. Reform will come when leadership steps up, articulates a clear vision, and stops finger pointing—and it’s happening at every level of the health care leadership today. André can identify with the mission and vision for Medtronic; so can I. I’m sure that everyone in this room can. I’m also
certain that we could all identify with a health care vision that calls for a healthier population, a better patient experience, and value for money or quality care at the least cost.

We could spend days wordsmithing this vision but the goals don’t change. We need strong leadership at both governance and management levels. And I believe that strong governance and direction should come from both the federal and provincial governments. I believe that strong management has to come from the administrators, nurses, doctors, and other health professionals in the system. And I suggest that governors and managers rise above the political rhetoric, the turf protection, and self-interest, and truly focus on the patient. The patient has got to be the centre of our universe, without exception.

André says that we have a $200-billion enterprise but no stated goals. He follows with the observation that we talk endlessly about sustainability, but we don’t have any idea what we want to sustain. I suggest that we are trying to sustain the status quo, and that will not work. And the tyranny of the status quo is precisely why we are where we are.

Imagine a system with strong leadership, clear goals, alignment of key stakeholders, and clear lines of accountability. Imagine a system where all actions are focused on making the patient experience better, or a healthier population, or value for money. Imagine a system where outcomes, both quality and cost, can be measured right down at the patient-physician interface. This system can happen right here in Canada. But again, André is right, the political environment must change, the leadership and health care must rise above the rhetoric and turf protection. We don’t need another debate about values or what we should do. We need a debate about structure, funding, and results. And we need a population that is not only ready for change; we need a public that actually demands change. It really is time to stop talking and start acting. André has given us a blueprint for change and, even though he says he’s just a reporter, let’s rally behind him and bring it to a reality. I, for one, will do what I can do to help. Thank you.
Heather:
Dr. Kitts, ladies and gentlemen. Thank you for your thoughts on escaping the tyranny of the status quo. Wonderful line; I appreciated that one. Thank you, Dr. Kitts.

Our third panellist today is Dr. Judith Shamian. She’s the president and CEO of the Victorian Order of Nurses, and she has guided that 113-year-old organization through a time of great transformation. She’s also currently president of the Canadian Nurses Association. Previously, she’s been president of the Registered Nurses Association of Ontario, executive director of the Office of Nursing Policy, and vice-president of nursing at Mount Sinai Hospital in Toronto. She holds a PhD from Case Western Reserve and a master’s degree in public health from New York University.

In 2002, she received the Golden Jubilee Medal from the Governor General. And most recently, she’s received Canada’s Most Powerful Women: Top 100 Award from the Women’s Executive Network. It’s a pleasure to welcome her as well. Dr. Judith Shamian.

Dr. Judith Shamian:
Okay, so I am the last—the bookend of this wonderful conversation. Thank you to the Conference Board, thank you to CIBC. Thank you, André, for a very thought-provoking presentation. I have to say that I have heard André speak several times over the last two months, and he always adds a new nuance and additional perspectives to it. And, actually tomorrow, we are in the same forum together again talking about different issues.

But let me start with saying that I am not interested in the discussion of financing and funding, until we solve one fundamental issue. We have heard from Heather and others that we are the sixth-most expensive health care system but our health care outcomes, if you look at the OECD data, are in the bottom quartile. Let’s first get busy and work on figuring out how we get value for money before we have a debate of whether or how we pay for it or not, and is it working or not. And
I suggest to you that if that becomes the centrepiece of the discussion, we will get distracted and we will not do what I think many of my colleagues talk about that we need to do.

I want to pick on two specific things before I talk about what I believe we need to do on the solutions. One is primary health care and the second is homecare. Around primary health care—I think Heather also mentioned that we have close to 5 million Canadians who have no family physicians or nurse practitioners. Nurse practitioners provide the same service as family physicians and provide a comprehensive approach above and beyond the notion of working in teams. I think the notion of solo practices is passé. We need to work as teams. Recently, there was an article that showed that in treating an ordinary blood pressure problem—one of the chronic illnesses—if you work as a team you get better outcomes.

