The Future of Medicare
Recovering the Canada Health Act

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I am doubly honoured to have been invited to give the Justice Emmett Hall 2nd Memorial Lecture. It is also a real pleasure. Twenty years ago, I inherited Mr. Justice Emmett Hall, so to speak, from my successor David Crombie, who had appointed him in 1979 to probe the Medicare diversion of funds, user fees and extra-billing allegations. But then, by a strange twist of electoral history, I, in turn, succeeded my successor and was appointed back to the National Health and Welfare portfolio early in March of 1980.

I will never forget my first trip—the first of many more—to see Emmett Hall in Saskatoon. The whole dossier, as well as the appointment, was highly charged, politically speaking. Or so it appeared: A personal friend of Diefenbaeker; appointed by the Conservatives; my departmental senior officials worrying that we would never get a report from him...But I discovered a humanist, with a sense of humour (just like his young brother of 90, Father Anthony!), a most pleasant and courteous individual.

Above all, in familiarizing myself with his life's work, I saw a man who, time and again, had had the courage to disagree with the prevailing opinions and who did not pay much attention to intellectual fads or to preconceived ideas.

Mr. Justice Emmett Hall was "everybody's arbitrator." Railroad workers and workers involved in other industrial disputes benefited from his competence. He was also a remarkable member of the Supreme Court of Canada; a civil libertarian, he made his mark through many judgments.

One his most famous rulings, the 1973 decision on the Nishgas, which recognized Aboriginal rights in Canada, profoundly influenced Prime Minister Trudeau who did not believe such historical rights existed. Negotiations started in 1976, and the bill settling the Nishgas' land claims, to be tabled in the House of Commons this fall, flows directly from that judgment.

Emmett Hall has also left Canadians with cornerstone reports of inquiry, the most famous of course being *The Royal Commission Report on Health Services* (1964) and *Living and Learning (*1968), the Hall-Dennis report on education in Ontario.

To sum up, Emmett Hall was a man of courage, of vision, and of intellectual and moral integrity.

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As a public policy issue, the subject of universal, accessible and public health care systems is a passion with me. But I do not

find it easy to analyze and discuss because it is still clouded with emotions, or obscured by ideologies or ignorance. It is close to impossible to quietly sit around a table and witness, or participate in, an objective discussion of our Canadian health care system. Listening to public policy experts and decision-makers, health care practitioners or administrators, or reading media reports, for example, usually leaves one with an impression that the speaker or author belongs to one of two camps: "for" or "against" Medicare. Even reading the works of health economists often leaves the same feeling.

That the question of Medicare be highly political is only normal; it potentially touches the life of everyone, and it constitutes the largest part of public expenditures. But this context does not make for a comfortable and enlightening thought process.

I was personally involved in Medicare on a daily basis—in the hot seat—for six consecutive years as a cabinet minister. Then, overnight, I became a passionate (but mostly silent) outside observer for the last 15 years. Not that I do not teach, nor speak nor write on health care issues and concerns. I do it regularly. But I tried, during those past years, to step back so I could better assess the realities of the health care system.

I am also very careful to respect the health politicians of the day, whatever the party in power or the level of government, and not appear to interfere in a job that will never be an easy one.

In fact, what will always interest me is the system, or systems, we have in Canada to deliver health care to our population. It is a system that grew out of our particular history and political culture. It was not imported, and, however good it is, it is not easily exportable. It has its strengths (it is true that at World Health Organization annual meetings, ministers from other countries come and say they want to visit Canada to learn about it) and its weaknesses. On the whole, it served and continues to serve Canadians rather well. In and of itself, it is more a question of pragmatic considerations than of principles; yet it is sustained by underpinning values that are fundamental to us as a society.

Since the *Canada Health Act (1984)*, some believe that the system is slowly but surely being eroded. Others say that it has ups and downs, but that basically everything is fine. Others, still, do not like it or do not consider it sound, for all sorts of reasons, and want to change it in a fundamental way. But many others, today, are simply not sure what is going on and are privately worried—or cynical—about loosing key entitlements.

