The Patient, The Condition, The Treatment

A CTF Research and Position Paper on Health Care

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News Release Executive Summary

About the CTF

The Canadian Taxpayers Federation (CTF) is a federally incorporated, non-profit, non-partisan, education and advocacy organization founded in Saskatchewan in 1990. It has grown to become Canada's foremost taxpayer advocacy organization with more than 83,000 supporters nation-wide.

The CTF's three-fold mission statement is:

- To act as a watchdog on government spending and to inform taxpayers of governments' impact on their economic well-being;
- To promote responsible fiscal and democratic reforms, and to advocate the common interests of taxpayers; and
- To mobilize taxpayers to exercise their democratic rights and responsibilities.

The CTF maintains a federal and Ontario office in Ottawa and offices in the four provincial capitals of B.C., Alberta, Saskatchewan, and Manitoba. Provincial offices conduct research and advocacy activities specific to their provinces in addition to acting as regional organizers of Canada-wide initiatives.

The CTF's official publication, *The Taxpayer* magazine, is published six times a year. CTF offices also send out weekly *Let's Talk Taxes* commentaries to over 800 media outlets as well as providing media comment on current events. CTF staff and Board members are prohibited from holding memberships in any political party. The CTF is funded by free will, non-receiptable contributions. The CTF does not receive government funding. The CTF's award winning web site can be found at: www.taxpayer.com

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The report's principal author, CTF federal director Walter Robinson, accepts full responsibility for any omissions or errors this report.

Table of Contents

1.0 Introduction

Many Canadians know of the Canadian Taxpayers Federation (CTF) as an impassioned, persistent and non-partisan organization that fights for the common interests of taxpayers; most forcefully on issues of fiscal responsibility, democratic reform and government accountability.

The CTF has played a constructive role in framing public debate and shaping public policy on a number of key issues. At the provincial level, the federation's model balanced budget legislation was adopted and implemented in Manitoba in 1995 and in Ontario in 1999. As well, several other provinces have incorporated key elements of the CTF's balanced budget work into their own statutes.

In terms of federal policy, the CTF spearheaded and mobilized public opinion in early 2000 to force the federal government to abandon its proposed assistance plan for Canadian NHL franchises a mere 72 hours after it was proposed.

More important, the CTF was the most vocal and influential organization during the six-month lead up to Budget 2000 (February 28, 2000) in articulating the justification (fiscal, social and political) for the re-indexation of the tax system (thereby ending bracket creep) to inflation. As a result of this measure announced in Budget 2000, Canada's 14.7 million taxpayers will save an estimated $20.7 billion in personal income taxes that otherwise would have been paid to the federal government between 2000 and 2004.

This activism on fiscal issues will continue. It is crucial that consistent pressure is applied to ensure that Canada's tax mix is optimal and competitive, debt reduction continues apace and expenditures are prioritized.

As well, increasing attention will be paid to various social programs and their viability. Of relevant note are the challenges in sustaining Canada's public pension regime as well as a variety issues stemming from the aboriginal policy file. But nowhere is this challenge more acute or immediate than in the myriad questions that arise when the issue of reforming our health care system is brought into focus.

1.1 Rationale: Why Health Care?

Why has the CTF produced a health care paper?

To start, health care is the number one social policy challenge for at least the next decade. Public opinion polls consistently show that it is the number one public policy priority for Canadians.

Canada is forecast to spend 9.3% of its GDP, or $95 billion (public and private funds) on health care in 2001. Without exception, health care spending is the largest component in each provincial budget, accounting for 62% of all new expenditures in the last three years. It is clear that health care is a taxpayer issue.

Former Saskatchewan premier, Roy Romanow is heading a one-man commission looking at the future of medicare. As well, a Senate committee chaired by Michael Kirby has already produced one volume (an encouraging tome) of an anticipated five-volume report looking at the past, present and future of our health care system. The provinces are also engaged in a variety of health care related research and consultative efforts.

Indeed, there is a sizable volume of research that has been produced by health care stakeholders, think tanks and others offering prescriptions for health care reform. However, the national debate surrounding health care reform has yet to reach a level of maturity.

Facts and measurement are discarded in favour of emotive hyperbole and best-practice evidence is unfairly viewed and judged through the filter of its country of origin. Worse still, talking heads and politicians (the dominant surrogates of the debate) still opt for facile bi-polar country comparisons, limiting left-right distinctions and/or demonization of their adversaries.

While such tactics make for good copy or television, they do little to broaden understanding of the issues inherent in health care delivery and reform. They discourage – rather than encourage – Canadians from taking ownership of our most pressing public policy issue. We should not delude ourselves; a full and frank discussion about the future of health care will be difficult.

The sage and prophetic words of Peter Drucker, the father of modern management, are instructive as to the tenor and gravity of this debate.

> In the last 40 or 50 years, economics was dominant. In the next 20 or 30 years, social issues will be dominant. The rapidly growing ageing population and the rapidly shrinking younger population means there will be social problems.[1]

This makes asking tough questions and challenging old assumptions that much more important. But we are not alone in tackling this issue. The World Health Organization confirms this when it notes:

> What makes a good health system? What makes a health system fair? And how do we know whether a health system is performing as well as it could? These questions are the subject of public debate in most countries around the world.[2]

With labour unrest in the health care sector brewing across the country, public anxiety that persists, and governments that continue to bicker over jurisdiction and assign blame instead of looking for solutions, the answer to “why health care” is self-evident. Constructive and challenging ideas must be brought forward to offer hope, stimulate debate and shape the eventual public policy solution path chosen.

1.2 Layout of the Report

For ease of reading, it was decided to order the nine chapters of this report in a manner consistent with answers to the following three questions:

- Where have "we" (read: Canada) been? Chapters 1 and 2
- Where are "we" (and others) now? Chapters 3 to 6
- Where are "we" (and should we be) going? Chapters 7 to 9

The remainder of this chapter identifies the CTF's core beliefs that underlie its approach to the health care issue and debate. It concludes by outlining the primary purpose which drove the production of this report. Chapter 2 explores the history of health care in Canada over the last century – from Confederation to the announcement of the Romanow commission – and details the changes in structure, governance, scope and financing levels showing clearly, ***where "we" have been.***

Chapter 3 is devoted to the *Canada Health Act:* its scope, its application and its five principles. Problems with these principles and the Act itself are briefly discussed and modernization of the Act is then proposed along with a consequent set of revised principles.

Chapter 4 embarks on a quantitative précis of national health indicators and statistics – drawing heavily from information complied by the Canadian Institute for Health Information (CIHI) among others – as well as offering up province-by-province statistical breakdowns, issues and trends.

Chapter 5 imparts an international focus looking at the organization of health care services and selected statistics from other countries. In addition, a glimpse of some of the reform options/approaches around the globe that have relevance to Canada are discussed.

Chapter 6 investigates the scope of the Canadian health care debate, dispels the most common myths that act as obstacles to meaningful discussion and reform, highlights the key stakeholders and offers a précis of the dominant issues in the Canadian health care debate. These four chapters provide the reader with a solid sense of ***where "we" are.***

Chapter 7 outlines the key forces that will shape Canadian health care and health policy in the future. Chapter 8 briefly catalogues the success and failures of the main (common) Canadian health care reforms to date.

Finally, Chapter 9 offers principles and proposals for reform and debate … ***where "we" are (and should be) going.***

1.3 List of Acronyms

In this report a variety of acronyms are employed and are listed below in the order that they appear to facilitate reader comprehension.

CTF	Canadian Taxpayers Federation
OMA	Ontario Medical Association
BCMA	British Columbia Medical Association
CIHI	Canadian Institute for Health Information
ER	Emergency room
IRPP	Institute for Research on Public Policy
CCB	Critical care bypass
ERD	Emergency room re-direct
RCMP	Royal Canadian Mounted Police
CHA	Canada Health Act
GDP	Gross domestic product
R&D	Research and development
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
CMA	Canadian Medical Association
CCF	Cooperative Commonwealth Federation
NDP	New Democratic Party
CAP	Canada Assistance Plan
EPF	Established Programs Financing
CHST	Canada Health and Social Transfer
CIHR	Canadian Institutes of Health Research
CFO	Canada Foundation for Innovation
WHO	World Health Organization
MRI	Magnetic resonance imaging (usually in reference to a MRI machine)
AMA	Alberta Medical Association
B.C.	British Columbia
RHC	Regional Health Corporation
RN	Registered Nurse
HSRC	Health Services Restructuring Commission (Ontario)
PCR	Primary care reform
CHEO	Children's Hospital of Eastern Ontario
ALC	Alternate level of care (meaning non-acute care)
CPP	Canada Pension Plan
OECD	Organization for Economic Cooperation and Development
NHS	National Health Service (Great Britain)
SHI	Statutory Health Insurance (Germany)
HMO	Health maintenance organization (United States)
CT	Computerized tomography
CIA	Canadian Institute of Actuaries

1.4 Seven Core Beliefs: Before We Can Move Forward

Before moving forward, it is important to identify some of the core beliefs held by the CTF when it comes to the health care system, the present debate and directions for reform.

Belief #1: Health care is in crisis

The word crisis has often been used to describe the state of parts, if not all, of Canada's health care system (structure, funding mechanisms and delivery framework) by commentators and analysts from a multitude of backgrounds and political persuasions.

According to Merriam-Webster's on-line collegiate dictionary, crisis is defined as:

> … an unstable or crucial time or state of affairs in which a decisive change is impending;[♦]

Surely this is the crossroads at which Canada now finds itself with respect to its health care system. To continue without fundamental reform would lead to a highly undesirable outcome, namely longer waiting lists, more hallway medicine, further de-listing of services (health care rationing) and a larger exodus of health professionals and research scientists out of the country.

Yet some "experts" insist that all this talk of crisis is a dastardly plan perpetuated by the enemies of medicare who are prone to exaggerate its weaknesses. Indeed this was the view espoused by the Tommy Douglas Institute in a study entitled *Revitalizing Medicare: Shared Problems, Public Solutions* released in January 2001.

In an overt attack on medicare's "enemies" (enemies being broadly defined as anyone who dares to challenge the status quo), the report cautions Canadians that it would be:

> Foolish, indeed disastrous, … to accept the diagnoses and "therapies" offered by Medicare's enemies. There is a great deal of money to be made by wrecking Medicare. [3]

Such rhetoric does a great disservice to the intelligence of Canadians who are clamouring for an encompassing (see next core belief) and engaging health care debate. Fortunately the report made headlines only for a day or two and then was relegated to the media trash bin once analysts revealed its selective research bias, blatant dismissal of real and systemic emergency room (ER) overcrowding issues and dated use of waiting list studies which have since been updated to yield more alarming conclusions, and these are just a few of the study's shortcomings. [*]

♦ This is one of three definitions found at Merriam-Webster Online, http://www.m-w.com.

* An incisive review of this study can be found at http://www.healthpolicyreform.org/writings/michael_rachlis.html.

As the Institute for Research on Public Policy (IRPP) task force on health policy pointed out in the summer of 2000:

> Canadians on waiting lists are not imagining their anxieties. Delays in diagnostic imaging and radiation therapy are real. Many smaller communities lack health resources. [4]

Moreover, media stories that detail critical care bypass (CCB) and emergency room re-directs (ERD) are commonplace. And the revelations about Canadians being sent south of the border, by our own workers' compensation boards no less, are now too frequent to ignore.

As the President of the Ontario Medical Association (OMA) put it in ***give it to me straight, Doc*** fashion to the Canadian Club of Toronto this past April, "there is a crisis in health care now – and the future looks even more daunting." [5]

Belief #2: Canadians are ahead of their politicians

According to the Conference Board of Canada:

> Health care has become Canadians highest national concern. It arrived on the scene around 1993 thereupon rising steadily until 1998 when it became the top national issue. As of May 2000, health care was still the top issue, identified as such by 52 per cent of Canadians. Further, over 90 per cent of Canadians identified health care as the highest priority for both provincial and federal governments for today and the next five years. [6]

James Frank, Vice-President and Chief Economist at the Conference Board also reminds us that calls for a national health care debate are not new. Back in 1996, the Conference Board's first annual edition of *Performance and Potential* recommended:

> The health care system in Canada needs a serious public review. It is too important to our quality of life and to our competitive position in international trade for anything less than a major undertaking to address the broader determinants of "health", the mix of public and private roles and the means of ensuring manageable costs. [7]

Public opinion polls (see Chapter 3.2) – even those polls conducted by the federal Liberal's own pollster – show increasing support for forms of user fees and consideration of "once taboo" market options for health care.

Yet it wasn't until this spring that the Romanow commission was established: a full eight years after health care showed up as a flight in trouble on the public opinion radar screen.

Belief #3: Health care IS a shared jurisdiction

Building on the previous core belief, Canadians are also resolute in their belief that health care is a shared jurisdiction. In an internal CTF survey in the summer of 2000 of its 83,000 supporters, 65% of respondents (note: the respondents constituted a representative geographic of the CTF support base) indicated their belief that health care was a shared jurisdiction.

While health care delivered in hospitals and by physicians is an exclusive constitutional domain of the provinces, the federal government also plays an important role in aboriginal health, RCMP health issues, the health of armed services personnel, pharmaceutical regulation and certification of medical devices.

The message is clear. Canadian taxpayers do not want to see their politicians bickering over jurisdiction on health care or wasting millions of dollars in futile and partisan ad campaigns. They simply want to see both orders of government work together in an open-minded and orderly pursuit for solutions. This is not to say that intergovernmental tension is not welcome in a federal system, indeed it is inevitable; rather just to point out that the health care blame game still employed by Ottawa and the provinces is tiresome and counterproductive.

Belief #4: The *Canada Health Act* is not the Bible

In testimony before the Kirby Senate committee on health care, former federal Health Minister Monique Bégin stated:

> The *Canada Health Act* has taken on a life of its own. It has now reached the status of an icon. Because of that, I personally think that no politician can reopen the *Canada Health Act,* even to improve it, because it will destabilize people too much. [8]

While Ms. Begin is entitled to her opinion, such thinking is limiting. The *Canada Health Act* (CHA) is a federal statute: nothing more, nothing less. Laws are passed to serve public policy purposes and are a product of the context of the time in which public policy debate gave birth to the law in question.

Governments constantly – or at least they should – evaluate the effectiveness of programs and regulatory frameworks to ascertain if their original public policy goals are still being served and if those goals, in fact, are still relevant. In this process, some laws remain unchanged, others are modernized and still others are wiped from the books.

The Act is not the Bible! Although it has been consistently bandied about as one by those who wish to foreclose discussions of excellence and quality, market reforms (be they internal or external) or heaven forbid, provincial experimentation. The Act is not a ***sacred trust***, it is merely a law that can be changed by Parliament if Canadians press for such change.

Belief #5: It is impossible to measure health systems by numbers alone

The Canadian health care debate is still in its formative stages, but already some farcical assertions and arguments have surfaced. One of the most dangerous – not to mention intellectually dishonest and insulting – is to use aggregate or even single numbers to make sweeping value judgements about a country's health care system. Commentators and politicians have used national health care spending as a percentage of GDP to compare and contrast one country's health care system vis-à-vis another.

For example, taken together, public and private expenditures in Canada account for 9.3% of GDP. Meanwhile the United States commits almost 13% (the highest in the world) of GDP to health care. As a result, health care analysts as well as politicians inform us that "obviously" our system is more efficient. Well, no, the numbers don't lead to this conclusion and actually they yield very little in the way of substantive conclusions whatsoever.

If lower spending equals efficiency, then would having Canada spend a mere 2.38% of GDP mean we were really efficient? Or if higher spending equals better care, wouldn't it we be wise to spend more than the Americans? Based on the "efficiency" logic, these are the preposterous conclusions to be drawn.

Where in this analysis is a breakdown of patient outcomes? Where do these numbers account for differing levels R&D activities on either side of the 49th parallel? How about access to the latest cancer or Alzheimer drugs to extend the length of life and the quality of life of patients? How does per cent of GDP reflect differing levels of HIV/AIDS infections in one population versus another? Or how does it account for aboriginal health or differing levels of urban violence resulting in hospitalization between one country and another? Numbers alone cannot answer these questions.

Moreover, there is no set or optimal level of health care spending for any given country. Expenditures are a function of patient use patterns, availability of human resources, access to technology, diffusion of medical knowledge, and thousands of other unique variables including national ability to pay.

This is not to say that cross-national comparisons should be discontinued. Rather, they should be evidence-based, looking at the impact of medical and health outcomes based on various input criteria (including funding levels). With this approach, best practices can then be identified and potentially adapted to the Canadian system.

Belief #6: The debate is too continental; it must become global

Further to the previous core belief, the health care debate must move beyond simplistic binary comparisons between the Canadian and American health care systems. For a country that prides itself on the ethno-cultural composition of its major urban centres or the extent of international trade and operations in which many Canadian companies are engaged, it is perplexing that our zeal for all things global disappears when discussing our most pressing and immediate public policy issue, health care.

For far too long Canadians have allowed politicians and other health care advocates to offer a simple and farcical either-or choice when it comes to health care. The script is as follows: either we keep and build on the status quo, public, not-for-profit Canadian system or we start a quick march down the slippery slope toward for-profit, two-tier, American-style health care.

To confine the realm of possible reform routes to a universe of two options (both of which are erroneously characterized) from one continent is insulting to the intelligence of Canadians.

There are dozens of other post-industrial societies in Europe and Asia that have modern health care systems yet we hardly hear anything about their approaches and consequent successes or failures. What sort of public-private blend of health care is employed in Sweden? What internal market reforms have been tried in Britain? How do medical savings accounts work in Singapore? What role does private insurance play in the Netherlands?

These are just some of the questions that have not been thoroughly researched. The answers they yield must then be injected into the Canadian debate. We must canvas the globe for ideas, lessons and solutions.

Canada's health care debate must have an open-minded global focus as opposed to the tunnel vision continental focus that has left our debate wallowing in ignorance.

Belief #7: The concepts of quality and excellence must enter the debate

When Canadians purchase a product or service, an inherent part of their pre-purchase decision usually involves a quality assessment. Retailers and service providers spend billions on advertising, quality control and training to ensure that consumers believe, feel and know that they are purchasing quality.

Yet when it comes to health care, quality is not one of the five "cherished" principles of the *Canada Health Act*. As the IRPP noted in its brief to First Ministers:

> After nearly a decade of cost cutting, some Canadians have lowered their sights for an excellent healthcare system to one that merely meets minimum standards. This is unfortunate. Canadians should demand and expect excellence. [9]

The Fyke report on the future of Medicare in Saskatchewan devoted a chapter of its final report to the concept of quality. While quality is an all-encompassing term, Fyke notes that the U.S. Institute of Medicine defines it as follows:

> Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. [10]

Fyke goes on to interpret and expand this definition:

> Essentially it boils down to doing the best job with the resources available. It means achieving stated goals and targets. It is measurable against accepted and valid standards. It is incompatible with waste, duplication and fragmentation. It is about minimizing underuse, overuse and misuse …
>
> It is unlikely to be achieved by a demoralized workforce … It does not thrive where there is conflict or lack of consensus on goals and mission. It is about leadership, goal setting, teamwork, process, measurement, commitment, incentives and accountability.[11]

Given this interpretation, it becomes apparent why quality is not a principle in the *Canada Health Act.* We're not doing the best job with the resources available, despite the best efforts of health care workers. We have little in the way of goals or targets. Moreover, political discourse only serves to perpetuate this lack of an ***outcomes focus*** since elected officials believe measuring their compassion by inputs (read: tax dollars) is a full day's work when it comes to health care.

Our system is a patchwork of duplication and fragmentation. The health care workforce is stressed and demoralized. As for incentives and accountability, these sound like principles more often seen in a competitive market environment.

In his introductory overview, Fyke succinctly noted that::

> We have not made quality the central preoccupation of health care, and as a result we do not achieve it. … Many attribute the quality problems to a lack of money. This claim has been convincingly refuted by evidence and analysis. In health care, good quality often costs considerably less than poor quality … Where money is tight, a quality agenda is imperative. [12]

We couldn't agree more.

1.5 Scope and Purpose

This report is not meant to be an exhaustive look at the challenges that Canada faces as it grapples to fashion a health care framework for the 21st century. Rather, it was written with the intent of providing a thorough look at several of the main elements of the present health care debate.

The purpose of this report is straightforward and three-fold:

1. To articulate various CTF positions – based on solid research, logic and argument – for reform of the Canadian health care system;

2. To serve as a foundation document and research tool that Canadians (health policy stakeholders, elected and non-elected officials, the media and the general public) can refer to when making interventions into this critical debate; and

3. To provoke a response, stimulate discussion and above all, to act as a catalyst to encourage Canadians to engage in and **TAKE OWNERSHIP** of the health care debate.

2.0 The History of Health Care in Canada [†]

Before analyzing where our health care system is headed, a cursory look back at the development of its founding principles, delivery structure and funding mechanisms is warranted. This chronological history highlights critical national (and some international) events in the development of our health care system.

Of course this chronology cannot reflect the context or the emotion of the debates of the day leading to the key events (legislation, creation of commissions, etc.) listed below. Federal-provincial squabbles along this path were fierce and point to an inherent and inevitable feature of our federal system; omnipresent tension and conflict between the provincial capitals and Ottawa.

The instructive component to be drawn from this history is that Canada's social fabric is much more than government programs. Therefore, changing and modernizing a social program does not necessarily harm the social fabric. On the contrary, Canada's social fabric is woven by its promotion of ideals, tolerance for debate, competing points of view and faith that free and open democratic discourse – while often stressful – strengthens the country. The history and development of Canadian health care is surely a testament to this faith.

The last century has truly been a "medical century." As historians have pointed out, we are by most indicators, the healthiest inhabitants of the earth in recorded history. Yet, Canadian historian Dr. Michael Bliss, from the Department of the History of Medicine at the University of Toronto, also points to the irony of this welcome success with an appealing winter analogy:

> The problem of health care is analogous to the problem of keeping a snowman from melting. The more we win the easy battles, the more expensive the next round becomes. And thus we have the current paradox of the healthiest peoples in history being driven to spend the highest sums ever on health care.[13]

1867 – British North America Act

The *Constitution Act (1867)*, formerly known as the *British North America Act* defines health care (see actual text below) as a provincial concern and assigns provincial responsibility for the health sector under Section 92(7).

> The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.[14]

The framers of Canada's constitution attached little importance to doctors and local hospitals relative to other issues being debated and divided amongst the federal and provincial governments at the time.

[†] Many sources were used to compile this history but the CTF drew most heavily on work from by the BC Medical Association (BCMA), the Ontario Medical Association (OMA), and the Kirby Senate Committee on health care.

From Confederation until the 1940s, hospitals were operated and managed by denominational groups, fraternal societies or charitable organizations.

In some instances, local governments operated facilities and private companies paid physicians to provide care to a defined group of people for the fee of one dollar per patient per year. Physicians also treated many poorer patients for free, utilizing fees paid by more affluent patients or their sponsors to cover this expense.

1883 – German Health Insurance

German chancellor, Otto Von Bismarck, ushers in a system of statutory health insurance, arguably, the earliest beginnings of the modern welfare state.

1911 – National Health Insurance (Great Britain)

"Great Britain launched a system of national health insurance rooted in the contracting experience under which physicians were paid capitation fees for providing services to the needy." [15] Canadians in uniform and Canadian nurses stationed in Britain saw first-hand the scope of this system and consequently stimulated debate and interest in this idea in their correspondence back home as well as upon their return to Canada.

1916 – Rural Municipality Act in Saskatchewan

Faced with rural depopulation of doctors and other professionals to larger centres and provinces, the Saskatchewan government amends its *Rural Municipality Act* to allow local governments (municipalities, townships, counties, etc.) to pay doctors a salary in return for the provision of services to citizens in these communities.

This is probably the first example of public-funded health care in Canada as the salaries were paid out of local tax collections (municipal revenues and property taxes). Indeed, it was a predictor of other initiatives to come from Saskatchewan in the following decades.

1919 – Liberal Commitment

On August 16, 1919, the Liberal Party of Canada, adopted the following policy on health:

> That so far as may be practicable, having regard for Canada's financial position, an adequate system of insurance against unemployment, sickness, dependence in old age, and other disability, which would include old age pensions, widows' pensions and maternity benefits, should be instituted by the Federal government in conjunction with the governments of the several provinces. [16]

1915 to the 1940s – Prepayment Plans

Individuals, companies and communities paid premiums for doctor (primarily) and hospital services in what widely became known as prepayment plans. Started by physicians, the popularity of these plans grew and set the early growth stage for private medical insurance in Canada.

1933 – Winnipeg Doctor's Strike

As noted earlier, many physicians still provided care for those who could not afford to pay for their own care. This charity became a larger and larger component of many physician's practices and actually resulted in a strike of Winnipeg doctors, who temporarily withdrew their services in an attempt to force the government to cover the costs of these low-income or no-income patients.

This strike, and the frustration felt by other doctors across Canada, was also a by-product of the New York stock market crash on October 24, 1929, which started the Great Depression. In Canada, the "dirty thirties" included an eight-year prairie drought complete with farm and business bankruptcies and doctors were saddled with unpaid bills that could not be collected from defunct private insurance plans.

1934 – CMA Releases *Medical Economics* Report

In the midst of the Great Depression, a committee of the Canadian Medical Association (CMA) releases *Medical Economics*, a report looking at health insurance schemes in Germany, Britain, France, the United States and South Africa. The report was clear in its support of public insurance. Yet it struck a prophetic tone that reverberates through to the present day:

> The most serious ill result which could grow out of health insurance would be its being considered as a "cure all" … There is grave danger in overselling all forms of social insurance as panaceas for the ills of mankind.
>
> Despite what may be said as to the need for a complete service, it is not to be forgotten that it is the public who, as consumers, have to decide what they are prepared to pay for. [17]

1940 – Royal Commission on Dominion-Provincial Relations (Rowell-Sirois)

Among other recommendations in what became known as the Rowell-Sirois Report, the Royal Commission (1937-1940) recommended "that health programs remain within provincial jurisdiction, with the federal government providing a guiding, yet limited, presence in the day to day management and delivery of health care to Canadians." [18]

1944 – Saskatchewan Health Insurance Bill

Saskatchewan's Liberal government introduced a bill into the legislature in Regina on March 31, 1944: *A Bill Respecting Health Insurance*. The bill would see the establishment of a commission to run a health insurance program for the province with appropriate benefits and contracting with hospitals and physicians. The Bill sailed through first, second and final reading in two days, passing on April 1, 1944. In June of 1944, Tommy Douglas and his CCF defeated the Liberal government.

1945 – Green Book Proposals

The federal government introduced several initiatives to restructure the financing and delivery of various social services – including health insurance – which had broad implications for the division of responsibilities between Ottawa and the provinces.

With respect to health care, it was "to be financed through a set tax on the population based on a percentage of income. The cost of the program to be shared between the federal and provincial governments, with the federal government contributing a maximum of 60%, and provinces 40%." [19]

Amidst the backdrop of a decade of rancorous federal-provincial squabbles, "fierce objections from Ontario, Quebec and Alberta caused the Government of Canada to back away from its post-war health insurance proposals." [20]

1947 – Saskatchewan Provincial Health Insurance

During the provincial election in 1944, CCF leader Tommy Douglas offered Saskatchewan residents comprehensive health insurance. On January 1, 1947, this regime went into effect. The plan was ***universal*** (covering all residents), ***compulsory*** (all residents paid into the plan) and ***comprehensive*** (covering essential hospital services). Annual premiums ranged from $5 per person to a maximum of $30 per family.

1948 – Federal Health Grants Program

Despite being thwarted in 1945, the federal government introduced its Health Grants Program in 1948, offering, on a 50-50 cost sharing basis, a shared plan to cover health care assessment, professional training and hospital construction.

While the provinces were still irate at this blatant constitutional intrusion, Ottawa argued that it was merely continuing its conditional grants regime (in effect for several years) of funds to be used for "nationally desirable objectives" including highway construction and vocational education. The courts upheld these grants as constitutional. The framework for these grants still exists today and is commonly referred to as the "federal spending power."

1948 – National Health Insurance System (Great Britain)

A full national health system was implemented in Great Britain. This influence combined with envious eyes cast toward Saskatchewan and the growing public debate and appetite (fuelled by the hardships of the Great Depression and World War II) for a variety of welfare-state programs was one of the strongest social forces in Canadian history.

1957 – Hospital Insurance and Diagnostic Services Act

A decade-long debate led to the implementation of the federal *Hospital and Diagnostic Services Act.* In the Act, the federal Liberal government of Louis St. Laurent offered to partner with the provinces and share the costs of eligible services with the provinces on an approximate[*] 50-50 basis. In return, the provinces agreed to make insured services under the conditions of ***universality, comprehensiveness, public administration*** and ***portability*** (insured residents would be covered in participating provinces). The Act passed by a vote of 165-0 in the House of Commons.

Medicare defenders rightly speak about Tommy Douglas and his determination during this period, but it should be noted that the private sector also responded to public demand, as Michael Bliss points out:

> Absent from the consensus on state health insurance, private insurers had begun to offer coverage. Physician organized firms, such as Windsor Medical and Associated Medical Services had begun business in the 1930s. By the 1950s and 1960s, many commercial firms offered a wide variety of medical and hospital plans. By the mid-1960s, physician groups had banded together under the umbrella of Trans Canada Medical Services and could offer close to national coverage. And private insurance companies also offered a growing range of product. [21]

Saskatchewan joined on July 1, 1958 and by 1961, "all provinces had signed agreements establishing public insurance plans that provided universal coverage for in-patient hospital care." [22]

1961 – Hall Royal Commission Announced

On December 21, 1964, Prime Minister John Diefenbaker announced the appointment of former Saskatchewan chief justice Emmett Hall to head the Royal Commission on Health Services with a broad mandate to:

[*] As the Kirby Senate Committee notes, "payment due to the provinces under the *Hospital and Diagnostic Services Act* were calculated as follows: a province's entitlement in a given year was equal to 25% of the average national per capita cost of the insured services, plus 25% of the cost of the insured services per resident of that province multiplied by the population of that province in that year. Overall, the federal government's contribution was equal to about 50% of the cost of insured services in Canada, although it was more in the provinces where the per capita costs were lower than the national average and less in the other provinces.

> … 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. [23]

1962 – Saskatchewan Expansion

The Saskatchewan NDP government extends hospital insurance to in effect become public health insurance by February 1962. In response, Saskatchewan doctors went on strike for 23 days (with support from dentists, pharmaceutical companies, and a variety of business groups). The government responded by importing doctors from Britain to deliver services with the whole situation ending up in a stalemate: the public insurance system remained but doctors retained the right to opt-out of the program and extra-bill patients above and beyond the provincial rate schedule for identified services.

Physician autonomy was one of the issues at heart of this strike and media support, to a large degree, sided with the doctors. As Bliss notes, concerning the environment within and beyond Saskatchewan:

> The general principle of fee-for-service payment had also been accepted and guarantees of patient freedom of choice enunciated. I should say that contract medicine had always been unpopular in North America and the leading example of a contract system, British National Health Insurance, was particularly unpopular with physicians. It was a diminishing model for Canadian patients because of its image of deteriorating quality. [24]

1964 – Royal Commission on Health Services

After two-and-a-half years of work, Justice Hall released a two-volume report chronicling the work and research of his commission on June 19, 1964. Arguably, it was, and remains, one of the most comprehensive research endeavours dealing with health care in Canadian history. In a nutshell, Hall called for a comprehensive national health insurance program to be administered by government.

> "As a nation we now take the necessary legislative, organizational, and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind." [*]

Tom Kent, a former senior policy advisor to Prime Minister Lester B. Pearson, told the Kirby Senate committee last year, in response to the Hall report:

> The aim of public policy was quite clearly and simply to … make sure that people could get care when it was needed without regard to other considerations. [25]

[*] Royal Commission on Health Services report, (Ottawa, 1964).

1966 – Medical Care Act

The federal response to the Hall commission, after some negotiation with the provinces, was enunciated with the introduction of Bill C-227, the *Medical Care Act* on July 12, 1966. After four months of heated debate, the Bill was passed into law on December 8, 1966.

The federal government would contribute, to each participating province, 50% of the national per capita average cost for each resident of the province. All provinces received equal per capita transfers, yet the total federal contribution to each province was also a function of provincial expenditures on health care.

The Act stipulated that federal funding would only flow if the participating province satisfied the four conditions of public administration, universality, portability and comprehensiveness: the same four principles articulated in 1957.

