CANADA 2020

The Canada We Want in 2020

Towards a strategic policy roadmap for the federal government

NOVEMBER 2011

SECURING OUR HEALTH SYSTEM FOR THE FUTURE

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ABOUT CANADA 2020

Canada 2020 is a non-partisan, progressive centre working to create an environment of social and economic prosperity for Canada and all Canadians.

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PREFACE

MAKING STRATEGIC CHOICES

GOVERNING IS ABOUT making choices. Sometimes the choices governments make are strategic, the product of hard thinking to address major hurdles which coalesce at a particular point in time. It is our belief that Canada is at such a point in time today and it is for this reason that we have produced this collection of papers to kick-start a discussion about the role of the federal government in Canada.

A serious public policy strategy for the country means doing less of some things, while focusing decisively and aggressively on a few important things. This requires in-depth analysis of the really big challenges and opportunities facing the country. It requires governments to be straight with Canadians about the risks and rewards that lie ahead, so that citizens will buy into a clear direction set by government.

The orientation of this volume – indeed the basic orientation of *Canada 2020: Canada's Progressive Centre* – is that the federal government has a vitally important role to play in developing and implementing strategic policies, focusing governments and other institutions in society on the big challenges the country faces, and mobilizing consensus for action. In other words, we believe that the federal government can be a force for significant and positive change.

This does not mean big government. It means intelligent, innovative, analytical and strategic government. It could conceivably result in smaller government, focused on a few big and important areas of policy that really matter to the country's future.

FIVE CHALLENGES FOR 2020

Today, Canada faces challenges and opportunities that are quite unprecedented in our recent history, although they may seem rather opaque to most Canadians. Our ability to overcome these challenges – and seize the opportunities – will determine the future trajectory of Canada's economy and society over the next generation. Our standard of living and quality of life could well hang in the balance. This is why we need federal leadership.

Canada 2020 contends that there are five fundamental, inter-related challenges confronting the country which require strategic political leadership and policy action from the federal government.

1 Increasing innovation and productivity Productivity growth and innovation are the sine qua non for economic prosperity. Canada's lack of productivity growth has been a worrying feature of the economy for decades. Since 1984, relative productivity in Canada's business sector has fallen from more than 90% of the U.S. level to 76% in 2007. There are no signs of things improving: quite the opposite in fact.

Since the 1990s, the federal government has been taking steps to try to reverse this trend, primarily by investing in university-based research and development and by cutting personal income and corporate taxes, the standard policy remedies for dealing with flagging productivity performance. Yet Canada's productivity growth has actually become worse over the past decade.

It is therefore time for a much more aggressive, focused and creative federal policy response to Canada's productivity growth and innovation challenge. Without this, we risk falling further behind and losing the revenues that enable us to sustain our standard of living.

2 Rising to meet the Asia challenge The global centre of economic power is inexorably shifting from the West to the East. This trend has been underway for twenty years, but it is now reaching a crescendo, partly as a result of the fiscal and economic problems plaguing Europe and the United States. There is no better evidence of this shift in economic and financial power than the recent efforts by the European Union to persuade China to help prop up the teetering European financial system.

Canada has been on a slow boat to China – indeed to Asia, more generally – for many years, notwithstanding the fact that we have some significant advantages over other countries in this region of the world. Over the past fifteen years, successive federal governments have made incremental attempts to broaden and deepen Canada's trade, investment and economic relationships with Asian economies. Despite such efforts, Canada is not really on the map in China and India today, in stark contrast to many of our major competitors.

It is time for the federal government to take a much bolder, more creative and aggressive approach to help deepen Canadian ties with Asia and enable Canadian businesses to take advantage of unprecedented market opportunities in the region. We must leverage our unique strengths and advantages and become an indispensible part of the new Asian century.

3 Squaring the carbon circle Canada has among the highest *per capita* levels of greenhouse gas (GHG) emissions in the world (although our total contribution to global GHG emissions is low as a result of the relatively small size of the Canadian economy). High Canadian emissions are due in part to our unique geography and harsh climate, but also to a weak culture of conservation and inadequate policy and regulatory regimes.

Modest measures to reduce emissions have been implemented over the past decade. But these initiatives have been neither significant nor strategic; as a result they have had little to no effect on Canada's overall GHG emissions.

Canada is also fast becoming one of the world's leading fossil fuel producers and exporters. It has even been suggested that Canada is "an energy superpower", or at least can realistically aspire to that goal. With that title are likely to come increased emissions, at least in the absence of meaningful measures to combat these.

As a G8 country, an original signatory to the Kyoto Protocol on climate change, and one of the world's largest per capita

carbon emitters, Canada has a moral responsibility to make progress on limiting GHG emissions (if for no other reason than to set an example for the big emitting countries). We are also at serious risk of missing opportunities in the low-carbon economy of the future and of becoming increasingly marginalized economically if we fail to act. It is therefore time for a serious, strategic effort, led by the federal government, to square Canada's carbon circle and put in place policies that will significantly decrease our GHG emissions.

4 Reducing income disparities and polarization Income inequality has been a creeping problem in Canada and other advanced economies for many years now. The bottom two quintiles of the income scale have seen their market incomes decline, in real terms, since the early 1980s (though transfers have resulted in some degree of after tax and transfer growth). At the same time, the top 1% of economic families have accumulated an ever-increasing share of Canada's wealth.

Income inequality, a feature of all market economies, is now giving way to income polarization. While this phenomenon is still more acute in the US than in Canada, some recent studies suggest the gap between rich and poor – and between the superrich and the middle class – is now growing faster in Canada than in the US.

Income polarization can have seriously perverse effects on the economy and on society. At an extreme, it can undermine social cohesion, unravelling the fabric of a country. The Occupy Wall Street protests, and their analogue in other countries, including Canada, are one early sign of the social discontent that can arise from income polarization and a growing perception that the economy is not working for most people.

Income polarization has not, up until now, been a big issue on the federal agenda. Various reforms to federal income security programs and the tax-transfer system have been put in place over the past twenty years, but these have not been aimed at dealing with income polarization. It is time for the federal government to analyze and consider the longer term effects of income polarization, and to consider strategic policy reforms to head off a looming problem.

5 Securing our health system for the future Universal, high-quality healthcare has been a defining feature of Canada and Canadian citizenship for 40 years. It is the public service Canadians value most. Yet the general consensus among experts is that if we stick with the current funding/administrative models and tax structure, Medicare as we know it is not financially sustainable.

Healthcare costs have been rising significantly as a fraction of our national income and as a share of government budgets (especially provincial budgets) for a generation now. The basic causes of healthcare inflation are well-known: expensive new technologies, procedures and drugs that permit us to live longer, coupled with an aging society.

While healthcare delivery is a provincial responsibility, healthcare financing – paying for the system – has been a dual responsibility, shared by federal and provincial governments, since the beginning of Medicare. In 2004, in response to rising costs and pressures on provincial treasuries, the federal government announced a major increase in federal fiscal transfers to the provinces for healthcare. With some $41 billion in transfers for health over ten years, the 2004 Health Accord was billed "a fix for a generation". Unfortunately, it has proven to be little more than a stop-gap for a decade.

