

Post-Romanow, post-Kirby; has anything changed?

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I am exceedingly privileged to be with you today. Whatever happens to our country's health care system, much will depend upon the daily, often unheralded, efforts of institutions such as yours and those who work within them.

People like me try to understand what is happening at the broad level of health and fiscal policy. You do that too, but you are also in the trenches. What you do every day in your work with patients and colleagues is more important by far than what people like me say every day. You and your colleagues must confront not just medical challenges but work within a complicated system regulated necessarily by a mixture of professional associations and government departments. You have my respect and admiration for confronting them.

My job is at the other end of the spectrum: to try to make sense, first for myself, then for readers, of where we have been and where we are likely to go with health policy in Canada.... I have watched with more than passing interest during my 30 years as a journalist how the Canadian health system has evolved, and especially the relationship of that system to public policy. And it is, therefore, on that subject that I want to offer some thoughts this morning.

National debate

Whether Canadians realized it or not, we have completed an extensive national debate about health care. It occurred in almost every conceivable way in a democratic society. There was extensive media debate. There were countless polls. There were innumerable conferences. There were legislative committees. There were federal-provincial meetings of ministers. There were special task forces at the provincial level—in New Brunswick, Quebec, Saskatchewan, Alberta. There was a multi-volume report from a Senate Committee under

Senator Michael Kirby. And, of course, there was Mr Romanow's Royal Commission.

If there has been a weakness, democratically speaking, in this national debate, it has come from the absence of serious divisions among the political parties. At the risk of only slight exaggeration, their contribution has largely consisted of leapfrogging the others in promising to spend more money on health care. They have tried, in other words, to outbid each other. This outbidding precluded the articulation of clear alternatives that might have helped Canadians to consider alternatives, to have been aware of a wider range of choices.

I would argue that, notwithstanding my own reservations about how the debate ended, it has ended for the foreseeable future. There was a political agreement, although there remain loose ends. The public did speak by all the means I mentioned. The result of the debate was, roughly speaking, to produce an outcome that the public wanted, based on the information it had, the way the debate was framed, and the options before it....

First, Canadians expressed support for the existing medicare system, including the five principles of the Canada Health Act. This was the system they knew, understood, and had grown up with. Change from the familiar is always scary, or at least unsettling. They looked at alternatives through only one lens: the Canadian system. They knew vaguely about one other system, the American one, and they resolutely did not want that system.

Second, they wanted, if possible, for medicare to be extended to other areas not now covered by the definition of "medically necessary services."

Third, they expressed concern that the system that they knew might not be there for them and their children. They wanted those concerns alleviated. They expressed widespread satisfaction with individual doctors and indeed the general medical services they received, but they worried about timely access to that system....

Fourth, they believed that if costs were rising too fast within the system, leading to long-term questions of sustainability, the reason lay in waste, duplication, and poor management within the system. They believed, in other words, that better administration would solve most of the funding concerns about the system. Whether they were right or wrong about this is irrelevant. This is what they believed, or at least hoped.

Fifth, they were not willing to pay additional taxes either to fix the existing system or to expand it. Only if, and this was a big if, they became convinced that no other conceivable means could be found to pay for the existing system would they consider additional taxes. And since they believed that better administration could improve the system and constrain its costs, they did not accept the need for higher taxes.

At the end of this long national debate, the public got what it wanted, what I call Medicare Plus. That is what Mr Romanow recommended; that is what, in essence, federal and provincial governments delivered. Canadians keep medicare. They get it expanded into new areas such as catastrophic drug coverage. Their governments will spend more than \$34 billion in additional money on the system over the next 5 years. They get the promise of administrative and organizational changes, combined with new oversight mechanisms such as a National Health Council. This answers their belief—or at least they think it answers their belief—that the system can be financially sustained through the elimination of waste and the introduction of better management. And the public does not have to pay a cent more from their own pockets,

either by paying directly for services or through the tax system. It is a dream come true.

This outcome, broadly speaking, depended on a series of assumptions. First, that Canadian “values,” are consistent only with a health care system like medicare. Any move away from that system, however slight, would be an affront to those values. Second, that all other health care systems are less efficient, to say nothing of less socially fair, than medicare. Third, that the proposed administrative

and operational changes will bring not only better service delivery and patient care but at a reduced cost, thus lessening the financial burden of the system on the public purse. Fourth, that the use of much of future federal government surpluses for health care represents an informed choice by Canadians of how they want their tax dollars spent, and that this additional health care spending will not constrain the ability of Ottawa or the provinces to finance other necessary government services.

