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**Canada's Health Care System
An Urgent Need for Change**

Following the second world war, the industrialised countries, with the exception of the United States, have all established public health systems. Here, in Canada, our health care system, which appeared both possible and highly desirable, was established in the sixties. For many years, it has worked very well and has even been seen by many as an example. The health of our population has considerably improved and millions of Canadians have been spared the financial hardships due to disease. Canadians have been very proud of their system which has become a characteristic distinguishing us from our American neighbours. Unfortunately, conditions have changed and our public system is now facing a crisis of such a magnitude that it threatens its future existence. We have to face this reality.

To understand what has happened, we must look at the profound changes that have modified, since the sixties, the economic, demographic and social context.

1. At that time, Canada enjoyed, since the end of the war, a long period of sustained economic growth. It seemed that there would be no end to the increase in our collective wealth. Nothing seemed impossible. Since then, we have experienced major slowdowns in our economy. It would be illusive to believe, in spite of the current prosperity, that we will not again go through recessions such as those of the eighties and the nineties.

2. Our population was growing at a rapid pace thanks to the high number of births and the strong flow of new well formed immigrants. The ageing of the population was totally unpredictable. Today, this phenomenon is accelerating. Statistics Canada reported recently that there will be 4,1 million Canadians over 65 by 2004. Within twenty years, there will be more people over 65 than under 21. Ageing of the population will therefore result in a continuous and inevitable rapid increase in the demand and the costs of health services. Moreover, these increasing costs will be borne by an active population which will be decreasing in relative terms.

3. The level of our taxes was relatively low and the budgets of our governments were in balance. Moreover, public debts were to all practical purposes inexistant. One hundred per cent of public expenditures were used for government activities and programs. Today, less than three-quarters of their revenues are used for these purposes. The balance is needed for the servicing of the huge debts incurred over the years by our governments because of their lack of foresight,

4. Since the national economies were sheltered, each country could adopt the economic and social policies which they deemed most appropriate together with the corresponding levels of taxation. Today, all countries have to adjust their

taxation on account of the opening of trade and globalisation. In this context, Canada has to lower the excessive level of our taxation as compared to our competitors which means less room for health expenditures.

5. The costs of the most essential health services, namely medical and hospital services, were increasing less rapidly than the general economy. They were not really affected by the costs of technological progress and of pharmaceutical drugs which, in any event, were not as important as they are today in the treatment of patients.

Today, there are two factors which, in addition to ageing, bring about a rapid and inevitable increase in the costs of health care:

- the spectacular progress made by medicine often means larger specialized teams and highly sophisticated and expensive equipments;
- drugs, with their rapidly increasing prices, play an ever more important role in the treatment of all forms of physical and mental illness.

The combined impact of these factors means that the costs of health care are now increasing more rapidly than the economy and the revenues of our governments.

6. In the sixties, the prevailing political philosophy was based on principles of equal opportunities, social justice and redistribution of income. Since confidence in the future was without limits, the new social programs such as old age security and family allowances covered all citizens without any distinction. While the ideal of social justice continues to be part of our values, the policy and program frameworks have undergone profound changes. Except for health, where our system has remained essentially unchanged, financial and other resources are now focused where needs are the greatest.

The combined impact of all these changes, that have taken place over the last three decades, has rendered our health care system no longer capable of meeting in a satisfactory manner the needs of the population. For example, in Quebec, there are presently more than 1000 patients waiting for cardiovascular surgery and that number is steadily increasing. The cardiovascular surgeons have denounced this situation which, in their opinion, results in deaths that could be avoided. The number of patients waiting for radio-oncology treatment has increased in recent weeks from 285 to 455. This, irrespective of the fact that a number of patients are, at very high costs, being treated across the border. Those are only two examples that illustrate how serious the situation is.