When the Act came into force on July 1, 1968, only two provinces initially participated: Saskatchewan and British Columbia. It wasn't until 1972, that all provinces had signed on with Ontario being the last to join.

1966 – Canada Assistance Plan (CAP)

Largely based on the *Medical Care Act* funding formula, the federal government also introduced the Canada Assistance Plan to cost share social services but it also applied to services for welfare recipients including drug coverage, dentists and vision care.

The public mood in the early years of national health insurance was demonstrably favourable toward the new regime. Bliss states:

> I think there was a golden age of Canadian health insurance in the early years of Medicare. These first few years were characterized by intense patient satisfaction, not to say delight at the apparent elimination of most forms of doctors' bills, balanced by very considerable physician satisfaction at receiving full payment for services which led to quite substantial income gains. And that led to ongoing perceptions. Patients could not help but noticing doctors, whatever their ongoing reservations about Medicare, seemed to be doing very well indeed out of the system, an anomaly that came to tarnish the image of the profession as the years went on. [26]

1969 – Action on Generic Drugs

The government of Prime Minister Pierre Elliot Trudeau "amends the *Patent Act* to allow production of generic drugs. Advocates for medicare claim this decision saved $211 million over the ensuing 14 years. [*]

[*] Taken from "A brief history of Canada's public health care system" found on the web at http://www.healthcoalition.ca/dates.

The Late 60s, Early 70s

By the early 1970s, the cost of health insurance to the provinces, on an annual basis, was rising twice as fast and the gross national product. Coupled with persistent inflation throughout the 1970s, governments attempted a variety of measures to control and rein in escalating health care expenditures. It did not take long for the blanket funding approach of 50% to the provinces to fall out of favour in "official" Ottawa.

As several federal observers have recently remarked to the Kirby Committee, a number of disadvantages or shortcomings in the 50-50 formula were identified including the fact that it was "unpredictable for the federal government; extremely cumbersome to administer; inflexible federal funding, which stifled innovation; and a perceived intrusion into an area of provincial jurisdiction."

1974 – A New Perspective on the Health of Canadians

In 1974, the Department of Health and Welfare released a report entitled *A New Perspective on the Health of Canadians,* prepared by the Hon. Marc Lalonde, then Minister of Health and Welfare. It expanded health care policy to include issues of lifestyle, environment and biology (now referred to as genetics). This signalled a federal policy beginning and an embrace of the concept now referred to as population health.

1977 – Established Programs Financing Act

The Trudeau government implements the *Established Programs Financing Act* (referred to as EPF) that went into effect on April 1, 1977 for the fiscal year 1977/1978. EPF financing ends the 50-50 approach to federal funding of health expenditures. Instead, a block-funding approach was employed.

Transfers to the provinces now entailed two components: a tax point transfer and a cash transfer. With tax points, the federal government vacated tax room to the provinces by lowering federal tax rates while provincial rates were consequently raised by an equal and offsetting amount: a revenue-neutral exchange.

The remaining cash transfer was then calculated by subtracting the tax point transfer from the total EPF entitlement, which was a function of a per capita formula that included hospital care and medical care, post-secondary education and extended health care, with an inflation escalator tied to the growth of the GDP. Both the provinces and Ottawa hailed the new EPF (about 70% for health care, 30% for education) arrangement as positive. The federal government limited its exposure to escalating health care costs – now pegged to population and economic growth, as opposed to provincial health budgets – and the provinces also gained more autonomy in their ability to raise revenues and determine health system priorities specific to each province.

The Late 70s, Early 80s – User Fees and Reprivatization

In spite of the EPF arrangement, health spending continued to rise due to increased patient demand and the increased costs of treatment, technology and pharmaceuticals. As inflation persisted and provincial deficits (along with the federal deficit) grew, provinces attempted to arrest health care costs by limiting doctors' fee schedules and annual allocations for hospital budgets.

Again, reference to the historical analysis of Bliss, this time offered before the Kirby Senate committee is enlightening:

> The Medicare system of 1968 was a pluralist system that allowed for the freedom of providers to practise outside the system. You could opt out; you could extra bill. It was not surprising, then, in the 1970s, that, as the provincial governments began to squeeze the Medicare fee schedule, more and more practitioners opted out … a kind of reprivatization occurred in health care. Many people saw the public system as a penny-pinching system and they wanted to work in the private sector where there was more freedom, more protection of incomes, and more possibilities for innovation.
>
> By the early 1980s, we were seeing across the country serious problems in our Medicare system. So many specialists had opted out that, in large parts of the country, it was impossible to have access to certain specialists under Medicare. That was particularly true in obstetrics and gynaecology. The issue of accessibility became very important. [27]

1980 – Health Services Review by Justice Hall

Justice Hall returns with the release of a report entitled *Canada's National-Provincial Health Program for the 1980s.* Justice Hall concludes that extra billing (permitted in Alberta, Manitoba, New Brunswick, Manitoba and Saskatchewan) along with user fees for hospitals (allowed in Alberta, British Columbia, New Brunswick and Quebec) threatened the principle of universality by compromising access to health care.

1984 – Canada Health Act

In response to the Hall review, the Trudeau government passed the *Canada Health Act* (CHA). Final reading in the House of Commons occurred on April 9, 1984 and it was passed unanimously. It went into effect on July 1, 1984.

In short, the CHA reaffirmed the principles of ***universality, portability*** and ***public administration*** and a modified principle of ***comprehensiveness.*** A new principle of ***accessibility*** was also added.

The CHA empowered the federal government to unilaterally reduce provincial transfers if provinces were found to be violating the CHA by allowing user fees, hospital surcharges, and the like. The penalty was a matching dollar for dollar reduction in cash transfers in equivalent amounts for aggregate fees charged.

1986 – Population Health Returns

Health and Welfare Minister, Jake Epp, releases a report entitled *Achieving Health for All: A Framework for Health Promotion*. The report focuses on solid incomes, stable employment, education levels, and a variety of other factors and their relation to health policy.

The report is reminiscent of the Marc Lalonde effort some 12 years earlier and indicated that population health was a growing discipline within the federal health bureaucracy.

1983-84 to 1995 – The Slow Federal Retreat

In the first of a series of measures to control costs and reduce the federal commitment to health care, EPF growth (on the education side) was capped at 6% in 1983-84. Later in 1984, the Progressive Conservatives led by Brian Mulroney came to power.

Despite a new government in 1984, a massive deficit forced continued federal withdrawal from health care funding over the next nine years in office. In 1984-85, the EPF escalator (on the education side) was capped at 5%.

The escalator was then capped at 2% (for health and education) less than the growth of the economy from 1986-87 to 1989-90. Thereafter, until 1994-95, EPF transfers were frozen at 1989-90 levels; the nominal amount changed only in response to population growth in each province.

On October 25, 1993, the Liberals led by Jean Chretien returned to power. Quickly the new government sang the old “transition of power” theme song: the books are worse than we thought, we must cut back.

Faced with the inheritance of a $42 billion deficit, Prime Minister Jean Chretien and his able Finance Minister, Paul Martin reduced the escalator by 3% in 1995-96.

1994 – The National Forum on Health

In response to emergency room crises, hospital closures, and increasing public concern about health care, Prime Minister Chretien announced the creation of the National Forum on Health in October 1994.

Comprised of a 24-member volunteer board (including the Prime Minster and the Minister of Health), the Forum was given a $12 million budget and a four-year mandate to consult with Canadians to develop a new vision for our health care system.

1995 – The CHST Budget

In the 1995 Budget Speech, the block-funding approach was changed to an envelope funding approach whereby the EPF and CAP were to be folded into a new federal allotment called the Canada Heath and Social Transfer (CHST). All federal funding for health care, post-secondary education and social assistance was contained in the "CHST envelope."

The CHST took effect for the 1996-97 fiscal year. Under the restraint measures imposed in the fight to reduce the federal deficit and in the new CHST envelope approach, cash transfers for health, according to the BCMA, fell from $18.5 billion in 1994-95 to $12.5 billion in 1998-99.

1997 – National Forum on Health Report

After four years of work, the National Forum on Health reports. The Forum made a variety of recommendations but most controversial were its recommendations for homecare and pharmacare programs. As health economists at the BCMA have noted:

> In the face of substantial evidence to indicate that the existing acute care system was approaching the breaking point, the Forum recommended that the home care initiative should be funded by reallocation of savings from reductions in the institutional sector. Surprisingly, the Forum also recommended tax increases, premium increases or both to fund the national pharmacare program. These thoughts, which flew in the face of both reality and public opinion, have seemingly relegated the Forum's rather high profiled work to the recycle bin. [28]

1999 – The Health Budget ♠

Fortunate to be riding the wave of a U.S.-led global economic recovery, by late 1998 Canada's fiscal situation had improved dramatically to a balanced budget and surplus situation. Budget 1999, tabled on February 16, 1999, committed an increase of $11.5 billion for health care over five years, broken down as follows:

- An immediate $3 billion cash infusion for the 1998-99 fiscal year;
- $8 billion over the next five years; and
- $1.4 billion over three years for specific measures in health research (the Canadian Institutes of Health Research – CIHR, the Canadian Institute for Health Information – CIHI, the Canada Foundation for Innovation – CFI, health information technology, aboriginal health and population health initiatives.

While provincial governments were appreciative of this renewed federal commitment, it only returned funding to 1995-95 levels.

♠ Budget 1999 initiatives sourced from Health Canada and Finance Canada web sites.

2000 – Pre- Election Health Accord

As growing fiscal federal budget surpluses were projected, provincial premiers bolstered by public opinion pressed the federal government for even greater re-infusions of cash transfers to the provinces for health care.

On September 11, 2000, the Prime Minister and all provincial and territorial leaders reached a new health care funding deal worth an additional $23.4 billion broken down as follows: [*]

- $21.1 billion in CHST cash transfers to the provinces over five years from 2001-02 to 2005-06;
- $1 billion for new medical equipment over 2001-02 and 2002-03;
- $800 million for primary care reform over four years; and
- $500 million to accelerate development on health information technology including electronic patient records.

Two months later, Prime Minister Chretien would go to the polls and win a third consecutive majority government, in part by ensuring that health care funding issue was perceived to have been addressed.

2001 – Commission on the Future of Medicare

On April 4, 2001, Prime Minister Chretien and Health Minister Allan Rock announced the appointment of former Saskatchewan Premier Roy Romanow, pursuant to Part 1 of the *Inquiries Act,* to head the "Commission on the Future of Health Care in Canada."

Mr. Romanow commenced his work on May 1, 2001, he is expected to report back to the Prime Minister no later than November 2002. The commission will have a $15 million budget at its disposal to, according to the Health Minister:

> … better understand and plan for the long-term challenges, such as changing demographics and rising costs of technologies and treatments, so that Canadians can continue to benefit from quality services in our universally accessible system. [29]

The Commission can immediately draw on the work of the Clair Commission in Quebec (January 2001), the Fyke Commission on Medicare in Saskatchewan which delivered its report to Premier Lorne Calvert on April 6, 2001, and the efforts of the Standing Senate Committee (the Kirby committee) on Social Affairs, Science and Technology which produced volume one of a planned five-volume initiative in March 2001.

[*] Funding information sourced from the Intergovernmental Affairs section of the Privy Council Office web site.

3.0 The Canada Health Act

As noted in the previous chapter, the principles of public policy that underlie our health system have been pivotal since their introduction in Saskatchewan in 1947 and on a national basis, since 1966 with the passage of the *Medical Care Act,* which were subsequently reaffirmed in 1984 with the passage of the *Canada Health Act* (CHA).

The CHA has been the focal point for much of the debate over health system reform. Each reform proposal is benchmarked against the CHA. Does it comply with or run afoul of the provisions of the CHA? So a logical place to start a discussion about the future direction of health care in Canada is with the CHA.

Although the CHA has acquired a mythical status, it is actually a small piece of legislation. It contains a mere 22 sections and on paper can be printed on 11 pages. To put it into perspective, the *Income Tax Act* runs some 1,400 pages long, plus another 700 plus pages in technical amendments, interpretation bulletins, etc.

The CHA, in its long form title is:

> An Act respecting cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services. [*]

To be eligible to receive CHST cash contributions the CHA lays out principles (5) with which provincial and territorial governments must comply. The CHA also delineates the penalties and remedies available to the federal government when provincial governments are found to be in violation the Act.

For the most part, the Act applies to hospital and physician care and services that are covered under provincial/territorial health insurance plans. The federal Minister of Health is required to table an annual report in Parliament as to the government's administration of the Act

3.1 The Five Principles

The five principles of the CHA are:

- **Public administration:** The administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority.

- **Comprehensiveness:** All medically necessary services provided by hospitals and doctors, and other services where the province so permits, must be insured.

- **Universality:** All insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions.

[*] Text of the *Canada Health Act* can be found at: http://laws.justice.gc.ca/en/C-6/text.html.

- **Portability:** Coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country without charge and without any minimum waiting period.

- **Accessibility:** Reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The first four principles in the list above were part of the *Medical Care Act* in 1966 and were reaffirmed in the CHA in 1984 with the addition of a fifth principle: accessibility.

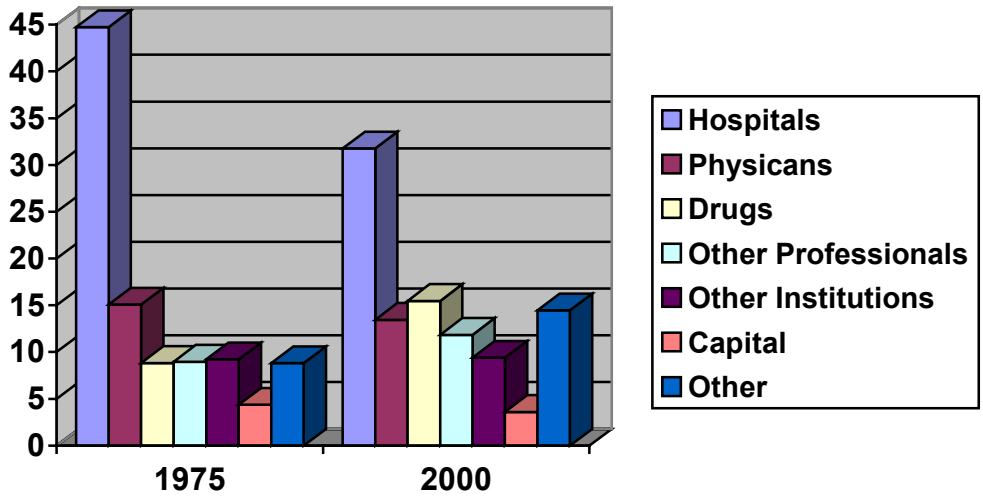
Health Canada describes these principles as the "cornerstone of the Canadian health care system" thereby ensuring that "all residents of Canada have access to medically necessary hospital and physician services based on need, not on ability to pay." [30] (The CHA can be found in Appendix A to this report).

3.2 The CHA: Diminished, Vague and Rigid

The CHA is:

- Diminished, as it is increasingly applicable to fewer services;
- Vague and open to interpretation, especially in the context of its "medically necessary" clause; and
- Rigid as it stifles provincial innovation.

The CHA applies to services delivered by physicians or those services received in hospitals. Yet the trend for the last 25 years has been away from health care delivery in both of these spheres. Consider the following graph derived from data compiled by CIHI (public and private expenditures). *



* All data derived from CIHI table "Total Expenditure by Use of Funds, Canada, 1975-2000 – Current Dollars" which can be found under **Fast** Facts at http://www.cihi.ca.

In 1975, hospital costs accounted for nearly 45% of all public and private expenditures in Canada. Meanwhile, physician costs accounted for 15% of total national health care expenditures. By 2000, hospital costs decreased by 29% to account for just 32% of national costs and physician costs declined by a more modest 11% to account for 13.45% of national health care expenditures.

The following chart depicts the fundamental changes that have taken place over the past quarter century in terms of the location and mode of health care delivery.

Area of Expenditure	1975 ($ millions)	Per cent of Expenditures	2000 ($ millions)	Per cent of Expenditures
Hospitals	5,454.8	44.71	30,235.6	31.78
Physicians	1,839.9	15.08	12,798.3	13.45
Drugs	1,076.2	8.82	14,707.8	15.46
Other HC Pros	1,094.6	8.97	11,248.8	11.83
Other Institutions	1,124.3	9.22	8,937.1	9.39
Capital	536.1	4.39	3,443.2	3.63
Other	1,074.6	8.81	13,756.0	14.46
Totals:	**12,200.5**	**100.00**	**95,126.8**	**100.00**

The proportion of hospital care has decreased due to a variety of factors. What were once complicated, extended length of stay procedures, are now day-surgery affairs handled in ambulatory centres or private facilities. Critics refer to this as passive privatization – as if technological advancement were something to be feared instead of embraced. As well, aggressive drug therapies have replaced or delayed surgical interventions historically performed in hospitals.

In addition, more patients now seek out alternative or allied health professionals directly such as registered massage therapists or physiotherapists instead of waiting for and receiving a referral after a visit to the family doctor. This activity is captured under the heading of other health care providers as is the use of dentists and vision care services. In the catch-all "other" category, the bulk of the increase over 25 years is attributable to downloading to local governments as well as an expansion of local public health initiatives including immunization, teen mother programs, etc.

"Defenders" of the status quo system continue to wrap themselves in the flag of the CHA even though it is applicable to less and less of the total health care tab. This blind adherence to a law crafted some seventeen years ago at a time when today's technological breakthroughs and advanced drug therapies could not have been envisioned is perplexing.

It is becoming increasingly clear that the CHA does not reflect the reality of health care in 21st century Canada. And now the CHA has been equated with our nation's values; a compelling heart string argument for sure but not one founded in logic or oriented toward progress. Dr. David Gratzer, a Toronto doctor and Donner prize recipient for his seminal book *Code Blue* (1999), laments this situation:

> Gone is the rhetoric about Canadians opposing user fees or private insurance. Instead, the experts speak of our "values" and policies that support these values. Public health care – like every area of public policy – ought to be undergoing constant experimentation and innovation. Instead we have a system that is ossified. One of the benefits of a federal system such as ours (federal funding but provincial administration) is the ability of individual jurisdictions to test new ideas. Canada should be witnessing 10 laboratories of health care experimentation. We have instead uniform stagnation. [31]

Another problem with the Act is that "medically necessary" is a vague and highly subjective term. Even services that have been de-listed form provincial health insurance plans could be deemed medically necessary for segments of the population. While beyond the scope of this paper, the CTF has learned that two Canadian constitutional scholars will shortly argue that the "medically necessary" qualifier and indeed, the CHA, violate the "security of person" provisions under the Charter of Rights and Freedoms.

Finally, the rigidity of the *Canada Health Act* stifles innovation in the provinces. For example, New Brunswick has a program of extramural hospitals that does not fall under the letter of the CHA but a valid case can be made that it falls under the spirit of the Act.

On a similar note, consider the following situation taken from testimony from the Kirby Senate committee:

> The Hon. Claude Castonguay indicated that the new prescription drug insurance plan initiated by the Quebec government would not qualify for federal funding under the *Canada Health Act* because it is made up of a mixture of public and private components. While all citizens are covered, beneficiaries are required to pay a premium and portion of the cost of their drugs. [32]

3.3 The "Principles" in Practice

Another interesting observation about the cherished five principles in the CHA is that they are routinely violated and at times, in conflict with one and another.

Turning to Dr. Gratzer's work again, he succinctly identifies the reality of the CHA's five principles out in the field:

> Portability should mean that a Quebecker getting medical care in Alberta shouldn't have to worry – the insurance coverage is portable. In fact Quebec doesn't have an agreement with the other nine provinces. Many physicians in English Canada are reluctant to take Quebec patients because the Quebec government pays low compensation to Quebec physicians. [*]

[*] CTF federal director Walter Robinson witnessed this situation first hand during his tenure as a trustee on the Ottawa Hospital Board of Directors from April 1998 to December 1999 as the issue of billing the province of Quebec for Quebec patients treated in Ottawa at Ontario billing rates proved problematic and was a source of revenue shortfall for the hospital.

> Even accessibility, it could be argued, doesn't truly exist. This is the principle that Canadians seem to hold most dear – that both princes and paupers will be treated equally by the health care system. Section 12(1)(a) of the Canada Health Act clearly specifies that this must be the case – provinces must provide services with "uniform terms and conditions." But exactly how uniform are services when the waiting time for an MRI scan topped one year in Victoria yet pro basketball player Shareef Abdur-Rahim was able to jump ahead of 984 people to get a scan? [33]

Some provinces insure invitrofertilization (test tube babies) procedures while others do not. British Columbia insures some 3,000 services, but prosthetic devices such as legs or a simple neck brace are not included.

The principles of the Act also conflict with each other. For example, universality in many respects is at odds with comprehensiveness. As the World Health Organization (WHO) has concluded:

> Clearly limits exist on what governments can finance and what services they can deliver. If services are to be provided for all, then not all services can be provided. [34]

3.4 The CHA vs. Public Opinion

Public opinion polling has consistently shown support for the concept of the CHA in general, but the depth of support for its component principles varies depending on the principle in question. Moreover, many of the health care reform options Canadians favour, would violate the letter and spirit of the CHA.

The following table from the *Canada Health Monitor* was reproduced in a comprehensive analysis of public attitudes toward the health care system by the Conference Board of Canada in October 2000. [35]

Question: How Important is it to maintain each of the five principles of the Canada Health Act?

	1991	1994	1995	1999
Universality	93	85	89	89
Accessibility	85	77	82	81
Portability	89	78	81	79
Comprehensiveness	88	73	80	80
Public Administration	76	63	64	59

From these results, we draw two conclusions. First, support for universality obviously remains high and we assert that Canadians equally view the principles of accessibility, portability and comprehensiveness as sub-sets of universality.

The other conclusion to be drawn is that support for public administration is declining which opens the debate to a larger discussion of two-tier medicine (which has existed in Canada since Confederation) and alternative delivery and perhaps administration by non-government organizations. Indeed, examination of more recent polls shows public opinion shifting in this general direction.

According to the *Montreal Gazette,*[36] a year-end survey (2000) commissioned by Global News and *Maclean's* found that:

- 54% of Canadians "affirmed they would accept user fees as a way of addressing spiralling health care costs"; and
- 47% said "they would accept a private system operating in tandem with the socialized system as a solution to the nation's health care crisis."

The *Gazette* story also showed that these results were indicative of a trend and buttressed earlier poll results including a 1999 Pollara (pollster to the federal Liberals) poll where 73% of respondents affirmed "Canadians have the right to pay for their own health care in private facilities if they can't get timely access to treatment through medicare."

In addition, a 2000 Compas poll found that "41% of Canadians believe individuals should have the option of choosing private health insurance," a finding consistent across all income groups.

On July 13, 2001 the *Globe and Mail* reported on a Price Waterhouse Coopers survey of 2,589 Canadians conducted from March 15th to the 31st. Among the findings:

- 61% stated they would pay for "unspecified" private services if the public system failed them;
- 59% were in favour of payments to upgrade treatment;
- 49% were in favour of paying for faster access to treatment; and
- 40% were in favour of user fees. [37]

On August 13, 2001, most national media outlets carried the results of an Ipsos-Reid survey commissioned by the Canadian Medical Association. Its findings included:

- Only 20% of respondents expressed confidence that either federal or provincial officials can "help improve the health care system";
- By contrast, 66% or respondents believe that doctors, nurses, and other health professionals along with voluntary health organizations can "help to improve the health care system";
- 61% believe that many people misuse the health system;
- 59% supported some form of "small service charges"; and
- 53% stated the system needs a complete overhaul.

In the survey commentary, Ipsos-Reid stated:

> Tracking this data reveals the pessimism about the health care system has increased over the past year. Canadians are less likely to agree that Canada's health care system is one of the best in the world, and more likely to disagree that there is nothing wrong with Canada's health care system. [38]

The support that Canadians expressed for the ability of health care providers to help improve or "fix" the health care system isn't surprising. But it yields a pressing question. How do health care providers feel about the manner in which they are being consulted for their thoughts on improving the system? We need only look back some nine months to find some disturbing answers.

On December 14, 2000, the *National Post* carried a report stemming from research conducted by Pollara that showed:

> Canadians and medicare's front line workers feel shut out of the decisions governments are making about the future direction of the beleaguered public health care system. Sixty-four per cent of the public, 84% of doctors, 75% of nurses and 67% of pharmacists are not satisfied with the inputs they have on these decisions. [39]

Finally, on August 23, 2001, the *National Post* led its edition with a front-page headline ***Public 'open' to private health***. Pollara surveyed 4,200 Canadians the week earlier and found:

> that "public frustrations and fears" about health care have grown to the point where such options, while not popular, are at least on the table for most Canadians.
>
> Michael Marzolini, the Liberal party pollster, told the caucus that "it is now at the point where you can open it for debate."
>
> … (Marzolini) said only three in ten of those polled believe Canada actually has a single-tier health system.[40]

As we asserted in core belief #2, the public is <u>definitely</u> ahead of their politicians when it comes to health care.

3.5 The Bottom Line

> Federal politicians, whatever their political affiliation, have all claimed that the Canada Health Act is the backbone of Canadian identity. [41]

This assessment from the IRPP speaks to the alarming degree of nationalism involved in the health care debate. The fact that we have tolerated such myth making is surely a prescient commentary on our collective apathy. The Americans have baseball, mom and apple pie. While we in Canada settle for unbelievably high taxes, the CBC and so it seems, the *Canada Health Act.*

Given almost 135 years of history, over a million lives lost in two World Wars, the Korean War, other battles and peacekeeping missions, the countless contributions Canadian scientists, activists, businesspeople, artists – and yes, politicians too – have made both within and beyond our borders, it stands to reason that our identity is much larger than a simple and increasingly unworkable 11-page, federal statute that is no older than a pimply faced teenager.

Thomas Kierans, former President of the C.D. Howe Institute, made the following astute observation before an OMA conference in 1999:

> In my view, the Canada Health Act was borne out of political desperation, of a failing dynasty, in order to live to fight another day and in order to secure the affection of Canadians for "introducing universal health care."
>
> Today more than 15 years later, the Canada Health Act is used to brandish at the margin painful penalties for discouraging provincial experimentation and health care reform.
>
> Yet, the Canada Health Act stands in the way of competitive, provincial experiments to meet challenges not dreamed of in the early 1980s. Moreover, these experiments are always less costly because any failures accrue to one province only and success can be adopted by all. [42]

So far it has been pointed out that the CHA's principles are just that, principles – not guarantees or laws – that sometimes conflict with each other. Additionally, it is clear that polling data reveal a widening schism between politicians and the public on the CHA and health care direction overall. But it is our politicians that discuss and debate health care reform – indeed very publicly before joint ministerial gatherings – for the most part. So what are they discussing?

Mark Kennedy, is an *Ottawa Citizen (Southam News)* reporter and one of Canada's longest serving full-time health care journalists. This lengthy but incisive passage gives us the answer:

> It's come to this. Every time I attend a meeting of Canada's health ministers, it's like waking up in a cold sweat on the family-room couch at 1 a.m. The TV is on and I'm watching a cheap B-movie. The actors are reciting thoroughly predictable lines that lack either spontaneity or originality. Then I'm hit with the sudden awareness that I've seen this movie before. Many times. Over and over and over. I can't escape.
>
> That's how health care reform gets discussed by politicians in Canada. By talking in circles, clinging to myths and achieving nothing. Before long, another health minister is appointed or another government comes to power, and they too think they're saying something new about medicare. When, in fact, it's the same old dreary screenplay.
>
> There's a basic scenario, which can be fiddled with depending on if it's an election year, what's in the headlines that month, and whether one mischievous province is particularly keen on causing grief for the federal health minister. It goes like this:

> The provincial ministers gather for a day to develop a "united front", a song sheet they can all sing from to bash their federal counterpart when he joins them the next day. Usually it has to do with underfunding, or how the federal government is unfairly imposing vague, unachievable standards on how to comply with medicare's five basic principles. The next day, the federal minister joins them and takes abuse but publicly refuses to cave in – either by giving them the money they want or by agreeing to go soft on enforcement of the *Canada Health Act.*
>
> At the end of it all, they walk out of the hotel ballroom to proclaim that they've had "full and frank discussions" and have made "progress" in improving the health care system that surely stands as the "number one priority" for all Canadians. Everyone wins. The provinces get to vent their frustration and the feds get to maintain their image as medicare's white knight.
>
> Too bad it doesn't improve the quality of health care in Canada one bit. [43]

On a related theme, *Globe and Mail* national affairs columnist Jeffrey Simpson put the following thoughts to paper:

> The act postponed for two decades the debate about choices and financing of health care. It choked off private financing for hospital and physician services, but it did nothing to broaden public coverage. The result is that most of the new services are being paid for privately. The act has become an icon. As such, it prevents rational debate about options. [44]

Coincidentally, this column was published on April 4, 2001, the day that Roy Romanow was appointed to head the Commission on the future of medicare. Canadians can only hope that Mr. Romanow will have the courage to think big and modernize the Act

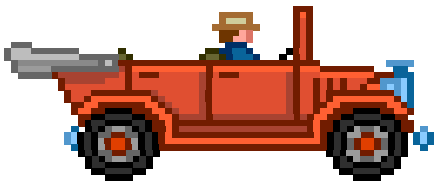
3.6 Modernize the Canada Health Act with New Principles

The polling data show that Canadians support the notion of the *Canada Health Act* but paradoxically support reforms that the Act expressly forbids. The choice becomes clear: reforms and changes must occur, so clinging to dreams and notions of health care's days gone by is futile.

The CTF proposes updating the principles of the CHA in order that it becomes a more realistic, flexible and useful document to guide health reform initiatives. The principles outlined below also ensure that reform proposals (see Chapter 9 of this report) are workable.

To recap, the current CHA principles are:

- Public administration;
- Comprehensiveness;
- Universality;
- Portability; and
- Accessibility



In light of the CHA's current rigidity and other problems, the antique car graphic seems appropriate. It is also reflective of increasing public dissatisfaction with a health care system being viewed as a broken-down old clunker. A great deal of affection and respect is sill accorded to its mechanics (doctors, nurses, etc.), but the gas is too expensive, repair bills are too high and in relation to foreign models, it looks less and less attractive.

The CTF proposes that the CHA be modernized with a "new" set of principles:

- Public governance;
- Universality;
- Quality;
- Accountability;
- Choice; and
- Sustainability.

Incorporation of these principles into a modernized *Canada Health Act* would put us on the fast track toward real health care reform.

A closer examination of each of these principles is warranted.

Public Governance

Changing public administration to pubic governance is a necessary first step. In almost every sector of public policy, alternate service delivery and public-private partnerships are becoming commonplace. Legislative structures and policy regimes have changed to enable new arrangements to take hold.

Governments are responsible for ensuring public services are delivered: this does not necessarily mean they have to physically deliver those public services. This separation of policy responsibility from operational follow-through is liberating. Government in turn is able to better concentrate its resources on becoming a regulator and steward of the public policy area in question while a variety of providers (depending on the service or policy area in question) then deliver services to all or compete with others in delivering services to varied subsets of the population.

At the federal level, examples of this shift from administration to governance include the National Airports Policy (1994) where Transport Canada divested its operational and funding responsibilities for over 700 airports to local airport authorities (LAAs). These LAAs are private companies with Boards of Directors determined by statute which operate airports as public trusts.

Another example of the administration to governance shift is found in the devolution of Transport Canada's air navigation services directorate (ANS) into the not-for-profit, multi-stakeholder NavCanada. NavCanada is the sole provider of air-traffic control services but has contracted certain components of its operations to other providers.

In health care, public governance could allow entities other than governments to administer components of provincial insurance plans. This governance shift could also lead to government continuing to regulate aspects of health care but devolving some or all of its funding (payer) role to regional health authorities, individual hospitals, physician pools (in primary care reform or target medical agencies) or directly to patients with the introduction of medical savings accounts (MSAs) or health care allowances.

Universality

As discussed in Chapter 3.4, universality retains almost universal (pardon the pun) support as a principle for health care in Canada. As the IRPP has noted, "universality equates eligibility for health services with citizenship." [45]

But Canadians also confuse the principles of accessibility, comprehensiveness and portability with universality. Or perhaps they view them as subsets of the universality principle. Regardless, this definition must be clarified to determine whether universality means mandatory participation by all Canadians or to make participation universally available to all Canadians.

