

# Getting Better Health Care:

Lessons from (and for) Canada

by Armine Yalnizyan



Canadian Centre for Policy Alternatives





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## About the Author

A long-time research associate at the Canadian Centre for Policy Alternatives, respected economist Armine Yalnizyan has spent the last twenty years putting the public into public policy. She has served on government advisory groups at the federal, provincial, and municipal levels, worked with international NGOs, taught economics at York University in Toronto, and authored a ground-breaking report in 1998 on income inequality in Canada, entitled *The Growing Gap*, published by the Centre for Social Justice. In 2002, she was honoured by being named first recipient of the Atkinson Foundation Award for Economic Justice which she used to better understand the economics of public health care in Canada. In 2006, she returned to the Community Social Planning Council of Toronto as its Director of Research.

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## Editorial from the Author

ALTHOUGH HOCKEY REMAINS Canada's national sport, debating the merits of the health care system is equally Canadian. Frequently criticized and under attack, Canadians may be surprised to learn what high esteem is held internationally for our approach to health care.

The Canadian approach to health care delivers equal or better health outcomes for equal or better value when compared to other countries. The founding principles of universality and accessibility have set the course for the direction of change, requiring reforms to meet these measures of performance.

Public confidence in the system has been regularly tested — in the 1930s during the Great Depression, in the 1950s when negotiations failed to secure the federal government's participation, in the 1960s confronted by a doctors' strike, and in the 1980s faced by the threat of user fees. Each time the "right" to health care has been questioned. Each time the fundamental value — that need and not the ability to pay will guide health care policy — has prevailed. Canadians rightly view their health care system as their single most valued social program.

Over the past 100 years, publicly insured services have continued to expand in their scope, from public health, to doctors and hospitals, to expansion of public drug programs, some access to supports for long-term care, home care and rehabilitation, and a renewed interest in immunization.

Along the way, Canadians learned that equity pays off. We learned that striving for equity sometimes means making sure everyone gets access to the same thing; and sometimes it means that interventions need to be targeted to at-risk and vulnerable populations.

International experience shows that universal access to quality care is a critical way forward for societies, rich and poor, to develop the potential of individuals and communities alike. Nothing is less costly to provide on such a scale than a publicly-insured system. Nothing is more powerful than a single-payer system to control costs and allocate funding so that treatments provide the greatest benefits to those in the greatest need. The current push for more private insurance reflects a growing emphasis on the "me" and less on the "we" that is the logic of a publicly fund-

ed system — and that simply defies the lessons learned from experience.

Public commitments to spend on health care are growing at a rate that outstrips anything else that governments do. Yet even today some parts of our society are falling behind in their access to health care. There are emerging ambiguities about what is and should be publicly supported, resulting in the current the re-evaluation of the relative roles of public and private insurance.

Social determinants of health are worsening in Canada. The health care workforce is aging. Serious challenges lie ahead. This handbook tells the story of how the Canadian approach to health care evolved, its formative roots being a response to poverty, not plenty. Now, in the midst of plenty, we are questioning the way forward.

**Armine Yalnizyan**



Our history paints a clear picture. Over time, an ever-larger number of Canadians have benefited from an ever-larger scope of publicly provided or subsidized supports, resulting in improved health and quality of life for every successive generation. By pooling risk through publicly-funded systems of care, we have collectively beaten the odds.

The real “game” is getting better health care, for all. Our winning approach has returned, time and again, to the twin strengths of fairness and pragmatism. We have learned a lot from each other over the past 100 years. This handbook reminds us of those lessons learned, to prepare us for the challenges ahead. Lest we forget.

# Executive Summary

THE GOAL OF THIS PROJECT was to develop a handbook for Canadians working with partners in developing countries who are looking for ways to reform health care, based in part on relevant lessons learned by Canadian health reforms.

In the process of conducting the interviews and reviewing our history, it quickly became apparent that we, too, in Canada need to revisit these lessons learned. They shed light on our current place in the continuing evolution of our approach to health care, and suggest some ways forward in the continuing debates over health reform.

Canadians are widely admired around the world for our approach to health care. Although we quibble endlessly about it at home, it gives cause to stop and think every time someone from a developing country asks: “How do you manage to provide health care for everybody in Canada? How could we get closer to that here?”

What would *you* say in response?

What follows is an attempt to answer those two questions.

This handbook examines key achievements and shortcomings of Canada’s health care system. It explores what works well, what doesn’t,

and it addresses future challenges to preserving and enhancing health care.

What makes the Canadian “approach” so unique is the high value we place on universal accessibility to doctors and hospitals. The founding vision behind Canada’s health care system is simply this: access to medical care should be based on need, not on the ability to pay.

It’s important to note that this approach — this principle of universal access underlying Canada’s health care system — emerged in response to poverty, not affluence.

Many aspects of health care are still not universally accessible in Canada, but as the system evolves an increasing number of Canadians benefit from a growing scope of publicly provided or publicly subsidized supports. The results are heartening: every successive generation of Canadians have enjoyed improved health and physical quality of life. The payoffs of Canada’s public health care system are irrefutable.

From the beginning, two core, unshakeable Canadian values have influenced the evolution of Canada’s health care system: fairness and pragmatism. It needs to be said that, despite almost

permanent debate, these values have stood the test of time.

Public confidence in the system has been regularly tested: in the 1930s during the Great Depression, in the 1950s when negotiations failed to secure the federal government's participation, in the 1960s confronted by a doctors' strike, and in the 1980s faced by the threat of user fees. Each time the "right" to health care has been questioned. Each time core values have prevailed.

Canada's history and experience underscores its citizens' steadfast desire for equal treatment, which reveals important lessons about the inter-

in the midst of re-evaluating the relative roles of public and private insurance — yet another test of our core, underlying values.

Improving the health of citizens involves far more than getting better access to health care. Yet how health care is provided — or denied — is a crucial factor in determining an individual's life chances and well-being. That is why this handbook takes a hard look at how health care (specifically publicly funded health care) is provided in Canada. While this handbook does not ignore the importance of health promotion, population health measures and public health initiatives such as water and waste systems, immunization or the control of communicable disease, its focus is on how access to care and cure has been organized in Canada.

Despite vast differences in income levels and degrees of organization among developing nations trying to get better health care, there are numerous points of convergence between their story and Canada's story. All are grappling with the challenges of heightened demands from citizens to have their health care needs met. All are creating change for the long-term and, in effect, transforming systems.

System-wide change takes time, often decades to accomplish, and there are many steps along the road to transformation. This handbook examines health reforms that transform systems over time. It breaks down the vastly complex issues of health reform into four main categories of change: governance; finance and coverage; human resources; and information systems.

Consider this a book of lessons from — and for — Canada.

The opening section, **Governance Matters**, examines how decisions in health care are made, how citizens have their say, and how power is exercised. The Canadian context is particular. It is a nation marked by diversity, a deeply decentralized federation governed by a constitution that lays out different federal and provincial responsibilities.

## ► The Canadian experience shows greater equity in health care has a pay-off — **more healthy individuals and societies.**

face between the health of individuals and the health of societies.

Canadians have learned that equity pays off. We have learned that striving for equity sometimes means making sure everyone gets access to the same thing; and sometimes it means that interventions need to be targeted to at-risk and vulnerable populations.

Over the past 100 years, Canada's publicly insured services have continued to expand in their scope, from public health, to doctors and hospitals, to expansion of public drug programs, some access to supports for long-term care, home care and rehabilitation, and a renewed interest in immunization.

Public commitments to spend on health care are growing at a rate that outstrips anything else that governments do. Yet even today some Canadian citizens have less access to health care than others. There are emerging ambiguities about what is and should be publicly supported through government spending. As a result, Canadians are

Despite the differences, both levels of government attempt to work together for common purpose under the principles of the Canada Health Act. Public sector regulations at both levels of government manage the functionality of health systems. These tools can be marshalled to help assure quality, supply and control costs. They also operate inside a bigger context, namely international law. Trade laws and international rules on intellectual property laws set the frame around how the delivery and “commerce” of health care is governed, and how pharmaceuticals are accessed. Another context that shapes reforms in governance structure is the world-wide pull towards greater decentralization and devolution of decision-making. This trend pits the potential for greater responsiveness and innovation against the potential for fragmentation and balkanization of service. Finally, governance structures are only as good as the accountability and public input structures that support them. Norms and standards of practice evolve through public input and the degree to which rules are observed to be broken or enforced. Public input comes through local experimentation, participation on boards and councils, the involvement of professional associations and unions, advocacy coalitions, lobbyists, public protests, court rulings and the media. The lesson learned: introduce change to any of these elements of governance, and you affect who decides what for whom in Canada.

The next section, **Finance and Coverage Matters**, looks at who pays for what, and how. It shows how the overarching trend of the twentieth century has been to broaden access and reduce health disparities. It describes the benefits of pooling risk. The “Canadian approach to health care” progressed from community-based objectives to national objectives. Over time, the funding base of this social project was ‘uploaded’ from local to regional to provincial to federally cost-shared public spending. The revenue source shifted from property taxes to income taxes and

general revenues. The lessons learned by pooling risk started small, but they grew. It became clear that the larger the group that pools risk, the less it costs each individual to insure against risk. It also became evident that the more people are insured to receive care, the less unnecessary risk they are exposed to, mostly because they get earlier preventive care, diagnosis, and treatment. “Single-payer” systems work because they are the cheapest way to pay costs, they cover the greatest number of people, and they provide incentive to finance the types of early interventions that produce the best health outcomes. Expanding coverage brought greater equity in Canada, but that’s not the end of the story. This section underscores the ongoing tension in determining what is publicly provided and what is considered a private responsibility. Canada’s balance between public and private is unique. Total spending on health care, public and private, continues to be a concern, both here and abroad. Paying for care is different than managing the costs of care. The greatest ability to manage costs comes through the public sector, which has the potential to view the needs of the whole system and reallocate spending to ensure greater returns on investment. Changes in demographics, technological possibilities and infrastructure needs can force a ‘re-think’ about where those returns are greatest, leading to reforms. One thing is clear: there is a payback on investments (or dis-investments) made over time in the determinants of health — measures that improve health through access to clean water, education, adequate housing and nutrition, decent jobs, workplace safety, healthy environments, and freedom from violence. There is nothing more complex or politically thorny than the issue of money. How health care financing is reformed determines who gets access to what.

The third section shows why **Human Resources Matter**: every nation is confronted by the basic problems of supply and demand. There just

aren't enough people for the level of services we want. We need more people, and we need to use the people we've got better. Without a strategy to train more people, especially in rich nations like Canada, the global shortage of doctors and nurses will cause labour costs to soar everywhere. The solution to today's problems lies neither in simply hiring more professionals nor in simply training more professionals. The solution lies in deploying a more effective mix of people, in using earlier interventions and techniques that bring care to the community and moves it away from acute care institutions to whatever ex-

can lever greater productivity from the existing supply of people who are providing care. But the sheer number of professionals available to do the work remains a limiting factor on how much care can be provided. One tool for boosting numbers that has been underutilized in Canada is the use of "return service" arrangements. Provinces, to varying degrees, offset the costs of tuition for graduating doctors and nurses in return for a limited term of service in areas designated as under-served. Demographic realities will place continued pressure to better coordinate and prepare resources for the future.

## › Access to health care is transformed through evolving approaches to governance, finance, human resources or information.

tent possible. The goal of primary care reform is to get the right person to do the right job at the right time. For the past 30 years, there have been attempts to move towards more multi-disciplinary approaches to care to relieve pressure from health professionals, particularly doctors and specialists. There are examples of success sprinkled across Canada, but progress has been slow. Demographic changes may accelerate the popularity of such an approach. In the next five years, about one-fifth of Canada's physicians and a third of its nurses are poised to retire. Only one nurse in 10 is under the age of 30. There are simply not enough graduates to take the place of those who are leaving. Rural and remote areas — always more challenging to serve — are particularly affected by these pressures. There has been creative use of mobile health units and telehealth services. Greater focus on training the full range of health workers and expanding the scope of practice of all members of the "team"

The final section, **Information Matters**, shows how systematic observation shapes change. The capacity to observe can be cultivated at many levels of sophistication. Some things take years to develop, other changes can be introduced immediately. Sometimes a simple pencil and paper tally system can make a difference; sometimes the challenge requires computer assistance. A new way of collecting information resulted in the birth of the public health movement over 150 years ago. Canada's institutions of research and statistics in health care have developed steadily over 100 years, and yet the development of data on many basic elements of the provision of care is still in its infancy. Surveillance and tracking of trends, once the purview of public health missions, has a renewed importance in a global era where the outbreak of new global pandemics is an ever-present threat. Both population health and patient care can be improved with changes in information systems, information flows, and knowledge transfer. Standardizing patient records can speed up access to appropriate care and identify bottlenecks. Careful observation of process can reveal if steps can be eliminated, processes streamlined and monitoring improved. That can improve scheduling and systems flow. Specialized clinics for routine procedures (such as day surgeries, immunization, or check-ups) can provide mini-assembly lines of care. That

can increase the quantity of patients served and the quality of care received. There can be more focused training for clerical and community workers, teachers and even volunteers. That can expand the pool of people who provide an effective first source of information, or who monitor health status. It is hard to overstate the degree to which information is a two way street: effective use of information relies on knowledge being effectively translated to and from the people who need care. This can shape the relevance of research. There is still minimal understanding of the gendered differences in the impacts of different drugs and treatments. Greater cost-effectiveness has become a political rallying cry with few empirical fortifications, as there is little data that helps assess what different forms of care cost or yield in terms of health outcomes. There is an urgent need to narrow the “10/90” gap: about 10% of the funds devoted globally to health research address the health issues of 90% of the world’s sick, who are poorest; the remaining 90% of health research money is dedicated to improving the quality of life and life chances of 10% of the world’s ill, who are among the most rich. Put simply, information systems can make or break the effectiveness of health care systems. What we don’t know can’t help us — in fact, it can hurt us.

## Concluding Thoughts

By explaining the way Canada provides health care, and how Canada came to deliver health care in its own unique way, this handbook reveals valuable links between Canada’s history of ongoing health reforms and the work underway in developing nations today. Perhaps surprisingly, these links are as relevant to Canadians as they are to citizens of developing nations. The whole world is in the grips of changing its approach to health care, nation by nation. The “Canadian approach” to health care is still a work in progress, still evolving.

Yet the transcendent message from the Canadian experience is resonant everywhere: the more a nation can share risk, the more a nation can turn access to health care into a universal right rather than a strictly market transaction, the better are its population health outcomes. That is a lesson worth heeding.

Canada’s system isn’t perfect. No system is. This handbook discusses the achievements and shortcomings of Canada’s approach to health care — what works well, what doesn’t, and the remaining challenges. Changing systems of governance, finance and coverage, human resources and information systems are all responses to a goal shared by people in developed and developing nations alike: getting better health care, for one and all.



# Sommaire exécutif

LE BUT DE CE PROJET est de développer un guide à l'intention des Canadiennes et des Canadiens qui collaborent avec des partenaires dans des pays en voie de développement qui cherchent des moyens de réformer les soins de santé, basé, en partie, sur des leçons pertinentes apprises par les réformes de la santé au Canada.

Durant le processus d'interviews et d'examen de notre histoire, il est vite devenu apparent que nous aussi au Canada devons revisiter ces leçons apprises. Elles font lumière sur l'endroit où nous en sommes en ce qui a trait à l'évolution constante de notre approche aux soins de santé, et suggèrent certains moyens d'avancer le débat continu sur la réforme des soins de santé.

Les Canadiennes et les Canadiens font l'objet d'une grande admiration à l'échelle mondiale pour ce qui est de leur approche aux soins de santé. Bien que nous débattions continuellement le sujet au pays, nous avons raison d'arrêter à chaque fois qu'un individu des pays en voie de développement demande : « Comment arrivez-vous à fournir des soins de santé à tout le monde au Canada? Comment pourrions-nous améliorer les choses ici? »

Que répondriez-vous?

Ce qui suit est une tentative de répondre à ces deux questions.

Ce guide étudie les réalisations principales et manques du régime de santé du Canada. Il explore ce qui fonctionne bien et ne fonctionne pas, et il traite des défis futurs qui restent à surmonter pour préserver et améliorer les soins de santé.

L'approche canadienne doit son caractère unique au fait que nous attribuons une grande valeur à l'accessibilité universelle aux médecins et aux hôpitaux. La vision initiale derrière le régime de soins de santé du Canada est simplement que l'accès aux soins médicaux doit être basé sur le besoin et non pas sur la capacité de payer.

Il est important de noter que cette approche — ce principe d'accès universel à la base du régime de soins de santé du Canada — est apparue en réponse à la pauvreté et non pas à l'abondance.

Plusieurs aspects des soins de santé ne sont pas encore accessibles universellement au Canada, mais au fur et à mesure que le régime évolue, un nombre croissant de Canadiennes et de Canadiens profitent d'une gamme plus large de mécanismes d'appui offerts et subventionnés par le secteur public. Les résultats sont chaleureux :

toutes les générations successives de Canadiens ont bénéficié d'une meilleure santé et d'une plus grande qualité de vie sur le plan physique. Les bienfaits du régime de soins de santé publique du Canada sont irréfutables.

Dès le début, deux valeurs canadiennes fondamentales et inébranlables ont influencé l'évolution du régime de soins de santé du Canada : la justice et le pragmatisme. On doit dire que, malgré le débat presque constant, ces valeurs n'ont pas changé à travers les temps.

La confiance publique face au régime a été fréquemment mise à l'épreuve : dans les années

## ► L'expérience Canadienne démontre que l'équité est rentable — une meilleure santé pour les individus et pour la société

1930 durant la Grande Crise, dans les années 1950 lorsque les négociations ont manqué d'assurer la participation du gouvernement fédéral, dans les années 1960 lors de la grève des médecins et dans les années 1980 lorsque nous avons fait face à la menace des frais d'usager. Chaque fois, le « droit » aux soins de santé a été questionné. Chaque fois, les valeurs fondamentales l'ont emporté.

L'histoire et l'expérience du Canada soulignent le désir constant de ses citoyennes et citoyens d'avoir un traitement équitable, ce qui révèle les leçons importantes concernant le rapport entre la santé des individus et la santé des sociétés.

Les Canadiennes et les Canadiens ont appris que l'égalité est rentable. Nous avons appris que la recherche de l'égalité signifie parfois que nous devons nous assurer que tous et chacun aient accès à la même chose; et quelquefois, cela signifie que des interventions doivent cibler les personnes à risque ou vulnérables.

Au cours des derniers 100 ans, les services assurés par le secteur public au Canada ont continué d'être élargis, de la santé publique, aux médecins et aux hôpitaux, aux programmes d'assurance-médicaments publics plus vastes, à un certain accès aux mécanismes d'appui pour les soins prolongés, les soins à domicile et la réadaptation, et un intérêt renouvelé envers l'immunisation.

Les engagements publics pour les dépenses dans la santé grandissent à un taux qui surpasse toute autre chose que font les gouvernements. Malgré cela, aujourd'hui certains citoyens canadiens ont un moins bon accès aux services de santé que certains autres. Il y a de plus en plus d'ambiguïtés entourant ce qui est ou devrait être inclus dans les dépenses du gouvernement. Conséquemment, les Canadiennes et les Canadiens sont dans le processus de réévaluer les rôles relatifs des assurances publiques et privées — encore une autre épreuve pour vos valeurs fondamentales sous-jacentes.

L'amélioration de la santé des citoyens requiert beaucoup plus qu'un meilleur accès aux soins de santé. Toutefois, la façon dont les soins de santé sont offerts — ou déniés — est un facteur crucial pour déterminer les chances de vie et le bien-être d'un individu. C'est pourquoi dans ce guide, nous étudions essentiellement la façon dont les soins de santé sont offerts au Canada (particulièrement les soins de santé financés par le secteur public). Tandis que ce guide n'ignore pas l'importance de la promotion de la santé, les façons de mesurer la santé de la population et les initiatives publiques de santé telles que les aqueducs et les circuits d'eaux usées, l'immunisation ou le contrôle des maladies contagieuses, son attention se tourne principalement sur la façon dont l'accès aux soins et aux traitements est organisé au Canada.

Malgré les vastes différences entre les niveaux de revenus et les degrés d'organisation chez les nations en voie de développement qui tentent d'obtenir des meilleurs soins de santé, il existe

bon nombre de points de convergence entre leur histoire et celle du Canada. Ils sont tous aux prises avec les défis des demandes croissantes des citoyennes et citoyens qui cherchent à faire combler leurs besoins de soins de santé. Ils planifient tous des changements pour l'avenir et, en effet, ils transforment les systèmes.