So we need to get busy working as teams and collaborating without having the professional silos that we so like to have and the tension between doctors, nurses, and others. Again, that’s last-century stuff, that’s not this century’s stuff. I know that in my capacity as the president of the Canadian Nurses Association, I worked very diligently and successfully to collaborate with the Canadian Medical Association. And I think one of our key successes—and I’m moving for a minute into how to do it—has been working with the premiers, the Council of the Federation, and saying to them, “Look, you cannot take the courageous steps in saying what needs to be done. We, as the professional groups, are willing to work with you, and have some of that discussion and take some of the bullets for you, because we need to transform.” Not transforming is not an option; basically, if you look at our health care outcomes, they’re absolutely horrible.

Our infant mortality rates, and some of our other outcomes, are going south, and people can argue whether the measurements of the OECD are right or wrong. But, when you compare us to ourselves over the last 5, 10 years, we are going down rather than improving. It’s not acceptable. I just came back yesterday from Geneva, from the World Health Assembly, and the topic this year is NCDs—non-communicable diseases—or what we talk about as chronic diseases. And that’s the
discussion in developed countries—low income, middle income—and we know that it’s a major issue. The way we deliver acute care, and we do a very good job, I agree, with the acute care. If you have a traffic accident or something, you want to be in Canada. But if you have COPD or you have asthma, go to another country. This is not the place where you will be treated properly. So, it’s the reality.

I think the notion of doing it differently is a must. Homecare—of course, it’s been at the centre of my existence the last eight years, and I discovered things that I didn’t know. And I thought that I was pretty knowledgeable about the health care system. I would ask you one question and I will move very quickly: How many of you look after and support a family member or neighbour or someone?

There are 3.1 million Canadians who do it day in and day out, and they don’t even call themselves family caregivers; they just do it, because that’s what we do. For every 30 caregivers, family unpaid caregivers, we have one professional paid caregiver. Good or bad? I don’t really know. We currently don’t do it well and we need to figure out how to do it better. But I know that when André asked how many of you would like to die at home—not tonight—you all said that that’s what you would like to do.

Well, we currently are not equipped with the services and the people and the education and the support of the families to do that, and it’s not complicated. In the VON alone, among my 15,000 staff, 9,000 are volunteers. And they provide care that you can’t even start to imagine. I love to tell the story about Aunt Mary, who used to be 85—she’s 90 now—having hip surgery. She goes home, there’s nothing in the fridge, there is nobody to drive her to the doctor, nobody to pick up her medication. Guess what happens? She’s back to emergency in 48 hours. And the next stop will be a long-term care facility, because we have not built what needs to be done beyond the acute care component of homecare.

And I would give a plug to the Conference Board. We just released today a very important piece of work, which the Conference Board worked on in partnership with VON, looking at the economic footprint of homecare and community care in this country. And we spend in this country—and we don’t really know exactly, because we don’t have
the data—anywhere between 4 to 5 per cent on home and community care. Well, if you think that home and community care is where the care needs to be provided, that kind of expenditure really doesn’t start to scratch the surface. So that’s another piece and I suggest that you go to the website and look at the report. There is a lot of very important information there, and it’s just the beginning of moving forward with that work.

Then how are we going to deal with it? That’s where I think the political agenda comes in, and there’s new language that talks about political determinants of health, never mind social determinants of health. And when I look at the front row and look at CIBC, look at The Globe and Mail editor, look at Anne, and look at the professional groups, we all need to be involved with how to do it. So we’ve been working with the premiers. But working with the premiers and working with the professional groups alone will not make it happen. We need corporate Canada, we need public civil society, and we need to move on it in a very significant, important way. We can make it happen; we have all the solutions. I call Canada the land of the “pilots” [pilot projects]. Anything you mention that you’ve seen in Cuba or England or whatever, we have it in this country. We evaluated it, but we either stopped doing it because somebody stopped funding it or because we don’t think that we could disseminate it. So hopefully working with politicians, with you, with corporate Canada, with the media and others, we will move that agenda. Thank you.

Heather:
Dr. Shamian, thank you so much. And please join me again in thanking all three of our guest panellists. Thoughtful and thought-provoking all.

