

CALEDON



INSTITUTE OF
SOCIAL POLICY

The Federal Government Can and Should Lead the Renewal of Canada's Health Policy

by

Michael M. Rachlis, MD, MSc, FRCPC

February 2003

The Federal Government Can and Should Lead the Renewal of Canada's Health Policy

by

Michael M. Rachlis, MD, MSc, FRCPC

February 2003

The Caledon Institute of Social Policy occasionally publishes reports and commentaries written by outside experts. The views expressed in this paper are those of the author.

Copyright © 2003 by The Caledon Institute of Social Policy

ISBN 1-55382-038-X

Published by:

The Caledon Institute of Social Policy
1600 Scott Street, Suite 620
Ottawa, Ontario, Canada
K1Y 4N7
Phone: (613) 729-3340
Fax: (613) 729-3896
E-mail: caledon@caledoninst.org
Website: www.caledoninst.org

Caledon publications are available from:

Renouf Publishing Company Limited
5369 Canotek Road
Ottawa, Ontario
K1J 9J3
Phone: (613) 745-2665
Fax: (613) 745-7660

Table of Contents

<i>Executive Summary</i>	1
<i>Introduction</i>	7
<i>The Romanow Commission: cautious steps in the right direction</i>	7
<i>The report does have some problems</i>	10
<i>A vision for a future health policy</i>	14
<i>The federal government has the financial capability to finance new programs</i>	16
<i>The health care system's problems can be diagnosed and treated</i>	17
<i>Money is not the main issue</i>	18
<i>PFI to P3s: Perfidious Financial Idiocy to Public Private Pickle</i>	22
<i>Conclusions about for-profit health care</i>	23
<i>Concerns about public health infrastructure and services</i>	23
<i>We can fix Medicare with innovation</i>	27
<i>Options for the federal government for a new health policy</i>	42
<i>Option 1: Federalism lite - a little bit more than more of the same</i>	42
<i>Option 2: Federalism per Romanow</i>	44
<i>Option 3: Federalism plus - leadership to protect Medicare and change the delivery system</i>	45
<i>Conclusion</i>	54
<i>Endnotes</i>	55

Executive Summary

Roy Romanow recently released his Commission's report of the future of health care in Canada. He recommended a modest program to start the renewal of Medicare. However, the federal government could go further to rejuvenate Canada's health care system. This paper first reviews Mr. Romanow's report, then outlines a vision for the federal government to forge a new health policy for the country, and finally concludes with a review of three options for a renewal of Canada's health policy.

The Romanow Commission: cautious steps in the right direction

Mr. Romanow's report has been praised as a blueprint for Medicare's salvation and vilified as an ideological defense of a faltering status quo. However, closer examination reveals it as simply a few cautious steps in the right direction. The report concludes that the house of Medicare has sheltered Canadians well. He claims that our dwelling is still on firm foundations after nearly 50 years and, therefore, needs renovation not demolition.

Mr. Romanow recommends a series of targeted funds over two years where there would be strict accountability for expenditures. The federal funding would be sequestered into a new Canadian Health Transfer to clearly separate health care funding from transfers for social services and postsecondary education.

The Commission report does have some problems. There is no mention of long term. The report hardly mentions public health. The proposed home care and pharmacare programs are less comprehensive than those recommended by the National Forum on Health five years ago.

The report also lacks an overall vision of the health care system. However, Mr. Romanow's small, pragmatic steps might be effective because they will be hard to resist. Because there is no overall blueprint, the report will not collapse completely if only some recommendations are implemented.

A vision for a future health policy

Under the original Canadian constitution, the British North America Act, the provinces were granted the constitutional authority for the regulation of hospitals and health professionals. However, the BNA Act granted considerable legitimacy for federal involvement in public health at that time primarily characterized by quarantine. The federal government has the constitutional responsibility for health care for Aboriginals on reserves. It also has, according to the provinces, a constitutional responsibility for off reserve Aboriginals. Again according to some provinces, the federal government should have the financial responsibility for the care of refugees, new immigrants, and official

language minorities. The federal government has a particularly strong claim for leadership if it is prepared to spend more money.

The federal government has the financial capability to finance new programs

Most Canadians want the federal government to implement the recommendations of the Romanow Commission with leadership and cash. Federal Finance Minister John Manley has claimed that the cupboards are bare and that the federal government only has a \$4 billion surplus for 2002-03. However, this figure is not credible. Without new spending initiatives, the federal government will have at least a \$9 billion surplus in 2002-03 and a \$15 billion surplus in 2003-04.

Furthermore, the federal government is not 'out of control.' The federal government's budget expenditures amounted to 15 percent of Canada's Gross Domestic Product (GDP) in 2001-02, representing the lowest share of GDP spent by the federal government in over 50 years.

The health care system's problems can be diagnosed and treated

There has been a reasonably consistent message from the various commissions and inquiries of the past 30 years. Unfortunately, the politics of the health care system have doomed many potentially useful reforms.

Money isn't the main issue

It is often stated simultaneously that 'health costs are spiralling out of control' and that 'our health care system is dangerously underfunded.' Both claims cannot be true and, in fact, neither is. It is true that government's costs have increased in the last five years, but this followed five years of restraint. Canada actually spends less of its GDP on health care now than it did in 1992. On the other hand, Canada has not starved its health care system overall either. During the past ten years, at a time when other public budgets have been slashed, government funding for health has increased by 20 percent per capita. According to the OECD, in 1999 only 4 out of 29 countries spent more of their GDP on health than Canada.

The real problem with Medicare is that it was designed for another time

When we first started debating Medicare over 80 years ago, most health problems were acute illnesses, like tuberculosis and accidents and injuries. However, now most health problems are chronic illnesses like heart disease, cancer and diabetes. Our system manages chronic illness poorly. As a result, thousands of Canadians die every year and tens of thousands are hospitalized because of complications from their chronic illnesses.

For-profit clinical services are overall of poorer quality and more expensive

In general, for-profit services cost more and provide poorer quality care. Public-Private Partnerships (P3s) cost more money than if the public sector went it alone. Permitting for-profit providers to enter a new sector or allowing the growth of for-profit providers means that it will be more difficult for Canada to maintain that health care is a public service under international trade agreements. The for-profit sector is, to say the least, not likely to be Medicare's saviour.

Public health services are under tremendous pressure

Public health is a victim of its own success. The elimination of the epidemics of infectious disease, which plagued Canadians up until the mid-twentieth century, has blinded Canadians to new threats including new infectious diseases such as West Nile. The Krever Commission and other reports have painted a bleak picture of Canada's public health system. Canada needs a rejuvenated public health system to deal with infectious diseases, chronic illnesses, environmental threats and bioterrorism as well as to provide key management support for the health care system.

We can fix Medicare with innovation

Fortunately, there are examples from all over the country that demonstrate that we can fix the health care system's apparently intractable problems.

- Emergency Room and hospital crowding can be prevented through comprehensive influenza management, providing home care and long-term care to the many hospital patients who don't need acute care, and by keeping people healthy in the community.
- Despite the many difficulties that Canadians do have accessing doctors, we actually have more doctors than ever before. Under the current system of payment and practice organization, doctors are richly rewarded for running revolving door style practices and penalized for providing comprehensive care. Several examples demonstrate that group practice and interdisciplinary teams can dramatically improve access.
- Prescription drugs have been the fastest growing cost sector since 1975. While patents have lengthened in the past 15 years, extended patent protection is not the major cause of escalating drug costs. Most of the increase in pharmaceutical expenditures is related to poor quality prescribing encouraged by drug company marketing to doctors. Drug costs can be moderated through the better use of non-pharmacological therapies, improving the quality of prescribing, especially integrating pharmacists into interdisciplinary teams, and reducing the costs of

medications dispensed through formularies and therapeutic equivalence programs.

- Canadians tend to wait too long for some services. However, there are a few situations where a limit of resources forces long delays. Most waits and delays can be alleviated through system redesign. For example, Sault Ste. Marie was able to reduce wait times from mammogram to breast cancer surgery from 107 to 18 days.

Options for the federal government for a new health policy

Option 1: Federalism lite – \$5 billion plus per year - no strings

- This is the option that is being demanded by Quebec, Ontario, Alberta and British Columbia. These provinces would welcome such an option while the other six provinces are unlikely to object.
- This option would do little to protect Medicare from erosion of public finance or incursions from for-profit care.
- In September 2000, the federal government attempted to tie its new spending, but the provinces forced it to provide most of the money in untargeted grants. But, the provinces paid a big price for their 'win' over the federal government. Because the money wasn't targeted, doctors, nurses and other health workers almost immediately strong-armed their provinces for large (albeit overdue) pay increases to do the same work as before. New untargeted money would likely do little to improve the system's efficiency or effectiveness.
- Untargeted federal funding is unlikely to have much impact on Canada's health. Most money would go to increased compensation.

Option 2: Federalism per Romanow

- Quebec, Ontario and Alberta oppose this option. BC and some other provinces also have reservations. However, the Ontario and Quebec governments are not politically popular and will fight elections this year. The Romanow financial recommendations do not substantially intrude upon provincial jurisdiction, whatever their symbolism. Furthermore, they are popular with the electorates in Ontario and Quebec. It is unlikely that the provinces that are opposed would be able to successfully fight the federal government's attempt to implement Romanow. However, there would be more conflict with this option than option one.

- More federal money would increase the federal government's political clout to enforce the Canada Health Act and Romanow did make two recommendations, which would rein in some types of for-profit care.
- Romanow's recommendations provide some targetting to parts of the system which most need new funding. Option two would therefore, improve effectiveness and efficiency better than option one.
- Because option two would result in more effective and efficient health care than option one, it would better improve the health of Canadians. However, because there is little focus on public health, this improvement would likely be quite marginal.

Option 3: Federalism plus – leadership to facilitate system change and money for full public coverage for home care, pharmacare and long-term care

- There would be more stress on federal/provincial/territorial relations with option three than with the other options. Quebec, Ontario and Alberta would oppose this option fairly strongly. Several of the smaller provinces would be interested but, except for Saskatchewan, might have problems saying so loudly. However, Quebec's opposition might be blunted because the province would be eligible for much of the money without substantial policy change. Ontario might well accept this option if there were a change in government. BC already has some of the best coverage and so could use much of the new money for other purposes. In general, Canadians would be very supportive of this option because it is most congruent with their aspirations for a more effective and efficient health care system.
- The increase in federal funding would increase the federal government's political clout to enforce the Canada Health Act. If this option included Romanow's suggestions, which would indirectly limit the growth of some types of for-profit care, then there would be reasonable protection of public finance and non-profit delivery.
- Option three would greatly improve the effectiveness and efficiency of health care delivery beyond option two. It would establish more efficient vehicles for delivering community programs. It would also establish a Modernization Agency to spread best practices and continuous quality improvement throughout the system.
- Option three would considerably improve the health and well-being of Canadians through enhancement of public health services, the better

management of chronic illness, and the faster flow of patients through the system.

Conclusion

We have a unique opportunity to rejuvenate Canada's health policy and our country. It is crucial that the federal government take action quickly to build on the Romanow report and go much further. In the past five years, the federal government has used its improved financial situation largely to pay down the debt and cut taxes. The choice is clear. Will the Liberal government cut taxes further or will it fulfill the promises it made in the last three election campaigns?

Introduction

Roy Romanow recently released his Commission's report on the future of health care in Canada. He has recommended a modest program to start the renewal of Medicare. However, the federal government could go further to rejuvenate Canada's health care system. This paper first reviews Mr. Romanow's report, then outlines a vision for the federal government to forge a new health policy for the country, and finally concludes with a review of three options for renewal of Canada's health policy.

The Romanow Commission: cautious steps in the right direction

Mr. Romanow's report has been praised as a blueprint for Medicare's salvation and vilified as an ideological defense of a faltering status quo. However, closer examination reveals it as simply a few cautious steps in the right direction. This section briefly reviews the report's contents, diagnoses its strengths and weaknesses, and then offers a prognosis for its future.

Mr. Romanow claims he clearly heard that Canadians still strongly hold the values that health care should be paid for according to the ability to pay and received according to one's needs for services. He recommends a health care covenant, which would enshrine these values and others into a mission statement for the health care system. The covenant would spell out the rights and entitlements of individual Canadians, providers and governments. The direct impact of such a covenant would be slight. However, it would reinforce the notion that the health care system is an important symbol of Canadian citizenship.

The report concludes that the house of Medicare has sheltered Canadians well. It claims that our dwelling is still on firm foundations after nearly 50 years and, therefore, needs renovation not demolition. The report maintains that Medicare is as sustainable as we wish it to be. It report points out that publicly financed care is more efficient than private finance. These conclusions have been strongly supported by almost all other commissions and inquiries in the past 40 years.

Mr. Romanow notes that our health care system is too focussed on doctors, hospitals and treatment – and not enough on community care and prevention. He also notes that other federal and provincial inquiries have reached similar conclusions, though it has been difficult for the provinces to make the needed reforms. In September 2000, the federal government tried to target its increases in health spending to these priorities but the provinces forced Ottawa to provide most of the money in untargeted grants. As a result, the provinces were pushed by their doctors, nurses and other health workers to pay out large (albeit often overdue) increases to do the same work the same way as before.

Even the targeted funds for high technology and primary health care turned out not to be on very tight strings. As result, despite the injection of \$23 billion over five

years, within months of the deal being signed the provinces were complaining that the federal government was not paying its fair share.

Mr. Romanow saw this phenomenon up close as Premier of Saskatchewan and now recommends that the federal government not make the same mistake again. He has recommended a series of targeted funds over two years where there would be strict accountability for expenditures. These include a rural and remote access fund (\$1.5 billion over two years), a diagnostic services fund (\$1.5 billion over two years), a primary health care transfer (\$2.5 billion over two years), a transfer for a limited home care program (\$2 billion over two years), and a catastrophic drug transfer (\$1 billion beginning in 2004-05). These total \$3.5 billion in 2003-04 and \$5 billion in 2004-05. He further recommends that the federal government raise the total transfer to \$6.5 billion in 2005-06 and then grow it at a pace slightly greater than GDP growth thereafter in a series of five-year plans. The federal funding would be sequestered into a new Canadian Health Transfer to clearly separate health care funding from transfers for social services and postsecondary education.

Mr. Romanow recommends federal support for an electronic medical record. Governments have expended large sums of money on this item in the past 10 years, with little to show for their efforts. However, the capability of new technology to improve the management of health services is enormous.

The Commission recommends a new technology assessment body combining the existing Canadian Institute for Health Information (CIHI) and the Canadian Coordinating Council on Health Technology Assessment.

The report suggests that the federal Department of Human Resources Development provide support to family and other informal caregivers through changes in Employment Insurance. There are no details specified for this recommendation.

Better pharmaceutical policy

The report recommends the establishment of a National Drug Agency, which would consolidate all drug approvals and monitoring. It also recommends the establishment of a National Formulary so that decisions about coverage would not be made on a province-by-province basis. The drug companies have been whipsawing the provinces by blitzing one province to get a new drug on its formulary and then mobilizing consumer groups in others to demand equal coverage.

The report recommends the federal government review the law concerning patent protection. At present, the brand-name companies use a series of legal ploys to extend patent protection artificially after the 20 year limit now in place. For example, once a generic company files notice to have its drug listed, the brand-name company files suit for patent infringement and simultaneously seeks an injunction blocking the generic from the market during the period of litigation. However, in other patent infringement suits,

injunctions are rarely granted. Instead a plaintiff recovers costs due to patent infringement only if its litigation is successful. Brand-name companies also have begun to file patents relating to specific manufacturing techniques just before the patent for that particular drug is about to expire. Mr. Romanow refers to these legal tricks as “evergreening.”

A national immunization strategy

The Report recommends a national immunization strategy. Canada is the only developed country with sub-national immunization schedules. The provinces currently decide upon their own immunization schedules. Some provinces are covering new vaccines for diseases like chickenpox, while others are not. Vaccines are not purchased at the national level, despite the opportunities for bulk purchasing to decrease overall costs. The proposed national strategy would include a countrywide immunization schedule and national purchasing.

Obstacles to for-profit care

Initial reports claimed that Mr. Romanow had recommended elimination of for-profit providers of care. In fact, Mr. Romanow has been careful to clarify that he did not recommend such a federal government intrusion into what he regards as provincial jurisdiction. However, he did expound at length in his report and his public statements on his concerns about health care for profit.