Il faut du temps pour modifier le système à grande échelle, souvent des décennies pour y arriver, et il y a plusieurs étapes au chemin de la transformation. Ce guide étudie les réformes de la santé qui transforment les systèmes sur une période de temps. Il fractionne les questions d'une grande complexité qui touchent la réforme de la santé en quatre catégories principales de changement distincts : la gouvernance, les finances et la couverture, les ressources humaines et les systèmes d'information.

Considérez cet ouvrage comme un livre de leçons tirées de l'expérience du — et pour — le Canada.

La section initiale, *Les questions de gouvernance*, étudie comment les décisions sont prises dans le secteur de la santé, comment les citoyens communiquent leurs opinions et comment le pouvoir est exercé. Le contexte canadien est distinct. C'est une nation marquée par la diversité, une fédération largement décentralisée qui est gouvernée par une constitution qui dicte des responsabilités différentes pour les gouvernements fédéral et provinciaux. Malgré les différences, les deux paliers de gouvernement tentent de collaborer pour un but commun conformément aux principes de la Loi canadienne de la santé. Les règlements du secteur public aux deux paliers de gouvernement gèrent la fonctionnalité des régimes de santé. Ces outils peuvent être contrôlés pour assurer la qualité, approvisionner et contrôler les coûts. Ils fonctionnent aussi à l'intérieur d'un contexte plus vaste, notamment les lois internationales. Les lois régissant le commerce et les règles internationales sur la propriété intellectuelle établissent le cadre qui dicte comment la

dispense et le « commerce » des soins de santé sont gérés et l'accès aux produits pharmaceutiques. Un autre contexte qui moule les réformes de la structure de gouvernance est que le monde entier favorise une plus grande décentralisation et la dévolution de la prise de décisions. Cette tendance réduit la possibilité d'une plus grande réceptivité et innovation contre la fragmentation possible et la balkanisation des services. Finalement, l'efficacité des structures de gouvernance est directement reliée à la responsabilisation et aux structures d'appui public qui les entourent. Les normes et les codes de pratiques progressent grâce à l'apport public et le degré auquel les règlements sont respectés ou ignorés. L'apport du public provient de l'expérience locale, de la participation aux commissions et conseils, de la participation des associations professionnelles et des syndicats, des coalitions partisans, des lobbyistes, des manifestations publiques, des décisions juridiques et des médias. La leçon tirée : en introduisant un changement à un de ces éléments de gouvernance, vous influencez qui décide quoi pour qui au Canada.

La prochaine section, *Les finances et les questions de couverture*, étudie qui paie pour quoi et comment. Elle démontre comment la tendance prononcée du vingtième siècle a été utilisée pour élargir l'accès et réduire les disparités dans la santé. Elle décrit les avantages de regrouper les risques. « L'approche canadienne aux soins de santé » va des objectifs communautaires aux objectifs nationaux. Pour ce qui est des dépenses publiques partagées, avec le temps, la base de financement de ce projet social a été passée du palier local au palier régional au palier provincial au palier fédéral. La source de revenu est passée des impôts sur la propriété aux impôts sur le revenu et revenus généraux. Les leçons apprises grâce à ce regroupement des risques étaient minimales au début, mais elles ont progressé. Il est devenu clair qu'en ce qui a trait au regroupement des risques, plus le groupe est grand, moins

il en coûte pour chaque individu assuré pour le risque. Il est aussi devenu évident que plus il y a de gens assurés pour recevoir des soins, ils sont exposés à moins de risques inutiles, parce qu'en général, ils reçoivent plus de soins, de diagnostics et de traitements préventifs. Les systèmes à source de paiement unique fonctionnent, parce que c'est la façon la plus économique de payer les coûts, ils couvrent le plus grand nombre de gens et ils offrent des incitatifs au financement d'interventions hâtives qui entraînent une meilleure santé. L'élargissement de la couverture a apporté une meilleure équité au Canada, mais ce

## › L'accès aux soins de santé se transforme par l'évolution de sa gouvernance, son financement, les ressources humaines et l'information.

n'est pas la fin de l'histoire. Cette section souligne la tension constante entourant la détermination de ce qui est offert par le secteur public et ce qui est considéré comme une responsabilité privée. L'équilibre entre le public et le privé est unique au Canada. Les dépenses totales au chapitre de la santé, publiques et privées continuent d'être une inquiétude, tant au pays qu'à l'étranger. Payer pour des soins, c'est différent de gérer les coûts des soins. La plus grande habileté de gérer les coûts vient du secteur public qui a la possibilité de voir les besoins du système tout entier et de réallouer les fonds pour assurer un meilleur rendement de l'investissement. Les changements démographiques, les possibilités technologiques et les besoins de l'infrastructure peuvent forcer une « reconsidération » de l'endroit où le rendement est le meilleur, ce qui entraîne conséquemment des réformes. Une chose est claire : sur une période de temps, il y a un rendement positif sur les investissements (ou désinvestissements), no-

tamment en ce qui a trait aux facteurs déterminants de la santé — les mesures qui améliorent la santé par l'accès à l'eau potable, à l'éducation, à l'hébergement adéquat et à la nutrition, aux emplois acceptables, à la sécurité au travail, aux environnements sains et à l'exemption de violence. Il n'y a pas de question plus complexe ou épineuse sur le plan politique que l'argent. Comment le financement des soins de santé est réformé détermine qui a accès à quoi.

La troisième section démontre pourquoi *Les ressources humaines sont importantes* : chaque nation se heurte aux problèmes élémentaires de l'approvisionnement et de la demande. Il n'y a simplement pas suffisamment de personnes formées pour les services que nous désirons livrer. Nous avons besoin d'un plus grand nombre de gens et nous devons mieux utiliser les personnes que nous avons. Sans une stratégie pour former un plus grand nombre de gens, particulièrement dans les nations riches comme le Canada, le manque de médecins et d'infirmières/infirmiers à l'échelle mondiale entraînera des coûts de main-d'oeuvre à la hausse, partout dans le monde. La solution aux problèmes d'aujourd'hui n'est pas de simplement embaucher ou former davantage de professionnels. La solution est en fait de déployer un effectif plus varié, d'avoir recours à des interventions plus rapides et des techniques qui apportent les soins dans la communauté et les éloignent autant que possible des établissements de soins aigus. Le but de la réforme des soins primaires est d'avoir la bonne personne qui s'acquitte des tâches précises au bon moment. Au cours des trente dernières années, il y a eu des tentatives d'adopter des approches plus multidisciplinaires aux soins de santé afin de réduire les pressions sur les professionnels de la santé, particulièrement les médecins et les spécialistes. Il y a des exemples de succès un peu partout au Canada, mais les progrès sont lents. Les changements démographiques peuvent accélérer la popularité d'une telle approche. Dans les prochains cinq

ans, près d'un cinquième des médecins au Canada et un tiers des infirmières/infirmiers arriveront au moment de la retraite. Seulement une infirmière sur dix est âgée de moins de trente ans. Il n'y a simplement pas suffisamment de nouveaux diplômés pour remplacer ceux et celles qui quitteront la profession. Les régions rurales et éloignées — toujours plus difficiles à desservir — sont particulièrement touchées par ces pressions. Il y a eu un usage créatif d'unités de santé mobiles et de services télé santé. Une plus grande attention à la formation d'une vaste gamme de travailleuses et de travailleurs de la santé et l'élargissement du champ d'activité pour tous les membres d'une « équipe » peut entraîner une meilleure productivité du personnel actuel qui offre les soins. Toutefois, le nombre de professionnels disponibles pour effectuer le travail demeure un facteur limitant le volume de soins qui peut être offert. Un outil pour augmenter les nombres, mais qui a été sous-utilisé au Canada, est l'utilisation des ententes de « retour de services ». Jusqu'à un certain point, les provinces contribuent aux frais de scolarité des médecins et des infirmières/infirmiers nouvellement diplômés en retour pour un engagement de service limité dans un endroit identifié comme n'étant pas suffisamment desservi. Les réalités démographiques continueront à exercer des pressions pour mieux coordonner et préparer les ressources pour l'avenir.

La dernière section, *Les questions d'information*, démontre comment les observations systématiques dictent les changements. La capacité d'observer peut être cultivée à divers niveaux de sophistication. Certaines choses requièrent des années de développement, d'autres changements peuvent se faire immédiatement. Quelquefois, un simple système de pointage avec papier et crayon peut faire la différence. D'autres fois, le défi requiert l'aide d'un ordinateur. Une nouvelle méthode de récolter des informations a résulté de la naissance du mouvement de santé

publique il y a plus de 150 ans. Au Canada, les établissements de recherche et de statistique en matière de santé se sont développés de façon constante au cours des derniers 100 ans, mais le développement de données sur plusieurs éléments de base en ce qui a trait aux services de santé est encore très élémentaire. Les tendances vers la surveillance et la récolte des données qui font partie du mandat de la santé publique ont maintenant une importance renouvelée dans une ère de mondialisation où l'éruption de nouvelles pandémies à l'échelle mondiale est de plus en plus menaçante. La santé de la population et les soins aux patients peuvent être améliorés en apportant des modifications aux systèmes, à la diffusion de renseignements et au transfert de connaissances. Des dossiers standardisés pour les patients pourraient accélérer l'accès aux soins appropriés et servir à identifier les endroits problématiques. Une observation méticuleuse du processus peut révéler si des étapes peuvent être éliminées, si le processus peut être simplifié et si la surveillance peut être améliorée. Ceci pourrait améliorer l'ordonnancement et le déroulement du système. Les cliniques spécialisées pour les soins routiniers (tels que les chirurgies de jour, l'immunisation ou les bilans de santé) peuvent offrir des « chaînes de montage » pour les soins. Ceci pourrait augmenter la quantité de patients desservis et la qualité des soins reçus. Il pourrait y avoir une formation plus concentrée du personnel de bureau et communautaire, des enseignants et des bénévoles. Ceci pourrait élargir le groupe de personnes qui deviennent une première source efficace d'information ou qui surveillent l'état de santé. Il est difficile de surévaluer à quel point l'information doit être diffusée dans les deux sens : l'usage efficace de l'information repose sur la transmission efficace de renseignements entre les pourvoyeurs de soins et les personnes qui nécessitent les soins. Il y a encore une compréhension minimale des répercussions différentes des traitements et des médicaments pour les deux sexes. Une plus grande

économie est devenue l'objectif politique avec très peu de preuves à l'appui, puisqu'il existe très peu de données pour aider à évaluer quelle forme de soins est plus économique et efficace en terme de résultats pour la santé. Il y a un urgent besoin de réduire l'écart « 10/90 » : environ 10 % des fonds dévoués à la recherche sur la santé à l'échelle mondiale traitent des questions de santé de 90 % des malades au monde, qui sont les plus pauvres; l'autre 90% de l'argent voué à la recherche est dédié à l'amélioration de la qualité de vie et aux chances de survie de 10 % des malades du monde, qui comptent parmi les plus riches. En bref, les systèmes d'information peuvent augmenter ou ruiner l'efficacité des systèmes de santé. Ce que nous ne savons pas ne peut pas nous aider — en fait, ça peut nous nuire.

## Conclusion

En expliquant la façon dont le Canada offre les soins de santé et comment le Canada est arrivé à livrer les soins de sa propre façon qui lui est unique, ce guide révèle des liens importants entre l'histoire de la réforme continue du Canada et le travail entrepris aujourd'hui par les pays en voie de développement. Il est peut-être surprenant que ces liens soient aussi pertinents aux Canadiennes et Canadiens qu'ils le sont aux citoyens d'un pays en développement. Le monde entier est en train de changer son approche aux soins de santé, nation par nation. « L'approche canadienne » aux soins de santé est encore un travail en cours en plein essor.

Toutefois, le message qui ressort de l'expérience canadienne résonne partout : plus une nation partage le risque, plus cette nation peut réussir à faire des soins de santé un droit universel plutôt qu'un marché commercial strict, et plus sa population est en bonne santé. C'est une leçon qui mérite d'être retenue.

Le système canadien n'est pas parfait. Aucun système ne l'est. Ce guide discute des réalisations et des manques de l'approche du Canada aux soins de santé — ce qui fonctionne et ce qui ne fonctionne pas, et les défis à surmonter. Le changement des systèmes de gouvernance, du financement et de la couverture, les ressources humaines et les systèmes d'information sont tous des réponses à l'objectif commun des gens des pays industrialisés et en voie de développement — une meilleure santé pour tous.

# Introduction

ALL AROUND THE WORLD, Canada is held in high esteem for its approach to health care. Founded on the twin principles of universality and accessibility, the Canadian approach means, in theory, that the provision of care is based on need, not ability to pay. At least that's the view from abroad. At home the story is less straightforward.

Canadians consistently regard health care as their single most valued social program; but, since the inception of Medicare half a century ago, decisions about its funding and delivery have been dogged by dispute. Today there is friction about what services and drugs to include in the basket of publicly insured health care, and how to reduce wait times for care. The “Canadian approach” is still evolving.

Developing nations struggling to respond to the health needs of their citizens often show interest in the seeming success of the Canadian model and want to know “what makes it tick”. This handbook provides an outline of the Canadian approach, showing how different aspects of the system work together, how we got here, and how we are adapting to emerging pressures and possibilities.

At first glance Canada's approach to health care may not seem particularly relevant to developing nations, given the stark differences in our general economic and social well-being, current standards of practice, and what is considered affordable. But Canada's past and present experiences are telling, for two important reasons:

- Where Canadians are today is not where we began. Canada's approach to health care emerged as a response to poverty, not a product of plenty. Concerns about economic disparities, and how to best help societies flourish, have always been a central part of our health care debates.
- Canada has, like all other nations, rich and poor, been facing strong demands for health reform; and the issues that Canada is wrestling with are strikingly similar to those of other countries.

Developed and developing nations alike are aware, as never before, of the urgent need to improve the health and life chances of vulnerable populations. Reducing health disparities

is both a sign of and a precondition for human development.

Despite vast contrasts in national income, countries around the world are trying to cope with problems in four key aspects of health-care systems: a) funding and coverage of service; b) human resources; c) governance; and d) the development and sharing of health information.

This handbook looks at how Canada has dealt with challenges in each of these areas. It offers up our experience, both positive and negative, and it sheds light on why reforms based on universality and accessibility are so difficult to achieve and maintain.

The launching of the Millennium Development Goals in September 2000 brought together, for the first time, rich and poor nations in common cause to achieve target objectives by 2015, including specific goals to improve basic health outcomes. These goals were reinforced in Canada in April 2005 with the release of the federal government's long-awaited revised International Policy Statement, which featured improved health as one of its five central missions in development.

Improving health is not only, or even primarily, a function of the health-care system. Social, economic, and environmental factors feature more importantly as determinants of health, as does the crucial role of a person's genetic make-up. Yet no one would deny that the ways in which health care is provided — or denied — form a decisive element in an individual's life chances and well-being.

For this reason, this handbook focuses on the provision of health care, specifically publicly funded health care. While it repeatedly re-

turns to the importance of health promotion, population health measures and public health initiatives such as immunization or the control of communicable disease, its main purpose is to outline how access to care and cure has been organized in Canada.

This document draws on input from a wide range of resources: benchmark Canadian documents; surveys of recent international conference proceedings; a committee of advisors who are experts in both health care and international development; insights from some of Canada's leading thinkers and doers in health care; and dozens of interviews with Canadian development officers and health professionals who have worked abroad in circumstances ranging from crisis intervention and emergency response to the development or enhancement of established public systems of care.

The goal is to provide a document that connects the dots — from health reforms, to the reduction of health disparities, to improved economic and social well-being. The links between health and development are the same in Canada as around the world.

Canada's system isn't perfect. No system is. This handbook discusses the achievements and shortcomings of Canada's approach to health care — what works well, what doesn't, and where the challenges lie. Changing systems of governance, funding and coverage, human resources and information systems are all responses to a goal shared by people in developed and developing nations alike getting better health care, for one and all.

Consider this a book of lessons from, and for, Canada.

# Governance Matters

WHO DECIDES WHAT for whom? That's what "governance" in health care is about: the institutions and practices that create and enforce legislation, and regulations that respond to public expectations.

Governance is more than just governments. It's about:

- How decisions are made
- How citizens have their say
- How power is exercised

Rules and codes of conduct are established by governments, professional associations, and unions of health-care providers. Norms and standards of practice evolve through public input and the degree to which rules are enforced.

Public input takes many forms: local experimentation in service provision, participation on boards and councils, union involvement, coalitions for advocacy and lobbying purposes, media campaigns, public protest, and court rulings.

## **The Canadian Context: Decentralization and Diversity**

In Canada governance is shaped by our constitutional structure, which sets out roles for both federal and provincial jurisdictions. The past few decades have seen increasing dispute over these roles.

Jurisdictional debates have been a perennial challenge in Canada's health sector, pitching the relative merits of centralized administration (by the federal government) against those of decentralized administration (by the provinces).

At the time of our Confederation, the British North America Act of 1867 assigned the federal government a relatively weak role when it comes to services that affect people's daily lives. The constitution explicitly gave responsibility over education, municipal services and other key sectors to the provinces, and inferred that the provinces would be responsible for health services as well. Over time, though, Canadians have consistently asked the federal level to play a role in achieving various social objectives, either by establishing national standards or with the use of federal funds.

## › The Five Principles of the Canada Health Act

Although decision-making around public health care in Canada is decentralized, the values that drive its provision in all jurisdictions are enshrined in federal law. The Canada Health Act lays out criteria for federal funding to ensure that Canadians receive similar access to and quality of health care, regardless of where they live.

- **Public administration:** the administration of the health care insurance plan of a province or territory must be carried out on a non-profit basis by a public authority;
- **Comprehensiveness:** all medically necessary services provided by hospitals and doctors must be insured;
- **Universality:** all insured persons in the province or territory must be entitled to public health insurance coverage on uniform terms and conditions;
- **Portability:** coverage for insured services must be maintained when an insured person moves or travels within Canada or travels outside the country; and
- **Accessibility:** reasonable access by insured persons to medically necessary hospital and physician services must be unimpeded by financial or other barriers.

The Canada Health Act also contains provisions that ban extra-billing and user charges. Under the terms of the health care insurance plan of the province or territory these can be:

- No extra-billing by medical practitioners or dentists for insured health services.
- No user charges for insured health services by hospitals or other providers.

But for the past few decades, the societal trend has been towards greater devolution of decision-making to the provinces, a trend reinforced in the 1980s and 1990s by fiscal pressures. The result has been an increasingly decentralized and uneasy federation.

The reality is that we don't have a single Canadian "system" of Medicare. Rather we have fourteen quite distinct "systems" — ten provincial, three territorial, and one federal.

The federal role is the most complex because it provides direct health services for aboriginal populations, the Armed Forces and its veterans, the Royal Canadian Mounted Police, and inmates of federal prisons. The federal government also has a public health function for the control of communicable disease and health promotion. It provides research and information and regulates pharmaceuticals, technological procedures, and

food and product safety for the entire Canadian market. Finally, and most critically in a profoundly decentralized system, it provides funds for the provinces' and territories' provision of health care services. It is by withholding these transfers of financial resources that the federal government can enforce compliance with the Canada Health Act, legislation that sets out the five founding principles for the provision of public health care for all citizens.

To further complicate matters, every province has now devolved decision-making in health care to regional authorities — all except Prince Edward Island, Canada's smallest province, which chose to re-consolidate authority over health care to the provincial level in 2005. Despite this trend, higher levels of government still make major public policy decisions. Individual hospitals, community health centres, and clin-

ics also retain important decision-making capacities — such as how much service to provide, how to allocate existing budgets or raise extra revenues, how many or what staff to hire, and how to purchase supplies.

Canada's social and geographic makeup is amazingly diverse. The country's relatively small population is spread across a huge, often very cold land mass, bounded by the distinct maritime cultures of three oceans. Over 80% of the population lives in urban centres, most of which run along a thin line near the border with the United States. The northern part of the country is sparsely populated, has limited infrastructure and experiences long harsh winters.

Diversity is built right into the cultural foundation of the country. Canada is often described as having three founding peoples: British, French, and First Nations. Much of Quebec's economic, political and social reality is impossible to reproduce in other parts of the country, and not just because of language. The chronic failure to address the unique situation and needs of First Nations peoples, both on and off reserve, remains an embarrassing legacy of Canadian public policy. Canada is officially bilingual, but is now one of the most cosmopolitan countries in the world, and it is increasingly dependent on immigration to grow.

Each of these geographic and demographic characteristics has had a profound impact on our health-care sector. Put together, they create a challenging environment for meeting the commitment to universality and accessibility in the provision of health care.

## Issues and Challenges

### The Public/Private Tension

While universality and accessibility are the two value-driven principles of Canada's approach to publicly insured health care, the key governance principle is public administration.