I will therefore discuss the subject matter from three angles. First, I will reflect on the need for a clear and appropriate set of "rules of the game." Second, I will extend that reflection to issues of enforcement of the federal legislation. And finally, I will elaborate on the question of the sustainability of our health care system. These are the themes that cover most questions raised in good faith by the public and that are of particular interest to me in terms of public policy on the eve of the third millennium. So "reforms," as such, are not what I will be discussing!

1. The "rules of the game"

Between 1958 and 1961, Canadians learned that being hospitalized was no longer an expensive, at times prohibitive, out-of-pocket item in any family budget, but was becoming "free"—i.e., pre-paid by their taxes. Ten years later, between 1968 and 1971, they also learned that visiting their doctors, family physicians or specialists was also becoming "free". The situation was simple; health care at the time

was about doctors' visits and hospital stays. Who paid who for what was also simple: 50% came from the feds, 50% was provincial.

People learned of the four boundaries of Medicare— what was **not** covered: ambulances, drugs outside hospital, dentists and optometrists. They also knew that these costs could be covered for welfare recipients, seniors, or children up to the age of 12, depending on one's province.

In the last 20 years, however, things became more complicated. We started learning that health was much more than physicians and hospitals. Health promotion and disease prevention, healthy life-styles and active living, primary care—all became part of the vocabulary.

We also witnessed the appearance of institutional user fees or extra-billing by physicians. The notion of a two-tiered system, that of double standards, as well as the arguments against a public health insurance ("socialized medicine's" long waiting lists and low quality care; patients as abusers of the system; the brain drain of physicians), shook the politicians and sparked a heated public debate. The public witnessed—and participated in— the first serious round of attacks against the system since its inception.

Then, around 1987, following the bitter Ontario doctors' strike, Canadians were assured that extra-charges would not be tolerated. After three years and some $245 million of cash penalties imposed to seven provinces (reimbursed after they stopped violating the Canada Health Act), Medicare was back on track. Canadians' attachment to their beloved No. 1 health care system had been reinforced in the process.

But is that still the situation today? No, it isn't. The same privatization forces that were at play in the early 1980s are still there, and their influence is compounded by the pressures to control governments deficits. But the frontal attacks of extra-charges to the patients have changed to covert, much subtler erosions of the system.

Surreptitious de-listing or de-insurance of services by provincial governments; private clinics operating both in and out of provincial plans for "medically necessary services" (and their medical practitioners keeping hospital privileges and having it both ways); treating GPs or specialists directing their patients to private labs and clinics for regular procedures for the full out-of-pocket cost; hospitals charging partial costs for exams because these might not be "medically necessary" (wanting a MRI is not like choosing to have a hair colouring!)—these are all erosions of Medicare. People started losing all sense of their entitlements to health care.

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Not that the public fails to understand that some changes to the rules of the game might be needed; they know about the rapid pace of change in medical technology, research breakthroughs, pharmaceutical discoveries. Nor are patients abusive consumers. They do support some restrictions to public payment in order to protect the future of Medicare. Excluding frivolous cosmetic surgery or paying "when there are forms to fill"—for employers, governments or insurers—have called for a wide consensus (although there seems to be more forms to pay by the day!). What is wrong, and the reason why I label these attacks "subtle," is that they take place behind closed doors without real public consultation, let alone any public knowledge.

In the case of the de-insurance of services, for example, there exist no provincial (or federal) accountability mechanisms. There is absolutely no transparency in the process. Citizens learn that they have to pay for something that used to be free while waiting as patients in their doctor's office.

So, when the Quebec RAAQ requires an eye exam and a general exams before renewing a driving permit, the visit to the O.D. is $80. and that to the GP is $10. Fine. If one goes to the ophthalmologist for a regular eye exam—just for health reasons, not when a form is required—this exam, which was free two years ago, is now $40, the same price an optometrist would charge.

"In Alberta...citizens are now encouraged by a systemic and vicious distortion of Medicare to avoid the long waiting list by going to a private clinic or hospital, where they will pay $750 for an MRI scan."