Mr. Romanow did make two recommendations that would somewhat impede profit-seeking businesses getting into health care. First, he suggests that diagnostic services such as MRI and CAT scans be explicitly identified as medically necessary under the Canada Health Act. This measure would thwart the plans of Ontario and some other provinces to allow for-profit operators to sell some of their scans at market prices while having their base expenses covered by public patients. Second, Mr. Romanow recommends that the federal government close a major loophole in the Canada Health Act, which allows Workers Compensation Boards to buy services outside of Medicare. For-profit surgical clinics depend upon contracts with these boards for the majority of their income and likely would struggle without them.

Keeping our health system Canadian

In his final chapter, Mr. Romanow recommends that the federal government move to protect Canada’s health system in international trade agreements. Mr. Romanow concludes that no one really knows the full implications for our health care system of NAFTA, GATS and other international agreements to which Canada is a signatory. The report concludes that Canada’s governments should take every opportunity to protect

health care in international agreements and continue to act as though health services are “...designed, financed, and organized in a way that reflects Canadians’ values.”

Attention to specific problem areas

The report pays considerable attention to the issues of Aboriginal health and access for remote and rural communities. The report notes that Aboriginal peoples have much poorer health status and access to health care services than do other Canadians. It notes the need for a comprehensive approach to Aboriginal issues. It recommends that all present funding for Aboriginal peoples’ health be pooled into one fund to facilitate the redesign of services. This suggestion offends some Aboriginal peoples, who believe that the crown should have perpetual responsibility for paying for the ‘medicine chest,’ which would include all health care. On the other hand, the change would provide an opportunity for many Aboriginal communities to use resources more effectively. At present over \$400 million is spent on transportation and pharmaceutical services. Much of the former could be recouped with better services in communities and much of the latter could be reallocated by dealing directly with drug addiction and substance abuse.

The report strongly supports better health care services in rural areas. It calls for new models of care to be developed, but does not define details and gives no examples.

The report also recommends that governments and providers work together to improve services to official language minorities, although there are no specific details to support this recommendation.

The report does have some problems

Mr. Romanow’s report does have some problems.

It recommends the creation of a Canadian Health Council which would have an extensive mandate including monitoring the system and its outcomes, assessing new technologies, making recommendations for its improvement, and facilitating public involvement. These are all essential management functions for a health care system to fulfill.

Other countries have established institutions, which deal with these issues. For example, the UK’s National Health Service has a quality assurance branch (the Commission on Health Improvement) and a separate one for continuous quality improvement (the Modernization Agency). In the US, the federal government inspects all nursing homes that receive federal funding (95 percent-plus of all nursing homes). But the states are responsible for most nursing payments.

Canada has not developed these key institutions, primarily because of our all too dysfunctional federation. The reaction by many, including Romanow, has been to give all these key tasks to one organization. However, the recommendation to give all these

responsibilities to one agency is fundamentally flawed because some of these mandates are in conflict with each other.

For example, the proposed Council would assess and, therefore, pass judgement on the system. And, at the same time it is supposed to be working in a collegial fashion to facilitate continuous quality improvement (CQI). However, organizations with police or judge functions will not be seen as friendly, informed colleagues for CQI activities. Attempts by the Colleges of Physicians and Surgeons at CQI have not been as well received as they might have been because the Colleges' main mandates are protection of the public through physician licensure.

It would be better to itemize the tasks to be performed and then allocate them to the best possible organizations (new or redesigned) that could be created within the current federal/provincial/territorial political reality.

Decreases in coverage for out-of-country care

Mr. Romanow recommends the elimination of the part of the Canada Health Act portability criterion that requires provincial health plans to pay for out-of-country care at the same rate that pertains within the home province. This criterion is being broken now by several provinces. Ontario started the erosion of this criterion in the early 1990s when it limited coverage to \$400 and then \$100 per day. Other provinces have fallen in step, while the federal government has winked at the practice. However, even if this measure sounds reasonable, it is unfair, unnecessary and damaging to the very values that Mr. Romanow espouses.

The recommendation is unfair because it penalizes people who get sick while travelling despite few illnesses being due to travel *per se*. Over 80 percent of hospitalizations are for emergencies or are related to pregnancy. Given that these people would have likely fallen ill in Canada in any event; given that they might, in fact, have reduced their risk of illness (especially due to falls on icy streets) by travelling; and given that the liability for the provincial health plan is no higher when the person is out of country; it is unfair to deny Canadians portability of their health plan in another country. Even with this criterion in place, most Canadians would want supplementary coverage because of the difference between Canadian and American health care costs, but basic out-of-country care could make the difference between an uncomfortable bill and bankruptcy.

The recommendation is unnecessary because the cost of out-of-country care is less than 0.25 percent of provincial health plans.¹ The cost to maintain this criterion is one dollar out of every 400 spent on health care.

The recommendation is damaging because it attacks the very value of solidarity upon which Medicare is based. Many Canadians travel south, but only some get sick. As with Medicare, why not pool our resources to pay for the few who will require care?

Long-term care goes missing

There is no mention of long-term care despite the fact that this sector amounts to roughly 10 percent of overall health care costs. There are important issues in this area. For example, the Ontario auditor recently reported that the province lacked standards of care for nursing homes and some homes lacked licenses.² The connections between long-term care, home care and acute care are crucial for a properly functioning system.

Public health

The report hardly mentions public health. It does note that there should be more prevention in primary health care settings. But this suggestion seems to be limited to individual lifestyle counseling on diet, exercise and smoking. The introduction to the report does refer to the need to act on the so-called “determinants of health.” The report suggests that the federal government invest more in “...public housing, a clean environment, and education...”

Starting with Marc Lalonde’s *Report on the Health of Canadians* released in 1974, there has been an ebb and flow of notions of how to best pursue ‘Population Health.’ The discussion and debate have at times been all consuming for persons concerned with health policy. Several commissions and task forces have recommended broad health status goals to drive overall policy making. Most provinces did establish Premiers’ councils on health, which attempted to improve policy coordination, but almost all have disappeared with little in the way of policy legacies.

The Commission could have said more about governmental coordination of social policy and the linkage of social policy to economic policy. The Commission also could have made some recommendations on the mechanisms by which the health care system could most productively interact with other sectors to best promote population health. This document will have more to say about this issue in a later section.

The report is also silent on the crumbling public health infrastructure, the threats from new diseases such as West Nile Virus, and the security threats of bioterrorism.

Lack of a comprehensive strategy to deal with waiting lists

The report does mention that there is little monitoring of waiting lists and, therefore, little hard information on the extent of problems. It does recommend more centralization and active management of waiting lists. However, the report could have been better at clarifying how mismanagement as opposed to lack of resources creates delays. Most experts who study waiting list issues (and there are very few in Canada) identify system redesign as the key breakthrough factor for permanent sustainable solutions to waits and delays. For example, a five-minute phone call between a family

doctor and a specialist might easily save 55 minutes of a consultant's time and three months of delay for the patient.

The report could have gone much further in recommending specific new institutions to facilitate action on waits and delays. Saskatchewan has very recently created a Quality Council, which features as members two of the world's leading experts on system redesign. But the report subsumes this function under the proposed new Health Council. And the report could have gone farther to recommend concrete strategies and tactics that can facilitate access and reduce wait times. This issue is discussed further in a later section.

The proposed home care and pharmacare programs are less comprehensive than those recommended by the National Forum on Health five years ago.

The National Forum on Health recommended full public coverage for necessary home care and pharmaceuticals. However, the Commission recommended that home care coverage initially be restricted to serious mental illness, post-hospital care (14 days at home or 28 days for rehabilitation) and palliative care (if a doctor says the person has less than six months to live).

Somewhat perversely, the proposal for post-acute home care would not cover patients (except mental health patients) who are diverted from hospital by home care. Many communities now have quick response teams, which can mobilize community resources and then send appropriate patients directly home from the ER with home care services. Increasingly, patients can have these 'quick response' services organized after a home visit. Neither of these patient groups would be covered by the Commission's recommendation.

The Commission's recommendations would only cover professional services. It would not cover non-professional services such as personal care (e.g., help with eating, going to the bathroom, etc.) or home support (e.g., housekeeping). However, these services have been shown to be extremely important for frail and elderly clients, in particular. They can dramatically reduce institutionalization by maintaining function and providing some monitoring for at-risk persons.³

The requirement that palliative care patients have only six months left to live is arbitrary and unnecessary. Furthermore, many patients can benefit from better symptom control with palliative care services during active cancer treatment. The vast majority of palliative care patients are referred too late now because many physicians fear that their patients will see palliative care a death sentence. There would be very few excess costs associated with elimination of any time limit. In fact, because palliative care often results in less costly care, eliminating arbitrary times and helping to facilitate referrals might well save overall resources.

The pharmacare recommendations would provide welcome relief for Canadians who lack catastrophic drug coverage. However, the proposed \$1,500 deductible means that few Canadians would see any benefits and those that did might well face some hardship before public coverage picked up the bills. The report rejects mixed funding for hospitals and physicians, noting it raises administrative costs. However, it passes no comment on the capacity of public drug coverage to lower administrative costs in this area. The report also misses the many advantages that could flow from integrating planning for pharmaceuticals with overall health planning. Catastrophic coverage limits government's role to that of passive third party payer.

There is no overall vision of the health care system.

Perhaps understandably, since this is a Royal Commission report, there is a considerable focus on governance, less so on health care administration, and even less on health care delivery where patients meet providers. Like other reviews of health care, the Commission says delivery must be changed, although there are few details of what an excellent delivery system would look like or feel like. However, Mr. Romanow's small, pragmatic steps might be effective because they will be hard to resist. And, because there is no overall blueprint, the report will not collapse completely if only some recommendations are implemented.

Cautious steps forward

The Romanow Report is a step forward for Canadians. It recommends that the federal government affirm its commitment to the Canada Health Act and substantially increase its financial commitments for health care. It recommends that the federal government use its new money to buy change, not the *status quo*. It recommends extending Medicare for some home care and pharmaceutical services.

The next section of this paper starts to fill in the vision for a broader health policy, which Mr. Romanow did not articulate.

A vision for a future health policy

Under the original Canadian constitution, the British North America Act, the provinces were granted the constitutional authority for the regulation of hospitals and health professionals. However, the BNA Act granted considerable legitimacy for federal involvement in public health at that time, primarily characterized by quarantine. The situation became more complicated after the Second World War when the federal government used its financial resources to help finance hospitals and ensure that the provinces provided first dollar coverage for hospitals and doctors. Justice Willard Estey commented.⁴

“Health is not a subject specifically dealt with in the Constitution Act either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority. Legislation dealing with health matters has been found within the provincial power where the approach in the legislation is to an aspect of health, local in nature. On the other hand, federal legislation in relation to “health” can be supported where the dimension of the problem is national rather than local in nature...or where the health concern arises in the context of a public wrong and the response is criminal prohibition...In sum, “health” is not a matter which is subject to a specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case upon the nature of scope of the health problem in question.”

Justice Estey reminds us that, notwithstanding provincial complaining, the federal government does have a constitutional responsibility for certain health matters. In particular, the federal government has the major responsibility for public health. Infectious diseases and environmental threats do not respect provincial borders. The threats of bioterrorism have highlighted that health can also be a threat to national security, which is a clear federal responsibility.

The federal government has the constitutional responsibility for health care for Aboriginals on reserves. It also has, according to the provinces, a constitutional responsibility for off-reserve Aboriginals. Again, according to some provinces, the federal government should have the financial responsibility for the care of refugees, new immigrants and official language minorities.

The federal government has a particularly strong claim for leadership if it is prepared to spend more money. Financial transfers played the key role in developing Canada’s health care system starting with the federal Health Grants program of 1948, and then continuing through the Hospital Insurance and Diagnostic Services Act of 1957, the Medical Care Act of 1966, and the not insignificant health funding under the 1966 Canada Assistance Plan. Finally, new dollars enabled the federal government to develop the Health Transition Funds of 1997 and 2000.

The second part of this paper develops an option for the federal government to use its constitutional and political legitimacy to work with the provinces to forge a new health policy for the country.

In brief, the argument is:

1. The federal government has the constitutional and political legitimacy to lead a renewal of Canada’s health policy.
2. The federal government has the financial capability to finance new programs.

3. The health care system's problem can be diagnosed and treated.
4. Options are available for the federal government for a new health policy on the basis of its constitutional responsibilities, its fiscal position, the values of Canadians and the relevant evidence.

Having made the first point, this document will proceed to delineate the others.

The federal government has the financial capability to finance new programs

Most Canadians want the federal government to implement the recommendations of the Romanow Commission with leadership and cash. Canadians also want the federal government to act on other priorities, including child poverty. However, Finance Minister John Manley claims the cupboards are bare. The Alliance warns that we must cut taxes and admonishes the Liberals for letting government grow out of control. But are the federal coffers really empty? Is the federal government really such a profligate spender? A closer examination reveals that Ottawa has the financial capability to pay for all of Mr. Romanow's recommendations, and more.

At the end of October, Finance Minister Manley claimed that the federal government's surplus would be only \$1 billion for fiscal year 2002-03, excluding \$3 billion for 'contingencies.' However, this figure is not credible. Consider the following facts. The federal government had a surplus of \$8.9 billion in fiscal 2001-02. The new expenditures and tax cuts planned for this year are limited and will be partly offset by the collection of tax revenues, which were deferred last year. The economy is predicted to grow by at least 3 percent this year, which is worth over \$7 billion to the federal treasury. Without new spending initiatives, the federal government will have at least a \$9 billion surplus in 2002-03 and a \$15 billion surplus in 2003-04. There is easily enough room to afford Mr. Romanow's recommendation for \$3.5 billion in 2002-03 and \$5 billion in 2003-04.

Jim Stanford, an economist with the Canadian Auto Workers, published a report for the Canadian Centre for Policy Alternatives the day before Mr. Manley's financial statement.⁵ He predicted a \$10 billion surplus for 2002-03 and \$17 billion by 2003-04. Mr. Stanford and his colleagues in the *Alternative Federal Budget* project have proven themselves to be far more accurate than the federal Department of Finance.

In the last three fiscal years, the Department of Finance has predicted small surpluses and strongly counseled Canadians not to expect more federal spending. The Department of Finance has predicted \$7.5 billion in collective surpluses for the last three budgets, while Mr. Stanford and his colleagues have predicted \$40 billion. The actual figure was \$39.7 billion.

Why have the department of finance officials been so wildly inaccurate in their

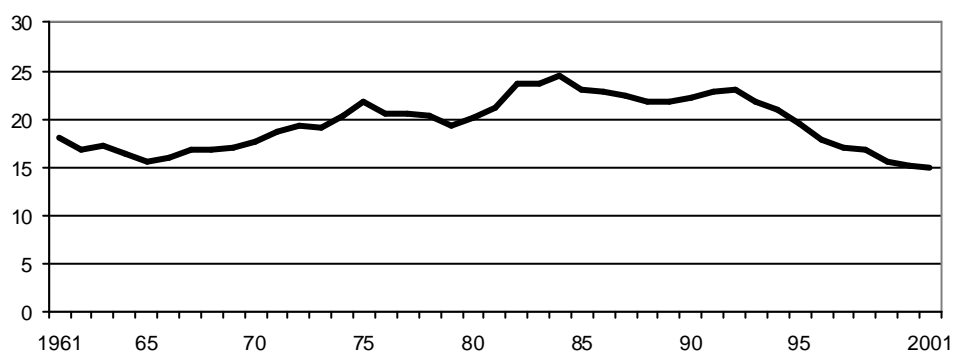
reports to Canadians? Is it possible that they are purposely trying to dull our demand for government spending?

As shown in Figure 1, the federal government's budget expenditures amounted to 15 percent of Canada's Gross Domestic Product (GDP) in 2001-02. This represents the lowest share of GDP spent by the federal government in over 50 years. Since 1961, the federal government's budget expenditures have averaged 19.6 percent of GDP and during the Conservative government's years, they averaged 22.4 percent. The current government's real legacy thus far is to have slashed the federal government by one-third.

Of course, the federal government has offloaded some of its responsibilities to the provinces. But the provinces are not suffering unduly either. Total provincial and territorial spending has fallen to 17.6 percent of GDP from an average of 20.4 percent during the life of the previous Conservative government. Clearly, Canadian governments have the capacity to finance reforms to our health care system as well as other needed government goods and services.

Figure 1
Federal government budget
expenditures as percentage of GDP

Source: Federal Department of Finance⁶



The health care system's problems can be diagnosed and treated

Sometimes it can appear that the health system's problems are beyond diagnosis and, even if they could be diagnosed, that there are no effective remedies. However, there is a reasonably consistent message from the various commissions and inquiries of the past 30 years. Unfortunately, the politics of the health care system have doomed many potentially useful reforms. The Ontario Health Review Panel,⁷ Ontario's major

inquiry of the 1980s, noted:

“There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention. The panel notes with concern that well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action.”