The “public” part of public health care in Canada is about the payment for — not the delivery of — services.

About 70% of all health care costs in Canada are publicly insured, that is, funded through government coffers. This “single-payer” system is admired around the world as being administratively efficient: one source pays the bills incurred for medically necessary services from doctors and hospitals, most laboratory and diagnostic services and some pharmaceuticals.

The public purse has traditionally relied on the purchase of service from the private sector, primarily from not-for-profit institutions of care. But that pattern is changing.

In recent years there has been a growth in the use of public funds to purchase care from investor-owned, for-profit facilities: private hospitals in Alberta, private day surgery in British Columbia, private home care and long-term care in Ontario, and private diagnostic clinics throughout the country.

Another trend has been the growing use of remuneration for appointments on hospital boards of governors. This trend jeopardizes one of the hallmarks of public health care: meaningful community involvement and voluntarism.

Direct payment has also become more common, with individuals opting to pay for access to speedier diagnostic tests and medically necessary procedures through private (for-profit) clinics, or paying for services that are no longer publicly insured.

There is heated debate about whether growing privatization — which is really the growing commercialization of care — is a problem or a solution for the long-term sustainability of publicly funded health care. There has been much debate too around whether Canada should have — or already has — a two-tier system of paying for health care, one that encourages some people to get care more quickly than others based on their ability to pay, not on their medical need.

A hallmark judgment made by the Supreme Court of Canada in June 2005 further exacerbates this public/private tension. The *Chaoulli-Zeliotis* case tested the nature of citizens' legal rights to health care. The ruling found that Quebec's laws governing public insurance for medically necessary services violated Quebec's Charter of Rights because they prohibited the purchase of private insurance or direct payment for these same services but provided no guarantee of timely access to service.

While that ruling was directed to Quebec, other provinces have similar prohibitions to prevent two-tier funding arrangements. The ruling has produced two government responses that may up-end existing principles and operating assumptions of the Canada Health Act, one from Quebec and another from Alberta. Both open the door to private health insurance and other aspects of greater private sector involvement in the funding and delivery of health care in Canada.

### **Decentralization of Decision-making**

All over the world, lower levels of government and communities of interest are demanding a greater voice in decision-making. People are seeking ways of making policies respond to their particular circumstances, and they are pushing for greater self-determination in allocating public resources.

Greater democracy and local control can be a powerful tool for addressing local realities in a timely fashion if they are backed up by financial resources linked to decision-making responsibilities.

Decentralization can be empowering or weakening, depending on how and why it takes place. The recent pattern of decentralization in Canada has occurred during a time when senior levels of government have focused on reducing costs and offloading responsibilities to lower levels of government or to individuals. Downloading,

as opposed to decentralizing, simply means that governments pass the buck without passing the bucks.

Decentralization indisputably has the potential to trigger significant change for a distinct group or to permit innovative approaches to stubborn problems. Individual doctors and nurses, collectives of people such as community boards, and local or grassroots organizations and individuals have a long history of influencing the delivery of care on the ground and of coming up with innovative ways of solving problems.

Still, if governments fail to define collective purpose and to facilitate the extension of "successful" models of practice, health-care systems can become increasingly balkanized and riddled with inequities over time. The challenge of decentralization, with its focus on micro-level solutions, is that it can lead to a macro result in which citizens end up with dramatically different access to services in different regions or sub-populations, fragmenting what should be a coherent objective.

The federal government is now struggling with the differences between the regions of Canada regarding citizens' access to acute care, prescription drugs, and home care. A recent infusion of billions of dollars in new federal funds has been loosely tied to improvements in all three areas. What is lacking, to date, is the crucial level of buy-in from all jurisdictions to establish and enforce benchmarks, standards and measures that approach common objectives in every part of the country. This is a reflection of the degree to which the federation has become regionalized and fragmented at this time.

### **Governing Drugs**

Prescription drugs are the biggest cost drivers in health care, both in public and private spending. For both clinical reasons and reasons of cost, tools that govern access to pharmaceuticals are critical in the face of increasing demand to cov-

er new and often expensive treatments through publicly funded systems.

The federal level of government determines what pharmaceuticals get onto the Canadian market and at what price, at least for patented drugs. The approval process for drugs is twofold: regulation of industry-based product safety-testing, and government-based assessments of clinical effectiveness.

The prices of new patented drugs and any increases in those prices are set through the Patented Medicine Prices Review Board. The Canadian retail price for patented drugs is, on average, 40% below the U.S. price for patented drugs. Not so for generic drugs, for which there is no price regulation, and which account for 30% to 40% of all prescriptions. Lower average prices for generics in the U.S. are a result of bulk-purchasing by large-volume players, such as the U.S. Department of Veterans Affairs.

Such arrangements take a lot of negotiating and the political will to push for a better deal from powerful pharmaceutical companies, something that Canada has not always shown. Since 1992 alone, Canada has twice extended the life of patent protection for new medicines. The financial impact of these federal moves hit the provinces, which saw severe limitations on an important tool for containing the rising costs of public drug programs: compulsory licensing. (See Box.)

Only a few jurisdictions in Canada use purchasing techniques to try to contain the soaring costs of drugs, even when it comes to the public purse. Some hospitals pool their budgets to bulk-buy drugs, but most do not. Some provinces have tried price/volume contracts for new drugs as a condition of entry on the public formulary, but most do not. Most jurisdictions simply don't have the scale to manoeuvre price discounts for commonly used drugs.

Co-ordinating purchasing power would reduce rather than increase costs through price-bidding. But it is politically difficult to broker.

### › Co-ordinated Purchase Another Way to Govern Drug Costs

We may not do it much at home, but at least one of our foreign-aid programs shows that Canadian officials think bulk-purchasing is smart and worth investing in.

The Global TB Drug Facility is a Canadian-sponsored aid project at the World Health Organization (WHO) that provides low-cost drugs to TB sufferers in dozens of the world's poorest countries. It began in 2001 with a \$15 million startup grant from Canada, and has since received another \$40 million in Canadian support, accounting for well over 60% of its budget.

On this shoestring, the GDF goes bargain hunting for the best prices of TB drugs — which means that the price of a standard six-month treatment for TB has dropped by more than 30% since the agency began its mandate. It has provided TB drugs to 4.4 million patients in 58 countries, of whom about 85% are cured of the potentially fatal lung disease. The program doesn't just buy drugs; it follows up to ensure that when drugs are delivered treatment is carried out properly, through a directly observed short-course treatment protocol.

TB is one of the world's leading killers, claiming more than 1.7 million lives annually. The WHO has set of a goal of halving the number of TB cases by 2015.

### › Compulsory Licensing A Way to Govern Drug Costs

In the case of drugs, compulsory licensing allows a government to override a patent in order to correct market failures — for example, when high drug prices impede achievement of a public health objective. A company other than the original patent holder of a medicine is then licensed to produce a generic version for the local market — not for export — but still pays a royalty to the patent holder. Governments then offer this lower-cost version of the drug through their publicly insured drug programs. Three sets of revisions to federal patent law since the late 1980s have constrained the use of this mechanism.

## › Patent Laws and Drug Prices

TRIPS (Trade-Related aspects of Intellectual Property Rights) is an agreement drawn up by the World Trade Organization (WTO) between 1986 and 1994 to ensure that intellectual property rights are respected within international trade. It came into force on January 1, 1995. In November 2001, in Doha, a WTO Ministerial conference agreed that TRIPS should not prevent members from taking measures to protect the public health of its citizens. The meeting therefore agreed that countries should be able to manufacture generic drugs made before the 1995 introduction of TRIPS and could produce newer drugs under the compulsory licensing system.

The original TRIPS agreement mandated that products made under compulsory licensing must be “essentially for the domestic market.” This rule worked for countries that had the capacity to manufacture drugs, but not for countries that would have to import generic drugs.

In August 2003, a decision was taken during WTO talks in Cancun to allow countries that produce generic copies of patented products under compulsory licence to export the products to eligible importing countries. Canada is one of a handful of nations that produce generic drugs. This change required amendments in Canadian and other producer nations’ patent laws. Any revision of patent legislation triggers intense lobbying by drug manufacturers for other amendments.

Canada was the first nation to introduce changes to domestic law. The federal government amended the Patent Act in 2003, and finalized enabling legislation in the Food and Drugs Act in May 2005. These changes permit the export of low-cost generic drugs to developing nations where they are desperately needed in relief of HIV-AIDS, TB, malaria and other public health problems. The first shipments are expected to be sent in 2006.

For example, when the federal government introduced a national immunization program in its 2004 budget, it let the provinces go their own way in purchasing the vaccines.

Although the potential savings at the national level could be enormous, it has been difficult to implement greater efficiencies — like a national formulary, or bulk-purchasing of common drugs — because of our fragmented approach to Pharmacare across the provinces and territories.

### **The International Law Factor**

International law and international trade agreements have set new limits on what governments can and cannot do.

Both the GATS (General Agreement on Trade in Services), which is now being negotiated, and Chapter 11 of the North American Free Trade Agreement (NAFTA, signed in 1992 with the United States and Mexico) have serious implications for Canada’s approach to public health services.

Trade laws require that Canada treat foreign corporations the same way it treats domestic corporations, or pay a penalty. The public health-care system is “safe” from international rules of commercialization only to the extent that ownership of the mechanisms of delivery remain non-profit. Governments, citing constrained public resources, are increasingly turning to commercial investor groups to raise finances to build new facilities or provide services. This may lead

to an irreversible and/or very costly evolution in how health services are provided.

However, continuing negotiations of international trade laws have also demonstrated the potential for different results. For example, rising political pressure has forced changes in international rules to make drugs that treat HIV-AIDS available at an affordable price, for African nations in particular. (See Box on page 8.)

By November 2001, trade negotiators had conceded that governments have a right to make public health a higher priority than intellectual property rights (patent protections for corporations). This is a major departure from the traditional purpose of trade agreements and intellectual property laws; it places human concerns above corporate concerns, and marks an important development in the architecture of international law.

### Accountability and Public Input

One of the reasons that Canada's approach to public health care has been held in such high regard, at home and abroad, has been its ability to attain and maintain strong public support. This in turn is a function of the degree to which health reforms over the decades have met public expectations, and inspired deepening confidence in the system.

Effective public health systems respond to the basic needs of the public, and provide structural avenues for change. Systems fail when they cannot respond to emerging conditions due to stasis, crisis or corruption.

The relevance of public systems depends on how and to what degree the public is involved. In Canada the infrastructure of feedback includes offices of elected representatives, committee structures of government, and regular sounding of the public (surveys, polls, public consultations). Change is urged through more direct channels too—for instance, through lobbying

and protest by organized groups, and through the media and the courts.

Grassroots movements have historically shaped the direction of health reform in this country, from the first health collectives established by Prairie farmers to the smoke-free movement of today. (See Boxes on page 10.) Starting as self-help or mutual aid circles; organized coalitions of citizens have led to the crafting of legislation and regulations that affect all members of society.

### The History of Medicare. Building Public Confidence in Collective Action

The roots of Medicare are on the Canadian prairie. In the early part of the century, farmers worked hard to scrape out a living for their families. They lived in harsh conditions—frigid winters, arid summers—in simple houses, often built of the very sod from which they raised their crops.

In his history of Medicare in Saskatchewan, C. Stuart Houston tells the story of how one small community took the first step toward socialized medicine. The town of Holdfast was a small one. Most of the people who lived nearby were poor immigrant farmers working to make a living growing wheat. The local doctor was a man named Henry Schmitt. He had moved to the area from the United States, but soon found that Holdfast was a difficult place to make a living. Doctors charged their patients directly; many people in Holdfast could not afford to pay. When Schmitt decided to move his practice to a larger community down the road, the people of Holdfast banded together and offered him a stipend to stay. Schmitt accepted—and became North America's first municipal doctor.

During the Great Depression of the 1930s, Saskatchewan expanded its municipal doctor scheme. Extreme drought was causing crop failures year after year. Farmers could barely feed their families, let alone pay for medical care when family members became ill. They organ-

› Anti-smoking Measures in Canada Grassroots Action to Legislative Controls

Tobacco use is the world’s leading cause of preventable death. Half the people who smoke today — about 650 million people — will eventually die as a result of tobacco use. If current smoking patterns continue, tobacco will cause 10 million deaths each year by 2020.

Canada is a world leader in tobacco control. Our anti-tobacco strategy is a co-operative effort between the federal and provincial officials, public health departments and municipal councils, and activists in the community and in the health sector.

Smoking rates have been slowly reduced for all age groups over the past two decades. It has been a gradual process, with an aggressive public education campaign supported by progressively higher taxes on tobacco products and stronger regulations around the consumption of tobacco. In recent years many communities have adopted by-laws that prohibit smoking in public places, reducing exposure to second-hand smoke.



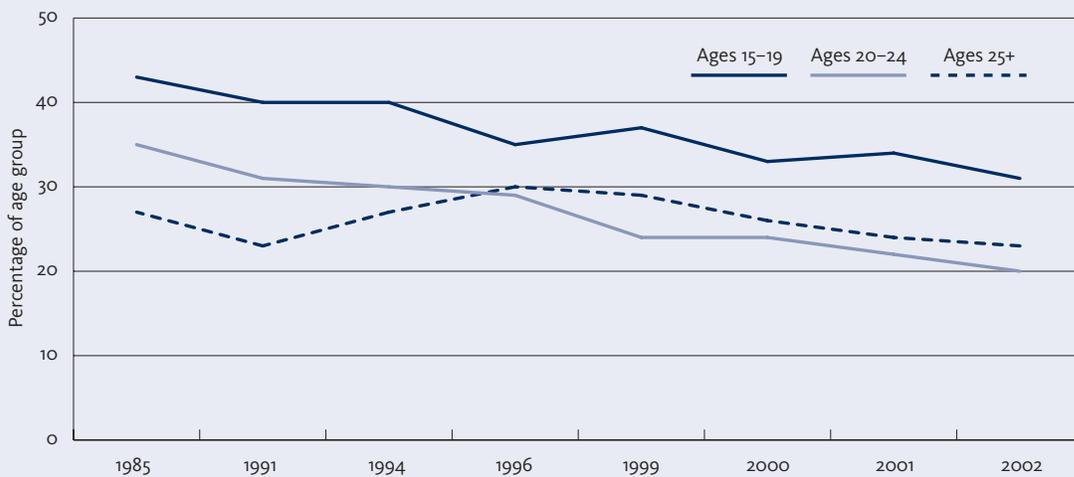
Canada is famous around the world for the graphic warning labels we require cigarette makers to place on their packages.

Despite these efforts, tobacco use remains Canada’s leading cause of preventable illness, disability and premature death. Each year, smoking contributes to the death of more than 45,000 Canadians.

Canada is a leader in international efforts to curb tobacco use. Rising smoking rates are of particular concern in developing countries. The health costs associated with tobacco use are devastating. Tobacco use also tends to exacerbate poverty; many studies have shown that the poorest households in low income countries spend as much as 10% of their incomes on tobacco.

Canada played a leading role in developing the World Health Organization’s Framework Convention for Tobacco Control (FCTC), which came into force in February 2005. The FCTC details the price, tax and other measures necessary to reduce the demand for tobacco. The convention not only offers a strong, overarching strategy but also gives countries enough flexibility to develop their own national policies.

**CHART 1 Smoking rates in Canada 1985–2002**



**SOURCES** 1985 and 1991 General Social Surveys; 1994 Survey on Smoking in Canada, Cycle 1; 1996/97 and 1998/99 National Population Health Surveys; 1999–2002 Canadian Tobacco Use Monitoring Surveys. Current smokers = daily + non-daily smokers

ized and lobbied for public insurance, a way to share the costs of keeping doctors in communities—and avoid catastrophic costs when illness struck. The system was first funded through property taxes and, beginning in 1934, through personal income tax.

In 1944 T.C. (“Tommy”) Douglas was elected premier of Saskatchewan. He introduced sweeping reforms to the province, bringing modern infrastructure such as running water and electricity to the province’s far-flung farming communities. But Douglas is probably best known as the father of Canadian Medicare. In 1947 he introduced universal hospital care to the province of Saskatchewan, at a fee of \$5 per year, per person. In 1961 Saskatchewan launched a program covering medical care outside of hospitals.

Saskatchewan’s experiment was watched closely across the country, and in 1964 a Royal Commission recommended that Canada adopt a national Medicare program based on the Saskatchewan model.

### **The History of Medicare:**

#### **The Era That Shook Public Confidence**

Over the last decade the Canadian system has been rocked by a number of factors that have shaken public confidence. Government responses have all involved public input to shape how the wrongs should be righted, and how to avert such future disasters.

After tainted blood products led to the infection of 1,200 people with HIV-AIDS and 12,000 more devastated by Hepatitis C, the federally appointed Krever Commission triggered an entire restructuring of how blood is collected and distributed in this country in the 1990s, and a renewed emphasis on federal regulation and surveillance of blood supplies.

In Walkerton, Ontario, seven people died and one thousand fell ill due to contaminated drinking water. A provincial public inquiry revealed managerial incompetence, corruption and cutbacks in public funding for environmental pro-

tection as the culprits. The province’s response included new regulations and partially restored public funding.

After almost 20 years of tight constraint or cutbacks in government spending, there are still unmet demands to invest in the minimal needs of public infrastructure throughout the country. The most consistently ignored reality is the desperate situation on native reserves. Some 150 aboriginal communities today live with “boil-water” advisories, and have done so for many years. The Ontario government’s October 2005 evacuation of one thousand residents of Kashechewan has highlighted this long-standing disgrace. Given that aboriginal populations are the “responsibility” of the federal government, it remains to be seen whether media attention alone in this situation and the federal-provincial dispute that accompanies it will suffice to provoke systemic reform and action.

Perhaps the biggest threat to public confidence has emerged as a result of massive government cutbacks in spending at the federal and provincial levels during the mid-1990s. The cutbacks led to a reduction in the scope and availability of health services and increased waiting times for care. Within less than five years, mounting public concern and the emergence of budgetary surpluses led the federal government to restore, then increase, funds to the provinces for health care.

At the same time worries about the future “sustainability” of public health care launched three provincial inquiries (Quebec, Alberta, and Saskatchewan), and two federal investigations (the Romanow Commission and the Senate Committee’s reports). The Romanow Commission (the Royal Commission on the Future of Health Care in Canada, April 2001 to November 2002) received thousands of written submissions (electronic and standard mail), heard hundreds of oral presentations and had over 30 million hits on its website. It launched a ground-breaking process of deliberative dialogue, expert panel

discussions following the public hearings, commissioned expert research, cable television debates and a substantial number of radio call-in shows with the Commissioner. It was the broadest consultation in Canadian history.

Given this level of public interest, it is not surprising that the federal, provincial and territorial governments brokered three major deals over four years on health care: in September 2000, February 2003 and September 2004. Each deal was accompanied by an ever louder call for accountability for the billions of dollars in new federal funds flowing to the provinces. The result was the creation of the Health Council of Canada, which treads a fine line between functioning as a public watchdog on what is happening in public health care across the country, and trying to move the provincial and territorial jurisdictions closer together in the pursuit of health-based objectives.

### **Summary: Seeking Balance and Accountability**

The focus for reform in democratic governance can be summarized by one word: “accountability.” Reforms that move public systems towards greater accountability are all aspects of reforms in governance. Governance issues in health care include:

- The way in which decision-making and responsibilities are divided between jurisdictions;
- The relative roles of governments, service providers and the public in influencing, making and enforcing norms and standards of practice;
- How the public and private sectors intersect, and how individual and collective interests are balanced;
- How major health issues/cost drivers in health care are managed;
- How international laws frame the options; and
- How systems and their legitimacy are sustained and informed by public input.

Canada’s approach to health care is in flux/evolving in virtually all of these areas. It remains a work in progress.