In hospital, a patient with a broken ankle who is told she also needs a leg cast learns that, if she chooses the regular cast, it is free, but should she prefer the ultra-light cast (who wouldn't?), it will be $85.

In Ontario, PSA tests to check for prostate cancer must now often be paid for by the patients. It is not much—$15 or $20—but surely this screening method is as "medically necessary" for men as a mammography is to women.

The examples given take place in a context where getting an appointment because of one's "connections" is becoming a generalized practice—a perverse deterioration of the public system.

Much more twisted is the case of MRI procedures, which should of course be insured as a medically necessary service. In Alberta, for example, citizens are now encouraged by a systemic and vicious distortion of Medicare to avoid the long waiting list by going to a private clinic or hospital, where they will pay $750 for an MRI scan.

Variations of this situation also exist in Ontario and elsewhere in the country. In Québec, if the MRI is given in a hospital, a patient might have to pay some $300-$350; in a private lab or clinic, the same scan will be double that amount. Somehow, as Richard Plain has illustrated so well, a medically required service changes nature and becomes a non-necessary, hence non-insured one. Who are we fooling?

Abortion—some 110,000 cases per year—should be like any other insured health care service. Yet women living in Prince Edward Island have no abortion services anywhere in the province. In New Brunswick, half of the women (about 500) needing abortions every year obtain this service at a clinic where they pay the physician's, nurse's and counselor's fees, overhead fixed costs, and the costs of materials (from $350 to $1,000.). The other half is able to access hospitals where the same intervention is free. In Newfoundland and Nova Scotia, physicians' fees are covered in a clinic, but not the other costs. These can go from $50 to $300. Only in 1996 did Alberta finally shift from no coverage to full coverage at clinics. In general, access is non-existent in rural or isolated areas. These are definitely unequal applications and outright breaches of the Canada Health Act that deny women health care services to which they are entitled.

In addition to all this, a significant shift of the burden of costs from the system onto individual patients relates to the drugs needed following day surgery in hospital. All the drugs patients used to receive "free" in hospital, they now have to pay for because they are at home for their recovery. I suspect that such "savings" by hospitals on the backs of patients amount to a substantial sum of

money. If, technically speaking, this practice may not be a legal breach of the Act, it is clearly contrary to its intent and principles.

These erosions take us to the concept of "medical necessity" as stated in the Act. I often hear people wish that the concept was clearly defined and spelled out in detail. I do not believe this to be feasible, even helpful. Physicians should continue to be responsible for judging, as professionals, what is needed for one's health restoration. All that the public needs to agree on is a general sense of distinguishing between "needs" and "wants," and the public does not have a problem with that distinction. What is wrong is when religious, moral or political priorities interfere. And, yes, women's torn ear lobes or teenagers' infected tattoos should be covered as being medically necessary. Nothing is easier that to moralize that "they did it to themselves". Following that logic, persons who are overweight, involved in many motor and sport accidents, or victims of smoking-induced lung cancer should also be excluded from free coverage!

My contention is that the *Canada Health Act* is the only set of rules people in Canada have in order to know their entitlements to health care. At this moment in time, these rules are blurred and citizens no longer understand what they will or should receive for the heavy taxes they pay. Since they are not familiar with the financial and administrative aspects—and why should they be?—and have lost a sense of their entitlements, individuals either accept ideological arguments about "being able to pay," or worry to no end about what is going to happen in the future. And they purchase more health insurance, forgetting in the process that they have already paid high taxes for a "free," universal, and comprehensive health care system.

Typically, a health insurance package for a couple can cost $176 a month ($2,112 a year) to cover an enhanced drug plan, home and nursing care, basic dental care, chiropractic care, and physiotherapy.[1]

How serious are these erosions of Medicare? Nobody knows, really. Why not? Firstly, because there is no comprehensive picture of what is happening in Canada today. The provinces have never complied with the request for information included in the *Act* (and nothing was done about it), and the recent annual reports of Health Canada, also made mandatory by the legislation, are now devoid of any significance. Of course, the 1995 *Canada Health and Social Transfer* did not help, wiping away as it did even a notional sense of what money goes to health.