As I said, the national debate is over. It was based on these assumptions. We shall now see in the next 5 years or so, as the additional money courses through the system, whether the anticipated outcomes occur. I think there is a reasonable chance that the outcomes will *not* occur as those who framed them believe. That is because I believe the assumptions are at least debatable, if not flawed.

Canadians had become conditioned to believe that there were only two health care systems, courtesy of our proximity to the United States: theirs and ours. I have never favoured the US system. It takes a larger share of GNP than ours and does not provide any insurance for 45 million Americans.

Aggregate health outcomes are not better in the US, despite the fact that Americans spend more of the country's GNP on health care than we do (14% compared to 9.6%).

These two weaknesses condemn the US system in my eyes, despite undeniable strengths of that system, especially for those insured. Many, I would say the majority, of Americans get timely access to top-quality medical care. However, defenders of our system were easily able to draw invidious comparisons, as when Mr Chretien declared that "down there, they check your wallet before your pulse..."

It struck me that Canadians did not realize and, with a few exceptions in the reports I mentioned, they were not asked to analyze an observable fact: that there are a number of other systems than the US one from which Canada could have drawn inspiration. These, in Europe and Australasia, offer a basic public system onto which has been grafted in different ways various private payments. These payments were deemed necessary to ease the burden on the public treasury and to allow the public system to cover a wider range of services, and in some cases, a much wider range of services, than Canadian medicare....All other countries are closer to Canada than the US on the spectrum of health care systems, but they provide or encourage some form of private payments....

There were, in other words, many other models from which Canadians and their various task forces and royal commissions could have drawn inspiration. Instead, we were locked into the public opinion straightjacket of Canada versus the US. Rather than help us escape that straightjacket so that the Canadian public could have been introduced to other options, Mr Romanow's report and his public comments repeatedly made reference to that Canada-US framework.... Royal commissions are supposed to be about opening eyes, not shutting them. In this regard, Canadians got an eye-shutter.

So one assumption, that it was the Canadian system or the US system, was wrong.

Another assumption, and a very deeply held one among so-called "reformers," is that administrative changes to the system will be a) good for patients and b) offer some relief from medicare's rising

costs. They are correct about a) but not necessarily about b).

By "administrative changes" I mean, among other things, more widespread adherence to "best practices"; personal medical cards; improved technology and record-keeping; group primary care practices bringing together doctors, nurses, nurse-practitioners, pharmacists (primary-care reform); regional health authorities. Every single report conducted on the Canadian health care system in recent years has recommended most, if not all, of these changes. These are what I call the "rational planners" response....

Primary care reform

Primary care reform has been on the nation's agenda now for a long time. Community clinics began in Saskatchewan and Sault Ste Marie in the late 1960s. By the 1970s, Quebec had its Centres locaux de service communautaires, Ontario its Health Services Organizations and Community Health Centres. Other provinces had similar programs. In the 1980s, more projects were under way, and various initiatives supported an expanded role for nonphysician primary health care providers. In the 1990s, the vocabulary changed from primary medical care to primary health care. The urgency of further change intensified—at least from governments. Between 1997 and 2000, Ottawa spent about \$150 million on what it called a Health Transition Fund to support more pilot projects of interdisciplinary primary care. And now, again, governments have identified primary health care reform as a top priority for the \$16-billion Health Reform Fund. The movement toward primary care reform, although discernible, has been slow, or at least slower than all this governmental activity would suggest.

That these changes will save money, however, is debatable. Primary care reform will require sweeteners for doctors to join, because this reform usually changes their method of remuneration away from fee-for-service. Once doctors are put on salary, or "capitated," their willingness to see as many patients might decline. And there is already

a shortage in many areas of family doctors. You know better than I do what the effect has been of the governments' decision, based on "rational planning" to reduce the number of positions in medical school, a decision now being reversed. Some friends who are family doctors tell me that some are not willing to work the killing hours of yesterday, especially young doctors with child-rearing responsibilities. And financial inducements seem to be tilted toward specialties.

Even if, as I think unlikely, these administrative changes of the "rational planners" do bring certain cost savings, they will be unable to stem the tide of new spending demands. They will not, in other words, alleviate the cost pressure on public treasuries of the health care system.

As for the bedrock assumption in this national debate, and in the Romanow report, that Canadian values are consistent only with our kind of medicare, I find this assumption both laudable and curious. Laudable because medicare does speak to values of sharing that reflect well on Canadians. Medicare, to use language not favoured in public debate, is an enormous income redistributor, since low-income people use it more than high-income people because their health indicators are worse. High-income earners could buy their own insurance, but they are taxed at higher marginal tax rates to support a system at least some of them do not need....