# Finance and Coverage Matters

OF ALL THE ISSUES in health reform, none is more complex or politically thorny than the issue of money. Finance is about access. Budgets determine who gets health services, and whether they get them through public provision or private purchase of care. Every budget has limits. Limits that create serious barriers to care have both private and public consequences, which raise important public policy questions, such as:

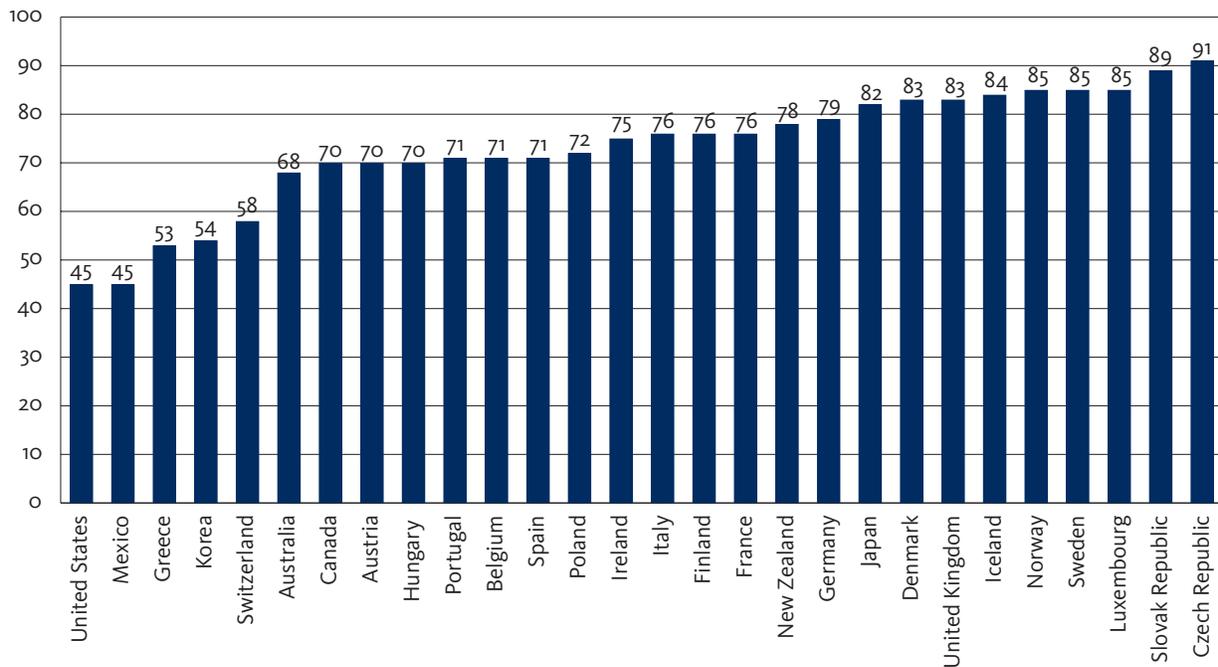
- Who should pay for what?
- Where can we realize the best value for our spending?
- How much is too much?
- Will today's decisions help us prepare for tomorrow's challenges?
- How long will today's solutions last?

The responses to these questions reflect social values as much as they do very real technical and income constraints. Decisions about access to care speak volumes about what a group, at a given time, thinks is important to achieve individually and as a society in the effort to improve health.

For most of the twentieth century, the financing and coverage of health care in Canada evolved in a clear direction, generally towards a broadening of access and a reduction of health disparities. Decisions about who should get care, and how to pay for that care, were originally a response to conditions of poverty, not plenty. Now, in a time of unparalleled prosperity, these same questions are once again being asked.

Although this chapter examines the evolution of publicly insured access to care in Canada, the challenges of introducing health reforms are the same everywhere around the world. There are always limits to what can be done, pitting what is ideal against what is possible. If improving population health is the goal of our health system, we need to have a basket of services that supports all members of society. What should be in and what out of that basket, and can those choices be sustained, politically and financially?

This is the story of how Canadians decided to strike a balance between public and private goals and, in so doing, found a balance between choice and equity.

**CHART 2 Public Health Expenditure** Percentage of Total Health Expenditure, OECD Nations 2003

**SOURCE** Organization for Economic Cooperation & Development (OECD) Health Statistics, 2005.

### The Public-Private Balance

Spending on health care is increasing all over the world. Only two (Finland and Austria) of the twenty-nine developed nations in the Organization for Economic Co-operation and Development (OECD) have bucked the trend towards spending an ever-increasing proportion of their economies on health care. A few more have managed to keep the share of public spending that goes to health relatively stable. Everywhere there is concern about the amount of money that is going to health care, whether that concern is about it being too much or not enough.

In 2003 only six OECD nations (France, Germany, Iceland, Norway, Switzerland, United States) spent proportionately more of their economies on health care than Canada did in 2003. About 10% of everything Canadians buy and sell is health-related, and about 7% of the Canadian economy is generated through the public provi-

sion of health care. Despite being famous for its “universal” approach to public health care, the private share of health spending has been growing in Canada over time. Until 1988, over three quarters of our spending was through public finance. Today Canada pays for about 70% of health care costs publicly, a relatively low share of public expenditures compared to other developed nations.

Most OECD nations (eighteen of twenty-nine) pay more of their health costs through public finances than Canada does. Their public financing averages 80% of total health spending.

When it comes to what’s covered by public insurance, all Canadians at least theoretically have access to their choice of doctors and hospitals, at no direct cost, through provincial public insurance schemes. The systems cover all medically necessary services, including most diagnostic procedures. Access to other publicly in-

sured health services — such as immunization, prescription drugs, physiotherapy, dental and eye care, home care, or long-term care — varies substantially from province to province.

The main reason for Canada’s relatively low public share of health spending compared to other nations is because pharmaceuticals were not originally included in our definition of medically necessary care. When federal cost-sharing came into the picture, it did not explicitly include the costs of Pharmacare, except when in hospital. Later expansion of provincial benefit plans have been inconsistent: both the level of coverage and who benefits from coverage vary from province to province. In comparison, most nations with publicly insured health care consider prescription drugs an integral part of the system for all.

If Canada lags behind other nations in how it has integrated drugs as part of health care, other countries have seen it as an international leader for how it finances access to acute care. Canada has a unique system of making sure that medically necessary doctors’ and hospitals’ fees are covered by public insurance funded through the general tax base. All jurisdictions provide “first-dollar coverage,” which eliminates all direct costs for users of acute care and most medical services. Canada has achieved this by prohibiting user fees and supplementary insurance schemes for medically necessary care by doctors and hospitals, through a combination of federal and provincial legislation. The focus on taxes rather than health premiums as the source of funding means that the price tag of public health care is geared to income. This means in turn that lower-income citizens don’t spend a relatively higher proportion of their budgets on basic health care.

This method of financing universal coverage of medically necessary services has made the system revolve around need, not ability to pay — at least until now. In recent years the demand for speedier access to constrained services has spawned a flurry of financing ideas that

propose a shift away from the tax base to other public insurance modalities — such as health premiums or co-pays (where a portion of the costs are covered by the user) — or private insurance options. There is no consensus that these other directions would be the best way of proceeding to ensure the viability and sustainability of the public system, and consequently the provincial governments that have signalled interest in such options have moved slowly on introducing large-scale reforms. The federal government has hesitated to impose sanctions on jurisdictions that have bent rather than broken the legal framework. This wavering has helped shift the decision-making climate. The provinces of Alberta and Quebec are now openly entertaining more private funding alternatives.

Pressures of demand are leading to other changes in the public/private mix. Canada’s publicly funded systems purchase delivery of service from the private sector; but these private-sector providers have primarily been not-for-profit entities and individual doctors. The past few years, however, have seen a growth in the public purchase of service from for-profit health enterprises, which are investor-owned and shareholder-directed businesses. The governments of the four largest provinces — Ontario, Quebec, British Columbia, and Alberta — have channelled much of their growth in capacity through these types of businesses, which include hospitals, day-surgeries, home-care and long-term-care providers, and diagnostic clinics. This trend has been hotly contested, with debate over the costs and health outcomes associated with investor-owned for-profit facilities.

As well, after more than a decade of deferred maintenance and deferred expansion of capacity, a wave of new capital investments is taking place in Canada’s public health infrastructure. Since the federal and provincial governments are now more inclined to reduce public debt than take on more debt, new construction is increasingly financed by public-private partnerships.

In these cases, private-sector business consortiums design, finance, build, and often operate new health facilities, and the public sector pays. Investors provide the equity and undertake the debt required to build facilities, while governments pay yearly leaseholder amounts. Contracts vary as to whether the facility is owned by the investors or the public at the end of the lease. There is little evidence that this financing alternative offers a real advantage to the public purse. It always costs more to borrow privately than it does through the government, and there is no real transference of risk to the private sector — a hospital serving the public will simply never go bankrupt and close. However, there is less public engagement in this discussion, and the drift towards private financing is politically expedient, for now.

There is a pervasive sense nowadays that the levels of service in health care are increasingly inadequate. This is partly a product of an aging population, a widening array of technological possibilities, and a society swept by the culture of immortality. But the levels of public service that are frequently felt to be inadequate are also a product of trends in public spending on health care in Canada.

### **The Federal-Provincial Balance**

Public funding for health care in Canada is a shared enterprise between senior levels of government, federal and provincial, while the delivery of public health-care is a devolved, mostly local enterprise, largely directed by regional health authorities. This complex way of providing public health care has had serious implications for how decisions are made about budgets and coverage of care through public insurance. It also has implications for any health plan that has to patch together funding from different sources and yet try to achieve population-based objectives.

From the late 1980s to the late 1990s, Canadians endured more than a decade of belt-tightening by federal and provincial governments. The era of budgetary cutbacks left every jurisdiction with fewer hospital beds and more unpredictable staffing arrangements for essential services.

To the degree that a “Canadian” approach to health care exists, it is a product of the federal-provincial cost-sharing arrangements established in the late 1950s [i.e. hospitalization]. In the early years, the federal-provincial deal for public health care provided both stability and growth, facilitating greater uniformity of access to basic medical services across the country. By the 1990s, when the federal government broke the deal and unilaterally withdrew cash support to the provinces, the same funding arrangement had become a source of instability and growing disparities in service.

Federal transfers to the provinces originally provided about half of the cash costs of public health care. By 1977 the provinces had sought and won a deal that would continue to see the feds support a fifty-fifty share of hospital and physician costs; but the federal government would provide half of that support through cash and half through the transfer of tax points. By voluntarily reducing how much they would tax, and letting the provinces take up that tax “room,” the feds were giving the provinces greater latitude to determine the scope and focus of public provision. By 1998, budgetary cutbacks had dropped the cash portion of federal transfers to about 10 per cent of provincial health expenditures. A new fiscal context made the tax transfers irrelevant.

The provinces were obliged to make up for billions in lost revenues because access to health care is both politically expected and legally statutory; but among them they had different abilities to pick up the fiscal slack through increased taxes or reallocation of spending. Most provinces were running deficits, and, like most governments around the world, they were unwilling to raise

taxes in an environment focused on attracting and keeping business investment.

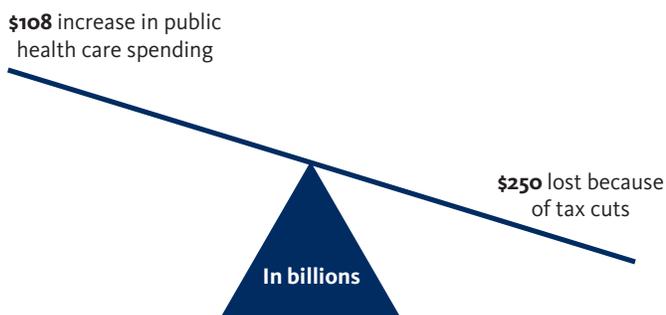
Cuts to health care seemed the only option. To varying degrees, provinces de-listed or reduced supports in health services that were not clearly statutory. All provinces increased their rationing of resources by closing hospital beds and cutting or restricting health budgets. Since about three-quarters of the costs of health care are in labour, layoffs became commonplace in hospitals and other institutional settings — which lengthened queues for diagnosis and treatment, and created backups in emergency rooms.

Since 2000, the country has seen major re-investments in health care, primarily through increased federal transfers to the provinces; but the new funds have not yet been shown to have improved access, nor have they been used by the federal government to explicitly promote more uniformity of access across the country. There remains a sense that current financing arrangements are inadequate to meet the “real” need.

While some provinces have emphasized more private-sector involvement, all provinces have endorsed proposals to move forward on the public side of the equation in at least two areas. Broader public coverage has been recommended as the solution to address the “catastrophic” costs of pharmaceuticals for people who face bankruptcy due to their health needs. Broader public coverage of home care and community-based care is also widely acknowledged as a tool to lighten the burden on hospitals, saving costs. Although the federal government has provided limited new funds for these objectives, and although everyone wants improvements in these areas, the variation in what is publicly insured continues to widen rather than close between jurisdictions — a point that speaks to the provinces’ deep retrenchment from national objectives and the increasingly regionalized distinctions in political priorities.

Provincial variability stems not just from what is covered through public insurance, but

**CHART 3** Since 1996, Tax Cuts Have Been a Bigger Fiscal “Threat” Than More Public Health Spending



**SOURCE** Derived from “Can We Afford To Sustain Medicare?” pp. 8–9, <http://www.nursesunions.ca/cms/updir/2004-07-29-Sustainability-Report-en.pdf>

also from the share of provincial budgets that is goes to health care. Quebec spends less than a third (30%) of its budget on health care, and this proportion has scarcely changed over most of the last fifteen years. Some provinces, such as Ontario, British Columbia, and Nova Scotia, have seen health’s share of public spending expand rapidly. In Ontario health care accounted for 44% of all provincial spending in 2005, up from 37% in 1995. The reasons for these differences between provinces have not emerged as a subject for discussion. Rather, the focus of interest has centred on the rising share of health costs in some provincial budgets.

The resulting sense is that the rate of growth in public health spending is not sustainable, given the much lower rate of growth in revenues. The reality is that governments themselves have actively constrained the revenue side, believing that they cannot ignore the pressures of “tax competition.” Virtually every jurisdiction has reduced personal and corporate tax rates in the past decade, not once but repeatedly. Put together, the federal and provincial governments increased spending on health by \$108 billion between 1995

CHART 4 Maternal Mortality

| Maternal Mortality        | Maternal Deaths per 100,000 Live Births |
|---------------------------|---|
| Developing Regions (2000) | 440                                     |
| Canada (1923–1937)        | 500                                     |
| Canada (1940–1945)        | 180                                     |
| Canada (1946–1965)        | 30                                      |
| Canada (2000)             | 7.5                                     |

SOURCE World Health Organization and Statistics Canada

and 2004. Over the same period, they reduced tax revenues by \$250 billion.

Money talks, and these figures say something about the public priorities and values that have emerged over the last decade.

### Expanding Coverage

For most of the past hundred years, Canadians' access to health care has been a story of slow, incremental expansion and a willingness to reduce health disparities as they become obvious.

In the nineteenth and early twentieth centuries, Canada had maternal and infant mortality rates comparable with those of developing countries today. Epidemics of polio, tuberculosis, cholera, typhoid, and other diseases ravaged the population. Public health interventions targeted to whole municipalities turned that tide around.

Toronto's first medical officer of health lost his own daughter to typhoid in 1912. That tragedy launched Dr. Charles Hastings' personal crusade to improve public health in the city. Hastings began inspecting Toronto's slums and found thousands of people living in overcrowded and filthy tenements. Photographs taken by Arthur Goss, the city's official photographer, helped rally pub-

lic support for the cause. Hastings demolished more than 15,000 outhouses and pushed for the creation of more waste-water treatment facilities (the first one in Toronto had been built only in 1910). By 1913 the first sewage system to transport waste was under construction. Hastings appointed public health inspectors and nurses to ensure that homes, abattoirs, markets, and restaurants met safety standards. He also launched a childhood immunization program.

By 1922, Toronto boasted the lowest mortality rate in North America. Sanitation, immunization, and clean water measures rapidly expanded in municipalities across the country, reducing maternal and infant mortality and extending life expectancy.

Just eighty-five years ago, Canada's maternal mortality rate was worse than that of many developing countries today. Since the 1990s Canada has had one of the lowest maternal mortality rates in the world.

Canada's unique contribution to health care, however, comes from the country, not the city. It started as an attempt by struggling prairie farmers to hang onto doctors in their communities by forming mutual aid circles. By collectively pitching in a small fixed amount, they could put together a yearly stipend to keep a doctor in place, ensuring safer childbirth, among other medical needs. This was literally a matter of life and death for members of communities separated by great distances, bound to a cold and often arid land where their livelihood — and ability to pay for care — depended on the weather. It also meant life and death for whole farming communities, which relied on high birthrates and healthy families for survival.

The first example of co-operative health financing came in the farming community of Holdfast, Saskatchewan, in 1915, and after that the practice spread rapidly. Provincial legislation in 1916 allowed the formation of hospital co-ops, giving municipalities the authority to band together into Union Hospital Districts, pooling their property

taxes to pay for the construction and operation of hospitals. Legislation also permitted municipalities to levy local taxes to fund contracts with doctors, who provided clearly specified services in return for yearly salaries, paid monthly. Doctors in the less-impooverished cities continued to charge fees for service. Over the next decade most rural municipalities formed some kind of partnership to provide access to these medical and hospital services to all residents of that catchment area for very minimal cost.

By 1934, the government of Saskatchewan had revised its legislation to permit municipalities new revenue-raising potential. It introduced a flat hospital tax, and as a source of funding it increased income taxes from property-owners and non-owners alike, instead of using property taxes. But as the Depression wore on the province found it harder and harder to raise enough money. Dire conditions meant that 20% of the doctors left Saskatchewan, and the provincial government had to step in with supplements to ensure monthly payment for the ones who remained. It would take more than a decade to relieve municipalities entirely of the need to raise local funds and to place financing on a purely provincially funded base.

The province already knew how critical large-scale interventions could be. In 1929, Saskatchewan had become the first province in Canada to create a program offering universal access to free tuberculosis (TB) treatment, funded by tax revenues. The goal was to get TB under control — it was the biggest single cause of death at the time. Although it was a disease that was preventable through immunization and manageable with early detection and intervention, even the relatively modest costs of such treatment made illness and untimely death a certainty for many residents of the prairies in the 1920s. The provincial government created a new path of options by eliminating direct costs, improving health, and increasing overall incomes and revenues.

By the 1940s, Saskatchewan had undertaken a major overhaul of its water and sewage treatment systems and provided universal access to medical treatment at hospitals for key diseases like tuberculosis, pneumonia, and cancer. An annual health care fee of \$5 even threw dental care for seniors into the deal. Of course the \$5 premium did not cover the entire cost of the health care reforms, most of which was funded through the province's general revenues. It was simply a way of finding additional revenues, and of linking them to services that were widely supported. This strategy was brought into place until the federal government could help share the costs of financing health, a promise that was made, then broken, in 1945, just after the end of the Second World War. Fully publicly insured medical care insurance (Medicare) finally assured universal access to primary care as well as acute care by 1962, guaranteeing coverage of physician care both inside and outside a hospital.

By the 1960s, after close observation by the rest of the country and gradual adoption of these tenets of coverage and financing, the federal government declared this model of care to be the goal for all jurisdictions in Canada. By 1971 federal-provincial cost-sharing meant that no Canadian paid directly for doctors, hospitals, and “medically necessary services.” After the dramatic doctor's strike in Saskatchewan in 1962, doctors were generally paid on a fee-for-service basis rather than salary, while most hospitals were paid a flat amount, based on a rating system. Medically necessary services were not explicitly defined, but were generally interpreted to mean all diagnostic, laboratory, medical, and surgical services. They were not consistently interpreted to include basic public health programs such as immunization, Pharmacare, dental care, physiotherapy, and rehabilitation, or long-term care of the aged and disabled, though many provinces provided some degree of these services, at least to target groups.

In 1970, Alberta became the first province to extend public insurance to cover the costs of drugs for seniors, albeit with high co-payments and premiums. Over the next five years, all but two provinces (the two smallest, Newfoundland and Prince Edward Island) started providing some public offset for the costs of prescription drugs for seniors, and some provinces had extended the group of beneficiaries to low-income residents. By the mid-1980s, all provinces had some kind of Pharmacare coverage.

Unlike doctors and hospitals, whose costs are almost 100% covered, there were and remain today substantial discrepancies in who gets covered by public insurance for prescription drugs. The limits vary as to how much beneficiaries of drug plans have to pay out of their own pockets, and what drugs are available under public insurance. Only four provinces (British Columbia, Saskatchewan, Manitoba, Quebec) have designed drug programs to cover all residents, but none have first-dollar coverage plans, and many have high co-payments and/or premiums. The public subsidization of market prices for drugs has grown over time, everywhere, making pharmaceuticals more affordable for a growing number of citizens over time. However, the costs of drugs are either prohibitive or “catastrophic” for a significant part of the population still today.

The public share of spending on all drugs has grown from 15% in 1974 to 39% in 2004. When it comes to prescription drugs, the share is higher: almost half the costs of prescription drugs (47% in 2004) are now covered by public drug benefit plans. For those who pay privately for their prescription needs, about one-third pay full costs directly. The rest are privately insured. The effort to contain costs through more private insurance (rather than out-of-pocket spending) is also growing.