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Secondly, nobody can tell how serious the problem is because of the very nature of the phenomenon of erosion. I did not refer to a Medicare "crisis" for obvious reasons; I am speaking of erosion, a term defined in the dictionary as "*that group of natural processes including weathering, dissolution, abrasion, corrosion, and transportation by which earthy or rock material is removed from any part of the Earth's surface*".[2] Erosion is that slow, unnoticed process that suddenly leads to landslides and collapses. Is that what we want?

2. A legal framework

Last October in Toronto, I suggested during a short panel presentation that we needed a new *Canada Health Act*, with the same five

principles, but based on *"an up-to-date, integrated definition, covering all health professionals and the spectrum of institutions and services delivering health care"*, and not heavily hospital- and physician-based, to the exclusion of any other forms of care.[3] I later repeated it to the Nursing Faculty in Fredericton. That conference, kicked off by John Ralston Saul's keynote presentation, was discussing the ideal "content" of Medicare. As a former politician, I should have known better than theorize to about an ideal situation!

"In reality, I am not sure we can re-open the *Canada Health Act* today for fear of losing it altogether. The opposition forces at play against Medicare, although of small, focused interest groups, still are, in my opinion, that dangerous."

In reality, I am not sure we can re-open the *Canada Health Act* today for fear of losing it altogether. The opposition forces at play against Medicare, although of small, focused interest groups, still are, in my opinion, that dangerous. It remains that, in the absence of perfect legislation, decisions have to be made to ensure that the rules of the game are respected and that the current Act is enforced. This is elementary public accountability.

A piece of legislation is a legal framework. It does not exist in a vacuum. Any legislative text requires interpretation. If clarification is required, it can be found in the two other Acts underlying the *Canada Health Act,*[4] in their regulations, and in decades of federal-provincial inter-relations and practices that together spell out the intent of the federal program and the conditions of its funding.

Regulations exist that can be adjusted to needs and evolution. Over the last few years, excellent reports and studies have been released by each province and by the federal government—the 1997 report of the National Forum on Health, for example. So it is not as if we do not know what direction public policy is taking in health matters.

The first question, then, is that of the enforcement of the legislation. However unpleasant and frustrating the exercise of federal-provincial relations can be at times, agreement can also—and must—be developed. But not at any cost. The formal endorsement by the federal government, on May 17, 1996, of the *Twelve Provincial Principles Underlying the Alberta Health Care System* is, in that respect, profoundly shocking. I cannot understand how both the Department of Justice and Health Canada (and maybe the entire federal cabinet) could support the federal signature on this joint document, which is at best an extraordinary exercise in legal sophistry.

Here are a few of the principles that were jointly approved by the federal and provincial governments:

4. *Ensure a strong role for the private sector in health care, both within and outside the publicly-funded system.*

7. *Consumers have the right to voluntarily purchase health services outside assessed need.*

8. *Maintain the restrictions on the role of private insurance while introducing measures to expand the opportunities for the private sector to deliver services within the single-payer envelope.*

9. *Private clinics should have the option of becoming completely private (patient pays) or allowing them to enter into a variety of funding arrangements with the public sector to cover the full costs of insured services.*

11. *The same physician can practice in both the public and private systems if he/she is offering insured services which are fully paid for by the public system and non-insured services which are paid for privately.*

So-called principles 9 and 11 go completely against the tradition and the spirit of the federal legislation: physicians (or hospitals) cannot be both in and out of Medicare. Since 1968, there always were "disaffiliated physicians;" but both they and their patients were obliged—for obvious reasons of conflicting interest and to avoid a two-tiered system—to be completely outside of the public system.

Today's situation leaves us with a major challenge: that of enforcing an Act after years of minimal action. I fully sympathize with the federal Health Minister as to the difficulty this presents. The challenge is the more demanding since, after 1984 and for nine years, no action was taken by the federal government other than the follow-up on the penalties I had started to apply for extra-charges. The cause lies with Conservative Prime Minister Mulroney's instructions to all his ministers not to make waves with the provinces, whatever the circumstances.