From the CTF perspective, the latter definition of universality would suffice. As is the case in several European countries, universal coverage is mandatory, however individual choice in choosing the type of coverage (pubic, private or some blend thereof) is paramount.

Quality

Building on the observations of the Fyke Commission (see page 11 of this report) in Saskatchewan, quality would be the third principle in a modernized CHA. A quality focus should ensure at a minimum that:

- Citizens receive medical care that is appropriate and evidence-based;
- Every reasonable effort is made to provide patients with the best pharmaceuticals, technology and diagnostic tools available (assessment of "reasonable" would admittedly be subjective based on geography to an extent as well as the acuity of an individual patient's medical problem); and
- Progression of the patient's treatment is a quick as possible and without undue delay.

Another important component of quality will be to continually benchmark treatments against national and international best-practice standards. With the convergence of medicine and treatment practices around the globe and the consequent acceleration and diffusion of knowledge, international benchmarks will become the primary if not sole measurement indicator of quality in the near future.

Accountability

Accountability must be more than a government buzzword, the health care system must exhibit its accountability in three key areas.

First, accountability must include consistent system monitoring and reporting on all aspects of the health care system including funding, resources, waiting lists and health outcomes. To be fair, the establishment of CIHI as a going concern in 1994 was the first in many steps that needed to be taken to ensure that quality can be measured. On a positive note, the information released by CIHI each year continues to improve and expand.

However, you can't manage what you don't measure. From waiting lists to out-of-province treatment of workers compensation clients or cancer patients, many provinces are still woefully inadequate in measuring such information and consequently, cannot measure the resources expended in many areas. (Health care statistics and other findings obtained through CTF *Freedom of Information* requests will be released later in the fall of 2001).

The accumulation and periodic reporting of quality data must be as transparent and public as possible, with due regard for individual privacy considerations. In areas where conflict prevails in this pursuit, individual privacy must never be sacrificed. Instead, aggregation of data to a higher level should be employed as the appropriate workaround.

Accountability, along with public governance, would also entail remedies for retribution or corrective measures. However, these measures must be decided in concert with the appropriate stakeholders (depending on the quality or service deficiency identified). This would be a significant change from the present situation where the federal government unilaterally acts as prosecutor, judge and jury in its enforcement of the CHA.

Choice

As identified under the public governance principles, some or all funding could be devolved from governments to lower-tier authorities/providers, or ultimately and ideally, consumers and patients (see "flawed economics" in Chapter 4.6).

If dollars followed patients or patients were more responsible for their health care purchases, choice would be necessary. Indeed, by introducing accountability into a modernized CHA, choice is a requisite by-product. At present, if monopolistic providers are found to be delivering poor quality health care, at best they are penalized, but more often than not they are simply replaced by another monopolistic provider.

So choice of providers, whether in a primary care setting, an environment of internal markets or medical savings accounts, is essential. On the international scene, a recent

ruling by the European Court in July affirmed the principle of choice.[*] In August, British Health secretary Alan Milbum stated, "it is my intention to make clear to health authorities that they are able to commission services from other European countries."

According to the *Sunday Times:*

> The move could reduce by months or even years the delays faced by patients awaiting prosthetic hips and knees, heart surgery, cataract operations and other surgical procedures. The European Court of Justice ruled that patients "facing undue delay" in their home countries could seek treatment in other EU states. Some health policy experts see the move – which effectively opens up the health service to overseas competition – as a crucial first step in breaking entrenched interests, including those of trade unions and professional bodies that represent hospital workers and clinical staff. [46]

Sustainability

In the last few years, provincial health ministers and premiers have spoken often of the need for "predictability" and "sustainability" in federal CHST transfers. While this desire is understood in the context of the CHST cuts in the mid 1990s, the remedy sought by the provinces – a funding "escalator" or "indexing" clause – is doomed to result in a repeat of history. The federal government gradually withdrew its cash transfer support for the simple reason that its payments were already linked to an escalator. In the early years, the more a province spent, the more Ottawa coughed up.

This remedy is an ideal political solution and also serves a short-term public finance need, but over a longer period it works against fundamental structural reform efforts and only deepens provincial dependence on the federal government as opposed to fostering autonomy and innovation. Therefore, for our purposes, sustainability is defined as an approach that ensures the health care system:

- Is sufficiently capitalized – future spending and demographic projections are accounted for and continually revised;
- Is properly serviced – adequate forecasting and consultative strategies are employed and incentives are built into the health care framework to ensure the appropriate mix of human resources (i.e.: doctors, nurses, radiation technologists, oncology nurses, psychiatrists, gerontologists, etc.) are available; and
- Is optimally balanced – direct government policy will probably still occur in many areas including research and population health initiatives. This balance, in a broader context, ensures that health care is properly positioned to complement other social policy initiatives.

[*] All information about the European Court ruling and its relation to "choice" taken from the *Sunday Times,* August 26, 2001, Web edition.

4.0 Health Care in Canada

From a fiscal perspective, health care in Canada represents a $95 billion annual expenditure or 9.3% of our GDP. But what exactly is health care? As our population ages this will become a formative and hotly debated question in public policy circles.

Most would agree that a visit to the doctor or surgery in a hospital is health care. How about vacuuming the home of someone who has debilitating arthritis? Or campaigns that encourage people to eat better, drink less alcohol and exercise more? Is this health care?

Section 3 of the CHA states:

> 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.[47]

This is a wide-ranging and encompassing definition. The Kirby Senate committee elaborated on this definition this past March:

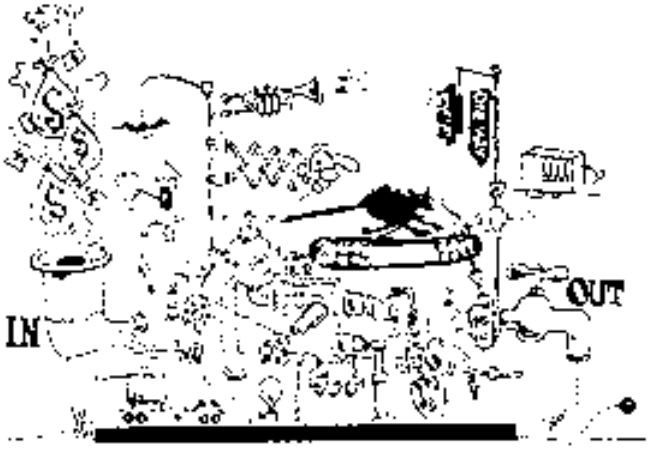
> For the purposes of our study, we defined healthcare as any activity the primary objective of which is to improve or maintain the health of individuals or to prevent the deterioration of their health. This definition is very broad and encompasses health promotion, disease prevention, health protection, public health and health research, as well as diagnostic services and treatment of disease. It also includes a wide variety of health care delivery sites (hospital, home, community, clinic, etc.) and a broad range of health care providers (physicians, nurses, nurse practitioners, pharmacists, physiotherapists, caregivers, etc.). [48]

Increasingly, governments and consumers will view health care from this broader perspective of population health.

4.1 Canadian Health Care: By the Numbers

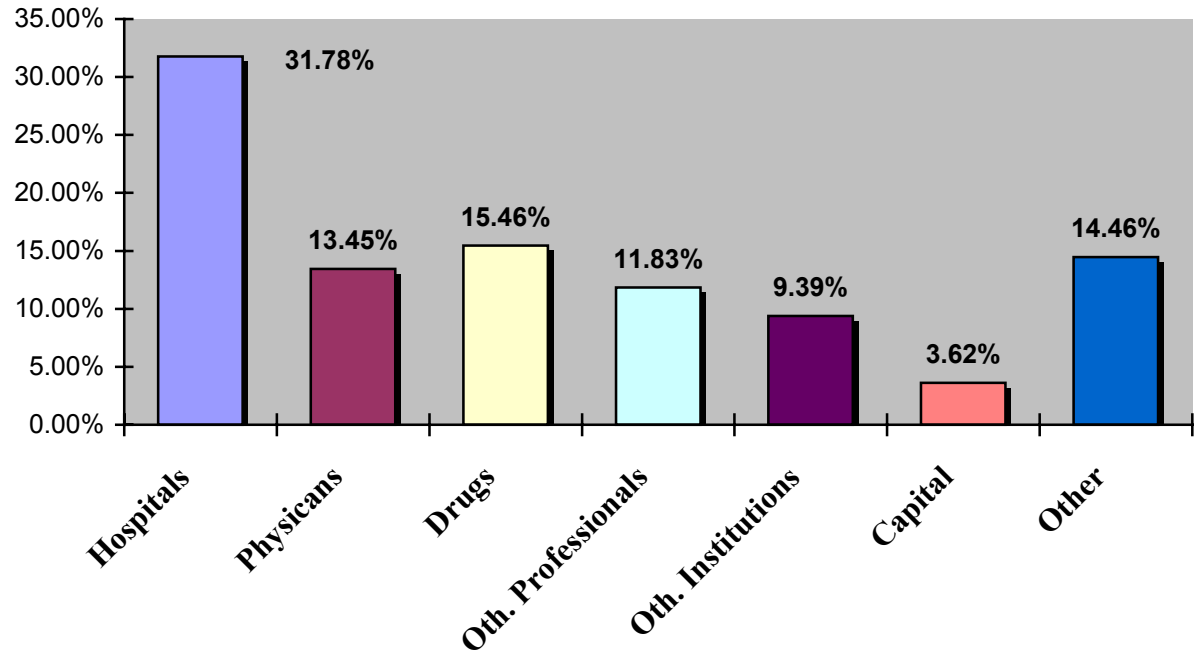
As noted above, as a nation we now spend $95 billion on health care.

But with Canadians expressing frustration with long waiting lists, emergency re-directs (ERD), delayed drug trials and scarce diagnostic technology, they can be forgiven for perceiving that the system is not churning out results in proportion to massive funds that are put in.



The questions of where this money is spent, by whom, and for what services must be answered to gain a greater appreciation not only for the levels of health care spending but also to identify trends which have ramifications for the future. These trends will affect the service delivery choices made.

Total Spending by Category (2000) *



Spending in 2000 ($95.1 billion) was up 6.9% from 1999, or 4.1% when inflation is discounted. On a per capita basis, this amount is $3,093.55.

The Public-Private Mix

In 2000, public health care spending accounted for 71% of total spending or $67.6 billion. This includes spending by all levels of government, provincial workers' compensation boards, other public insurance schemes and in some instances, ambulance fees, prescription drugs and some homecare services.

Conversely, private spending accounted for the other 29% or $27.5 billion. This spending includes dental work, most vision care, alternative medical treatments, physiotherapy, massage therapy and prescription drugs. Approximately 30% of this spending (1998) was covered by employer sponsored health insurance plans while the rest was paid directly by Canadians.

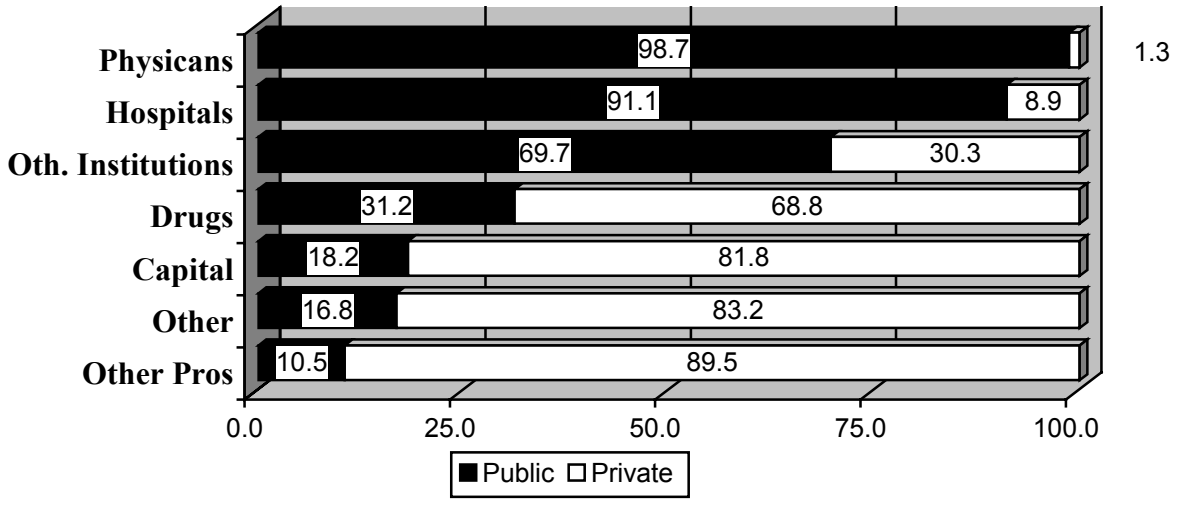
* All figures in Chapter 4 are taken from the CIHI publication *Health Care in Canada (2001)* or from the CIHI website at http://www.cihi.ca.

The following table provides the current dollar, dollar per capita and percentage breakdowns of public and private spending for 2000.

	Total Spending ($ millions)			Per Capita ($)			Percentage Split	
	Public	Private	Total	Public	Private	Total	Public	Private
Alberta	6,721.1	3,166.2	9,887.3	2,242	1,056	3,298	68	32
British Columbia	9,238.6	3,470.1	12,708.7	2,273	854	3,127	73	27
Manitoba	3,024.4	905.1	3,929.5	2,635	788	3,423	77	23
Newfoundland	1,294.6	306.0	1,600.6	2,403	568	2,971	81	19
New Brunswick	1,559.5	657.8	2,217.3	2,061	869	2,930	70	30
Nova Scotia	1,945.8	734.2	2,680.0	2,068	780	2,848	73	27
Ontario	25,500.9	11,810.4	37,311.3	2,185	1,012	3,197	68	32
P.E.I.	276.3	112.5	388.8	1,989	810	2,799	71	29
Quebec	15,192.2	5,556.0	20,748.2	2,061	754	2,805	73	27
Saskatchewan	2,394.9	766.3	3,161.2	2,340	749	3,089	76	24
N.W.T.	187.7	18.8	206.5	4,462	446	4,908	91	9
Nunavut	153.5	11.4	164.9	5,541	413	5,954	93	7
Yukon	98.0	24.5	122.5	3,196	798	3,994	80	20
Canada	**67,542.5**	**27,539.3**	**95,126.8**	**2,198**	**896**	**3,094**	**71**	**29**

Spending differences across the country are a function of the age of the provincial population, degree of urbanization, prevention vs. treatment approaches and total fees or salaries paid to doctors, nurses and other allied health professionals.

Public and Private Expenditures: Per cent by Category



From this graph, one ascertains the public/private expenditure mix by service category.

Miscellaneous CIHI Data

While the figures presented so far are only the tip of the iceberg, nonetheless they provide a general picture of health care spending across the country. Further data on individual provincial expenditures and related measurements are found in Appendix B of this report. The following table displays some of the range of data collected by CIHI.

	Physician Billings ($)		911 coverage	# of Ministers	Median term in office
	Family	Specialists	Mar.2001	Jan 1990 – Feb 2001	
Alberta	175,427	237,410	75 - 99 %	4	41.5 months
British Columbia	175,589	240,396	75 - 99 %	7	22 months
Manitoba	140,169	181,708	75 - 99 %	5	25 months
Newfoundland	150,987	215,256	0 - 49 %	6	28.5 months
New Brunswick	162,498	255,065	100 %	4	34 months
Nova Scotia	140,427	221,114	100 %	6	23.5 months
Ontario	200,076	278,195	75 - 99 %	7	28 months
P.E.I.	195,642	248,509	100 %	5	29 months
Quebec	138,122	177,089	75 - 99 %	4	38.5 months
Saskatchewan	185,454	252,570	50 - 74 %	7	19 months

As the chart above indicates, from 911 coverage to the duration of health ministers in their portfolios, there is a wide variation in health care data across the country. However, the main provincial complaint was, and still is, the federal government's unilateral reduction of transfers during the mid-1990s. According to data derived from the *Public Accounts* and provincial sources, cash transfers to the provinces for health care were as follows:

Fiscal Year	Total EPF or CHST Transfer	Health Care Component
1990/1991	$ 13.826 billion	$ 11.972 billion
1991/1992	$ 16.247 billion	$ 13.369 billion
1992/1993	$ 17.916 billion	$ 15.029 billion
1993/1994	$ 16.829 billion	$ 14.450 billion
1994/1995	$ 17.332 billion	$ 14.846 billion
1995/1996	$ 16.790 billion	$ 14.426 billion
1996/1997 *	$ 14.911 billion	$ 12.679 billion
1997/1998	$ 12.421 billion	$ 10.567 billion
1998/1999 ♥	$ 16.018 billion	$ 13.621 billion
1999/2000	$ 14.891 billion	$ 12.662 billion
2000/2001	$ 15.5 billion (projected)	$ 13.180 billion (projected)
2001/2002	$ 18.3 billion (projected)	$ 15.561 billion (projected)

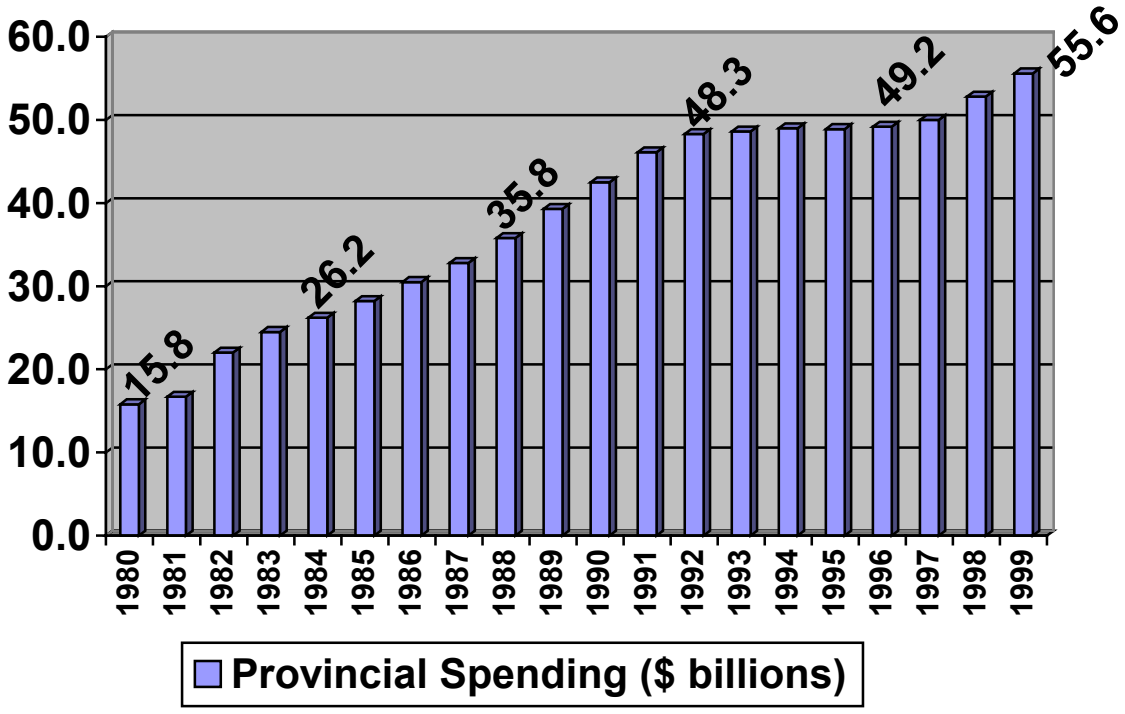
* All figures derived taken from the *Public Accounts.* With the establishment of the CHST in 1996/1997, health transfers were no longer reported as a separate line item. From 1996/1997 federal health-only cash transfers reflect an 85.03% calculation based on the average of EPF transfers directed to health from 1990/1991 to 1995/1996.

♥ 1998/1999 figure includes a valuation of $3.284 billion.

4.2 The Provincial Picture

In August 2000, Canada's premiers and territorial leaders released a document entitled *Understanding Canada's Health Care Costs.* Prepared in advance of the historic meeting between the First Ministers in September 2000, this document laid out the provincial case for increased funding as well as identifying national (province by province) reform efforts to date along with the forthcoming challenges to provincial health care regimes.

According to the Conference Board, between 1989/1999 and 2000/2001, an average of 62% of new provincial expenditures were devoted to their health portfolios. As large as this figure is, it merely continues a 20-year trend as indicated by continuous spending increases portrayed in the graph below. *



According to the Premiers, these cost increases were not uniform in terms of internal provincial expenditures patterns. During the period from 1990 to 1999:

- Provincial hospital expenditures increase modestly by 16%;
- Costs for physicians climbed by 30%;
- Other expenditures (including homecare) jumped by 50%; and
- Drugs costs escalated by a phenomenal 87%.

* Graph adapted from *Understanding Canada's Health Care Costs,* Figure 10, page 16.

4.3 Qualitative Provincial Snapshots

While the previous section provides a global picture of health care spending across the country, a more detailed survey of major activity in each province over the last 12 to 18 months is warranted (note: territorial issues are not included in this overview).

This analysis is not exhaustive, rather it focuses on the key issue or issues that preoccupied each provincial government.

Alberta

The pivotal issue in Alberta over the last 18 months was the passage of Bill 11 introducing limited private health care. The government passed legislation that included provisions allowing hospital authorities and other health agencies to purchase limited surgical services from private providers.

Specifically, concerns were raised about the development of private surgical clinics and the lack of legislated restrictions in Alberta. [49] The government responded, noting, "our proposal will prohibit queue jumping and prohibit clinics from charging any Albertan for a medically insured service. Alberta is the first province in Canada that moved to ban two-tier health care and legally prohibit the development of a parallel, private health care system." [50]

Opinion polling in the province found that 59% of Albertans supported the legislation, and that 72% felt that this would help reduce some waiting times. [51] However, the Klein government expended a great deal of political capital and attracted national attention with the passage Bill 11.

In response, Premier Klein took to the TV airwaves province-wide on January 31, 2000, to outline the Alberta's ***six- point plan for health.*** It included measures to:

- Improve access to quality publicly funded services;
- Improve management of the health system;
- Enhance the quality of services;
- Increase the promotion of wellness – healthy living;
- Foster new ideas for improving the health system (innovation); and
- Protect the publicly funded health system.

In enacting the plan, the Alberta government pledged to increase spending on health care by $1 billion over three years, hire more medical staff (doctors, nurses, etc), establish a Health Services Utilization Commission, purchase new equipment, fund telehealth efforts, and support innovation and pilot projects. [52]

Initial results of the six-point plan yielded promising indicators:

- Non-urgent cardiac patients saw a one-week reduction in wait times;
- Joint replacement wait times declined to four weeks;
- Prostate cancer radiation treatment wait times were reduced from seven weeks to four weeks;
- Breast cancer radiation treatment wait times were reduced from 13 weeks to four weeks; and
- The average wait time for an MRI scan was reduced to six weeks. [53]

As part of the six-point plan, Bonnie Lang, a former MLA, was selected as Chair of the ***Health Services Utilization Commission*** in May 2001. Terms of reference for the commission included fostering continuous improvement in the performance of the health system by informing stakeholders. [54]

On another front, after acrimonious talks with the Alberta Medical Association (AMA), the health ministry agreed to increase physicians' wages by an average of 22% over two years. Some 6,000 Alberta doctors will benefit from the $390 million agreement. Of these funds, $90 million will be allocated to the hiring of new physicians over the next few years. [55]

In 2000, an annual health survey of Albertans found that 63% rated the system as good, up slightly from 1999 where 57% of respondents offered the same rating. Quality of care was rated good or excellent by 86% of respondents, up from 79% in 1999.

British Columbia

In February 2000 the government of British Columbia called for a restoration of the federal partnership (read: the original 50-50 funding formula) in funding health care. A February 7, 2000, a news release outlined the government's concerns about public confidence in the health system. Then Health Minister Penny Priddy stated:

> There is no question that the public's trust in our health-care system has been severely shaken … Bringing back a level of confidence in the health system is going to require much more than the provinces can do on their own. [56]

Ms. Priddy also sought federal support for primary care reform and an expanded homecare network. The government's orientation seemed to be that of magical spendthrift: looking for more money from the federal government, while putting stock in innovations (better management) as the key to long-term system viability.

Faced with federal intransigence with respect to increasing federal transfers, the B.C. government initiated its own Health Action Plan. Formally introduced in December 2000, the plan allocated $180 million in additional new dollars toward improving health care. The action plan placed a strong emphasis on supporting health care workers, nurses in particular, doctors and other health care professionals, enhanced homecare and an emphasis on prevention and personal responsibility for health outcomes.

To address access issues in remote rural communities, telehealth initiatives are being pursued. Strategic use of information technologies allow rural health centres to have the clinical advice of specialists in urban areas. The province provided $3 million for telehealth with the intention of funding another $9.5 million over the next two years. [57] On another front, the government initiated an $11.7 million pilot project using non-profit agencies to assist in the delivery of continuing care.

In May 2001, the BCMA called for the establishment of a independent multi-stakeholder authority to govern health care among other recommendations in a solid report. Disputes with nurses and concern over B.C. health premiums have also been the focus of provincial attention.

Given the change of government in May 2001, it is too early to tell whether the B.C. Liberals will scale back or modify any of the initiatives pursued by the former NDP administration.

Manitoba

In March 2000, the PC government announced a five-point plan to deal with a shortage of nurses. The action plan aimed to:

- Increase the supply of nurses by making more spots available for students and by bringing nursing professionals not working in their field back to nursing, and through international recruiting;
- Improve access to staff development at the regional health authority level;
- Improve the use of available nursing resources;
- Improve working conditions; and
- Establish an advisory council. [58]

Following the election of the NDP government in 2000, the spending floodgates opened up dramatically. In the tradition of blaming previous governments, Health Minister Dave Chomiak stated:

> We've started to make up for 10 years of neglect regarding nurses and other professionals. While we are short some 600 today, we have put in place measures to deal with that over the next few years. [59]

To address doctor shortages (especially in rural areas), a ***five-point plan*** was introduced. Manitoba will add 15 new training positions for medical students with $5.9 million being allocated to this program. [60] As well, in April 2001, Manitoba established the first permanent program to assist international medical graduates obtain medical licenses in Canada. [61]

As part of the province's 2000 Budget, health care was highlighted as an area of utmost priority. Finance Minister Greg Selinger said:

> With better planning and a six percent increase over last year's expenditures, we can take further action in the areas of most urgent need … After a decade of neglect, we have seen significant progress in our health care facilities. Until recently, hallway medicine was the institutionalized method of coping with extreme stress in our emergency wards. By opening beds and augmenting community supports we have taken a great deal of pressure off our acute care system. [62]

Budget 2000 increased health spending to $2.4 billion, $135 million more than was spent in fiscal 1999. Budget 2001 increased funding further to a new high of $2.6 billion or 38% of total provincial spending. According to the government, hospitals are now providing 1,400 more ultrasound tests and up to 400 more CT scans per month. [63]

As in other provinces, the federal blame game is alive and well in Manitoba. In August 2000, Premier Gary Doer said a new report on the future stability of Canada's health care system demonstrates why the federal government must restore transfer payments to the provinces, as jurisdictions like Manitoba grapple with sustaining medicare while also innovating in health care delivery. [64]

A government poll released on December 8, 2000 found that:

- 76.7% of respondents indicated they are moderately satisfied or satisfied with Manitoba's health care system;
- 83.1% believe that access should be based solely on need;
- 40.3% of those who used the emergency reported their condition could have been dealt with by doctor's office or clinic;
- 58.1% said they would probably use telehealth;
- 52.7% put investing in health care ahead of tax cuts; and
- 57.8% believe the health care system is staying the same or getting better. [65]

In May 2001, the government introduced legislation designed to prohibit the establishment of private hospitals. A loophole was also closed that had previously allowed for third party billing – billing one person for services given to another. Amendments were made to both the *Private Hospitals Act* and the *Hospitals Act* to prohibit overnight surgical stays at private facilities. Health Minister Chomiak commented:

> The legislation is one way to ensure that precious health care resources are being used to address patient care in a universally accessible system. An important goal of this legislation is to close the door on two-tier medicine in our jurisdiction. [66]

Newfoundland

On March 3, 2000, the government launched a better health (http://healthy.nf.ca) web site to act as a portal for residents seeking information on health care services, providers, issues, etc. It is part of a concerted population health focus that Newfoundland is promoting.

In Budget 2000, the government committed $136 million in new spending for health initiatives raising the total provincial outlay to $1.3 billion or 42% of government expenditures. Health and Community Services Minister (now Premier) Roger Grimes noted:

> Health care remains government's top priority. Despite a period of significant federal cutbacks, we have continued to invest millions in the health of our people. And we are doing so again this year. [67]

The budget included money for new hospital construction and upgrades, new equipment, community care programs, doctors and nurses shortages and specific initiatives in cardiac and cancer care. A ***special review team*** was announced to address deficit and funding issues for regional health boards along with a newly formed Human Resources Planning Council to address longer-term health care labour issues.

On August 30, 2000, then Minister Grimes sounded the alarm about escalating health care costs noting that five and six per cent annual health budget increases are unsustainable.

> We are on an extremely dangerous course which, if not contained, could lead to financial disaster for Newfoundland and Labrador. We have reached a crossroad, not only in this province but across Canada, with respect to health care and we must redefine the health care system of the future and ensure maximum use of every available dollar. It is becoming clear that we must begin to rearrange our services to recognize the major shifts taking place in the province, including a smaller proportion of children as compared to seniors. [68]

In Budget 2001 new Health minister Julie Bentley beat the same drum again. Another $11 million for physician recruitment and retraining, $82 million for capital improvements, $50 million in base budget improvements for health boards. In total, $162 million in new spending to bring the health budget to $1.4 billion. [69] In June 2001, the government also contributed $30 million in matching gifts to hospital capital campaigns.

New Brunswick

In May 2000, Health and Wellness Minister Dennis Furlong announced that departmental spending would increase by $143 million for fiscal 2000. [70] Areas targeted for new funding were familiar: hospital services, regional health corporation (RHC) deficits, new MRI machines, new medical school positions, and infrastructure spending. Indeed, RHC deficits including accounting audits and external operational reviews have been an ongoing preoccupation of provincial health officials for the last two years.

Nursing retention has also been the focus of concerted government attention. On April 9, 2001, the government outlined an $8 million retention and recruitment strategy which included summer employment for nursing students, tuition reimbursements for RNs, bursary programs and improved forecasts to identify nursing needs.

On May 4, 2001, Health and Wellness Minister Dennis Furlong announced that departmental spending would increase by $130 million to $1.324 billion for fiscal 2001 up from $1.194 billion in fiscal 2000. [71] Representing almost a carbon copy from a year earlier, more money was earmarked for hospitals, rehabilitation specialists, MRI scanners, ambulance services, etc. Earlier this year, New Brunswick was engulfed in turmoil with health care workers withdrawing services in the midst of fractious negotiations with the government.

Nova Scotia

Early in 2000, the government realigned its Health Ministry to become more integrated and patient focussed in response to a report from the provincial Auditor General. During a provincial health ministers meeting in March, Health Minister Jamie Muir stated:

> The federal government must return to the table as a full partner. Ottawa is putting us in a very difficult situation especially now as we prepare the provincial budget. When you see that the wealthier provinces like Ontario and Alberta are worried, just imagine the impact on a smaller province like Nova Scotia. Fundamental changes are going to have to be made if we are to ensure a sustainable and secure health care system for today and into the future. [72]

On January 1, 2001, the *Health Authorities Act* came into effect. Nine regional health authorities replaced four regional health boards. The government also took steps to streamline the nursing homes admissions process. The sustainability alarm was sounded by Minister Muir in a statement on February 1, 2001.

> We have to control costs in a health-care system that doubles its spending every 15 years. At this rate, future generations won't be able to afford quality health care. This government won't allow that to happen. At the current rate of growth, health spending would consume all provincial spending within nine years. [73]

Nova Scotia unveiled its nursing strategy in April 2001. Nursing retention, recruitment, nursing school admissions, co-op education initiatives and an Internet strategy all figured prominently in a $5 million plan. [74] The government is also implementing a sophisticated medical information system to link hospitals around the province. Finally, primary care reform efforts figure greatly in the government's health reform agenda.

Ontario

In March 2000 and again in June 2000, the Ontario government, in concert with the other provinces, called for the restoration of federal health transfers. This call was buttressed by a province-wide advertising campaign to draw attention to a $4 billion reduction in federal cash transfers.

Shortly after the Harris government came to power in Ontario in 1995, it established the Health Services Restructuring Commission (HSRC), an arm's length body with a mandate to provide recommendations for modernizing health care delivery. After two years of study, the HSRC recommended the closure or amalgamation of dozens of hospitals.