Broader access and public insurance for the costs of prescription drugs has continued to expand in fits and starts, especially over the past five years. There has been some effort to streamline

procedures to get on public formularies (the list of publicly insured drugs), with some possibility for the development of a national formulary. There are no federal supports for the purchase of prescription drugs, though this has become a point of discussion for future reform.

### The Sharing of Risk

The lessons learned through pooling risk may have started small, but they grew. It became clear that the larger the group over which the risk is pooled, the lower the costs of insurance against risk. It also became evident that the more people are insured, the less unnecessary risk they are exposed to, mostly because they get earlier preventive care, diagnosis, and treatment. That is the reason that single-payer systems work so well: they are the cheapest way to pay, to cover the most number of people, and can pay for interventions that produce the best health outcomes. There is no financial incentive imbedded in the system to see more sick people in order to make money.

From smaller to bigger groups; from individual charity to collective risk-pooling; from local to provincial to shared federal funding; from property taxes to income taxes and general revenues; from regional to national objectives: the overarching trend in the provision of health care over the past century has been towards broader coverage and greater equity.

New talk emerging from the provinces of Alberta and Quebec flies in the face of this history. The latest proposals from these jurisdictions float the idea of private insurance as a supplementary or alternative mechanism to finance either non-medically necessary services (which remain undefined) or Medicare itself. While more use of private insurance might facilitate access to services for people who have a greater ability to pay, it is a troubling trend for anyone concerned about improving population health or reducing disparities in health.

## › Extending the Reach of Coverage

**Early 1900s** 152 hospitals exist in Canada in 1901, providing care for dying and disabled among those who have no resources to be cared for at home; funded by charity, primarily religious.

**1912 and later** Public health campaigns aim to reduce maternal mortality, cholera, typhoid, and polio through immunization, and to make improvements to water sanitation and waste disposal; primarily in urban centres; funded through local taxes.

**1915 and later** Co-operatives in rural communities band together to provide yearly stipends to ensure that a doctor remains in the community and to build hospitals; funded by pooled municipal property taxes.

**1929** Saskatchewan offers publicly funded diagnosis and treatment for tuberculosis, then the leading cause of death; covered by provincial revenues.

**1934** Saskatchewan expands the municipal doctor scheme by letting municipalities raise new forms of revenue; shift from property taxes to flat hospital tax and income taxes, but province needs to supplement due to Depression's impact on incomes.

**1944** Saskatchewan grants pensioners free medical, hospital, and dental services. Treatment of diseases such as cancer, tuberculosis, mental illness, and venereal disease is made free for all. Other provinces begin to adopt similar policies.

**1947** Saskatchewan launches the first universal hospital insurance program; establishes a health premium of \$5 per person, per year.

**1957** Canada passes the Hospital Insurance and Diagnostic Service Act, which introduces federal-provincial cost-sharing for hospital care; mix of federal general revenues and provincial general revenues.

**1962** Saskatchewan launches a public insurance plan that covers medical care .

**1968** Canada passes the Medical Care Act, introducing federal-provincial cost-sharing for medical services outside hospitals; it becomes available in all provinces and territories by 1972; funded by federal general revenues and provincial general revenues.

**1970** Alberta introduces first provincial drug benefit plans for senior citizens, with three income-gear levels of monthly premium rates and 20 per cent of costs covered by the user (co-pay). By 1975 all but two smallest jurisdictions had plans for seniors. By 1986 all provinces had drug plans, including coverage for low-income residents. Provincial drug programs continue to evolve, mostly expanding coverage and changing the mix of payment. All payment involves co-pays and/or co-insurance.

**1984** The federal government passes the Canada Health Act, which enshrines in law the principles that guide Canada's public health insurance scheme, explicitly prohibiting user-fees and extra-billing by doctors.

**2004** Canada introduces the first national immunization program for five children's communicable diseases; creates Public Health Agency of Canada to target prevention of chronic disease and respond to infectious disease outbreaks and public health emergencies; funded uniquely by federal general revenues.

The proposal to shift away from systems that are solely publicly insured to hybrid solutions that include private insurance is a thinly veiled rebuke of the income redistribution that occurs by virtue of universal public health care insurance. Public insurance is funded by general revenues, which in Canada are largely based on income taxes. Those who earn the most income pay the most taxes, while those earning the least pay the least. When public insurance is financed through general revenues, the most wealthy — who use the system the least — subsidize the least affluent, who tend to use the system the most. Evidence

## ► Universally accessible health care says “solidarity” in a concrete way — and just happens to be the smartest choice economically.

shows that those who are less well off also tend to be more ill more of the time. Ample research documents how relying on one system for the public (read low-income) and a range of alternatives for those who want better service and are willing to pay for it end up short-changing those who are both sick and poor.

Health care is without doubt the most solid manifestation of the principle of solidarity, the child of an era that grew up in the Depression and through World Wars. It gives form to the notion, “There, but for the grace of God, go I.”

This approach also makes solid economic sense. Nothing is cheaper to provide at such scale than a publicly insured system, which is essentially a single-payer system. Nothing is more powerful than a single-payer system to control costs and allocate investments so that interventions have the greatest possible impact. Single-payer systems may not end up with these results, but no other structure matches their potential to achieve cost and clinical efficiencies.

The push for more private insurance may speak to a growing emphasis on individual benefit, but it defies the simple logic and political strength of extending collective benefit. If it signals a new trend in Canada, the past extension of health benefits will probably be reversed over the coming decades.

### Controlling Costs

The big challenge for governments in health care is its affordability: how to pay for the things that keep everyone as healthy as possible, and how to make this level of payment politically feasible and attractive. “Social marketing” of the benefits of health care is important, but in the end governments’ spending power determines the degree of access to health care that all citizens will enjoy.

Talk of affordability is often limited to the ability to pay. But beyond their ability to pay, governments also have the ability to manage costs. Government decisions affect both the public purse and individual wallets, and shape total health care spending in the economy. Public spending has greater potential to control costs and extend benefits than private spending, but that potential needs to be actively pursued.

Unlike individual consumers, governments can achieve economies of scale, streamline administrative processes, negotiate better deals, set rules, assess cost-effectiveness, and allocate spending to where the returns on investment are greatest. Each of these public policy levers requires thoughtful implementation and monitoring.

### Single-Payer Systems

Over time Canada’s public spending on health care has become synonymous with the single-payer system. There are many advantages of single-payer systems. With just one place to submit bills to and receive payment from, the system reduces duplication in administration of different methods of payment. On average, about

1.8% of Canada's provincial and territorial costs for health care go to the structure that pays the bills. Comparative studies show that Americans pay, on average, three times as much per person for the process of paying bills for doctors' and hospital services, primarily because there is a multiplicity of payment systems and each of those has its own administrative costs. Multiple insurance systems in other countries where there are large public systems, but parallel private systems for enhanced benefits, also drive up administrative costs.

Beyond administrative efficiencies, single-payer systems also have a built-in advantage in their ability to negotiate better deals and extend purchasing power. Canadian jurisdictions have seen this advantage both used and ignored over time. Single-payer systems set fee schedules for doctors' services and rates for hospital budget-setting. Governments, as the single biggest purchasers of service, generally get better prices than individuals or private insurers do. The rule of thumb is the bigger the population base, the greater the economies of scale, which can open the door to volume discounts.

Setting fee-schedules, rates and prices in this kind of context is essentially a political process. There are better and worse eras of bargaining; much depends on the relative power of the people and groups trying to get a deal. Each round of negotiations depends on the different parties' points of view about what happened in the last round of bargaining, and the objectives for the new round of bargaining. Although cost controls are easier to achieve through single-payer systems, they are not always a high-priority objective.

### **Controlling the Cost Drivers:**

#### **The Case of Drugs**

The power of single-payer systems could be used more effectively in our procurement systems, particularly in drug programs. Prescription drugs are the fastest-growing cost driver in health care

spending, on both the public and private side. The provinces all have different ways of addressing the rising costs of drugs. Their policies also influence costs for private insurers. The following techniques have an impact on the development and pricing of new patent drugs, as well as on the share of the generic drug industry in the market for prescription drugs.

- **Generic substitution:** All of Canada's provincial drug plans have a policy to cover only the costs of a generic drug in place of a patent drug if they are basically, or chemically, the same. The effectiveness of this policy has been somewhat blunted by changes to patent law that limit the use of compulsory licensing. (See Section One—Governance, page xx.) Individuals can opt to pay the difference between the cost of the generic and cost of a brand-name drug.
- **Reference-based pricing:** In a system introduced in British Columbia in 1995, the province controls what it will pay by grouping drugs that treat the same condition and are deemed to be therapeutically equivalent, whether they are chemically the same or different. The plan limits payment to cover the full cost of the least expensive alternative, or the "reference" drug in a therapeutic class. Doctors can prescribe a more expensive drug, but if patients covered by the public plan opt for that choice they must pay the difference between its price and the reference price.
- **Direct price controls:** At the federal level, the PMPRB (Patented Medicine Prices Review Board) sets price controls on the wholesale prices of new patent medicines coming onto the Canadian market. (See Section One—Governance Matters, page 3.) Generic drugs are not covered by its mandate. There are three guiding criteria for pricing patent drugs, which together ensure that Canadian prices of patented medicines will never be the highest in the world:

### ► Bulk Purchasing in Canada An Option With Potential

In the wake of 9/11, the federal government took steps to increase the nation's emergency preparedness for acts of bioterrorism. It bulk-purchased ciprofloxacin, smallpox vaccines, and potassium iodide. The Cipro example alone saved Canadian taxpayers millions of dollars by shaving more than \$3 off the \$4.70 cost of each pill.

- New patented drugs that fall into an existing therapeutic class have their prices limited so that the cost of therapy is in the range of other existing drugs that are used to treat the same disease and sold in Canada.
- Breakthrough drugs have their prices limited to the median of the prices for the same drugs charged in other specified industrialized countries, as set out in the Patented Medicines Regulations. These reference nations include France, Germany, Italy, Sweden, Switzerland, Britain, and the United States.
- Existing patented drug prices cannot increase by more than the Consumer Price Index (CPI).

In general, Canadian governments do not use economies of scale to push for better deals in supplying drugs, even when they are on public formularies and known to be dispensed in huge and rising quantities every year. Everyone essentially pays the retail cost for every pill, even when hundreds of millions of pills are dispensed annually. Some hospital groups and large pharmaceutical retail chains have figured out the benefits of bulk-purchasing, and both Saskatchewan and Ontario have attempted price-volume contracts with pharmaceutical suppliers, with varying degrees of success; but this remains a limited option. In contrast, in the United States,

although unit prices are higher, large insurers such as the Veterans Administration are more likely to strike price-volume deals.

### Improving Returns on Public Investments

All budgets may be limited, but there are still choices to be made about what to spend on. If improving health is the goal, what should we be buying? Demographics are an important factor in how much we spend on health care and where that spending is focused.

With fertility rates having peaked about sixty years ago, and low birthrates today, Canada's population is aging. As a result the country's health needs are now less centred on infant and maternal mortality and control of infectious diseases than they were a hundred or even fifty years ago. Thanks to generations of investment in public health and growing prosperity, most Canadians now enjoy longer life-spans, and general population health has improved. These trends have shifted what we do in the name of health care, influencing both what is publicly insured and the associated costs.

Demographic realities have led to an increased interest in how to extend coverage of pharmaceuticals and long-term care or home care. And an increasing proportion of health spending goes to care for diseases that are not limited to but are largely associated with the elderly. Cancer care, cardiac care, vision care and joint replacements are among the health services most in demand. An aging population is looking to improve and extend not just life expectancy but also its quality of life, which leads in turn to an intensified interest in health promotion and the reduction of preventable illness.

The allocation of public resources, which are always too scarce to meet all needs, is a task fraught with difficulties. Increasingly technological approaches to care mean that the bulk of public spending on an individual's health care is now consumed in that person's last six weeks of life. These heroic measures come at a high price.

Sometimes simpler, less costly, and earlier interventions have more beneficial impact on population health. Unfortunately, there is no simple formula to calculate the best return on public investments. The decisions are guided partly by evidence, partly by politics.

For example, some Aboriginal communities have brand-new health facilities, equipment and computers, but no one to operate the technology, and no physicians. Meanwhile many of these communities lack proper sanitation systems for water and waste, which, if in place, would have a greater impact on health than all the technology combined. A number of reserves, struggling with rates of alcoholism, have become “dry” communities, and people coming into the community are checked for alcohol. That kind of policing can make a great difference to community well-being and health, even more than the availability of new equipment and surgery. So can a community dedicated to reducing violence against women.

Even when cost-benefit evidence is compelling, it doesn’t always turn the tide. Politicians are more likely to have to field complaints about access to tertiary care (specialists, or surgeries, for instance). Even if the greatest impact of public spending comes from investments made in health promotion rather than health care — such as campaigns targeted to reducing smoking, or improving the practice of safe sex — that is not what individuals say they want from the public system. They want better, faster care for what ails them now.

Chronic health problems — illnesses such as diabetes, asthma, cardiac disease, and other long-term conditions — are increasingly likely to be what ails Canadians, and treating them is becoming more and more costly. Because drugs can now prevent, manage, and treat disease, their use is expanding rapidly. What has not changed are the lessons to be learned from history: there are even larger gains from public health interventions that provide better sanitation, offer health

promotion, and work to prevent communicable diseases than from medical interventions.

Canada’s spending within the health-care “envelope” has gradually aligned with some of these realities.

### Reallocating Health Spending

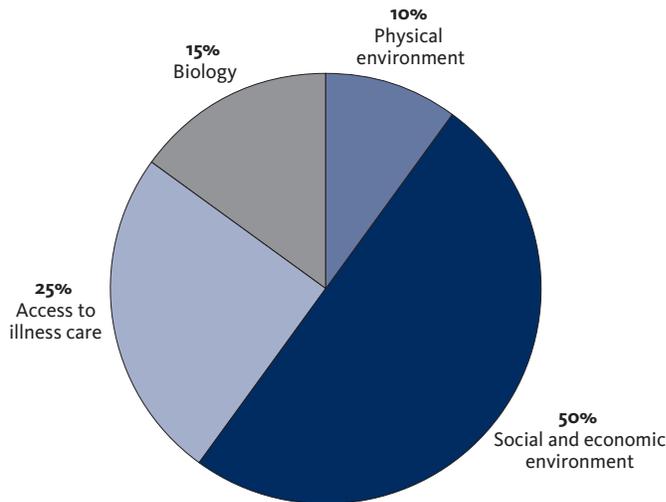
In Canada the allocation of resources faces two key challenges:

- Balancing investment in the treatment of disease with initiatives to address the determinants of health.
- Balancing investments in primary care, acute care, and tertiary services.

Today doctors and hospitals account for less than two-thirds (62%) of public spending, a steady decline since 1975, when doctors and hospitals accounted for over three-quarters (77%) of public spending on health. Drugs now take up 9% of public spending, up from 1.8% in 1975. Home care, medical transportation, and health research are also growing areas of expenditure, especially more recently: between 1975 and 2005 they grew from 1% to 5% of all public spending.

Canada’s approach to public health is another key to overall health spending. Public health interventions — such as food safety inspections, health promotion, prevention of communicable disease, and community mental health — accounted for about 3.5% of all public spending on health from 1975 to the early 1990s. After 2000, spending on this aspect of health care expanded rapidly. It now accounts for about 6% of provincial and territorial expenditures, though again with great variation among the provinces. (On average, OECD nations spend about 3% of their health-care budgets on public health interventions.) The federal government itself introduced major new investments in public health measures in 2004, including a national immunization program to combat five communicable diseases

**CHART 5 What Makes You Healthy?** Estimated Health Impact of Determinants of Health on Population Health



**SOURCE** Data from CIAR (Canadian Institute for Advanced Research). Graph created by Saskatchewan Health. June 1997.

of childhood and a new Public Health Agency of Canada. (See “Health Human Resources.”)

Getting a bigger bang for the buck is a concern among policy-makers who need to balance health care against other needs within public spending, and primary care reforms have an important cost dimension.

Health problems are much easier to deal with, and less costly, if you catch them early. So one goal of the primary care reform movement is to move more care “upstream.” From a strictly budgetary point of view, it is cheaper to pasteurize milk than it is to bury hundreds of people who have died from typhoid. It is cheaper to prevent sexually transmitted infections through safe-sex education and condom distribution than to treat people with anti-retroviral drugs.

It is also cheaper to keep people out of hospitals, if at all possible. In Ontario the average cost per inpatient hospital day was \$1,471 in 2002. Across Canada, the default care system is the emergency department of a hospital — the

only place where health care is guaranteed to be available twenty-four hours a day, seven days a week. But this is an extremely expensive option. More than half of the users of emergency rooms in Canada (57%) are non-urgent cases. Seeing a family doctor for a sore ear, eye, or throat can cost the health system \$30. Going to emergency at midnight for the exact same care can cost ten times that much — \$300. Canadians are increasingly using emergency departments because they don’t have access to a family doctor or a nurse to provide more simple forms of care in a timely fashion. (See Section Three—Health Human Resources.)

### The Social Determinants of Health

Attaining and maintaining good health are not just products of the care system itself. While Canada is justifiably proud of its illness care system, Canada’s social policies have a far greater impact on the health of Canadians than access to doctors and hospitals does. Studies by the Canadian Institute for Advanced Research show that access to illness care is far less important to the health of a population than is the social and economic environment that people live in.

Measures that improve the determinants of health — such as access to clean water, education, and enough income to assure adequate housing and nutrition — can help to keep the cost of the acute care system down. Still, the tighter the resources, the more difficult it is to make public investments in these areas at the expense of a system of care that supports people when they are faced with serious illness or death.

For example, all the provinces cut welfare supports deeply in the early 1990s, a time of economic recession and ballooning government deficits. Health programs were trimmed too, though not as sharply. A decade later most provinces were introducing food programs, such as Quebec’s OLO program, designed to improve the health of babies. Since 1991 eligible low-income pregnant women have been given regular

rations of nutritious (one egg, one litre of milk, one orange — OLO) during the last twenty weeks of gestation. This program has dramatically reduced the number of low birth-weight babies in the province, although life can remain hard after the infant is born. The welfare cuts have not been reversed, nor have cut-backs to income supports for the unemployed.

By 2005–06 most governments were into a phase of budgets that were balanced or running surpluses. Even in this environment it remains difficult to reverse cutbacks from a decade before — which in turn makes it difficult to tilt the balance from investments in health care towards greater investment in the determinants of health. Adequate housing and food, clean water and air, and education and employment opportunities can profoundly shape health outcomes; but greater value continues to be placed on the public commitment to health care, and that is where the resources remain.

The lesson seems to be: if you value it, you pay for it. If governments can't or won't pay for it publicly, and individuals can't or won't pay for it privately, society has to live with the consequences.

That has always been the case. In 1964, when Justice Emmett Hall recommended that the federal government wade in to support the establishment of a Medicare system across all parts of the country, he and other advocates of change faced considerable concern about the costs that such a system would bring. The Hall report responded with the facts: “A nation that in 1962 spent \$756 million on cigarettes and tobacco and \$973 million on alcoholic beverages can afford the programme we recommend which would involve an additional \$466 million in 1971.”

Today Canadians spend about \$15 billion on alcohol bought in stores and \$14 billion on tobacco products. Another \$12.5 billion flows to government coffers from people who gamble on state-run lotteries, casinos and VLTs. Taken together that's over \$41 billion a year, and the

amount is growing every year. In September 2004 the federal government invested \$41 billion over ten years to stabilize the public system of health care. Some people say this isn't enough. Others say that it is proof that public spending is out of control, and that health care will sink the public ship.

### **How Much is Too Much?**

More money spent doesn't always mean better or more access to care. Canada spends just under 10% of its economy on health care, while the United States spends 15% of its considerably larger economy on health care and still has over forty million people without insured access to care. As a whole, the American population has lower life expectancies and higher infant/maternal mortality rates.

People are concerned that demographic pressures and technological change will catapult our spending on health care. What we all need to be aware of is that some health spending has a distinctly preventive focus, and that going in that direction can drive down costs in the future. Of course no one can accurately predict whether, on balance, costs will be driven up or down over time. Still, a recent report indicates that, even with no change, things on the health front will not necessarily become unmanageable. The report, from the federal Department of Finance, projected health-care costs, holding constant both the way in which we deliver care and the demand for care, and adjusted only for aging. According to these projections, by 2040 Canada will be struggling with the implications of the biggest cohort of elderly it has ever seen: more people will be relying on health care right when, as retirees, their contribution to the economy and public revenues will be most limited. But the report found that even at health care's most challenging time, its public costs will still only approach 10% of the economy, which is hardly a figure that suggests there is no room for any other spending.