To be fair, it was then hard to expect that the new Liberal government, elected in November 1993, would have started its mandate by attacking the provinces, even if the issue were Medicare! But it might have been the right thing to do. To make things more difficult, the Alberta-Canada agreement jointly signed since then is fundamentally wrong and should be rescinded. And to make matters a political nightmare on top of everything else, the anticipated increases in federal transfers for health were reduced by at least $30 billion of cash payments. In the final analysis, however, what Canadians expect from a minister of health is leadership.

It is true that the federal legislation offers a quasi-automatic mechanism of enforcement against user fees by hospitals and extra-billing by physicians, a mechanism seen by all to be clear and fair. The Act has been tested, and the problem brought under control. In that sense the *Canada Health Act* has clearly been a success. But the subsequent violation of the Act—such as the kinds of erosion I have cited—fall under a more general procedure, calling for interpretation and discretionary power, as well as political will. In that sense, it is more demanding of those responsible for protecting our national health care system.

To start, an evidence-based complete picture of the situation is needed to document the problem we know exists. If there is such a report, Canadians have never been informed of it. Recent "analyses" are based on little more than anecdotal information. When an exact picture of the situation has been established, what then becomes essential is a strategy. Are there possible strategies?

Unless the politics of "laisser-faire", including heavy privatization, have been secretly adopted, funding for home care as a new program will have to be negotiated between the federal and the provincial governments. In addition to a national "home care" program, a form of "pharmacare" could also be the object of similar discussions. The resulting agreement might be sanctioned by more than one legal approach. A new piece of legislation, parallel to the *Canada Health Act*, is what comes spontaneously to mind. However, the 1984 legislation could also be amended, opening the door both to new money—which should be made by cash transfers, not tax points ("no cash, no

clout")—and to the possibility of correcting the present legislation's drawbacks.

Because it is urgent to clarify what Canadians are entitled to, and since a new agreement on home care may take time, there is need, however, to see whether other avenues of action are open in the immediate future. I would submit that a great deal could be achieved by way of revised or new regulations and of inter-government memos of understanding.

One example is establishing that the coverage of drugs resulting from day surgery, when the patient is back home, will be considered an intrinsic part of Medicare entitlements. Correcting this situation is feasible at the administrative level, according to experts. Each case of current erosion should thus be examined and corrected through the most appropriate mechanism, short of reopening the Act.

This being said, I still do not know what mechanisms or procedures can be used, other than an amendment to the Act, to rectify what I consider an aberration (the origin of which escapes me), namely, the exemption of Workers' Compensation Boards from adhering to the present legislation. So we have, as in Alberta, situations whereby the WCB funds are used to subsidize private clinics and hospitals!

One recurrent sore point with the provincial governments, besides the argument of underfunding, has to do with the continuing enforcement of the *Canada Health Act.* For example, *A Renewed Vision for Canada's Health System*, the consensus document of the Conference of the Provincial/Territorial Ministers of Health (released in January 1997) calls for a new advisory administrative mechanism outside of both orders of government that would serve as a reference body for disputes, and that could eventually act as a conciliation or arbitration body.

Historically, the provinces have always requested that the control of the federal legislation be granted to them under one form of council or another. This, of course, makes no sense, and is unacceptable. But there might be conditions under which an advisory body could help, provided the federal government remains responsible and accountable for its own legislation.

3. The sustainability of the health care system

One very discomfiting trend observed recently by health economists is that of the public/private ratio of health expenditures in Canada. The stable 75/25% ratio Canada enjoyed for 25 years, an average ratio for many countries, is now down to a 69.7/30.3% ratio of public to private spending. Although the literature usually attributes this to the increased use and cost of pharmaceuticals, I am interested in a good study of the increase in private hospitals and clinics, their relationship to the public sector and the services offered, in order to have a good grasp of what could well be another erosion of Medicare. (The media recently reported the existence of over 1,000 private clinics in Ontario alone!)