Almost all commissions have supported public finance and argued for similar changes in the delivery system. However, as the Ontario Review Panel noted these recommendations are, by and large, still waiting to be implemented. This section argues:

1. While the federal government must spend cash to lead reform, money is not the key issue.
2. For-profit care is likely to make things worse.
3. Public health should be the major priority for the federal government.
4. Innovation will be Medicare’s true savior.

Money is not the main issue

It is often stated simultaneously that “health costs are spiraling out of control” and that “our health care system is dangerously underfunded.” Both claims cannot be true and, in fact, neither is.

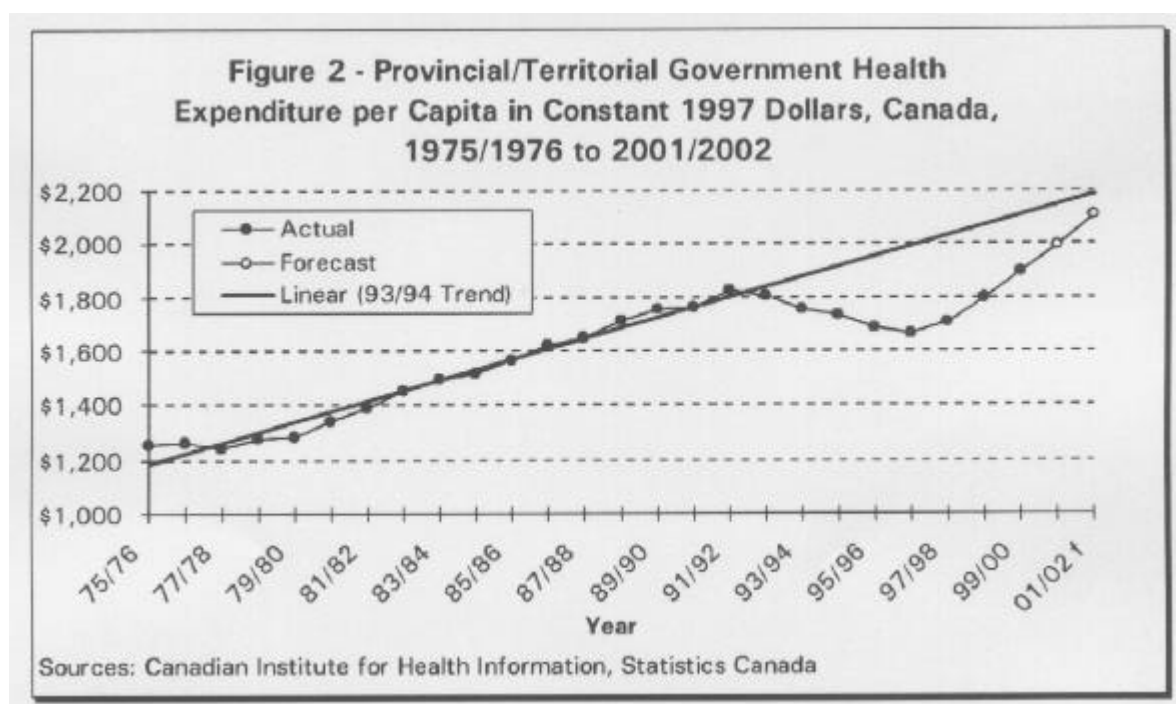
First, costs are not out of control. It is true that government's costs have increased in the last five years, but this followed five years of restraint. Canada actually spends less of its GDP on health care now than it did in 1992. And, health care costs in Canada appear to be under better control than those of our major trading partner, the United States. It is forecast that the difference between the two countries for 2001 (9.7 percent of GDP in Canada and 14.0 percent in the US) will be larger than ever.⁸

On the other hand, Canada has not starved its health care system overall either. During the past 10 years, at a time when other public budgets have been slashed, government funding for health has increased by 20 percent per capita. Figure 2 shows that provincial government health care spending per capita is nearly back on the 20 year plus trend line from which we departed in 1994. Up until that time, health care costs were increasing at roughly 2.5 percent annually per capita in real terms (compounded). In an unprecedented decline, government health care costs decreased by 10 percent from

1993-94 to 1997-98. However, in the past five years, governments have played catch-up and their costs have increased by over 25 percent. Furthermore, according to the most recent OECD information, which uses 1999 data, only 4 out of 29 countries spent more of their GDP on health care than Canada.⁹ Our health care system does need some new money for certain goods and services (e.g., MRI scanners and home care nurses) and to re-establish federal leadership for health policy. But just because parts of the health system do need more funding does not mean that the whole system is grossly underfunded.

The real problem with Medicare is that it was designed for another time

When we first started debating Medicare over 80 years ago, most health problems were acute illnesses, like tuberculosis, diphtheria, and accidents and injuries. However, now most health problems are chronic illnesses like heart disease, cancer and diabetes. Our health care system copes relatively well with acute illness and Canadian outcomes after heart attacks¹⁰ and car accidents¹¹ compare favorably with anywhere else in the world. But our system does poorly with chronic illness. For example, studies have shown that more Americans with high blood pressure have their blood pressure properly controlled¹² and more American women are screened regularly for breast cancer.¹³ Typically fewer than 40 percent of persons with chronic illnesses are even taking the correct medication.^{14,15} As a result, thousands of Canadians die every year and tens of thousands are hospitalized from heart attacks, strokes, kidney failure and other complications from their chronic illnesses.¹⁶



At the beginning of Medicare almost all care for complicated conditions was provided in hospitals. Patients were often admitted to hospital for ‘investigations,’ a rarity today. As a result, what was once provided under one roof is provided under many. Patients frequently find that it takes them months to get all their tests and see the right specialists.

For-profit clinical services are overall of poorer quality and more expensive

Depending on the exact wording of the survey, approximately two-thirds of Canadians are opposed to so-called two-tier medicine in which the wealthy pay privately to jump queues in the public system for doctors and hospital care.¹⁷ The current public/private debate is increasingly focussed on the extent of public coverage (especially home care and pharmacare) and whether governments and health authorities should contract out their publicly funded clinical services to for-profit corporations. During the 1980s and 1990s, hospitals contracted out non-clinical services (e.g., laundry and food) as well as laboratory services. There was very little evaluation of these policies. It is only in the past five years that there has been a major thrust to contract out surgical and other clinical services. Some claim that if the public pays it does not matter who delivers the service, but others claim that profit is incompatible with care.

The evidence

In May 2002, a group led from McMaster University reviewed all the individual studies that compared the mortality rates of for-profit and non-profit hospitals.¹⁸ The group found 15 studies that met their rigorous requirements. There were 14 studies of adults, which included over 36 million patients, and one maternity study, which included over 1.6 million births. Adults had 2 percent higher death rates in for-profit hospitals, while the infant mortality rate was 10 percent higher. The investigators estimated that, applying these results to Canada, if all hospitals were converted to for-profit status there would be an additional 2,200 deaths per year. This is higher than the numbers who die every year from suicide, colon cancer or car accidents. The for-profits tended to have fewer staff and less well trained staff. These factors have been found to be associated with higher death rates in other studies of the quality of hospital care.¹⁹

The McMaster group recently published a second review comparing for-profit and non-profit dialysis care.²⁰ They found that for-profit dialysis clinics had 8 percent higher death rates than non-profits. The poorer results in for-profits were linked to fewer staff, less time allowed for dialysis, and lower doses of needed medications. The results suggest that in the US there are 2,500 premature deaths every year for people on dialysis because their care is being provided by for-profit clinics. The investigators calculated that there would be approximately 150 premature deaths per year if Canada contracted out all its dialysis care to for-profit clinics.

A review in 2000 found that for-profit nursing homes tended to have poorer quality than non-profits.²¹ For-profits tended to have fewer and poorer trained staff and

had higher staff turnover. They also had more violations found by federal inspectors; higher rates of skin ulcers, pneumonias, falls and fractures; greater use of restraints; and less spending on food. One Canadian study by Evelyn Shapiro and her Manitoba group concluded that residents in for-profit facilities had higher rates of hospitalization for 4 out of 8 conditions, which are sensitive to poor quality of care in nursing homes.²² There is little peer-reviewed literature comparing for-profit with non-profit home care, but the few studies point in the same direction of poorer quality in for-profits.

Himmelstein concluded that for-profit US health maintenance organizations (HMOs) rated lower than non-profit HMOs on all 14 quality indicators measured by the National Committee for Quality Assurance.²³ The authors estimated that there would be an extra 5,925 breast cancer deaths annually in the United States if all HMOs were for-profit.

It also appears that for-profit care is more expensive. Woolhandler analyzed 1994 data from all 5,201 acute care hospitals in the US²⁴ and found that for-profit hospitals were 25 percent more expensive per case than public facilities. Private non-profit hospitals were in the middle. Fifty-three percent of the difference in cost between public and for-profit hospital care was due to higher administrative charges in commercial facilities.

Silverman used data from the entire American Medicare program, which insures all persons 65 years and older as well as those with certain chronic illnesses, and found that health spending was higher and increasing faster in communities where all beds were for-profit compared with communities where all beds were non-profit.²⁵ Spending was growing fastest in those communities that had converted all their beds to for-profit care during the study period. Spending fell the most in those communities which converted all their beds to non-profit care.

Two Canadian case studies add to this international evidence. In 1997, the Manitoba government attempted to contract out 25 percent of Winnipeg's home care services to the for-profit sector. Even though originally 30 for-profit firms had displayed interest, ultimately only Olsten applied for a contract. Furthermore, Olsten withdrew after only six months because it could not make money on what was being paid for public sector care.²⁶ In 1993, the Prince Albert District Health Board discontinued a contract with a private laboratory and saved approximately 50 percent of the costs.²⁷

Recent rhetoric claims that introducing more private markets in health care finance and delivery would lead to more efficient health care.^{28,29} However, the reality is the opposite. Overall, more private finance would decrease access and quality while increasing costs. It is often assumed that for-profit companies wring efficiencies by eliminating unnecessary production costs. Silverman's work and economic theory strongly suggest that for-profits will find it much easier to expand revenues than to decrease costs. From Justice Emmett Hall's 1964 Royal Commission on Health Services to the 2002 Romanow Royal Commission, Canadian inquiries have consistently

concluded that health care is not a normal market good. Asymmetry of information between providers and patients prevents the consumers of health care from being fully informed – a key factor for the establishment of any market. The consequent public policy reactions of legislation and regulation (for doctors, hospitals, drugs and so on), which are necessary to protect consumers, present further barriers to the establishment of a traditional market.

As a result of these special features of health care markets, commercial enterprises tend to find it more profitable preferentially to select healthier clients, deny needed care, and sell questionably appropriate services than to improve efficiency.³⁰

PFI to P3s: Perfidious Financial Idiocy to Public Private Pickle

Recently, advocates for more private sector involvement in health care have suggested that governments contract with commercial firms to build and manage hospitals and other health facilities. In 1992, the British Conservative government introduced the Private Finance Initiative (PFI) to facilitate the building of public works. The concept has since spread to Canada under the name of ‘public-private partnerships’ or P3s. The Ontario government used a P3 to build highway 407 north of Toronto and plans to use P3s to build two hospitals. British Columbia and Alberta are also actively investigating using P3s to build new health facilities.

The concept behind P3s, as stated by their proponents, is that the private sector provides the capital and takes on the risks while the public sector reaps the benefits. However, the risks are never really transferred to the private sector. The public is still responsible for needed services or infrastructure even if the private sector walks away. For example, the Ontario provincial auditor concluded regarding highway 407:³¹

“We observed that, although cited as a public-private partnership, the government’s financial, ownership and operational risks are so significant compared to the contracted risks assumed by the private sector that, in our opinion, a public-private partnership was not established.”

Second, the costs of capital for these projects are much higher. Allyson Pollock and her colleagues at University College in London have dissected the experience of the PFI in Britain and concluded that the PFI capital costs are twice what they would have been if the hospitals had been publicly constructed.³² To quote Richard Smith, the editor of the British Medical Journal, “...the schemes produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital.”³³ Any homeowner knows that a 1-2 percent higher mortgage rate translates into tens of thousands of dollars in extra interest payments over 25 years.

When the Nova Scotia government announced its decision to end its P3 program used to build schools, Finance Minister Neil LeBlanc noted that the previous government

had used the P3 concept to push the expenses off the province's books – not because it was a good idea.³⁴ Far from transferring risk, the P3 schools program in Nova Scotia cost taxpayers an additional \$32 million which, LeBlanc noted, could have built three other schools. It looks like P3s are yet another private sector chimera. They are certainly no saviour.

Avoiding problems with our trading partners

Canada has asked that health care be reserved as a public service under the North American Free Trade Agreement. However, the US does not accept that Canadian health care is a public service. Experts do differ in their degree of concern about this issue, but they tend to agree that the more commercial health care activity Canada allows, the more difficult it will be to maintain that health care is, in fact, a public service.^{35,36} Mr. Romanow has concluded that no one really knows with certainty how significant trade issues are for Medicare. He has advised the federal government to be more protective of the public nature of the health care system.

Conclusions about for-profit health care

- For-profit care is, in general, more costly and of poorer quality. There is strong evidence that for-profit hospitals cost more and provide poorer quality care. There is strong evidence that for-profit dialysis clinics provide poorer quality care than not-for-profit clinics. There is suggestive evidence that for-profit long-term care homes provide poorer quality care and weaker evidence that for-profit home care provides poorer quality care. Much less research has been conducted in other areas including lab and diagnostic services.
- Public-Private Partnerships (P3s) cost more money. The private partner borrows the money to front the project, but has to pay higher interest rates than if government put up the cash. The public sector still retains most of the risk.
- Permitting for-profit providers to enter a new sector or allowing the growth of for-profit providers means that it will be more difficult for Canada to maintain that health care is a public service and prohibit for-profit providers from entering the Canadian market.

Concerns about public health infrastructure and services

Public health prevents illnesses and, therefore, its successes are silent victories. However, there are signs that the veneer is peeling and the damage to public health's infrastructure is increasingly visible. Despite almost constant headlines about a crisis in

the illness-treatment system, many observers think that if there is a crisis it is in public health:

- Justice Horace Kreever noted in his report³⁷ that “Public health departments in many parts of Canada do not have the resources to carry out their duties.”
- A report on public health infrastructure was presented to federal/provincial/territorial Deputy Ministers of Health in June 2000, but they refused to allow the report to be tabled. The report noted that “There seems to be agreement that only one crisis can be handled at a time.”³⁸
- The Canadian Medical Association Journal referred to public health as “being on the ropes.”³⁹

Canadians are prevented from hearing about these problems because government directly employs public health practitioners. While hospitals and doctors routinely leak damning reports or amplify their problems to the media, public health mainly suffers in silence.

Dr. John Frank, one of Canada’s senior public health physicians and Director of the Canadian Institute of Population and Public Health, has identified five major issues of public health consequence:⁴⁰

1. One world, no boundaries
2. New epidemics of chronic disease
2. Environmental degradation and change
4. The perils of untested new technologies
5. Public health: an evaluative conscience for the clinical care system

Each of these is described briefly in turn.

1. One world, no boundaries

While Canadians are smug about the elimination of epidemics of infectious diseases, there are daily reminders that an innocuous outbreak thousands of kilometers beyond our borders can quickly wreak devastation here. HIV/AIDS did not exist in North America prior to 1980, but it is now one of the leading causes of death for young men. The West Nile virus did not exist in North America prior to 1999, and that year caused only 62 known human infections and 7 deaths. However, after the carnage is added up from 2002, there will likely have been 4,500 confirmed cases and 300-plus deaths.⁴¹ As of December 31, 2002, Ontario reported over 300 confirmed or probable

cases and seven deaths. The Great Lakes states of Ohio, Michigan and Illinois were the hardest hit area of the continent, reporting nearly half of US cases.

West Nile might be on its way to becoming a truly modern plague. Or, it may peter out in the next few years. Or, a vaccine might be developed. However, it is noteworthy that this potential catastrophe is occupying considerably less political attention than the *crise du jour* in the health care system.

Tuberculosis is usually considered a disease of the past, but worldwide it is more common than ever. It has become particularly troublesome because an increasing percentage of cases are resistant to multiple antibiotics and can only be treated with long, expensive courses of antibiotics. Canada's public health system appears unable to mount the most basic control programs. A recent study documented that only 20 percent of immigrants to Ontario adhered to TB follow-up. Only 6 percent were given therapy to prevent future episodes of TB.⁴² Dr. Barbara Yaffe, an associate medical officer of health with Toronto's Public Health Department, admitted that monitoring of immigrants with inactive cases is inadequate.⁴³ In 2001, the Department of Public Health received 3,300 referrals from federal Immigration officials for inactive TB. They should be monitored regularly for 3-5 years but, Dr. Yaffe admitted, "...we have had to cut back on our follow up. In fact, we do quite minimal follow-up at this point."