As we approach the end of the Health Accord in three years' time, innovative, strategic policy approaches on health-care financing are urgently required. We also need the federal government to provide leadership on the organizational and accountability issues that underpin our health system in Canada.

The scope of federal government activity clearly extends well beyond these five issues. But our belief is that informed, strategic decision-making in these areas will go a long way towards securing the Canada We Want in 2020.

Our choice to address all the issues together has two implications. First, we will, as we move on, have an opportunity to examine the links between areas (for example, the effect carbon policy will have on our trading relations or the links between income inequality and productivity). Second, the broad scope of issues will give us a chance to reflect more critically on the role of the state, and the effectiveness of policy in general in addressing the key issues of our time.

KICK-STARTING THE CONVERSATION

This volume contains 15 papers, three in each of the five areas identified above. We have brought together a group of authors, all experts in their respective areas, and asked them to approach the issues from a strategic policy standpoint.

For this is what has been missing. The areas have all received attention in the past, but often not in a truly strategic way. Perhaps this lack of policy strategy and priority attention is due to the fact the tipping point has not yet been reached in any given area (although it is looming large in some, notably healthcare financing). Perhaps it is because governments and politicians lack the ideas to address these issues. Perhaps it is because of scepticism that the federal government can really make a difference. Perhaps we have reached the limits of innovative public policy and governance. Or perhaps we are just avoiding the issues – in a collective state of denial – in the hopes that they will resolve themselves in an acceptable way through incremental policy action.

Whatever the cause, it is time for Canada to break out of this mindset. Many elements of Canadian society – the business community, NGOs, governments at all levels, educational institutions, and Canadian citizens generally – must work to address the challenges. No single entity has the solution. A collective effort is required.

Our goal is to kick-start a strategic policy conversation throughout the country about The Canada We Want in (or by) 2020. Such a conversation has not been evident to date in Parliament, in general elections, in political party platforms, or in the media – indeed in any of the places you would usually expect to see it. The time for that conversation is now. Perhaps it will lead to a consensus among political, business, academic and other leaders in Canadian society that the federal government needs to chart a strategic direction for the country to secure Canada's prosperity and the quality of life Canadians have come to expect. We present this volume as a starting point. ■

INTRODUCTION TO OUR PROJECT

THIS VOLUME MARKS the culmination of Phase 1 of our project: *The Canada We Want in 2020*.

The overall aim of the project is to launch a debate about the role of the federal government in Canada. This publication is intended to act as a focus for discussion and a core around which we can bring in ideas from a wider range of people. It is, in this sense, a starting point.

Canada 2020 has called on fifteen authors to share their wide-ranging views in the five areas. Sometimes they agree on policy prescriptions, sometimes they disagree. But what all authors have in common is a belief in the value of discussing the options and thinking strategically about the issues that Canada faces.

In Phase 2 of the project we will stimulate further conversations in each of our five chosen areas. We will host a series of panel discussions and web-based exchanges that draw on the papers in this volume. These discussions will tease out areas of agreement and disagreement and begin to focus on implementation challenges. We expect to conclude this phase by mid 2012.

Phase 3 will see us narrowing back down and reaching conclusions. Drawing on the materials from the previous phases, Canada 2020 will produce a final, consolidated publication towards the end of 2012. This document will summarize our conclusions in each of the five areas. It will take into account recent changes and lay out proposed future strategies. ■

WHAT YOU CAN DO

Our aim is to draw as many viewpoints as possible into this project.

There are several ways you can get involved:

// **Attend our series of panel discussions in 2012**

// **Check our website: download documents, watch interviews and webcasts and make comments**

// **Contact us directly to arrange joint presentations or discussions**

Details are on our project site at: **www.canada2020.ca**

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SECURING OUR HEALTH SYSTEM FOR THE FUTURE

CANADA'S UNIVERSAL HEALTHCARE system is putting enormous pressure on provincial and federal treasuries at a time of fiscal deficits. Healthcare costs are rising as a percentage of GDP due to our aging society and healthcare inflation. Our existing health coverage is both unsuited to our country's current health needs (focused on acute rather than chronic care) and uneven across the country. Several groups – First Nations, older people with chronic conditions, those with significant pharma costs and no private drug coverage, and the victims of lapses in medical safety – are particularly ill-served.

Such problems are not unique to Canada. Healthcare costs are rising faster than GDP in all developed countries, which certainly suggests that there will be no easy solutions in this area. Nevertheless, the papers in this section lay out clear options for moving forward in a way that will ensure that Canadians in 2020 and beyond will have access to the healthcare services they need and want.

All of our healthcare contributors are firmly in support of a continued universal public healthcare system for Canada and all highlight the leadership role that the federal government must play in healthcare. While healthcare delivery remains a provincial responsibility, our authors are of the view that the federal government has a key function in focusing constructive public attention and debate on healthcare and in projecting a vision of a better health system for Canada.

Healthcare costs are rising faster than GDP in all developed countries

Change is needed in our health system not only because of financing issues, but also because of the unevenness of coverage between provinces and groups. Our health system was designed for earlier times. Recognizing this we must make decisions that make it more relevant to the challenges of today, most notably chronic illness and the high cost of outpatient drugs (and variability of coverage across the country). Today, too many healthcare decisions are played out in the public arena and taken in response to public pressure, rather than being based on critical evaluation of need, the efficacy of treatments and an appropriate strategic direction for a system that will always be financially constrained.

The federal government has a key function in focusing constructive public attention and debate on healthcare

The 2014 federal-provincial healthcare negotiations should focus on real health outcomes and finding ways to develop a patient-centred network of providers that is truly accountable to patients. Allowing the negotiations to get bogged down in discussion of the minutiae, or hijacked by those who would prefer accountability to be clouded, would be a missed opportunity for all Canadians.

Raising more money for healthcare will certainly be controversial, but if we want to maintain a world-class system, we will have to pay for it.

All authors identify the need for concrete change in the way our public health system operates. **Mark Stabile** focuses on the requirement for better evaluation of which medical procedures we will fund. **Philippe Couillard** is concerned with bringing physicians into the management of the system and ensuring that innovation in health provision is both effectively analyzed and rewarded. **Francesca Grosso and Michael Decter** focus on the need for simple indicators, better evidence-based decision-making and a systems approach that allows health personnel to move seamlessly between care settings.

The two papers that address the issue of funding both reject user fees and argue in favour of new, health-specific social insurance premiums. Raising more money for healthcare will certainly be controversial, but if we want to maintain a world-class system, we will have to pay for it. This will take a societal consensus that can only be achieved with federal government leadership, real explanation of the options and costs and much better accountability to the public.

Efficiencies are important, but not on their own sufficient to carry our health system into the future. For in 2020 we hope to have in place not just a patched-up healthcare service, but a truly regenerated system that is well-positioned to adapt as we advance.

LESSONS FROM 2004, PERSPECTIVES FOR 2014

PHILIPPE COUILLARD

Dr. Philippe Couillard, PC, MD is presently a Strategic Advisor, at SECOR Group. From 2003 – 2008 he served as Québec's Minister of Health and Social Services. He has held many positions within medicine, including as Professor at the Université de Sherbrooke and chief surgeon and director of the Surgery Department at the Centre Hospitalier Universitaire de Sherbrooke. He is the chairman of the Health Research Foundation of Canada, a director of two Canadian biotechnology companies and a partner at Persistence Capital Partners, a private equity investment firm. Dr. Couillard is a member of the Queen's Privy Council for Canada and sits on the Security and Intelligence Review Committee.