Now, what we’re going to do, in the remaining 25 minutes or so we have, is I’m going to do my best Peter Mansbridge and lead in that issue, panel, is what I’m going to do. I’m going to try my very best, except I come, as you can perhaps see on the table, with a stack of my own questions. But the greater stack was in Michael Bloom’s hand, and they’re your questions, and they’re far more important than mine. So what I’m going to do is inter-mix mine, but I’m going to predominantly
rely on yours. So we have them written or we have two microphones at the side if you’d like to ask your question in person. Anne Golden has given me the authority—if you enter into a commentary—to put you on a funding escalator and send you right out of the room. This is about questions only, so we can solicit expert opinion from our speakers and guests.

So, that is what we’re going to start with. I want to talk about the barriers you all mentioned, but one of the barriers in terms of leadership—political leadership. And this is a question directed at André. First of all, you talked about Saskatchewan. You want the provinces to take the leadership and also you see Saskatchewan as having the best of the health care systems right now, and Brad Wall taking a leading role. What makes him such a potential leader in health care?

**André:**
I think, first of all, why does it have the better system? Because it’s more seamless. So they’ve broken down the hospital walls to a certain extent. You have a more seamless patient journey, etc. So that’s the key to their providing better care. Why is someone like Brad Wall important? I think because he has challenged the mythology—this whole mythology of Tommy Douglas—and he’s done it from his home turf. And I think that’s really important. He speaks openly about the need to integrate private and public care, talks about the facts. The things that we don’t mention—like that Tommy Douglas was a big supporter of user fees—little things like that. And not only does he talk about it, but he’s acted. So Saskatchewan has things like private surgical clinics, which have been very successful. They haven’t undermined medicare. In fact, they’ve enhanced it. They have things like the surgical initiative, where they have pooled waiting lists, so there are no waits. Instead of waiting for one surgeon, you wait for all 50 surgeons, and the one who’s available takes your case. Little tiny things like that—what Judith talked about us being a land of pilot projects. In Saskatchewan, they’re actually implementing, so they’re scaling up. And I think that’s our biggest challenge in Canada—we’re not scaling up the stuff that we know works.
Heather:
Premier Brad Wall, along with P.E.I. Premier Ghiz, are going to be the leaders in this innovation push and look for best practices across the country. I’m wondering from our other panellists whether you also look to Saskatchewan as leading the way right now, or whether there are other provinces, other jurisdictions, that you think are leading and where the rest of the country can learn?

Dr. Kitts:
We have innovation happening regularly in this country in many places. It’s true that Saskatchewan is doing very well; so are Ontario and B.C. Interesting things are happening there as well. Inasmuch as we can say, there is some risk in having this fragmented distribution of health care in Canada because of the Constitution—it does have some downfalls, but it does have an advantage, if we can harness the advantage. We have these provinces going forward in experimenting with things that we should look at, publicize, bring forward, and share. I think we’re not very good at showing and sharing best practices and innovation in this country and a body like the Population Health Fund was initially created to do that. I’m not sure that it’s actually doing this. Maybe we need to rethink this and find a way to create this forum—without the jurisdictional hurdles that we have once in a while in health care and other issues in Canada—where people would just come forward and show what they’re doing and let people learn from them, and do the same. Why is it taking so long?

Heather:
Dr. Shamian, anything else to add on that point?

Dr. Shamian:
Yeah. I actually work with both Premier Wall and Premier Ghiz in this innovation approach, and I think the point for us is that they are moving forward with some small-scale issues. My hope is that, through their efforts, they will learn to work together as the family of premiers. And they will learn to crawl and walk and will reach transformation. And I
do agree with Jack that, hopefully, the federal government will join in, but at this point working with the premiers. The one last comment I would make to André on why Premier Wall is successful: he also has engaged the public in Saskatchewan very deeply. So there is a conversation. It’s not the top down or for political or professional interest; it is an integrated society conversation.

Heather:
Okay. Before we move on to your next question, just picking up on the point you made of Ottawa and where does it fit in this current scheme now, with the hands-off, write the cheques, and let you decide, no-strings-attached approach to the funding. Dr. Kitts, does Ottawa have to be at the table?

Dr. Kitts:
I think it absolutely has to be at the table if it’s going to be called a Canadian health system. We have 13 systems right now and I think they’re growing further apart. And without a federal umbrella—with clear direction on equitable, universal, portable health care—I think we’ll just drift further apart and I think we would see a day where you’ll want to choose where in Canada you want to live depending on what the health care is.