Finally, as mentioned earlier, Canada is the only developed country with sub-national immunization schedules.

2. New epidemics of chronic disease

The main health problems currently facing Canadians are chronic illnesses. While some chronic illnesses such as coronary heart disease have waned, other illnesses such as diabetes and asthma have dramatically increased their incidence. There is currently a growing epidemic of childhood obesity, which is fueling the epidemics of diabetes and end stage kidney disease and may portend a future resurgence in coronary heart disease.

3. Environmental degradation and change

While there is a raging political debate about whether human activity is responsible for threats to the environment, there is no debating that there is major environmental change and that this has grave implications for human health. There is widespread contamination of ground water from which many Canadians, especially in rural areas, draw their drinking water.⁴⁴ And yet, there appears to be less public health capacity to protect us from outbreaks of water-borne illness like those in Walkerton, Ontario and North Battleford, Saskatchewan.⁴⁵ The estimates of the costs to renovate Canada's water systems are in the tens of billions of dollars.⁴⁶

There are also concerns about air quality, especially in the Greater Toronto Area and BC's lower mainland.⁴⁷ It has been estimated that in the city of Toronto alone there are approximately 1,000 premature deaths, 5,500 hospital admissions and over 60,000 cases of bronchitis in children every year due to polluted air.

Finally, global warming may change the distribution of a number of insect-borne diseases including West Nile and malaria.

4. The perils of untested new technologies

Canadians rely upon public health agencies to protect us from dangerous drugs, foods and other products. There have been recent concerns that the fine balance between making effective drugs available in a timely fashion and protecting the public from dangerous products has tipped in favour of the drug industry.⁴⁸ Seven drugs approved since 1993 and later withdrawn from the market have contributed to at least 1,000 deaths across North America.

In addition, there have been recent concerns about 'mad cow disease,' E. Coli contaminated hamburger, contaminated herbal and alternative health products. Finally, there are also concerns about the explosion of genetic tests and procedures, which are touted to a worried public. However, closer evaluation often reveals that the benefits may have been overblown, especially for low-risk persons.⁴⁹

5. Public health: an evaluative conscience for the clinical care system

As Dr. Frank describes it, health care systems have been based on treating those who "come through the door" and not on who actually needs care. As a result, family doctors spend approximately one in eight visits treating people for colds, even though most should not be seen at all or advised on the telephone. While public health has responsibility for a geographical area, family doctors typically only take responsibility for one episode of care for their patients. Very few family doctors have lists or rosters of patients and fewer still have lists of patients with certain conditions, which require detailed follow-up (e.g., diabetes).

Manitoba has developed a registry and follow-up program for childhood immunizations, but across the country there is little public health involvement in these clinical preventive services or with those for cervical cancer or breast cancer.⁵⁰

All provinces except Ontario have moved to some form of regional authority model for health services. For example, in the western provinces, typically hospital, long-term care, home care, mental health and public health services are now under one budget and one management team. The regional authorities have not been able to

achieve their full potential because they are just now starting to plan services around their populations. The old system of waiting for patients to come through the door still dominates planning and resource allocation.

Public health: pay a little now or a lot in the future

Public health is a victim of its success. The elimination of the epidemics of infectious disease, which plagued Canadians up until the mid-twentieth century, has blinded us to the threats of new infectious diseases. We are also ignoring the huge potential for public health to deal with chronic illnesses, environmental threats and new technologies. Finally, we are paying little attention to the potential for public health to improve the functioning of the health care system. We seem to have forgotten the public health maxim that one cannot ever build a big enough hospital at the bottom of the cliff without first building a fence around the top. Public health is the fence around the top of the cliff.

We can fix Medicare with innovation

Fortunately, there are examples from all over the country demonstrating that we can fix our health care system's problems. Canadian typically identify the following problems with their health care system:

1. Hospitals and emergency rooms (ERs) are overcrowded.
2. It's hard to find a doctor.
3. Drugs are unaffordable.
4. There are long waits and delays throughout the system

This section examines these key symptoms, probes each for a diagnosis and then offers examples of successful therapies

Eliminating crowding in ERs and hospitals

What's the diagnosis?

Many Canadians erroneously believe that ER overcrowding is due to too many persons presenting with minor illnesses. While these patients are a nuisance in ERs and suffer inconvenience, they generally wait until there are no other emergent and urgent patients to see. Severe ER crowding only occurs when there are more ER patients waiting for admission than there are available inpatient beds. This leads to a situation that has been dubbed "hallway medicine," in which ER staff must provide care to

critically ill patients while still attempting to deal with new patients coming in the door.

It is important to look beyond the headlines to determine who are in the hospital beds when the gurneys build up in the ER.

- The worst cases of hospital gridlock usually coincide with annual surges of influenza activity.⁵¹
- At least one-third of hospital patients do need some care (e.g., home care) but not acute hospital care.^{52,53}
- Many hospital patients could have had their acute episode of illness prevented with better management of their chronic conditions.⁵⁴
- Many illnesses can be completely prevented.⁵⁵

What are the prescriptions?

1. Comprehensive influenza management

Canadian urban hospitals tend to operate at over 90 percent capacity. In care systems with little reserve, the most important management issue is surges in demand. Nearly every winter, there is a two to four week surge in influenza cases following a two to three week warning period. If this surge coincides (as it often does) with an increased demand for elective surgery, the system's supply of acute care beds is rapidly depleted, stretchers fill emergency room corridors, and ambulances are diverted.

In 1999-2000, the annual influenza epidemic was unexpectedly severe. Emergency departments overflowed from London to Los Angeles. In Canada, a number of cities – Vancouver, Toronto and Montreal included – faced gridlock in their hospital systems. However, the same was not true for Saskatoon, Calgary and Edmonton. These cities had implemented comprehensive influenza management plans in advance of the surge and were able to avoid gridlock. These plans included:

- Immunization of people over the age of 65 and those with chronic illnesses.
- Immunization of all health care staff.
- The monitoring of the community for influenza activity, especially long-term care facilities.
- Management of outbreaks in long-term care facilities (LTCFs) including the prompt use of anti-viral medications. The frail elderly may not be immune after vaccination so it is crucial to treat them as soon as flu is found within a facility.
- Overall bed management plans including the scaling back of elective admissions and working with local physicians to keep their offices open additional hours (to deal with milder cases).

2. Give patients the level of care which is appropriate for their condition

Up to 50 percent or more of days in hospital are for patients who should be receiving care in other locations including home, hospice, long-term care or rehabilitation facilities.^{56,57} Approximately 70 to 80 percent of cancer patients die in acute care beds or emergency departments when they would prefer to die in their own homes or home like settings. Edmonton established a regional palliative care program in 1995.⁵⁸ By the second year of the program, there had been a reduction in the proportion of cancer deaths in acute care facilities from 86 percent to 49 percent. If every community mounted such a palliative care program, there would be approximately 1,800 hospital beds freed up for acute care patients. This is roughly the same number of beds as for the whole city of Winnipeg.

Paralleling the growth and interest in palliative care for advanced cancer; concerns have been raised about other end-of-life issues. Too many older persons who do not wish aggressive medical treatment are nevertheless given such treatment before they die.⁵⁹ Advanced Health Care Directives offer older people and their families an opportunity to choose the level of intervention that they wish before a life-threatening illness develops.

Dr. Willie Molloy and his group at McMaster University implemented the LET ME DECIDE directive in 1989. It allows people to document their wishes in the event of non-reversible (e.g., Alzheimer's or certain strokes) or reversible (e.g., pneumonia, bleeding ulcers) life-threatening illness. A study of the LET ME DECIDE directive showed that the participants used 61 percent fewer acute hospital days. The investigators estimated that overall health care costs were 33 percent lower for the participants in the LET ME DECIDE homes.⁶⁰

3. Better management of chronic illness to prevent complications

While Medicare was designed to provide acutely ill patients with access to hospitals and physicians, managing chronic illness and an aging population requires community-based care and a focus on maintaining function and health. A system designed mainly for acute care will be overwhelmed with chronic patients who develop complications. Over the past 10 to 15 years, provinces and communities have gradually developed some community programs that reduce the demand for acute and long-term care institutions.

For example, a pilot project in British Columbia provided 4-12 hours of health promotion to patients who were applying for long-term care. After 36 months, the patients receiving health promotion were 39 percent less likely than members of the control group to have died or to have been placed in a long-term care institution.⁶¹

Diabetes affects only about 6 percent of the population, but diabetics have 32 percent of the heart attacks, 51 percent of the new cases of kidney failure and 70 percent of amputations.⁶² Better control of diabetes can greatly reduce these complications.⁶³ The Sault Ste. Marie Group Health Centre is Canada's largest alternatively funded group

practice and has 44,000 enrolled patients, 60 doctors and over 100 nurses. It also has an electronic medical record with a registry of over 2,200 diabetic patients. Since January 2000, the Centre has documented major improvements in all aspects of diabetes control.⁶⁴

Congestive heart failure (CHF) is the number one cause of non-reproductive hospital admissions in adults. The Sault Ste. Marie Group Health Centre uses specially trained nurses to follow their CHF patients after discharge. This project decreased the rate of readmissions by over 60 percent within the first six months.⁶⁵

4. Preventing chronic illness

Adult onset (or type II) diabetes was very rare in First Nations people prior to contact with Europeans. Now, more than 25 percent of adults over 50 years of age in some Aboriginal communities suffer from this condition.⁶⁶ A healthy lifestyle (including diet, non-smoking and exercise) could prevent over 80 percent of coronary heart disease cases.⁶⁷ However, it is a challenge for health care systems to translate these theoretical gains into tangible outcomes.

Several Aboriginal communities have developed prevention programs which reinforce First Nations culture. The Kahnawake School Diabetes Prevention Project of the Mohawk Nation has led to improvements in diet and rates of physical exercise in children.⁶⁸ However, other programs have not had similar success.⁶⁹

These programs show potential, but they also highlight the health system's limited ability to engineer the massive social change required to effect population lifestyles. For example, the Kahnawake intervention involved bans of 'junk food' from the school.⁷⁰ This might not be a popular policy with fast food chains, which presently sell their products in 30 percent of American high schools.⁷¹

It is important to ensure that health promotion is incorporated into clinical practice. As a society, we need to continue to develop strategies that will allow us to achieve more of our potential for prevention.⁷²

Improving access to doctors

What's the diagnosis?

Canadians are encountering increasing difficulty in finding a family doctor and there are complaints of long waits for specialists. Despite these claims of shortage, Canada actually has more doctors than ever before. According to the Canadian Institute for Health Information's latest data, there were 58,546 doctors in Canada in 2001.⁷³ The physicians per capita ratio rose from 152 per 100,000 in 1981 to 195 per 100,000 in 1993, a 28 percent increase. Then it dropped to 187 in 1997, rising to 189 in 2001.

A recent CIHI report concluded that, after adjusting for various demographic changes in the general Canadian and physician populations, the functional doctor patient ratio had declined by 5 percent from its all time peak in 1993.⁷⁴

Despite the alleged mass migration of Canadian physicians to the United States, only a small proportion of Canadian doctors leave the country in any one year. The outflow actually peaked in 1978 when 873 of all Canadian doctors departed and only 192 returned for a net loss of 681 or 2.7 percent of all physicians. In 2001, 609 doctors left Canada, while 334 Canadian doctors returned for a net loss of 275 or 0.5 percent of the physician workforce.⁷⁵

Of course, there are different numbers in different provinces and regions. Quebec has 14 percent more doctors per capita than the Canadian average and Saskatchewan has 19 percent less. From 1995 to 2001, there was a 14 percent increase in the number of specialists (per capita) in Nova Scotia but a 9 percent decrease for Ontario family doctors. Nevertheless, the stories of perceived shortages are similar everywhere in the country.

Where have all the doctors gone?

Most Canadian doctors receive the vast majority of their income from fees for service. Under fee for service, doctors are penalized if they provide comprehensive care and are greatly rewarded if they see as many patients as possible. Fee schedules pay much more on a fee-for-time basis for procedural rather than cerebral services. Put more crudely, fee for service pays doctors much more to cut and prod than listen and think.

For example, in Ontario,⁷⁶ a gastroenterologist earns 62 percent more for a complete endoscopic examination of the colon than for a full consultation⁷⁷ and an ophthalmologist receives nearly nine times as much for a cataract extraction and lens insertion than for a consultation.⁷⁸ In each case, the consultation would take longer than the procedure. An obstetrician/gynecologist is paid 25 percent more for a hysterectomy than for a normal vaginal delivery even though the delivery takes more time and is fraught with more danger.⁷⁹

Although these perverse incentives have been with us for decades, there does appear to have been a recent accelerated departure from comprehensive care. An Ontario study of family physician practice patterns between 1991 and 1997 found reductions in the numbers of family physicians working in hospitals or nursing homes, delivering babies or providing house call services.⁸⁰ There was a 55 percent increase in the proportion of family doctors who did nothing other than see patients in their offices.

Several reports have suggested that better use of teams could improve access, but there is a paucity of effective teamwork in health care, particularly outpatient settings. Specialists often see patients who could be seen by family doctors or nurses, while specially trained nurses or others could perform much of the day-to-day work of family doctors. Provincial Medicare plans do not allow nurses to bill, while doctors cannot bill

for independent work performed by their nurses, and there are very few interdisciplinary clinics using alternative funding mechanisms. Furthermore, there are few routine arrangements encouraging specialists and family doctors to cooperate.

What are the prescriptions?

Primary health care reform

In three small towns in southwestern Saskatchewan, one doctor working in a high-functioning team with three nurse practitioners and the rest of the regional staff (long-term care, public health, mental health, home care) manages over 3,200 patients. This is over twice the patient load of a regular family doctor. And, depending upon the location, 80-98 percent of non-emergent patients can be given an appointment within 48 hours of calling for one.

If all family physicians could work in a similar high-functioning team practice, Canada would need at most 15,000. According to the Canadian Institute for Health Information, in 2001 Canada had over 29,627 family physicians, which translates into roughly 26,600 full time equivalents.

Shared care: better use of specialists

Specialists, like family doctors, can be more efficient if they work in teams with family doctors, nurses and other care providers. Traditional specialty practice in Canada is based on seeing patients in consultation who are referred by family doctors. This arrangement is very inefficient because frequently a family doctor only needs a quick phone call with the specialist to clarify a specific issue.⁸¹ In some communities, some specialists provide ongoing care to patients that could be provided by family doctors with some intermittent 'coaching' from the specialist. Our present complement of specialists could greatly extend their range, with the appropriate supports.

For example, the Hamilton HSO (Health Service Organization) Mental Health and Nutrition Program has 23 full time equivalent mental health counselors and 2.2 psychiatrists working with 87 family doctors in 51 different sites. In 1999, the family doctors made 4,200 referrals to the program. This program increases the access to specialist expertise without increasing their supply

These programs do not prevent patients from seeing specialists. Rather, they ensure that the specialists available are used to their full potential. New funding mechanisms are required to implement such novel approaches. Otherwise, there is no

compensation for the specialists to provide advice and continuing education to other team members.

Telephones and telehealth

Health care personnel can also increase their productivity by doing more work on the telephone. A Dartmouth University study found that when telephone calls replaced follow-up visits for patients with chronic illness, overall health care costs were reduced by 30 percent, with improved health outcomes.⁸² A recent California study found that placing sophisticated video equipment in the homes of home care patients allowed nurses and doctors to care for more patients with no deterioration in outcomes or patient satisfaction.⁸³

A number of studies have found that patients greatly appreciate being able to speak with a nurse before deciding whether to go to an emergency department or other health facility. A British experimental trial found that nurse telephone advice after regular office hours reduced patient visits to primary care centres by 38 percent, home visits by 23 percent and the need for telephone advice from doctors by 69 percent.⁸⁴ Other patient outcomes were slightly better in the nurse advice group. The province of Quebec has had a province-wide nurse telephone advice line (Info-Santé) since 1994. The nurses are based in the province's network of 160 community health centres or CLSCs (centres locaux services communautaires) although after-hours calls are routed to a regional number. An evaluation of the Info-Santé showed a very high rate of satisfaction; 76 percent of callers said that without the service they would have gone to an emergency room or a doctor's office.⁸⁵ New Brunswick, British Columbia and Ontario also have a province-wide service and other provinces are actively engaged in planning similar services.

