BRITISH COLUMBIA MEDICAL ASSOCIATION

Turning the Tide – Saving Medicare for Canadians

Part I of II
Laying the Foundation for Sustaining Medicare

A Discussion Paper by BC's Physicians

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Table of Contents

List of Figures

List of Tables

BCMA Policy Statement

The British Columbia Medical Association is committed to a public health care system in which physicians can provide patients with timely access to quality medical care.

The BCMA believes the principles of the Canada Health Act to be basically sound, but recognizes that they were written for a different day and a different environment. The principles remain insufficiently defined and have been subjected to varying interpretations.

In order to restore and preserve a national health care system for Canadians, a revised set of core objectives for the health system must be enunciated. These objectives must protect and enhance the principles of the Canada Health Act, but must augment those principles through the addition of specific patient care and management standards.

Patient care objectives must articulate the need for the system to focus on delivering high quality health care services that are readily available, provided seamlessly and in a timely fashion to the people of British Columbia.

Management objectives must seek to ensure a sustainable, accountable and equitable public program, starting with a consistent multi-year planning process that the public accepts and supports. Choices will be required with respect to the scope of services covered under the public program and publicly funded health care expenditures must be transparent and reflect government's ability to pay.

The BCMA is committed to communication and dialogue on revitalizing the health care system. The Association asserts that Canadians as a whole share a joint responsibility in ensuring that Canada's health care system maintains a quality standard of the highest level.

This paper was commissioned by the British Columbia Medical Association Board of Directors in response to growing concerns over the state of the health care system.

The BCMA Council on Health Economics and Policy (CHEP) reviews and formulates policy through the use of project oriented groups of practising physicians and professional staff. The project group for this paper includes Dr. Arun Garg, Pathologist, New Westminster; Dr. Brian Gregory, Dermatologist, Vancouver; Dr. Michael Lawrence, General Practitioner, Vancouver; and Dr. Heidi Oetter, General Practitioner, Coquitlam. Staff support was provided by Mr. Darrell Thomson, Director of Economics and Policy Analysis, Mr. Robert Hulyk, Policy Analyst and Ms. Linda Kowalski, Administrative Assistant.

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Turning the Tide – Saving Medicare for Canadians

Part I of II - Laying the Foundation for Sustaining Medicare

Introduction

For more than three decades Canadians took pride in having one of the best health care systems in the world. In recent years, however, that pride has turned to dismay as reports of system failure and patient suffering proliferate across Canada. Long waiting lists for treatment, crowded emergency departments and unacceptable delays for diagnostic testing are now the Canadian norm, rather than the exception. Timely access to needed care is no longer a cornerstone of the Medicare program. This is not what Canadians envisioned for Medicare. British Columbia's physicians share the public's concern over the current and future state of our medical care system.

Canadians can no longer afford to ignore this state of deterioration, since today's problems reflect only the "tip of the iceberg". Canada's population is rapidly aging. As the generation of "baby-boomers" approach retirement, the country will face an explosion in the requirement for, and the technological capability to provide, an expanded scope of health care services aimed at reducing suffering and improving the quality of life. These golden opportunities, although eagerly awaited, will place an unprecedented strain on the country's ability to accommodate the level of care that will be expected.

In spite of the seriousness of the current state of affairs, Canadians have a brief window of opportunity over the next few short years to restore and renew the health care system. However, before this can happen, a focussed and objective discussion of the issues must occur. Rhetoric and ideology must be set aside. The public must take control of this discussion, as there are hard choices to be made around the breadth and scope of Canada's health care programs. The principles of accountability and sustainability will be at the forefront in making those choices.

Many see the coming millenium as a time of hope and fresh beginnings. It is, therefore, appropriate that this paper is about the future restoration of excellence to our health care system. In this regard, the doctors of British Columbia stand ready with the public to identify those aspects of Medicare that are to be preserved and those that require revision.

