Slide 1
Strengthening Canadian Medicare: How are we doing? What needs to change?

In a variety of roles – as a patient, family physician, teacher, researcher and caregiver – I've been a witness to the evolution of health care in Canada. I was born in 1942, making me what is sometimes referred to as a "war baby". So the first 24 years of my life were pre-medicare. **Slide 2** This slide represents my first encounter with the Canadian health care system. These are the hospital bills for my mom and me and the bill from the obstetrician who presided at my birth. The total cost, $148, seems quite modest, but my dad's annual salary at the time was only $3600 - so the charges for my birth amounted to 4% of our family income that year. I wonder if my parents thought I was worth it.
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I was in medical school at the University of Western Ontario during the gestation and birth of medicare. As medical students in the pre-medicare era, we encountered two classes of patients: private and public. Actually we mainly saw public patients, who lacked private insurance or the means to pay for their care, and were housed in multi-bed wards, commonly referred to as "the charity wards". Participating in the care of **private** patients was a rare privilege and occurred only with the consent of the patient and the attending physician. On the other hand, it was not unusual for public patients to be examined en masse by a troop of us students, with only the privacy afforded by a curtain and, as I remember, no choice in the matter.

By the time I opened my family practice, all of Canada's provinces and territories had joined the medicare program. However, under the Medical Care Act of 1966, physicians were able to extra-bill beyond the fee payable through the provincial/territorial medical care plan. Although most family physicians, including me, did not extra-bill, the practice became sufficiently common among specialists, that extra-billing came to be seen as a threat to the principal of access to care based on need. This concern ultimately led to the passage of the Canada Health Act in 1984 which allows the federal government to deduct from federal transfers any money collected through extra-billing or user fees. In 1986, the Ontario Medical Association struck against provincial legislation that banned extra-billing. Participation in job action was half-hearted, particularly among family physicians. Many,

including myself, continued to work during the strike, which ultimately collapsed without concessions by the government.

Since that time I've had the opportunity to view medicare from the vantage points of family physician, health services and policy researcher and family caregiver. In recent years, I've been a participant, observer and analyst of the primary care renewal efforts that began in Canada at the start of this century.

Of course, the medicare we have is not the program envisioned by Tommy Douglas or Emmett Hall, the two great architects of Canada's medicare program. In 1961, referring to the proposed Saskatchewan Medical Care Insurance plan, Douglas said: "This medical care plan…will prove to be the forerunner of a national medical care insurance plan. It will become the nucleus around which Canada will ultimately build a comprehensive health insurance program which will cover all health services – not just hospitalization and medical care – but eventually…all other services which people receive." Featured prominently in the Hall Commission Report was a "Health Charter for Canadians", said to have been written by Hall himself, calling for a comprehensive, universal health service program for Canadians that "includes all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide." The Commission made specific recommendations for coverage of vision care, dental care and pharmaceuticals. The medicare program envisioned by Douglas, Hall and others has yet to be realized.

Ted Marmor, Professor Emeritus in the School of Management, the School of Law and the Department of Political Science at Yale University, has referred to Canadian medicare as a public policy miracle. To me, what makes it truly miraculous is that in a society where access to almost all goods and services depends on the ability to pay, the majority of Canadian citizens and policy makers supported, and continue to support, a program that rests on the principle that access to and quality of medical and hospital care should be determined solely on the basis of need. Many of us take pride and delight in this anomaly, while brushing aside unsettling questions about the limits of medicare. If the principle of care based on need deserves our support in relation to hospital and physicians' services, why should it stop there? What about other beneficial health services such as pharmaceuticals, vision care, dental care, home care, chiropractic services and rehabilitation therapies?

There is now a compelling body of evidence demonstrating the association between strong primary care systems and superior health outcomes and greater health equity. Primary care refers to the care provided by family physicians and, increasingly, by primary care teams that include family physicians, nurses, nurse practitioners and other health professionals such as pharmacists, dietitians, social workers occupational therapists and mental health workers.

Statements by Canadian policy makers and commentators recognizing the importance of primary care to health system performance and health outcomes are becoming increasingly commonplace. In his opening remarks at the 2012 Accelerating Primary Care conference, Fred Horne, Alberta's Minister of Health and Wellness referred to putting "primary health care where it rightfully belongs, at the centre of the health system". The Drummond Commission on the Reform of Ontario's Public Services recommended in its 2012 report that the government "Make primary care a focal point of a new integrated health model".