Making prescription drugs affordable

what's the diagnosis?

Increasingly, Canadians are concerned that they cannot afford the medications they need.⁸⁶ Within a couple of years, Canada will spend more for prescription drugs than for doctors' services. Prescription drugs has been the fastest growing area of costs for public or private plans since 1975. Only 43 percent of the costs of prescription drugs are paid for publicly, compared with 70 percent for overall costs and 90 percent-plus for hospitals and doctors.⁸⁷

Under the Canada Health Act, the provinces are to provide first dollar coverage for medically necessary care from doctors and in hospitals. Canadians have access to medications while in hospital but, as with home care, there is no requirement under the Canada Health Act that provinces cover outpatient pharmaceuticals. Gradually,

provinces built up their pharmaceutical coverage – typically starting with tuberculosis and other communicable diseases. The picture across the country now resembles a patchwork quilt, with some provinces providing universal programs with user charges while others cover only certain diseases (e.g., cancer or diabetes) or groups (e.g., the elderly or those on social assistance).

Patent protection is not the major cause of escalating drug costs.

A convincing case has been made against the extended patent protection that the pharmaceutical companies have wrought from Canadian and other legislators in the past 20 years.^{88,89} While this is an important issue, the lengthening of pharmaceutical patent protection has had relatively little impact on overall drug expenditures. An Industry Canada study, which was used by opponents of patent extension, estimated a \$290 million cost to consumers from 1993 to 2000 because of extended patent protection.⁹⁰ This is not a trivial amount of money, but it represents only 2 percent of Canada's annual prescription drug costs, which are expected to reach \$14.6 billion in 2002.⁹¹

Most of the increase in pharmaceutical costs is related to poor quality prescribing

Doctors tend to prescribe new drugs when they may be no more effective than older cheaper drugs *and* they also tend to over-prescribe drugs of all types. A recent study showed that a high blood pressure medication, chlorthalidone, which is over 40 years old, is more effective than two very new drugs and is less than 3 percent of the cost of the latter.⁹³ A recent study for British Columbia estimated that the province's pharmacare per capita expenditures for high blood pressure medication for the elderly had risen by almost two and a half fold from 1986 to 1996.⁹⁴ However, only 4 percent of this increase was due to price increases and 96 percent was due to the prescribing of newer, often less effective, and potentially more dangerous medications. A recent Ontario study showed that most of the patients who were prescribed the latest generation of anti-arthritis drugs had not been tried on less expensive medications, some of which are 3 percent of the cost of the newer drugs.⁹⁵

A Quebec study showed that in one calendar year, one in two of the province's seniors were given a potentially dangerous prescription.⁹⁶ Thirty percent had been prescribed valium-like drugs inappropriately. On the other hand, as mentioned previously, only 20 to 40 percent of patients with chronic illnesses like asthma, high blood pressure or coronary heart disease are taking the correct medications. Every year hundreds of thousands of Canadians are hospitalized and thousands die because of poor quality prescribing – either too many of the wrong drugs or too few of the right ones.

Poor quality of prescribing is due to:

- *Drug companies marketing practices overwhelm doctors' lack of knowledge and training in pharmacology.* Drug companies spend more than twice as much on marketing as they do on research and development.⁶⁵ Almost all of these resources are poured into the promotion of new medications to doctors,

particularly the key opinion leaders within a particular community. The information given to doctors is glossy in its portrayal of benefits but the discussion of side effects is in fine print. Reviews have concluded that Canadian doctors have deficient training in clinical pharmacology, the basic science of drug prescribing.⁹⁷ Once in practice, doctors may claim they get their information on the use of drugs from medical journals and conferences but, when tested formally, they appear to be influenced by the pharmaceutical companies' marketing efforts.^{98,99}

- *Patients do not have easy access to purveyors of non-drug therapies.* Many disorders can be treated solely with non-drug therapies and others are treated more effectively when non-drug therapies are used to complement pharmaceutical therapy.^{100,101} However, physicians, particularly family physicians, have restricted access to psychologists, social workers, dietitians, rehabilitation therapists, chiropractors and other professionals who provide non-pharmaceutical therapies. Furthermore, these services are usually not covered by provincial Medicare plans.
- *Pharmacists are the experts in medication but, outside of hospitals, they typically work in isolation from doctors and other professionals.* There are numerous studies showing that more integration of pharmacy services lead to better outcomes for patients.¹⁰² Canadian pharmacists' knowledge is greatly underutilized and they have relatively few professional interactions with physicians.

Savings through administrative efficiencies: public payment

It is estimated that pharmacare would realize one-time only savings of 10 to 20 percent through the efficiencies inherent in public administration.¹⁰³

What's the prescription?

If the main reason for unsustainable drug costs is inappropriate prescribing, then the solutions must involve improving the quality of care. There are three general directions for needed reforms:

1. Better use of non-pharmacological therapies
2. Improving the quality of prescribing
3. Reducing the costs of medications dispensed

Better use of non-pharmacological therapies

Patients should have easy access to purveyors of non-drug therapies such as physiotherapists, social workers, dietitians and exercise therapists. For example, all persons with coronary heart disease could benefit from rehabilitation through exercise training, but few such patients have access to exercise programs.

Coronary heart disease (CHD) is the most common single cause of death in Canada. The past 30 years also have seen the development of many effective surgical and pharmaceutical treatments. However, it has been known for over a decade that strict adherence to an ascetic diet and a vigorous but contemplative lifestyle can obviate the need for medication or surgery in many, perhaps a majority of cases.¹⁰⁴ There are many studies showing that even a moderate health promotion regime can reduce the amount of medication or surgery required by cardiac patients.¹⁰⁵ However, relatively few patients with coronary heart disease have the opportunity to engage in a comprehensive rehabilitation program. Typically, planners looking at narrow day-to-day bottom lines see these programs as frills.

The Toronto Rehabilitation Centre's cardiac program is the largest and one of the oldest such programs in North America, treating 1,600 patients per year. One of the Centre's patients was the first heart transplant recipient to run the Boston marathon. The program includes:

- Fitness evaluation and individualized exercise prescription. Patients must take at least one of the Centre's classes every week (as well as completing four other sessions per week).
- A lecture series for patients and their families covering a variety of topics related to living with coronary heart disease.
- Peer group support for the patients who are accommodating themselves to a potentially fatal illness with major lifestyle change.

Improving the quality of prescribing

The public is accustomed to seeing the pharmacist as simply a dispenser of drugs rather than a skilled professional with at least five years of postsecondary education including four years of pharmacy. In the past twenty years, hospital pharmacists have become key players within multidisciplinary teams. Outside of hospitals, there are few examples of such high functioning teams. Integrating pharmacists into clinical teams with physicians is the best way to improve the quality of prescribing. The better the pharmacists are integrated into practice, the more effective the quality improvement.

Sometimes even small interventions can be effective. An Ontario study provided feedback to physicians on their prescribing of antibiotics along with mailed educational material to alert doctors to more appropriate antibiotic usage. Compared with control physicians, the experimental group had reduced costs and increased the use of first-line drugs.¹⁰⁶

In the early 1980s, Harvard researchers Avorn and Soumerai demonstrated that so-called 'academic detailing' could improve physicians prescribing.¹⁰⁷ In academic detailing pharmacists visit doctors' offices and use the same techniques as drug company detailers, including sophisticated communications strategies and glossy materials left with the doctors. But the information they provide is non-biased. Despite the cost of the intervention, the program saved \$2 for each dollar spent on the intervention.¹⁰⁸

Gradually, there has been increasing use of academic detailing in Canada. Dr. Bob Nakagawa, currently director of clinical pharmacy services for the Fraser Health Authority in British Columbia, started a program of academic detailing in North Vancouver. The program features newsletters and one-on-one visits by a clinical pharmacist. An evaluation of the program using a control community in the B.C. southern mainland found that there had been an improvement in prescribing quality and enough savings in drug expenditures to offset the costs of delivering the program.¹⁰⁹

This type of program has spread to three other provinces: Nova Scotia, Saskatchewan and Alberta. In Saskatchewan, the Saskatoon District Health Board pharmacy program runs the program 'RxFiles,' with financial support from the Department of Health. RxFiles develops its topics from speaking with physicians and now contacts over 30 percent of the province's family doctors including over 60 percent in Saskatoon, Regina, North Battleford, Prince Albert and some rural areas.

A next step in integration is to have pharmacists seeing physicians' patients in consultation. Dr. Jana Bajcar, a University Toronto professor of pharmacy combines her academic pursuits with practice as part of the St. Michael's Hospital's family practice department. She will see a patient in the clinic or at home and then provide expert advice to the doctor regarding the patient's drug management.¹¹⁰

There are fewer examples of pharmacists practicing full time with physicians. Two exceptions are the REACH and Mid-Main Community Health Centres in East Vancouver. The pharmacists dispense prescriptions to clinic patients but also deal with outside pharmacies and provide both formal, scheduled continuing education as well as opportunistic teaching on pharmacotherapy to other clinical staff.

Reducing the costs of the medications dispensed

In 1969, Canada implemented a system of compulsory licensing which greatly facilitated the access of generic drugs to the Canadian market. Generic drugs are chemically identical to brand name drugs and sometimes even manufactured by brand-name companies. During the 1980s and 1990s, Canada lengthened the period of patent protection, which increased the time that brand-name drugs retained their market exclusivity.

However, most newly patented drugs are not dramatic innovations, or category 2 drugs as defined by the Patented Medicines Price Review Board (PMPRB), “the first drug product to treat effectively a particular illness or which provides a substantial improvement over existing drug products, often referred to as ‘breakthrough’ or ‘substantial improvement’”¹¹¹ From 1994 through 2000 there were only 30 new category two drugs approved compared with 570 drugs in categories one and three.

Category 1 drugs are ‘line extensions’ or reformulations of existing products (e.g., a long-acting version of an existing drug). Category 3 drugs are defined as “a new drug or new dosage form of an existing medicine that provides moderate, little or no improvement over existing medicines.” Sometimes category 3 drugs are referred to as ‘me-too’ products because they are frequently manufactured by changing only a small part of an existing drug (e.g., adding one hydrogen atom to an existing drug allows for a new patented agent).

The large number of ‘me-too’ drugs does offer opportunities to re-establish competition in the marketplace. For example, there are over 20 non-steroidal anti-inflammatory drugs (anti-arthritis drugs) available in Canada. These drugs are similar in overall effect to aspirin (ASA) but some are over 100 times more expensive. Some drugs work better for some people. Others work better for others. Some people tolerate some drugs better than others do. Usually, there is no *a priori* reason to start with anything other than the least expensive drug in a particular therapeutic class.

Hospitals have historically used formularies, which limit the drugs available within an institution. The formulary committee decides which arthritis medications they will stock and which they won’t. A Manitoba study concluded that introducing a formulary into long-term care facilities produced substantial cost savings.¹¹² In the 1980s, some American health plans and health maintenance organizations started using the formulary process outside of hospital. This process is usually referred to as ‘therapeutic substitution’ where different drugs that treat the same illness are grouped together in a therapeutic class and the most cost-effective ones are made available for first-line prescription.¹¹³

British Columbia introduced its own version of therapeutic substitution, the reference drug program in 1995. British Columbia’s program requires patients to use the most cost-effective or ‘referenced’ products unless their doctor completes a special authorization form and sends it to BC Pharmacare.¹¹⁴ The BC government claims that it has saved \$200 million dollars in the program’s first five years, with annual savings running at approximately \$44 million per year.¹¹⁵ Evaluation of the reference drug program has shown that it decreased costs for drugs without depriving patients of effective therapies.¹¹⁶

What doesn’t work: Charging patients for drugs

Studies of medical care and hospital care have demonstrated that financial barriers (e.g., user fees or private insurance) can deter poor and other vulnerable groups from accessing the health care system^{117,118} In Canada, we have similar evidence of the deleterious effects of user fees for drugs. In the late 1990s, the Quebec drug plan began levying user charges on the elderly and poor who had previously been exempt from these charges. Evaluators found that drug use decreased by 14.7 percent among welfare recipients and 7.7 percent among the elderly.¹¹⁹ Emergency room visits increased 71 percent. Visits to doctors' offices increased by 17 percent. Emergency room visits by the mentally ill grew by over 558 percent. The policy was estimated to have caused an extra 2,000 hospital admissions. An American study has also found that user charges for drugs for seniors led to decreased use of essential drugs and increased numbers of admissions to nursing homes.¹²⁰

Shortening waits and delays throughout the system

What's the diagnosis?

Waits and delays are signs of a possible capacity demand mismatch. Anyone who has ever queued for a bus or waited to see the principal knows that waits and delays are a fact of life. Sometimes these delays are due to true lack of capacity to meet demand. However, most of the time spent waiting in the health care system is not due to capacity shortage. Investigations of waits and delays should first assess whether, in fact, there is insufficient capacity to meet demand. If there is insufficient capacity, then new resources are required. If there is sufficient capacity, then different tactics are required.

A sign of sufficient capacity is a steady state of wait times. New cases being admitted match the ones being discharged, but there is a backlog of work resulting in waiting periods. In this case, temporary increases in resources can deal with the backlog and then the service can see patients immediately.

However, patients with serious illnesses usually need several tests or treatments that must be administered in tandem. And, if there are waits of any length for some, then patients often wait excessive time overall. There were not as many problems at the advent of Medicare. There were fewer diagnostic and therapeutic procedures available and most seriously ill or suspected seriously ill patients were admitted to hospital for 'investigations.' With the great decline in the number of hospital beds, and increasing emphasis on not admitting patients unnecessarily, these patients now have to go through their series of tests and treatments as outpatients.

For many Canadians, waiting for care has begun to look like 'the Russian chicken three-step' – the way Russians bought chickens in 1985. First, our doughty comrade would have to line up for two hours to get a chicken voucher stamped. Then and only then could he get into the second line and wait two hours to show the voucher and get a chicken. Finally, our Russian friend would face waiting in a third line to give over his voucher, buy the chicken and exit the store.

Much cancer care in Canada looks like the Russian chicken story. For example, to be screened for breast cancer, first a woman has to line up for a mammogram. Although the wait is generally not too long for this test, she then has to wait for the radiologist to read the x-ray and for the report to get back to her family doctor's office. If it is positive, then and only then, can she get into the second line and wait for a biopsy. Then the biopsy has to be read by the pathologist and the report is sent back to her family doctor's office. Finally, if the biopsy is positive, then and only then can she get into the third line and wait for surgery. Care for other complicated illness can also resemble an endless series of merry go-rounds from which a patient never emerges. At each step, the patient might have to wait months for the next visit or investigation.

What's the prescription

When capacity is sufficient to service demand

In this situation one needs to deal with the backlog and then eliminate separate waiting times within the system. Using our Russian chicken example, there would have been a 67 percent time saving if the consumer could have just waited in one line instead of having to suffer through three.

Sault Ste. Marie, Winnipeg and several other communities have centralized wait list management of breast cancer work-ups. In most of Ontario, a woman with a positive mammogram is referred back to her family doctor who arranges the referral for a biopsy. But, in the Sault, the breast centre organizes the referral. It should not be difficult to plan, because if a community does 1,000 mammograms one week, there will be approximately 40 biopsies needed the following week and then roughly 4 surgeries the week after. The women who have positive mammograms this week can automatically be slotted into next week's biopsy appointments and then the women with positive biopsies can be booked for surgery the second week.

As a result, Sault Ste. Marie was able to reduce wait times from mammogram to breast cancer surgery from 107 to 18 days. And it only took a couple of months to accomplish this. Using similar techniques, the Calgary Regional Health Authority reduced time for transferring admitted patients from Foothills Emergency Room to other regional hospitals from 4.5 to 1.0 hours.

When capacity is insufficient to meet demand

When there is insufficient capacity to meet demand, there are usually cries to increase capacity. But, as managers in most other sectors know, one can also try to modify the demand. The US National Institute of Medicine has delved into these issues to a much greater depth than any organization in Canada. The Institute's 2001 book *Crossing the Quality Chasm* is simultaneously an indictment of that system's current

poor quality and access and a prescription for reform.¹²¹ The actual mechanics of patient care are not too different between our two countries and Canada could learn a lot from *Crossing the Quality Chasm*.

The Institute of Medicine recommends ten rules for health care organizations to redesign their care processes. The first rule is that care should be based on continuous healing relationships with a health care team, not just on in-person visits with doctors. Shared care mental health programs, such as the Hamilton HSO Mental Health and Nutrition Program described earlier, are examples of teams of providers working together to meet their patients needs in whatever manner is most appropriate.