Heather:
Interesting. But André, you say the leadership is going to come from the provinces, you anticipate. Does Ottawa have to be there, too?

André:
I think Ottawa has to be there in some way. I think there are two ways it can be there. One is that Ottawa’s role is to bring some equity to the system. Not equality, but to ensure that there is some access to basic services for everyone so there’s not too much difference. That’s one; that’s a political role. The other one that we often ignore is that Ottawa is also a big provider. It's the fifth-largest health system in our country. They’re responsible for Aboriginal people, RCMP, and the armed
forces. So I think one of their roles should be leading through example. And sadly, they have the worst health system. It’s an abysmal care system for First Nations, in particular, and I think that’s what Ottawa should be doing at this point. If they don’t want to play the political role, then play the delivery role. Because you can’t abdicate that; it is a constitutional argument. But you know, politically, it’s a perfectly legitimate point to say we believe in decentralization. We have to live with that and there is some benefit to it. As we heard, the Council of the Federation is becoming stronger, more active, so it’s not all bad. But get your delivery model down right.

**Heather:**
Okay. This next question from the audience actually flows out of that. So we’re looking to Saskatchewan, and some of the other provinces, for example. The next question from you is, “Which country’s health care system do you most admire?” So where do we look—if Canada’s is not unique, as André has said, and we’re deluded in believing that it is—where else are other countries doing things better? Let me start with you on this, Dr. Shamian, because you’ve just come back from Geneva. We’re talking about how much you’re travelling; what are you seeing internationally that Canada could learn from and adopt here?

**Dr. Shamian:**
For me, the notion is who achieves the best health outcomes, and then work backward from there to what they do different. If we look at it consistently, the Nordic countries have the best health outcomes. Their approach to public health, their approach to the concept of health being different in the health care system, is very different. So, tomorrow, for example, André and I will be listening to the ambassador from Norway. And Norway is leading the chart on the notion of governance for global health. And the idea is that health is not just an issue of health ministries and so on; it’s the business of transportation, it’s the business of all society, all business systems, and so on and so forth. So they provide the visionary leadership and their health outcomes are better than ours.
**Heather:**
So, Norway. France though, the World Health Organization points to France. It’s considered a leader internationally, is it not? Anyone want to jump in on that?

**Dr. Couillard:**
I’d say it’s always risky to try to transplant a system.

**Heather:**
Okay.

**Dr. Couillard:**
Because underneath the system there’s the history, the politics, the social values. If you take Nordic countries, for example, it’s true that they have the best health outcomes—probably more because of what they’ve been doing on the social determinants of health, I would say, and also look at the differences taxation represents in their countries in general. Norway is in a special category because of the oil income they have. But if you look at the other Nordic countries, taxation represents roughly 50 per cent of GDP, which is much more than we do; it’s a collective choice.

**Dr. Couillard:**
The gap of income is much narrower among individuals than it is in our country, which leads to better health outcomes per se.

**Heather:**
Perhaps not outcomes, but at least in funding models, is that an example that we can look to the best?

**Dr. Couillard:**
What I like about France is the idea that the state regulates—it steers but it doesn’t row, if I can say so. It regulates, it sets the prices, and it lets providers use the public funding to the benefit of the patient, and this is what people appreciate there. But their system also has to be
looked at in more detail. They have many more physicians than we have. We have 2.2 physicians per 1,000 people, they have 3.2. It’s 1 physician per 1,000 more than we have. So it would be thousands of more physicians for every province and, of course, they pay them much less than we pay our physicians. Always goes hand in hand, so it’s very hard to say, “I want this system, like in France.” I’m sorry, I don’t want to take too long, but when I was in office, a physician came to me and said, “Why don’t you give us the French system?” I said, “My friend, you want the French system? Sign here, we’ll do it tomorrow.” So again, let’s be careful about this.

Heather:
Well, as André made the point, you cannot transplant a culture into the Canadian environment but perhaps learn from it. Thank you for waiting; could you please introduce yourself and direct the question to one of our guests?