The problems are numerous: the shortage of trained personal, the migration of experienced physicians toward the United States, the scarcity of essential equipment, the heavy burden imposed on relatives of chronically sick people, the treatment in the United States of cancer patients, the deteriorating condition of numerous buildings, etc. People are, with good reason, worried to such an extent that they openly wish they will not get sick.

Unfortunately, the factors responsible for the current crisis are still at work. Without a doubt, ageing and the increasing costs of medical services and drugs will continue to add to the pressure on the system. In other words, the approach which consists in reacting to each new crisis by filling the gaps and by the sporadic addition of more funds is no longer sufficient.

However, what seems to be evident to most people is not so for many. Our health care system has become a sacred cow not to be touched. That explains the gap between the frozen characteristics of our system and the real world in constant evolution. In all sectors of activity, except for health services, adaptation has been and continues to be the rule.

Health constitutes a highly complex field of activity. For that reason, we should not be looking for a unique and uniform solution. The problems must be tackled in more than one way and account has to be taken of the varying situations from province to province. Furthermore, we must not lose sight of the fact that the numerous attempts to improve the situation simply through the injection of additional funds have, as a rule, provided only temporary relief.

Our health care system, with the passage of time, has become inefficient and reacts very slowly and with difficulty to the changing needs resulting from new lifestyles and the ageing of the population. For example, in Québec, our system is subjected to a heavy bureaucracy, a highly centralised decision process and to rigid collective agreements. The administrative structures must be reduced and simplified, the rigid regulatory framework must be relaxed, the emphasis must be placed on the quality and continuity of care, the list of insured services must be revised, the methods of financing the services and the remuneration of doctors and other professionals will have to promote greater efficiency, etc. To varying degrees, similar problems exist in other provinces. The corrective actions, which have been debated for years, will have to be pursued without respite in order that the huge resources involved are utilized more efficiently. However, on the short term, more efficient ways of delivering health services and greater productivity cannot alone resolve the crisis.

There is presently, without a doubt, a need for additional funds in the system. A serious gap between needs and the capacity of the system has resulted from the budget constraints of recent years. And it will necessarily take some time before the impact of the changes that are introduced in the system will be felt. For that reason, I believe that an interim increase in the public financing of the system is essential in order to address the more urgent problems and to allow the needed changes to take place and bring about their impact.

Unfortunately, at the political level, health continues to be a highly contentious issue. The federal government does not want to limit itself to providing funds and

is evidently wishing to play a role. It has proposed to increase the level of its financing through the establishment of a national program of primary and home care. The provinces find this proposal, to say the least, inappropriate while they are struggling with their existing plans. They argue, with good reasons, that they know what has to be done and that what they need most is additional funds.

Instead of its proposed plan, the federal government could play a much more useful role by bringing to the provinces transitional financial help. The objective would be to give the provinces some room or margin to allow them to develop new approaches and to introduce changes to their plans capable of improving the situation in a durable way. In the middle of the sixties, the federal government created a health resources fund to enable all the provinces to have the human resources and the equipment necessary for the introduction of medicare. Using that successful initiative as a model, the federal government could create a health transition fund to help the provinces make the necessary changes to their respective plans. The setting up of such a fund, to which it could allocate at least the funds intended for the national primary and home care program, would give the federal government an essential role fully compatible with its responsibility with respect to health services and the visibility it is seeking in this field.

Contrary to a primary and home care national program, this approach has the advantage of not pressuring the provinces into increasing in a permanent way the level of their health expenditures when they are not even in a position to finance adequately their existing plans.

Before discussing the changes which are or could be introduced by the provinces to their plans, a brief review of the Canada Health Act and its application to the provincial plans is necessary. According to the act, all Canadians must have free and equal access to the services that are covered. In reality, these objectives or principles are widely breached. It is evident that medical services are not always accessible or that they are more accessible to some people than to others and that the necessary level of quality is not always there. The situation is also clearly deteriorating. Consequently, the first and foremost objective must be to give back to each and all Canadians access without undue delay to quality care.

