Medicare: It's Decision Time

by

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Foreword

It will soon be two years since the Caledon Institute published my suggestions for *What Should Be Done About Medicare.* Very little has in fact been done, with inevitable consequences. Problems have mounted. More now needs to be done, more urgently. Meantime, awareness of medicare's failings has grown. Its critics have more scope. Those who are its opponents, wanting to erode it and perhaps destroy it, have gained strength, in the media, in sections of the federal Liberal party, and especially in provincial politics of various brands.

At the same time, however, pressures to renew medicare have also strengthened. Its friends seem to be coming to more consensus about what should be done. If so, they may greatly influence the report of the Romanow Commission later this year: both its content and what governments do about it. In any event, public discussion over the next half year or so is likely to be decisive. By next spring, Canadian medicare will be set either to renewal or to erosion.

This paper offers an updated contribution to the discussion. Those who read its predecessor will find no differences of purpose or principle, but attention is directed especially to the revised proposals that a changed situation requires.

It was suggested that a new commitment to federal cost-sharing might begin at 20 percent and progress over some years to 25 percent. Whether that graduation would have been adequate two years ago is debatable. Certainly it is not good enough now. More backlogs have to be made up, in equipment and in staffing, new investments have to be put more urgently in place, before program improvements materialize. Effective action to renew medicare now requires a federal contribution of a level 25 percent from the start.

With that has to go another major change. The condition for 25 percent sharing is agreement on modernized interpretations of the medicare principles. Two years ago, I thought this could be developed gradually, in line with step-by-step escalation of the cost share from 20 to 25 percent. Accelerated sharing means that modernized programs also have to be defined from the start. The accessibility principle needs to be specified as meaning prompt care, efficiently delivered with the use of modern technology. The principle of comprehensive service must embrace a full range of preventive care, including early diagnosis.

Such program improvements will take time. Federal-provincial negotiation will need to establish not only their nature but a timetable of some years, at the end of which the permanence of the 25 percent share can be confirmed.

This negotiation makes it necessary to face an issue many of us had hoped to dodge. While all the modernization proposed could be embodied in administrative agreements between Ottawa and provincial governments, a new Canada Health Act – including the 25 percent commitment – could do more to establish trust in place of the past financial uncertainty and political controversy. I have come to think that its advantages now outweigh the risks that could attend legislative revision.

In the previous paper, I took it for granted that federal financing would come from the consolidated revenue, the one pot into which tax revenues go and from which spending comes. The process is sacred to the Finance department, but the public interest in democratic policy-making would be better served if some taxes were identified with appropriate programs. The

federal contribution to health care could best be drawn chiefly from taxes on the indulgences and pollutions that can harm health, such as tobacco and alcohol, automobile and industrial pollution. That this identification be established – a rare victory for political sense over bureaucratic convenience – has been made important by the current fashion for cutting income taxes.

Where we are

The uncertain future of medicare does not come from public opinion. By a wide margin, most Canadians want health insurance according to the five principles that identify medicare. There is little on which the public will is so clear. Medicare's troubles are rooted in our federalism, in the political difficulty of providing what people want when that requires the collaboration of federal and provincial governments.

The essence of the problem is simple. The federal governments of the 1950s and 1960s used cost-sharing to induce provinces into programs consistent enough to constitute Canada-wide medicare. Subsequent governments have seen it as an offspring left on the doorstep: too attractive to be disowned, but a burden to be resented. From Trudeau through Mulroney to Chrétien, they have contrived to scale down their commitment. The provinces in their turn have resented the increasing transfer of the financial burden to them. Squeezed between the two resentments, the resources provided for medicare have fallen increasingly short of its growing needs.

That diagnosis is, of course, over-simplified. In public affairs there are always complications. In this case the resources, however inadequate, could have been better managed. That they have not been is, however, itself partly a symptom of the basic trouble. In a resentful relationship, neglecting to do the laundry comes easily when the other party has failed to stoke the furnace.

The more fundamental effect is that medicare today is still organized much as it began, fitted to the society and the technology of 35 years ago. For 25 or so of the intervening years it remained, in most respects, a remarkable success. It had quickly become too popular for politicians to risk much messing about with it. As is usual in service organizations, the early effect of financial constraint was a shortening of sight. Current services were pretty well maintained, investment was not. Purchases of up-to-date equipment were postponed. The most obvious tool for the more efficient delivery of effective care – comprehensive, computerized information – was not seized. Staffing was squeezed and became increasingly demoralized. Some fringe services were cut, others became slower. Yet even as deficiencies began to grow, discontent to mount, it was provincial politicians who got almost all of the blame. Federal politicians cut their financing but managed to go on blithely claiming to be the dedicated defenders of medicare against the evil axis of provinces, doctors and assorted reactionaries.

Until in their hubris they went too far. In 1995 the federal government had strong reason to cut its expenditures. But it did much more than that to its support of health and social programs. With the cuts came a change of method. Ottawa removed the last vestiges of commitment, of the cost-sharing by which it had got the provinces to undertake programs fitted to national principles. The replacement – the CHST, or Canada Health and Social Transfer – is unrelated to program costs. Ottawa can vary the amount as it decides. The contract for medicare was already tattered. In 1995, it was unilaterally and unceremoniously thrown out.

In the politics of federalism the consequence of such destruction is not a vacuum. It is a no-man's-land to fight over. In this case, it is to fight in confusion. Formally, medicare principles are not in dispute. Their popularity requires serious politicians to declare dedication. But many are as dedicated, or more, to the tax cuts that their financial backers expect. The spoken question is how to sustain medicare despite rising costs. So far the political struggle is about how to cut taxes, federal or provincial as may be, but have the other side blamed for weakening medicare. The advantage in this is now with the provinces. Federal reneging was so patent, the CHST such a cop-out, that everyone can see that the emperor at this point has neither clothes nor clout. Even if Ottawa provides more CHST money, as it did in preparation for the last election, there is no way to know whether the money has in fact been used for health care, no direct benefit attributable to it, no accountability, no more than ephemeral political credit.