Some such private institutions offer expensive general health checkups to business executives; that is one thing. A number, however, offer services or perform procedures under contract for provincial ministries of health. Then the question of the basis on which they are reimbursed and of what is a fair profit margin are legitimate issues for public policy.

Again, taxpayers need to know why such a trend, where it is taking us, and what are the rules applying here. As Bob Evans said in the 1997 inaugural Emmett Hall lecture,

the extraordinary growth dynamics represented by private business cannot be reconciled with "the mutual adaptation and containment" required to sustain our public Medicare.

Supporting the federal legislation was the assumption that, in Canada, the private sector would not be able to create, equip, and sustain private hospitals, except for a very few isolated cases of no consequence. If this is no longer a valid assumption, the whole situation should be reviewed by governments—and the public informed.

Of course, public underfunding will be cited as the cause of this situation. Claude and Monique Forget wrote recently: "*The system will crack under the tensions generated by fiscal constraints*," voicing what many think.[5]

So what about the funding of Medicare today? As already mentioned, just between 1985 and 1995, the cumulative loss by the provinces of anticipated increased revenues from Ottawa amounted to some $30 billion. The 1999 federal budget has since somehow stabilized the situation by introducing an additional $11.5 billion in cash payments for health over the next five years under the *Canada Health and Social Transfer.*

Although I have yet to hear a satisfactory answer as to what the optimal funding for health care should be, in Canada or anywhere else, the fact that we have now returned to a level of total health expenditures that drops us back closer to the medium range of OECD countries' spending provides us with a standard of measurement as good as any. We have to remember that, between 1985 and 1995, Canada had increased its total health expenditures dramatically, without offering better services, or more services, or different services to the public. Canada had become, and still is, the second most expensive country in the world in terms of total health care expenditures.

There is little doubt that ten years of cuts in federal transfer payments to the provinces (and not just on health), as well as the provinces' passing on these cuts to hospitals, forced our health care system to contemplate changes at long last—changes, but not true reforms. To date, these changes have largely taken the form of downsizing and amalgamation of institutions, rather than that of systemic rationalization and integration of services.

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The Canadian public has felt the cuts very deeply because, apart from Québec with its established network of community health centres (CLSC's)—even if these have not yet really met the challenge of *le virage ambulatoire/* ambulatory care—the provinces had no alternative structures capable of managing the transition away from hospital care into lighter (and cheaper) community programs. The infrastructures needed to complement hospitals—for both primary care and home care—were simply not there when the cuts were imposed to the system.

We are still awaiting them. For example, in Ontario, contracts are being signed right now[6], after three years of studies and discussions, for five small pilot-projects called "*Primary Care Reforms*" of rostering of patients around GP's who can choose a reformed fee-for-service or capitation. The mountain gave birth to a mouse...

Is this shift in services not implemented because of underfunding? I doubt it, but again, we do not know for sure. A few years back, Doug Angus *et al.* concluded that a more efficient hospital care system, including substitution of services for home and continuing care, could save up to 15% of its budget, i.e., $7 billion for 1990 alone[7]. Where is that money? Did federal and provincial cuts amount to, underreach, or surpass this potential saving?

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Since the cuts brought simple downsizing but no true reform, is there now still room for additional savings when true reforms take place? I suspect the answer is Yes. I have to admit, however, that every responsible person familiar with our health care system with whom I talked about this when preparing for this lecture told me that some money—not big amounts, wherever it comes from (the provinces or Ottawa)—is definitely needed.

In addition to increased operational budgets, it seems that real capital investments are also urgent, and the amount of $5 billion is quoted. According to Sonnen and McCracken, annual capital spending was close to $2 billion between 1989 and 1995, with $1.2 billion for construction or renovation of structures, and the balance for machinery and equipment.[8]

Finally, there is the case of the complete spectrum of services needed for home care, long-term care, and mental health community care. If, as a hypothesis, the potential savings due to more efficient hospitals were to be redistributed toward new community primary care services, there would still be a need for new funding for home care. As of now, this still is grossly underfunded, getting between 2% and 4% of provincial health budgets.