Irene Nelson:
Irene Nelson, health policy researcher. It’s a question I guess to André Picard. I wonder … I wish we Canadians did agree on 80 per cent in terms of values, in terms of ways to improve the health care system. I don’t think we do and I take issue with a lot of what’s been said tonight in terms of ignoring the evidence that for-profit delivery has worse health outcomes. So I wonder what you would say to the very solid research by P. J. Devereaux and others on for-profit dialysis clinics and other types of hospital procedures that lead to higher mortality, higher morbidity, and the tons of evidence from long-term care. From the for-profit nursing home industry, where there are higher ulcer rates, dehydration, high blood pressure, ulcers, unavoidable hospitalization. There is such strong evidence that for-profit delivery is harmful and costs more, and I wonder why that evidence hasn’t been brought into play. Whereas, you’re claiming that private clinics in Saskatchewan have improved health. I haven’t seen that evidence and I follow it very closely. Thank you.
André:
I think unquestionably what we know is that poorly regulated care is bad care, whether it’s private or public; that’s the issue for me. So I think the issue with P. J. Devereaux’s work—for example, he did show very well that these for-profit clinics in the U.S. had poor outcomes. That they are very poorly regulated is the issue to me. It’s not the funding model; that, to me, is secondary. I said in my talk that I’m not a proponent of “let’s blindly privatize things, let’s regulate properly”—that’s to me the message that we get from Europe. Good regulation, good public administration—we kind of have the worst of both in Canada and in the United States. As well, they have really poor regulation of the private, and poor public … less of poor public administration, actually. So to me, that’s the issue. And I think that’s less than 20 disagreements still, so I think we still have the 80 per cent agreement.

Heather:
Picking up on the point that Dr. Shamian made and Dr. Couillard countered, in terms of the Nordic countries setting up conditions—social conditions—that lead to better outcomes, the question from the audience was, “How do we here in Canada convince politicians to set up those frameworks to lead to the social conditions that lead to those better outcomes?”

Dr. Couillard:
Briefly, it goes much beyond health care. It’s a much broader discussion about taxation, social justice, the place of public programs in the daily lives of its citizens, and it is not solvable only talking about health care. I just want a few seconds on this issue of for-profit service.

First, I’d say that this public-private discussion is not a priority—it’s not the main issue we have to deal with in health care—and I think André made a good point about this. The second thing is, I agree with him that it’s a lack of regulation that is the problem, not profit or non-profit. If you think about it, the GP clinic in our country is a for-profit
private corporation with shareholders, balance sheets, income statements, and commercial transactions. It’s not how it’s done, but the way it’s regulated and also who pays and what they pay for.

In France, I would remind people—and, again, I’m not the proponent of this; I don’t think this private thing is the main thing we need to do in health care in Canada—but in France, roughly 45 per cent of the in-patient surgical beds are private. Nobody is in the streets about this even when there is a socialist president. Why? Because the price is set by the state and the state is very strong, gives very strong oversight of quality and safety.

**Heather:**
Okay. Couple of questions dealing with end-of-life care issues. Dr. Kitts, maybe I’ll begin with you on this—they are related. Number one, do you think we should begin developing a pan-Canadian end-of-life-care policy framework? If so, who should lead that discussion? And related to that in reference to André, and I’ll come back to you on this, the whole idea of rationing health care outside of end-of-life care, what do you have in mind? But let’s begin with end of life. Do you think we know how much cost is attached to end of life? Maintaining life is now able to be prolonged beyond what anyone would have conceived 50 years ago—in Tommy Douglas’s day—so do we need to have a pan-Canadian discussion of end-of-life policy?

**Dr. Kitts:**
I think absolutely we do and I think it has to be a pan-Canadian discussion because this is a societal debate. You can’t count on the doctors or the health professionals or someone else to make the decision. But we do know that a substantial amount of health care spending does occur in the last six months of life. And it’s ironic, but the advances in technology and the advances in medications have allowed us to keep people alive much longer. And that seems to be the goal now—keeping them alive. We don’t look at the quality of life and I don’t think it’s fair to put
the onus back on the health care professionals to decide whether they are going to treat or not. So absolutely it’s overdue and it is a societal decision.

**Heather:**
It’s interesting we are watching it play out at the Supreme Court level with the Hassan Rasouli case.

**Dr. Kitts:**
Yes.

**Heather:**
The doctors versus the family’s wishes. André, where do you fall on this part of it?

**André:**
Well, because I used the word “rationing,” people are going to say that I advocate death penalties or something like that.