"There is nothing wrong with change, if it is in the right direction"

Winston Churchill

Seven years ago, our country's first ministers gathered in Ottawa with the intention of achieving an accord that would fix healthcare "for a generation". Sadly, this ambition remains unrealized.

What progress there has been has taken place on the "production" side of our healthcare system: wait-times for targeted procedures have improved (albeit at considerable cost). On the negative side, there remain significant cross-country disparities in coverage for prescription drugs, home and long-term care. Attempts to improve accountability have fallen short of expectations.

As 2014 approaches, some would like the existing accord – including the 6% escalator – to be renewed as is. This would be a missed opportunity. Our country's leaders must learn from the experience of 2004 and use the forthcoming *rendez-vous* as a unique opportunity to make real and perceivable improvements in healthcare for all Canadians.

WHAT WAS MISSING IN 2004?

Looking back at 2004, what is striking was the lack of detailed and meaningful discussion of healthcare, *per se*. Most of the discussion centered on funding, volumes and wait-times, leaving quality, performance and most of the core healthcare issues facing Canada on the sidelines. In hindsight, this focus on the production line rather than on the real value delivered to the user was highly predictable, given the often anecdotal level of most media coverage of healthcare and the realities of our modern political world.

This is not to say that reducing wait times is not important. Shorter wait-times help bolster user-confidence in our healthcare system. But even more pressing is the need to improve the performance of overall healthcare networks. Healthcare services should address our society's changing needs and the resulting patient experience should be comparable to that of citizens of other affluent countries. The focus should be on delivering high quality, seamless, safe services in a timely fashion.

THE ROLE OF THE FEDERAL GOVERNMENT

Since most healthcare responsibilities lie at provincial/territorial level, the federal government is one step removed from the immediate delivery of services. In spite of this, the federal government can – and should – assume a position of leadership, leveraging its financial contribution to become an influential agent for change and focusing the entire country's attention on healthcare (still most Canadians' number one priority).

My first piece of advice follows from Hippocrates' aphorism: "First do no harm…" The federal government should be a facilitator and a collaborator, not a self-appointed policeman in this very complex sector. There is much that is good in our healthcare system and it could easily be destabilized by succumbing to the temptation of a scorched earth policy. Change, in order to be long lasting, has to be incremental and feasible: services are delivered as we deliberate, 24 hours a day, 7 days a week, thanks to the efforts of some of the best teams in the world.

Having said that, the key areas that require attention are as follows.

Securing better value for money

It is difficult to argue that Canada's healthcare sector is not well-funded. In 2009 we ranked 6th among OECD countries in both *per capita* healthcare spending and health spending as a % of GDP. Since the budgetary drought of the mid-nineties, healthcare costs have increased rapidly. Globally, all developed countries face the same decoupling of healthcare expenses and GDP growth. Variations in funding mechanisms across countries – subsidized private insurance, social insurance, tax-based funding with or without user fees – have limited impact on countries' ability either to "bend the cost curve" or to improve performance (with the exception of the poor performance and equity of the very few systems that are based purely on private, unsubsidized insurance).

The reality is that healthcare is a "luxury good" accessible to affluent societies such as Canada. As such, it is unlikely that the annual rate of increase in expenses can be brought down to less than 4-5% without adverse consequences, followed by rebound overspending. So, the focus should not only be on mitigating costs but also on pursuing better value for money.

This is particularly important for Canada. Over the past two decades we have slipped backwards in performance relative to our peers. This has not escaped notice: the OECD estimates that by increasing our efficiency in healthcare we could save (or reallocate) up to 2.5 % of our GDP by 2017.[1]

We are not facing a black hole, nor are we likely to see the apocalyptic downfall of our healthcare system. However, if we do not make improvements, we will see a growing gap between supply and demand and an increasing level of dissatisfaction leading to "default" and anarchic privatization of the financing of services, instead of a harmonized and regulated integration of providers, for the benefit of patients.

Payment reform should stand as the cornerstone of the next wave of healthcare reform

Rather than seeking to change the way we fund the current basket of publicly insured services, we should look to reform our payment models. How we pay providers and institutions has a profound impact on the choices they make (or do not make) and on the performance of the overall healthcare system. Thus, payment reform should stand as the cornerstone of the next wave of healthcare reform. The key is to reward the creation of real value (high quality outcomes for patients) rather than only volumes of procedures or interventions.

[1] OECD (2011) *Economic Policy Reforms: Going for Growth 2011*. Paris: OECD. Chapter 6, p.229.

Practically speaking, the value of reducing the wait-time for knee replacement surgery to less than six months is much reduced if the patient does not also have good access to better integrated care (including seamless transition between outpatient treatment and hospital, home care and rehabilitation, followed by preventative measures aimed at avoiding other similar ailments). Such a scenario is not a fantasy. It is a concept elegantly described by Michael Porter,[2] amongst others, and one that is being implemented in many of the foremost managed care organizations around the world. In such a system, value is defined and measured from the perspective of users rather than system managers. Evaluation focuses on high quality outcomes rather than the number of procedures performed in defined clinical situations.

We need physicians to participate in the management of the system

In helping to define – not implement, that is a provincial responsibility – such changes, and ensure that they are adapted to the varying realities of our system (rural, urban, teaching, etc.), the federal government has an opportunity to spell out what a "patient centered system" really means.

The current block funding of institutions, with annual indexation, provides little or no incentive to innovate or improve efficiency (and if efficiency gains are made, savings cannot easily be identified, captured and reallocated to other parts of the healthcare network, such as primary care). Savings on paper fail to materialize in reality, more money is requested the following year and another circle of virtual savings – and very real expenses – begins.

Many argue that the best way to address this problem is with activity-based funding (ABF) for our hospitals, the equivalent of fee-for-service for physicians. While this would be a move in the right direction, ABF is not the whole answer. Isolated ABF risks being inflationary and putting too much emphasis on hospital care in the continuum of services. A better response would be to base a substantial portion of payment on outcomes (assessed from the perspective of the patient) rather than solely on the number/type of procedures performed. Timely access then becomes an important, but not unique, determinant. Employing, once again, the example of knee replacement surgery, the desired outcome would be an integrated, timely, safe and patient-centered management of the condition: osteoarthritis of the knee.

When it comes to physicians, we should move in the opposite direction. Rather than the current fee-for-service model, new models combining some form of capitation (being paid for keeping a defined population healthy), with incentives for productivity, good practices and outcomes should be identified and promoted.

Fixing the dysfunctional relationship between physicians and healthcare institutions

At the birth of our public healthcare system, a Faustian bargain was struck. Many medical organizations opposed Medicare and physicians in both Saskatchewan and Quebec went on strike, in the middle of the October crisis. In response, governments allowed physicians to retain a free entrepreneur status within publicly-funded hospitals, a feature unique in the OECD and, to this day, the source of constant tension between managers and professionals. The other promise of 1970, that a competitive level of compensation for physicians would be maintained, has been honoured, despite bumps along the way.