There are long wait times for psychiatrists in many communities. However, in the shared care programs, a family physician can refer the patient to a mental health counselor, talk to the mental health counselor for five minutes, or speak to the psychiatrist on the telephone. When the shared-care psychiatrists visit family doctors' offices, they spend most of their time discussing cases with the doctors and mental health counselors. Using this format, the psychiatrist can actually provide consultations on 5-10 patients per hour instead of just one. As a result of the Hamilton HSO Mental Health and Nutrition Program, these doctors' referrals to local psychiatric outpatient clinics have fallen by over 60 percent.¹²³

Once we step out of the box of health care confined to in person visits, the possibilities for modifying demand are almost limitless. Patients can get their needs met by telephone or email. Some visits can be more effectively done as a group (e.g., for diabetes). If patients have a need to see a doctor on that day, they can. However, most patients are happy to check in with the group, get their routine tests performed by a nurse, and then leave. Canadians have become accustomed to online banking. Patients should be able to access their file in a secure fashion to find out test results and post their own monitoring (e.g., for high blood pressure or diabetes).

Finally, if even after the application of ingenuity, there is still too much demand for the capacity, then there is an ironclad case for more resources.

Tools to improve performance

The Institute for Health Care Improvement was founded in 1991 by Harvard pediatrician Dr. Donald Berwick. It has grown to be the world's preeminent organizations concerned with quality improvement in health care. The Institute for Health Care Improvement sponsors conferences and workshops. Many of the most innovative thinkers in health care are consultants associated with the Institute for Health Care Improvement. The recently established Saskatchewan Quality Council has hired Dr. Berwick as an advisor.

Dr. Berwick and others associated with the Institute for Health Care Improvement have been key consultants to the UK National Health Service. The Institute for Health Care Improvement methods needed refining for the British single-payer system, but there have

been several major successes. For example, East Kent reduced its wait times for neurophysiologists from seven months to two weeks. The West Middlesex Hospital reduced its wait time from first presentation to full diagnosis of prostate cancer from six months to two weeks.

The Calgary Regional Health Authority has made particular use of the Institute's techniques and has taught the rapid cycle methodology to dozens of clinical managers. In 2001-02, Calgary completed 14 rapid cycle change projects and this year nearly 30 are underway.

Options for the federal government for a new health policy

The previous sections have made the following points:

1. The federal government has a legitimate role to play in leading the renewal of the country's health policy.
2. Medicare, with public finance and non-profit delivery, was and remains the right policy direction
3. While the federal government must spend cash to lead reform, money is not the central issue for renewal of our health care system.
4. Public health should be the major priority for the federal government.
5. Innovation will be Medicare's true savior.

This section outlines a series of options for the federal government to consider as it responds to the Romanow Report and reformulates the country's health policy in concert with the provinces and territories. Each option is assessed for:

1. Implications for federal/provincial/territorial relations.
2. Implications for protection of public finance and non-profit delivery.
3. Implications for the effectiveness and efficiency of the health care delivery system
4. Implications for the health of Canadians.

Option 1: Federalism lite – a little bit more than more of the same

The Standing Senate Committee on Social Affairs, Science and Technology (the Kirby Committee) recommended an extra \$5 billion per year in federal funding for health care. The Romanow Commission recommended an extra \$3.5 billion for 2003-04, \$5 billion for 2004-05, and \$6.5 billion thereafter, to grow at a rate slightly greater than the economy.

Under this option, the federal government would put approximately \$5 billion extra into the Canadian Health and Social Transfer (CHST). The federal government would not target any of its new money.

Implications for federal/provincial/territorial relations:

- This is the option that is being demanded by Quebec, Ontario and Alberta. These provinces would welcome such an option, while the other seven provinces are unlikely to object loudly.

Implications for protection of public finance and non-profit delivery

- This option would do little to protect Medicare from erosion of public finance or incursions from for profit care. Canadians would still have to pay more private bills for services not covered by the Canada Health Act (e.g. , home care, long-term care and pharmacare). However, adding money does make the federal government a more legitimate player and, therefore, could permit better enforcement of the Canada Health Act.

Implications for the effectiveness and efficiency of the health care delivery system

- In September 2000, the federal government attempted to tie its new spending to priorities such as primary health care, home care and medical equipment, but the provinces forced Ottawa to provide most of the money in untargeted grants. The federal government did manage to target roughly 4 percent of the new funds for new medical equipment and 3 percent for primary health care reform. But the provinces paid a big price for their 'win' over the federal government. Because most of the money was not targeted, doctors, nurses and other health workers almost immediately strong-armed the ir provinces to pay large (albeit overdue) pay increases to do the same work as before.
- Even the funds for high technology and primary health care were not really targeted. Some provinces used the high-tech funds to buy lawn mowers, icemakers and woodworking tools.^{124,125} Initially Ottawa wanted five criteria for primary health-care pilot projects, but the provinces forced the federal government to fund them if they met only one.
- New untargeted money would likely do little to improve the system's efficiency or effectiveness.

Implications for the health of Canadians

- The health care system plays little role in overall health status, which is mainly determined by other factors such as income, child development, housing and the environment. Public health services such as control of communicable diseases and environmental threats are the part of the health

system that is the most important for determining health. The provinces have tended to give far more generous increases to hospitals and physicians services than to public health. The political demand for the treatment of identified individuals almost always trumps that for prevention, unless there is an epidemic in progress.

- Therefore, untargeted federal funding is unlikely to have much impact on Canada's health.

Option 2: Federalism per Romanow

Under this option, the federal government would provide targeted funding for a variety of key policy areas including a rural and remote access fund (\$1.5 billion over two years), a diagnostic services fund (\$1.5 billion over two years), a primary health care transfer (\$2.5 billion over two years), a transfer for a limited home care program (\$2 billion over two years), and a catastrophic drug transfer (\$1 billion beginning in 2004-05). The report also recommends the creation of a Canadian Health Council appointed by the federal, provincial and territorial governments which would have an extensive mandate including monitoring the system and its outcomes, assessing new technologies, making recommendations for its improvement, and facilitating public involvement.

Implications for federal/provincial/territorial relations

- Quebec, Ontario and Alberta oppose this option. British Columbia and some other provinces also have reservations. However, the Ontario and Quebec governments are not politically popular and will fight elections this year. The Romanow financial recommendations do not substantially intrude upon provincial jurisdiction, whatever their symbolism. Furthermore, they are popular with the electorates in Ontario and Quebec. It is unlikely that the provinces that are opposed would be able successfully to fight the federal government's attempt to implement Romanow. However, there would be more conflict with this option than option one.

Implications for protection of public finance and non-profit delivery

- More federal money would increase the federal government's political clout to enforce the Canada Health Act.
- As mentioned in section one, Romanow's report did include suggestions that would indirectly limit the growth of for-profit care. Romanow recommended that diagnostic services such as MRI and CAT scans be explicitly identified as medically necessary under the Canada Health Act. He further recommended that the federal government close a major loophole in the Canada Health Act, which allows Workers Compensation Boards to buy services outside of Medicare. For-

profit surgical clinics depend upon contracts with these boards for the majority of their income and would likely struggle without them.

Implications for the effectiveness and efficiency of the health care delivery system

- Romanow's recommendations do provide some targeting to parts of the system that most need new funding. Romanow also recommended improved technology assessment. Option two would therefore, improve effectiveness and efficiency better than option one but not as well as option three.

Implications for the health of Canadians

- Because option two would result in more effective and efficient health care than option one, it would better improve the health of Canadians. However, because there is little focus on public health, this improvement would likely be quite marginal.

Option 3: Federalism Plus – leadership to protect Medicare and change the delivery system

Under this proposed option, the federal government would offer substantially more funding for health policy renewal to pursue seven key priorities

1. Reform of community-based health care services, including full public coverage for home care and long-term care
2. Renewal of public health
3. Full public coverage for pharmacare
4. System redesign to deal with waits and delays
5. Technology assessment
6. A national health advisory forum
7. Medical diagnostics

1. Renewal of community-based health care services including full public coverage for home care and long-term care

From the Dr. John Hastings *Report on the Community Health Centre in Canada* released in 1972 to the Romanow Commission in 2002, nearly every federal and provincial report on health care has called for the strengthening of primary health care. The key features of primary health care reform include:

- Group medical practice
- Integration of other providers such as nurses to create multi-disciplinary teams
- Clear identification of the population being served using either a patient list or

- a geographical area
- Primarily non-fee-for-service funding.
- Care developed according to the needs of the population and public health principles

There is considerable misunderstanding about the role of primary health care, leading the public to underestimate its strategic importance for the health care system. Most people think of primary health care as family doctors, period. Even policy-makers tend to think primary health care means children with runny noses. Primary health care is much more than family doctors: it includes the services of all other key professionals with whom a patient might have first contact such as home care nurses, public health nurses, social workers, pharmacists, dietitians, therapists from a variety of disciplines, and others. As outlined in previous sections, without effective primary health care, hospitals become swamped with patients whose episodes of illnesses could have been prevented or whose illnesses require home not hospital care. It will be impossible to efficiently implement home care and pharmacare without real primary health care reform.

The federal government has attempted to support primary health care renewal through two versions of the Health Transition Fund. The first, initiated in 1997, provided \$50 million per year for three years, while the second embodied in the 2000 federal-provincial-territorial agreement provides \$200 million per year for four years. Mr. Romanow also identified interdisciplinary team practice as a key method to improve outcomes and decrease costs. Despite the federal stimulus and the stated priority for primary health care by federal and provincial commissions, there has been little progress on primary health care reform.¹²⁶ By and large, the provinces have had their primary health care policies heavily influenced by provincial medical associations.

As a result, the provinces often find that their new models of care do not work very well. For example, after quarreling with physicians at the beginning of its mandate, in 1996 the Harris government essentially invited the Ontario Medical Association to design the plan for primary health care reform, the Family Health Networks. Other groups – including the 55 existing, multi-disciplinary community health centres, other community providers, public health, nursing organizations, and consumer groups – were all but excluded from the policy development process. The Ontario government proudly proclaimed in its budget in May 2000 that 80 percent of Ontario's nearly 10,000 family doctors would be part of these networks within four years.

Despite the stated priority of the Ontario government, its Family Health Networks program has not been a success thus far. First, judged on its own terms, less than 300 doctors had signed up by December 2002, representing approximately 3 percent of Ontario's family doctors.¹²⁷ Far from being multi-disciplinary, there are fewer than 10 nurse practitioners involved and not many other professionals. Not surprisingly, an interim evaluation noted that the program had had little impact on first contact of care and that doctors were insufficiently prepared for their new managerial roles.¹²⁸ There was little change in pattern of practice after doctors converted their practices. This led the evaluators to conclude that simply changing method of physician payment without

changing other structural practice elements would not lead to different outcomes for patients.

In the meantime, the existing community health centres in Ontario languish in purgatory despite a positive evaluation¹²⁹ and over 100 communities that want such centres. The centres' budgets have been frozen for 10 years and the staff have had no increases during this period.

Curiously, the evaluation of the Family Health Networks noted that there was less than expected support for the Family Health Networks from the OMA. Even when the province essentially transferred its policy-making to OMA, only a few family doctors within the OMA who were true believers pushed for reform. And they were and are a minority within the organization. As a result, the eventual reforms, weak as they might be, still have little political support within the profession. Furthermore, this initiative, which is costing so much money and policy attention, has had no impact on the other 97 percent of family practices.

Commissioner Romanow recommended an infusion of \$2.5 billion over two years into primary health care services but with few details of their structure. If primary health care is to have a salutary effect on the system it should be based on public health principles, support community alternatives to hospital care (especially home care and long-term care), and facilitate the integration of private practitioners.

- Canada provides world -class care to heart attack patients but we do little to prevent people from having heart attacks, even those who are at high risk because they have already had a heart attack. We also need primary health care centres that develop and support community prevention programs like the Kahnawake school diabetes prevention program, instead of just those focussed on individual patients
- Many patients in hospital beds should be receiving care in other parts of the system such as home care or long-term care. However, at present there is often not enough support to care for complicated patients in these settings. Long-term care, home care and hospital care are intimately interconnected. It is impossible to plan rationally without using all three components. For example, cuts to hospital care have “passively privatized” care. When patients are discharged early or deflected from hospital by so-called ‘quick response teams’ of home care personnel, they often find themselves having to pay for services not covered by the Canada Health Act.
- Ontario’s massive plan for Family Health Networks faces apathy from most practitioners, outright antagonism from a large minority and eager interest from only a few. Part of the problem is that these family doctors have little experience working in teams, even with other doctors. Therefore it would be sensible to start with small projects, which assist private family doctors to better manage their patients and introduce them to teamwork. The Hamilton

HSO mental health and nutrition project is an excellent example of such a project. It doesn't require much change from family doctors, it provides them with a tangibly better service for their patients, it builds relationships, and it whets doctors' appetite for more change. Other similar kinds of projects include the Calgary home care partnership project which links one home care nurse with all of one doctor's home care patients. Doctors are thrilled with the better care their patients receive and learn to work more effectively with nurses.

Federal rationale for funding a network of primary health care centres

There are several rationales for the federal government to take the unusual step of promoting a pan-Canadian network of primary health care centres:

- *Public health.* A network of centres would provide an ideal infrastructure to provide surveillance for communicable, environmental and other threats. The system would also provide a platform across the country for a public health response to terrorist threats such as smallpox or anthrax.
- *Health care renewal.* If the federal government wants to ensure that its money will, in fact, lead to health system renewal, it will ensure the renewal of primary health care services. And if the federal government wishes to ensure that effective models of primary health care are, in fact implemented, then it will have to target its money more carefully to models which have been recommended for decades but which have faced almost insurmountable political barriers within the maelstrom of provincial politics.
- *Access for vulnerable groups.* There needs to be a safety net for access to vulnerable persons such as new Canadians, Aboriginals, those with chronic mental illness and the homeless, who have difficulty accessing the traditional system.

Almost all provinces have some community health centres and others are slowly putting them into place. Quebec is the only province that took Dr. Hastings' report to heart and implemented a full network of 160 primary health care centres – the CLSCs (centres locaux services communautaires). They provide basic primary health care including services from family physicians. They are responsible for home care, local public health, children's mental health and Info-Santé, the province's telephone health advice line. Recent Quebec government policy has reasserted the key role CLSCs will play in system renewal.¹³¹

Most regional health authorities in Western Canada and several in the East have plans for primary health care reform using community health centre type models, but they are being implemented slowly because of the strong competition for dollars from

hospitals. Four reports in New Brunswick have recommended the community health centre model since 1989, but the province is only starting its pilot projects this year.

The federal government has more constitutional legitimacy for public health than health care. Several provinces are upset with their liability for what they perceive to be the federal government's financial responsibility for health care for off-reserve Aboriginal peoples, refugees, new immigrants and official language minorities. If the federal government wished to pursue option three, it could act on the basis of its legitimacy for public health and to ensure service delivery for these identified groups.

The federal government would not administer such centres. They would remain the provinces' responsibility. The centres could be open to whatever other clients the province deemed appropriate besides the identified groups. The centres would not in any way eliminate private practice. They would likely employ a minority of family doctors just as in Quebec, where the CLSC network employs fewer than 20 percent. But community health centres would have a key role to liaise with private practitioners and integrate them into the overall network of care.

Costs

It would cost roughly \$4.75 billion to completely fund home care and long-term care services publicly.¹³² This money would then become part of the CHST fund and grow at the same rate. Mainly, these would not be new funds because the public money would largely replace private funding. In addition, the federal government should provide an extra \$2 billion to help establish the network of primary health care centres. This funding should be phased in over four years. The federal government would work with the provinces to ensure that the network of centres was established.

2. Renewal of public health

The federal government would offer to work with interested provinces to revamp local public health services (e.g., health promotion and public health nursing services) and establish a national immunization program. The federal government would also pay for and provide all vaccines that were part of a national immunization schedule. In return, the provinces would agree to meet federal standards in these areas including meeting targets for immunization and communicable disease surveillance and control. As well, provinces would permit unrestricted contact between local public health services and Health Canada. In many provinces, local public health agencies are now required to access Health Canada through their provincial public health office. This requirement sometimes impedes knowledge and innovation.

Costs

\$500 million including \$220 million for vaccines in the first year.¹³³

3. Full public coverage for pharmacare

The federal government should offer to support provincial pharmacare programs under the Canada Health Act. The provinces would agree to first dollar coverage for all medically necessary drugs. A committee comprising the federal government and all participating provinces would decide upon the drugs covered in a national formulary. Ultimately, the federal government should replace all private costs for prescription drugs.