Slide 4 This chart summarizes the Commonwealth Fund's 2010 assessment of the comparative performance of the health care systems of seven high-income countries. The performance rankings were based on health data compiled by the Organisation for Economic Cooperation and Development - the OECD - and on international surveys of patients and primary care physicians conducted by the Fund. The top two rankings are dark blue and the lowest three rankings are light blue. Underlying this picture are some potential policy lessons about primary care. Two countries stand out in overall performance: the Netherlands and the UK. Although they differ substantially regarding health care financing and the role of private insurance, they have much in common when it comes to primary care policy and system characteristics. Both countries have invested heavily over the last two decades in strengthening primary care. Shared features include: mandatory patient registration with a primary care provider, the absence of primary care user charges, local primary care governance, primary care gate-keeping, capitation-based blended payment for primary care physicians, interdisciplinary primary care teams, and major investments in quality improvement and electronic medical records in primary care.

While many other high-income countries focused attention on primary care policy and investments during the 1990s, Canada barely managed to tread water - and has yet to catch up. As a result, Canada's primary care

performance continues to lag behind many of our peers, particularly in timely access to primary care and primary care infrastructure. The next few slides draw on data from the Commonwealth Fund's International Health Policy Surveys. They highlight opportunities for improvement in Canadian performance by showing the gap between Canada's performance and that of the best performing countries in primary care access, patient centredness and engagement, quality of care, and infrastructure.

Slide 5 Whether assessed from the perspective of the general adult population, people with chronic or recent serious health problems, or primary care physicians, the gap for many measures of access to primary care is wide. These radar graphs, and those that follow, show the percent of respondents who responded favourably to the relevant items, with the concentric lines representing increments of 20% from the centre of the graph to the outer 100% line. The blue line shows Canada's performance, while the red line shows the best performer among the countries surveyed. Access measures include such things as the percentage of people who report having an appointment with a doctor or nurse the same or next day the last time they were sick, the percentage of people who found it easy or very easy to get medical care outside regular practice hours without going to the emergency room and the percentage of primary care physicians who reported having an arrangement for patients to be seen by a doctor or nurse, if needed, when the practice is closed.

Slide 6 On patient reported measures of patient centredness and patient engagement, Canada's performance is not substantially lower than the best performers. Patient centredness measures include the percentage of people who report that their regular doctor or someone in their doctor's practice always spends enough time with them and always involves them as much as they want in decisions about their care.

Slide 7 The quality of primary care in Canada appears similar to that of the best performing countries on most measures. Quality of care measures include such things as the proportion of sicker adults who report that their regular doctor or someone in their doctor's practice always helps coordinate or arrange the care they receive from other doctors and places, the proportion of people with diabetes who reported that their feet were examined in the past year and the percentage of seniors who reported having a flu shot in the past year.

Slide 8 Primary care infrastructure in Canada is plainly inferior to that of most other countries included in the Commonwealth Fund surveys, ranking in the bottom half on all but one measure in the 2012 survey of primary care physicians. For example, Canada ranked second last in the percentage of primary care physicians whose practice included at least one non-physician health care provider. Canada also ranked second last in the use of electronic medical records by primary care physicians and on several measures of the functionality of their electronic medical records. Infrastructure for performance measurement, feedback and quality improvement is seriously underdeveloped in Canadian primary care relative to most of the comparator countries. **Slide 9 (blank)**

After two decades of stagnation, many of the provinces and territories began in the early 2000s to invest in policies and programs designed to strengthen primary care. These initiatives were enabled by an improved fiscal climate and spurred by growing public and professional dissatisfaction with the status quo, the reports of the Romanow Commission and of the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby, both of which highlighted the centrality of primary care to health system performance, and, finally, federal funding targeting primary care reform channeled through the Primary Health Care Transition Fund in 2000 and the Health Reform Fund in 2003.

Several primary care reform initiatives have been implemented broadly in one or more jurisdictions. They include primary care networks, interprofessional primary care teams, patient enrollment with a primary care provider, blended physician payment schemes and targeted financial incentives, local or regional primary care governance, expansion of the pool of primary care providers (both physicians and other health professionals), implementation of electronic medical records and quality improvement training and support.