Making our hospitals efficient will occur when best practices are adopted, when the division of labour between physicians and nurses is at long last updated, and when a mode of remuneration for physicians rewarding outcomes, and not only processes, is arrived at.

Speaking of reforms—what I set out not to do!—I find bothersome in the extreme the disconnected accountability between physicians and their global fee schedule budget, hospitals and their separate envelopes, and other health programs with their distinct budgets. Physicians, those who "call the shots," should be directly connected to, and have a responsibility for, health budgets.

It would be interesting to hear the views of health economists on proposals such as the Forgets' one of creating an internal market through small "targeted medical agencies," to provide care along the lines of the GP fundholding scheme now operational in Britain, but with important corrections reform.[9]

Conclusion

The health care system in Canada is the result of the constantly renegotiated and fragile equilibrium between three key partners: the provincial governments, the federal government, and organized medicine. None is over and above the others; none has the control of the system. Each can disrupt it seriously, yet all are needed to make it function smoothly.

On the whole, it has definitively served Canadians well. But I remain convinced that it is the citizens and their voices that "saved" Medicare in the early 1980s and forced the relative respect of the *Canada Health Act* in the years thereafter.

I want to see citizens play a key role in our health care system, other than that of better-informed patients or silent taxpayers. When I first heard of the concept of a "report card" at our meetings of the Ontario Premier's Council on Health, Well-Being and Social Justice in the early 1990s, I saw the tremendous potential it had for health. (At the time, it was being discussed with children in mind.) I started promoting the idea around 1995.

It is now clear to me that there co-exist at least three very different definitions of the concept. One could be equated with a consumers' guide about practitioners, institutions and services. The second refers to releasing objective performance measurements of the system; I believe this is what the current federal Minister of Health had in mind in his famous speech to the C.M.A. in September 1998.

Finally, instead of judging the components of the system—a major political irritant with the provinces—there is a third approach: one that would regularly report on the health status of the people of Canada. To have any validity, this last type of "report card" would have to go beyond averages and means, giving disaggregated statistical data, accounting for the most vulnerable subgroups of the population. Progress should be reported to the public on an annual or biennial basis.

Such a report card on the health of Canadians could result from grassroots action at the local level by concerned citizens, assisted by experts. It could also be the result of a more formal initiative—a National Council of Citizens, for example. Not a research institute, nor a bureaucracy, but a council made up of wise, concerned citizens, an independent body whose reports should not be "cleared by the Minister's office", one that develops credibility and clout, and tells it the way it is.

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Innovative work is required from those who have reflected on current issues of governance, especially on an appointment mechanism. Who the individual members will be and how they are chosen are key ingredients of success and integrity. Federal-provincial ownership must be completely by-passed; this political reality is not the council's mandate. Whether the council should report directly to Parliament through the Minister of Health as well as to the Conference of Provincial/Territorial Ministers, or whether different lines of reporting should be the best and most significant accountability to Canadians, is another key question.

Such an initiative would be challenging, controversial, difficult to design and implement—but it would give voice to the power of the weak.

Endnotes

1 Liberty Health.

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3 Margaret A. Somerville, ed., *Do We Care? Renewing Canada's Commitment to Health*, McGill-Queen's University Press, Montreal, Kingston, 1999, p. 97

4 The *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1967).

5 Claude E. Forget and Monique Jérôme-Forget, *Who Is in Charge? A Blueprint for Canada Health Care Reform*, Institute for Research on Public Policy, Montreal, 1998, 152 p.

6 In Hamilton, Chatham, Paris, the area around Kingston, and in a site being selected to replace Wawa.

7 Douglas E. Angus, Ludwig Auer, J. Eden Cloutier and Terry Albert, *Sustainable Health Care for Canada*, Queen's-University of Ottawa, 1995, 146 p.

8 Carl Sonnen and Mike McCracken, "Downsizing, passive privatization and fiscal arrangements" in Daniel Drache and Terry Sullivan, Eds., *Health Reform: Public Success, Private Failure*, Routlegde, London and New York, 1999, p. 234.

9 Op. Cit.