If the politics of medicare do not change, the only question is how far, how soon it will be eroded.

How to move on

The politics can be changed, if the federal government makes the main move. The creation of Canada-wide medicare required a federal initiative; so does saving it by modernizing it.

Taking the lead in a matter constitutionally assigned to the provinces is always a risky federal role, however national the need. It will not come easily to the present government. Even when it has a sense of direction – which is not often – its steps are cautious. Aggressive provincial politicians have become accustomed to making the running. Neither politically nor bureaucratically is Ottawa in good shape for firm setting of policy. It needs some energizing from outside.

The responsibility for that lies with friends of medicare. The public wish is plain enough. The task is to put it into clear policy. Activists among health care professionals have been doing much of the work for years. Their growing influence on their colleagues is indicated by the Canadian Medical Association's recent call for a health charter. Vague though that is in detail, its significance is clear: The time is ripe for reformers to seize.

To do so requires some attitudinal shift. For a long time, the first need has been to defend medicare against changes urged as improvements to sustain it but likely in fact to undermine it. Some defenders have consequently become resistant to any idea for change, suspecting that however good it looks it will turn out to be a Trojan horse. Understandable as that is, it risks disaster. Some of medicare's present failings plainly derive not from under-funding but from failure to adapt its organization to changing needs and circumstances. There is wide agreement on the lines of reorganization that would deliver better, fairer, faster health care. Working out the details is business for medical, not lay, people; but the collaboration of other reformers is essential. Medicare refashioned for today, at an acceptable cost, has to be described firmly enough, presented clearly enough, for politicians of various stripes to be driven to action. An effective coalition for that purpose requires political art. It will take shape, if at all, later this year, round the report of the Romanow Commission.

If that report is soft, if it cautiously offers a range of options, the Chrétien government can be expected to make a soft response, a combination of grand declarations and uncreative tinkerings. The way thereafter will be downhill.

If, however, Mr. Romanow is true to his Saskatchewan antecedents, to the wishes of most Canadians, to the logic of social justice in the public policy of Canada, he will make a strong report. It will define, firmly and clearly, how to strengthen medicare by modernizing it. What follows will not, however, be determined by the report as such. It will depend on the friends of medicare. Will their heads be clear? Will there be a reform coalition ready to rally vigorously round a strong Romanow report? If so, public opinion will respond strongly; and we can then expect to find that Mr. Chrétien's old virtue survives, that his heart can still move with Canadians generally. In that case the report will be acted on, medicare will be renewed.

How successfully it is renewed will depend on how well the difficulties as well as the opportunities are foreseen. Medicare, established for the Canada of 35 years ago, quickly became one of the major social forces that combined with scientific advances and technological change to fashion a different Canadian society. If we were starting over, the medicare we would now institute would also be different. To make the adaptation, to modernize medicare to fit Canada today, will require considerable flexibility from both health care professionals and government officials.

Money

For Ottawa's politicians, however, the emotionally difficult change will not be from the way medicare began. It will be to turn from the folly of 1995, from the H component of the CHST. It will be to restore what they have spurned, their predecessors' principle of financial partnership with the provinces.

The emotion is not only a normal dislike for admitting error. Imposing taxes to subsidize spending by other governments is not attractive politics. The present federal reluctance to get into new cost-sharing is understandable. So – politically, though not morally – was the retreat from the former cost-sharing of welfare and universities, where federal money bought neither influence nor recognition.

Medicare, however, is different. It is different not only because it matters so much to so many. It is different because federal politicians are identified, however sorrowfully, with it, for better or for worse. The medicare that all Canadians know was created by federal initiative; it is defined by federal legislation; and for as long as most voters can remember, the federal Liberal party has presented itself as the dedicated defender of medicare against all comers.

Of course, some measure of health insurance would now operate without Ottawa's involvement. If there had been no federal initiative in the 1960s, all provinces would have been politically driven to a health scheme, of one kind of another, in the 1970s. If tomorrow the federal government finally washed its hands of all responsibility, public health insurance plans – of varied kinds – would survive in all provinces. The hand-washers, however, would not survive.

They would not survive because Canadians have come to value universal access to health care as an equal right of us all, wherever in Canada we and our family members may live or may move. We know it is thanks to federal involvement that provincial health services are pretty much the same. Whether politicians like it or not, medicare is not Albertan or Nova Scotian. In the public mind, it is Canadian. It was made that way. To keep it that way is Ottawa's interest as well as responsibility. To keep it that way it must, under the Canadian constitution, be in committed partnership with the provinces.

A federal statute about a matter in provincial jurisdiction has, in itself, the force of a pious wish. Medicare is not Canadian because the words that define it are written in the Canada Health Act. It is Canadian because the words have been backed by money provided by all Canadians through federal taxes. Provincial taxes alone could not provide Newfoundlanders with the same health care Albertans can afford. But such redistribution, which could be arranged by various techniques, is not the governing factor in medicare finance. The principles defined by federal statute are expensive to implement. They make medicare the largest item in the budgets of all provinces, rich and poor. And it is an item especially likely to be driven upwards, as medical practices and public expectations respond to the scientific advances that breed costly new treatments. There should also be efficiencies, particularly from more sophisticated diagnosis and better preventive care. But it takes time for those to show up in cost savings. Efficiencies will not materialize from the improvisations that come with financial uncertainty. They require the foresight and steady planning made possible by assured financing.