Spending on health care

From 1997 to 2002, Canada spent an additional \$34 billion on health care, to bring total national

spending from public and private sources to about \$112 billion. About 70% of that money is now spent through the public sector, up slightly from 5 years ago. My question to you is this: has anybody noticed discernible improvements in the health care system in that period? If the answer is yes, then you will be rightly optimistic that the roughly \$36 billion we are going to spend in additional dollars in the next 5 years will improve matters even more. If the answer is no, then we might want

to retain some skepticism about the next \$36 billion.

Put matters another way. In the last 3 years (2000, 2001, and 2002), health care spending increased by 8.5%, 8.4%, and 6.3%. This is faster than any other measurement: other government programs, the consumer price index, total government revenues, growth in gross domestic product. It is true that in the mid-1990s, health care spending had been constrained as the country licked its horrible deficit problem. So it could be argued that some of this spending represented "catch up" for the reductions of before—but by no means all of it.

Ask any provincial treasurer. It does not matter which party. Arithmetic knows no political favourites. They will tell you two things. First, that health care spending is rising, has been rising, and is projected to rise faster than any other government program. Second, that its share of total provincial spending is rising, has been rising, and is projected to rise still further....

Do the math. If by far the single largest item in your personal household budget is rising, has risen, and is projected to rise faster than your income, something has to give. You either need higher income, you have

to cut back on other spending, or a combination of both. Or you could go to the bank and borrow.

This is governments' dilemma, irrespective of political stripe. It is what I call the remorselessness of arithmetic. Health care spending is the largest budget item. It is growing faster by far than any other program. The public will not pay additional taxes. Maybe they are wrong in this, but they will not, and Mr Romanow said they did not have to. Something has to give, and that something is other government programs....

The easier way for provinces to try to deflect criticism either that they are not spending enough on health, or that in spending what they do on health they are squeezing other programs, is to blame the federal government. Indeed, no sooner did the two levels of government "agree" on the \$36-billion injection of funds than every provincial government screamed that it was not enough and that they would be back rapping on Ottawa's door very shortly. Just now, they are insisting that a conditional promise by Ottawa of \$2 billion more must be paid; indeed, the provinces have already put the money into their budgets even though Ottawa did not guarantee that they would receive it.

What I have suggested inferentially, I will now put plainly. We had a national debate, but we missed an opportunity in that debate to get ahead of the game, to change the system so that it could truly be sustainable and not continue to be a spending machine that leaves everything in its wake. I am sadly confident that sometime later this decade, we shall have to engage in another national debate, many tens of billions of dollars later, about changing this system unless we are prepared to pay higher taxes dedicated principally or precisely for health care.

Big Deal for Canadians

You fairly ask what I would have done. And I will answer. I would have proposed a kind of Big Deal to Canadians. I have no use for the US system, so I would have got that option off the table. I would have said to Canadians: "Look, do you realize how costly this system is? Here are the numbers." Then I would have said, "And do you realize how narrow

is the coverage, in the sense that we are paying fully only for services provided by doctors and hospitals, and that elsewhere we have a patchwork system?" And I would have then said, "Health care is changing away from hospitals and doctors toward drugs and long-term acute care and community outreach clinics, and these are not fully integrated into the public system, publicly financed."

So the Big Deal I would have offered was this: an extension, not a retrenchment, of the public system to include coverage of at least some of those areas now covered only in a patchwork way. In other words, more public coverage, as in almost every other public system. But to pay for the wider coverage, I would have said, "We are going to include more income-tested private coverage, so that the public system can be extended and be there for those who need it in a way that the public treasury can afford."

I do not know how Canadians would have responded to this kind of framing of the issue. It may be that such an argument would have been shredded by defenders of the status quo. It may be that the public is so fearful of any change outside the existing model that it would have rejected it....

Journalists seldom admit error. I do, publicly and willingly. And so as a defender of public health care (in my own way to be sure), I hope that I am wrong, and if so, will say so at an appropriate moment. I hope to be wrong in the sense that the monies to be spent and the "rational planners'" reforms to be implemented will improve the system and make it sustainable. This is the biggest bet that our generation of Canadians has taken. I hope the bet is won, although for reasons I have explained, I think it will be lost. If you meet again in 5 or 6 years, I preach modestly for a return invitation. If I am proven wrong, I will gladly eat crow, and given the widespread unpopularity of journalists, it will be an opportunity none of you will want to miss. ❁

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