It is now time for a "new deal" to be struck between the medical profession and public organizations. Most importantly, we need physicians to participate in the management

[2] Porter, M.E. & Teisberg, E.O. (2006) *Redefining Health Care: Creating value-based competition on results.* Boston: Harvard Business School Press.

of the system (with adequate compensation for doing so). The best healthcare institutions have strong physician leaders who collaborate with administrators.

Under such a model, physicians and other health professionals (including nurses) would play a pivotal role in identifying best practices and making decisions about optimal resource use. I observed, first hand, enormous benefits from the active involvement of physicians in dealing with a major epidemic of *C. Difficile* in 2004. Based on this and other experiences, I truly hope to see the emergence of a new generation of physician/leader/managers collaborating with administrators and other health professionals, to the benefit of patients.

Adapting the system to meet our changing needs

At its inception, Canada's Medicare was narrowly defined as covering services provided by physicians, especially in hospitals. This made sense at the time. In the second half of the 20th century Canada's population was young and acute health issues were the major concern. This is no longer the case. We therefore need to adapt our system to meet our country's changing demographics and needs.

Canadians too often face a "disease lottery". In acute situations patients receive excellent care and incur few out-of-pocket expenses, apart from prescription drugs, coverage of which varies considerably by province. But the system's response to more contemporary challenges (such as Alzheimer's disease) is highly deficient. Only rudimentary home care is provided and families and caregivers are left facing significant financial challenges.

Overall, Canadians pay more privately and out-of-pocket for healthcare than most of our western European counterparts: in 2009 Canada ranked 22nd among OECD members in terms of the percentage of total healthcare spending that is publicly funded (70.6%). This is a direct consequence of the exclusion from the initial definition of Medicare of many of the services required to meet our current challenges (an aging population with chronic health issues).

Canadians too often face a "disease lottery"

The solution seems obvious: extend public coverage of non-core services. But this raises funding issues. Unless we choose to modify physician-hospital coverage to balance this extended basket of services (which would be very difficult, politically), we would need to find extra funds. Efficiencies deriving from reform of payment models should yield some money, but there is no escaping the fact that if new services are to be covered, new money will be required. In the world of healthcare, money always comes from citizens' pockets, one way or another, so a form of co-payment (or social insurance model) would need to be introduced, or else taxes would need to be significantly increased. It is the responsibility of all governments to present these choices to the electorate, clearly and with their respective costs and benefits explained.

Finding better ways to manage demand

Historically, our system has managed to control costs only by reducing supply. This led to one of the worst decisions of the nineties: cutting medical school enrolment without increasing the supply and influence of allied professionals, such as nurse practitioners. The irony is that today the shortage of professionals (a self-inflicted wound) is invoked as a key argument against proposed changes… the typical story of the dog biting its own tail.

Managing demand does not necessarily mean introducing user fees or other forms of co-payment. Although there is nothing inherently wrong with these widely-used methods, my view is that they would simply waste

energy and resources and yield little positive impact. Where such revenue models are in place, there have been constant demands for exclusion, leading to a decreasing number of payers supplying an increasingly marginal amount of money, at considerable administrative cost. There is also evidence to show that, when faced with fees, users reduce their utilization of all services, both unnecessary and necessary, which can cause problems down the line.

Nevertheless, an open discussion of the merits of these funding options should be part of our political debate. Taking refuge in the "prohibition" of user fees in the Canada Health Act is not an adequate response, underestimating, as it does, the capacity of informed citizens to engage in a meaningful conversation on the question.

In my view, though, there are more equitable ways to control demand. First, an evidence-based process should be put in place to establish optimal use of new technologies and pharmaceuticals. Once more, the focus should be on outcomes: it is not so much the number of MRI machines that matters (above a certain minimum) but how they are used.

On the budgetary side money should flow to integrated primary care organizations that purchase specialised services "upstream" in the system, based on outcomes and documented needs. (The National Health Service in the UK is presently moving in this direction, an experiment worth studying.) Lastly, efforts should be made to induce competition among providers who vie for public payment.

An evidence-based process should be put in place to establish optimal use of new technologies and pharmaceuticals

While such implementation decisions take place, of course, at the provincial/territorial level, there remains a powerful role for the federal government in signalling the type of system that is mostly likely to be able to meet the needs of Canadians in 2020 and beyond.

Supporting a more meaningful discussion of private vs. public

This is the most difficult, sometimes obsessive, part of our conversation on healthcare. Proponents present the private sector as a panacea, opponents see it as the devil incarnate. Both sides are wrong.

Across the political spectrum, most observers agree that family medicine groups in Ontario and Quebec have improved primary care delivery and that they demonstrate the public sector's capacity to innovate. Such groups are essentially a form of partnership between the public system and a private (often for-profit) corporation. Their hybrid nature has not, though, stood in their way. Likewise, when the state acts as an insurer (in the context of workers' compensation, for example), it loses its statist inhibitions, employing the services of private providers, negotiating prices and encouraging competition just as the private sector would. But bring the discussion round to other types of services (e.g. high volume, low intensity procedures such as minor surgery and diagnostic procedures) and endless objections are raised.

The social problem associated with the presence of private providers in our healthcare environment is not their existence, but the fact that their resources are not accessible to all. Public funding of privately-delivered services is a simple concept that overcomes this problem, works to the advantage of all and is entirely compatible with the Canada Health Act. So, where there is sufficient density to ensure competition, it makes every sense that the state should determine the price of

selected procedures and that all providers – public and private – should compete for the privilege of serving patients.

It is important to note, however, that while such competition is feasible in our main cities, where many providers coexist, competition between providers has little practical meaning in our remote and sparsely-populated communities where there is only one regional provider. This is one of the factors that sets us apart from western European countries. Another is the larger number of (often less well-compensated) physicians in such countries. Healthcare systems cannot be dislocated from their social-historical context, nor can they be transferred as blueprints between societies. But we can observe lessons from elsewhere and adapt them to our reality.

Defining and promoting accountability in healthcare

Too often, federal-provincial conversations on healthcare end up as power and visibility struggles. There is no need to go down that path again. Healthcare is, in large part, a provincial responsibility and, by insisting on being visible and in control, Ottawa runs the risk of transforming the debate on improved, sustainable patient care into a constitutional battle. In 2004, as the federal government insisted that provinces should be held accountable for their use of federal transfers, the last days of the conference were spent discussing the merits of asymmetric federalism, rather than health outcomes.

Within the existing constitutional framework, credible and visible accountability must, though, be established. It is legitimate for the federal government to use its spending power to initiate change and then to receive credit for it.

A starting point would be for the federal government to state that change and experimentation (including in coverage and funding methods) are welcome, so long as universal coverage and equity are preserved. It can acknowledge that there are significant gaps in coverage and a high degree of inequality across the country. It can be open about the fact that extending health coverage to new areas will require new funding from governments and citizens. It can state unequivocally that nothing in the Canada Health Act prevents competition among providers, under public funding.

It could also facilitate the creation of an explicit and credible mechanism for ensuring accountability. We need a renewed Health Council, composed of existing provincial Quality Councils or Commissioners, with representatives from the health professions and the public. The role of this jointly-funded but independently-governed "Institute for Innovation in Healthcare" (which would subsume our existing Canadian Institute for Health Information as a data provider) would be to research best practices around the country, make them visible and promote their adoption.