The management of all this is the business of provincial governments. Whether they conduct it within the medicare principles wished in federal legislation depends on whether Ottawa does its part. It is not doing so by CHST money fixed not according to medicare costs but by federal choice in response to the vagaries of political pressure and election timing. The Canada Health Act has practical force only if it is accompanied by commitment to an assured share of the costs of implementing its principles. Doing that well will always require difficult choices, but ending the present crisis of uncertainty requires just one simple decision by federal politicians and officials: to set aside, for medicare even if for nothing else, their dislike of cost-sharing.

The basic decision is simple. Its implementation is more complex. Five issues are important: legislation of the share; its size; the formula for its calculation; its timing; the conditions attached to its payment.

First, the Canada Health Act will have to be amended. It now provides for a payment to each province "as part of the Canada Health and Social Transfer;" there is no specification either of an amount or of a way to determine one. This is not partnership. The statute laying down principles for provincial programs should also define the federal commitment to share in the costs of these programs.

Second, the share has to be chosen. The 50 percent of postwar years, used for other programs besides medicare, reflected a relation between federal and provincial revenues that is now long gone. At the other extreme, the CHST of 1995 was equivalent to only about 15 percent of total provincial costs for all the three programs, once shared, which it replaced. That was too low, as even Ottawa was driven to recognize before the 2000 federal election. To estimate the equivalent percentage for medicare today has little meaning, because the three kinds of expense – medicare, social services and assistance, postsecondary education – have moved differently under the impact of the CHST; a ballpark figure would be somewhat less than 20 percent. That the renewal of medicare requires more than this present federal funding is not in serious dispute, and opinion seems to be moving to quite a wide consensus: 25 percent is the reasonable minimum for a return to financial partnership in medicare.

In the fiscal year beginning next April, that is likely to call for about as much money as Mr. Martin now has allocated to the total CHST. The effect on the federal budget will therefore depend on what is done about the

S (for social) component. It will not disappear with the H for health. The provinces will demand continued compensation for their lost CAP and postsecondary financing.

A reasonable guess is that the S component could be negotiated as some $6 billion. The net effect will be to put that much more into medicare. It is certainly a significant increase in federal spending. Before some hands are raised in horror, however, it should be seen in perspective. It is considerably less than the size of the errors that the Finance department usually makes in calculating annual revenues. At one time they were regularly under-estimated, so that the fiscal plans supposedly best for the economy were lost in extra borrowing. Nowadays the errors are under-estimates, so the plans are disposed of by the phoney year-end accounting of shovelling money into foundations from which it can be spent in later years (without even pretence of the parliamentary scrutiny given to departmental spending).

This is not to suggest that we make light of $6 billion. It will do much to improve health care, a far greater public good than many of the uses to which public money is put.

The third of the five issues is how to divide federal funding among provinces. The straightforward way is to transfer to each province 25 percent of its own medicare expenditure. The alternative is to add up the expenditures nation-wide and divide 25 percent of the total according to provincial populations. In the original form of cost-sharing, this alternative had two advantages. First, it curbed the tendency of richer provinces, particularly, to be somewhat relaxed in their spending of "fifty-cent dollars;" this consideration will be considerably weaker when only 25 cents on the dollar is spending that does not require provincial taxation. Second, the alternative provided some redistribution from richer to poorer provinces; this consideration too is weaker at the 25 percent level. It is also strongly arguable that in any event the acceptable degree of fiscal redistribution should all be provided through one transparent 'equalization' program, not by tagging on to other programs as well.

The balance of principled argument may therefore now favour straightforward reimbursement of 25 percent of each province's own spending. The even weightier factor is that since the 1960s political clout has shifted from poorer to richer provinces. However, there remains the possibility of – as well as precedent for – a sensible Canadian compromise: 12½ percent by the direct method, 12½ percent by the alternative formula.

How to implement cost-sharing involves two other issues: timing and conditionality. They are both mingled with the broader issue of how to manage the medicare partnership.

A federal-provincial agency

On that, the ice has cracked. For 33 years the federal government loftily insisted that, as the legislator of medicare principles, it is the investigator and the sole judge of whether the provinces are being faithful to those principles; if it sees unfaithfulness, it will mete out punishment by withholding money. More than three years ago, in the Social Union Framework Agreement of February 1999, Ottawa supposedly signed on to the principle of a little more flexibility. Now it has actually done something. It has consented to a formal process – in effect, a tentative kind of non-binding arbitration – aimed to avoid or resolve disputes.

That is little in itself, but it does concede for the first time that the provinces are

entitled to some say in the practical interpretation of medicare principles. The next step becomes possible. There can be positive collaboration to modernize medicare.

In the beginning there seemed no need for collaborative arrangements; cost-sharing at 50 percent gave the federal government all the control it needed, without raising tricky constitutional issues. Soon the popularity of medicare made public opinion its real guardian. Then, as the federal government pared down its funding and relations with the provinces became increasingly confrontational, it also became afraid that any acceptance of the demands for consultative arrangements would be an admission of weakness, to be exploited by aggressive governments of the more powerful provinces. Collaboration about medicare would turn out to be collaboration in its diminution.

So it might well have been, and still could be, if the federal government does not restore assured, cost-related financing; if it does so, however, the other half of the partnership will require a mechanism for regular consultation and collaboration. The purpose is neither to replace the provinces' management of their programs nor to impair federal accountability for the principles of medicare. A collaborative mechanism is the bridge between the two, bringing political reality into harmony with the way most Canadians already see medicare: as a joint responsibility within our federalism.

Structuring the mechanism is, of course, a matter for negotiation. My starting suggestion would be that Ottawa and the provinces appoint, by consensus, an advisory council with a wide range of expertise. It would be jointly funded to employ an executive director and staff, who would therefore be neither federal nor provincial officials. This agency would report to a joint committee of health ministers, for which it would conduct investigations and make recommendations over the whole range of medicare principles and practices.