The content and pace of primary care reform have been highly variable among the provinces and territories. **Slide 10** This chart, based on key informant interviews and a review of the literature, shows the extent to which each of the provinces and territories has implemented features of primary care systems that appear on the basis of evidence and international experience to enable high levels of primary care performance. Green cells indicate widespread or system-level implementation; yellow cells indicate limited implementation and empty cells indicate no implementation.

Many of these features have been implemented widely in one or more provinces or territories. As William Gibson has famously said: "The future is already out there, it's just very unevenly distributed."

In the case of most reforms introduced over the last decade, some delay is to be expected before their impact is felt, especially for complex interventions such as interprofessional teams, which require a realignment of primary care culture. Nevertheless, serial administrations of the Commonwealth Fund patient and provider surveys identify trends over time in a subset of measures, some of which are shown in the next few slides.

Slide 11 Canadians' confidence in the health system has increased steadily during the 2000s. The percentage of Canadians who think the system works well and merely needs tweaking has increased, **Slide 12** while the percentage who think the system needs a complete rebuild has declined. The precipitous fall in confidence between 1988 and 1998 bears witness to the disastrous consequences of health care funding constraints and cutbacks during the 1990s. **Slide 13** Canadians' rating of the care provided by their regular doctor or place of care has also risen. **Slide 14** Access to primary care is becoming more timely. More Canadians with chronic or recent serious health problems are being seen the same or next day when sick and fewer are waiting six days or longer. **Slide 15** The use and functionality of electronic medical records are increasing, but are still at or near the bottom in international comparisons. **Slide 16 (blank)**

The next few slides compare results for Ontario, Canada and the top international performer from the 2013 Commonwealth Fund International Health Policy Survey of Adults in 11 countries on selected measures of access, coordination of care, and prevention and health promotion. For each measure, Ontario is shown in green, Canada in red, and the best international performer in blue. **Slides 17-31 Slide 32 (blank)**

The last decade has seen profound changes in the funding and organization of primary care in most provinces and territories. As is clear from the chart I showed earlier, progress has been uneven and no province or territory has all the elements in place to raise primary care to the level of the best performing systems internationally. The system features that, based on international evidence and experience, enable high-performing primary care need to be spread widely within and across the provinces and territories. Given that

primary care reform is unfinished in every province and territory - and barely begun in some – substantial additional investments are required.

The plea for continuing investment in strengthening primary care or expanding medicare coverage of prescription drugs, home care, vision care, physiotherapy, prescription drugs, vision care, chiropractic or dental care runs up against several arguments. The main ones relate to rising expenditures on health as a proportion of provincial/territorial government budgets and rising total public and private health care expenditures as a proportion of gross domestic product. Often the two are lumped together as a concern about medicare's "sustainability".

These issues feature prominently in Jeffrey Simpson's recent book, *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century*. Regarding provincial/territorial health care budgets, Simpson worries, understandably I think, about health care "crowding out" other spending such as education. He writes that "...health care is devouring budgets…as more money gets shoveled into health care" and that "Before the end of this decade, health care will likely consume more than half the budget of every province." (You will note that the health care as glutton metaphor is prominent in Simpson's writing.) These statements assume that taxes will not increase in keeping with government health care spending. Simpson's position – and he's by no means alone - is that tax increases can't or won't and, reading between the lines, shouldn't happen.

Although not widely advertised as such, Canada is a low tax country. In 2010, the last year for which international comparative data are available, total tax revenue in Canada as a percentage of GDP was twelfth lowest, at 31%, among the 34 OECD countries. Eight countries had tax revenues above 42% of GDP.

Proclamations about the necessity of maintaining low taxes as a stimulus to economic growth routinely issue from editorials, op-eds and the mouths of politicians, both in and out of government. In April 2013 the Conference Board of Canada issued *How Canada Performs: A Report Card on Canada*, which ranked the performance of 17 high-income countries in seven categories including economic performance and social quality of life. **Slide 33** This slide shows the correlation - or rather the lack of correlation - between the Conference Board rankings of economic performance and tax

revenues as a percentage of GDP as reported by the OECD. It appears that low taxes are not essential to economic success after all.