Primary care reform (PCR) was first introduced in 1998 to four communities, Hamilton, Paris, Chatham, and Kingston. Three more were added later in 1998 – Ottawa, Parry Sound and Thunder Bay. In total 200 doctors participated, with 200,000 patients enrolled as of 1998-99. The Ontario government anticipated that 80% of the province's family doctors would eventually join these networks. Today, the pickup of doctors enrolling in PCR initiatives has stagnated and it has become a common source of opposition attacks.

In April 2000, the province announced an additional $73.7 million to expand hospitals in Brampton, Etobicoke and Georgetown; mostly allocated towards new construction and renovations. [75] In May 2000, an additional $1 billion in capital funding was fast-tracked to assist with aggressive health reforms and 70 projects identified by the HSRC. [76] In June 2000, the global hospital budget increased by $435 million for fiscal 2000. [77]

The funding announcements continued through the summer of 2000 including $2.6 million for the Hamilton Cancer Care Centre and $800,000 in operational grants for the Henderson Site MRI.[78] As well, $9.1 million in expansion funding for Princess Margaret Hospital was announced.[79] In July, capital expenditures for the Children's Hospital of Eastern Ontario (CHEO) were increased to $28 million.[80]

In late 1999 the former chair of HSRC, Dr. Duncan Sinclair, observed that the province may have started its restructuring efforts from the wrong end. Dr. Sinclair noted that primary care reform and telehealth initiatives should have been initiated in advance of hospital restructuring. His words would turn out to be somewhat prophetic.

In April 2000, the province appointed a supervisor to replace the board of the Hamilton Health Sciences Corporation. The need for a supervisor became apparent when the results of a PriceWaterhouseCoopers operational review were published. The hospital was accumulating large operational deficits to the tune of $1 million per week. [81]

In February 2001, a supervisor was appointed by the province to oversee the Fort Erie Hospital in response to the refusal of that institution's board to sign an amalgamation agreement with seven other hospitals in the region.[82] On Friday, June 29, 2001, Health Minister Tony Clement removed the entire 28-member board of the Ottawa Hospital after an independent operational review by the Hay Group revealed the hospital was on track to run up an accumulated $150 million deficit, the largest in provincial history.

In July 2001, the Ontario government mailed a lengthy health care survey to over 4 million homes and continues to indicate that it will leap frog the Kirby Senate committee and Romanow commission in engaging Ontarians, and likely Canadians, in a meaningful and frank dialogue about the future of health care and options for reform.

Prince Edward Island

Issues of concern on PEI over the past year and a half included a reorganization of provincial pharmacy services, nursing scholarships, a $6 million nursing strategy, along with federal funding shortfalls.

Budget 2001 increased the Health and Social Services budget by $23.3 million to $340 million. Over the past five years, the PEI health budget has increased by 19%. [83] Minister Jamie Bellam commented:

> Health care remains a number one priority for Islanders, and this budget is meant to reflect the importance we place on health care services. At the same time, we recognize that longer-term solutions are needed to assist Islanders to improve their health and subsequently reduce demand on the system, so that it is sustainable for us, and for future generations. [84]

Quebec

In June 2000, then Health Minister Pauline Marois announced the establishment of a nine-member commission (headed by Hydro Quebec executive Michel Clair) to examine the future of health care in Quebec. In making the announcement Mme. Marois stated:

> Everything is on the table, all the doors are open; the only thing that I will never accept is a proposal for a two-tiered public health system … Our tax system is progressive – wealthier Quebeckers generally pay more tax than poorer people – maybe this type of reasoning can be applied to health care, I don't know, we'll listen to what people have to say. [85]

In January 2001, the Clair commission reported back with recommendations for reform including:

- Establishment of a $2 billion compulsory old-age insurance scheme (funded by taxpayers or the private sector or some combination thereof) to cover the non-medical costs for ageing baby-boomers with a simultaneous de-listing of some health services from the provincial health care plan to ease cost pressures;
- Promoting family medical groups (similar to PCR in other provinces) of six to ten physicians to offer 24 hour medical care including nurses and telehealth;
- A 120% tax credit to promote private giving for medical infrastructure and capital needs; and
- More integration of specialists and allied health professionals in community practice settings.

While most provinces cautiously hailed the establishment of the Romanow commission in April 2001, Quebec Premier Bernard Landry slammed the door on Quebec support or participation in this effort. In Quebec separatist circles Mr. Romanow is perceived as a "centralist" and conspirator with Jean Chretien in the ***night of the long knives*** leading up to the repatriation of the Constitution in 1982. [86]

On May 16, 2001, Health Minister Remy Truduel proposed legislation granting regional health boards the authority to assign privileges to doctors and dentists in which hospitals they can practice. As part of this new approach, the Quebec government proposed to set up a regional nursing commission, peoples' forums for each Quebec health region along with the establishment of a health ombudsman to receive public complaints and examine issues such as waiting lists. [87]

Also in May, and similar to developments in B.C. and Ontario, a team of 25 radiologists announced plans to open a ten million dollar private MRI facility in downtown Montreal in June which was expected to handle as many as 30,000 patients a year. Scans will be paid for out-of-pocket or covered under private insurance. The clinic will also conduct an array of diagnostic imaging procedures and is expected to help alleviate MRI backlog in the Montreal region where patients are waiting up to nine months before receiving a scan.

Saskatchewan

In Saskatchewan, a shortage of health care workers and migration of health professionals to other provinces has been an ongoing concern. Despite the stable employment of nurses, the number of nursing vacancies had risen from less than 1% a decade ago to 3.3% by 1998. This resulted in calls to increase the number of nursing graduates each year coupled with a need to identify nurses who have left the profession that might be lured back.[88] A Health Human Resources Council was established with a five-year mandate to recruit and retain health professionals in Saskatchewan. [89]

In December 2000, the government and the Saskatchewan Medical Association reached a three-year deal on doctor funding. Fees will increase by nine percent over three years, with $8.5 million to modernize the fee schedule. There was also a provision for $5.8 million to help increase the supply of doctors in the province.[90]
In January 2001, $70 million of new hospital funding was announced. The funding was targeted for reducing deficits, supporting services or purchasing new equipment. [91]
On March 30, 2001, new health budgets were announced as part of the provincial budget. Total allocations for fiscal 2001 will climb to $230 million, up 11.6% over the previous year. Since 1995-1996 the health ministry's budget has increased by 42%.[92]

In 2001, an additional $54 million was provided to health districts to help cover projected operating deficits. Twenty-five of 32 districts were projecting budget deficits for the year ending March 2001.[93] This prompted health minister John Nilson to state:

> The Health system is facing increasing pressures due to growing demand for services, rising costs, new technologies and drugs. The provincial government and districts will have to take a careful look at the appropriate balance between meeting the demand for health care services and establishing a sustainable level of spending in the coming year. [94]

On April 6, 2001, the Fyke Commission delivered its report on the future of health care in Saskatchewan.

Analysis: Common Themes

This cursory survey of the provinces yields a remarkable degree of commonality in approaches. In short, most provinces:

- Continue to lay a great deal of blame at Ottawa's doorstep when it comes to funding issues, specifically CHST cash transfer levels;
- Have sounded the alarm about the unsustainability of year over year growth in health costs that are larger than – sometimes double – provincial revenue growth;
- Are trying to address physician and nursing shortages through "money" strategies along with attempting to better forecast future human resource needs;
- Find themselves dealing with health authority/health district and/or hospital deficits amounting to tens of millions and hundreds of millions of dollars (for larger provinces) with the only remediation strategy available being a provincial bailout;
- Face growing public demands to expand homecare programs, provide ALC (alternate level of care) beds and add more drugs under provincial insurance plans; and
- Affix great hope and promise for cost savings resulting from primary care reform (see Chapter 8.3 for a definition of primary care reform), further community health integration and telehealth initiatives.

4.4 The Sustainability Issue: Will We Bust the Bank?

Premiers and health ministers speak of the "sustainability issue" with respect to health care spending. Simply put, even single-digit increases in health care spending that double annual revenue growth or GDP growth cannot be sustained over the long-term.

So the question then becomes not ***if*** the health care budget will consume 50%, 75% or even 100% of tax resources, but ***when?*** Based on data derived from all provincial budgets, the CTF has projected when each province's (territories have been excluded) health care expenditures will reach 50%, 75% and 100% of total expenditures.

This analysis was calculated by applying the average annual growth rate in health care expenditures over the past three years (1999/00 to 2001/02 except for Quebec which uses data from 1998/99 to 2000/01) for each province. This average growth rate is then annually projected forward into the future starting in fiscal 2002, assuming constrained 2% overall spending growth (reflecting cost containment in other budget envelopes to account for health increases as well as tax relief measures) in each provincial budget.

Alberta

Health care spending as a % of overall expenditures (Fiscal 2001)	29.06%
3-year average growth rate in health care spending:	7.51%
3-year average growth rate in overall spending:	8.06%
Fiscal year in which health will consume 50% of provincial spending:	**2012**
Fiscal year in which health will consume 75% of provincial spending:	**2020**
Fiscal year in which health will consume 100% of provincial spending:	**2025**

British Columbia

Health care spending as a % of overall expenditures (Fiscal 2001)	39.93%
3-year average growth rate in health care spending:	6.72%
3-year average growth rate in overall spending:	3.81%
Fiscal year in which health will consume 50% of provincial spending:	**2007**
Fiscal year in which health will consume 75% of provincial spending:	**2016**
Fiscal year in which health will consume 100% of provincial spending:	**2022**

Manitoba

Health care spending as a % of overall expenditures (Fiscal 2001)	38.30%
3-year average growth rate in health care spending:	6.72%
3-year average growth rate in overall spending:	1.65%
Fiscal year in which health will consume 50% of provincial spending:	**2014**
Fiscal year in which health will consume 75% of provincial spending:	**2034**
Fiscal year in which health will consume 100% of provincial spending:	**2047**

Newfoundland

Health care spending as a % of overall expenditures (Fiscal 2001)	41.70%
3-year average growth rate in health care spending:	5.20%
3-year average growth rate in overall spending:	1.28%
Fiscal year in which health will consume 50% of provincial spending:	**2007**
Fiscal year in which health will consume 75% of provincial spending:	**2020**
Fiscal year in which health will consume 100% of provincial spending:	**2030**

New Brunswick

Health care spending as a % of overall expenditures (Fiscal 2001)	35.73%
3-year average growth rate in health care spending:	3.72%
3-year average growth rate in overall spending:	0.49%
Fiscal year in which health will consume 50% of provincial spending:	**2022**
Fiscal year in which health will consume 75% of provincial spending:	**2046**
Fiscal year in which health will consume 100% of provincial spending:	**2063**

Nova Scotia

Health care spending as a % of overall expenditures (Fiscal 2001)	34.76%
3-year average growth rate in health care spending:	2.19%
3-year average growth rate in overall spending:	0.73%
Fiscal year in which health will consume 50% of provincial spending:	**2197**
Fiscal year in which health will consume 75% of provincial spending:	**2415**
Fiscal year in which health will consume 100% of provincial spending:	**2569**

Ontario

Health care spending as a % of overall expenditures (Fiscal 2001)	37.44%
3-year average growth rate in health care spending:	3.03%
3-year average growth rate in overall spending:	0.77%
Fiscal year in which health will consume 50% of provincial spending:	**2030**
Fiscal year in which health will consume 75% of provincial spending:	**2071**
Fiscal year in which health will consume 100% of provincial spending:	**2099**

Prince Edward Island

Health care spending as a % of overall expenditures (Fiscal 2001)	35.50%
3-year average growth rate in health care spending:	3.52%
3-year average growth rate in overall spending:	3.12%
Fiscal year in which health will consume 50% of provincial spending:	**2025**
Fiscal year in which health will consume 75% of provincial spending:	**2052**
Fiscal year in which health will consume 100% of provincial spending:	**2072**

Quebec

Health care spending as a % of overall expenditures (Fiscal 2000)	32.34%
3-year average growth rate in health care spending:	3.19%
3-year average growth rate in overall spending:	2.10%
Fiscal year in which health will consume 50% of provincial spending:	**2038**
Fiscal year in which health will consume 75% of provincial spending:	**2072**
Fiscal year in which health will consume 100% of provincial spending:	**2097**

Saskatchewan

Health care spending as a % of overall expenditures (Fiscal 2000)	35.02%
3-year average growth rate in health care spending:	4.18%
3-year average growth rate in overall spending:	3.15%
Fiscal year in which health will consume 50% of provincial spending:	**2019**
Fiscal year in which health will consume 75% of provincial spending:	**2038**
Fiscal year in which health will consume 100% of provincial spending:	**2052**

While the analysis above is academic in nature, it serves to highlight the sustainability issue. Projected dates for passing the 50%, 75% and 100% thresholds are conservative estimates as demographic shifts, technology costs, population changes etc. are not factored into the calculations.

A summary of the preceding calculations is found below:

	% of budget on health	% on health rank	50 % of spending	75 % of spending	100 % of spending
Alberta	29.06 %	10	2012	2020	2025
British Columbia	39.93 %	2	2007	2016	2022
Manitoba	38.30 %	3	2014	2034	2047
Newfoundland	41.70 %	1	2007	2020	2030
New Brunswick	35.73 %	5	2022	2046	2063
Nova Scotia	34.76 %	8	2197	2415	2569
Ontario	37.44 %	4	2030	2071	2099
P.E.I.	35.50 %	6	2025	2052	2072
Quebec	32.34 %	9	2038	2072	2097
Saskatchewan	35.02 %	7	2019	2038	2052

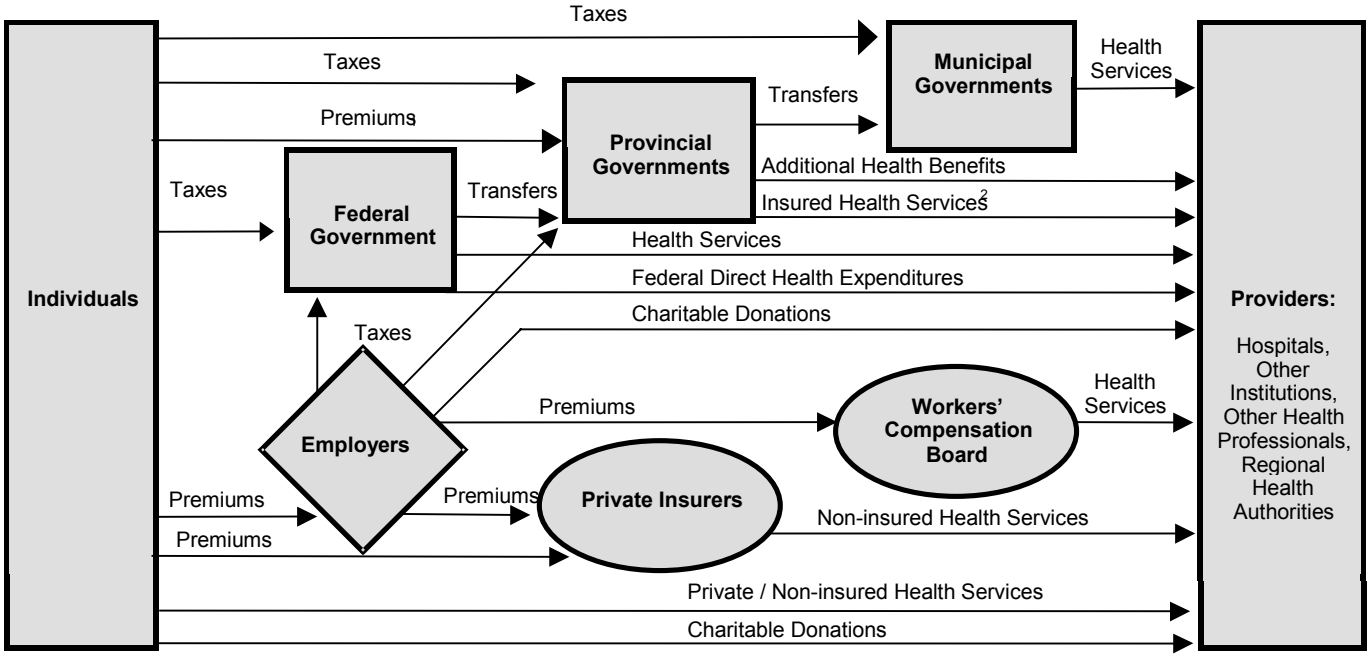
The other factor to be considered is this that the national pressures from health care cost escalation will truly be felt when the three “have” provinces (B.C., Ontario and Alberta) reach the point where 50% of their budgets are expended on health.

When this point is reached, it is feasible – if not probable – that the have provinces would seek to renegotiate the equalization formula downwards to free up fiscal room for other public expenditures. This would have adverse effects on the “have not” provinces and diminish their collective ability to run non-health programs on equalization transfers even if the CHST funding formula remained constant.

4.5 The Funding Model

While most Canadians would rightly state that the federal and provincial taxes fund health care, the funding flow of money from taxpayers into the system is much more complex.

FUNDING STRUCTURE OF CANADA'S HEALTH CARE SYSTEM*



1 Two Provinces, British Columbia & Alberta, levy health premiums.
2 Medically-necessary hospital & physician services
* Based on charts prepared by Health Canada 1999

While the diagram above [95] provides a more detailed overview of the funding flows within our health care system, it also points to the "flawed economics" of health care consumption. Patients are basically divorced – except when they pay directly for private / non-insured health services – from the ramifications of their health care consumption decisions.

As Dr. David Gratzer notes:

> The trouble with medicare is medicare itself. That is the principles upon which the system rests doom it to failure. Today's reforms attempt to preserve the framework of the system and, by doing so, ensure that success will never be achieved. The efforts may be well intentioned – but so are the engineers in the joke who attempt to force water to flow uphill. Here is what the Canadian experts miss: *the fundamental flaw of the medicare system is that patients bear no direct costs for the medical services they receive.* [96]

The widely held perception that Canadian health care is "free" persists. Of course it is not free, it comes with a $67.5 billion public pricetag that is growing each year and shows no signs of abating anytime soon.

4.6 Flawed Economics

Unlike most other sectors of economic activity – from buying a car to seeking out living accommodations – the laws of supply and demand are rarely applied in health care. Market incentives to regulate behaviour are eschewed by policy architects and proponents of such reforms are routinely demonized by status quo defenders of the health care system.

As Claude Forget notes, such reactions run counter to our status as a post-industrial society:

> In a high-income, highly educated society where innovation, initiative and user-friendliness are generally encouraged, there is no room for a one size fits all, publicly-managed, under-capitalized and over-regulated health "system." [97]

The pursuit of public policy goals in this environment have been seen to run contrary to market imperatives. This need not be the case. With the principles of universality and accessibility, or what the Europeans term ***solidarity***, health care becomes a redistributive function of government in the interests of equity for all. Whereas market systems seek out efficiency and delivering services at the lowest possible cost and make opportunity cost tradeoffs.

The challenge for those advocating health care reforms is to identify the "flawed economics" within our health care system and then advocate reforms to address these flaws while not straying from the principle of universality.

To start, a look at work conducted by the C.D. Institute back in 1994 is instructive:

> Two fundamental features differentiate supply and demand in the health services sector from those in most others. First, although reasonably accurate predictions can be made about the average incidence of various illnesses in a given population, individuals face a great deal of uncertainty about what health problems they will have and, therefore, what health services they will need at different times of their lives. To reduce the uncertainty resulting from the unpredictable cost of illness, it is clearly efficient to have some form of insurance, public or private, that protects individuals and families against the potentially disastrous financial consequences of severe illness. Second, the health services industry is characterized to an extreme degree by what is known as "information asymmetry" between buyers and sellers. The buyers of health care services are typically much less informed than the sellers about the true value of what is bought and sold. [98]

These features are unfortunately mutually reinforcing. With Canadian patients being fundamentally disconnected (except for passively paying taxes at source from their paycheques) from the funding/purchasing decision, there is little incentive to learn more about the service – neither its health effects nor its cost – one is purchasing (i.e.: being advocated or prescribed by a health professional). In this environment, suppliers (who are also disjointed from the price setting mechanism: this is done by the funders, usually governments) have little incentive to choose or seek out different treatment options.

Therefore costs tend to be high in such a system. From an economic point of view we have a system with the following characteristics:

- A dizzying variety of perverse incentives work against optimal patient care, cost containment and the pursuit of quality (a full listing of these incentives is found in Appendix C);

- Consumers perceive health care to be free and given the inherent value of the product, this can lead to over-consumption;

- Physicians, while they have been well-trained "to make cost-effective diagnostic and treatment decisions" [99], nonetheless are still divorced from other decisions made by other specialists and practitioners through the treatment chain;

- Physicians are also pressured by patient demands for extra and sometimes expensive testing procedures that if denied, can sour the physician-patient relationship and represent a potential loss of income in future fee-for-service billings should the patient seek out a new first-line physician; and

- Due to the domination of bureaucratic forces, the incentives to minimize costs, and assess system performance and outcomes on an evidence basis are minimized.

Reform efforts to date (see Chapter 8 in this report for more detail) in health care have tended to focus on cost containment on the supply side of the delivery divide. These reforms include freezing or limiting fee-for-service schedules, capitation of total physician billings, hospital closures and/or amalgamations and regionalization of health services, especially across metropolitan areas.

The other challenge is found in the funding structure of our health care system, or more aptly put, its lack of capitalization.

When medicare was nationally rolled out in 1966, Canada had approximately eight working age Canadians for each retiree. In effect, we had a relatively youthful and healthy population. Today, Canada has five working Canadians for each retiree (see Chapter 7 for more detail on "demographics"). As a result:

> The share of the population age 65 and over goes from its current 13 percent to more than 18 percent by 2020 and to 25 percent by 2040 while the number of seniors per working-age people rises from 18 percent to 28 percent then to 41 percent. [100]

Yet, Canada continues to fund health care from current tax revenues. In other words, tomorrow's surgeries and cancer treatments are primarily funded from today's calculations. The problem being that actuarial arithmetic reveals that this approach is similar to a ponzi scheme where the pyramid only survives as long as more and more individuals are recruited at the bottom rung to pay for expenditures at the top.

The problem or the challenge rests with ensuring that this financing burden does not disproportionately fall on successive generations who, given declining fertility rates, longer life expectancies and modest immigration levels will unquestionably have to pay more for health care.

But in another sphere, the federal and provincial governments have attempted through tax policy (RRSP contributions), fiscal policy (a 73% increase to CPP contribution rates over six years from 1997 to 2003) and the investment of CPP funds in the market to address the capitalization issue when it comes to the sustainability of the public pension system.

This was due in part to the realization stemming from the 15th report on the Canada Pension Plan (1995) in which the Chief Actuary estimated unfunded CPP liabilities in excess of $500 billion. In 1999, the Fraser Institute pegged the unfunded liabilities in the health care system at $1.277 trillion. [101] Which begs the question, if the government took timid steps to address the capitalization issue with the CPP, why hasn't the same logic been applied to health care where the capitalization threat is 2.5 times larger than the situation with the CPP in 1995?

The answer, unfortunately, is that medicare, while Canadian politicians like to call it an insurance plan, it is more akin to a welfare scheme. Insurance plans, by statute, must set aside pools of funds to account for unfunded liabilities and other unforeseen events, Canadian health care policy architects have chosen not to do this.

In summing up the structural flaws of medicare, economist Fred McMahon put it best:

> The system is so flawed it works only when flush with cash, as it was in its early days when a youthful population and relatively inexpensive care enabled a wealthy government, enriched by a growing economy, to overwhelm system flaws with the power of money. [102]

5.0 The Global Perspective

This section includes cross-national comparisons in the OECD, the World Health Organization (WHO) rankings, international models of health care organization and funding, and a snapshot of reform/delivery efforts in selected countries.

5.1 Canada and the World: OECD Data

The following tables, sourced form the OECD, employ traditional statistical measures to place the Canadian health system in the international context. [103]

	% GDP Spent on Health		% Pop'n w/ universal coverage	Infant Mortality deaths per 1000 live births		Life expectancy females		Life expectancy males	
Data Year	**1998**	**Rank**	**1997**	**1996**	**Rank**	**1997**	**Rank**	**1997**	**Rank**
Australia	8.6	8	100	5.8	16	81.3	9	75.6	6
Austria	8.0	15	99	5.1	10	80.6	12	74.3	16
Belgium	8.6	8	99	6.0	18	81.8	5	74.7	11
Canada	9.3	6	100	5.6	13	81.4	8	75.8	5
Czech Republic	7.1	19	100	6.0	18	77.5	25	70.5	26
Denmark	8.3	12	100	5.6	13	78.4	23	73.3	22
Finland	6.9	21	100	3.9	3	80.5	14	73.4	20
France	9.4	4	99.5	4.8	7	82.3	2	74.6	12
Germany	10.3	3	92.2	5.0	9	80.3	15	74.1	17
Greece	8.4	10	100	7.2	22	79.4	19	74.6	12
Hungary	6.8	22	99	10.9	27	75.1	29	66.4	29
Iceland	8.4	10	100	3.7	1	81.3	9	76.4	3
Ireland	6.8	22	100	5.5	11	78.6	22	73.4	20
Italy	8.2	13	100	5.9	17	81.6	7	75.3	8
Japan	7.4	18	100	3.8	2	83.8	1	77.2	1
Korea	5.1	28	100	7.7	25	78.1	24	70.6	25
Luxembourg	6.0	26	100	4.9	8	79.8	17	74.1	17
Mexico	5.3	27	72	17.0	29	76.6	28	72.0	23
Netherlands	8.7	7	74.6	5.7	15	80.6	12	75.2	9
New Zealand	8.1	14	100	7.3	23	80.1	16	74.9	10
Norway	9.4	4	100	4.1	5	81.0	11	75.4	7
Poland	6.4	25	100	12.2	28	77.0	26	68.5	28
Portugal	7.7	17	100	6.9	21	78.7	21	71.4	24
Slovakia	n/a	n/r	n/a	10.2	26	76.7	27	68.9	27
Spain	7.0	20	99.8	5.5	11	82.0	4	74.6	12
Sweden	7.9	16	100	4.0	4	81.8	5	76.7	2
Switzerland	10.4	2	100	4.7	6	82.3	2	76.2	4
Turkey	4.8	29	66	42.2	30	70.8	30	66.2	30
United Kingdom	6.8	22	100	6.1	20	79.7	18	74.6	12
United States	12.9	1	45	7.3	23	79.4	19	73.6	19

In 1998, Canada ranked 6th (9.3%) among the OECD nations after the United States (12.9%), Switzerland (10.4%), Germany (10.3%), and Norway and France (tied at

9.4%), in terms of health expenditures as measured as a percentage of GDP. This analysis also reveals that despite Canada's wealth, we still rank only in the middle of the pack, 13th place, in terms of infant mortality rates. On another front, although Japan commits only 7.4% of its GDP to health (18th place), it ranks 1st overall in life expectancy for both women and men.

Going further, a comparative analysis of specific health system stats for member OECD nations yields other interesting results.

	Doctors per 1000 population		Beds per 1000 population		Admissions per 1000 population		Length of stay per 1000 population	
Data Year	**1997**	**Rank**	**1997**	**Rank**	**1997**	**Rank**	**1997**	**Rank**
Australia	2.5	18	8.3	8	163	10	15.8	3
Austria	2.9	15	9.1	5	266	2	9.7	13
Belgium	3.7	3	7.3	12	n/a	n/r	11.1	8
Canada	2.1	22	4.4	19	97	19	8.4	16
Czech Republic	3.0	11	9.0	6	211	5	11.8	7
Denmark	3.3	5	4.6	18	199	7	7.1	20
Finland	3.0	11	7.9	11	267	1	11.1	8
France	3.0	11	8.6	7	231	4	10.7	10
Germany	3.4	4	9.4	4	200	6	12.5	6
Greece	4.1	2	5.0	16	n/a	n/r	n/a	n/r
Hungary	3.1	8	8.1	9	245	3	9.8	12
Iceland	3.3	5	n/a	n/r	n/a	n/r	n/a	n/r
Ireland	2.1	22	n/a	n/r	149	13	7.6	18
Italy	5.8	1	5.8	14	184	8	8.1	17
Japan	n/a	N/r	16.4	1	95	20	42.5	1
Korea	1.2	26	4.8	17	n/a	n/r	13.0	5
Luxembourg	3.0	11	8.1	9	n/a	n/r	n/a	n/r
Mexico	1.6	25	1.1	25	61	22	4.2	24
Netherlands	n/a	N/r	11.3	3	110	18	31.7	2
New Zealand	2.2	21	6.1	13	136	14	6.6	21
Norway	2.5	18	14.7	2	159	11	9.3	14
Poland	2.4	20	5.4	15	135	15	10.4	11
Portugal	3.1	8	4.1	21	118	17	9.3	14
Slovakia	n/a	N/r	n/a	n/r	n/a	n/r	n/a	n/r
Spain	2.9	15	n/a	n/r	n/a	n/r	n/a	n/r
Sweden	3.1	8	4.0	22	n/a	n/r	6.6	21
Switzerland	3.3	5	n/a	n/r	175	9	14.7	4
Turkey	1.2	26	2.5	24	69	21	6.1	23
United Kingdom	1.7	24	4.4	19	151	12	n/a	n/r
United States	2.7	17	3.9	23	126	16	7.3	19

Canada is in the middle in most of these statistical categories among its OECD peers ranking 22nd (2.1) in doctors per 1,000 population, 19th (4.4) in beds per 1,000 population, 19th (97) in admissions per 1,000 population and 16th (8.4) in length of stay per 1,000 population.

International data is also useful for planning purposes. For example, the table below shows the trend and pace of the ageing population (% of the population over age 65) for OECD nations over the past 40 years. Canadian policy makers need to examine countries such as Italy, Sweden, Germany and Greece to investigate the stress that the ageing population is putting on their health care systems to see if best-practice service delivery and cost mitigation strategies can be adapted to our environment.

Data Year	1960	1970	1980	1990	1995	1998	1998 rank
Australia	8.5	8.3	9.6	11.1	11.9	12.2	22
Austria	12.2	14.1	15.4	15.1	15.1	15.4	11
Belgium	12.0	13.4	14.4	14.9	16.1	16.5	5
Canada	7.6	8.0	9.4	11.3	12.0	12.3	21
Czech Republic	9.6	12.1	13.5	12.5	13.2	13.7	18
Denmark	10.6	12.3	14.4	15.6	15.3	14.9	14
Finland	7.3	9.1	12.0	13.4	14.2	14.7	15
France	11.6	12.9	13.9	14.1	15.2	15.8	8
Germany	10.8	13.2	15.5	15.3	16.1	16.6	3
Greece	8.1	11.1	13.1	14.0	15.6	16.6	3
Hungary	n/a	n/a	n/a	n/a	14.1	14.5	16
Iceland	8.1	8.9	9.9	10.6	11.3	11.5	25
Ireland	10.9	11.2	10.7	11.4	11.4	11.4	26
Italy	n/a	n/a	13.2	14.9	16.6	17.6	1
Japan	5.7	7.1	9.1	12.1	14.5	16.2	7
Korea	2.9	3.1	3.8	5.1	5.9	6.6	28
Luxembourg	10.8	12.6	13.6	13.4	14.1	14.3	17
Mexico	n/a	3.7	3.8	4.2	4.7	5.1	30
Netherlands	9.0	10.2	11.5	12.8	13.2	13.5	19
New Zealand	8.7	8.4	9.7	11.1	11.5	11.6	24
Norway	10.9	12.9	14.8	16.3	15.9	15.6	10
Poland	5.8	8.2	10.1	10.1	11.1	11.8	23
Portugal	n/a	n/a	11.6	13.4	14.6	15.1	12
Slovakia	6.7	9.2	10.4	10.3	10.9	11.2	27
Spain	8.1	9.4	11.2	13.6	15.3	16.3	6
Sweden	11.8	13.7	16.3	17.8	17.5	17.4	2
Switzerland	10.2	11.4	13.7	15.0	14.7	15.1	12
Turkey	3.7	4.4	4.7	4.0	4.7	5.2	29
United Kingdom	11.7	13.0	15.0	15.7	15.7	15.7	9
United States	9.2	9.8	11.2	12.4	12.5	12.4	20

5.2 Canada and the World: The WHO Analysis

In mid-June 2000, the World Health Organization released its first-ever comparative analysis of 191 national health systems in operation around the globe which Dr. Hugh Scully, then president of the CMA, termed a "wake up call" for Canada. The WHO analysis determined that Canada ranked 30th in terms of overall health system performance.