There are many respects in which closer collaboration could facilitate innovations and efficiencies, and some respects in which it would help in the making of difficult decisions about the cost-effectiveness of possibly marginal procedures. The agency would provide a focus for such collaboration as well as for broader consultation on health policy. Administratively, it could be used to supervise the implementation of agreements on such matters as computerized health records, health care information, a national drug formulary, bulk purchasing, facility sharing. This work would be particularly helpful to the smaller provinces.

Not least importantly, the agency could foster public accountability by preparing regular reports for the ministerial committee to issue.

The structuring of such an agency will involve some prickly issues, both of form and of personnel. The path of negotiations will be paved with jurisdictional posturing. But the disputes of recent years have at least made it clear that the public would like to knock politicians' heads together and make them get on with the job for which people hold the two levels of government jointly responsible. Arguments will not end on the day a new commitment to partnership is declared. But even the most narrow-sighted must recognize that prolonging the arguments is politically unprofitable.

Nevertheless, quite some time will pass before the new agency is operational. The immediate need is simply for a firm agreement on its nature. The conditions for 25 percent cost-sharing can then be established with the necessary confidence that they will be collabo-

ratively fulfilled. On that basis, the timing of the financial transformation can also be committed. It could be 25 percent of costs beginning next April, provided there is provincial acceptance of two extensions to the principles of medicare.

The declared objective of the Canada Health Act – "to protect, promote and restore the physical and mental well-being of residents of Canada" – is not achieved simply by providing "reasonable access to health services without financial or other barriers." What is reasonable has become increasingly stretched. The first condition for new federal financing should be that it means access to services of the quality made possible by contemporary medical science and information technology, delivered promptly, professionally and cost-effectively. Those are, of course, a layman's words for drafting instructions, not the final lawyer's words. Similarly, the principle of "comprehensiveness" needs to be extended to cover more than physician and hospital services and to make it clear that medical necessity means more than necessity for the treatment of illness; to promote well-being requires equal attention to diagnosis and to the prevention of ill health.

The next two sections of this paper will discuss how such revised principles will change the practice of medicare. In that light, federal-provincial consultations can yield the implementation timetable for the provinces that will commit the federal government to unbroken continuation of its 25 percent funding.

Primary care and community

Primary medical care in the 1960s was a cottage industry. The dominant model was the family doctor providing, in his office or by house calls, all available care short of assignment to the hospital bed or the surgeon's knife. Much of "best practice" had hardly changed in decades. Patients' health records were stored in the doctor's head or hand-written files. He – she was still rather rare – most often practised alone or with just one partner, assistant or stand-in.

Medicare had to begin with what was. The matching method of remuneration, by fee-for-service, continued; that was settled by the Saskatchewan doctors' strike. All that changed was where the money came from. And in most of Canada the rest has stayed pretty much unchanged.

The computer and other technologies have since revolutionized the ways in which most service activities are organized. It is an exaggeration to say that, exceptionally, the delivery of primary health care has been stuck as it was more than a generation ago; an exaggeration, but not by much. Canadian doctoring has been slower to adapt to technological change than has the organization both of publicly-financed care in much of Europe and of predominantly private care in the United States.

The reason is surely not that our medical professions are inherently more conservative than others. The stronger reason lies in the governance of health care within Canadian federalism. The split between federal principles and provincial operation would not have mattered if the two levels of government had followed the style of which medicare was intended to be a shining example, the style defined at the time as cooperative federalism. Instead, the writhings of politically competitive federalism have blocked the requirements of program development.

Advances in medicine are commonly dramatized in esoteric procedures, but even primary health care is now too complex, scientific

and technological changes too rapid, "best practice" in many respects too constantly reassessed, for a physician in sole practice to be abreast of all that he or she might do for anywhere near all the people who come through the office door. Many nevertheless get excellent care; many – those who are less articulate as well as those with problems difficult to diagnose – may not. Others do not get through the door; in many communities many doctors now refuse to take new patients. A conscientious physician may feel able to cope only by restricting the practice to daytime office hours four or five days a week. Much primary care is therefore diverted to overburdened hospital emergency rooms, where treatment is often episodic though more costly to the taxpayer. Other people go to walk-in clinics where treatment is by definition episodic and possibly superficial. With it all, just one doctor, at most, has the background to the individual's health and sickness, recorded in a handwritten file and in varying degrees remembered.

There is widespread agreement on what ought to be done. Modernized health care calls for team work, for groups of physicians, nurse practitioners and other professionals, able and organized to provide comprehensive primary care, available round the clock, committed to the health of the community each group serves. The size of the group, the range of its professional personnel, its operational detail will necessarily vary according to the population and character of its community. In larger towns and cities, that will be defined not by area of residence but by the exercise of patient preferences. In remote areas the "team" may still amount to no more than one doctor or nurse per community, but linked by state-of-the-art communications with one another and with larger facilities outside the region.

All the groups will require close links not only with hospitals and specialist clinics but also with other public agencies, and to fit into regional boards or whatever form of decentralized health management the province may structure. The uniform requirement is that an efficient health service must be built with contemporary information technology. Primary care units, clinics, hospitals, specialists, related agencies need to share computerized, consistent patient records. That is essential for cost-effective care utilizing advances in medical science. A proviso is also essential: as with taxation, privacy has to be protected. The information system can and must be structured so that individuals are identified only to those who need to know in order to provide care.

All of this is an old prescription. Twenty years ago Tommy Douglas – talking about how "a health care system that is lamentably out of date" should be reorganized – said: "We have to move increasingly toward care through clinics. We've got to provide financial inducement for doctors to form clinics and go into clinics, whether they are paid on a salary or a fee-for-service basis." Other politicians are now catching up with what has long been the disinterested view among practitioners, organizers and students of medicare.