**Heather:**
Oh dear.

**André:**
But the issue is really that we have this notion that death is a failure. We have this medical model and it’s not. Providing a good death is just as important as providing a good life. And what we do is … we do all this irrational care at the end of life, which you know that I know from my parents—they don’t want that. If you are dying of prostate cancer and you’ve got a week to live, you don’t need a hip replacement. It’s not funny because it happens all the time and is just….

**Heather:**
Laughing at the absurdity of it, I suppose.
André:
But it’s an example of something that I hear about every single day—that money should be spent on giving pain relief, caring for people in their home instead of putting them in this institution and sticking them full of tubes. That’s not what people want. And again it comes back to what I said at the very start of my talk. We’ve lost sight of what patients want, and they don’t want all these heroic efforts that are going to lead to nothing except more pain. They want a good death.

Heather:
Dr. Shamian, do you want to add something?

Dr. Shamian:
We had Senate reports and other things that talked about hospice care and dying at home. That’s the preference, and most of Canadians you ask don’t get their final wish. And it doesn’t need to be medicalized. So if you look at the number of volunteers that provide hospice care and are there with the family to support and so on, that doesn’t cost a lot of money. So we can provide a lot of those choices right at home. Taking somebody—even if they are not going to do the hip replacement—to die in the hospital, that’s a lose-lose all around. It’s a loss for the system and the family and the individual.

Heather:
Okay, a big issue to deal with in the future. Three questions that I found thus far fall into one subject area. They are directed at Dr. Shamian and Dr. Kitts and Dr. Couillard. It has to do with Aboriginal health. Dr. Shamian, in the first part directed to you, what would you do to increase the number of Aboriginal nurses? And then to both Dr. Kitts and Dr. Couillard—if you were a minister—or formerly, as you were a minister, Dr. Couillard—what would you do to improve health specifically for Canada’s Aboriginal people? Let’s begin with the Aboriginal nurse question. Dr. Shamian.
**Dr. Shamian:**
Again, the land of the pilot. We have programs in Saskatchewan and Manitoba where the retention of Aboriginal nursing students is very high and others where 80 per cent quit after the first and second years. So we know how to keep them in the system and we need to generalize that. The other thing is that we need to look at the social determinants. We need to look at education. We need to go into those communities and work with children’s literacy in elementary school, not wait for high school; that’s too late. We should provide children with the role models and provide the opportunities for them to spend summers and otherwise to learn about it—play nurses, play doctors, play whatever. And groom them to those notions and, again, we have successful models.

**Heather:**
Okay. Dr. Kitts and Dr. Couillard.

**Dr. Kitts:**
I think the social determinants are key, and we need to focus on them and we need to go to them, educate them, and create more physicians and nurses in that area. But I think another thing is, we know that quality health care is critical mass: critical mass of physicians, critical mass of patients, critical mass of nurses. And where you don’t have critical mass, I think we need to work much better on an integrated system where the patients or those who need health care and check-ups can quickly access the nearest place that gives them the appropriate care. So I think transportation becomes a real bonus for that.

**Heather:**
Again, we are looking at multifactoral responses to these issues, not just within health care specifically. Dr. Couillard, on this point?
**Dr. Couillard:**
Anyone who has visited Northern communities immediately sees how housing is at the heart of many of these social and medical issues. Unacceptable things happen in these overcrowded houses and it seems to take us ages to provide appropriate housing for these communities. And I was part of that story. It usually happens when you have a meeting with the community and everybody agrees that you are going to build the 300 houses in the next two years—yet two years later, only 10 have been built. Because what’s been happening has been constant fights between the federal level, the provincial level, and the band level, on who’s going to pay, who’s going to manage, who’s going to oversee this. So that’s a tragedy.

Education, of course. As you said, the reason we don’t have more nurses and doctors coming out of the Aboriginal communities is because they don’t finish high school in large enough numbers to go to university. This is where the effort has to start. And I would end by remembering a very positive experience I had with the communities, with the Cree in Northern Quebec who, following the James Bay Agreement, were allowed to develop their own health care system and their own organization to their own priorities. And we’ve controlled their funding after a transition period and it worked quite well; so again, empowerment and trust are the heart of the issue.