This analysis prompted the *Sudbury Star* to write in an editorial:

> Would you rather have a heart attack in downtown Toronto or Malta? Where do you think you'd stand a better chance at survival? Well if you consider the World Health Organization to be a reliable judge of health-care systems, then the correct answers should be the Mediterranean Island not somewhere near the corner of Queen and Yonge Streets. [104]

WHO ranked national health systems by various measurements including overall health system performance and system responsiveness.

In terms of **Overall Health System Performance**[105], the top countries were:

1 -	France	7 -	Spain
2 -	Italy	8 -	Oman
3 -	San Marino	9 -	Austria
4 -	Andora	10 -	Japan
5 -	Malta	30 -	Canada
6 -	Singapore	37 -	United States

In terms of **System Responsiveness**[106] (over 2000 key informants evaluated national systems on the basis of dignity, autonomy, confidentiality, prompt attention, quality of basic amenities, access to social support networks during care and choice of care provider),[107] the rankings were:

1 -	United States	6 -	Japan
2 -	Switzerland	7 -	Canada
3 -	Luxembourg	7 -	Norway
4 -	Denmark	9 -	Netherlands
5 -	Germany	10 -	Sweden

The WHO report ranked Canada 12th in terms of life expectancy, 12th in terms of the health of our population and 18th in terms of the distribution of equitable health across the population. A *Southam News* story on the report's findings succinctly summed up the message for Canadians:

> Christopher Murray, director of WHO's Global Program on Evidence for Health Policy was blunt in his assessment of the findings. "According to this report, Canada does not have the best health care system in the world," Mr. Murray said. [108]

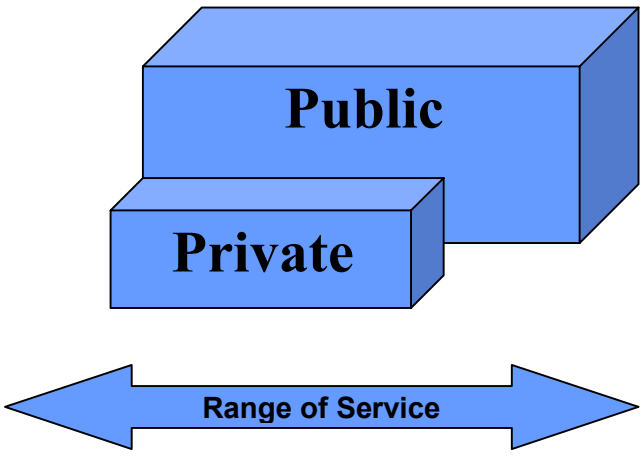
5.3 Organizing and Financing a Health Care System

According to WHO, health services can be organized in three fundamental forms: hierarchical bureaucracies, long-term regulated contracting authorities or shorter-term market based interactions. Overlaid on top of these organizational forms, is the crucial payment or financing function.

Given that the coming debate in Canada will be partly about finding the appropriate mix between public and private financing, it is useful to turn to the work of University of Toronto Professors Carolyn Tuohy and Colleen Flood for guidance.

> In very simplified terms, there are four models for structuring the relationship between public and private finance in health care:
>
> **Parallel public and private systems:** For a given range of services a separate, privately financed system exists as an alternative to the public sector and without public subsidy.
>
> **Co-payment**: Across a broad range of services, financing is partially subsidized through public payment, with the remainder financed through out-of-pocket payments and/or private insurance. The degree of co-payment may be scaled according to the income of the patient.
>
> **Group based**: Certain population groups are eligible for public coverage; others rely on private insurance.
>
> **Sectoral:** Certain health care sectors are entirely publicly financed; others privately financed. [109]

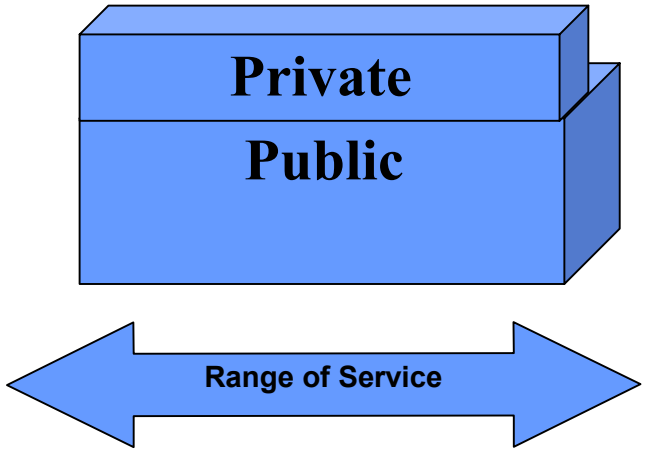
Parallel



Countries where this public/private financing split is employed include:

- Britain
- Australia (Hospitals)

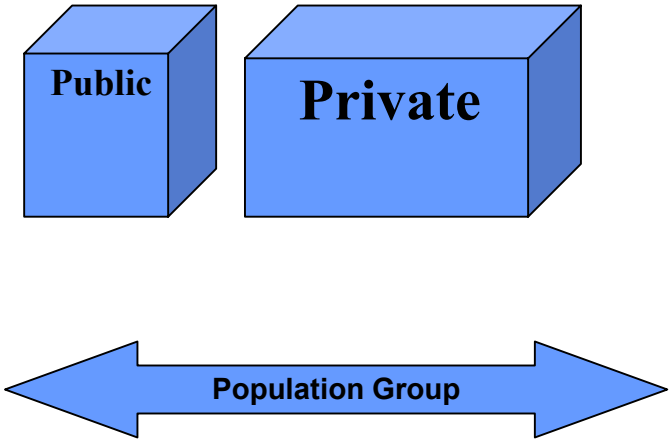
Co-payment



Countries where this public/private financing split is employed include:

- Australia (Medical)

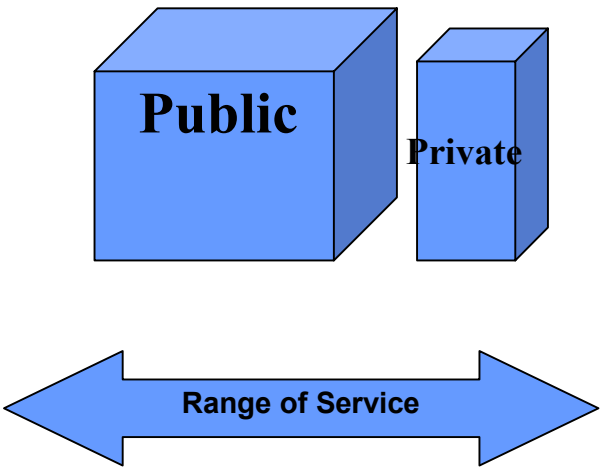
Group-based



Countries where this public/private financing split is employed include:

- United States
- Germany
- Netherlands
- Australia (insurance)

Sectoral



Countries where this public/private financing split is employed include:

- Canada

Given the extent of detailed discussion about the Canadian environment in other chapters of this paper, a further overview is unwarranted.

Australia [**]

Population (1999):	18,705,000
GDP on health (1998):	8.6 %
Public share:	72.0 %
Private share:	28.0 %
Public satisfaction:	Not available

Commonwealth funding (the federal level) is provided to the states in block or envelope fashion under indexed, five-year agreements. The Australian system is a combination of models. Its medicare program provides access to hospital and medical services to all Australian citizens and permanent residents. Universal, first-dollar coverage is available to all in-patients in public hospitals. Patients can be treated as "public" or "private" patients in public hospitals: being treated as a "public patient" comes with no choice of doctor and the doctor's salary is paid by the hospital. Being treated as a "private patient" in a public hospital comes with a choice of physician and more amenities, but at added cost.

As well, Australians can opt for treatment in private hospitals, the majority of expenses being covered by private insurance and out-of-pocket payments. In this sense the hospital sector can be defined as a **parallel** system.

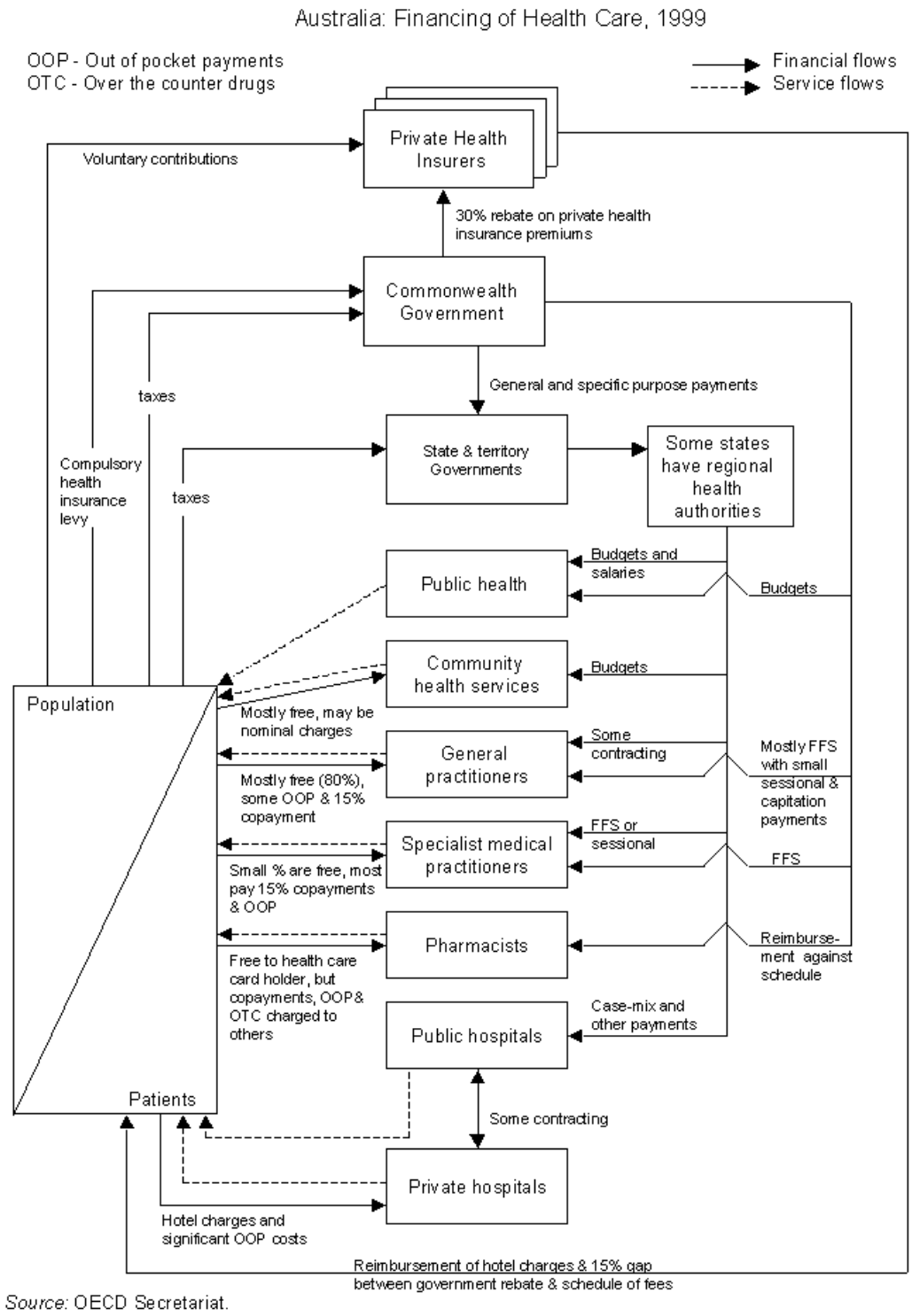
Medical services are delivered on a fee-for-service basis. Physicians can "bulk bill' the medicare plan for patient services at 85% of the fee service schedule. In this arrangement they cannot extra-bill patients. Or physicians can bill patients directly at their discretion with medicare paying 85% of the fee schedule. The remainder is paid out-of-pocket or by insurance coverage. The exception here is direct billing for hospital services for "private patients" in public or private hospitals, where only 75% of the scheduled fee is paid. In this sense, medical services can be defined as employing the **co-payment** model.

Co-payment also exists for pharmaceuticals with appropriate income-testing measures and overall caps that minimize excessive cost exposure. Insurance can also cover drug costs for the co-payment portion. Insurance premiums are regulated and community rated (meaning differential premiums are forbidden). As of June 1999, 44 of these plans existed with four operating on a for-profit basis. About 16 plans were group specific (i.e.: military personnel, etc.) with the rest open to the public. Insurance is therefore organized on the **group-based** model.

Recent efforts to increase insurance purchase participation include a 30% refundable tax credit and a "Lifetime Health Cover" plan to encourage younger Australians to purchase insurance with lower premiums.

[**] Data for all country profiles taken from various sources: population (WHO 2000 Report), % GDP (OECD Health Data, 2001), Public and private share – Marigold Foundation (*Beyond the public-private debate*, July 2001) or the Kirby Senate Committee, and public satisfaction ranking (% saying they were fairly or very satisfied with their health system) from the OECD web site. All country profile descriptions draw heavily on the work of the Marigold Foundation and work done by Professors Tuohy and Flood.

Graphic: Australian System



Source: OECD Secretariat.

Great Britain

Population (1999):	58,744,000
GDP on health (1998):	6.8 %
Public share:	84.0 %
Private share:	16.0 %
Public satisfaction:	57.0 %

The British National Health System (NHS) is based on the principles of ***equity, comprehensiveness,*** and ***no charge at the point of service.*** It has undergone fundamental change over the past decade, first, with reforms brought in by the Thatcher administration in 1990, and more recently with modifications made by the Tony Blair Labour government in 1999. The system is funded primarily through tax collections with 11% of the British population also covered by supplementary private insurance.

Prior to 1990, the Department of Health allocated budgets to 14 regional health authorities (based on previous years costs plus inflation and other adjustments including the authority's size, population age strata and overall health), which in turn disbursed funds to 145 district health authorities who were responsible for and managed the activities of public hospitals and family practitioner committees (which in turn paid doctors).

The *National Health Service and Community Care Act (1990)* basically abolished this system in favour of "internal market" reforms designed to introduce more choice and competition into the system. The NHS itself continues to be financed through taxes (therefore subject to global budget and national fiscal policy cost constraints) but its internal service delivery and funding activities took on the form of a regulated market.

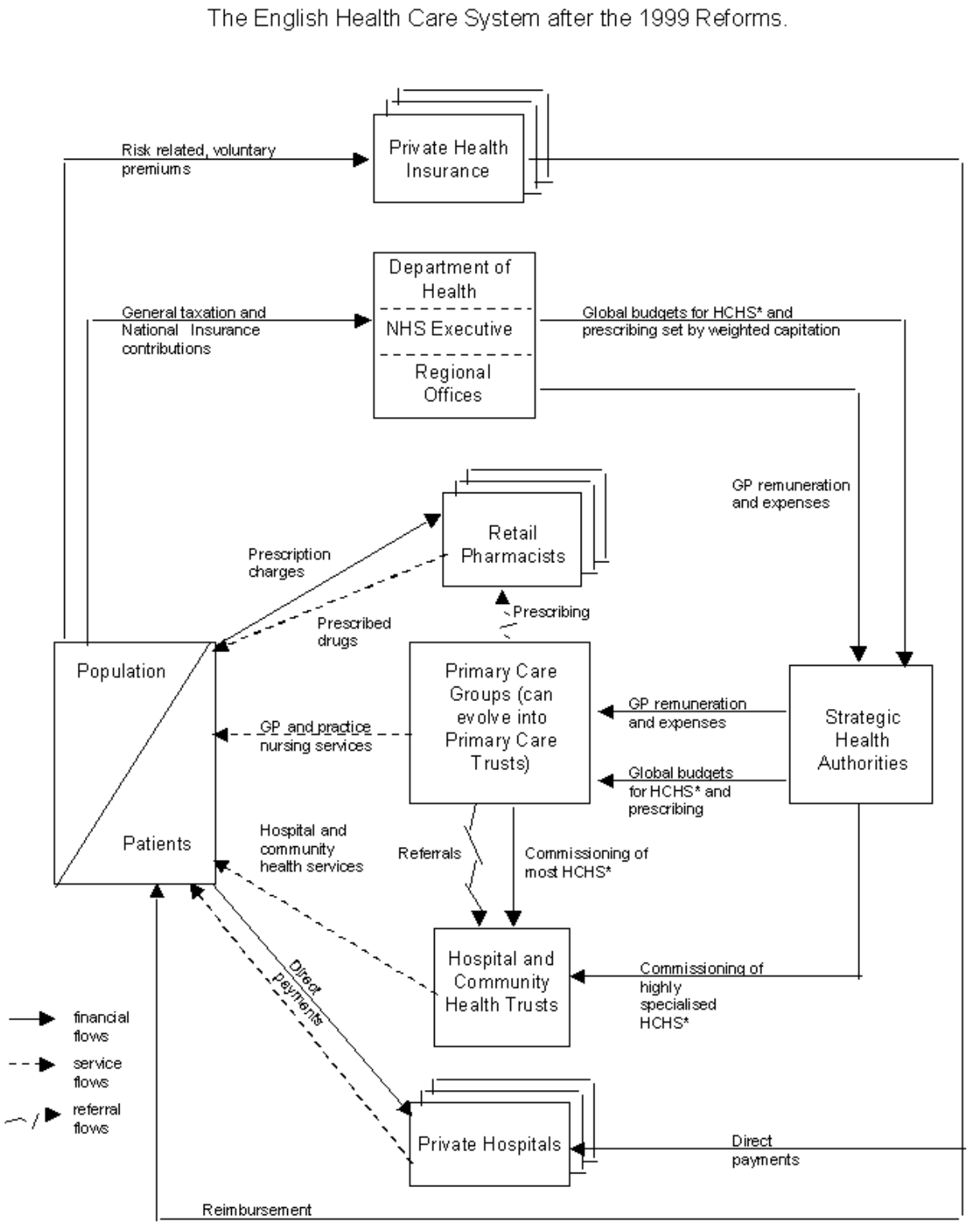
Internal market reforms entailed:

1) Creating a purchaser-provider split;
2) Transforming hospitals into self-governing NHS trusts (quasi crown corporations) which competed for funds/contracts from health authorities and doctors; and
3) Doctors had the option of becoming fundholders to not only treat patients but also purchase limited services (elective surgery, etc.) for their patients.

Providers of services were forced to compete with each other for contracts so district health authorities (now 100) could choose between NHS trusts on the basis of price, value, and range of service offerings. Simultaneously, fundholders could compete for services from health authorities and also purchase services from NHS trusts.

The Labour government has effectively continued the internal market reforms although Thatcher-esque terms of contracting and purchasing have been replaced by partnership and commissioning. However, patients can no longer choose their doctors and instead will be enrolled in primary care groups that will eventually become primary care trusts. A smaller coterie of private services still exist in Britain for de-listed procedures, cosmetic surgery and long-term care. In this sense, the British health care environment is a **parallel** system.

Graphic: British System



*HCHS: Hospital and Community Health Services

Source: Department of Health, England.

Germany

Population (1999):	82,178,000
GDP on health (1998):	10.3 %
Public share:	75.0 %
Private share:	25.0 %
Public satisfaction:	58.0 %

Bismarck's (1883) system of statutory health insurance (SHI) comprised of competing sickness funds has essentially lasted for over a century. Between 86% and 88% of the German population are enrolled in sickness funds that are self-administered, non-profit organizations. These funds are financed through matching contributions by employers and employees.

Less than 10% of the funds are run by private insurance companies and according to the C.D. Howe Institute (1994), Germans had a choice of over 1,270 funds from which to choose. About 9% of Germans above a pre-set income threshold have chosen to opt out of the sickness funds and purchase private insurance where premiums are a function of private market dynamics, based on age, gender, and health history.

Sickness funds cover about 61% of all health expenditures and are **group-based** around:

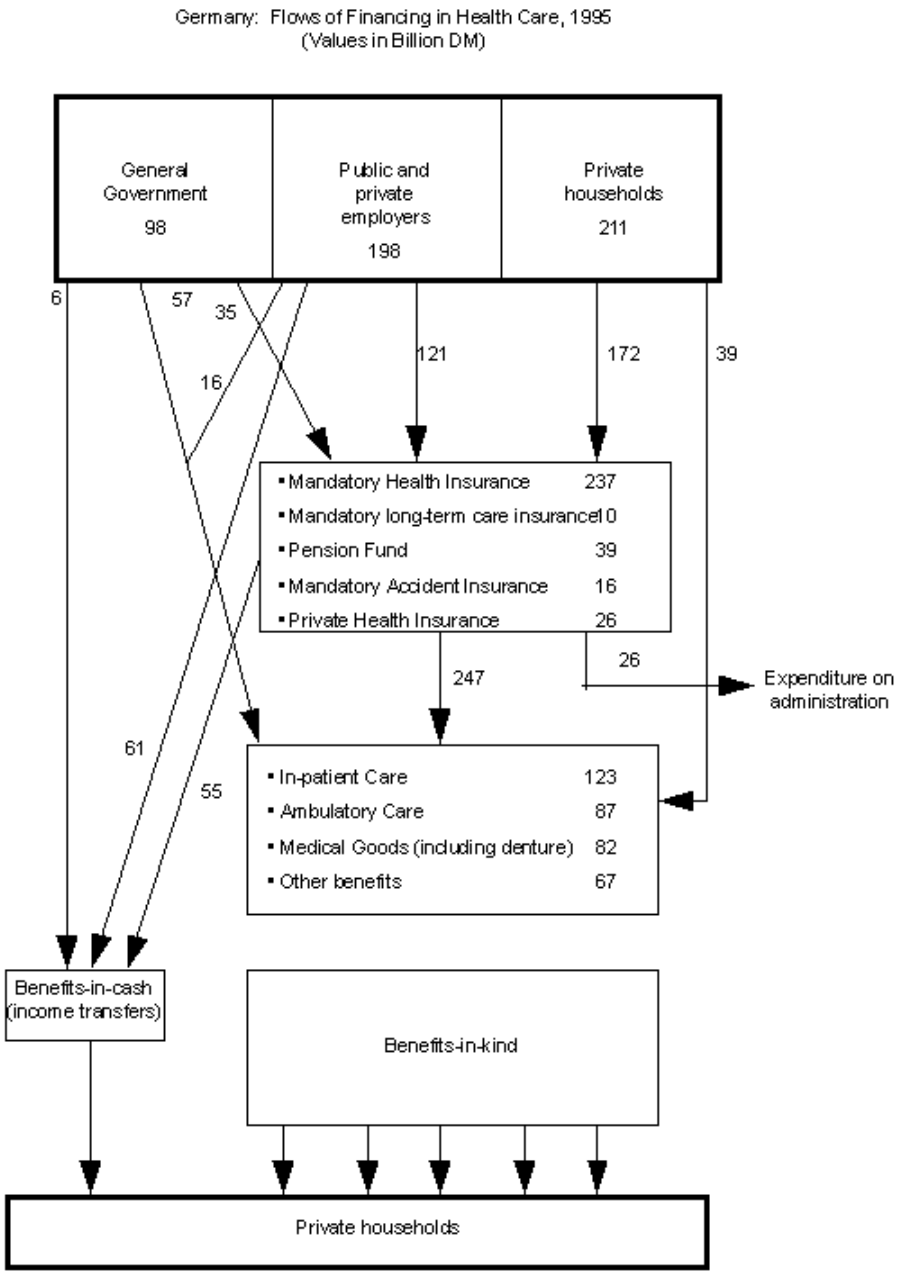
- Skilled crafts in each region (guild funds);
- Firms, where employees or retirees of a company are covered (factory funds);
- Agrarian measures, where agricultural workers in a region are covered (agricultural funds); and
- Regional populations who are not covered by another fund (general fund).

Sickness funds negotiate with primary care physicians, specialists and hospitals to determine fee schedules. Historically a high degree of separation existed between primary care providers in ambulatory settings and physicians and allied health professionals that practiced in hospitals.

In 1995, legislative changes enabled long-term care insurance to cover homecare and other non-institutional types of community care as opposed to pure long-term care just in hospitals. Further reforms are now underway to better integrate the activities of doctors, ambulatory specialists and hospitals.

Approximately 61% of German health expenditures are covered by the sickness funds, 7% from private insurance, 20% from taxation revenues, and about 12% from out-of-pocket payments. Similar to Canada, the German federal government is responsible for the health care regulatory framework while the Lander (provinces) are responsible for health care delivery. Hospitals are run by community groups, faith based organizations, local governments or the Lander.

Graphic: German System



Source: Adapted from Federal Office of Statistics, 1998

Note: The Benefits-in-Cash which are not included in most of the diagrams are included here

Netherlands

Population (1999):	15,735,000
GDP on health (1998):	8.7 %
Public share:	72.6 %
Private share:	27.4 %
Public satisfaction:	70.0 %

When describing the Dutch system, it should be noted up front that while the OECD measures the public share at 72.6%, it is a touch misleading as the Dutch government contributes less than 15% in direct taxation revenues. There are actually five main financing/insurance pillars in the Dutch system:

- sickness funds (similar to Germany);
- private health insurance;
- a compulsory, private scheme for government employees and their families;
- public health services; and
- the Exceptional Medical Expenses Fund.

Over 60% of the population is covered by sickness funds while 33% of the population have been expelled [*] from the funds and can buy private insurance. The remaining 7% are covered by government employee plans. The sickness funds are financed through employee and employer contributions, in effect, a payroll tax.

The Dutch can purchase coverage (uniform premiums in each fund) from some 25 regionally based funds and the 33% who have been expelled can choose from over 53 private insurers. These funds cover primary and secondary care expenses plus pharmaceuticals.

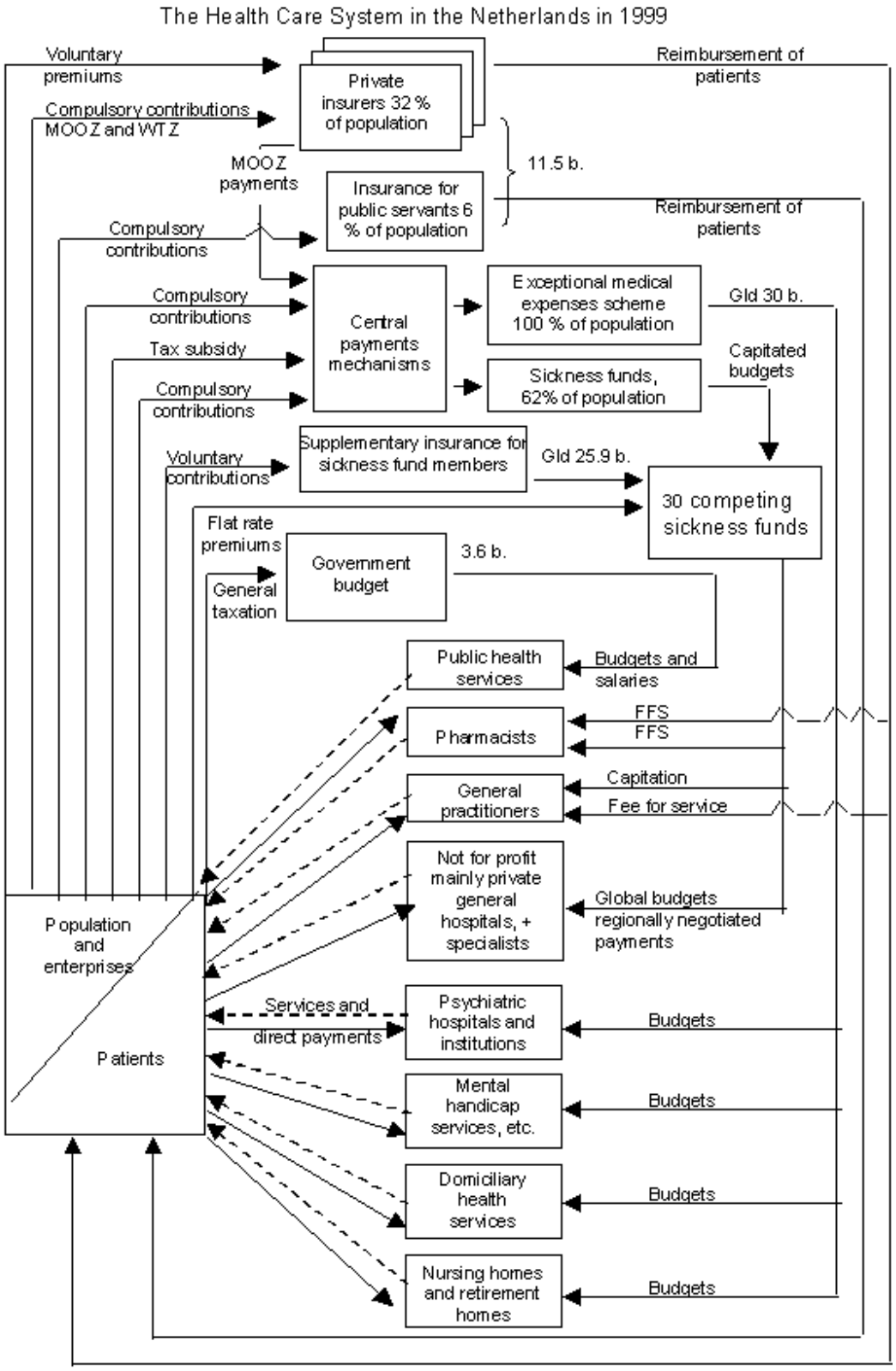
The Exceptional Medical Expenses Fund is paid for by employers and contributions are a function of employee wages. Retirees and the unemployed contribute through clawbacks on their benefit entitlements. This fund covers all catastrophic expenses and accounted for almost 45% of health care spending in 1998. Shortfalls are financed from general taxation revenues.

Similar to Canada, hospitals are operated as private, not-for-profit corporations. Doctors who treat patients covered by sickness funds receive a salary. Doctors who treat citizens covered by private insurance bill on a fee-for-service basis.

While some market mechanisms have been introduced such as allowing sickness funds to compete nationwide as opposed to being confined to regions along with changes to the premium structure, the entire system is still heavily regulated and monitored by the government. The Netherlands employs a **group-based** model.

[*] According to the Heritage Foundation, once individuals pass a defined income threshold, they are expelled from the sickness fund system and may buy private insurance, if they so desire.

Graphic: Dutch System



Source: Adapted from *The Reform of Health Care - A Comparative Analysis of Seven OECD Countries*, Health Policy Studies No. 2.

Singapore

Population (1999):	3,522,000
GDP on health (1998):	3.1 % [*]
Public share:	35.8 %
Private share:	64.2 %
Public satisfaction:	Not available

In Singapore, the system places considerable emphasis on personal and generational responsibility for health expenditures. At the primary care level, citizens can visit private clinics (1,900) or government polyclinics (16). For secondary and acute care, private and public hospitals exist. And in each domain the 80/20 rule is in effect.

	Private provision	Public provision
Primary care	80%	20%
Secondary/acute care	20%	80%

On the public side, primary care is provided at 50% of the cost, citizens pay the rest. In public hospitals (5 acute care, 2 obstetrics related, 1 community-style and 5 specialty clinics), citizens pay full cost for Class A coverage (which we would term a fully-private room) to Class C (ward style) where they pay 20% of the cost; the government picks up the other 80%. Levels of care are comparable for all "classes" and low-income individuals are eligible to receive partial or full cost re-imbursement depending on circumstances. On the public hospital side a **co-payment** model is in use.

In private hospitals (13) and primary care settings, billing is on a fee-for-service or daily basis. While fees are not regulated, the public fee schedule serves as a floor from which most private prices are then determined.

Three government programs exist to help offset financing of health care: Medisave, Medishield and Medifund. A new program, Eldershield will be introduced in the 2nd quarter, 2002.

Medisave (part of the Central Provident Fund) is compulsory, and while available for hospital costs throughout one's lifetime, it is geared toward offsetting health costs in later life. It is true pre-funding. Employees and employers contribute up to 40% of an employee's income as Medisave is also used for general retirement expenses and housing needs. Citizens can withdraw for health costs to a preset maximum. Medishield (1990) provides supplementary coverage on top of Medisave.

Medifund is basically a general welfare scheme that offsets costs for the poorest and disbursements are paid out to institutions and providers. In terms of financing, Singapore best resembles a **group-based** model.