There are also interested views. It is entirely understandable that many doctors like the independence and entrepreneurship of working on their own, with only subordinates to accommodate. Older doctors, particularly, may value freedom to vary their working hours and choose their vacation times. They are fully entitled, of course, to stay out of groups. What they are not entitled to is the same scale of remuneration as doctors who undertake the contractual commitments of group practice. But any threat of reduced income for even a small minority is enough to induce, in doctors as in members of other trade unions, solidarity for a time, if not forever. And doctors united are a

lobby powerful enough to awe almost any provincial government most of the time.

Modernizing medicare requires, as Tommy Douglas recognized, financial incentives to move doctors into group practice. Incentive, as every champion of market economics knows, is supposed to mean carrot and stick: gain if you get it right, loss if you don't. In the real world, however, the masters of business are nowadays foremost in insulating themselves from the downside of the equation. Government reluctance to apply it to doctors becomes, in this context, understandable. But if doctors can keep their present incomes while staying outside groups, moving in will have to give them assurance of a good deal more. That reorganization can reduce costs in the long run is then beside the point; the immediate increase is what matters to politicians.

In short, most provincial governments – tender to established interests, financially pressured, reluctant to get into rows with doctors when their health programs are troubled anyway – have been and are painfully slow to act individually to reorganize primary health care. Change will come more readily if they are facing the upsets together, if they are given a common impetus to get on with the job. That impetus would be federal money conditional on reorganization.

Contracts for group care will necessarily include some element of capitation fee or salary in the remuneration of doctors, probably combined with some continuing fees for some services. The balance between the two may well vary with circumstances, but in all cases the total can provide a considerable incentive although the continuing fees are below current scales. In fairness therefore, as well as in protection of the public purse, the scale of fees for doctors who choose to stay outside can be set to decline, not overnight but in time significantly.

It should be emphasized that what is here under discussion is primary care. For various kinds of specialized services, group practice may not be advantageous even where it is feasible. Reforming the way that primary care is organized and remunerated in no way prejudges whether fees – high fees – for service may remain appropriate for some surgeons and consultants.

The details of all this are provincial business. There are two main matters for negotiation in light of a meaningfully refined definition of the principle of "reasonable" access to care. The first is to spell out standards of the kind that the Canadian Medical Association indicated in its recent proposal for a "health charter." Against the background of current concerns, it is especially important to define the meaning of "prompt" care by specifying the maximum waiting periods that are acceptable for various kinds of diagnosis and treatment.

The second area for negotiation is a realistically definite timetable. The delivery of primary care will not be transformed in the first year that the federal government contributes its 25 percent to medicare costs. The condition must, however, be clear. The commitment of federal taxes requires agreement on the feasible speed of progress to new standards for the health care assured to Canadians.

Comprehensive and preventive

The principles enunciated in the Canada Health Act require provinces to provide "comprehensive" hospital and physician care. In fact provincial programs provide, in varying degrees, more: notably, they pay some of the cost of prescribed drugs of some kinds for some categories of people. At the same time, however, the physician services actually available

fall short of those required to serve the declared purpose of improving "health and well-being."

Putting medicare into better shape involves clearing up these anomalies. They are a continuing reflection of the dominant motive that drove its establishment: the high cost of being sick. Before medicare, doctor and hospital bills could be financially ruinous even for well-to-do people; for others, illness and injury often had to be treated inadequately or not at all. Tax-financing brought such relief from such great anxiety that for a time other health problems seemed of little account. By now, however, public opinion has long been aware of changed needs. It is public policy that has lagged, as is common, well behind.

The changes are of four main kinds. Drugs are a much bigger, and costlier, component of therapy. New technology has made greater independence possible, but again often costly, for people partially disabled by sickness or injury. Social changes, however, have reduced the extent to which care can be given within a family. Most importantly, scientific advances have not only brought more effective treatments of maladies. With fuller understanding of its nature and causes, much more can be done to lessen the incidence of ill health. Diagnosis can be earlier and more precise; prevention can take more precedence over cure. They can, but not in practice by much. Resources are still not directed to early diagnosis and preventive care with anything near the dedication, vigor and organization devoted to treating illness.

Again, Tommy Douglas got it right 20 years ago: "Let's not forget that the ultimate goal of medicare must be to keep people well rather than just patching them up when they are sick... . It seems to me that this is the task that lies before us." That it still does is not due solely to the inertia of established interests and attitudes. Prevention is cheaper than cure in the long run; but meantime, before their results mature, new preventive measures are an additional cost for a system already overburdened with the urgent needs of the sick. And there is a practical-seeming rationalization: no medical interventions, however new and improved, can prevent the human follies that are major causes of poor health and injury in contemporary affluent, competitive society.

Such adult-centred thinking ignores the core of preventive care: it means, above all, care in childhood. The early years are the most decisive for lifetime health, mental as much as physical. With what we now know about the causes of poor health, as well as about the economic imperative of investment in human capital – in the education and energy of people – the highest priority in health care surely is to ensure that fully comprehensive services are universally accessible for children.

A new Canada Health Act should therefore provide that the principles of medicare call for access, "without financial or other barriers", not only to hospital and physician care but to comprehensive services for the legislation's declared purpose, the well-being of Canadians.

The qualification of "reasonable" remains necessary but must be more precise. For example, provincial administrations have recently demonstrated, by the use to which some federal funding for new equipment has been put, that state-of-the-art diagnosis is not sufficiently recognized as a key to effective, efficient care. Federal commitment to 25 percent of costs should be conditional on explicit recognition of the priority. With it goes, for people of all ages, regular examinations as the trigger for early diagnosis.