Some critics argue that increased user fees or co-payments and expanded access to private insurance for those who can pay will relieve pressure on the public system. These suggestions can create as many problems as they might solve.

It is one thing to say that health services are covered; it is quite another to make sure that people are actually able to get care. A classic problem with private insurance schemes is that people hesitate to make a claim, because they fear their premiums will increase. People who are sick or in a high-risk group may face prohibitively high premiums, or they may not be able

### › Publicly-insured health care encourages preventive interventions, which can improve health *and* reduce costs

to purchase insurance at all. In the health field, this can have disastrous consequences because the earlier you catch a problem, the cheaper it is to treat it.

One of the reasons why public insurance works, and can control costs, is that it does not

penalize people with higher premium rates for being sick or getting sick. Public insurance schemes can also encourage the use of cheaper, more preventive measures to reduce preventable disease.

Where the money comes from also makes a difference to how much needs to be spent. After all, when funds are pooled, real savings can be realized. Sometimes user fees are seen as a critical way of raising revenues and deterring utilization that is raising costs. Indeed, there are clear cases in which unnecessary use of the system has occurred because it is “free.” But it is not always possible to distinguish between necessary and inappropriate utilization; and, besides, user fees will not eliminate inappropriate utilization. Those who can pay will still use the service, and those who need the care but can’t pay the fee end up not getting the service in time, resulting in higher costs (in human and medical terms). Plus, the administration of user fees requires additional time and money.

One thing is certain: we will be spending more on health care in the coming decades. How much more, and in what way, is a matter of political and personal choice.

### Summary: Striving for Equity

For most of the past century, Canadian health reforms have promoted greater equity and equitable access in many ways. Publicly insured services have continued to expand in their scope, increasing public commitments to spend on health care at a rate that outstrips anything else that governments do. Yet even today some parts of our society clearly have less access, and there are emerging ambiguities about what is and should be publicly supported.

The principles of universal coverage, portability, and comprehensiveness enshrined in the Canada Health Act have ensured that, to a large extent, Canadians have access to relatively equal health services across the country—particularly when it comes to primary care. Inequities are sharpest around high-tech tertiary care—particularly expensive new diagnostic services such as MRIs. The availability of these services is determined primarily by population density. Large urban centres have more facilities. People in rural and remote areas must travel long distances to get access to them.

Even as we are trying to expand our system to make care more equal across the country, we are also facing questions of how to limit the care we pay for out of the public purse. The system has also grown more expensive as medical science has advanced. We share a border with the United States—the world leader in research and development of health products and services. This means that cutting-edge technologies are available to Canadians who can afford them, just a short drive away. This creates con-

stant pressure on our system to expand public coverage to include highly advanced and often experimental treatments.

It is a fact of life that science advances faster than the public purse. It's also a fact that more money spent doesn't always mean better health outcomes, or even better access to care, at least as far as societies are concerned. We are struggling in Canada to strike a balance between those things.

Today there is increasing insistence that the move towards an increasingly privatized approach to health care is inevitable. This logic has been rejected for more than a decade by the Canadian population. What comes through repeatedly are Canadians' values: the simple recognition that, no matter your income, gender, background, or any other factor, serious illness can afflict us all, and the belief that none of us deserves care more—or less—than anyone else.

Apart from this steadfast sense of right to equal treatment, Canadians' history and experience has revealed important lessons about the interface between the health of individuals and the health of societies. We have learned that striving for equity sometimes means making sure everyone gets access to the same thing; and sometimes it means that interventions need to be targeted to at-risk and vulnerable populations.

Universal treatment and the reduction of disparities are complementary goals. Both are critical for achieving improvements in health, for individuals and for whole populations. There is simply no better recipe for a healthy life than living in a healthy society.



# Human Resources Matter

AT THE HEART of any health-care system are the people who provide the care. Without enough doctors, nurses, and other health-care providers, even the most advanced system will fail. An investment in health-care reform—introducing an immunization program, for example, or expanding a clinic—will never be effective if there are not enough people on the ground to deliver the service.

These people on the ground are known in general as “health human resources.” And all health systems struggle with four seemingly constant problems related to these valuable human resources:

- Assessing how many different kinds of health workers the system needs
- Training and recruiting the right number of people
- Deploying the most effective mix of people
- Making sure these people get, or have received, the best training possible.

## **A Basic Problem of Supply and Demand**

When it comes to health care today, countries around the world face one thing in common: a shortage of health-care “professionals” — doctors, nurses, pharmacists, diagnostic technologists, and others — the people who have to receive years of expensive training in the field of medicine before they can do their jobs.

Too often there is simply not enough qualified people around to provide the necessary care in the appropriate location. The number of professionals available to do the work becomes a very real limiting factor on how much care can be provided.

Still, not all roads to improved health require long stops at a doctor’s office or a hospital, or visits to a pharmacist or diagnostic technologist. A central goal of health systems is to get the right person to do the right job at the right time. The right person could be one of the many “non-professionals” who work in the field of health care: a community worker, for instance, or a health aide or even a clerical worker trained to take on a routine administrative or educational aspect of care.

Having a “non-professional” in place can free up doctors or nurses to focus their time on the things that only they can do. In essence this is what is called a multidisciplinary or team approach.

As obvious as that approach might seem, it frequently meets with resistance — from different groups of professionals, especially — and can lead to conflict between professionals and trained health workers over issues of scope of practice, decision-making authority, and legal responsibilities. These problems can make the shortage of help much worse than it needs to be.

### Facing Change in Canada

Canada, like many other Northern nations, is facing growing demographic pressures. The demand for health services is increasing with the aging of the baby boom, the unusually large cohort of people born immediately after World War II. This same age cohort also accounts for a disproportionately large segment of the people providing health services. Not enough young health professionals are available to replace the growing wave of retirements, let alone meet increased levels of demand.

Canada is also grappling with the problem of how to meet the health-care needs of its chronically underserved rural and remote areas. Canada, like developing nations, has an increasing concentration of people living in big cities. Although 30% of the population lives in rural, remote or northern locations, only 17% of family doctors practice there. Almost 30% of the people in the Northwest Territories have no access to a family doctor. Remote areas are where health needs and labour shortages tend to be most acute, and where necessity can become the mother of invention — a situation familiar to many development workers.

These kinds of pressures will undoubtedly force big changes in how people in Canada come into contact with health care. But an enduring

lesson of recent decades is that once you have adopted a particular focus, big change becomes difficult to achieve. In Canada our focus for the past half-century has been on primary care: on treating an individual’s complaints with medical care and cure delivered by doctors, often in hospitals and increasingly using drugs.

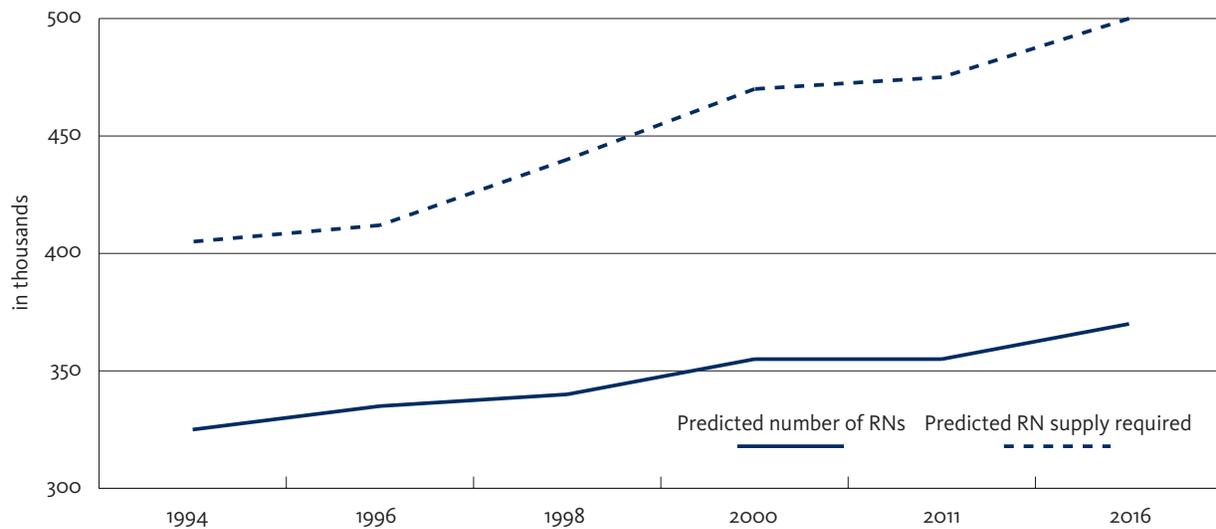
Today primary care reforms remain as important and difficult to achieve as they were in the 1970s, when such groundbreaking documents as the Lalonde Report sketched the way forward. Since that time, there have been repeated efforts to shift the emphasis of spending in health-care budgets “upstream,” moving it from doctors and acute care in hospitals to community-based care, programs of health promotion, and more active prevention of disease — such as immunization or smoking-cessation programs.

But in Canada, even existing levels of care are frequently seen as being inadequate — and critics are concerned that we will be unable even to sustain those levels. As a result, like the shift towards more multidisciplinary approaches to care, the attempt to recalibrate the health system by placing a greater emphasis on improving wellness and population health — through preventive measures and health promotion — is slow and frequently resisted.

The resistance is not just because different groups of care providers hold different ideas about how best to improve health. It is also about shifting power dynamics, triggered by the reallocation of scarce public dollars.

### To Train or to Import: That is the Question

In the next five years, about one-fifth of Canada’s physicians and a third of its nurses are poised to retire. Only one nurse in ten is under the age of thirty. There are simply not enough younger professionals to take the place of those who are leaving.

**CHART 6 Predicted Supply of Registered Nurses to 2016**

**SOURCE** Health Canada, Office of Nursing Policy, Ryten 2002, CNAC Report

Although enrolments at medical and nursing schools have risen in every region of Canada over the past decade, the anticipated number of graduates will also not be enough to offset the decline in capacity to serve.

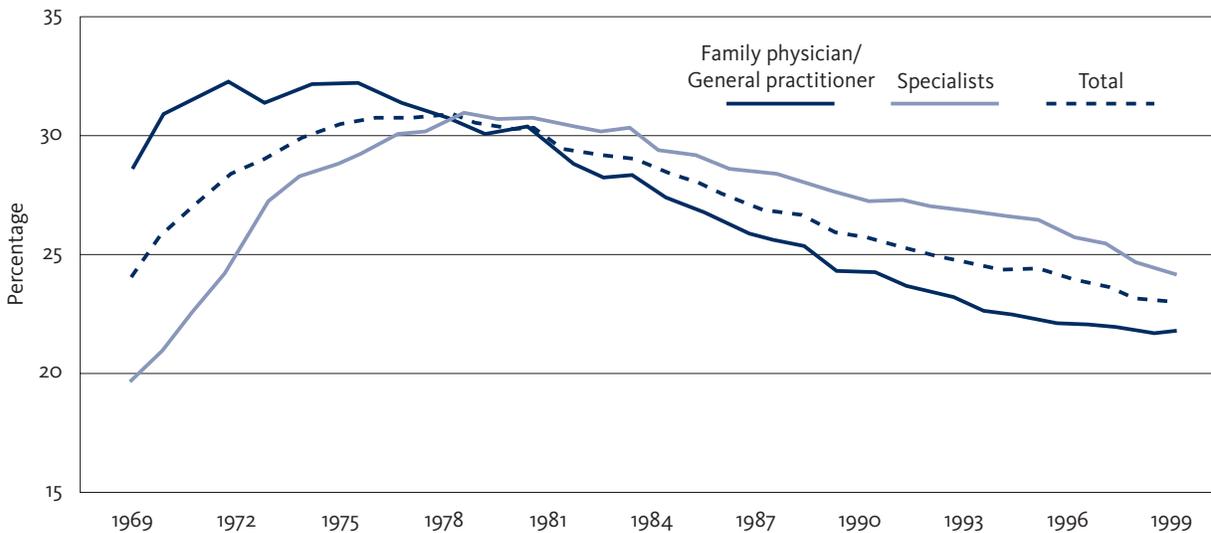
The track record of universities and colleges when it comes to training in the field of health and medicine is marked by a checkered history of over- or under-shooting the “right” number of spots. That’s partly due to the difficulties of planning for the future, and partly the political reality of competing institutions making competing claims for public resources.

A more appropriate kind of planning for the future would ideally link health personnel requirements to basic facts about the population in the area to be served. This necessary information includes demographic, health, social, and environmental factors particular to the group or area, plus consideration of the health issues that are likely to emerge over the next decade given these known factors. But sometimes this kind of planning is eclipsed by budgetary constraints.

Strangely, for example, a number of regions in Canada are struggling with both nursing shortages and mass layoffs of nurses.

Variations in budgets are not the only wild card. Getting the “right” number of new doctors and nurses depends on the other investments that are being undertaken to promote health. The demand for acute health-care services can be offset by education campaigns to reduce smoking, better access to information about reproductive health, immunization programs, or projects for water purification or safe housing. Then too, introducing more of a team approach in providing care could offset the requirements for some types of health workers, while increasing the need for others.

Education and training are a costly public policy option, particularly when it comes to health professionals. They call for a serious investment of time and money for the individual too. In Canada it takes four years to get a nursing degree, with tuition ranging from \$3,000 to \$5,000 a year. It takes at least six years of post-

**CHART 7 International Medical Graduates as a Percentage of Active Canadian Physicians, 1969–99**

**SOURCE** Dr. Mamoru Watanabe, Canadian Physician Workforce. The role of IMG's, International Medical Graduates National Symposium Proceedings, 2002. Data from Southern Medical Database, Canadian Institute for Health Information

secondary education to become a medical doctor, plus two to three additional years of training to become a family physician. Tuition fees have been steadily climbing in Canada: medical-school tuition now costs, on average, \$10,000 per year. At the leading medical schools, tuition is even higher — more than \$16,000 a year which is triple the fee in 1997.

Tuition fees also do not cover the full costs of post-secondary education, here or elsewhere. Each physician and nurse receives significant public support and investment in his or her training. In the province of Ontario, tuition fees contributed only 44% of the costs of a university education in 2002. They represent a much lower share of the costs in other provinces.

Clearly, determining how many spaces should be made available in universities and through residencies is not a decision to make without planning. Yet planning is fraught with difficulties.

The short-term answer at the macro level has been the same one used at the micro level: buy your way out of the problem.

In Canada this answer has meant importing the solution. For instance, if Canada is to implement its planned reforms to primary care, we will need many more nurses than we now have. Yet neither existing trends in enrolment nor planned expansion of training spots makes this a likely reality, at least over the next decade. The only remaining solution is an influx of foreign-trained nurses.

This solution has huge implications for the developing world as countries struggle to retain their existing cadre of health professionals and realize returns on their own public investments, made with government revenues that are so much harder to come by.

In the past Canada has relied heavily on foreign-trained physicians to meet short-term physician needs. In the late 1960s, Canada imported more physicians on a yearly basis than it educated.

From the mid-1970s to the early 1980s, 30% of our employed physicians were trained abroad. Today 23% of our physicians are foreign-trained.

Since it takes about a decade to train a doctor, and since the wave of retirements will probably begin within the coming ten years, our reliance on other nations' investments in doctors is about to increase again.

Canada's inadequate investment in training and growing reliance on importing the necessary supply of health professionals results represent a profound inconsistency in our foreign aid and development policies, immigration policies, and domestic health policies.

The approach also creates friction between jurisdictions. Some provinces put more resources into training, while others focus on recruiting and relocating health professionals.

### **“Return Service”: Maximizing Public Investments**

Virtually every jurisdiction in Canada today offers some way of reducing the costs of tuition if graduates — particularly graduates of medical and nursing schools — in return provide a certain period of service. The arrangements for what is called “return service” are generally focused on underserved communities, especially in rural and remote northern locations.

At the federal level, for example, Health Canada offers to reimburse the tuition of nurse practitioner students in exchange for a year of service in British Columbia's Pacific region for the First Nations and Inuit Health Branch.

Saskatchewan, as a jurisdiction, has more than doubled its training of nurses since 1999, though like many other provinces, it made deep cuts in the early 1990's, from 500 training seats to 180 and has not yet returned to the 500-seat benchmark. It has used bursaries to retain graduates, for nurses as well as other health professionals, now offering over 600 bursaries a year. The amounts range from \$2,000 to \$10,000 for

up to two years of training, and they are tied to a “return service” requirement.

Return service programs sponsor medical undergraduates, residents, and trainees through loans, bursaries, and grants. Nursing students in later years of study can be eligible for different forms of financial support too. Return of service agreements provide financial assistance to the student — from \$4,000 to \$15,000 depending on the program — that may be partially or fully waived on condition that the graduate commits to practice in the sponsoring jurisdiction within a few months of professional registration. Typically the period of service is one year, though some jurisdictions require a two-year commitment.

Sometimes this type of financial assistance is limited to residents of the area, particularly in smaller provinces and territories, in an attempt to stem the out-migration of young people. These programs have also been used to increase the interest of certain groups to consider medical and nursing professions, as a form of affirmative action and capacity-building within communities. For example, British Columbia has a unique program that aims at increasing the supply of Aboriginal health professionals. It focuses on Aboriginal nursing recruitment strategies and mentorship programs, including partial loan forgiveness for graduates who work in designated underserved areas.

Some Canadian jurisdictions are using return service arrangements as a way of integrating foreign-trained physicians. In return for an assessment of skills and the provision of training to meet local qualifications, the province of Ontario demands a five-year return of service agreement. Upon completion of the program, selected applicants must spend five years of practice in one of the province's 140 underserved communities. Ontario offers additional financial incentives for doctors who opt to serve in small remote communities in designated northern areas.

Although they are not current practice, return service arrangements could be integrated into federal policies for development assistance in health. At present, Canada's impact at the international level is as a consumer rather than a producer of the skills that are in desperately short supply everywhere around the globe. Providing financial support for health professionals who make a commitment to work for a period of time in underserved areas around the world could shift Canada's position from a net importer to a net exporter of these critically needed skills.

### **Primary Care Reform, Really: A Few Alternatives**

Both studies and practice have shown that a wide range of trained personnel with a variety of skill levels can provide ready access to basic health services, not only in areas with plenty of service options but also in areas where care is hard to come by. Instead, the prevailing tendency is to entrust health-related tasks to a narrow range of people, especially doctors and specialists, who are considered to have the greatest amount of expertise.

Medical schools today are producing more specialists than family doctors or general practitioners. The proposals of nurses' unions and associations to widen their scope of practice, using their existing training to the fullest extent in the workplace, have met with resistance from the medical profession. Registered nurses, in turn, have expressed concern about the expanded use of licensed practical nurses and other trained non-professionals in their traditional areas of practice. Unions of health-care workers continue to advocate for improved training opportunities for non-professionals. They see this as a way of alleviating shortages by expanding the range of tasks that these workers can routinely take on. But such proposals are more often dismissed than taken up.

The tendency to specialization is also now facing a counter-current, particularly among the youngest generation of health professionals. The curriculum of today's course-work and residencies increasingly includes an emphasis on team work. Attitudes about scope of practice, while still complex, seem to be changing.

Such change is long overdue. Despite decades of attempts to reform the delivery of primary care, about one-third of Canada's primary care physicians still work alone, in private practice. In 2002 only an estimated 10% of doctors were working in multidisciplinary practices.

### **The One-Stop Shopping Approach**

The multidisciplinary approach is not by any means a new concept — nor did it originate as a policy response to labour shortages among professionals. It emerged from a different approach to attaining and maintaining health.

Since the 1970s, community health centres in English-speaking Canada, and centres locaux de services communautaires (CSLCS) in Quebec, have been providing a "one-stop shopping" approach to meeting health needs, and not just when people are sick. It emphasizes the connection between individual and population health, integrates the provision of care with involvement in the community, and stresses pro-active interventions (medical and otherwise) to attain and improve wellness. (See Box on page 37.)

In addition to providing medical care through teams of doctors, nurse practitioners and nurses, this type of primary care approach also tends to offer access to a range of other health-related professionals such as dietitians, physiotherapists, occupational therapists, dentists, and mental health workers.

What sets them apart from the growing numbers of more typical multidisciplinary medical clinics is that, particularly in the larger towns and cities, these centres also focus on addressing social needs before they become health problems. Their initiatives include:

### › A Different Approach to Community Health Care Needs

The past thirty years of research show that the type of care delivered in community health centres can save the health-care system somewhere between 17% and 30% per patient treated as compared to traditional fee-for-service, and the care can also lead to sustained improvements in health outcomes. These results occur in both rich and poor communities, in urban and rural locations.