[*] Singapore %GDP and public-private split data taken from *World Health Report: 2000*. The Marigold Foundation report was used extensively in this section as most other literature on Singapore (predominantly American) focuses solely on medical savings accounts and discounts the analysis of the entire system.

5.4 Commonalities

In the five countries profiled, several common traits emerge:

- Each country seems to embrace a balanced mix of public and private financing and service provision;
- Each country has implemented structural or sectoral reform changes in the last decade;
- Varying degrees of co-payment exist across most income groups except for the poorest who are funded and assisted through a large risk pool cross-subsidized (either by taxes, premiums or both) by other citizens and residents; and
- Universality (or solidarity) seems to be the principle applied in all systems but with varying degrees of comprehensiveness.

Unfortunately, only Singapore totally addresses the issue of individual responsibility for health care costs throughout one's lifespan with compulsory pre-funding of future expenses.

Singapore has ostensibly eliminated the unfunded liabilities that are inherent and problematic in most other national health systems. Other nations have fundamentally settled for pay-as-you-go approaches and/or pooling of generational risk issues.

6.0 The Canadian Debate

As already noted in several passages in this paper, our national debate to date on real health care reform (governance, financing and delivery) has been twisted into a binary, emotive and ill-informed morass. The debate is comprised of three basic dimensions:

- Myths and distortions;
- Issue prominence; and
- Stakeholder entrenchment.

6.1 Myths Deserve a Reality Check

Part of the problem with the health care debate is that the lens through which many Canadians have viewed it is limiting and crowded.

It is limiting in terms of the pithy eight-second sound bites on television news that advocates, on one side of the reform divide or the other, are forced to explain health care issues. Although other media such as newspapers and the Internet exist to broaden the scope of the debate, in this visual age, the television is often the first and sometimes only source Canadians consult for news.

The health care debate is crowded and predictable, similar to our constitutional quagmire: every time the issue gains altitude on the public policy radar screen, the same pundits and public policy surrogates show up to fly. As *Ottawa Citizen* writer Mark Kennedy pointed out earlier, even if the political actors change, the script resembles another Rocky movie. Same old, same old.

What is important to note is the phrase employed in paragraph one above, Canadians have ***viewed*** this debate, now it's time to participate. In order to do so effectively, it is important to dispense with some of the common myths that have been repeated so often that they have become congenial truths.

Myth #1: Canada has the best health care system in the world

While politicians continue to spew out this gibberish, public opinion polling reveals that fewer Canadians are apt to believe this statement. As shown in Chapter 5 of this report, on seven different measurement criteria, Canada did not score any higher than 7th place in the 2000 WHO Health Report. Indeed, we finished 30th overall.

> **Reality check:**
> In order to advance the health care debate, Canadians should challenge this "best system in the world assertion" at every turn. Ask the proponent by what measure(s) is Canada the best? What reputable global survey supports this conclusion?

Myth #1 is an assertion of opinion, not an empirical statement of fact.

Myth #2: The American system is a free-market unregulated bazaar

Part and parcel of the U.S. vs. Canada as the only two models of health care delivery in the universe argument, the binary types usually throw in aspersions about the unregulated, dog eat dog world, only the rich survive nonsense. This vitriol usually manifests itself in varying permutations of the myth above.

However, according to the OECD, 55% of health care spending in the U.S. is private, with the other 45% coming from the public sector. In addition, the oldest (and disabled) and the poorest Americans are covered by Medicare (a federal program) and Medicaid (administered by the States) respectively. Twenty five percent of Americans list either of these two programs as their primary sources of health insurance. Finally, a variety of statutes at the federal and state level cover everything from insurance premiums to designating primary care givers to dictating what core services HMOs must cover. [*]

> **Reality check:**
> To ensure a rationale discussion of differences in approach in North America, this hyperbole cannot be left unchallenged. Simply ask who regulates insurance companies? What professional bodies accredit health care practitioners? What statutes exist governing health care service delivery? If the system is unregulated then the answers to these questions should be: no one, no group and none. Of course such answers would be patently untrue.

Myth #2 is a demonstrable falsehood, not an empirical statement of fact.

Myth #3: The Canadian system is a public system with public providers

Turning to CIHI data, it is true that Canadian health care is predominantly publicly financed at 71% compared to 29% private financing. However, doctors, dentists, hospitals, laboratories, and walk-in clinics are private operations. In addition ambulance services, physiotherapy centres, vision care and homecare services can also be privately provided.

> **Reality check:**
> Simply ask proponents of this argument for what government department does their doctor work? Or ask them who paid the lab technician who drew blood at the local clinic during their last physical: the government or a private company?

Myth #3 is also a misconception and the point in refuting it is to show that we have a mixed system, public administration with a variety of private providers.

[*] Adapted from the work of Dr. David Gratzer. For a further debunking of anti-American health care myths, refer to Chapter 3.5 of *Code Blue* by Dr. Gratzer.

Myth #4: Canadians have access to some of the best technology in the world

This is not something you would want to tell to people who wait weeks for sleep deprived EEGs (a brain wave scan), months for CT scans or sometimes up to a year for an MRI scan.

If you visit the Ottawa area don't say this too loudly to anyone waiting to have kidney stones crushed. Private funds were raised to purchase a lithotriptor (a machine that crushes kidney stones using ultrasound), however, at last report, the Ottawa Hospital couldn't convince the Ministry of Health to fund technicians to operate the machine.

Due to cost cutting and the delay of capital acquisitions in every province, when it comes to MRIs for example, we fare poorly compared to other OECD nations. Canada has only 1.7 MRI units per million population.* Only Poland, Greece, Hungary, the Czech Republic and Slovakia are worse off for MRIs than Canada. The United States, Japan, Iceland, Korea, Turkey, Luxembourg, Great Britain and 13 other OECD nations better serve their populations in this category.

> **Reality check:**
> MRIs are just one example where this myth is laid to rest. From seismic equipment in B.C. Hospitals to much needed dialysis equipment in Ontario, Canadians are not getting the consistent access to the latest proven technologies.

Myth #4 also indirectly points to the issue of waiting lists. While Canadians do have access to some technology, it doesn't rate amongst our international peers, and theoretical access – in reality – is denial by rationing.

Myth #5: Canadians will not accept more private service and/or financing options

Increasingly – as the polling data in Chapter 3 reveals – Canadians are open to discussing and debating the merits of private service and/or financing options. Indeed, this is what entire debate on the future of health care is about, choosing among competing options.

> **Reality check:**
> This myth has neither been proven nor disproved. However, it is clear that Canadians yearn for this debate, including the federal Minister of Health who stated during the news conference to announce the appointment of the Romanow Commission:

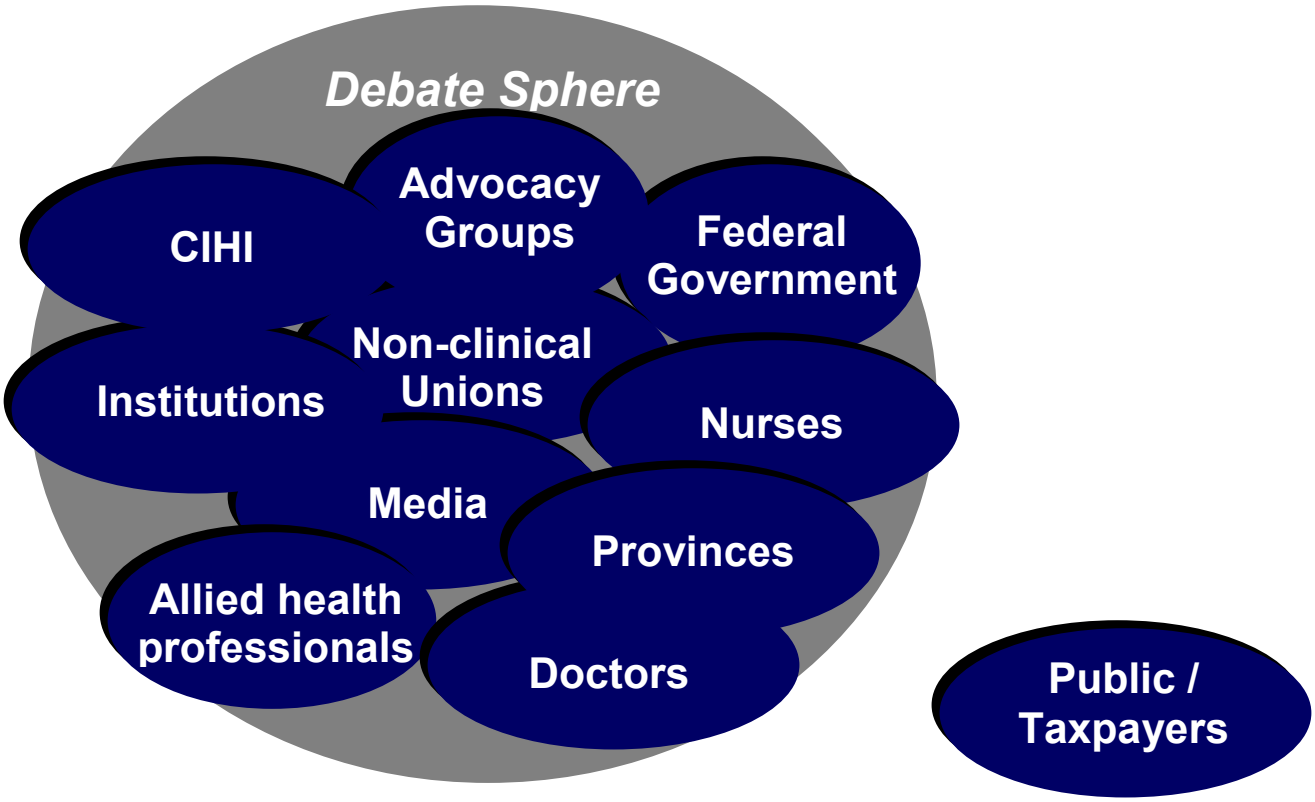
> It is time for dialogue on choices for the 21st century – based on real and serious Ideas, not empty sound bites. [110]

* This OECD statistic taken from BCMA publication *Turning the Tide, I of II*.

6.2 The Stakeholders

In one sense, 31 million Canadians are the ultimate stakeholders in the health care debate. However, as a Pollara poll in late 2000 found: 64% of Canadians believe they have had insufficient input into shaping health care decisions. As noted in the previous myths section, this is due in part to the dominant role that established stakeholders have played in monopolizing the discussion about the future of health care.

The graphic below illustrates the major actors in the debate sphere and the positional placement for the general public that reflects their frustration as captured by Pollara.



While the sphere does not capture all stakeholders in the debate, it does reflect the multitude of interests involved. Moreover, it is a fair depiction, based on polling data, to lump general public/taxpayer input, influence and satisfaction outside of the sphere at this time.

For the health care debate to be truly successful, the general public (complete with the conflicts between population sub-sets) must demand – through continuous intervention – that their rightful place be in the middle of the debate sphere and that all other stakeholders acknowledge this necessity for success. As simultaneous funders and consumers, there is no other position than that of pre-eminence for the public to occupy in the coming debate.

6.3 The Issues

The demands and desires of many of the stakeholders identified above are well documented through their organizational websites, publications and professional associations (where applicable) and do not warrant repetition in this paper. However, a high-level overview of the main issues in the health care debate and a brief description of each are warranted.

The CTF scanned in excess of 1,000 newspaper stories from major national and regional daily newspapers (in both languages) in the last twelve months to compile the following list of the top 21 (as measured by print coverage) component issues (listed in alphabetical order) in the health care debate. A summary of and/or commentary on each issue is provided.

Canada Health Act

The bulk of this discussion has been captured in Chapter 3 of this report. The relevance of the Act and its principles continue to be questioned. Defenders of the current health care system use it as a shield to repel all who dare to suggest improvements, modernization or discussing greater private sector participation in the delivery of health services. The CHA is also raised in the context of federal intrusion into the provincial constitutional jurisdiction of health care.

The Canadian vs. The U.S. system

Reflecting the narrowness of the health care debate in political circles, the Canadian vs. U.S. system choice is discussed as the two probable outcomes of health care reform. Increasingly, editorial opinion and public opinion is denouncing this myopic view of our health care reform options.

CIHI – Canadian Institute for Health Information

Founded in 1994, CIHI has been releasing annual reports since the spring of 2000 which amass and interpret data from all provinces concerning health care activity ranging from physician billings to surgical outcomes.

On a positive note, CIHI is effectively marketing its data for broad public consumption and increasingly health care economists, researchers, advocacy groups and professional associations are all using this data for base measures and statistical comparisons.

However, some health economists lament the time-insensitive nature of some CIHI data because CIHI does not have the legislative authority to demand adherence to collection schedules in contrast to the power Statistics Canada has at its disposal.

CHST Funding (Provincial Demands)

As discussed in Chapter 4.1 of this report, the provinces continue to demand full restoration of the CHST transfers cut by Ottawa in 1996. While they have made some progress in recent federal budgets, this is still a point of friction between the federal government and the provinces. However, the public has rightfully tired of this argument and views the CHST cuts issue as water under the bridge. This reality was clearly exhibited by Canadians who responded to the premier's calls for an additional $7 billion in CHST transfers this past summer with a collective yawn.

Clair Commission (Quebec)

Established by the Quebec government in June 2000, the Clair commission conducted a province-wide research effort and inquiry into the future of the Quebec health care system. Most notable amongst its recommendations in January 2001 was the recognition that pre-funding health care expenditures for ageing baby boomers was an essential strategy for dealing with the cost pressures this demographic group would place on the provincial health and social services system in the near future.

Demographics

A fuller discussion of demographic implications for the health care system is found in Chapter 7 of this report. The demographic issue, specifically the strain that a burgeoning seniors population will place on our health care system in the next quarter century, has been hotly debated. One school of thought – espoused by those who favour top-down bureaucratic tinkering strategies for health care reform – minimizes the impact that an ageing population will have on our system and collective ability to finance health care. They point to better pharmaceuticals and a healthier seniors population as evidence and justification for their "care free" attitude.

The other school of thought points to actuarial projections, current cost trends, increased use of expensive technological interventions and treatments along with future workforce projections to sound a more urgent alarm about demographic pressures in the near, medium and long-term. Adherents to this school of thought include market-based reformers, the provincial premiers, and a coterie of reputable actuaries (those whose profession is to understand the financial ramifications of future trends).

Diseases

With the ageing population comes the progression of the diseases of ageing. Included in this group are heart disease, cancer (expected to afflict one in three Canadians in the next 10 to 15 years), Alzheimer's and other brain protein related ailments. As well advocacy groups for kidney patients and arthritis sufferers have garnered a fair amount of media coverage in the last year.

The other areas of disease that have captured public (or continue to capture) attention include HIV/AIDS, hemorrhagic fevers and superbugs with their resistance to aggressive antibiotics therapy.

Drugs / Pharmacare

The debate on drugs can also be divided into various sub-parts.

The wide-scale use of pharmaceuticals continues to cause some concern, especially the costs of drugs to provincial insurance plans. Physician over-prescription of antibiotics along with incorrect consumption by the public continues to be an issue. The length of patent protection granted to international manufacturers of medications is an ongoing debate.

The delay in Health Canada Health Protection Branch approval for new drugs is a heated debate, especially for those diagnosed with terminal or debilitating chronic ailments. Alternative or homeopathic pharmaceuticals (the regulation of and access to) is an emerging issue. Finally, a variety of advocacy groups including seniors, low-income advocates and Canada's political left are relentless in their push for a national pharmacare plan.

Ethical Choices in Research

Research advances are a source of great excitement in the medical community and the population at large. Yet inherent in many encouraging research breakthroughs are ethical questions. While scientific breakthroughs seem to be rapid, the ability of our legislative framework to address their consequent ethical dilemmas is lethargic. This stems partly from a fear to address the ethical questions, as they are divisive, challenge core values and conceptions of faith and life and rarely confine themselves in convenient partisan silos.

From reproductive technologies to stem cell research, mapping the human gene to cloning (just to name a few), Canada's legislators are ill-equipped to deal with the tough ethical issues these breakthroughs present.

Fyke Commission (Saskatchewan)

The Fyke commission reported to the Saskatchewan government in April 2001, and many observers looked to this report for clues to foreshadow the work of the Romanow commission. While well intentioned and adequately researched, the commission's recommendations focussed on bureaucratic solutions and the classic "shifting of resources approach" that has been a hallmark of Canadian health care reform efforts (see Chapter 8 in this report for elaboration of this point) over the last decade.

Hospital Closures/Mergers

Hospital closures and shifting of service centres continue to make headlines in communities across Canada. Affected stakeholders agree with the need to integrate health services to meet community needs and better serve the local population, however, paternalism takes over and all argue for saving "their" hospital and instead closing the "other" facility down the street or on the other side of town.

Hospital / Health Authority Deficits

In 9 of 10 provinces (except Ontario), a regional health board/authority model is employed for coordinating and integrating resources for health services delivery to large urban or rural populations. In several provinces, some health authorities (and in Ontario, hospitals) continue to run operational deficits.

Human Resource Shortages

As Chapter 4.3 of this report noted, it was evident that most provinces were taking steps to address physician and nursing shortages. As well, current shortages of radiologists and forecast shortages of gerontologists have also made headlines.

International Rankings / Approaches

Canada's relative position to other countries and the provision of health care has been the subject of media attention as a result of recent WHO and OECD reports. As well, several feature stories have profiled approaches to health care in countries such as Australia, Sweden, Great Britain and France. These stories have focussed on the use of co-payment options (user fees) and other strategies to reform health care and reduce waiting lists. A commonality in many international stories is the fact that many other countries are also struggling with doctor and nursing shortages.

Kirby Senate Committee

The Standing Senate Committee on Social Affairs, Science and Technology released Volume 1 in its study of health care in March 2001. Volume 2 is due to be released in mid-September 2001. While the study definitely had a federal bias, it was still a welcome addition to the debate. Of particular interest was the revelation that user fees or income clawbacks were considered in the original design of medicare. Media speculation has since focused on whether the Senate's work is still necessary in light of the establishment of the Romanow commission.

MRIs

MRIs are to health care what tax cuts have been to small-c conservative fiscal policy. Lack of access to MRIs is seen as a key touchstone in the need for reform of medicare. Private clinics have sprouted up in four provinces offering MRI scans for fees ranging from $500 to $850. MRIs are also tied into the waiting lists debate and the larger question of the applicability of the *Canada Health Act.*

Organ Donation (Transplantation)

With each tragic death of a young person come stories of grieved family members offering six and seven organs for transplantation into other humans. Organ donation registries have been established and high profile Canadians (ex: Don Cherry in Ontario) have been recruited to encourage more Canadians to consider organ donation.

Population Health [*]

In the midst of the health care debate, a parallel focus on population health has been the subject of increasing media attention. Proponents of this concept assert that the strength of our health care system is just one of twelve key determinants of population health. The twelve determinants are:

Biology and genetics	Childhood development	Culture
Education	Employment/Working conditions	Gender
Health care systems	Income and social status	Personal habits
Physical environment	Social environment	Social networks

The concept has been endorsed by the federal and all provincial governments; receiving significant funding for further study. It will no doubt figure prominently in the work of the Romanow commission as it is jurisdiction neutral, read: a invitation for federal involvement.

Primary Care Reform

PCR is trumpeted by every single province – without exception – as an integral part of provincial reform efforts to contain costs, improve services and positively affect population health. Media coverage has tended to focus on PCR successes or political analyses of perceived barriers to PCR efforts such as physician intransigence, lack of information technology and patient buy-in to support it. Part and parcel of this coverage have been stories concerning the application and promise of telehealth technology.

[*] For further information on population health, visit http://www.population-health.com.

Research

Apart from the ethical quagmires research advances present, the implications of stem cells, the genetic code and other advances have been widely and positively reported raising the hopes of many Canadians presently coping with incurable illnesses.

Media reporting has focused on the commitment of Ottawa (CIHR) and the provinces, through various matching or tax credit schemes, in contributing increasing sums of money to medical research. Critics, including the CTF, have questioned whether the money is actually supporting pure research or whether it is another form of corporate welfare to pharmaceutical companies in near-market product development activities.

Romanow Commission

With the establishment of the Romanow commission on April 4, 2001, Mr. Romanow has given conflicting signals as to whether he is open to a full dialogue in considering all delivery and financing options for health care in the 21st century or whether he is wedded to the current rigidity inherent in the CHA and merely paying lip service to those who advocate real changes.

The other area of scrutiny of Mr. Romanow's work has been largely driven by "inside baseball, Ottawa political punditry." The question posed is simple: Is Mr. Romanow's commission merely a cover for the federal Liberal government to further defend itself against provincial attacks and pressure or is the commission a sincere attempt to engage Canadians in a meaningful dialogue about the future structure and workings of the Canadian health care system? Only time will tell.

7.0 Forces Shaping the Future: The Gang of Four

A modern proverb states, "I'm looking forward to the future, I plan to spend all of my time there."

Indeed, we will all be spending a great deal of time in the future. While medical advances like virtual surgery, stem cell research and promising drug therapies hold great promise to find cures for cancer or AIDS in the next quarter century, the costs and uncertainties that come with this exciting outlook are daunting.

There are numerous forces that will shape and alter health care delivery and financing over the next quarter century, but principal among them are what the CTF calls ***The Gang of Four: Demographics, Technology, Pharmaceuticals*** and ***Expectations.***

7.1 Demographics

While the first wave of baby boomers will not turn 65 until 2010 already the warning signs of the stress that an ageing population will place upon our health care system are apparent.

To start, consider the percentage of health care resources devoted to various age groups as presently identified and forecast by Canada's first ministers. [111]

Percentage of Health Spending By Age Group

Age Group	1999/2000	2009/2010	2019/2020	2026/2027
0 – 14 years	7.4	5.8	5.0	4.5
15 – 44 years	26.4	22.3	18.9	16.6
45 – 65 years	20.9	24.2	19.8	19.0
65 years plus	45.3	47.7	58.3	59.9
Total	100.0	100.0	100.0	100.0

Today, seniors account for 13% of our population, however, by 2026 they will account for 21% or our population. Furthermore, the projected 60% of health care spending on seniors is a base-case (read: conservative) projection. This has led some to ask can we afford health care in the future? With due deference to their academic concern, the question is not ***if*** we can afford the future, but ***how*** do we afford the future?

On a related front, in July 1996, *Fraser Forum* reported that the federal Office of the Superintendent of Financial Institutions (OSFI) had calculated the taxes an average family would need to pay to sustain the country's health care system only accounting for demographic shifts. In 1995 the family health care tax burden was 48%, by 2040 it was projected to reach 94.5%.

To compound matters, we should remember that average life expectancy has increased by 30 years in just the last century. Not only will an increasing segment of Canadians be older, but they will live much longer.

As the U.S. based Institute for the Future has noted:

> Baby boomers have transformed many institutions and aspects of society along their life cycle – including the workplace, financial institutions and government. As baby boomers interact with the health care system, their expectations and preferences will also transform these institutions as the health care industry adapts to accommodate baby boomers' demands and numbers. They will access the system not only for themselves but also for their parents and children. Boomers' involvement in their own care will distinctly be different from that of past generations … They will accelerate the movement and awareness of self-care and wellness and will irreversibly alter the traditional doctor-patient relationship. [112]

While much of this demographic growth seems intuitive, sadly, public policy architects have been slow to grasp its ramifications. And the Department of Finance is still not presenting a projection of the costs to our health care system and other social programs as a result of the ageing population.

Former Auditor General Denis Desautels mentioned this shortcoming in his 2000 Report to Parliament:

> The Budget planning framework remains at two years. But in its fall fiscal update, the Department of Finance now provides five-year forecasts of revenues and expenditures, based on an average of private sector forecasts. Extending the fiscal outlook from two years to five is an important step in the right direction, but still falls short of what is needed to show the impact of the impending demographic shift one to three decades ahead. [113]

This ageing demographic has shifted resources and attention in the health care system. Twenty-five years ago, general health care, for most part, was defined as primary (visits to the doctor) or acute (stays in the hospital for surgery, etc.). These two silos represented the bulk of physician expenses and majority consumption of health system dollars.

While vaccinations, antibiotics and biotech advances have dramatically lengthened the anticipated lifespan for women and men, longer life has brought with it a whole new set of medical challenges. But none more profound from a structural point of view than a shift toward greater and greater chronic care (dealing with long-term illnesses and ailments) in addition to primary and acute care.

This shifting in what WHO calls "the burden of disease" will necessitate larger outlays of health care funds. Incidence of heart disease and cancer will increase. Alzheimer's and Parkinson's will also stress our system as will the demands for pharmaceuticals for a variety of maladies from arthritis to unipolar major depression. This shift to chronic care has not been matched with an equally important shift in terms of infrastructure provision, most notably long-term care or alternate level of care (ALC) beds.

Part of the crisis in Canadian hospitals is a result of bed-blockers. Bed-blockers can be defined as patients occupying acute care beds in academic health-science centres even though they no longer warrant acute care supervision. Due to a lack of long-term or ALC beds (read: facilities), doctors are loathe sometimes to discharge these patients from acute care facilities as the continuum of care is not complete for their patients. This gap manifests itself in calls for more public money to be allotted to homecare and long-term care facilities.

The other major problem stemming from the demographic shift is the greying of our medical workforce. From doctors to nurses and from pharmacists to psychologists, our medical workforce is getting older.

According to CIHI:

> For several years, the average age of doctors has been creeping up. In 1999, almost four in 10 physicians (39%) were 50 or older. This compares with only 35% in 1995. Specialists tend to be somewhat older than family doctors. In 1999, the average age of a family doctor was almost 46, whereas the average age for a specialist was nearly 49. The average age of nurses in Canada is rising. In 1999, only one in 10 RNs working in nursing was under 30. The ratio was one in eight (13%) in 1994. At the same time, the number of RNs age 50 to 59 has grown. There are now almost 53,000 nurses in this age group, many of whom will leave the workforce over the next decade. [114]

It is important to note as well that the greying of our population is not a temporary phenomenon confined to the baby boom generation. Coupled with declining fertility rates and increased life expectancy, as a society we will permanently become much older.

As disturbing as this data is from a declining service and increasing cost perspective, the Canadian Institute of Actuaries have pointed out that other factors such as technological advancements, better pharmaceuticals and magnified patient expectations are an even greater cause for concern. Patients are no longer willing to accept the eventuality of dying young or living with pain as they would have just 10 or 20 years ago. Expectations are much more intense and encompassing.

In a submission (March 21, 2001) to the Kirby Senate Committee entitled *Health Care in Canada: The Impact of Population Aging,* the CIA recommended:

- Better data collection to measure demographic and other cost drivers in the health care system;
- Consideration of pre-funding health care expenditures;
- Informing the population about their health care consumption expenditures noting that “individual financial responsibility needs to be built into the system;” and
- Regular actuarial reviews of health care costs as is done with public pensions.[115]

7.2 Technology

It is a gross understatement to state that technological advancements have fundamentally changed medicine. More to the point, it is axiomatic. The fiscal challenge from a public policy perspective is to understand the impact of technology on costs. This challenge is doubly difficult due to the frenetic speed at which technology advances. Sir Winston Churchill (1949) succinctly captured this dilemma:

> Science bestowed new powers on man and at the same time created conditions which were largely beyond his comprehension and still more beyond his control. [116]

Nonetheless, the system has learned one important lesson; new and more effective technologies are increasing overall health care costs. The cost acceleration will only continue as information technologies become increasingly intertwined with biotechnological advancements.

As the BCMA effectively noted: [117]

> Through new technology, previously untreatable illnesses become treatable and the health status of the population improves. However by expanding the realm of interventions, costs invariably rise. Consider the following examples:

Type of New Technology	Specific Examples
Creation of a new service	Prenatal surgery, prenatal ultrasound, and genetic surgery
Creation of a complimentary service which does not completely replace old technology	Coronary angioplasty and coronary artery bypass surgery
Technology which may prolong life and consequently increase potential future utilization	Triple therapy for AIDS treatment extends life from 10 to 17 years
Technology which may allow or extend treatment of previously untreatable patients	Care for premature infants from 1500 to 1000 g
Technology which may increase average costs of treatment, but also increase effectiveness	Hospital-based technologies
Technology which provides high volume diagnostic tools with low positive detection rates	Mammograms where significant majority of reported abnormalities are non-malignant, but still require full scope of tests

The U.S. Institute for the Future identified several key medical technology advancements that will serve to further drive health costs higher over the next decade. A brief description of four of these advancements follows which will no doubt increase the overall cost of the Canadian health care system as well.

Rational Drug Design

No longer will random combinations (the systematic and time-consuming combining of tens of thousands of compounds in a lab to produce drugs) be the preferred option for drug development. A rapid shift to rational drug design is underway whereby drugs are developed at the molecular level to attack the chemical composition of a target – a receptor or enzyme – to turn the target on or off.

This area of technology shows great promise in cancer research, the diseases of ageing, and antiviral therapies to fight diseases such as HIV and influenza.

Imaging

A significant trend in imaging is miniaturization. Just as computers and hand-held devices become smaller and more powerful so to will MRIs. As images become clearer in the realm of television and computers, this same trend is occurring in the field of diagnostic imaging. The most promising benefit from advances in imaging will be the reduction in the need for invasive surgical interventions to diagnose internal maladies. As the Institute for the Future noted:

> Historically, new imaging technologies have been additive – new technologies do not replace old ones but rather supplement their uses. In a cost constrained health system, more restraint will be exercised on the use of new imaging systems. Comprehensive analyses of cost effectiveness, including the full life-cycle cost of the equipment, will become commonplace. [118]

The related issue with advances in imaging is one of human resources. As some Canadians have seen with MRIs, having a machine in a local hospital is one thing, having qualified staff to actually run it is sometimes another issue entirely.

Genetic Mapping

The Human Genome project has provided medicine with a crystal ball to see the future. Clinical trials for identifying individuals susceptible (due to their genetic composition) to everything from cancer to Huntington's disease are well underway. Once identified, strategies for prevention, avoidance or modification of the eventual condition can be executed. The costs inherent in this testing are high but equally costly will be the demands (from patients and clinicians) for a regulatory framework that addresses ethical and privacy concerns based on the results genetic mapping will yield.

Will insurance companies discriminate against those susceptible to various cancers? Will home testing kits proliferate on the market that could yield false positives (i.e.: home pregnancy tests)? Will a eugenics movement resurface calling for the creation of advanced races and sterilization of those with serious diseases of heredity? These are important – if not chilling – questions that will potentially consume as many public resources as the advancements in genetic mapping will no doubt command.

Artificial Blood

The Krever Inquiry and related report from the mid-1990s clearly chronicles a dark chapter in Canadian history. Tens of thousands of Canadians whose very lives depended on a safe and effective blood supply were erroneously infected with the HIV and hepatitis viruses. It is not the CTF's intent to lay blame or pass judgment; that was part of Justice Krever's role.

However the episode did heighten public awareness of the fragility of the blood system. With new fears and protective measures now being put into place to guard against the uncertainty surrounding the transmission of the human form of mad-cow disease through blood products, searches for alternatives to blood have intensified. A blood-type, neutral product would be a great boon to surgeons and relief workers alike.

The main challenge is the long-lead time in development and the high costs that would probably be charged by artificial blood suppliers to recover some of their immense development costs. Governments and blood agencies could be required to make significant financial outlays to build a supply for national needs, both civilian and military.

7.3 Pharmaceuticals

> Retail drug sales became the second-largest component of total health expenditures in 1997, overtaking physician services. Drug costs now account for over 15% of total spending … The percentage growth in drug spending between 1985 and 1998 was more than twice as high for overall health expenditure. [119]

This increase – documented by CIHI – is a function of many variables including an ageing population, greater use of drugs in disease prevention and treatment, and more access to prescribed and over-the-counter products. This explosion in drug use resulted in an 87% increase in provincial allocations for drugs (see Chapter 4.2 of this report). Despite this budget pressure, it is important to remember that costs of this increased drug use have been borne directly by Canadians as almost 69% of all drug costs are financed privately by Canadian employers, insurers and through out-of-pocket expenses.

The issue of drug costs is the sleeping giant of the health care debate. Provinces already provide varying levels of coverage for elderly and low-income residents. Now political pressure is being placed on them to provide coverage to all residents. This is a costly proposition and part of this debate will revolve around the issues of:

- Extending or restricting patent protection for large pharmaceuticals;
- The merits of a national pharmacare program; and
- Allowing drug companies to freely advertise (they can't now) their product.

As these issues develop, look for Canadian pharmacists to become a larger stakeholder in the health care sphere.