The further major addition to the specifications for cost-sharing should be to define preventive care for children. Again, details and

timing are matters for negotiation. High quality prenatal care and baby clinics are the start. Also essential are regular medical, optical and dental check-ups for pre-schoolers and at school, along with follow-up pharmaceutical, tooth and eye prescriptions and treatments. First-dollar coverage for all such services is central to contemporary public health insurance. Children should also have ready access to nutritional supplements and school meals, though here we come to bigger problems about where to draw the line both as to the scale of service and the age to which children are eligible. To set the age high – to go all the way to secondary school graduation, say – is desirable but hardly realis-tic as a present beginning. But there would surely be ready agreement to the inclusion of all pre-teens. In other words, the condition for 25 percent federal funding of modernized medicare would be that it provides access to fully comp-rehensive care up to the age of twelve. The lead-time for achieving that need not be long.

How soon more comprehensive and preventive health services can be extended up the age scale will depend on experience, on future economics and tax tolerance, and on success in cost containments – including the extent to which preventive care for children shows up in lower treatment costs later. The most conspicuous of the desirable extensions – pharmacare and homecare – may depend particularly on whether the kind of tax measure suggested later in this paper proves to be acceptable.

The Act and privatization

The modernization of medicare requires – to summarize thus far – two major changes in the operation of provincial programs. Primary care should be delivered predominantly by community-based groups of professionals linked through contemporary information systems; and there should be much more emphasis on early diagnosis and on preventive care, especially by ensuring that fully comprehensive services are accessible for all pre-teen children. These reforms will be feasible, Canada-wide, in the context of federal-provincial collaboration underpinned by assured federal finance for 25 percent of medicare costs.

All this could be done by a federal-provincial agreement – a charter if more impressive language is favoured – with no more than minor amendments (such as removal of the reference to the CHST) to the present Canada Health Act. But that would be an awkward contrivance even for a government as little disposed to have Parliament in session as is the present administration. In the current uncertainty, as well as against the past of distrust and controversy, new legislation will carry a lot more weight. While Parliament cannot write in stone, the drafting and debate of legislation do more to concentrate minds – political, official and public – than can be done by deals between governments, however seriously meant. Both legislation's greater formality and its more public transparency strengthen the chances that trust will grow and policy will stay firm.

New legislation would also provide an opportunity to clarify the relation between medicare principles and profit. As a definition of the principle of public administration, the present Act declares that "the health insurance plan of a province must be administered and operated on a non-profit basis by a public authority." Indeed it must. But the wording is easily misinterpreted. It can be read, by both some critics and some friends, as if the words "insurance plan" were not there, as if the intent was that health care itself should be operated on a non-profit basis. In truth, of course, it is and it isn't. Almost all hospitals and some ancillary services are, as they always have been, non-profit organizations; most doctors' offices and some other ancillary services are run for

profit. Whether a service is supplied by a public or private agency is not a matter of medicare principle.

There is a "mono" in medicare, but it is not monopoly – only one supplier. It is, in the language of economics, monopsony – only one buyer. All the services provided within medicare are paid for from one source, from tax revenues. That is the matter of principle, essential to the social justice of health care provided according to need, not depth of pocket. But the non-profit public agency does not do the doctoring or X-raying or whatever. It buys the service on the patient's behalf. Whether a particular service is bought from a for-profit or non-profit organization is a matter not of principle but of practical convenience, of getting best value for the tax dollar.

That is not always easy, in health care any more than in personal shopping. A hospital may provide excellent care, but only after painfully and even dangerously long waiting periods. A for-profit competitor may under-bid a public agency because it is more efficient, but perhaps because it skimps on service or because it quietly charges patients for supposedly extra services.

It is important that new legislation be entirely clear. As it is, critics get away with the assertion that the Canadian Health Act infringes personal liberty by prohibiting people from spending their own money to buy private health care. That is nonsense. True, private care is hard to find, but the reason is not legal prohibition. It is the way markets work. There has to be enough demand for business to be profitable. There is not enough, in most of Canada for most of the services available within medicare. But that does not make them unavailable. The continental economy works, as opponents of governments presumably think it should. Private facilities are readily available for all comers in the United States, where the demand makes them profitable.

What medicare prohibits is not private care but the mingling of public and private money. Privilege within medicare cannot be bought by piggybacking private payment on to tax-financed services. Or, it could not. The old defences, against user fees and extra billing and the like, remain. But of late, long waiting periods have resulted in another kind of privilege. People step outside medicare to get a particular service – notably, diagnosis by MRI – quickly. It costs more than most people can afford. But if the finding, for those who can afford, is that early treatment is needed, the hospital cannot ignore it. The financially fortunate person gets back into medicare. Money has bought queue-jumping.

The only cure for this is less queuing. It is improved equipment and staffing of hospitals. But clearer wording in a revised Canada Health Act could foster better understanding of such problems and their solutions. It would help medical administrators to concentrate on getting the best value for tax dollars, whether from non-profit or from for-profit sources, while ensuring that better or faster care is not obtained by slipping private payment on top of public finance.

A further, safeguarding clarification is also needed. The arcane provisions of recent trade agreements, of NAFTA and WTO, create possibilities of challenge to medicare. It may be alleged by aggressive US corporations to entail restrictions or subsidies actually or potentially damaging to their interests. If such corporations become more involved in the supply of some services in some provinces, the risk of legal challenge to medicare may increase. How to head it off has been shown, fortunately, by the United States. The Americans insist that their laws can still trump the supposedly free trade

agreed with us. The draftsmen of a new Canada Health Act should be able to strike an appropriate balance: make it clear that medicare as a single-payer system is not designed to require single suppliers; but make it entirely clear that tax-financed medicare is by design immune to challenge on the grounds that it restricts commercial investment or trade.