This document provides information concerning the fundamental challenges facing Canada's health care system. They are complex, as are the policy choices to be considered. An exhaustive examination of each of these matters is not feasible for this paper, however, a concise synopsis is within reach.

The goal of this paper is to lay the groundwork for a fundamental discussion about the future direction of our health care system. To this end the paper proposes a revised set of core objectives for Canada's health care system, which focus on patient care, system and management issues – objectives which protect and enhance the principles of the Canada Health Act. These key objectives provide a framework for developing a more sustainable and accountable health care program.

This is the first of a two part document, with Part II to follow with an assessment of potential reform initiatives, each gauged against the framework outlined in this document.

Chapter 1 The History of Medicare in Canada

Medicare, as we know it today, is scarcely more than a generation old. When Quebec joined the remainder of the provinces under the federal Medical Care Act in 1972, it marked the first time that each province and territory in Canada had provided comprehensive hospital and medical insurance to residents. Yet, during its short existence, Medicare has become a defining element of Canada's social fabric. Today, it is a source of both pride and concern for Canadians.

It was not always this way. Many people are unaware of the complicated and controversial events that led to the creation of the Canadian Medicare program:

> *The evolution of the Canadian system of organizing and paying for health care services has been a long, complex, and stormy struggle, often beset with extraordinary conflict and influenced greatly by the political and economic vicissitudes and crises of this turbulent twentieth century.*
>
> - Malcolm G. Taylor, Professor of Public Policy and Historian on the Canadian Health Care System, (Taylor, 1990, p. 33)

As we focus on the future of the health care system, it is important to understand the past. The purpose of this section is to provide an overview of that past, highlighting the major events between 1867 and 1999 that have shaped modern day health insurance in Canada.[1]

The Early Years

Canadians are fortunate today to enjoy one of the highest standards of living in the world. However, in the late 1800's, Canada's developing economic state faced many challenges, with the issue of health care among the top concerns. Canadians suffered from tuberculosis, influenza, and high infant and maternal mortality.

Hospitals were predominantly operated and managed by the Church or charitable organizations, with some additional facilities funded and operated directly by municipalities or private companies. Hospitals were often a central part of the community, and community members played a significant role in the ownership, organization and delivery of health care. Western Canada had few major medical centres, and physicians outside urban areas practiced "frontier medicine," serving many small and rural communities with horse and buggy. Physicians were most often far removed from the possibility of outside assistance.

Patients were expected to pay virtually all costs associated with health care out of their own pockets and were often required to pay the physician and the hospital separately. Those individuals who could not afford to pay for care relied on philanthropic organizations, public assistance, or the good will of providers.

[1] The BCMA would like to express its gratitude to Mr. Malcolm G. Taylor for his work on the history of the Canadian health care system.

The signing of the British North America Act (BNA Act), in 1867, signified the birth of Canada as a sovereign nation, designating federal and provincial powers. Responsibility for health care was established as an exclusive power of the provincial legislature.

Health care was originally considered a relatively minor piece in the legislation, relegated to seventh place in importance in the Act, behind such items as taxation ability, provincial borrowing authority, public lands and the establishment of provincial prisons. Although the BNA Act was amended in 1982, and renamed the Constitution Act, the section on health care did not undergo amendment.

Events Forge the Need for Policy

The continued forging of the country's health care policy was, in no small way, influenced by war and economic disparity. In what must be considered a bizarre twist of fate, the outbreak of World War I was a significant contributor to the introduction of public health insurance in Canada. During a time of great need, the sheer number of young males who were unable to join the armed forces due to poor health dramatically increased the nation's focus on health care. Rejection rates for recruits into the armed forces reached as high as 50% in some areas of the country. The most startling aspect of these rejections was that a majority of them were for "preventable or remediable conditions" (Taylor, 1990, p. 33).