7.4 Expectations

> People no longer want the health care system to deliver basic services but now expect to have all the options, all of the time, wherever they live. [120]

In the preceding quote, the provincial and territorial ministers of health have summed up the largest factor that will drive costs for health care: patient and family expectations.

The demand for immediacy and instant satisfaction is prevalent in society in terms of the 500-channel digital universe, customization of purchases from clothing to automobiles, and the proliferation of pre-packaged and prepared foods on our supermarket shelves.

These changes have had a profound effect in health care. The information asymmetry (while still prevalent) between doctors and patients has shrunk dramatically. The Internet allows for the instantaneous diffusion of medical knowledge and patients have been transformed into knowledgeable consumers and passionate advocates for their own health care consumption.

Other factors that fuel this "empowerment" of consumers include a more educated population, a decline of individual deference toward traditional institutions, greater awareness of health issues and increased exposure (due to demographic shifts and media focus) to the health system.

Yet we should not view this patient-to-consumers transformation solely from the present perspective. As Michael Bliss noted, this empowerment is punctuated with a hint of historical revenge:

> I do not believe patients were ever as ignorant of their health care interests, were ever as manipulable, as first physicians and then their policy-making successors tended to believe … Whether or not the health-care consumer was the poor ignoramus once posited by the health-policy establishment, we are nowadays seeing massive evidence that the health care consumer knows his or her own mind, is determined to be sovereign in the health care marketplace, and will not accept other's attempts to manipulate his demands, whether the manipulator be physician, insurer, or politician.[121]

Rising expectations among Canadian health care consumers will manifest themselves in several ways:

- Demands for patient charters or a bills of rights;
- Demands for accountability measures (with appropriate discipline and retribution) when the health system under-performs; and
- Demands for greater consumer sovereignty which will collide with current legislative and regulatory structures.

8.0 Reforms to Date: Deckchairs on the Titanic?

The Canadian experience with reforms to the health care system in the last decade fall into three broad categories:

- Structural and governance reforms (regionalization);
- Fiscal and legislative reforms (cost containment and shifting); and
- Integration and service delivery reforms (primary care reform).

While each category of reforms has included innovation and achieved limited success, none of the reforms implemented to date has addressed the flawed economics of health care outlined in Chapter 4.6 of this report.

8.1 Structural and Governance Reforms

Throughout the late 1980s and early 1990s, all provinces and territories (except for Ontario, Yukon and Nunavut) moved away from an environment of direct ministry management of hospitals and health services to a regional approach of financing and delivering health care.

Province/Territory	Year of Regionalization	Province/Territory	Year of Regionalization
Northwest Territory	1988-1992	Prince Edward Island	1993
Quebec	1989-1992	Alberta	1994
New Brunswick	1992	Newfoundland	1994
Saskatchewan	1992	Nova Scotia	1994
British Columbia	1993	Manitoba	1997

In the regional model, health care authority is divested to regional boards (some appointed, some elected, some mixed) for delivery of all health care services across a defined geographic region.

These services include hospital care (acute and community), community health and promotion, and public health programs. Services are funded through a block budget, allocations from the province and revenue flows are augmented through private and community fundraising.

Depending on the province, regional boards/authorities may also have responsibility for mental health services and capital construction. In most instances, physician billing, collective bargaining with nurses, other allied health professionals and pharmaceuticals remains with the province. In addition, special purpose agencies are set up to coordinate province-wide cardiac care and cancer treatments.

Major infrastructure expansion (read; new facilities) is usually financed from departmental or province-wide capital budgets (i.e.: the Ontario SuperBuild fund) with an increasing emphasis on public-private partnerships to share costs through build-own-operate-and-transfer (BOOT) arrangements or long-term lease back contracts.

While some will argue that the regionalized approach has resulted in more integration of services in metropolitan and rural areas, others point out with equal certainty that former provincial health care bureaucracies have merely been offloaded and duplicated in miniature in each region. Furthermore, some provinces including New Brunswick and Ontario (with its merged hospitals, a quasi-regional approach) are facing enormous financial challenges with their health authorities that continue to operate at a deficit.

8.2 Fiscal and Legislative Reform

Governments of all partisan stripes hit the deficit wall in the early to mid-1990s. As a result, cost containment and expenditure reductions were prevalent. The health care sector was not immune to this fiscal imperative.

Reforms – sometimes in concert with the move to regional authorities – included hospital closures and/or mergers, bed reductions, de-listing of services, amalgamating laboratory operations, workforce reductions (especially in nursing) through early retirement and departure incentives, and delay of needed capital purchases or routine life-cycle maintenance on equipment and buildings. Coupled with federal funding changes (converting EPF to the CHST) in 1996, these cost reduction efforts were a limited short-term success.

Due to increased patient demand and consumption along with the costs of pharmaceuticals and technology, provincial spending (inflation adjusted) shot back up by the mid to late 1990s.

In less than a decade, Canadians have seen first-hand the impacts of earlier provincial decisions. Nursing reduction efforts have been totally reversed with the provinces spending millions (signing bonuses, etc.) to poach nurses from each other and lure thousands more back from the U.S. and internationally.

The shifting of surgical procedures from in-hospital to ambulatory (day-surgery) facilities – while laudable – presented a greater need for ALC beds. As well, an ageing population demanded more long-term care beds. But with the demolition, conversion or outright sale of closed hospitals, provincial governments were (and still are) faced with the prospect of expending billions in new facility construction.

Instead of focussing on health system performance, quality and accountability in this stage of reforms that would have reduced costs in a sustainable fashion, provinces implemented short-term cost containment strategies. As University of Toronto Professor Colleen Flood notes:

> Improving accountability is vital for the simple reason that all systems, when faced with the imperative to contain costs, have strong tendencies to shift costs rather than to improve performance. [122]

8.3 Integration and Service Delivery Reform

It seems as though health ministers – federal or provincial – can't go a week without making a speech on primary care reform or issue a news release on the subject. Primary care reform has taken on the same cure-all status that regionalization of health delivery enjoyed in the early 1990s. A brief discussion of the "new" fad is warranted.

A CMA working group defines primary care as:

> Primary medical care consists of first-contact assessment of a patient and the provision of continuing care for a wide range of health concerns. Primary medical care includes the diagnosis, treatment and management of health problems (conditions); prevention and health promotion; and ongoing support, with family and community intervention where needed. [123]

The four main elements of primary care include: first-contact care, continuity of care, coordination of care and comprehensiveness of care. Over half of Canada's doctors are general practitioners and most interactions with the health care system begin with a visit to the family doctor.

The idea behind PCR is that changing the funding structure, administrative structure and delivery structure of individual health care strengthens the doctor-patient relationship. Teams of physicians, nurses and other specialists band together, with the aid of telehealth technology to provide seamless, 24-hour care to a defined population of patients and their families.

Some of the stated goals of utilizing this model include a decrease in usage of hospital emergency rooms for non-urgent situations, wellness promotion, better access to medical professionals and cost containment.

Patients are rostered into PCR practices. Funding then flows to the PCR practice on a population basis. Finally, the team, doctors, nurses, etc., deliver various components of a patient's care as required. As the CMA noted, the "obligations on the part of the practice would be to provide a comprehensive range of diagnostic, therapeutic and preventive services and to be available to respond to patients' needs at all times."

On paper this delivery model yields many advantages. However, critics have noted that PCR is partly a copy of 1960s British reforms to restrict and contain physician billings. They note that if the aim is to contain fee-for-service billings by physicians who see their patients too often, a reverse and equally perverse incentive exists in a capitation arrangement where physicians are compensated on a salary or per-patient basis.

In this arrangement, the incentive to over-bill has been removed but a new incentive to under-serve and restrict the work of the PCR practice emerges. Primary care reform efforts have met with mixed success across the country to date.

9.0 Conclusion and Recommendations

This report, as its sub-title indicates, is a combination research and position document. The aim has been to précis a variety of research that has been conducted on health care and weave it together in a fashion to highlight similar themes and offer commentary from a CTF perspective.

The World Health Organization has defined four broad functions for national health systems. Effective health systems:

1) Provide services;
2) Provide resources – generating the human and physical resources that make service delivery possible;
3) Finance themselves – raising and pooling capital to pay for the resources used for health care; and
4) Provide stewardship – setting and enforcing the rules of the game and providing strategic direction for all the different actors involved.

In the Canadian context, as this report has shown, our health system is failing us in each of these four functional areas. In many instances services are not being provided in a timely manner (waiting lists for surgery, MRI scans, etc.). Resources are at a premium and the acuity of nursing and physician shortages seems destined to worsen.

On the financing side, Canada continues to employ a pay-as-you-go approach to health care which is unsustainable. As for stewardship, government decisions with respect to funding transfers and capital acquisitions have been less than stellar. This experience has diminished the capacity and suasion of governments to provide strategic direction to our health care framework. While we have no doubt arrived at a crisis point, all hope is not lost.

If the Romanow commission lives to the spirit of its mandate, not merely the letter of its enabling directive, Canadians will have the opportunity to take ownership of the health care file and work in partnership health care practitioners and government to build a modern, health care governance framework for the 21st century.

A Modernized Canada Health Act

To build this framework, the *Canada Health Act* must be modernized. The principle of ***universality*** must remain and incorporate the other notions of accessibility, comprehensiveness and portability in clear and workable terms.

Public administration should be replaced with the principle of ***public governance***. And four new principles of ***quality, accountability, choice*** and ***sustainability*** should be added to a modernized CHA.

Guiding Principles for Reform

Our survey of the Canadian environment along with differing international approaches to health care financing and service delivery yields instructive lessons for Canada.

These lessons, combined with the pressures and cost drivers of demographic shifts, technological advancements, increased pharmaceutical usage and exploding patient expectations, point the CTF to identify three guiding principles that must govern reform and the redesign of the Canadian health care system.

Individual Accountability and Responsibility

> ***Canadians must become more accountable for their health care consumption decisions.***

Experience from other jurisdictions with small user fees or varying levels of co-payment with appropriate low-income exemption levels shows that universality is not compromised. And a RAND corporation study of 2,000 families over 12 years – one of the most thorough social study experiments in history – shows that reasonable fees do not adversely affect health outcomes.

Indeed, individual accountability was part of the original Liberal resolution in 1961. As Tom Kent told the Kirby Committee:

> The value of the services that you obtained from public health insurance would become a part of your statement for income tax purposes, within limits, and so on, so that it would never be overwhelming in any one year for any individual or family, and it would mean that people who paid little or no tax would pay nothing for their health care, but people who had relatively large incomes, had a significant tax, would pay something.[124]

Intergenerational Fairness

> ***Health care funding must move from pay-as-you-go financing to sustainable pre-funding for each generation of Canadians.***

Adequate provisions must be made now to support the anticipated health care expenditures of the baby-boomers and each generation thereafter. Globally, many countries have abandoned the pay-as-you-go approach for financing public pensions, even in Canada this shift is starting to take place, albeit more slowly. The same shift must occur as it pertains to future health care costs.

Establishment of health care savings allowances similar to RRSPs would be a concrete policy expression of the intergenerational fairness principle. Modelling a new regime on the Singapore model could also provide funding to uphold the aforementioned principle of individual accountability.

Embrace Innovative Approaches

> ***Governments must act quickly to involve new providers (including the private sector) in all facets of health care service delivery including technology purchases and major facility construction.***
>
> ***Provincial experimentation should also be encouraged and supported whether it is on the financing or service delivery side.***

Canadian hospital officials have identified billions of dollars of needed capital improvements (information technology & medical devices) and construction projects for the next decade. The public sector, with other competing infrastructure priorities, simply does not have the capacity to adequately respond to the hospital sector's needs.

Innovative, flexible and workable public-private partnerships must become the rule as opposed to the exception. They can be used for facility construction, flexible leasing arrangements for technology such as MRIs, and the provision of human resources, for non-clinical and clinical tasks.

Provincial experimentation with vouchers or allowances, alternate hospitals, co-payment for prescription drug or innovative tax credit schemes for major equipment donations should also be encouraged.

The Challenge

The principal and laudable aim of medicare was to provide health services without hindrance. Today the system stands in crisis and the greatest hindrance to reform is the intransigence of health care bureaucrats and politicians who refuse to accept that the problem with health care may be the system itself.

Its present global funding configuration is unsustainable and its orientation must change to place the patient at the centre of every interaction. This report has been critical of many facets of the health care system. This is not meant to belittle the efforts of the women and men who work within the system.

The sign of a healthy democracy is one that finds fault with itself, for if it can't, it has ceased to be a democracy. An honest, open and thorough debate on the future of health care is needed. Anything less would constitute an immoral disservice to those who went before us and an abdication of our duty to those who will come after us … for me must leave them a better country than that which we inherited.

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APPENDIX A

The *Canada Health Act*

Canada Health Act

CHAPTER C-6

An Act relating to cash contributions by Canada and relating to criteria and conditions in respect of insured health services and extended health care services.

Preamble

WHEREAS the Parliament of Canada recognizes:

-- that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the Constitution Act, 1867, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

-- that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;

-- that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;

-- that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;

-- that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the Canada Health Act.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" [Repealed, 1995, c. 17, s. 34]

"cash contribution" -- "cash contribution" means the cash contribution in respect of the Canada Health and Social Transfer that may be provided to a province under subsections 15(1) and (4) the Federal-Provincial Fiscal Arrangements Act;

"contribution" [Repealed, 1995, c. 17, s. 34]

"dentist" -- “dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" -- "extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,
(b) adult residential care service,
(c) home care service, and
(d) ambulatory health care service;

"extra-billing" -- "extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" -- "health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" -- "health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" -- "hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include:

(a) a hospital or institution primarily for the mentally disordered, or
(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" -- "hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,
(b) nursing service,
(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,
(d) drugs, biologicals and related preparations when administered in the hospital,
(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
(f) medical and surgical equipment and supplies,
(g) use of radiotherapy facilities,
(h) use of physiotherapy facilities, and
(i) services provided by persons who receive remuneration therefor from the hospital, does not include services that are excluded by the regulations;

"insured health services " -- "insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" -- "insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,
(b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,
(c) a person serving a term of imprisonment in a penitentiary as defined in the Penitentiary Act, or
(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" -- “medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" -- "Minister" means the Minister of Health;

"physician services"-- "physician services" means any medically required services rendered by medical practitioners;

"resident" -- "resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services" -- "surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge" -- "user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. 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.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

CASH CONTRIBUTION

Cash contribution

5. Subject to this Act, as part of the Canada Health and Social Transfer, a full cash contribution is payable by Canada to each province for each fiscal year.
6. [Repealed, 1995, c. 17, s. 36]

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;
(b) comprehensiveness;
(c) universality;
(d) portability; and
(e) accessibility.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;
(b) the public authority must be responsible to the provincial government for that administration and operation; and
(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or
(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;
(b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, the provinces concerned agree to apportion the cost between them in a different manner, or
(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reason of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, access to those services by insured persons;
(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;
(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and
(c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

CONDITIONS FOR CASH CONTRIBUTION

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and
(b) shall give recognition to the Canada Health and Social Transfer in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or
(b) the province has failed to comply with any condition set out in section 13, and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;
(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and
(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any set out in section 13, the Governor in Council, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or
(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.
Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3).

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, consultation with the minister responsible for health care in the province, that the default is continuing.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists. 1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical

practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs (a) to (d) of the definition "extended health care services" in section 2;
(b) prescribing the services excluded from hospital services;
(c) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and
(d) prescribing the manner in which recognition to the Canada Health and Social Transfer is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the Federal-Provincial Fiscal Arrangements Act, as it read immediately before April 1, 1984.
Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces.

REPORT TO PARLIAMENT

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed.

APPENDIX B

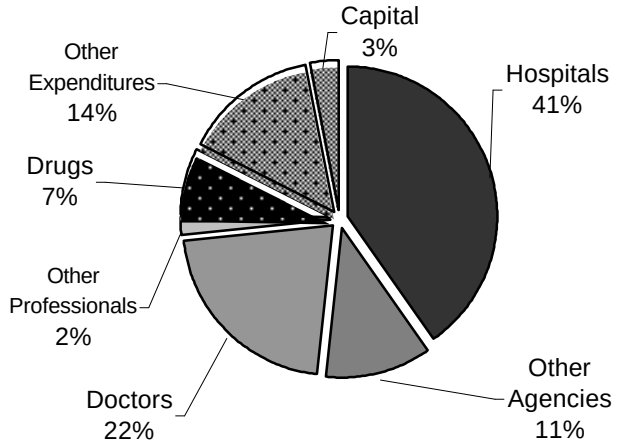
Provincial / Territorial Fact Sheets

British Columbia -- Health Care Facts

Population: 4,063,800 2000
3,291,379 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	7,505	7,622	7,752	7,812	7,943
Per 100,000	193	192	194	194	195
Specialists	44.8%	45.0%	45.0%	45.5%	45.4%
Nurses	28,348	28,974	28,004	27,911	27,730
Per 100,000	730	746	721	693	682
Full-time	50.0%	49.5%	48.2%	N.A.	67.4%

Breakdown of Health Spending: 1999-2000



BC joined Confederation in …	1871
Hon. Colin Hansen	
Ministry of Health Services	
Hon. Sindi Hawkins	
Ministry of Health Planning	
2 Ministers of State	
Regional Health Authorities:	51
Hospitals:	102
Health Centres:	34

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data

($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 5,027.1	$ 5,196.4	$ 2,197.0	$ 635.1	$ 1,236.9	$ 103.1	$ 238.8	$ 551.2	$ 234.4
1991-92	5,616.7	5,697.0	2,379.3	734.2	1,349.9	128.9	281.5	631.7	191.6
1992-93	6,002.9	6,178.6	2,578.1	792.2	1,331.1	142.0	314.7	811.7	208.9
1993-94	6,288.4	6,496.9	2,660.7	787.4	1,444.9	147.5	337.2	885.5	233.8
1994-95	6,586.4	6,932.8	2,733.6	896.7	1,536.3	152.3	317.5	1,035.5	261.0
1995-96	6,789.9	7,058.4	2,706.6	901.5	1,598.1	152.5	333.0	1,123.9	242.9
1996-97	7,062.5	7,214.4	2,890.0	967.5	1,597.9	153.2	372.2	964.6	269.0
1997-98	7,224.0	7,498.4	2,983.7	942.5	1,632.1	152.0	422.6	1,133.8	231.7
1998-99	7,479.0	7,810.6	3,135.2	948.1	1,701.6	160.8	460.5	1,260.2	144.2
1999-2000	8,017.0	8,278.3	3,346.4	967.8	1,813.1	162.9	524.2	1,210.8	253.3
2000-2001	8,745.0	8,728.0	3,526.2	982.6	1,899.9	165.1	630.5	1,254.9	268.9
2001-2002	9,634.0	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	32.8%	25.9%	29.0%	9.6%	23.7%	8.4%	98.6%	21.2%	3.0%
Net 7 Year	18.2%	11.3%	14.4%	-5.0%	9.0%	-6.2%	84.0%	6.6%	-11.6%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in British Columbia as stated in Table 6 of Budget Documents

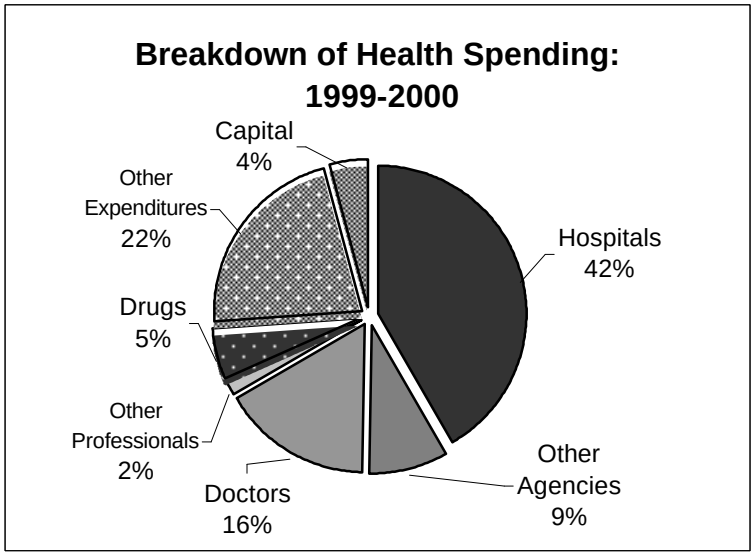
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Alberta -- Health Care Facts

Population: 2,997,200 2000
2,547,636 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	4,472	4,511	4,762	4,962	5,014
Per 100,000	161	159	164	168	167
Specialists	46.4%	47.4%	47.2%	47.2%	48.0%
Nurses	20,751	21,428	21,988	22,044	22,172
Per 100,000	746	755	756	745	740
Full-time	54.2%	54.5%	55.0%	N.A.	54.4%



Joined Confederation in …	1905
Hon. Gary Mar	
Alberta Health and Wellness	
Regional Health Authorities:	17
Special Boards(Mental Health & Cance	2
Hospitals:	60
Health Centres:	71

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 3,864.0	$ 4,092.3	$ 2,081.0	$ 277.2	$ 774.1	$ 169.6	$ 180.7	$ 435.0	$ 174.6
1991-92	4,098.0	4,276.9	2,196.4	290.1	857.9	162.8	192.0	477.6	100.1
1992-93	4,133.0	4,571.0	2,337.4	272.9	914.0	163.1	210.1	505.4	168.0
1993-94	4,002.0	4,471.7	2,231.4	251.6	924.1	159.9	204.3	568.5	131.9
1994-95	3,799.0	4,087.3	1,842.7	258.8	872.9	147.2	209.3	720.3	36.0
1995-96	3,618.0	3,904.9	1,630.4	451.0	792.6	87.5	205.5	631.6	106.2
1996-97	3,814.0	4,164.5	1,759.6	468.6	768.7	82.7	229.3	762.0	93.7
1997-98	4,235.0	4,648.5	1,969.3	489.5	803.7	84.1	249.8	946.0	106.1
1998-99	4,809.0	4,960.2	2,064.3	470.2	880.5	93.3	272.6	1,075.7	103.6
1999-2000	5,117.0	5,789.0	2,409.6	507.1	947.3	96.5	314.0	1,273.9	240.7
2000-2001	5,625.0	6,326.8	2,595.7	534.6	991.4	105.9	350.7	1,517.5	231.0
2001-2002	6,271.0	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	48.1%	54.8%	40.9%	106.6%	13.6%	-28.1%	67.6%	110.7%	541.7%
Net 7 Year	33.4%	40.2%	26.2%	91.9%	-1.0%	-42.7%	52.9%	96.1%	527.0%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Alberta as stated in Expense of Budget Documents, Ministry of Health and Wellness

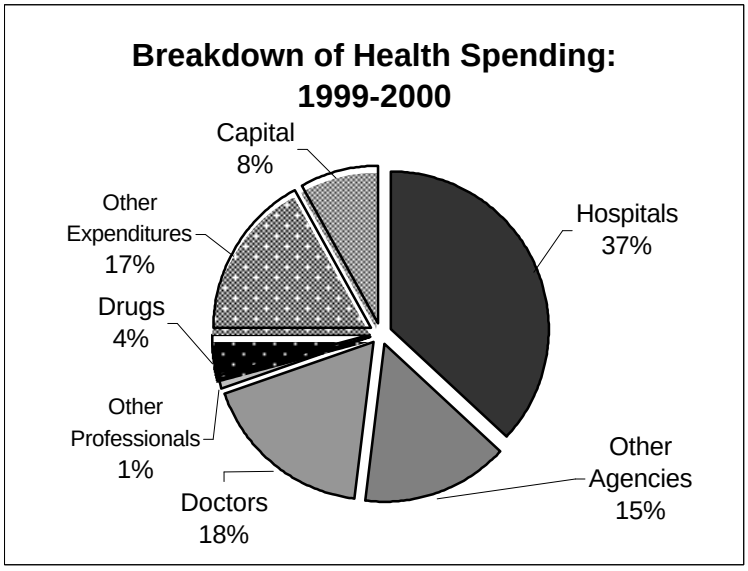
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Saskatchewan -- Health Care Facts

Population: 1,023,600 2000
1,007,115 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	1,475	1,747	1,530	1,568	1,567
Per 100,000	145	171	149	153	153
Specialists	40.4%	34.7%	41.4%	39.8%	40.5%
Nurses	8,508	8,456	8,455	8,553	8,543
Per 100,000	835	827	825	834	835
Full-time	47.2%	46.1%	46.3%	N.A.	50.8%



Joined Confederation in …	1905
Hon. John Nilson	
Saskatchewan Health	
Regional Health Authorities:	32
Plus Lloyminister District:	1
Hospitals:	70
Health Centres:	73

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data

($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 1,532.5	$ 1,667.1	$ 702.7	$ 244.6	$ 252.4	$ 35.7	$ 90.6	$ 166.9	$ 174.2
1991-92	1,597.7	1,653.5	717.3	254.1	265.7	39.4	92.3	176.8	107.9
1992-93	1,552.9	1,628.7	701.2	256.3	265.2	31.0	77.6	181.9	115.6
1993-94	1,496.0	1,508.1	681.8	253.1	247.2	21.1	49.7	196.5	58.8
1994-95	1,539.1	1,576.6	635.7	271.8	295.6	17.8	58.3	210.2	87.2
1995-96	1,560.6	1,600.5	617.2	265.1	295.1	17.7	65.6	262.6	77.2
1996-97	1,614.1	1,646.5	636.5	267.9	299.0	18.3	63.3	277.1	84.4
1997-98	1,681.2	1,777.1	649.1	273.9	327.0	19.2	66.5	304.7	136.7
1998-99	1,775.5	1,874.2	695.7	280.0	336.7	21.5	77.6	326.8	135.9
1999-2000	1,961.5	2,031.0	752.5	304.5	358.1	23.4	87.2	341.5	163.8
2000-2001	2,098.4	2,095.2	797.7	312.1	375.1	23.3	110.9	344.5	131.5
2001-2002	2,207.2	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	36.3%	32.9%	25.5%	14.8%	26.9%	30.9%	90.2%	63.9%	50.8%
Net 7 Year	21.7%	18.3%	10.9%	0.2%	12.3%	16.3%	75.6%	49.3%	36.2%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Saskatchewan as stated in Expense of Budget Documents, Health, Expenditure

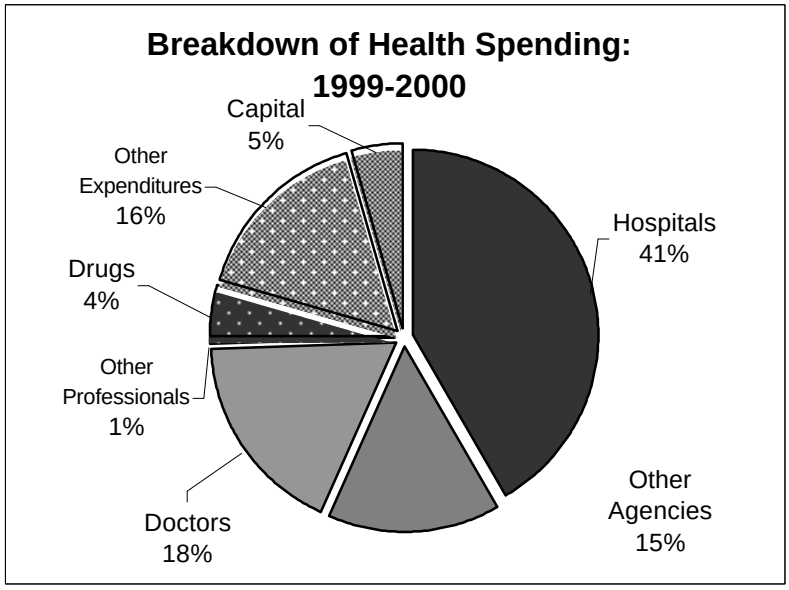
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Manitoba -- Health Care Facts

Population: 1,147,900 2000
1,105,608 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	1,973	2,013	2,018	2,049	2,082
Per 100,000	174	177	177	179	181
Specialists	49.7%	50.1%	49.9%	49.0%	49.0%
Nurses	10,490	10,510	10,185	10,211	10,051
Per 100,000	925	925	895	894	876
Full-time	41.6%	42.4%	44.9%	N.A.	45.0%



Joined Confederation in …	1870
Hon. Dave Chomiak	
Manitoba Health	
Regional Health Authorities:	12
Hospitals:	78
Community Health Centres:	25

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns						
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 1,671.3	$ 1,783.7	$ 909.5	$ 263.3	$ 253.3	$ 16.6	$ 49.8	$ 199.5	$ 91.7
1991-92	1,759.5	1,788.4	894.0	267.4	286.7	17.6	57.3	188.4	77.0
1992-93	1,864.0	1,893.7	973.3	289.0	284.8	20.5	71.7	188.7	65.8
1993-94	1,858.8	1,842.9	952.5	279.8	287.1	20.0	66.8	195.5	41.1
1994-95	1,854.9	1,866.2	969.6	290.4	276.5	19.7	59.2	214.3	36.3
1995-96	1,848.8	1,914.0	974.0	296.8	271.3	21.0	86.4	231.2	33.3
1996-97	1,811.9	1,923.6	906.6	300.9	337.3	16.7	69.6	251.8	40.8
1997-98	1,825.7	1,993.1	918.5	299.4	353.2	16.6	75.1	261.8	68.6
1998-99	1,925.6	2,137.9	983.2	311.4	391.2	16.9	89.5	284.5	61.3
1999-2000	2,300.9	2,433.2	1,011.7	363.8	435.4	16.6	104.3	390.6	110.7
2000-2001	2,505.1	2,752.7	1,195.9	413.4	456.8	16.9	136.2	422.4	111.1
2001-2002	2,587.8	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	35.1%	47.5%	23.3%	42.4%	65.2%	-14.2%	130.1%	97.1%	206.1%
Net 7 Year	20.4%	32.9%	8.7%	27.7%	50.6%	-28.8%	115.4%	82.5%	191.4%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Saskatchewan as stated in Expense of Budget Documents, Health, Expenditure

All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

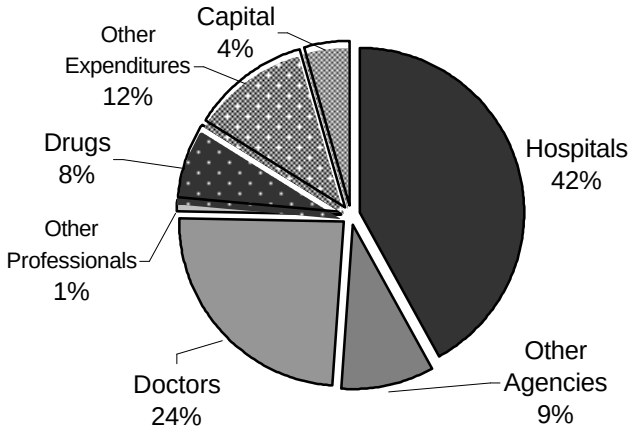
APPENDIX B

Ontario -- Health Care Facts

Population: 11,669,300 2000
10,299,571 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	20,216	20,202	20,469	20,701	21,176
Per 100,000	182	180	180	180	181
Specialists	51.0%	51.6%	52.1%	52.7%	52.9%
Nurses	80,198	78,067	78,825	78,197	81,679
Per 100,000	722	694	692	679	700
Full-time	54.8%	53.3%	47.7%	N.A.	53.7%

Breakdown of Health Spending: 1999-2000



Joined Confederation in …	1867
Hon. Tony Clement	
Minstry of Health and Long-Term Care	
Regions:	7
Hospitals:	121