Indulgences

The modernization of medicare proposed in this paper will substantially increase its call on federal revenue next year. Its total cost, federal and provincial, will not decline thereafter. Nor, however, will it soar in the way that scare-mongering opponents of medicare predict. Certainly the ageing of the population will increase some costs, but where we are heading is much where some countries already are, without catastrophe for their medicare. While the last few years of life are usually the most expensive medically, they are not more expensive because they now more often come in people's eighties rather than their seventies, health in those seventies having been much what it used to be in people's sixties. And ageing is not the only trend. Better preventive care will not save money in the short run, but in time it will much reduce many health costs. The immediate benefit from reorganizing the delivery of primary care will be almost entirely to improve its quality; in time, however, its efficiencies will join preventive care in containing cost increases. Collaboration among provinces and with Ottawa will make some cost increases considerably easier to contain than they have been in competition and conflict.

None of this, however, alters the fact that the medicare with which we are now dissatisfied is expensive and better medicare will cost more in the short run. In the longer run, it need not take an increasing share of national income but is unlikely to take less; and the pressure to spend more soon will still be strong. It is no friendship to medicare to brush off the need for sensible restraint.

Some of the strongest resistance to sensible restraint comes in fact from sources by no means friendly to medicare; from departments of Finance, led of course by Ottawa. Their instrument is the consolidated revenue, one pot into which all revenues go and from which all expenditures come. The consolidation is necessary, Finance officials say, for the flexibility with which they have to manage the nation's finances. It enables them to take off here, put on there, as they steer through economic perils.

This is the elitist nonsense of lord high panjandrums, not bothering to make even a token bow to democracy. No matter that Parliament legislates programs. No matter that the Ministers of line departments are responsible to Parliament for implementing the programs. As long as revenue is consolidated, Finance is in control, with the power to tighten or loosen screws as the year unfolds, including the power to cover up its own frequent miscalculations.

The public interest is different. It is to identify what we pay with what we get. Billions less or more from the consolidated revenue mean nothing to most people. Particular taxes and particular programs mean a great deal. This is not to say that Finance is wholly wrong. A degree of flexibility is necessary. A substantial consolidated revenue will have to remain. Some kinds of spending are too indirect in their public impact to be linked to a particular tax. But those are not reasons to defy commonsense by throwing everything together. Democratic public policy would be better served, political discussion would be more responsible, if major purposes of expenditure were broadly identified with appropriate sources of revenue.

For example, government would be better understood if the first call on personal income tax were seen as being to pay interest on the public debt – that is, to honour commitments made to people, particularly people for whom the bonds are, directly or indirectly, their savings for retirement. Again, it would be healthy to think of the corporate income tax as particularly financing measures that benefit the economy, from research and development and postsecondary education to transport infrastructure to industrial subsidies.

There is a particularly clear linkage for the federal share of medicare costs. People would well understand its identification with indulgences and pollutants, especially those that contribute to the need for health care. Tobacco is the first candidate, automobile and industrial emissions close behind, then alcohol. It would not be hard to add specific sales taxes on a variety of other goods and services, but I am not proposing that the identification could or should be tight. Indeed, the next section suggests a way in which personal income tax can also play some beneficial role in medicare finance. The proposal is that some broad associations with appropriate taxes would help considerably to inform discussion and decision about the scale of a program at once so desired and so demanding as medicare.

Restraints

More rational fiscal arrangements will be helpful in the financing of medicare, but they do not touch the dilemma at its core: how to have social justice without conspicuous waste. The essence of medicare is that your personal finances have nothing to do with going to a doctor, taking your child to a doctor. Whether you have only a dollar in your pocket or tens of thousands of dollars in the bank makes no difference; needed care is equally available. But needs can be imagined. If finding out costs nothing, why not be sure? And why should the doctor take risks? When neither the seeker nor the provider has to count the cost, it is inevitable that some treatments are given because they will do no harm rather than do good.

The extent of such waste is vastly exaggerated by enemies of medicare. Most doctors are highly responsible citizens. There are probably more people not going to the doctor when they should, particularly for diagnosis, than there are people going when they need not. Certainly over-doctoring and over-drugging are marginal to the total cost of health care. But they are already enough in the public mind to be fuel for critics, and the problems of cost containment will increase when we have pharmacare and home care. To ignore them is to invite reluctance to spend money on renewing medicare and to strengthen the tax-cutting politicians who would prefer to diminish it.

The most common proposal to contain costs has always been to impose user charges. They accompany the more comprehensive coverage (notably, for drugs) that is usual in European health insurance. If the charges are low, as in Sweden, they barely cover their administrative costs but seem to deter some unnecessary calls on doctors' time and drug supplies. Even low charges, however, will also deter some people from getting attention they (and their children) need. The principle of universal accessibility becomes even more important as health is directed more to prevention rather than cure. Certainly any compromise of Canada's stand against user charges should still exempt children from them.

For adults, it has to be said that modest user charges would be less unjust than the device that opponents of medicare, led by the Fraser Institute, have been pushing in recent years. That is the MSA (Medical Savings

Account). It is more widely saleable than user fees in that treatment for minor ailments would remain "free" for everyone. In addition, most versions of the scheme would provide a tax break, in effect, for thoroughly healthy people. For major illness there would be insurance against catastrophic costs, presumably subsidized for people labelled as "poor." In some area between minor and major ill health, however, treatment would require payments severe enough to be a deterrent for many people. In sum, the MSA scheme would be markedly regressive as between rich and poor people with similar health problems. Since it would also be intrusive and administratively expensive, the Fraser Institute's championship is somewhat surprising. The likeliest explanation is that MSA would fit easily with a major shift to privatization in the delivery of health care.