Too often, federal-provincial conversations on healthcare end up as power and visibility struggles

The Health Council should present an annual report directly to the federal-provincial-territorial assembly of Health Ministers. Each provincial/territorial government's response to its recommendations would be evaluated by their respective Quality Council, and ultimately sanctioned – or rewarded – by the electorate. This mode of reporting, coupled with the absence of elected officials on the Council, would ensure its credibility and independence from political/electoral cycles.

When it comes to federal funding levels, there is little doubt that arrangements will be renewed, at least at the new "baseline" level reached in 2014. But the 6% escalator

The present federal government has one strategic decision to take: does it want 2014 to be a low-profile, rubber-stamping event, or does it want renewal of our ailing healthcare system to be part of its legacy?

should remain open for discussion and its continuation linked to substantial progress in performance.

One option would be to place all new funds (beyond the 2014 baseline) in a dedicated "fund for innovation", accessible to any province or territory willing to implement changes that result in increased performance from the patient's point of view. Access to the fund would be dependent on initiatives being approved by the relevant provincial Quality Council (with input from the public and health professionals). Results would be assessed through an arm's length process (for example by an academic review or the Quality Councils themselves) and the findings would be tabled and debated in the provincial legislature, which would then be accountable for results.[3]

CONCLUSION

Our healthcare system is not in crisis. But, like other publicly-funded systems, it is suffering from the classic tension between needs and resources. Thirty years from now, this tension will still be there, and a new society with its specific needs, challenges and unpredictable technological advances will have emerged.

Our responsibility is to take a step forward and to use the 2014 horizon as a catalyst for change and improved patient care. All of us – citizens and governments alike – have a role to play and bear a share of the responsibility. The present federal government has one strategic decision to take: does it want 2014 to be a low-profile, rubber-stamping event, or does it want renewal of our ailing healthcare system to be part of its legacy? If the latter, it should act accordingly and ensure that the 2014 discussions live up to their potential as a formidable lever for change.

FOUR FEDERAL INITIATIVES TO IMPROVE AFFORDABILITY, PRODUCTIVITY AND ACCOUNTABILITY

FRANCESCA GROSSO AND MICHAEL DECTER

INTRODUCTION

Maintaining a high quality healthcare system in the current era of slower economic growth and greater healthcare demand will be a huge challenge for Canada. The task of addressing and managing this challenge falls largely to public sector decision makers (since the public sector currently provides 70% of Canadian health services financing). Such decision makers must cope with the combined effects of two key factors: (i) an aging population and higher dependency ratios but also (ii) the vast number of new healthcare interventions, both diagnostic and in treatment, and the seemingly boundless public appetite for these. It is not aging *per se* that is the problem but aging in the context of increased healthcare options.

The Government of Canada has an important leadership role to play in ensuring a sustainable, high quality healthcare system into Canada's future. This paper describes four key initiatives that would help it build on past successes and provide more dynamic and substantive leadership at this critical time. Each initiative has the potential to drive both an improvement in delivery and an increase in the affordability of healthcare.

BACKGROUND: CHANGES ALREADY MADE

Beginning in the early 1990s, the federal government made significant changes and invested substantial sums in the areas of health information, health research and health informatics.

// **Health information** The Canadian Institute for Health Information (CIHI), was first proposed in the early 1990s by then federal Deputy Minister of Health Margaret Catley-Carlson to consolidate, rationalize and improve the collection of health information. Prior to this, four separate taxpayer-funded bodies were engaged in the collection of information: Statistics Canada, Health Canada, the Hospital Medical Records Institute (HMRI) in Ontario and MIS in the rest of Canada. The information they provided was often up to three or four years out of date. HMRI and MIS were therefore merged into CIHI. Health Canada transferred much of its health statistics activity to the new organization and a strong bond was built between CIHI and Statistics Canada as the Chief Statistician serves as Vice Chair

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of the CIHI Board. CIHI's budget – which is drawn from both federal and provincial sources – has increased from about $10 million a year to over $40 million. The Institute now stands as an important cornerstone of health information in Canada. With significant analytical capacity, it provides critical data on issues such as hospital admissions, discharges and lengths of stay in a timely manner.

// **Health research** In 2000 Dr Henry Friesen, Chair of Canada's federally-funded Medical Research Council (MRC), convinced the federal government to transform the organization into the Canadian Institutes of Health Research (CIHR). The aim was to move away from a research agenda driven largely by the MRC and its staff, to one with broader linkages to the health system as a whole. This important federally-led initiative has resulted in both an increase in and a diversification of federal health research dollars. Funds now flow to thirteen virtual health research institutes which are much better linked to clinical decisions and health policy. At the same time the Canadian Health Services Research Foundation, (CHSRF) was established to link the health information and research areas. Its mandate is to "promote the use of evidence to strengthen health service delivery in Canada".

// **Health informatics** Canada Health Infoway was created to lead the development of electronic health records. Although the provinces worked with the federal government on this initiative and are represented on its governing board, the $2.1 billion in financing provided to date has all come from federal coffers.

These key investments have positioned Canada to be much more effective in applying evidence both at the point of patient care and in the management of healthcare services. But are these initiatives bearing fruit? Is the sizable federal investment that has already been made making a difference to Canadian healthcare?

WHAT NEEDS TO BE DONE

Despite all the investments, many health funding decisions are still driven by vested interests advocating for their particular causes, rather than by hard evidence as to the efficacy of treatment. Individual patient cases land on the front page of our daily newspapers and cause public opinion and politicians to swing in favour of new treatments. Public fears rather than medical evidence drive many decisions. As an example, all available data supports the view that we are over-medicated, yet payments to pharmacists for reviewing patient medications are only gradually being introduced.

In order to capitalize on existing investments and achieve an effective and affordable health system for the future, the Government of Canada must move to put in place an evidence-based set of strategies: it needs to provide very specific leadership, in partnership with the provinces and territories, to achieve concrete goals in health services performance. Below we outline four key initiatives that we believe would help it do so.

1 Improve accountability to drive quality improvement

One of the key thrusts of the 2004 Healthcare Accord was an improvement in accountability. However this fell short due to a failure of political will and problems with the detail of the accountability. What we have ended up with instead is too much measurement and too little management.

What were supposed to be "comparable indicators", on issues such as waiting times, became different indicators in different

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provinces. Such obfuscation has meant that it is hard to hold the provinces to account. While the differences in indicators are slight, they are sufficient to preclude any sensible national comparison or overview.

Consider the analogy of the labour force survey. This provides both public and private sector decision makers with a great deal of information on how the economy is doing and on unemployment rates province-by-province, within various age groups and across gender lines. Such information enables targeting of remedial efforts: the labour force survey provides an effective framework for decision making about employment and economic policy. If provinces were to set different measures for unemployment (as they do for healthcare) then most of this value would be lost.

Another problem has been the massive number of indicators developed. When it comes to healthcare indicators, more is not better: what is required is a simple set of easily understood indicators that measure quality, timeliness, affordability and access.

The federal government needs to show courage and leadership in the next round of health negotiations with the provinces and insist on a limited set of relevant indicators across the country. The aim should be to make the system more accountable (but accountable to the public – who can draw their own conclusions about performance – as opposed to the provinces being more accountable to the federal government). Canadians have much to gain and nothing to lose from having a more accountable healthcare system.