The good results come from a greater emphasis on preventative forms of care, in individual and group sessions; more auxiliary services through multidisciplinary teams; longer hours of access to health-care professionals; more routine follow-up, by phone as well as in person; and more patient training to improve self-care and wellness habits.

Quebec is the only jurisdiction in which this approach to primary care is sufficiently extensive to be an option for all residents. Beginning in 1972, a network of geographically defined centres locaux de services communautaires (CLSCs) was created to provide coverage for the entire Quebec population. CLSCs are open evenings and weekends. They offer mental health, public health, and home-care services, and are the sites of the province's health telephone advice line, Info-Santé. They liaise with community organizations, municipal officials, and police to assess and address the determinants of health.

Together Quebec's 146 CLSCs employ 1,500 salaried physicians and have a ratio of five nurses to every one doctor. These results stand in strong contrast to the ratios in private practice: physicians' organizations typically recommend one nurse for two or three doctors.

Despite the extent of their reach, the CLSCs still operate, and are seen as an alternative to private practice. Only about 20% of family physicians and general practitioners work in CLSCs, either full-time or part-time. Recent reforms in Quebec have placed the province's traditional commitment to this approach to health in question.

Other provinces have much further to go. In Ontario the first community health centres (CHCs) opened in the mid-1970s, but expansion has been slow. The number of CHCs increased from 29 to 56 between 1991 and 1995, when no more applications were accepted by the province. The existing CHCs provide service to only 2% of the population, and the province focused its primary care reforms on hospitals and doctors in private practice. In late 2005, the province changed its approach to the role CHCs could play, announcing an expansion of 22 new CHCs and 17 satellite sites.

The CHCs in Ontario offer a range of health services that can include community outreach and support, health promotion and education, mental health services, and programs to reduce preventable illness and injury. Unlike the Quebec model, they cannot act as brokers for other health services in the community, such as home-care providers; and their hours tend to be more restricted than are those of their counterparts in Quebec.

- Outreach to high-risk populations, such as homeless people, the elderly, sex-trade workers, people at risk of developing HIV-AIDS, or low-income households;
- Engagement with immigrant communities, which experience language barriers to health and social services;
- Expanded prenatal and neo-natal care, with a particular focus on nutrition and breastfeeding; and
- Early childhood development initiatives.

## › Responsive primary care doesn't require only highly specialized professionals. It just needs good training for the job at hand.

This approach to care doesn't depend on the existence of a large team of service providers.

### **Tried and True: Nurses as the Hub of Care**

Canada offers financial incentives to encourage doctors and nurses to practice in the North and other remote, underserved areas, but this policy tends to attract mainly new and less experienced health professionals. Turnover of personnel is high, and these regions remain chronically underserved.

Since the early twentieth century, Northern nursing stations have permitted communities to have most of their primary care needs — including access to emergency care — addressed by trained but not overspecialized personnel. The hub of such operations has usually been the local nurse. Today nurse practitioners are becoming a highly valued substitute for a family doctor, especially in rural and remote locations.

Nurse practitioners are registered nurses with additional education that enables them to provide a broader range of basic acute health care — from assessing, diagnosing, and treating non-complex injuries and disease to delivering babies, ordering tests, referring patients to specialists, and prescribing drugs. Just as importantly, they focus their practice on health education and preventive care, often providing many of the same health promotion services that are found in community health centres.

The use of nurse practitioners is expanding rapidly in Canada — by 20% between 2003 and 2004 alone. Even so, only eight of the thirteen provinces and territories license nurse practitioners. There are 878 nurse practitioners currently employed in the country, compared to 60,600 doctors and 247,000 registered nurses.

### **Taking Care to the Community**

Canada has a long history with the development of portable and mobile health services, dating back at least to the provision of emergency medical and dental services in the travelling voluntary units that serviced the British Imperial Army during the Boer War (1899–1902). Nowadays, mobile health units have proved to be an effective way of bringing health care to Northern and rural communities, where there is limited access to specialized health services.

The Canadian National Institute for the Blind (CNIB), for instance, takes eye care to remote areas. Each year the Eye Van travels across Northern Ontario from early spring to the end of autumn. Ophthalmologists volunteer for one-week periods to examine, treat and perform minor surgery on about 5,000 patients.

Similarly mobile services can be used to overcome barriers to access among marginalized urban populations, even in areas with the heaviest concentration of health providers. In Toronto, for example, many immigrant women in the city hold down two jobs in addition to caring for their own families. Few of them have

time to attend to their own health needs, assuming they can find a doctor with whom they can communicate. To meet this need the Immigrant Women’s Health Centre uses a van to provide education and basic clinical services to immigrant and refugee communities. The staff comes from diverse backgrounds and offers health services in many languages. The van goes to where the women are — in the workplace — and offers preventive health care and health screening.

This kind of approach shifts the focus to early detection and information that is relevant to people’s situations and needs. Despite limited resources, this form of outreach has achieved remarkable health outcomes by providing simple treatments and emphasizing prevention.

### **Summary:**

#### **Better Coordination, Better Planning**

Given a growing and ever-changing demand for health care around the world, one of the biggest problems in the delivery of health care today is the supply and availability of trained professionals and non-professionals.

Part of that problem revolves around costs; part of it is a matter of changing the mind-set that has been in place for so long.

One part of the solution lies in shifting service provision towards more multidisciplinary approaches to care — getting the right person in the right place at the right time doesn’t always require a doctor. Another part of the solution is to put more emphasis on “upstream” interventions: immunization or clean water programs can improve wellness for a whole population. Both types of change can offer cost-effective and clinically-effective complements — and sometimes alternatives — to medical care that treats individual illness.

Health-care personnel requirements — whether satisfied through training or importing — need to be linked to the needs of whole populations, particularly the needs of populations in remote areas. There are many approaches to improving health and attaining timely accessible primary care, from programs of health promotion and an expansion of community health centres to new roles for nurses and portable and mobile health services.

In the end, there is only way to get the care part of health care: through people. There is a global shortage in the supply of health professionals, but much can be done to alleviate the pressures faced by these linchpins of the system. We can improve the way existing human resources are deployed across the full spectrum of care. And we can focus more on planning for future human resources needs. These are two things we can all do much better in every part of the world.



# Information Matters

IT MAY BE HACKNEYED but it is true: information is power. The way information is developed, managed and controlled shapes how health reforms take place. Those changes are based on how knowledge becomes transferred from information to policy, from policy to practice.

The way medicine is practiced and the ways of promoting health rely not only on the strength of what we know and the things we learn, but *who* knows and learns. Policy and practice that remains uninformed of trends can be wasteful, even harmful.

Improvements in health and well-being, for individuals and for society, depend on patient records, demographic data, surveillance systems, routine monitoring, and the undertaking and the incorporation of research.

It is common business practice to invest about 1% of revenues on evaluation and feedback. We spend about \$100 billion a year (and rising) through public funds on health care. Nowhere near 1% of these amounts goes to improving information flows, and governments are just beginning to realize the impediment this under-investment represents. It means decision-

makers are often flying blind and inefficiencies are harder to weed out.

Canada's institutes of research and statistical agencies are well respected around the world for their precision in measurement and tracking, and their rigour in interpreting the facts. This knowledge base has helped Canadians for the better part of the 20th century. But, in health care, this kind of work is still in its infancy.

We are still grappling with how to collect, exchange and coordinate health information. This is not simply a technical pursuit. The search to standardize health data and facilitate its exchange raises important issues about privacy and control.

Inadequate information can lead to bad decisions, even corruption. A focus on improving information systems can help allocate resources more wisely. That can be at the patient level, making sure access to care is being streamlined, or at the governance level, making more coherent, efficient decisions that save time and money. More lives can be saved and the quality of life improved with more timely and appropriate interventions.

## › Observation Shapes Change The Birth of Public Health

The early 1800s saw massive social change in England, with the Industrial Revolution triggering huge population dislocation and concentration, and a doubling of the population in just 50 years. Poverty was rampant.

By 1834, amendments to the Elizabethan Poor Law (1601) set off a revolution in administration. New local reporting units were established, armed with an unprecedented hierarchy of rules. These rules governed who was eligible for economic relief, and those charged with running the system found themselves stewards of a new source of social statistics.

The Poor Law amendments were triggered by a report by Edwin Chadwick in 1832, whose recommendations for treatment of the poor were largely ignored. In 1842, Edwin Chadwick tried again, producing the Report on the Sanitary Conditions of the Labouring Populations, based on epidemiologic evidence gathered by Poor Law officers and physicians.

This time Chadwick sidestepped the idea that poverty was the root cause of disease, and chose to focus the data towards emphasis on the “sanitary idea” — improvements to water systems, drains and the management of waste was the first step in routing out disease.

Chadwick’s second report paved the way for Britain’s first Public Health Act to be passed into law in 1848.

It was not until 1880 that “germ theory” provided a scientific explanation of infectious disease. By then physicians and social reformers had already recognized that the health status of a population is related to environmental factors such as clean water, safe working conditions and decent housing.

Chadwick proved that the success of public health initiatives rests not just on the availability of systematic data, but on the way the story is told.

These lessons are as true today as they were then.

Health reforms seek to change the behaviour of providers and patients, and ultimately society as a whole. Financial incentives are one way to change behaviour; but information plays an equally important role, through education, through the news, through research and analysis, through outreach, and through social marketing.

This section looks at how reforms to information systems have the potential to improve:

- Population health
- Patient care
- The relevance of research

### Improving Population Health

The goal of improving population health starts with understanding characteristics of that population and the nature of the trends that are being addressed. This includes trends in the population itself (rates of birth and death, age structure, immigration, relocation, patterns of settlement density) as well as trends in the scale and location of various types of disease.

Population health has been a topic of concern and action for over 160 years. (See Box.) This awareness was only made possible after information about populations began to be systematically collected.

### **Public Health Movement Triggered by Systematic Collection of Information**

Public health reforms, first introduced in the mid 1800s, were triggered by work of Edwin Chadwick who studied the impact of changes gripping the populations of Britain. The population of England and Wales had doubled over the previous 50 years, and society was being transformed by the Industrial Revolution. Urban overcrowding and endemic poverty unleashed much physical hardship. Without doubt, public health reforms resulted in major improvements in population health, greatly reducing, if not eliminating, epidemics of childhood infectious disease and extending life expectancy. These reforms were widely taken up in the wealthier industrialized countries over the next century and are still making their way through less developed settings.

Over the course of the 20th century, the medical community adopted new models of health and disease, and new approaches to health care. Improved capabilities have tilted the orientation of care towards more technological solutions.

Today, as in Chadwick's time, we are in the midst of massive social transformations brought on by rapid growth in the global exchanges of goods, international travel, environmental degradation and displacement of populations by armed conflict and economic change.

In this new context, the threat of pandemics — like SARS, avian bird flu, mad cow disease, and HIV-AIDS — has risen, bringing to the fore the importance of very old approaches to health care, particularly disease surveillance and public policy measures that target the communicable aspects of disease. These techniques are heavily reliant on the quantity and quality of information.

This time around, however, the scope of information sharing has expanded, from neighbourhoods, to municipalities, to regions, to nationwide tracking. There is even a newly emerging role for international cooperation on health-in-

formation sharing in order to detect trends more effectively and rapidly.

These new realities remind us of the critical role played by the organization of information in the attempt to prevent disease and provide care. Doctors are important, but so too are countless others connected directly and indirectly in the provision of care. Indeed, how we organize the exchange of health information affects society's ability to grasp and shape the course of health outcomes, for individuals and populations alike.

Experience shows: if you can't measure it, you can't manage it. Just as importantly, if you can't communicate the problem, you can't solve the problem.

### **Importance of Surveillance and Tracking, Now as Then**

Toronto's struggle to control the outbreak of SARS (severe acute respiratory syndrome) in 2003 was a dramatic case in point. The city's public health units were using yellow sticky notes all over the wall to trace contacts for the SARS epidemic. The units were already under-resourced due to funding constraints, and there were no extra people to develop a protocol for entering or tracking data.

Without an information surveillance system and a way of communicating what was going on, it took days to identify what was happening and plan a response to contain the spread of the disease. Those days witnessed an exponential increase in the number of people who contracted SARS. Ultimately 44 people died and hundreds fell ill with SARS, many of them health workers.

Though Canadians are generally regarded as world-class "counters", the system wasn't prepared for this challenge. We have lots of highly reliable, well-organized data on a huge range of issues, going back a long way in time. But we are just starting to translate some of that capacity and culture of observation into the field of population health.

**Statistics Canada** The Dominion Bureau of Statistics, precursor to Statistics Canada, was formed in 1918 by the federal Statistics Act as a centralized national agency responsible for conducting censuses and providing information to other levels of government on a range of social and economic parameters. It replaced the piecemeal arrangements that had developed over time. It changed its name, not functions, to Statistics Canada in 1971.

**National Research Council** Founded in 1917, the NRC was the first body to provide government support of university-based research. By the 1930s it branched out into labs, both producing and supporting research. In 1936 the federal government took its first steps to support Canadian medical research through the Associate Committee on Medical Research, which became a division of NRC research by 1946. By 1960 the NRC Division of Medical Research was an autonomous body.

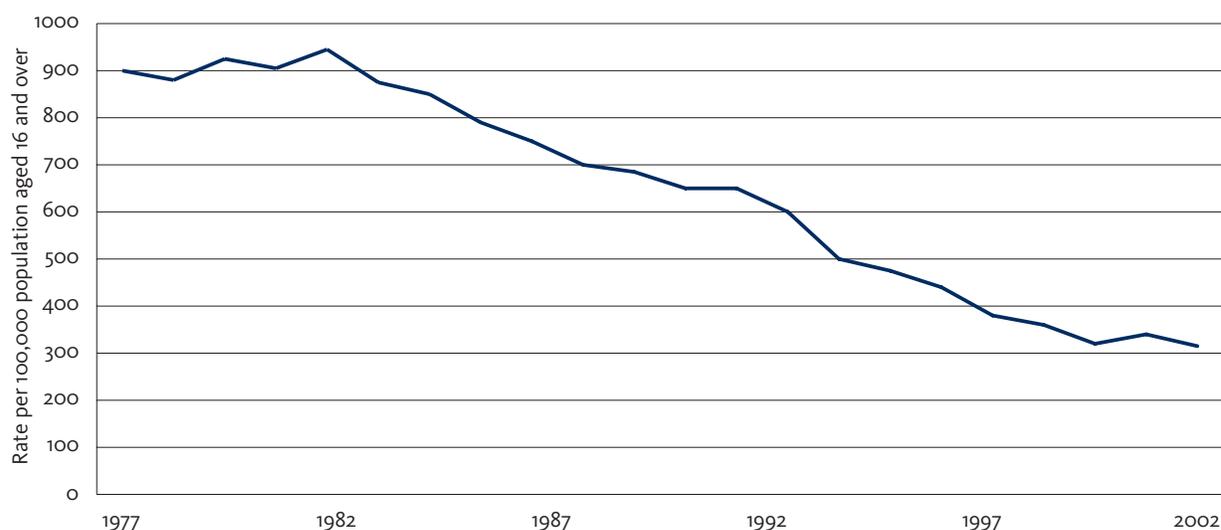
**Medical Research Council** Legislation passed in 1969 transformed the NRC Division of Medical Research into the MRC as an independent body reporting to Parliament.

**National Health Accounts** Health Canada compiled the first set of comprehensive Canadian health data in 1963, based on public and private sector expenditures data collected by Statistics Canada surveys. The accounts were transferred to CIHI (see below) in 1995.

**Canadian Institute for Health Information** CIHI was established in 1994 to serve as a national mechanism to coordinate, develop and maintain a comprehensive and integrated health information system in Canada. The system collects information on health expenditures, service providers, utilization, and health indicators. The first policy-oriented population health report came out in 2004.

**Canadian Health Services Research Foundation** The CHSRF was formed in 1997 with a one-time federal endowment to strengthen the scientific bases for decisions made by people running health services. It was the product of two sets of needs: The Medical Research Council sought more applied research into the delivery of health systems, and the federal government, through the National Forum on Health, sought an evidence-based platform to inform health system decisions. In 1999 a further endowment included funds for a 10 year program of research on Canadian nursing issues.

**Canadian Institutes for Health Research** Legislation passed in 1999 dissolved the Medical Research Council and created the CIHR, shifting health research from a purely bio-medical model to a more integrated multi-disciplinary approach, with a focus on the underlying determinants of health and disease.

**CHART 8 Rates of Impaired Driving Incidents Have Been Generally Declining for the Past Twenty Years**

**SOURCE** Statistics Canada

Capacity does not spring from nowhere. Over the past century, Canadians have cultivated a rich set of institutions to generate research and statistics, through universities, within governments and through publicly-funded bodies such as Statistics Canada.

History has proved, time and again, that integrating and coordinating information is the key ingredient to more successful assessment of problems.

Information gathering doesn't have to be technologically sophisticated. Pencil and paper will do. But recorded information is better when it is standardized, so that categories can be tallied and trends revealed. Information is also more useful when it is collected on an ongoing basis. This is really disease surveillance in an informal way, capturing the information through observation, and not losing the learning. The point is to systematize information that comes in, through surveys, health records, even through stories.

#### **Information is a Two-Way Street**

That leads to the importance of the second element in developing an information system: communication. Communication needs a *two-way* flow of information. Successful communication requires a) reliable and accessible top-down communication from governments and decision-making bodies and b) the ability of advocacy groups to provoke change from the grass-roots up by taking powerful stories and connecting them to data, linking the micro event with the macro trend. Both processes create the momentum for changes in social attitudes and substantive changes in outcomes.

A striking example of this kind of change is a campaign designed to reduce deaths from drunk driving. It started with a handful of women around a kitchen table in 1980. Mothers Against Drunk Driving (MADD) now has over one hundred chapters in the United States and Canada. Its sustained focus has created imaginative pub-

## › Train the Trainers Expanding the Pool of Knowledge

People can avoid preventable illnesses and improve their health without relying exclusively on doctors and nurses, if they get the right information at the right time.

Community health centres, public health nurses, and health activists across Canada have long understood the value of organizing, training and supporting informal groups and linking them to the formal health care sector.

Community-based care networks have been shown to harness existing energy and compassion and use it to supplement the capacity of health care systems. This kind of knowledge upgrading has had the greatest impact on vulnerable communities, such as those suffering from HIV-AIDS; people struggling with poverty and/or homelessness; young pregnant teenagers; or communities facing barriers to access (remoteness or language).

Professionals can train non-professionals to help expand a community's access to care. They can be taught to provide simple diagnostics, more effective ways of providing home-based care, or simply assess when it's time to refer to a professional or a hospital. This develops a bigger pool of informed people who can monitor changes in health status and help people directly or by connecting them to other resources. This approach can lead to substantial health gains in a community at relatively low cost.

lic education campaigns and triggered new legislation at every level of government.

The result? Alcohol-related deaths have dropped from 60% to 40% of all fatal traffic accidents over twenty years in the United States. The trend is the same in Canada, where the national rate of impaired driving has plummeted to one-third its level in 1981.

### Improving Patient Care

Everyone wants to have access to timely, appropriate interventions that can deflect disease, quickly treat the course of ailments, or minimize the challenges of chronic or terminal illness. Indeed, that is the goal of most health reforms.

Quick service is one dimension of getting the right care at the right time. Good quality care also depends on the appropriateness of the service, and the ability of service providers to connect patients easily to other competencies depending on changes in the patient's health status.

For any given service, the speed and quality of care can be greatly improved by better integration of information between elements of care.

### Standardizing Data:

#### The Role of Patient Records

Getting the right type of care is easier if everyone is talking about what is happening to the patient in the same way. The more information is standardized, the more information can be integrated across "silos" of care. Standard formatting of patient records makes health care more portable between different service providers, institutions, and jurisdictions, and facilitates the study of disease.

For all these reasons there has been a push towards electronic health records in this country. The push-back has sometimes been based on privacy concerns; but it remains true that there is as yet no widely accepted input protocol, or standardized format.

Most patient records remain handwritten, and most are in the possession of the physician,

though pharmacists, hospitals and other institutions retain some records too. Such fragmentation of information is challenging to overcome, regardless of the known benefits of better integrated information.

Patient health can also be improved by better disseminating information; that is, actively getting information out to people and teaching them how to use it.

This includes information that patients can use to help themselves, as well as information that can train and upgrade the skills of non-professionals so they can facilitate the provision of care.

### Identifying Bottlenecks

Better information can also help address an ever-present aspect of health care: bottlenecks in service. Some bottlenecks emerge from resource limitations (not enough money, not enough space, not enough staff), and chronic shortages can lead to serious problems for patients.

But not all bottlenecks are a result of under-resourcing. Some arise from the inefficient use of existing resources. How can you tell the difference?