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$15,346.0	$ 16,423.9	$ 7,569.8	$ 1,484.3	$ 4,256.3	$ 215.1	$ 912.7	$ 1,559.1	$ 426.7
1991-92	17,588.0	18,418.6	8,554.8	1,688.5	4,853.8	230.4	1,038.4	1,697.1	355.6
1992-93	17,758.0	18,894.1	8,535.6	1,890.2	4,700.6	235.0	1,223.2	1,881.9	427.7
1993-94	17,684.0	18,472.1	8,442.7	1,663.1	4,540.7	229.2	1,231.2	1,950.8	414.4
1994-95	17,848.0	18,787.2	8,330.5	1,694.4	4,682.1	222.9	1,208.3	2,054.2	594.8
1995-96	17,607.0	18,419.4	8,258.6	1,666.1	4,453.6	221.0	1,408.7	1,944.2	467.2
1996-97	17,760.0	18,736.7	8,500.8	1,647.9	4,579.6	247.0	1,311.0	1,961.0	489.5
1997-98	18,389.0	19,111.3	8,040.5	1,719.5	4,977.4	272.7	1,404.5	2,092.3	604.4
1998-99	19,054.0	20,403.9	9,024.7	1,883.3	5,064.1	249.9	1,566.7	2,117.8	497.5
1999-2000	21,715.0	21,823.7	9,159.3	1,988.6	5,263.2	254.9	1,647.2	2,559.8	950.7
2000-2001	22,628.0	23,966.4	9,936.7	2,150.5	5,635.7	265.0	1,919.3	2,759.3	1,299.8
2001-2002	23,686.0	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	26.8%	27.6%	19.3%	26.9%	20.4%	18.9%	58.8%	34.3%	118.5%
Net 7 Year	12.2%	12.9%	4.7%	12.3%	5.7%	4.3%	44.2%	19.7%	103.9%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Ontario as stated in Expense of Budget Documents, Health and Long-Term Care

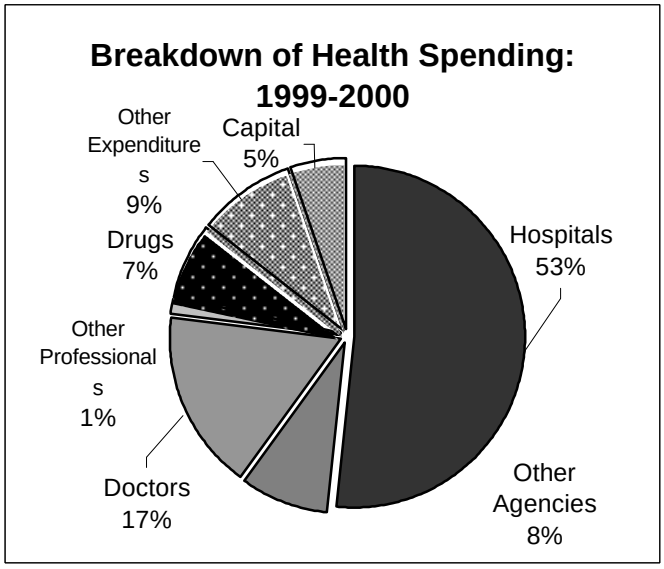
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Quebec -- Health Care Facts

Population: 7,372,400 2000
7,004,436 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	15,243	15,315	15,481	15,582	15,770
Per 100,000	210	210	211	212	214
Specialists	50.4%	50.6%	50.4%	50.3%	50.4%
Nurses	57,291	59,160	56,825	57,980	58,750
Per 100,000	788	810	776	789	797
Full-time	39.2%	49.0%	48.1%	N.A.	50.9%



Joined Confederation in …	1867
L'hon. Rémy Trudel	
Ministre de Sante et Services Sociaux	
Regional Health Authorities:	17
Hospitals:	91
Community Service Centres:	133

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 8,774.7	$10,407.0	$ 5,789.9	$ 877.1	$ 1,884.8	$ 191.4	$ 520.4	$ 846.5	$ 296.9
1991-92	9,531.2	11,461.5	6,188.0	960.9	2,029.4	224.1	631.9	944.9	482.3
1992-93	9,823.9	11,648.2	6,303.8	961.6	2,096.3	190.9	656.7	1,067.0	371.8
1993-94	9,963.4	11,881.4	6,400.4	951.1	2,158.8	187.5	695.9	1,083.6	404.1
1994-95	13,137.0	12,023.9	6,353.8	916.5	2,214.6	183.6	757.4	1,082.0	515.9
1995-96	13,101.0	11,993.0	6,279.0	900.5	2,220.9	191.1	823.5	1,122.6	455.4
1996-97	12,934.0	11,426.0	5,793.1	921.1	2,231.0	167.0	704.8	1,200.9	408.0
1997-98	12,997.0	12,030.5	6,533.0	997.8	2,152.0	172.3	695.3	1,083.0	397.1
1998-99	14,596.0	13,190.1	6,905.1	1,040.9	2,361.8	153.3	801.5	1,278.1	649.5
1999-2000	14,828.0	13,317.6	6,878.3	1,105.5	2,281.2	164.9	951.5	1,243.8	692.4
2001-2002	15,993.0	14,250.0	7,339.2	1,170.2	2,395.1	163.6	1,023.1	1,404.3	754.4
2001-2002	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	21.7%	18.5%	15.5%	27.7%	8.2%	-10.9%	35.1%	29.8%	46.2%
Net 7 Year	7.1%	3.9%	0.9%	13.1%	-6.5%	-25.5%	20.5%	15.2%	31.6%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Quebec as stated in Expense of Budget Documents, Santé & Services Sociaux

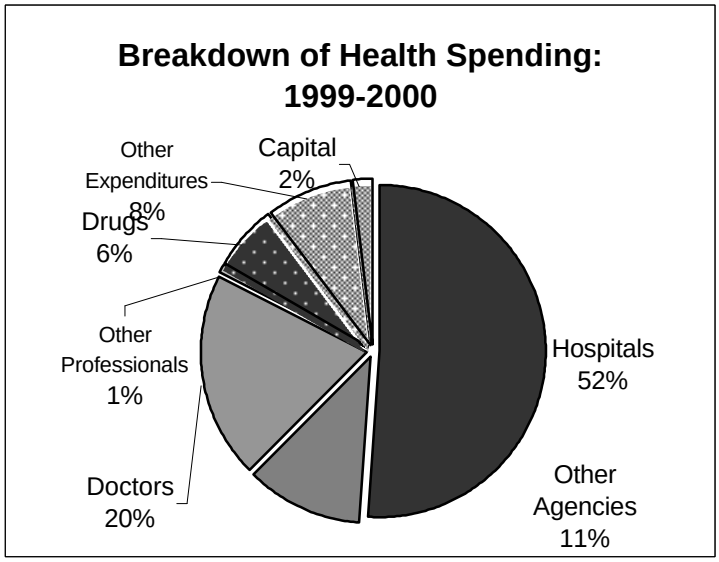
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Nova Scotia -- Health Care Facts

Population: 941,000 2000
909,693 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	1,746	1,766	1,830	1,868	1,898
Per 100,000	188	189	195	199	202
Specialists	47.1%	47.7%	48.3%	48.9%	49.8%
Nurses	8,738	8,587	8,525	8,615	8,699
Per 100,000	938	919	911	917	924
Full-time	61.4%	59.6%	59.4%	N.A.	61.2%



Joined Confederation in …	1867
Hon. Jamie Muir	
Department of Health	
District Health Authorities:	9
Hospitals:	34

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 1,224.3	$ 1,282.3	$ 753.7	$ 96.2	$ 199.0	$ 19.9	$ 82.4	$ 79.4	$ 51.7
1991-92	1,293.2	1,355.2	814.0	105.2	209.6	17.1	83.2	86.8	39.2
1992-93	1,326.8	1,357.6	814.2	105.4	213.2	13.9	90.9	85.4	34.6
1993-94	1,271.8	1,309.6	724.5	107.3	264.5	11.1	87.7	77.4	37.0
1994-95	1,238.5	1,268.5	685.6	102.1	251.2	12.8	81.6	84.2	51.1
1995-96	1,273.6	1,312.0	696.8	141.4	246.5	12.5	84.5	92.3	37.9
1996-97	1,286.2	1,317.5	708.7	145.2	267.6	11.9	82.6	92.3	9.1
1997-98	1,426.7	1,628.2	913.5	159.0	297.3	9.5	87.8	132.3	28.8
1998-99	1,632.0	1,663.4	886.6	178.7	319.7	11.4	102.9	143.1	21.0
1999-2000	1,767.4	1,775.0	909.2	202.4	355.0	12.3	112.2	147.2	36.7
2000-2001	1,750.6	1,711.2	834.1	203.9	360.6	11.3	116.7	147.4	37.1
2001-2002	1,819.0	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increas	41.4%	34.9%	21.7%	99.7%	43.6%	-11.7%	43.0%	75.1%	-27.4%
Net 7 Year	26.7%	20.3%	7.0%	85.1%	28.9%	-26.3%	28.4%	60.4%	-42.0%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in Nova Scotia as stated in Expense of Budget Documents, Health

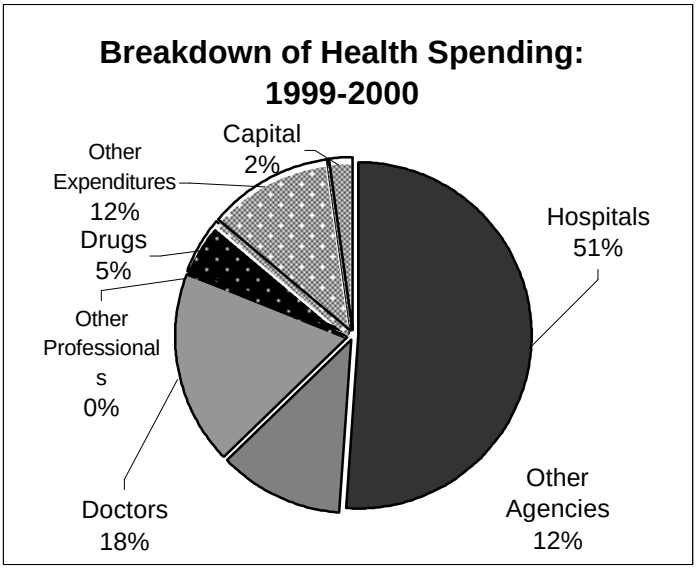
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

New Brunswick -- Health Care Facts

Population: 756,600 2000
740,128 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	1,122	1,127	1,152	1,162	1,153
Per 100,000	149	149	153	154	152
Specialists	41.0%	41.7%	41.4%	41.0%	41.1%
Nurses	6,126	7,412	7,456	7,710	7,376
Per 100,000	814	983	990	1,022	975
Full-time	60.0%	54.4%	54.1%	N.A.	54.9%



Joined Confederation in …	1867
Hon. Dennis Furlong	
Department of Health and Wellness	
Regional Health Authorities:	7
Hospitals:	27
Health Centres:	27

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns						
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	$ 1,040.0	$ 1,075.1	$ 518.6	$ 109.3	$ 173.8	$ 6.6	$ 58.4	$ 132.0	$ 76.3
1991-92	1,095.1	1,109.6	544.7	113.4	191.2	7.2	61.5	143.1	48.6
1992-93	1,119.4	1,151.7	633.7	135.1	193.1	6.3	56.6	82.6	44.5
1993-94	1,170.0	1,153.7	613.4	139.2	197.3	4.6	53.1	107.9	38.3
1994-95	1,203.9	1,198.6	624.9	140.4	208.5	4.8	53.6	109.1	57.3
1995-96	1,207.1	1,244.6	624.4	138.8	208.5	4.8	57.0	118.2	92.8
1996-97	1,272.1	1,228.3	636.8	139.2	215.0	4.7	50.9	119.3	62.6
1997-98	1,273.2	1,207.7	620.6	144.3	225.9	5.1	54.7	125.1	31.9
1998-99	1,307.1	1,288.2	658.7	151.2	234.9	4.5	61.2	145.5	32.2
1999-2000	1,514.0	1,357.0	692.0	159.1	244.2	4.1	69.0	159.3	29.3
2000-2001	1,601.0	1,462.5	747.4	159.1	257.9	4.1	74.7	187.7	31.6
2001-2002	1,683.0	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	33.0%	22.0%	19.6%	13.3%	23.7%	-14.6%	39.4%	72.0%	-44.9%
Net 7 Year	18.4%	7.4%	5.0%	-1.3%	9.1%	-29.2%	24.7%	57.4%	-59.5%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in New Brunswick as stated in Expense of Budget Documents, Health and Wellness

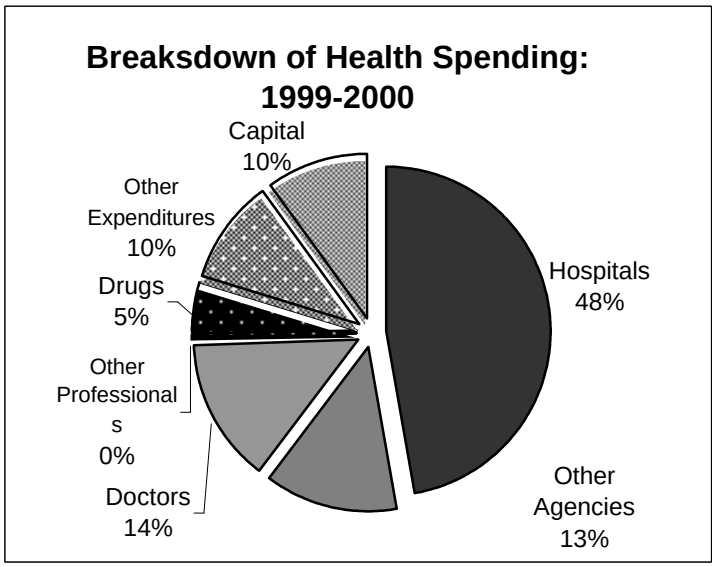
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Newfoundland -- Health Care Facts

Population: 538,800 2000
578,064 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	928	932	926	925	927
Per 100,000	166	168	170	171	172
Specialists	38.7%	38.9%	39.5%	39.9%	38.4%
Nurses	5,261	5,210	5,340	5,264	5,394
Per 100,000	938	940	979	973	1,001
Full-time	62.5%	58.9%	59.0%	N.A.	72.6%



Joined Confederation in …	1949
Hon. Julie Bentley	
Department of Health & Comm. Service	
Regional Health Boards:	7
Hospitals:	14
Health Centres:	26

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	812.3	859.5	484.5	117.3	126.6	10.5	35.6	65.7	19.3
1991-92	829.6	859.6	493.1	119.0	127.0	8.0	40.7	64.0	7.8
1992-93	842.5	886.2	512.9	104.7	131.7	6.8	43.6	65.6	20.9
1993-94	832.3	877.3	499.9	102.8	132.3	6.2	47.8	70.1	18.3
1994-95	870.8	909.8	516.5	104.0	135.8	6.2	52.1	76.1	19.1
1995-96	736.2	930.2	513.4	115.6	139.0	6.1	53.9	82.3	20.0
1996-97	911.2	923.5	507.5	119.3	140.1	5.3	53.2	90.8	7.2
1997-98	1,030.5	981.2	519.6	130.6	153.6	5.6	52.1	99.2	20.7
1998-99	1,154.8	1,077.6	574.9	147.8	160.7	5.9	55.6	116.8	15.9
1999-2000	1,212.4	1,218.1	576.3	158.5	170.3	5.5	59.8	124.2	123.4
2000-2001	1,298.0	1,223.4	604.9	165.9	186.3	5.8	64.1	128.4	68.1
2001-2002	1,401.7	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	49.1%	34.5%	17.1%	59.5%	37.2%	-6.5%	23.0%	68.7%	256.5%
Net 7 Year	34.4%	19.8%	2.5%	44.9%	22.6%	-21.1%	8.4%	54.1%	241.9%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health as stated in Expense of Budget Documents, Health and Community Service

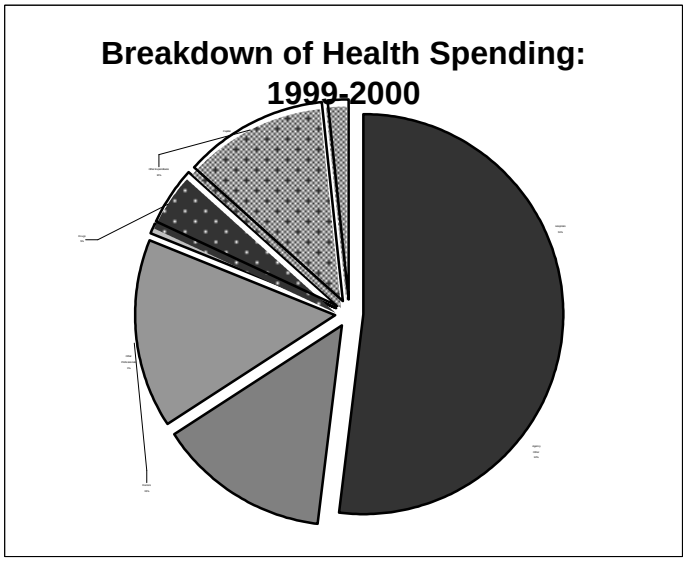
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Prince Edward Island -- Health Care Facts

Population: 138,900 2000
130,544 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	170	165	175	180	178
Per 100,0(	125	121	128	131	128
Specialists	41.8%	42.4%	42.9%	42.8%	41.0%
Nurses	1,340	1,281	1,277	1,232	1,255
Per 100,0(	984	936	933	895	904
Full-time	43.1%	8.0%	42.5%	N.A.	41.6%



Joined Confederation in …	1873
Hon. Jamie Bellam	
Department of Health & Social Services	
Regional Health Authorities:	7
Hospitals:	9
Health Centres:	18

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91		$ 176.5	$ 95.7	$ 25.2	$ 28.8	$ 1.9	$ 6.8	$ 16.5	$ 1.4
1991-92		193.9	101.3	25.9	30.1	2.0	7.6	18.4	8.6
1992-93	275.9	196.9	102.8	28.5	32.1	2.1	7.6	18.5	5.3
1993-94	286.8	207.8	108.7	31.9	31.4	2.1	7.4	18.8	7.6
1994-95	282.6	197.8	108.8	25.3	31.0	2.0	7.8	18.9	4.0
1995-96	272.7	204.7	113.6	26.4	31.8	1.7	8.7	20.5	2.0
1996-97	231.0	215.8	115.3	31.1	32.6	1.9	8.4	22.2	4.3
1997-98	285.3	213.5	112.0	29.4	33.6	2.0	9.3	23.4	3.8
1998-99	296.9	234.1	119.7	30.0	36.5	2.1	10.8	24.7	10.3
1999-2000	307.9	247.8	128.6	34.8	37.4	2.2	11.6	29.0	4.1
2000-2001	327.4	256.0	129.9	34.9	37.7	2.3	13.1	31.9	6.2
2001-2002	340.4	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
7 Year Increase	15.8%	29.4%	19.4%	37.9%	21.6%	15.0%	67.9%	68.8%	55.0%
Net 7 Year	1.2%	14.8%	4.8%	23.3%	7.0%	0.4%	53.3%	54.2%	40.4%

7 Year Increase: Refers to change in spending between 1994-95 and 2000-01

Net 7 Year: Refers to 7 Year inflation adjusted increase accounting for CPI of 14.62%

Provincial Budget refers to Provincial Spending on Health in PEI as stated in Expense of Budget Documents, Health & Social Services

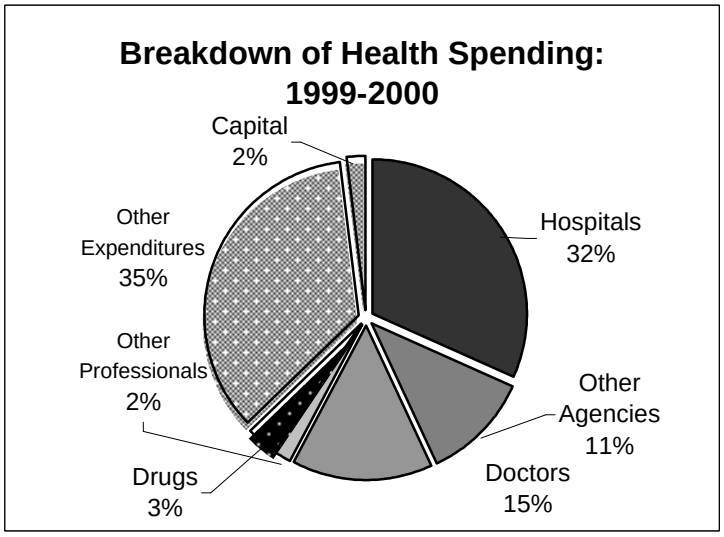
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Yukon -- Health Care Facts

Population: 30,700 2000
27,778 1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	47	50	46	41	41
Per 100,000	147	155	146	132	134
Specialists	14.9%	14.0%	13.0%	14.6%	14.6%
Nurses	228	252	241	243	237
Per 100,000	715	783	765	781	772
Full-time	70.2%	51.6%	54.4%	N.A.	53.6%



Joined Confederation in …	1897
Hon. Don Roberts	
Department of Health & Social Services	
Hospitals:	2
Health Centres	9

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data
($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	N.A.	$ 39.3	$ 16.9	$ 2.5	$ 8.1	$ 0.6	$ 1.3	$ 9.3	$ 0.6
1991-92	N.A.	47.2	18.5	3.1	9.1	0.7	1.7	10.5	3.5
1992-93	N.A.	49.3	19.8	3.6	9.8	0.8	2.0	11.3	2.2
1993-94	N.A.	60.5	26.1	5.1	9.4	0.8	2.2	10.3	6.6
1994-95	N.A.	73.9	25.3	7.0	9.8	0.9	1.8	11.9	17.1
1995-96	N.A.	66.5	24.5	7.0	10.0	0.9	1.3	12.5	10.3
1996-97	N.A.	66.7	25.1	7.3	10.9	0.8	1.4	13.3	7.9
1997-98	N.A.	70.0	24.1	7.8	11.2	1.2	1.9	23.4	0.3
1998-99	N.A.	75.5	24.0	8.1	11.2	1.1	2.2	25.0	3.9
1999-2000	122.4	78.5	24.8	9.0	11.4	1.4	2.7	27.5	1.6
2000-2001	133.8	80.2	24.5	9.1	11.5	1.4	2.0	27.8	3.9
2001-2002	137.1	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
3 Year Increase	N.A.	8.5%	-3.2%	30.0%	17.3%	55.6%	11.1%	133.6%	-77.2%
Net 3 Year	N.A.	-6.1%	-17.8%	15.4%	2.7%	40.9%	-3.5%	119.0%	-91.8%

3 Year Increase: Not applicable

Net 3 Year: Not applicable

Provincial Budget refers to Provincial Spending on Health in Yukon as stated in Expense of Budget Documents, Health & Social Services

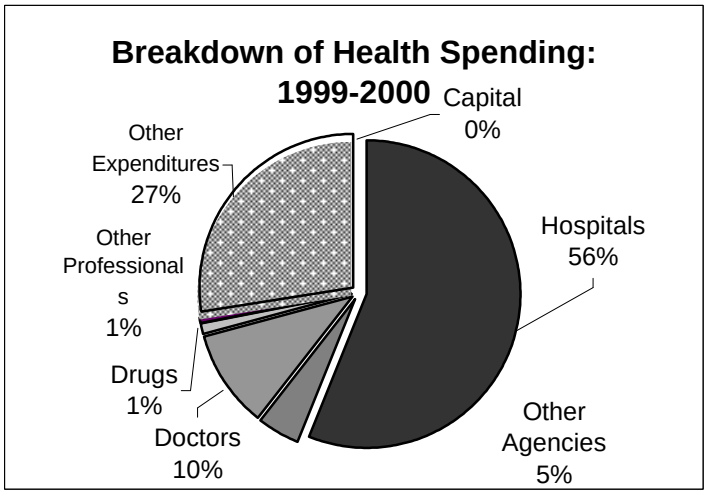
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Northwest Territories -- Health Care Facts

Population:	42,100	2000
	58,904	1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	61	66	62	53	47
Per 100,0C	90	158	151	129	112
Specialists	19.7%	21.2%	24.2%	34.0%	38.3%
Nurses	551	252	241	243	237
Per 100,0C	815	603	586	591	563
Full-time	28.1%	N.A.	N.A.	N.A.	N.A.



Joined Confederation in …	1870
Hon. Jane Groenewegen	
Department of Health and Social Services	
Regional Health Authorities:	9
Hospitals:	3
Health Centres:	25

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data

($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	N.A.	190.7	109.8	5.0	15.8	2.5	2.5	46.6	8.5
1991-92	N.A.	220.9	139.8	5.6	17.2	2.5	3.1	50.7	2.1
1992-93	N.A.	210.6	120.7	6.3	18.0	3.3	3.8	52.0	6.6
1993-94	N.A.	220.5	125.5	7.6	19.0	2.5	2.0	57.9	5.9
1994-95	N.A.	211.5	115.2	8.2	19.3	2.5	1.0	61.4	4.0
1995-96	N.A.	223.4	115.9	12.3	20.0	2.1	1.1	63.3	8.8
1996-97	N.A.	212.1	109.1	12.4	20.5	2.2	1.2	64.0	2.7
1997-98	260.1	239.0	127.5	11.7	19.7	2.6	1.3	66.1	10.2
1998-99	269.0	286.5	137.9	11.1	20.3	2.6	1.6	67.3	45.6
1999-2000	174.5	142.3	79.9	6.4	14.5	1.5	0.9	39.0	-
2000-2001	190.5	159.9	82.9	7.0	16.2	1.6	1.0	40.1	11.1
2001-2002	202.7	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
5 Year Increase	N.A.	-24.4%	-28.0%	-14.6%	-16.1%	-36.0%	0.0%	-34.7%	177.5%
Net 5 Year	N.A.	-39.0%	-42.7%	-29.3%	-30.7%	-50.6%	-14.6%	-49.3%	162.9%

5 Year Increase: Not applicable

Net 5 Year: Not applicable

Provincial Budget refers to Provincial Spending on Health in NWT as stated in Expense of Budget Documents, Health & Social Services

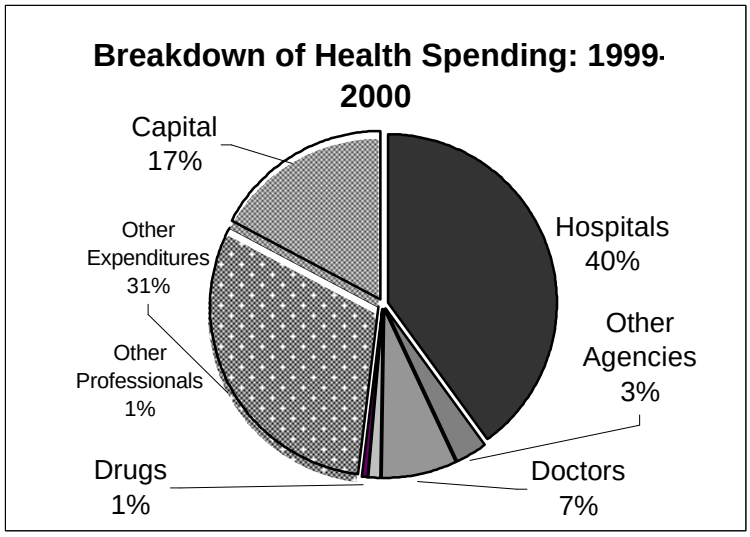
All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

Nunavut -- Health Care Facts

Population:	27,700	2000
	N.A.	1999

Health Professionals	1996	1997	1998	1999	2000
Physicians	N.A.	N.A.	N.A.	11	7
Per 100,00	N.A.	N.A.	N.A.	41	25
Specialists	N.A.	N.A.	N.A.	9.1%	14.3%
Nurses	N.A.	109	120	106	93
Per 100,00	N.A.	421	453	393	336
Full-time	N.A.	N.A.	N.A.	N.A.	N.A.



Joined Confederation in …	1996
Hon. Ed Picco	
Ministry of Health and Social Services	
Hospitals:	0
Health Centres:	25

Breakdown of Provincial Health Care Spending:

Canadian Institute for Health Information and Provincial Budget Data

($ millions)

		CIHI Data and Expenditure Breakdowns							
Year	Provincial Budget	Total	Hospitals	Other Agency	Doctors	Other Professionals	Drugs	Other Expenditures	Capital
1990-91	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1991-92	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1992-93	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1993-94	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1994-95	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1995-96	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1996-97	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1997-98	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1998-99	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
1999-2000	N.A.	$ 147.5	$ 58.8	$ 4.5	$ 10.9	$ 1.4	$ 0.8	$ 45.7	$ 25.3
2000-2001	121.6	126.2	42.9	3.1	10.1	1.3	0.8	52.3	15.7
2001-2002	123.4	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.	N.A.
2 Year Increas	N.A.	-14.4%	-27.0%	-31.1%	-7.3%	-7.1%	0.0%	14.4%	-37.9%
Net 2 Year	N.A.	-20.2%	-32.8%	-36.9%	-13.1%	-12.9%	-5.8%	8.7%	-43.7%

2 Year Increase: Not applicable

Net 2 Year: Not applicable

Provincial Budget refers to Provincial Spending on Health in NWT as stated in Expense of Budget Documents, Health & Social Services

All other Statistics taken from Canadian Insititute for Health Information Health Expenditures by Province Table C

APPENDIX B

APPENDIX C

Problematic Incentives

Taken from: *Code Blue* by Dr. David Gratzer (1999)

Problematic Incentives

From ***Code Blue*** (1999), by Dr. David Gratzer

For the patient …

- Patients have an incentive to use the emergency room as the 24-hour office of a family physician. *Emergency rooms are convenient.*
- Patients have an incentive to run to the walk-in clinic for every minor ailment, including the common cold. *Walk-in clinics are easily accessible, and the consultation is fast.*
- Patients have an incentive to recover from surgeries in hospitals as opposed to undergoing day surgeries. *Recovery is more convenient in a hospital setting.*
- Patients have an incentive to get every diagnostic test for even the most minor complaints. *Tests provide peace of mind.*
- Patients have an incentive to stay in the hospital for lengthy periods of time. *Hospital care is easier than self-care.*
- Patients have an incentive to see many doctors about the same problem. *Many opinions are better than just one.*
- Patients have an incentive to have every ache and pain of old age checked out. *Aches and pains of old age require no treatment, but attention is nice.*
- Patients, even though young and healthy, have an incentive to see their doctors for annual checkups. *Frivolous checkups ease hypochondriac concerns.*

For the doctor …

- Doctors have an incentive to see as many patients as possible. *In a fee-for-service system, more services mean more fees.*
- Doctors have an incentive to order many tests. *Tests make diagnoses easier and keep patients happy.*
- Doctors have an incentive to see healthy patients frequently. *Visits from healthy patients make healthy incomes.*
- Doctors have an incentive not to treat complicated cases. *Complicated cases are rarely compensated in an adequate manner.*
- Doctors have an incentive to treat minor illnesses. *Minor illnesses are easy to treat, and they pay well.*
- Doctors have an incentive to leave the country for greener pastures. *High incomes are highly tempting.*
- Doctors have an incentive to overservice patients with surgical procedures. *Surgery pays well.*
- Doctors have an incentive not to discuss treatment options and promote healthy living. *Billing schedules don't compensate for conversation.*

For the health care administrator …

- Health care administrators have an incentive to not cooperate with those of other hospitals. *Cooperation reduces global budgets and infringes on managers' autonomy.*
- Health care administrators have an incentive to introduce new, redundant services. *Expansion increases global budgets.*
- Health care administrators have an incentive to fill beds with low-needs patients. *Bed-blocking reduces demand on global budgets.*
- Health care administrators have an incentive to negotiate rigid contracts with unions representing orderlies, food workers, and other support staff. *Contractual limitations help to enlarge global budgets.*
- Health care administrators have an incentive to produce excessive rules that slow down decision making. *Bureaucracies need administrators.*
- Health care administrators have an incentive not to contract services out. *Fewer services require fewer administrators.*
- Health care administrators have an incentive to limit government restructuring efforts. *Restructuring kills administrative jobs.*

For the politicians …

- Politicians have an incentive not to close redundant hospitals. *Closures are politically unpopular.*
- Politicians have an incentive not to clash with health care administrators, unions, and doctors. *Disagreements make poor public spectacles.*
- Politicians have an incentive not to change the system. *Medicare is popular.*
- Politicians have an incentive to make cost-cutting decisions for short-term budgetary gain that result in higher costs in the long-term. *Short-term gains reflect short-term reality: the next election is always just around the corner.*
- Politicians have an incentive to allow waiting lists to develop. *Some type of cost control must occur.*
- Politicians have an incentive not to invest in high-tech diagnostic equipment. *MRI and CT scanners are expensive to buy and run.*
- Politicians have an incentive to limit a patient's ability to seek services. *The availability of health services must be limited in the name of cost control.*
- Politicians have an incentive to limit a doctor's ability to practice medicine. *The doctor-patient relationship is important, but saving money is more important.*
- Politicians have an incentive not to collect systemic information. *Information on waiting lists and mortality is damning.*
- Politicians have an incentive to allocate resources to better service the government's voter base. *Politicized medicine has political results.*