Fortunately we already have the health services data gathering and analysis capacity in place, through the institutions mentioned above, as well as a host of provincial health services organizations (such as the Institute for Clinical Evaluative Sciences in Ontario) that can contribute. What is needed now is political will.

What we have ended up with is too much measurement and too little management

2 Tackle safety in health delivery

The Baker Norton study, jointly commissioned by CIHI and CIHR and released in 2004, documented huge safety issues in the Canadian healthcare system. These take an enormous toll both in terms of human suffering and financial cost to the system. The authors calculated that between 9,000 and 23,000 Canadians die unnecessarily each year, as a result of avoidable errors within the health system. Since then, others have looked at the burden that avoidable injuries pose to the healthcare system. It is estimated by Baker and Norton that the equivalent of nine hospitals, each with 200 beds, are utilized just for "repair" work.

The Baker Norton report led to the creation of the Patient Safety Institute (PSI) headquartered in Edmonton and funded by the federal government. Despite the excellent efforts of this organization, the safety problem in Canadian healthcare (and in the healthcare systems of other nations) remains both large and intractable. A much more forceful national effort is required to solve it.

Other jurisdictions, including American states such as Minnesota, have been grappling with this problem. They have used legislation and a number of other tools, such as mandatory public reporting of adverse events, to address it. Meanwhile, Canada has stuck with a largely voluntary approach, relying on the PSI and somewhat strengthened health facility and health services accreditation through Accreditation Canada (even this is voluntary in some parts of the country). The PSI's budget is a paltry $10 million a year against a total Canadian healthcare budget of over $140 billion.

Contrast this with the enormous mandatory efforts undertaken in civil aviation. Each plane crash in Canada is thoroughly investigated to determine the cause and indicate remedial actions. Pilots are tested and recertified frequently. Healthcare providers, by contrast, can often practice for an entire career without formal recertification or assessment of their competency. The healthcare system tends to run on the basis that regulatory colleges, run overwhelmingly by the healthcare professionals themselves, will deal with outlier behaviour. There is no focus on systemic aspects of the lack of safety in healthcare.

The safety problem in Canadian healthcare remains both large and intractable

One way for the federal government to change this would be for it to commission a smaller-scale Baker Norton review, looking at specific indicators across the country, on an annual basis. This would keep the safety issue front and centre. Other ways of addressing the problem include increasing the PSI's funding and insisting on mandatory review and accreditation of hospitals and staff. It would be nice to think that hospital stays could be made as safe as flying.

3 Transfer healthcare delivery for First Nations and Inuit

Statistics Canada reported in 2000 that life expectancy for aboriginal people was markedly shorter than the Canadian average: 7.4 years shorter for men and 5.2 years for women. In addition, aboriginal communities saw increased rates in: infant mortality (22% higher); tuberculosis (6.2 times higher); diabetes (almost 20% higher); and foot amputations as a result of diabetic foot ulcers (18 – 22% higher). These are dismal statistics.

The First Nations and Inuit Health Envelope was introduced by the federal government in 1994. At that time it totaled more than $1.1 billion for all health programs; today it amounts to about $2 billion per annum. The continuing huge difference in health outcomes between First Nations/Inuit and other Canadians begs the question: is this money being well spent?

The federal government has made some progress in shifting responsibility and dollars to aboriginal organizations and provincial governments, but a much more rapid transfer is needed. Fortunately there are some models of successful practice from which to learn.

- In BC, a tripartite agreement between the federal government, the province and aboriginal authorities has resulted in placing $318 million in the hands of a new BC First Nations Health Council. This has given tribal councils greater power to solve issues within their own communities, rather than having to abide by decisions made in Ottawa or by an ineffective system of regional offices run from Ottawa.

- In 2006 the federal government provided $3.1 million to a partnership struck between Saint Elizabeth Health Care, an NGO with expertise in nursing care, and the Assembly of Manitoba Chiefs. The aim was to map ways to manage diabetic foot ulcers and avoid amputations. The parameters were realistic and included there being no commitment to increase healthcare staffing levels in areas that cannot attract such resources under normal conditions. The pilot project built capacity and care pathways that assisted health care staff to utilize prevention strategies, undertake early detection, and then provide treatment and quick access to specialists as required. The result was embraced by the Assembly of

Manitoba Chiefs and local communities and has since been expanded.

- In Ontario, Aboriginal Health Access Centres – aboriginal community-led, primary health care organizations – have, since 1994, brought tens of thousands of aboriginal community members into the circle of care and support.

These examples make sense. Provinces and NGOs have expertise in implementing health care delivery and aboriginal communities understand their own needs. The federal government, not really an expert in either, provides the financing.

It should therefore move ahead to:

- dismantle the inefficient and ineffective First Nations and Inuit Health Branch (FNHIB) and regional health bureaucracy;
- shift dollars into more agreements such as the tripartite one outlined above;
- promote health among First Nations youth; and
- contract out to NGOs for specialized services such as the non-insured Health Benefits Program, currently run by Health Canada (the management of which could be akin to the Veterans Affairs drug administration or health delivery for the Canadian Armed Forces).

4 Stabilize human resources in the health system

Canada's health system has numerous human resources problems that undermine its effectiveness. These include quality concerns, chronic shortages and a poor distribution of health professionals. In order to address these, the federal government should support the provinces to:

- encourage professionals to leave practice before their skills deteriorate;
- break down the barriers that prevent individuals practicing in the care setting of their choice;
- provide professionals with cost effective, attractive alternatives to higher pay.

All three problems could be at least partially addressed by reform of the pension system for healthcare workers.

A lack of pension portability is the main reason why healthcare workers are unwilling to move out of an acute-care setting into a community-care setting. A community-care setting is not only less costly for the funding government, it can also provide a less stressful work environment and a better quality of life for healthcare professionals. Many such professionals are willing to accept somewhat lower wages in return for these benefits, but the sticking point is that hospital employees cannot take with them their generous defined benefit (DB) pensions. Likewise, community-care organizations (which are also provincially funded) find it hard to attract qualified workers in the first place because of their lower pension offerings.

A lack of pension portability is the main reason why healthcare workers are unwilling to move out of an acute-care setting into a community-care setting

Extending DB plans to other parts of the health system (beyond acute care settings) would cost money, albeit not a great deal of money. In Ontario, for example the Healthcare of Ontario Pension Plan estimated that it would cost just $20 million to bring most of the community sector in line with the hospital sector on the issue of DB pension

premiums. At least some of this increase in the pension envelope could be funded by the federal government.

Negotiations should have very specific goals in place for performance, for productivity, for safety and for affordability

The biggest direct contribution the federal government could make to reforming healthcare pensions would be to enable physicians to belong to DB pension plans. This would help keep costs in check as many physicians would consider trading pay increases for the ability to belong to a DB plan. The actual move would be funded not by the taxpayer, but by participating physicians through their medical corporations. However, effecting such a switch would require changes in Canada Revenue Agency (CRA) legislation. While the required changes are of some complexity, they are certainly not insurmountable.[1] A similar legislative change was made in 2002 when the federal government revised the law to enable doctors to create medical corporations that would benefit from similar tax regimes to other small businesses. This move helped physicians immeasurably and provided the provinces with significant leverage in negotiations with medical associations.