Canada did eventually place 619,636 service people in uniform - a significant military force for a nation with only 8 million people. This force also included more than 3,000 nursing sisters. During the war period, many of these young Canadians received a first-hand look at the National Health Insurance Program which provided basic, publicly funded health care to British citizens. This program piqued the interest of many Canadians, including those in the ruling Liberal party which, on August 16, 1919, adopted the following policy on health:

> *That so far as may be practicable, having regard for Canada's financial position, an adequate system of insurance against unemployment, sickness, dependence in old age, and other disability, which would include old age pensions, widows' pensions and maternity benefits, should be instituted by the Federal government in conjunction with the governments of the several provinces.* (Taylor, 1990, p. 39).

Of further significance, between 1915 and 1935, various municipalities, companies and individual citizens began to pay for medical and hospital services through what were called "Prepayment Plans". Prepayment plans were a form of health insurance, whereby those enrolled would pay a set amount per month for partial or full coverage. They primarily focussed on physician services, however, prepayment plans for hospital services also evolved in this period, on a much smaller scale. Physicians initially developed and organized these plans, however, as time went on, businesses, private insurance companies, and municipal governments developed their own variants.

One of the first modern prepayment plans was introduced in Saskatchewan in 1916. Facing the possibility of losing physicians in some communities, the provincial government amended its Rural Municipality Act to permit "municipal doctor plans". These plans paid physicians salaries to provide specified medical services to their communities and were funded from municipal and property taxes.

Just at a time when prepayment plans were gaining prominence, the stock market crash of October 24, 1929, signaled the start of the Great Depression. The impact of the Great Depression on health care policy and delivery in Canada was significant, as it tested the ability of insurance plans to provide coverage for services while tax and premium revenues plummeted. In many municipalities in the 1930's "the medical profession bore the brunt of providing medical care to the indigent and their stacks of unpaid bills would be empty legacies for their heirs" (Taylor, 1990, p. 4).

In response to the serious consequences of the depression, the Canadian Medical Association's Committee on Economics released the report "Medical Economics" in 1934, that included a review of health insurance programs in Germany, Britain, France, South Africa and the United States. The report described in great detail the plight of the Canadian public and physicians in the 1930's and clearly advocated for the need for public insurance in Canada, based upon a set of guiding principles, including (Shillington, 1972, p.22):

- equal coverage for the poor,
- mandatory participation for those earning below a certain income level,
- benefits for dependents of insured persons,
- voluntary physician participation in the plan,
- patient freedom to choose and change physician,
- physician selection of preferred method of payment,
- absence of economic barriers between doctor and patient.

However, the report also cautioned against the problems that such a system might create:

> *The most serious ill result which could grow out of health insurance would be its being considered as a "cure-all" … There is grave danger in overselling all forms of social insurance as panaceas for the ills of mankind.*
>
> *Despite what may be said as to the need for a complete service, it is not to be forgotten that it is the public who, as consumers, have to decide what they are prepared to pay for. It is not the responsibility of the medical profession to attempt to force upon the public a service for which the people are unwilling to pay, nor is it the responsibility of the medical profession to provide services which the public are able, but unwilling, to pay for* (Taylor, p. 24).

The CMA report on the economics of medical practice was used extensively by government and physicians over the next decade and remains a useful document for reflecting the basic tenets of the development of a health care system.

At the provincial level, in response to public interest the BC government embarked on a plan in 1935 to introduce a combined system of health benefits (physician and hospital coverage) and cash benefits to replace lost income due to sickness. The initial proposal involved mandatory enrollment for all employed persons earning less than $2,400/year, with voluntary enrollment beyond that amount. The government would contribute one-half of the regular rates on behalf of registered indigents. Benefits were to include medical and hospital care and other benefits as finances allowed. The plan was to be administered by a health insurance commission, which had the authority to set benefits and service standards.

By early 1936, both the British Columbia College of Physicians and Surgeons and the British Columbia Manufacturer's Association had voiced their objections to the plan, albeit for different reasons. The business community objected to the increased taxation implications, while physicians were wary of the broad and unrestricted powers of the proposed commission and that the government was not prepared to fully underwrite the program.