**Heather:**
We could have an entire panel discussion focusing on that one small portion, so we are just touching on it here.

If you would introduce yourself and ask a question to our guests.

**Arthur Kapoor:**
Thank you. My name is Arthur Kapoor. I’m an emergency doctor here in Ottawa. And when we were talking about doing more than the patients want at end of life, I often see the other side, where patients want more tests to be more certain of what’s being done. We have a fascination with technology. People think: “If I get a diagnosis based on a doctor or nurse’s exam, it’s not as good as if I’ve had a test.” And the
demand for technology—when it’s at an individual level with me and the patient, it’s difficult to say, “Well, it’s not reasonable; you don’t need that.” I’m wondering—one, if in your research, you’ve seen that that’s a big problem, as I seem to think it is; and two, where that decision should be made, who may decide what’s reasonable, or how far do we go?

**Dr. Couillard:**

It’s definitely a problem. It’s the *House* phenomenon, where we think that everybody can magically be saved if you bring in enough technology. That’s *House* [the TV show] in 48 minutes, with 12 minutes for commercials, and everybody is magic. That’s the impression, that’s what we sell people on, and it’s not true, as you know very well. So how do you fix that? I think that on three levels—first, and we don’t talk about this enough, we have a sense of entitlement in Canada, but we don’t talk about the flip side, which is responsibility. So patients have a responsibility to be more informed and say, “Listen, I don’t want every little tube stuck into me. I don’t need that.”

Second, physicians, I think, have to be gatekeepers. That’s part of their role. One of the reasons we pay them very well is they should be gatekeepers to the system and say, “No, this is not appropriate.”

And third, you do it with incentives. You have formularies for drugs; you probably need them for, I think increasingly, medical technologies. Maybe we need formularies for interventions, although I know doctors would resist that bit. But I think it’s a combination of those things to say, “Listen, we don’t have to do every single thing to cover our butt; sometimes the best thing a doctor can do is nothing.” We forget that that’s often the most important medical intervention: to say hold on, take a breath, you are going to be fine.

**Heather:**

Dr. Kitts wants to get in on that.
Dr. Kitts:
I think what Dr Couillard is saying is, it’s not the physician wanting to do everything; it’s the family and patient wanting to have everything done. And I think one of the key things is people think medicine is a science. It’s still very much an art, and so there is no black and white and it’s a game of probabilities. And one complaint I always get is someone is terminal with cancer or whatever, and the doctor won’t tell them when the patient is going to die. They don’t know. They just don’t know, and if they guess it’s … so I think the problem is, when you are having this difficult debate, it’s not the time for a physician who has a strong bias or family with strong bias to have that debate. It has to be a societal debate, and everybody accepts it, and it’s never going to be black and white and 100 per cent: it’s going to be a probability.

Heather:
And Dr. Shamian, before we move on.

Dr. Shamian:
I do believe in evidence-based practice and I think we have, more than we desire, forms of evidence-based practice. I recently had a family experience where an oncologist said to one of my family members, “No, we are not going to do this, because the evidence doesn’t show blah, blah, blah.” So the family member wasn’t overly excited about it, but the oncologist was very clear: this is the evidence, but it does require that the physician or the nurse practitioner take the time and repeat until the person understands it—so they don’t walk out thinking, “Oh, this is a bad doctor or a bad nurse practitioner. I’m going to go and look for somebody else.”

Heather:
Okay, you sir, at the microphone. Our last question, then we’ll do a quick rapid-fire round to wrap up.
Ian Campbell:
Thank you very much. My name is Ian Campbell. I’ve been working in health care leadership in various areas within the province over many years and recently relocated to Ottawa. A recent article in an Ottawa magazine raised, to me, issues linked to what Dr. Shamian has talked about regarding evidence-based care and Dr. Kitts has talked about, the social dialogue. In pursuing the reform that, André, you’ve challenged us to get to and we need to do, when we have the societal discussion, that maybe it’s reluctant to pursue change and implement? When we have strong evidence of support of a pilot? And, as an example, to try to bring it down to brass tacks, the Insite clinic in Vancouver has very strong demonstrable benefits and health benefits. And yet, we have a struggle within our society in terms of how we would expand that model into cities such as Toronto, Montréal, or even here in Ottawa. How do we find the balance in that structure?