Slide 34 This slide shows the relationship between tax revenues and rankings of social quality of life based on 16 measures, including income inequality; child, working-age and elderly poverty; youth unemployment; gender income gap; social support; life satisfaction; suicides; homicides; and burglaries. The correlation between the two is strong and highly significant in statistical terms, It appears that low taxes may incur a large social cost without an economic benefit – the worst of both worlds. **Slide 35 (blank)**

Simpson - and others – view the increasing share of GDP accounted for by health expenditures as a drag on the economy. He observes with alarm that "When medicare began, health care claimed 7 percent of the country's economy; today it eats up 11.7%" (again the health care as glutton metaphor). But is that necessarily a bad thing? The Conference Board of Canada, in its January 2013 report, *Health Care in Canada: An Economic Growth Engine*, describes the health sector as "an important driver of economic growth" and reported that: "Health care spending in Canada contributed 10.1 per cent of the national GDP in 2011 and supported 2.1 million jobs – directly and through the supply chain." They estimate that "For every dollar spent on health care, the various levels of government collect 21.7 cents in taxes."

Ironically, the main solutions proposed by Simpson and his ilk - increased private delivery and a parallel private system that would allow those with private insurance or deep pockets to obtain faster or better service outside the public system - are more likely to increase rather than decrease total health care expenditures. To quote the Organisation for Economic Cooperation and Development (an organization that has always been "private sector friendly"): "Whatever the role played in a health system, private health insurance has added to total health expenditures… Countries that have multiple sources of private coverage, including those with significant private health insurance market size, tend to be those with the highest total health spending levels per capita, such as the United States, Switzerland, Germany and France."

The OECD also points out: "when public cover is not comprehensive or universal, private health insurance has enhanced access to care. But such access is often inequitable, largely because private health insurance is

typically purchased by high-income groups…Privately insured patients may benefit, in particular, by obtaining shorter wait times for elective surgery. But there is no clear evidence that waiting times are also reduced in the public sector…"

Expanding private payment would have the additional perverse effect of exacerbating income inequality, the most potent social determinant of health. As shown in a report issued in May 2013 by the Canadian Institute for Health Information, *Lifetime Distributional Effects of Publicly Financed Health Care in Canada*, publicly financed health care redistributes income from richer to poorer Canadians.

Summing up, continued investments are needed to strengthen medicare and, if need be, there's room to increase taxes to make those investments. But facts and evidence are not the main determinants of public policy. When all is said and done, the struggles over medicare are about values.

Jeffrey Simpson - and again he's in considerable company – sees what he calls "the ideological prisms through which defenders observe the system" as the fundamental barrier to fixing medicare. He goes on to say that "Ideology, inspired by vacuous slogans about 'Canadian values' should be replaced by a more functional framework of what works best at lower cost for Canadians". He contrasts the "ideology" of medicare's supporters with the practical, presumably non-ideological views of people like himself.

Simpson has this wrong. The clash isn't between ideology and pragmatism, but between competing sets of values: libertarian on the one side and communitarian on the other. The libertarian perspective in its most extreme form is captured in Margaret Thatcher's famous statement "There is no such thing as society. There are individual men and women, and there are families." Or as Lily Tomlin has said with tongue in cheek: "Remember, we're all in this alone".

Libertarian values include personal responsibility, unfettered autonomy and choice, small government, low taxes, personal as opposed to public spending, and unconstrained opportunities for increasing individual income and wealth.

Communitarian values include shared responsibility, equality, fairness, collective rather than individual solutions to social problems, redistribution of wealth and income, and a sense of community.

But values and beliefs are not randomly distributed in the population. As the next two slides show, they vary systematically with income. The graphs summarize data from a 2012 EKOS poll commissioned by the Conference Board of Canada and compare the views of low- and high- income respondents on the determinants of health and private health care. **Slide 36** This slide shows the percentage of high- and low-income Canadians who see lifestyle, the physical environment, publicly funded health care and income level as "extremely important" determinants of Canadians' health. Ironically, the Canadians who benefit the most from income as a determinant of health are the least likely to recognize its importance. **Slide 37** They are also most likely to support private delivery of health services and least likely to see parallel private health care as a threat to the public system. **Slide 38 (blank)**

The relationship between values and income means that the struggle to maintain, improve and expand medicare as a program that embodies the core value articulated by Douglas and Hall - health care access and quality based solely on need - will continue to face opposition from individuals and organizations whose economic and political clout is disproportionate to their numbers. The battle lines today are essentially the same as they were when medicare was being debated in the 1960s - but the outcome remains uncertain. It's up to us to decide what we want.