Without information it is difficult to distinguish system malfunction from genuine system inadequacy.

- Who needs what, where?
- Who is providing what, where?
- Who can provide what, where?

Once this kind of information is gathered on a systematic basis, it becomes easier to tackle the tough governance and rationing decisions, like determining if the same resources could be used differently to better effect, or if something needs to be added to the mix. Again, Canadian health care systems are in their infancy in trying to collect and assess this type of information.

Most proposed health reforms aim to improve Canada's health care system by placing the focus

on changes that can be made to improve access to acute care (doctors and hospitals). But it needs to be stressed that the success or failure of the acute care system is largely a function of how primary health care is structured and accessed.

Primary health care is the way people get access to information and supports that can improve their health, for example, immunization programs, regular check-ups, nutritional advice, reproductive health information, and mental health supports.

There is a growing emphasis on such practices, targeting early education, early detection and early intervention. It is widely understood that problems caught early on have a much greater likelihood of responding quickly to simple measures, and often these measures aren't even "health care".

Timely bits of information from patients or for patients can make a huge impact on reducing needs for medical treatment down the line.

Not all these information exchanges occur through doctors and nurses:

- Children are taught many basics about health and health care in school.
- Community outreach workers connect with "at-risk" populations in a variety of settings.
- People assessed as facing the same problem benefit from group counseling, whether that involves referral to resources, or techniques to minimize acceleration of disease or deterioration of health.

These approaches can free up the time of professionals to focus on the more specialized information they are trained to provide. They all maximize the way we use existing resources.

### Streamlining and Coordinating Information Flows

Patient care can also be improved by streamlining the steps needed to access medical treatment. There are numerous examples across

## › Improving Information Flows

### Designing Better Team Approaches Can Improve Information Flows:

- Capital Health Edmonton decreased delays for access to diabetic education by over 90%, from up to eight months down to two weeks, by dropping the requirement that patients see a diabetic specialist on the first visit to the centre. Patients were assessed by both a nurse and dietician before entering the program, and had follow-through care.
- A family doctor in southwestern Saskatchewan serves over 3,200 people — a practice more than twice as large as the national average — and sees up to 98% of his non-emergency patients within 48 hours because he works with three nurse practitioners, one in each of three towns he serves. These four professionals work with regional staff offering public health, mental health and home care as well as two long-term care facilities. Dr. Tony Hamilton notes he can spend more focused, productive time with complicated cases because of the wealth of information that flows from this structure of support. This mode of medical practice is also common in urban centres through community health centres.
- Over the past decade the Hamilton HSO Mental Health Program increased access to services for mental health patients by 900% while decreasing referrals to the psychiatry outpatients' clinic by 70%. It relies on 23 full-time mental health counsellors and two psychiatrists who work with 87 family doctors in 36 practices at 51 sites — covering 180,000 patients. Not only has capacity to serve increased; access to the psychiatrists by phone is still possible at very short notice, a source of comfort to many in the program.

### Eliminating Steps Can Improve Information Flows:

- The development of comprehensive centres for breast cancer can eliminate unnecessary waits at transition points between diagnostic tests. Sault Ste. Marie, Ontario provided immediate ultrasounds for women with suspicious mammograms and, if necessary, went on to provide biopsies. Wait times from first test to final diagnosis plunged from 107 to 18 days, a 75% reduction.
- Alberta's Hip and Knee Replacement Project introduced a more streamlined process of consults between family doctor, laboratories, diagnostic technicians, specialists and schedulers at hospitals. Hours of access to operating theatres were also extended. Better scheduling and management reduced the “ping-pong” of patients. On average, the journey from seeking help to getting it fell from 82 weeks to 11 weeks

Canada where the creation of a “one-stop shopping” approach has sped up the transition from problem-spotting, to diagnosis to treatment of disease. (See Box.)

Sometimes it is possible for a given group of providers to see more people, simply by changing the way things are done.

- Patients can be better profiled upon intake to stream them into the appropriate level and type of care.
- Case managers can help navigate the system, provide patient reminders and monitor developments.
- System capacities can be better matched with length of routine procedures.

These process or “flow” issues all depend on relatively simple bits of information. Marshaling these facts strategically can help speed access and increase the number of patients who can be served, without necessarily having to increase staffing.

Better scheduling and use of feedback loops can keep the flow from getting jammed and save precious time, for both patient and provider.

The rise of clinics that are specialized in a particular procedure is another information-intensive change in how care is being re-organized, resulting in improved access to high quality care.

The recent proliferation of specialty clinics for cardiac care, cancer care, joint replacements and orthopaedic care, and cataract surgery have permitted dramatic improvements in the number of patients that can be served quickly and efficiently.

The standardization of both information and procedure turns these clinics into mini-assembly lines, speeding up the “turn-around” time and flow-through of patients.

The specialization of service increases the intelligence gleaned from exchange with patients, particularly those suffering from complications, leading to further improvements in care.

### Improving the Relevance of Research

Canadians and their elected leaders generally understand that finding a cure for cancer is not the biggest issue in health research, as dazzling as it is. Our collective obsession seems to be with health systems, not just technologies.

This has led to excellence in the development of conceptual frameworks and strategies like the Lalonde Report (1974) and the Ottawa Charter (1986). More recently the Healthy Living Strategy (2005) has advanced this health promotion agenda in its approach to chronic disease and integrated research. This framework is reflected in

the World Health Organization’s emerging risk-reduction strategies for global health.

Our philosophy of research has been informed over decades of slow and steady observation, and facilitating capacity building processes. We’re not as good at the “take charge” approach, and it shows in our ability to translate policies into action; but that can be a strength, not just a weakness.

Canadians regularly question how dollars are devoted to health research and who benefits from that research. Some of the country’s lead thinkers are at the forefront of a global movement that sees research as integral to the “health” of the health system, built right into the capacity to serve rather than a silo that sits apart from the fray.

This view invariably leads to discussions about who gets access to money for research, whose issues are considered important enough to research. One aspect of these concerns is Canada’s participation in the push to narrow the “10/90” gap in health research.

### Narrowing the “10/90” Gap

Pneumonia and diarrhoeal disease are the world’s two biggest “killer” diseases, accounting for about 11% of the total global burden of disease. But only one-fifth of 1% of health research funding is spent on finding ways of addressing these problems more effectively.

Like other aspects of the great divide between the developing nations and rich, industrialized nations, there is an extreme mismatch between problems and resources to solve them.

About 85% of the world lives in low- and middle-income countries. These populations bear 92% of the global burden of disease. High income nations are home to only 15% of the world’s population, and bear just 8% of the incidence of disease.

Yet, of the vast amounts spent annually on health research by the public and private sectors, less than 10% is devoted to diseases or con-

ditions that account for 90% of the global burden of disease.

It is estimated that in 2001, global spending on health-related research and development reached \$106 billion (US).

Almost half those amounts were spent through private for-profit companies, mostly driven by the growth in developing new drugs. This kind of pharmaceutical research benefits an ever-shrinking proportion of the world's populations.

The private sector also contributes funding for health research through philanthropists. Private not-for-profit funding accounted for 8%

**> 10% of research in health is focused on issues that account for 90% of the global burden of disease.**

of all health research by 2001, and is more inclined to examine health issues affecting developing nations.

#### **The Purpose of Health Research: Commercial vs. Social Interests**

Public funding for health research has been stepped up in many countries. In Canada, public funding for health research is complex.

One distinct strand of public funding seeks to translate primary research conducted in universities into commercial applications, viewing health care as an engine of economic growth.

Another strand of publicly funded health research is focused on provision of care, including better assessing the social determinants of health and improving the relevance of care for different populations.

This latter body of empirical work is very new, but is viewed as an important step in more rigorously addressing issues of health inequalities here in Canada.

#### **Understanding the Significance of Gender Differences in Health Care**

Better understanding of the gender-specific aspects of health and health care rank high in this new orientation to research.

Women's health is simply different than men's, for anatomical and biochemical reasons. Women's bodies react differently to drugs; women's reproductive health issues are categorically different, and more ongoing, than men's; women's nutritional needs are different, especially during gestation and lactation.

In terms of ill-health, women tend to outlive men, but face higher complexity of disease, including a much higher incidence of osteoporosis or arthritis than men. There seems to be gender-bias in how drugs are prescribed: women tend to be over-medicated and, not surprisingly, tend to have more adverse reactions. While breast cancer may be the most obvious gender-specific affliction for women, cardiovascular disease kills roughly 10 times more women each year than breast cancer, and cardiovascular diseases are on the rise among women, a function of increasing stress, age, obesity and factors like poverty.

Women face a higher incidence of poverty than men, in Canada as elsewhere, which means they have a higher likelihood of hunger and inadequate shelter. These social factors all lead to increased risks to health. Single mothers are at particular risk: the great majority are low-income (81% vs. 15% of partnered mothers); more than half experience food insecurity (54% vs. 10%); and 40% experience violence compared to 7% of partnered mothers. The impact on the next generation is not insignificant.

Better research into how women need, receive and respond to care is a central part of making the provision of health care more focused and relevant. So is assuring better value for money.

#### **Assessing Cost-Effective Health Practices**

It is nothing short of remarkable that, after more than a decade of concern expressed by govern-

ments about the future financial sustainability of public health care, governments have made little progress in assessing how health care dollars are spent, and how to improve the cost effectiveness of treatment.

Different approaches to primary care and even different approaches to acute care have different cost implications. Yet most jurisdictions have little if any case-costing data to assess the benefits and costs of different ways of providing care. Alberta and Ontario are the most advanced in this area of inquiry, and even these jurisdictions will note their methodology is still in its infancy.

Decades ago, governments were more inclined to calculate estimates of returns on public investments, for example in the areas of infrastructure, housing and utilities. Academics gained much attention through the development of “human capital” theory in the 1960s and 1970s. This methodology helped show how investments in education more than pay off for individuals (through their incomes) and for society as a whole (through GDP) over time. The most recent application of this type of study has looked at the life-long economic impacts of investments in early child development.

Today’s research offers few insights on the relative merit of different investments through the public sector. Canadian governments and academics alike tend to view public provision primarily in terms of streams of expenditure, not linked to the streams of benefits being purchased. This puts the focus of analysis on the bottom line and on the short term, with programs “eating up” the annual budget, and adding fiscal pressure.

Confidence in public services has been eroded by years of under-funding, a focus on government waste, and claims of better service from the private sector. The public interest cannot be well served without evidence showing that the taxpayer’s dollar can buy things that individual consumers cannot. Citizens and elected lead-

ers alike need more relevant research, research that can reveal the most effective ways to invest in the pursuit of better health and better health care, for one and all.

### **Summary: What You Don’t Know Can’t Help You**

Information flows make or break health care systems. The health of individuals and whole populations can be improved by simple measures. All improvements rely on improvements to the way information is standardized and tracked over time. What you don’t know can’t help you.

Integration and coordination of information is key to speeding up access to appropriate interventions across a wide spectrum of care. Integration and coordination is also key to improving how systems flow and function.

Improvements in how information is collected and used can happen immediately, but expanding the capacity to know is a slower process. Every stage builds on the knowledge gleaned from the previous step. This is as true of institutions of knowledge creation as it is of the pool of people who deliver care. Widening the capacity to learn and understand is a two-way street of knowledge generation and knowledge assimilation.

The relevance of research depends on who uses the information, and to what purpose. There are different objectives for generating new understanding, none more stark than the contrasting body of research undertaken for developed nations versus developing nations.

There is an emerging awareness of the importance of gender differences, and differences between commercial and social objectives. Social forces shape what is considered relevant. Research just reflects these balances of power.

Despite the rich history of knowledge development in the field of health care, Canada is still in its infancy in generating new ways of understanding how to improve health care.



## Recommended Resources

### Foundational Documents

The Canada Health Act, Overview.  
<http://www.hc-sc.gc.ca/medicare/chaover.htm>

The Hall Commission *Royal Commission on Health Services: 1964: Volume I, June 19, 1964;* and the *Royal Commission on Health Services: 1965: Volume II, December 7, 1964.* Justice Emmett M. Hall, Chair. [http://www.hc-sc.gc.ca/hcs-sss/com/hall/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/com/hall/index_e.html)

The Lalonde Report Marc Lalonde, Minister of National Health and Welfare, *A New Perspective on the Health of Canadians: A working document* Ottawa: 1974.  
[http://www.hc-sc.gc.ca/hcs-sss/com/lalonde/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/com/lalonde/index_e.html)

The Ottawa Charter *The Ottawa Charter for Health Promotion* (World Health Organization, 1986). <http://www.ldb.org/iuhpe/ottawa.htm>

The National Forum on Health, *Canada Health Action: Building on the Legacy* Ottawa: 1997. [http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/1997-nfoh-fnss-v1/index\\_e.html](http://www.hc-sc.gc.ca/hcs-sss/pubs/care-soins/1997-nfoh-fnss-v1/index_e.html)

The Romanow Report Commission on the Future of Health Care in Canada, *Building on Values: The future of Health Care in Canada*, Ottawa: November 2002, Roy J. Romanow, Q.C. Commissioner. <http://www.hc-sc.gc.ca/english/care/romanow/index1.html>

The Kirby Report The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role* (seven volumes, see particularly *Volume 6, Recommendations for Reform*) Senator Michael J. Kirby, Chair.  
<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repocto2vol6-e.htm>

## Free Statistical Sources

Canadian Institute for Health Information  
<http://www.cihi.ca>

Statistics Canada. <http://www.statcan.ca>

Health Indicators. <http://www.statcan.ca/bsolc/english/bsolc?catno=82-221-X>

Canadian Community Health Survey.  
<http://www.statcan.ca/bsolc/english/bsolc?catno=82-621-X>

Spending on R&D in Health.  
<http://www.statcan.ca/bsolc/english/bsolc?catno=88-001-X20060039191>

Quarterly Health Reports.  
<http://www.statcan.ca/bsolc/english/bsolc?catno=82-003-X>

OECD Health Statistics. [http://www.oecd.org/topicstatsportal/0,2647,en\\_2825\\_495642\\_1\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/topicstatsportal/0,2647,en_2825_495642_1_1_1_1_1,00.html)

## Selected Canadian websites that provide free publications and links (including links to provincial sites)

Public Health Agency of Canada.  
<http://www.phac-aspc.gc.ca> (note particularly the chronic disease, health promotion and public health sections)

Canadian Institutes for Health Research.  
<http://www.cihr-irsc.gc.ca/e/22979.html>  
 (publications page, sorted by type of institute of research)

Canadian Health Services Research Foundation. <http://www.chsrf.ca> (forum for knowledge exchange—academic, applied, popularized—between researchers and decision-makers)

Canadian Women's Health Network.  
<http://www.cwhn.ca/indexeng.html> (forum for information, resource and strategy exchange for women, specializes in gender-sensitive analysis of health policies, practices, and research)

Canadian Public Health Association.  
<http://www.cpha.ca> (extensive links to publications, national and international organizations, initiatives)

Centre for Health Services and Policy Research, University of British Columbia (CHSPR). <http://www.chspr.ubc.ca/> (not just provincially based research, particularly rich site for primary care, and drug policy analysis)

Canadian Society for International Health.  
<http://www.csih.org> (capacity building focus in developing nations, service and community development oriented)

Canadian Coalition Global Forum on Health Research. <http://www.ccghr.ca> (capacity building focus, research and international partnership oriented)

Patented Medicine Prices Review Board.  
<http://www.pmprb-cepmb.gc.ca> (regulatory mechanisms on patented pharmaceuticals, comparative analysis of pricing)

Canadian Agency for Drugs and Technologies in Health. <http://www.cadth.ca> (cost- and clinical-effectiveness assessments)

IMS Health Canada.  
<http://www.imshealthcanada.com> (analysis on drug utilization, based on Canada's biggest drug data base—commercial)

National Evaluation of Cost-Effectiveness of Home Care. <http://www.homecarestudy.com>

Canadian Nursing Advisory Committee (2002). [http://hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-cnac-cccsi-final/cnac-cccsi10\\_e.html](http://hc-sc.gc.ca/hcs-sss/pubs/care-soins/2002-cnac-cccsi-final/cnac-cccsi10_e.html) (resources and publications)

Canadian Alliance of Community Health Centre Associations.  
<http://www.cachca.ca/> (focus on community-based modalities of primary health care delivery, links to organizations at the sub-national level, current research)

Canadian Health Coalition.  
<http://www.healthcoalition.ca> (citizens' mobilization and advocacy, links to organizations at sub-national level, links to campaigns, research)

## Selected Resource Documents

### Health as Development

World Development Report 1993: Investing in Health. Published for the World Bank by Oxford University Press.  
[http://www-wds.worldbank.org/external/default/mainpagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187511&siteName=WD&entityID=000009265\\_3970716142319](http://www-wds.worldbank.org/external/default/mainpagePK=64193027&piPK=64187937&theSitePK=523679&menuPK=64187510&searchMenuPK=64187511&siteName=WD&entityID=000009265_3970716142319)

*Social determinants of health: the solid facts.* Second edition. Eds. Richard Wilkinson and Michael Marmot. World Health Organization 2003. <http://www.who.dk/document/e81384.pdf>

Lincoln C. Chen, MD “Mobilizing health and finance to dampen disease and build systems” Keynote Address to Second Consultation Commission on Macroeconomics and Health World Health Organization, Geneva October 29, 2003. <http://www.who.int/macrohealth/infocentre/speeches/keynote/en/>

### History

C. Stuart Houston. *Steps on the Road to Medicare: Why Saskatchewan Led the Way*, Montreal: McGill University Press; 2002.  
 See review <http://www.cmaj.ca/cgi/content/full/169/1/50>

Aleck Ostry, *The Roots of America's First Comprehensive Public Health Insurance System*, *Hygeia Internationalis: An Interdisciplinary Journal for the History of Public Health*, Vol 2. Issue 1, (2001), pp. 25–44.  
<http://www.ep.liu.se/ej/hygiea/ra/007/paper.pdf>

History of emerging public health concerns in Toronto in the 1800s.  
<http://collections.ic.gc.ca/toronto/land.html>

Origins of public health in England (reform of Elizabethan Poor Laws), various readings, best of which comes from: <http://www2.rgu.ac.uk/publicpolicy/introduction/historyf.htm>

### Innovation and System Redesign

Donald M. Berwick, M.D., M.P.P., *As Good As It Should Get: Making Health Care Better in the New Millennium*, Boston, Massachusetts: Institute for Healthcare Improvement, September 1998. See <http://www.ihl.org/ihl> for continuing examples

Michael Rachlis, M.D., *Prescription for Excellence: How Innovation is Saving Canada's Health Care System*, Toronto: HarperCollins Publishers Ltd., 2004

### Current Debates

*Defining the Medicare Basket: Health Care Decision Making in Canada*, Colleen Flood, Carolyn Tuohy, Mark Stabile, et al., Working Paper Series, Montreal: Institute for Research on Public Policy, 2004. [http://www.irpp.org/wp/archive/medicare\\_basket/papers.htm](http://www.irpp.org/wp/archive/medicare_basket/papers.htm)

*Access to Care, Access to Justice: The Legal Debate over Private Insurance*, Colleen Flood, Kent Roach, Lorne Sossin eds., Toronto: University of Toronto Press 2005. See for example [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=909262](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=909262)

Gregory P. Marchildon, *Health Systems in Transition: Canada*, European Observatory on Health Systems and Policies, Vol. 7, No.3 (2005) published by Copenhagen, Denmark: World Health Organization. <http://www.euro.who.int/Document/E87954.pdf>

*Putting Health First: Canadian Health Care Reform in a Globalizing World*, Matt Sanger and Scott Sinclair, eds. Ottawa: Canadian Centre for Policy Alternatives, 2004 (One of three “consortia” reports produced for the Romanow Commission). [http://www.policyalternatives.ca/documents/National\\_Office\\_Pubs/putting\\_health\\_first2004.pdf](http://www.policyalternatives.ca/documents/National_Office_Pubs/putting_health_first2004.pdf)

Canadian Medical Association and Canadian Policy Research Networks, *Taming the Queue* (2004 and later colloquia—2005, and 2006, organized by CMA alone—include presentations on disease management technique. Only 2004 is available on line). <http://www.cprn.com/en/doc.cfm?doc=581>

Frank Cesa, *International Medical Graduates: A Case Study*, Health Canada, Health Policy Research Bulletin from the series Health Human Resources: Balancing Supply and Demand (no date). <http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/rmdd/bulletin/ehuman1.html#105>

Armine Yalnizyan, *Can We Afford to Sustain Medicare?* Paper produced for the Canadian Federation of Nurses Unions, July 2004. <http://www.nursesunions.ca/cms/updir/2004-07-29-Sustainability-Report-en.pdf>



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