There is a better way to contain overutilization of health services, a way that does not breach the principle of access without charge. It has been on the suggestion list for 40 years. Initially, its administration would have been a lot of work. Now a computer program could readily track the costs to the public purse of the medicare services received by each individual or family. They could be totalled and reported for each year. That alone would make the prescribers and providers of health care, as well as its recipients, more conscious of its costs. Further, the report could be the basis for payment of some of the cost, in a socially just way related to income.

For this purpose the medicare account, as it might be called, would be brought into the assessment of federal income tax. The costs of preventive measures – including care for preteen children as well as all diagnostic services – would not be included. (This is an afterthought, compared with the plan as I have suggested it in the past.) The value of other medicare services received by the individual or family would be reckoned, like many other social benefits, as part of income – but only up to a low ceiling, a small percentage of the family's other income. People with very low incomes, paying no tax anyway, would of course be unaffected. For others, suppose that the ceiling was set as 10 percent of regular income, before reckoning in the medicare account for tax purposes. At the current rate of 16 percent on low taxable incomes, this would mean an extra tax of at most 1.6 percent of income. On an income of $20,000, for example, that would be $320: the maximum even if a serious illness had required medical services costing tens of thousands of dollars.

The ceiling would rise, at present tax rates, to 2.9 percent of six-figure incomes. Only for the very rich indeed could the extra tax reach the level of medical expense that is catastrophic for other people.

The 10 percent ceiling is suggested as an illustration of what might be judged fair and reasonable. It and other details, such as provisions for deferrals or carry-forwards, require public consultations as well as careful consideration by tax experts. One possible refinement, for example, is that the ceiling percentage should vary with age or other circumstances.

The political objection to this tax recovery proposal has always been that people feel they have already paid through their taxes to have health care available; to have to pay more when they use it is unfair. Logically, this is rather like saying that, since you have already paid for roads through provincial and municipal taxes, it is unfair to have to pay gas taxes in order to put the roads to personal use in your car. Emotionally, however, the resentment has force, especially since people with middle and higher incomes think of taxes particularly as income taxes. If the primary financing of medicare were identified with tobacco taxes and the like, it would be easier to see the fairness of relating

use of the service to a small part of one's bill for income tax.

Both these related tax proposals – indulgence and pollution taxes dedicated to much of the federal medicare bill, together with a supplement from personal income tax – are made for federal finances only. They do not depend on provinces doing anything similar. For federal politicians to make the suggestion would be unwise as well as unnecessary. But if provinces were interested there would indeed be advantages, and harmonization would not be difficult.

What is at issue in the income tax proposal, however, is neither administrative nor tactically political. Nor, in my view, is the nature of medicare in question. Medicare means that the health care you receive never depends on your putting up money for it. That principle is not violated if, having income enough to be taxable, you are later required to make a contribution, graduated according to your level of income, towards the cost of the benefit you have received.

There is, however, an ethical question. The tax contribution would not only restrain some marginal uses of health services. It would mean that a person in poorer health pays more tax than a person with the same income but in better health. That is unfair. It is not, however, as unfair as the user fees in other health care systems. Any measure to contain low-priority uses of public services inevitably has some unfair side effects.

For that reason, all believers in social justice would prefer to do without such constraint. Practitioners of social justice, however, must recognise that the resources available for public services are limited. True, they could be significantly increased by a reformed tax system. But for practical policy today we have to live with the tax revenues now politically feasible. Their effective deployment among many uses necessitates constraints. A small, income-graduated tax on service use is the least unfair constraint in sight for medicare. Unless someone can produce a better alternative – after 40 years of silence – it is an important item in the renewal of medicare. It is different but necessary company for the extensive improvements that can provide all Canadians with more comprehensive, better, fairer, faster health services – before medicare's opponents gather, from present discontents, enough political clout to undo it.

Summary conclusion

This paper has dealt only with provincial medicare programs operating in accordance with federally legislated principles. It has ignored health services provided directly by the federal government, including those in aboriginal communities. They are the least effective in Canada. Their organizational problems are sharply different from those of joint programs and the health problems too shamefully neglected to be treated as a side issue in this paper.

In summary, these are the proposals for sustaining and modernizing the medicare that serves most Canadians:

- The federal government should draft a new Canada Health Act in light of public discussion centred round the work of the Romanow Commission.

- After consultations with provincial governments, the new legislation should be enacted to take effect from April 2003.

- The Act would fully maintain the existing principles of medicare but would define them more precisely.

- The principle of accessibility would be defined to mean prompt access to health care of the quality made possible by contemporary technology, including primary care efficiently delivered by community-oriented team organizations.

- The principle of comprehensiveness would be defined to embrace a full range of preventive care, emphasizing early diagnosis at all ages and giving priority to services that help to foster the mental and physical well-being of children.

- The principle of public administration would be more clearly stated, ensuring that medicare is entirely tax-financed; while this does not predetermine how far the organizations used to deliver services are public or private, in neither case are additional private payments allowed.

- Agreed timetables for program improvements implementing the redefined principles would be negotiated with the provinces.

- Subject to such agreement, the new Canada Health Act would commit the federal government to assured, continuing contributions of 25 percent of the provinces' costs for medicare programs covered by the Act, effective as of April 2003.

- The details of the 25 percent formula would be settled in negotiations with the provinces.

- The Act would also provide for federal participation in an agency, jointly financed and governed, for health policy; it would be designed to facilitate consultation and negotiation under the terms of the Act and to provide for collaboration in all respects in which it is appropriate and useful.

- The Act would make it clear that medicare in Canada is a public service immune from any kind of challenge under the terms of any agreements regarding trade or investment.

- Federal funding for medicare would be identified as coming primarily from taxes on indulgences and pollutions.

- In order to contain inefficiencies in the provision of medicare services, the federal personal income tax should provide for a limited after-use charge, graduated to income.

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