Costs

It has been estimated that roughly 10 percent of overall prescription drug expenditures could be saved through a national pharmacare program.¹³⁴ As with physicians and hospital insurance, there would be savings from reduced administrative expenditures and the ability of the federal government to bargain for good deals with drug companies. The Canadian Institute for Health Information estimates that the cost of prescription drugs will reach \$14.6 billion in 2002¹³⁵ with approximately 57 percent paid privately.¹³⁶ If a public plan realized 10 percent savings, then the shortfall to be picked up by the public purse would be \$7.5 billion. This program would be phased in over four years.

4. System redesign to deal with waits and delays: A Canadian Modernization Agency

There should be a new agency established to alleviate the waits and delays in the system through improvements in quality and access. Saskatchewan recently established a Quality Council, which has a broad mandate including quality improvement, technology and drug evaluation, as well as monitoring, assessing and reporting on the performance of the system.

As with the Canadian Health Council proposed by Romanow, the mandate for the Saskatchewan Quality Council is too internally contradictory – playing the role of both police and judge – to be workable. Quality improvement is an arduous task, which must involve complete trust between the facilitators and workers in the system. People in the system are much less likely to develop trust with an organization if it can also hurt their service (e.g., by reporting that they are providing substandard care).

Costs

In the UK, the National Health Service created a new organization, the Modernization Agency, to focus entirely on quality improvement. Canada should establish a similar organization dedicated to this function alone. It should initially be funded with \$5 million rising to \$50 million per year over three years. As the major agency dealing with quality improvement, this figure would represent less than \$2 per

capita or 0.01 percent of public health care expenditures. The new Saskatchewan Quality Council has approximately \$3 per capita funding which will rise to \$5 per capita.¹³⁷

5. Technology assessment council

The assessment of technology and pharmaceuticals should be given to a re-vamped Canadian Coordinating Office for Health Technology Assessment. The Coordinating Office has a board composed of representatives from the provinces, territories and federal government and reports to the Council of Deputy Ministers of Health.

Costs

The Canadian Coordinating Office for Health Technology Assessment's current budget of \$3.7 million is completely inadequate for these tasks. It is imperative that we not only assess new drugs before they come on the market, but also implement systematic surveillance to discover rare, but dangerous, side effects which only become apparent when the medication is given to millions of persons (versus the thousands who are typically assessed to get new drugs onto the market). The new agency's budget should be raised to \$50 million per year over three years.

6. A national health advisory forum

One of the major reasons for the slow pace of fundamental reforms (such as primary health care) is that most discussions about health policy occur behind closed doors between system stakeholders and government. As a result, there is little transparency and vested interests almost always trump good evidence.

For example, every analysis of the health care system concludes that the current fee for service payment penalizes quality medical practice and teamwork while crippling innovation. However, there is very little movement on this issue when the provincial governments negotiate reform in the health system behind closed doors with their medical associations. Tomes of critical thinking are left outside when doctors and governments start horsetrading in sequestered backrooms. The interest of citizens and individual doctors are often checked as well.

As a further example, the September 2000 federal/provincial/territorial agreement was supposed to lead to the development of 14 key performance indicators. The public was supposed to be consulted during this process. This could have been a unique opportunity for democratic influence on health policy direction. However, there were no public consultations because according to one government representative, "there just wasn't time."

The federal government with the provinces and territories should organize a permanent forum for discussion of health policy issues. The board of the forum should be made up of providers, consumers, academics and governments.

Paul Sabatier, a professor of policy studies at the University of California at Davis, has suggested that such forums can speed effective policy implementation by ensuring that the best evidence is used in policy debates.¹³⁸ If the issues are carefully selected and the forum is run according to the proper rules one can achieve ‘policy oriented learning’ which involves “relatively enduring alterations of thought or behavioral intentions.” In other words, individuals and organizations can change they way they think and act if subjected to evidence-based discourse. To achieve policy oriented learning, policy forums should be public, should feature at least two distinct positions, and should focus on those issues with a medium level of conflict. The reason for the latter point is that trivial issues don’t force sides to marshal their arguments and choosing issues with high levels of conflict tends to lead to heated rhetorical confrontation. Furthermore, the issues which are most amenable to discussion in such a forum are those which are at least somewhat susceptible to quantitative analysis because this helps keep the debate at a scientific level.

Using the example of the perceived doctor shortage, when the evidence that there are more doctors than ever is entered into the public debate, it forces a different discussion. Physician organizations then have to acknowledge that the real causes of access problems have little to do with actual numbers of doctors. Rather, the solutions to access problems involve changes to physician practice styles with associated reforms in payment method and training.

Governments tend to avoid conflict but it is only through controlled conflict that movement is made on difficult policy issues.

Costs

The federal government should contribute \$10 million per year allowing for 30 staff, four national meetings, and ten regional meetings per year.

7. A medical diagnostics fund

As recommended by the Romanow Commission, it is important that Canada purchase new diagnostic equipment. However, it is essential that this not be one-time funding. Canada needs new MRI and CAT scans, but we also need to renew our stock of older technology imaging equipment.

Costs

It is recommended that the federal government spend \$500 million per year on medical diagnostics. The federal government would make its grants to the provinces in

this area congruent with the assessments performed by the technology assessment council.

Implications of Option three

Implications for federal/provincial/territorial relations

- There would be more stress than with option 2 and much more than with option 1. Quebec, Ontario and Alberta would oppose this option fairly strongly. Several of the smaller provinces would be interested but, except for Saskatchewan, would have problems saying so publicly. However, Quebec's opposition would be blunted because the province would be eligible for most money (including that for community health centres) without substantial policy change. In general, Canadians would be very supportive of this option because it is most congruent with their aspirations for a more effective and efficient health care system.

Implications for protection of public finance and non-profit delivery

- Option three would extend public finance to first dollar coverage for home care, long-term care and pharmacare.
- More federal money and active leadership would increase the federal government's political clout to enforce the Canada Health Act.
- If this option included Romanow's suggestions, which would indirectly limit the growth of for-profit care, then there would be reasonable protection of public finance and non-profit delivery.

Implications for the effectiveness and efficiency of the health care delivery system

- Option three would greatly improve the effectiveness and efficiency of health care delivery beyond option two. It would establish a more efficient vehicle for delivering community programs. It would also establish a Modernization Agency to spread best practices and continuous quality improvement throughout the system.

Implications for the health of Canadians

- Option three would considerably improve the health of Canadians through improvements in public health, the better management of chronic illness, and the faster flow of patients through the system.

Table 1: Funding for Option 3

	2003-04	2004-05	2005-06	2006-07
Long term care and home care	\$0.2 billion	\$1.0 billion	\$2.5 billion	\$4.75 billion
Primary health care	0.2	0.7	\$1.3	2
Public health	0.2	0.5	0.5	0.5
Pharmacare	0.5	2.0	5.0	7.5
Modernization Agency	0.005	0.025	0.05	0.05
Technology assessment	0.01	0.02	0.04	0.05
National Health Advisory Forum	0.01	0.01	0.01	0.01
Medical diagnostics	0.5	0.5	0.5	0.5
Total	\$1.625 billion	\$4.755 billion	\$9.90 billion	\$15.36 billion

Conclusion

We have a unique opportunity to rejuvenate Canada's health policy and our country. It is crucial that the federal government take action quickly to build on the Romanow report and go much further.

This paper outlines a comprehensive option for the renewal of Canada's health policy. The costs for option three for next year are estimated at \$1.6 billion rising to \$15.4 billion in 2006-07. The federal budget surplus for 2002-03 is likely to be \$9 billion. As long as economic growth averages at least 2 percent over the next four years (a conservative estimate) and there are no major tax cuts, these new expenditures are affordable. This is particularly so because most of the new federal spending replaces private spending. If the federal government funded option three through the surplus, it would provide windfall savings to those firms and individuals who are currently paying privately for these health services.

Or the federal government could raise taxes to support its new spending. In this case, many businesses and individual taxpayers would still be better off because their new taxes would be less than their current private health care spending.

In the past five years, the federal government has used its improved financial situation largely to pay down the debt and cut taxes. Now, it still has a large budget surplus. The choice is clear. Will the government cut taxes further or will it finally fulfill the promises it made in the last three election campaigns?

Endnotes

-
- ¹ Katz SJ, Cardiff K, Pascall M, et al. Phantoms in the Snow: Canadians' use of health care services in the United States. *Health Affairs*. 2002;21(3):19-31.
- ² Ontario Provincial Auditor 2002 annual report. Released December 3, 2002. Accessed at: <http://www.gov.on.ca/opa/english/r02t.htm> on 021204.
- ³ Hollander M, Tessaro A. Evaluation of the maintenance and preventive model of home care. Hollander Analytical Services. Victoria. 2001.
- ⁴ Estey J. observed in *Schneider v. The Queen*, [1982] 2 S.C.R. 112, p. 142:
- ⁵ Canadian Centre for Policy Alternatives. Alternate Federal Budget 2003. Economic and Fiscal update. October 29, 2002. Accessed at: <http://www.policyalternatives.ca/afb/afb2003-fiscal-statement.pdf> 021205.
- ⁶ Government of Canada Fiscal Reference tables. Accessed at: http://www.fin.gc.ca/frt/2002/frt02_e.pdf 030102
- ⁷ Report of the Ontario Health Review Panel. (Chair, Dr. John Evans). Government of Ontario. Toronto. 1987.
- ⁸ US data from Department of Health and Human Services accessed at: <http://cms.hhs.gov/statistics/nhe/projections-2001/t1.asp> 030103. Canadian data from Canadian Institute for Health Information accessed at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_18dec2002_e 030103.
- ⁹ OECD data accessed at: <http://www.oecd.org/EN/statistics/0..EN-statistics-12-nodirectorate-no-1-no-12-no-no-2.00.html> 021231.
- ¹⁰ Rouleau JL, Moye LA, Pfeffer MA, et al. A comparison of management patterns after acute myocardial infarction in Canada and the United States. *New England Journal of Medicine*. 1993;328:779-784.
- ¹¹ Boulanger BR, McLellan BA, Sharkey PW, et al. A comparison between a Canadian regional trauma unit and an American level 1 trauma center. *Journal of Trauma*. 1993;35:261-266.
- ¹² Joffres MR, Hamet P, MacLean DR, et al. Distribution of blood pressure and hypertension in Canada and the United States. 2001;14:1099-1105.
- ¹³ Katz SJ, Zemencuk JK, Hofer TP. Breast cancer screening in the United States and Canada, 1994. *American Journal of Public Health*. 2000;90:799-803.
- ¹⁴ Wolf HK, Andreou P, Bata IR, et al. Trends in the prevalence and treatment of hypertension in Halifax County from 1985 to 1995. *Canadian Medical Association Journal*. 1999;161:699-704.
- ¹⁵ Anis AH, Lynd LD, Wang X, et al. Double trouble: impact of inappropriate use of asthma medication on the use of health care resources. *Canadian Medical Association Journal*. 2001;164:625-631.
- ¹⁶ McColl A, Roderick P, Gabbay J, et al. Performance indicators for primary care groups: an evidence based approach. *British Medical Journal*. 1998;317:1354-1360.
- ¹⁷ Romanow remedies find wide support. *Toronto Star*. December 6, 2002.

-
- ¹⁸ Devereaux PJ, Choi PTL, Lacchetti C, et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *Canadian Medical Association Journal*. 2002;166:1399-1406.
- ¹⁹ Aiken LH, Clarke SP, Sloane DM, et al. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association*. 2002;288:1987-1993.
- ²⁰ Devereaux PJ, Schunemann HJ, et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta analysis. *Journal of the American Medical Association*. 2002;288:2449-2457.
- ²¹ Rachlis MM. The hidden costs of privatization: an international comparison of community and continuing care. In: *Without foundation: How Medicare is undermined by gaps and privatization in community and continuing care*. Eds: Cohen M, Pollak N. Canadian Centre for Policy Alternatives - BC Office. Vancouver. 2000.
- ²² Shapiro E, Tate RB. Monitoring the outcomes of quality of care in nursing homes using administrative data. *Canadian Journal of Aging*. 1995;14:755-768.
- ²³ Himmelstein DU, Woolhandler S, Hellander I, Wolfe SM. Quality of care in investor-owned vs. not-for-profit HMOs. *Journal of the American Medical Association*. 1999;282:159-163.
- ²⁴ Woolhandler S, Himmelstein DU. Costs of Care and Administration at For-Profit and Other Hospitals in the United States. *New England Journal of Medicine* 1997;336:769-774.
- ²⁵ Silverman EM, Skinner J, Fisher E. The association between for-profit hospital ownership and increased Medicare spending. *New England Journal of Medicine*. 1999;341:420-426.
- ²⁶ Shapiro E. The cost of privatization: Olsten Corporation and the crisis in American for-profit home care. Canadian Centre for Policy Alternatives. Winnipeg. 1997.
- ²⁷ Armstrong P, Armstrong H, Fuller C. Health care, limited: The privatization of Medicare. Canadian Centre for Policy Alternatives. Ottawa. November 2000. Accessed at: <http://www.policyalternatives.ca/publications/health-care-ltd.pdf> 030121.
- ²⁸ Hasan MM. Let's end the nonprofit charade. *New England Journal of Medicine*. 1996;334:1055-1057.
- ²⁹ Leslie C. The private clinic debate. *The Medical Post*. May 9, 2000:22-23.
- ³⁰ Evans RG, Barer ML, Lewis S, et al. Private highway, one-way street: The Deklein and fall of Canadian Medicare? Centre for Health Services and Policy Research, University of British Columbia. Health Policy Research Unit Discussion Paper series. HPRU 2000;3D. March 2000.
- ³¹ From Ontario Provincial Auditor's Annual Report 1996. Accessed at: <http://www.gov.on.ca/opa/english/r96t.htm> 021228
- ³² Pollock AM, Shaoul J, Vickers N. Private finance and 'value for money' in NHS hospitals: A policy in search of a rationale. *British Medical Journal*. 2002;324:1205-1209.
- ³³ Smith R. PFI: perfidious financial idiocy. *British Medical Journal* 1999; 319: 2-3.
- ³⁴ NS Tories dump P3 schools program. *Halifax Daily News*. June 23, 2000.

-
- ³⁵ Johnson J. How will international trade agreements affect Canadian health care. Discussion paper #22. Royal Commission Health Care. Accessed at: http://www.healthcarecommission.ca/Suite247/Common/GetMedia_WO.asp?MediaID=1069&Filename=2_2_Johnson_E.pdf. 021104.
- ³⁶ Rachlis M. A Review of the Alberta Private Hospital Proposal. Caledon Institute for Social Policy. March 2000. Accessed at: www.caledoninst.org 021104.
- ³⁷ Commission of Inquiry on the Blood System in Canada. Final Report. Ottawa: Canadian Government Publishing -- PWGSC;1997. P. 1073.
- ³⁸ Sullivan P. Canada's public health system beset by problems: report. Canadian Medical Association Journal. 2002;166:1319.
- ³⁹ Anon. Public Health on the ropes. Canadian Medical Association Journal. 2002;166:1245.
- ⁴⁰ Frank JW Presentation to the Commission on the Future of Health Care in Canada. April 2002.
- ⁴¹ West Nile virus data from US Centers for Disease Control -- <http://www.cdc.gov/ncidod/dvbid/westnile/index.htm> and Ontario Ministry of Health http://www.gov.on.ca/health/english/program/pubhealth/wnv_mn.html#surveillance
- ⁴² Uppaluri A, Naus M, Heywood N. Effectiveness of the immigration medical surveillance program for tuberculosis in Ontario. *Can J Public Health* 2002;93:88-91.
- ⁴³ Barber J. Efforts against tuberculosis not good enough. *Globe and Mail*. April 24, 2002
- ⁴⁴ McQuigge M. Water: A clear and present danger. *Canadian Journal of Public Health*. 2002;93:10-11.
- ⁴⁵ van Netten C, Pereira R, Brands R. Drinking water supply and management practices in British Columbia, 1997-98. *Canadian Journal of Public Health*. 2002;93:14-18.
- ⁴⁶ Urquhart I. Safe water: Who's going to pay? *Toronto Star*. October 30, 2002.
- ⁴⁷ City of Toronto. Moving towards cleaner air. A progress report on the air quality strategy for the City of Toronto. From: http://www.city.toronto.on.ca/environment/movingto_report.pdf accessed 021123.
- ⁴⁸ Guyatt G. Newly developed drugs pose more dangers for patients. *Straight Goods*. October 28, 2002. Accessed at: <http://goods.perfectvision.ca/ViewFeature.cfm?REF=704> 021123.
- ⁴⁹ Anderson MR, Peacock S, Nelson J et al. Worry about ovarian cancer risk and use of ovarian cancer screening by women at risk for ovarian cancer. *Gynecologic Oncology*. 2002;85:3-8, 2002 Apr.
- ⁵⁰ Roos LL, Traverse D, Turner D. Delivering prevention: the role of public programs in delivering care to high-risk populations. *Medical Care*. 1999;37:JS264-JS278.
- ⁵¹ Menec VH, Roos NP, Nowicki DL, et al. Seasonal patterns of Winnipeg hospital use. Manitoba Centre for Health Policy and Evaluation. Winnipeg. 1999. (Accessed at: http://www.umanitoba.ca/centres/mchp/reports/reports_97-00/seasonal.htm 021102 1330h EST)
- ⁵² Saskatchewan Health Services Utilization and Research Commission. Hospital and home care study. mimeo. March, 1998.
- ⁵³ DeCoster C, Peterson S, Kasian P. Alternatives to acute care. Manitoba Centre for Health Policy and Evaluation. July 1996.