CONCLUSIONS

The federal government has a crucial role to play in achieving sustainable and high quality healthcare services in Canada. With a focused and strategic approach the Government of Canada can assist provinces in modernizing Canadian health services. It can also realize a return on the significant investments it has made over two decades in improved health information, health informatics, health research and evidence gathering.

Negotiations for renewed health funding for the provinces post the expiry of the current Health Accord in 2014 should have very specific goals in place for performance, for productivity, for safety and for affordability. These should be set out in advance by the Government of Canada. There will, as always, be howls of jurisdictional protest from the provincial premiers but if the federal government sticks to specific and public performance goals, Canadians will be better off.

[1] Under CRA rules employers can be pension plan sponsors provided they have workers who qualify as employees. Medical corporations do not meet CRA rules for inclusion because their physician employees, also shareholders, are not classified as employees.

PAYING FOR THE HEALTHCARE WE WANT

MARK STABILE [1]

THE PROBLEM

Well before the great recession of 2008, Canada's healthcare system was sending out signals that it had a financing problem. Healthcare costs in Canada have outpaced growth in tax revenue and gross domestic product (GDP) for much of the past few decades. While there have been times of faster and slower growth (during the 1990s while the federal government balanced the budget, healthcare cost growth slowed significantly), on average between 1980 and 2006 the annualized growth in healthcare expenditures was 7.5%. The average annualized growth in GDP over that same period was 6.1%. The result is that we now spend considerably more on healthcare, both in absolute terms and as a percentage of GDP, than we did in 1980.

On the whole, this is certainly a good thing. Healthcare has improved tremendously over this time period with new technologies, procedures, and medications that have helped many people. No doubt, some of the spending increase has been wasteful, some of the care may be excessive or of marginal benefit, and some may even be harmful, but the overall story is one of success. Most of us would not want to return to the healthcare system we had in 1980.

Over this same period, governments have increased the proportion of their budgets that they spend on healthcare. The Ontario government spends approximately 40% of its total budget on health: in 1980 this figure was less than 30%. This increase is a function of many things: shares consist of both a numerator (healthcare spending) and a denominator (all public spending) and these are subject to changes in economic growth, tax policy, and policy decisions on spending for other things. But, overall, healthcare has become the most significant item of public spending by provinces. Again, there are many good reasons for this, and Canadians have indicated time and again that they prefer a majority publicly-financed, universally-accessible healthcare system that provides high quality care based on need. This is, however, an expensive proposition, hence the financing problem described above.

It is important to note that this problem is in no way unique to Canada. Across the OECD, in countries with systems that are similar to ours, and in countries with systems that are quite different, healthcare costs are growing faster than GDP. Indeed, when one looks at the countries that we typically

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compare ourselves to in terms of economic development – including the UK, continental Western Europe, and the broader commonwealth – there is no country in which healthcare costs have grow more slowly than the overall economy.

This is both comforting and concerning. It is comforting because it suggests that it is not the Canadian Medicare model that is at the root of the problem. The problem is universal. It is concerning because it suggests that efforts to make our system work better – more efficiently, more equitably, and with better quality – while clearly important and necessary, are not on their own likely not solve our financing problem. All of the healthcare systems in the developed world are trying to make their systems more efficient, less wasteful, etc. Many are far ahead of Canada in terms of important reforms to payment and delivery within the public system. Once again, none have succeeded in getting healthcare costs to grow more slowly than GDP.

It is also worth noting that the financing problem I have described does not suggest that the healthcare system is not economically sustainable. There is no single right answer to the question "how much of our GDP should we spend on healthcare?". Most wealthy countries spend around the same as Canada. A few spend a little more. All have seen growth in the amount spent on healthcare. Rich nations have the luxury of spending on things they value and if Canadians are getting valuable care from their healthcare system, there is no reason why we should not spend more on health and less on other goods. But we do need to figure out how we are going to pay for it.

Economic sustainability is not the same as fiscal sustainability. What is clear is that, across Canada, governments cannot afford to pay for the healthcare system we have now, along with all other public expenditures, employing only the current revenue base. Most provinces are in significant deficit. All are dependent on large transfers from the federal government continuing past 2014. Some efficiencies are certainly possible, but if we want more healthcare in the future, we will almost certainly need to pay more for it. So where should the money come from? Public or private sources?

OPTIONS FOR REFORM

Given that we will almost certainly be spending more on healthcare tomorrow than today (forecasts across the OECD are in agreement that healthcare costs in the developed world are going up, not down, over the next 50 years), we need to decide how we will pay for it. The options for increasing revenue fall into four broad categories:

1. Increase the taxes we already have in place.
2. Cost-share with patients in the form of user charges, deductibles, etc.
3. Allow for more private financing/ insurance.
4. Diversify public funding streams with new public revenue models.

Note that none of these options preclude finding more efficiencies, reducing waste, and improving quality in the system – we need continually to do all of these as well!

Raise taxes

Option one, raising taxes, is certainly a possibility. Taxes as a share of GDP have come down in Canada over the last decade, so there is an argument to be made for raising certain taxes again. The benefits of general taxation are well established, but the public resistance to tax increases remains, so I will not spend time on them here.

Cost-sharing

There have been several proposals over the years to increase cost sharing with patients.

[1] I would like to thank my co-authors for work that I draw on for this article: Irfan Dhalla, Colleen Flood, Jacuqeline Greenblatt, Sevil Marandi, and Carolyn Tuohy. I would also like to extend a special additional thank you to Carolyn Tuohy for an ongoing collaboration and exchange of ideas that has significantly influenced my thinking.

Most recently, Quebec proposed a healthcare deductible on doctor visits. There are two main arguments in favour of such a proposal. First, if one believes that there is inefficient use of healthcare services that is patient driven, then imposing some price on care will increase efficiency. Second, cost sharing has the potential to raise revenue.

Economists, including myself, have argued that using cost sharing to raise revenue is not likely to be a particularly fruitful policy option. There are several reasons for this. First, cost-sharing systems are expensive to set up and administer. Second, given our values in Canada, we mostly agree that any system of cost sharing should exempt the poor and people who are very sick and need to make heavy use of healthcare services. However, since the poor and sick are the biggest users of healthcare (the two often go together) exempting them from user charges (which I agree is a good idea) significantly reduces the revenue that can be raised by such a system. These two points together mean that cost sharing is unlikely to solve our revenue problem.

Increased private funding

Canada's public-private spending mix has hovered around 70% public, 30% private for several years. This is on the low side of public financing compared to many OECD countries. One reason for this is the nature of the public-private mix in Canada. In WHO parlance, Canada has complementary private insurance: private insurers cover items/sectors of health that are not covered publicly. For example, since pharmaceuticals outside the hospital are not covered publicly for many Canadians, a large share of Canadians have private insurance to cover such expenses.

Given the large role that pharma plays in modern medicine, it should not be surprising that Canada's private share of financing is relatively high. Jurisdictions such as the UK and Sweden have supplementary private insurance systems in which private insurance is available to cover items that are also covered by the public system. Individuals choose private coverage because it offers some amenities not provided publicly, such as shorter waiting times, nicer facilities, etc. (they cannot, though, opt out of paying for public care through general taxation).