The other principle of the Canada Health Act has to do with the public administration of the provincial plans. This principle has to do with the means of production of services and it is applied in an extremely rigid way as if it was on the same level as the other principles. This doctrinaire approach has had a very negative impact on the evolution of the provincial plans and on their ability to meet the needs of their people.

Here is an example illustrating the inadaptation of the act in the current context. In Quebec, a new prescription drug insurance program was introduced in 1996.

All the beneficiaries are required to pay a premium and a portion of the cost of their drugs. Group insurance plans by private insurers have been maintained but are now subject to certain requirements. Under the old arrangements approximately a million and a half people had no coverage. Under the new program, all citizens are covered either privately or publicly. The new plan constitutes a huge improvement, keeping in mind the importance of drugs in any treatment program. The setting up of such a plan would have been impossible in the absence of a private or non-public component. Actually, it even brought a reduction in the level of public expenditures. Under the Canada Health Act, this program would not qualify because of its private component and the fact that there is a contribution on the part of the insured.

Personally I believe that the time has come to review the Canada Health Act to bring it in line with today's reality and to allow the provinces to make some of the changes that are urgently needed to meet the needs of their populations. More specifically, I believe that there should be more room for the production of services through private means particularly at the primary and home care level. Private clinics operating within appropriate limits could go a long way into reducing the pressure on the public system.

Among all the changes that are being discussed or introduced, there are some that are more basic than others:

1. New sources of financing the system must clearly be developed. Since they would complement public financing, they would have, while respecting the fundamental objectives of the system, to come from private sources. This means that new forms of public-private partnerships for the delivery of services have to be developed.

In this context, the health transition fund could stimulate private investments for the purchase of equipment, the development of well organised medical clinics, long term care facilities and for other similar initiatives. The matching principle, under which public funds would be granted for each dollar of private fund, could be used. To be eligible, each project would have to satisfy some conditions related to the eligibility of patients, the quality and continuity of care, the opening hours, etc.

2. The productivity of the system must be improved. The introduction of some competition within the system would, in the opinion of many, give the best guarantees of success. In Great Britain, an interesting method of financing, which contains an element of competition, has been introduced. In Canada, the creation of a system of medical savings account (MSA) has been proposed. Under such a system, each individual would receive each year a credit in his account that he could use for his health needs. The unused credits at the end of a year could be transferred to the following year or to a RRSP. This approach, in addition to the element of competition that it provides, would also have the great

advantage of giving the citizen a greater say in the decisions with regard to his health and encourage him to utilize his budget more judiciously.

These examples demonstrate the fact that it would be possible to develop new sources of financing in concert with private concerns and to increase competition within the system without taking the road toward a two-tier system. The changes introduced in many European countries, which are confronted with problems identical to ours, also confirm that it is possible.

Unfortunately time does not allow me to discuss another important issue. It is obvious that more and more Canadians, not necessarily wealthy ones, believe that their freedom of choice with respect to their own health is, under current conditions, unjustly constrained. Rather than having to face long waiting periods, they would be ready to pay in order to avoid the inevitable stress associated with long delays and to be treated more readily. But how do you reconcile such a basic aspiration with the fundamental objective of equal access to all. There is obviously no easy solution to this dilemma which, nonetheless, will have to be resolved.

We must not accept the argument of idealists and politicians who argue that an adaptation of the Canada Health Act would inevitably mean the end of our public system. The great majority of Canadians deeply wish to retain equal access to all to quality care. However, nothing allows us to think that they are not ready to accept some changes in order to achieve this goal.

Our governments must act before the situation becomes out of control. The initiative however has to be taken by the federal government. The establishment of an health transition fund would stimulate the injection in the system of greatly needed funds, would help the provinces make their plans more productive and adapted to the needs of their citizens and would foster greater private sector participation. Let us hope that our political leaders will have the courage to recognize that our health care system has to be adapted to meet the needs of Canadians.

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~~April, 2000~~

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