Heather:
How we find the balance? Dr. Couillard, do you want to respond to that?

Dr. Couillard:
I was part of that discussion on Insite and I was basically in agreement with the fact that we should open one in Montréal and Québec at that time—but then it starts. Where is it going to be, in what neighbourhood, why here, why not there? And it never ends. At the end of day, someone has to make a decision and says it’s going to open there and then you live with the consequences. I just want to say a few words about evidence-based practice. I always like also to use the word “evidence-informed” because there are also components of pure science that play in the decision, whether it’s a clinical decision or a policy decision. And if I go back to a clinical decision …. When I was teaching neurosurgery, I used to give a course on informed consent, where I would ask residents to do role-playing. I would present to them a clinical situation and I would prove to them that, only using things that are evidence-based
and true scientifically, could you steer the patients into making two very different decisions. So there is bias there because again, as you rightly said, medicine is not pure science.

**Heather:**

Okay, last question in hand, although there are several others with variations on this. I do want to ask you this before we conclude because it’s directly responsible or in response to your role here. To all of you that are still here, and André, what can the public do? Obviously this is an interested group; what can these people do? What can we all do to bring forward the solutions needed to change the health care system, to start the debate, to continue the debate, and to bring forth those solutions? What’s your one point as we do a rapid fire on this final question? Dr. Shamian.

**Dr. Shamian:**

I would like us collectively to come up with what are the health outcomes that we think this country should achieve over the next 5 to 10 years.

**Heather:**

Dr. Kitts?

**Dr. Kitts:**

I think stop accepting mediocrity when it comes to anything about acute care.

**Heather:**

And going to your politician with that, or how or doing what with that?

**Dr. Kitts:**

Start with the politician.

**Heather:**

Agitating on that.
Dr. Kitts:
And governance.

Heather:
Dr. Couillard, what does the public do?

Dr. Couillard:
Open a space of free discussion, free of preconceptions, where decision-makers and politicians are safe if they voice certain opinions and try even to voice ideas that they would like to put forward. And be engaged in participating. You rightly said that, in Saskatchewan, the public was engaged from the start. I think this is a big problem; we are sometimes afraid in politics of what the public will say. True, we should not be. People are well-informed, well-educated, and they know what they want and we should ask them and they will tell us very frankly.

Heather:
And André, the last word to you.

André:
Well, I would echo Dr. Couillard: try to create this space for open dialogue and focus on the basics. Medical care can’t be all things to all people at all times. Think about what would be essential to you, what’s essential to your neighbours. We can deliver that—we can deliver it well, so create this space for our politicians, and our other social leaders can do it.

Heather:
This has been very much one of those open spaces, I think. So let me say, first of all, thanks to all of you for all these wonderful questions. On your behalf, thanks to our outstanding panellists: Dr. Shamian, Dr. Kitts, and Dr. Couillard. Let’s share our appreciation again.

And especially to our CIBC Scholar-in-Residence for his tour de force lecture—André Picard, ladies and gentlemen. Again, just a reminder on a couple of housekeeping points. What you heard tonight
from André really forms the basis for what he’s written about. And he’s going to be completing a very in-depth analysis of health care reform and the Conference Board is publishing that. So you’ll be able to obtain that in person and online, and there is another book launching in future, so you’ll be hearing more about that. Thank you again, André.

Anne Golden, thank you for organizing all of this. The Conference Board—thank you for inviting me, as well, to share in what was an incredibly interesting evening. And thanks to you not just for the questions but for participating in such record numbers—a true measure of your interest in this vital issue.

As André says, his entire text challenged us. Someone called it a “call to action,” so there is a call—a gauntlet laid down for you—and we even had some suggestions for how you could pick it up and run with it and then carry on this debate to move on to some successful solutions. You can help create the environment that André said is necessary for change. Thank you all very much for being with us today.
The topic of health care reform interests Canadians everywhere. Canadians take pride in having one of the world’s most comprehensive health care systems, one that costs more than $200 billion annually to operate. Surveys reveal that public health care is at the core of Canadians’ national values—a defining element of our character as a country. Conviction about its importance remains strong even though many people feel frustrated with aspects of its performance. This is the collective challenge: How do we “fix” a system that we love as a nation?

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