Private supplemental insurance does not offer a ready solution to the problem of increasing public healthcare costs

Some have suggested this option as a solution to Canada's public healthcare financing problems. A few points are worth noting here. First, countries that have such systems in place still have the same financing issues that Canada has: public healthcare costs are growing faster than GDP. Therefore, the existence of this type of private insurance does not, in and of itself, eliminate financing problems. Second, these countries generally have a higher share of public health spending (usually above 80%) and broader public coverage than Canada does. Private systems there are generally small, covering around 10% of individuals. Their share of total health expenditure is even smaller, often at only around 1%. Third, what evidence there is on the relationship between public and private supplemental systems suggests that private insurance does not decrease costs in the public system. If anything, public expenditure often increases through complementary utilization, increased overall utilization, and the fact that tax subsidies for private insurance are built into many tax codes (including ours: employer contributions to employee health insurance are not taxable).

Therefore, while it is fair to say that countries can have private supplemental insurance and remain committed to public,

universal and accessible insurance (both the UK and Sweden would be good examples of this), private supplemental insurance does not offer a ready solution to the problem of increasing public healthcare costs.

New public revenue models

The final option for increasing revenues available for healthcare is to diversify the public financing stream. I have argued elsewhere, along with colleagues from the University of Toronto, that one possible expansion would be to incorporate more social insurance funding into the Canadian healthcare system.[2]

A national body that evaluates both medical technologies and best practices, across sectors and types of providers, is a key element

Many European countries use social insurance funding – characterized by a clearer link between funds collected and benefits received – to finance parts of their system. The experience in such countries suggests an increased willingness to pay on the part of citizens if they clearly perceive the connection between premiums and benefits. Often collection systems are arm's length from the government. Individuals are required to pay a monthly amount that is scaled to earnings, which is used to cover the cost of the health services provided. In many European systems employers are also required to contribute on behalf of their employees. The fund is usually kept separate from general tax revenues, although in some jurisdictions, general taxes are used to augment the fund where necessary.

Public finance theory suggests that earmarking funds in this way is not optimal and can create inefficient restrictions in public allocations. However, the benefits of providing increased public funding to sustain and extend public coverage (funding prescription drugs through a social insurance pool might be the ideal place to begin), of tapping into willingness to pay for increased healthcare costs among Canadians, and of potentially increasing the redistribution of risks and income among Canadians through a broader Medicare basket, outweighs, in my view, the costs of such a scheme. Given the limitations of the other possibilities for increasing revenue, this final option has the greatest potential both to improve the scope and quality of the healthcare system, and to meet with (limited) public approval.

WHAT SHOULD BE COVERED BY PUBLIC FINANCE?

Raising more revenue will not, on its own, be sufficient to sustain the healthcare system over the long run. It must be coupled with a strong movement towards evaluation of what should and should not be publicly funded, and a rebalancing of the role of the private sector to cover care that does not meet the criteria for public funding. A national body that evaluates both medical technologies and best practices, across sectors and types of providers, is a key element in making sure that public revenues are allocated to the most effective forms of medical treatment. When a drug provides significant benefit at a modest cost (e.g. insulin for diabetics), it would be covered for all who stand to benefit. When practice decisions by physicians result in high costs and little benefit, they would not be reimbursed (e.g. MRI scans for minor headaches and back pain).

Canadians will have to recognize that the public sector cannot cover all tests and treatments regardless of how minimally effective they may be. Where the potential benefits of diagnostic testing/treatment do not merit public funding, it is reasonable to expect that individuals who still choose

[2] See Flood, C., Stabile, M. & Tuohy, C. (eds.) (2008) *Exploring Social Insurance: Can a Dose of Europe Cure Canadian Health Care Finance?* McGill-Queen's University Press, and Stabile, M. & Greenblatt, J. (2010) "To Prefund Pharmacare for Canadian Seniors… or Not?" *IRPP Study No. 2.*

to pursue such care should be free to do so outside the public system, using personal resources.

All of these changes are possible without undoing any of the current structure of Canadian Medicare, including any changes to the Canada Health Act. The remaining challenge is getting from here to there.

A ROADMAP FOR CHANGE

There is a role for strong federal leadership in moving towards these changes in Canadian Medicare. The 2014 negotiations offer the opportunity for the federal government to foster coordination on both evaluation and on diversifying funding streams. Along the way, there is scope to address the growing perception among the young of intergenerational inequities (in financing and care) by gradually shifting the nature of public coverage. The following steps could be part such a transformation:

1. Use the 2014 negotiation to agree on a framework for diversified public funding. Options here include having the federal government act as the collection and redistribution agent for social insurance premiums and using these funds to replace some or all of the current Canada Health Transfer. If the federal government were to take on collection, it could also phase in tax point transfers to the provinces to increase the overall amount of funding available while keeping its revenue share about the same. The federal government does not, though, have to act as the collection agent. It could promote this change while taking a back seat in terms of implementation.

2. In those provinces where drugs are covered for the elderly but not the general population, eligibility by age could be gradually phased out by raising the eligibility age over time, while simultaneously phasing in drug coverage through social insurance premiums. This would leave coverage for the current elderly in place but reduce the claim of the baby boom on a drug plan funded by younger generations, thereby improving intergenerational equity.

Use the 2014 negotiation to agree on a framework for diversified public funding

3. In those provinces with more general drug coverage, such as Quebec and BC, the coverage budget could be more explicitly linked to social insurance premiums and phased in over time.

4. The federal government could establish, or require the establishment of, a national evaluative body (it need not be a federal body). This body could build on the experience and expertise of existing provincial bodies (although thus far the existing provincial bodies have not reached the scale that would be required to properly evaluate technology and best practice at the level of, for example, the National Institute for Health and Clinical Excellence in the UK). Buy-in to the recommendations

A benefit of a national organization for evaluation is that there would be greater consistency in coverage across Canada

of this body could be required for receipt of federal transfers through both the Canada Health Transfer and any future social insurance framework. A benefit of a national organization for evaluation is that there would be greater consistency in coverage across Canada. Currently, provinces that deem technologies ineffective are often pressured into reversing decision because the same technology is offered elsewhere in Canada.

5 As public coverage for all truly medically necessary services increases, the role of private insurance would change, with complementary insurance covering those items deemed insufficiently cost-effective for public coverage. The private market for this care and coverage would likely be small but sustainable. There are many items/treatments which are unlikely to yield sufficient benefit to secure public subsidy, but for which there is significant consumer demand.

If these changes were adopted, the Canadian healthcare system in 2020 would have kept the best of what we have, and built in elements – diversified public funding, effective evaluation of technologies and practices, and universal access to important medical care regardless of type – that other successful societies have adopted and tested. It would allow all Canadians access to those services most essential for improved health, not just those we deem important today, but those that will emerge going forward. Perhaps most important of all, it would put in place sufficient revenue to fund broad-based public healthcare, alongside structures to ensure that we only fund those services that are the most valuable.

[3] Measurement of patients' satisfaction and of subjective quality of experience has been extensively studied, particularly in the context of chronic diseases. A good review of the question can be found at http://phi.uhce.ox.ac.uk/home.php..

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