-
- ⁵⁴ Hutchison B, Woodward C, Norman G, et al. Provision of preventive care to unannounced standardized patients. *Canadian Medical Association Journal*. 1998;158:185-193.
- ⁵⁵ Stampfer MJ, Hu FB, Manson JE, et al. Primary prevention of coronary heart disease in women through diet and lifestyle. *New England Journal of Medicine*. 2000;343:16-22.
- ⁵⁶ Saskatchewan Health Services Utilization and Research Commission. Hospital and home care study. mimeo. March, 1998.
- ⁵⁷ DeCoster C, Peterson S, Kasian P. Alternatives to acute care. Manitoba Centre for Health Policy and Evaluation. July 1996.
- ⁵⁸ Bruera E, Neumann CN, Gagnon B, et al. Edmonton regional palliative care program: impact on patterns of terminal cancer care. *Canadian Medical Association Journal*. 1999;161:290-293.
- ⁵⁹ Molloy DW, Urbanyi M, Horsman JR, et al. Two years experience with a comprehensive health care directive in a home for the aged. *Annals of the Royal College of Physicians and Surgeons of Canada*. 1992;25:433-436.
- ⁶⁰ Molloy DW, Guyatt GH, Russo R, et al. Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. *Journal of the American Medical Association*. 2000;283:1437-1444.
- ⁶¹ Hall N, De Beck P, Johnson D, Mackinnon K, Gutman G, Glick N. Randomized trial of a health promotion program for frail elders. *Canadian Journal on Aging*. 1992;11:72-91.
- ⁶² Institute for Clinical Evaluative Sciences. Diabetes in Ontario: An ICES practice Atlas. Accessed at: www.ices.on.ca 030108.
- ⁶³ UK Prospective Diabetes Study Group. Intensive blood glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in type 2 diabetes: UKPDS 33. *The Lancet*. 1998;352:837-853.
- ⁶⁴ Braglia P, Apostolon C, Wetzl T, Lee H. The Health Promotion Initiative in Diabetes (HPID) Outcomes Management Program at the Group Health Centre. Presentation to the Canadian Diabetes Association Annual Meeting.
- ⁶⁵ Lee H, Garniss D, Oliver R et al. A community hospital-based heart failure program decreases readmission rates. Abstract for Society of General Internal Medicine meeting in San Diego May 2001.
- ⁶⁶ Young TK, Reading J, Elias B, O'Neil JD. Type 2 diabetes mellitus in Canada's first nations: status of an epidemic in progress. *Canadian Medical Association Journal*. 2000;163:561-566.
- ⁶⁷ Stampfer MJ, Hu FB, Manson JE, et al. Primary prevention of coronary heart disease in women through diet and lifestyle. *New England Journal of Medicine*. 2000;343:16-22.
- ⁶⁸ Macaulay AC, Parais G, Potvin L, et al. The Kahnawake schools diabetes prevention project: intervention, evaluation, and baseline results of a diabetes primary prevention program with a native community in Canada. *Preventive Medicine*. 1997;26:779-790.
- ⁶⁹ Daniel M, Green LW, Marion SA, et al. Effectiveness of community-directed diabetes prevention and control in a rural Aboriginal population in British Columbia, Canada. *Social Science and Medicine*. 1999;48:815-832.

-
- ⁷⁰ Walker AG. Mohawks take charge to prevent type 2 diabetes. *Medical Post*. January 15, 2002:p.5.
- ⁷¹ Markel H. Diagnosis Supersize. *New York Times*. March 24, 2002:A4.
- ⁷² See: Rachlis MM. A paper prepared for a workshop on intersectoral action and health sponsored by Health Promotion and Programs Branch Alberta/NWT/Nunavut Region, Health Canada. Available from the author at: michaelrachlis@rogers.com
- ⁷³ Canadian Institute for Health Information. Supply, distribution, and migration of Canadian Physicians 2001. Accessed at: http://secure.cihi.ca/cihiweb/en/AR14_2001_tab1_e.html
- ⁷⁴ Chan BTB. From perceived surplus to perceived shortage: What happened to Canada's physician workforce in the 1990s?
- ⁷⁵ These data were compiled from a series of reports published by Health Canada and the Canadian Institute for Health Information.
- ⁷⁶ From OHIP fee schedule websites
http://www.gov.on.ca/health/english/program/ohip/sob/physserv/a_consul.pdf accessed 021111
- ⁷⁷ From http://www.gov.on.ca/health/english/program/ohip/sob/physserv/s_digest.pdf accessed 021111.
- ⁷⁸ From: http://www.gov.on.ca/health/english/program/ohip/sob/physserv/y_specia.pdf accessed 021111
- ⁷⁹ From: http://www.gov.on.ca/health/english/program/ohip/sob/physserv/v_female.pdf accessed 021111
- ⁸⁰ Chan BTB. The declining comprehensiveness of primary care. *Canadian Medical Association Journal*. 2002;166:429-434.
- ⁸¹ Kates N, Crustolo A-M, Nikolaou L, et al. providing psychiatric backup to family physicians by telephone. *Canadian journal of Psychiatry*. 1997;42:955-959.
- ⁸² Wasson J, Gaudette C, Whaley F. Telephone care as a substitute for routine clinic follow-up. *Journal of the American Medical Association*. 1992;267:1788-1793.
- ⁸³ Johnston B, Weeler L, Deuser J, et al. Outcomes of the Kaiser Permanente tele-home health research project. *Archives of Family Medicine*. 2000;9:40-45.
- ⁸⁴ Lattimer V, George S, Thompson F, et al. Safety and effectiveness of nurse telephone consultation in out of hours primary care: randomised trial. *British Medical Journal*. 1998;317:1054-1059.
- ⁸⁵ Hagan L, Garon G. Info-sante CLSC: Un service efficace? *Canadian Journal of Public Health*. 1998;89:125-128.
- ⁸⁶ Morgan SG. Issues for Canadian pharmaceutical policy. In: *Canada Health Action: Building on the Legacy*. Papers commissioned by the National Forum on Health. Health Canada. Ottawa. Volume 4. 1998:677-735.
- ⁸⁷ Canadian Institute for Health Information.
- ⁸⁸ Jeffrey Robinson.
Prescription Games: Money, Ego, and Power inside the Global Pharmaceutical Industry. McClelland & Stewart Ltd., Toronto. 2001.

-
- ⁸⁹ Derfel A. 'Free Trade Area of the Americas' Experts: Prescription Drug Costs Will Soar Montreal Gazette April 19, 2001. Accessed at: <http://www.commondreams.org/headlines01/0419-01.htm>.
- ⁹⁰ Rubin K. How Ottawa manipulated drug patent protection. The Hill Times. December 8, 1997.
- ⁹¹ Canadian Institute for Health Information.
- ⁹³ ALLHAT Officers and Coordinators for the ALLHAT Collaborative research group. Major outcomes in high-risk hypertensive patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic. Journal of the American Medical Association . 2002;288:2981-2997.
- ⁹⁴ Morgan S. Price and productivity measurement in a pharmaceutical sector sub-market: the real cost of treating hypertension. Centre for Health Services and Policy Research. University of British Columbia. Research Report HPRU 01:12w. November 2001.
- ⁹⁵ Mamdini M, Rochon, Laupacis A, et al. Initial patterns of use of COX -2 inhibitors by elderly patients in Ontario: findings and implications. Canadian Medical Association Journal. 2002;167:1125-26.
- ⁹⁶ Tamblyn RM, McLeod PJ, Abrahamowicz M, et al. Questionable prescribing for elderly patients in Quebec. Canadian Medical Association Journal. 1994;150:1801-
- ⁹⁷ Anderson GM, Lexchin J. Strategies for improving prescribing practice. Canadian Medical Association Journal. 1996;154:1013-1017.
- ⁹⁸ Avorn J, Cehn R, Hartley R. Scientific versus commercial sources of influence on prescribing behavior of physicians. American Journal of Medicine. 1982;73:4-8.
- ⁹⁹ Schwartz RK, Soumerai SB, Avorn J. Physician motivations for nonscientific drug prescribing. Social Science and Medicine. 1989;28:577-582.
- ¹⁰⁰ Ornish D. Avoiding revascularization with lifestyle changes: the multicenter lifestyle demonstration project. American Journal of Cardiology. 1998;82(10B):72T-76T.
- ¹⁰¹ Mynors-Wallis LM, Gath DH, Lloyd-Thomas AR, et al. Randomized controlled trial comparing problem solving treatment with amitriptyline and placebo for major depression in primary care. British Medical Journal. 1995;310:441-445.
- ¹⁰² Galt KA. Cost avoidance, acceptance, and outcomes associated with a pharmacotherapy consult clinic in a Veterans Affairs Medical Center. Pharmacotherapy. 1998;18:1103-1111.
- ¹⁰³ Lexchin J. A national pharmacare plan: combining efficiency with equity. Canadian Centre for Policy Alternatives. Ottawa. 2001. Accessed at: <http://www.policyalternatives.ca> 021206
- ¹⁰⁴ Ornish D. Avoiding revascularization with lifestyle changes: the multicenter lifestyle demonstration project. American Journal of Cardiology. 1998;82(10B):72T-76T.
- ¹⁰⁵ Cleroux J, Feldman RD, Pterella RJ. Recommendations on physician exercise training. Canadian Medical Association Journal. 1999;160(9 suppl):S21-S-28.
- ¹⁰⁶ Hux JE, Melady MP, DeBoer D. Confidential prescriber feedback and education to improve antibiotic use in primary care: a controlled trial. Canadian Medical Association Journal. 1999;161:388-392.
- ¹⁰⁷ Avorn J, Soumerai SB. Improving drug therapy decisions through educational outreach: A randomized controlled trial of academically based "detailing". New England Journal of Medicine. 1983;308:1457-1463.
- ¹⁰⁸ Soumerai SB, Avorn J. Economic and policy analysis of university-based drug "detailing". Medical Care. 1986;24:313-331.

-
- ¹⁰⁹ Nakagawa B. The Community Drug Utilization Program. A presentation to the Second National Conference on Cost-effective Drug Therapy. November 27 -28, 1997.
- ¹¹⁰ Bajcar J, Vaillancourt R. Integrated delivery of pharmaceutical care in family practice: a case example. *Pharmacy Connection*. Sept/Oct 1996:26-33.
- ¹¹¹ Patented Medicine Prices Review Board 1998 Annual Report. PMPPRB. Ottawa. 1999.
- ¹¹² Yakabowich MR, Keeley G, Montgomery PR. Impact of a formulary on personal care homes in Manitoba. *Canadian Medical Association Journal*. 1994;150:1601-1607.
- ¹¹³ Doering PL, Russell WL, McCormick WC, et al. Therapeutic substitution in the health maintenance organization outpatient environment. *Drug Intelligence and Clinical Pharmacy*. 1988;22:125-130.
- ¹¹⁴ Maclure M, Potashnik TM. What is direct evidence-based policy making? Experience from the drug benefits program for seniors in British Columbia. *Canadian Journal on Aging*. 1997;(suppl 1):132-146.
- ¹¹⁵ Personal communication with BC Ministry of Health. March 3, 2000.
- ¹¹⁶ Schneeweiss S, Walker AM, Glynn RJ, et al. Outcomes of reference pricing for angiotensin -converting-enzyme inhibitors. *New England Journal of Medicine*. 2002;346:822-829.
- ¹¹⁷ Brook RH, Ware JE, Rogers WH, et al. Does free care improve adults' health? Results from a randomized trial; *New England Journal of Medicine*. 1983;309:1426-1434.
- ¹¹⁸ Manning WG, Newhouse JP, Duan N, et al. Health insurance and the demand for medical care: evidence from a randomized experiment. *American Economics Review*. 1987;77:251-277.
- ¹¹⁹ Cardwell M. Quebec drug plan backfires. *Medical Post*. April 13, 1999.
- ¹²⁰ Soumerai SB, Ross-Degnan D, Avorn J, et al. Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes. *New England Journal of Medicine*. 1991;325:1072-1077.
- ¹²¹ Crossing the Quality Chasm: A New Health System for the 21st Century. The Institute of Medicine. National Academy press. Washington. 2001. (Also available at: <http://books.nap.edu/books/0309072808/html/index.html>)
- ¹²³ Kates N, Crustolo A-M, Farrar S, et al. Integrating mental health services into primary care: lessons learnt. *Families, Systems & Health*. 2001;19(1):5-12.
- ¹²⁴ Morris C. NB government defends lawn tractor purchases for hospitals. *Canadian Press Newswire*. April 4, 2002.
- ¹²⁵ Canada press Newswire. Provinces spend Ottawa's medical fund on saws, steamer. June 10, 2002.
- ¹²⁶ Hutchison B, Abelson J, Lavis J. **Primary care in Canada: so much innovation, so little change**. *Health Affairs*. 2001;20(3):116-31.
- ¹²⁷ Ontario Ministry of Health Press Release. Ernie Eves government announces London's first Family Health Network. December 17, 2002. Accessed at: <http://www.newswire.ca/government/ontario/english/releases/December2002/17/c4644.html> 030107

-
- ¹²⁸ Price Waterhouse coopers. Ontario Ministry of Health and Long Term Care. Evaluation of primary care reform pilots in Ontario. October 31. 2001. Toronto.
http://www.ontariofamilyhealthnetwork.gov.on.ca/english/pilot/pilot_eval_2.pdf
- ¹²⁹ Shah C, Moloughney BW. A strategic review of the community health centre program. Ontario Ministry of Health and Long Term Care. Toronto. May 2001. Accessed at:
http://www.aohc.org/Articles/chc_review1.pdf 030107.
- ¹³¹ Santé et Services Sociaux Québec. L'Allocatin des ressources et la budgétisation des services de CLSC et de CHSLD.
- ¹³² The total cost of long-term care is forecast to be \$10.4 billion with 27.5 percent private funding (\$2.86 billion private). Canadian Institute for Health Information. Health spending to top \$112 billion. December 18, 2002. Accessed at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_18dec2002_2_e#charts 030107. The total Public cost of home care for 2002 is estimated at \$4.21 billion (based on costs of \$2.77 billion for 1998/99 and 11 percent annual increases since. Canadian Institute for Health Information Home care study. Accessed at: http://www.cihi.ca/cihiweb/en/downloads/spend_nhexenhance_e_Feasstudy.pdf. Private home care costs are not known with certainty but if they amount to the same percentage as for long-term care, they would total \$1.69 billion. Therefore, the total private long-term care and home care expenditures amount of approximately \$4.75 billion.
- ¹³³ Based on costs of \$7.11 per capita for vaccines. See: Boomer R. Nova Scotia medical officer calls for national immunization standards. Halifax Daily News. December 5, 2002.
- ¹³⁴ Lexchin J. A national pharmacare plan: combining efficiency with equity. Canadian Centre for Policy Alternatives. Ottawa. 2001. Accessed at: <http://www.policyalternatives.ca> 021206
- ¹³⁵ Canadian Institute for Health Information. Health spending to top \$122 billion. December 18, 2002. Accessed at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_18dec2002_2_e#charts 030107.
- ¹³⁶ Canadian Institute for Health Information. Drug expenditures in Canada. 2002. Accessed at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR80_2000sum_e 030107.
- ¹³⁷ Personal communication with Laurie Thompson, interim executive director Saskatchewan quality Council. 030107.
- ¹³⁸ Ellison BA. Intergovernmental relations and the advocacy coalition framework: The operation of federalism in Denver water politics. *Publius*. 1998;28(4):35-54. Accessed at: http://plsc.uark.edu/plsc4283/CLASSNOTES/advocay%20framework_and.htm . 030123.