The combined objection of the College and the Manufacturer's Association forced the government to revisit their proposal and, following only lukewarm public support in a 1937 referendum, the government ceased its efforts to implement the plan almost immediately. At that point, the British Columbia Medical Association began work on the development of their own prepayment plan for medical insurance, which successfully culminated in 1940. The plan was called Medical Services Associated (MSA), and was the first prepaid medical insurance plan of its kind in British Columbia. The BCMA and individual physicians covered the initial costs of underwriting the plan, which was available only in Vancouver, Burnaby and New Westminster.

The MSA continued to operate as a medical insurer until the introduction of the Hospital and Diagnostic Services Act (1957) and the Medical Care Act (1966). Following these pieces of legislation, the MSA re-oriented itself as an agency providing extended health insurance and continues to operate in BC to this day.

Although the development of Canadian health care policy and social programs was being shaped by these many events, the impact of the Second World War and post-war recovery years were by far more significant. Whereas World War I had sparked a groundswell of brief support for public health insurance in Canada, the end of World War II signified the culmination of over sixteen years of hardship endured by Canadians. The support among grass-roots citizens for the fabrication of a better social safety net was overwhelming:

> *The realities, even at their best, could never, of course, match the hopes engendered by the frustrations and deprivations of ten years of depression and six years of war. There was a mood of rebellion against the universal risks of unemployment and sickness, disability and old age, widowhood and poverty, a pervasive dissatisfaction with precarious minimum wages, drought stricken farms, grudgingly-granted relief payment, and a suspiciously-administered, means-tested old age pension* (Taylor, 1987, p.2).

During the course of the war the federal government and other agencies were already planning social policy for a post-war Canada. The final report of the Royal Commission on Dominion-Provincial Relations (the Rowell-Sirois Report) was presented to government in early 1940. While not the primary focus of the Commission, they recommended that health programs remain within provincial jurisdiction, with the federal government providing a guiding, yet limited, presence in the day to day management and delivery of health care to Canadians.

By 1942 the federal government had launched an Interdepartmental Advisory Committee on Health Insurance chaired by Dr. Heagerty, Federal Director of Public Health Services. Several other organizations, such as the Canadian Medical Association, also initiated studies.

The CMA unanimously adopted the following two historic resolutions in 1943:

1. The CMA approves the adoption of the principle of health insurance.

2. The CMA favours a plan of health insurance which will secure the development of provision of the highest standard of health services, preventative and curative, if such plan be fair both to the insured and to all those rendering the services.

The purpose of these resolutions was to lend support to the upcoming proposal for a national insurance program. In their final presentation to the House of Commons Special Committee on Social Security, the CMA pledged full cooperation and support for a national health insurance program:

> *The CMA desires to assure the Committee that our entire organization, stretching from sea to sea, stands ready to render any assistance in its power towards the solution of one of the country's most important problems, namely, the safeguarding of the health of our people* (CMA Presentation to the House of Commons Special Committee on Social Security, 1943, Proceedings, p. 141).

Indeed, not long thereafter, the medical profession in British Columbia determined that a set of guiding principles was required to set out the rights and obligations of physicians. In 1945 the medical profession released the following principles on voluntary prepayment schemes (BCMA Archives):

1. That they are operated on a non-profit basis;
2. That they provide the fullest service possible;
3. That they are free from annoying restrictions and limitations;
4. That they are financially sound;
5. That where privileges are extended to associations the membership will largely fall within the low-income group level;
6. That the promotional and administrative costs are at a low level;
7. That the right of free choice of doctor shall be observed;
8. That the remuneration will be based on the schedule of fees of the College of Physicians and Surgeons of British Columbia;
9. That funds be protected and expended for the provision of medical benefits;
10. That the interest of the member is protected;
11. That the patient-physician relationship be preserved, as in private practice.

In fact, 1945 marked the first attempt to introduce a national health insurance program in Canada. The Liberal government introduced the Dominion "Green Book Proposals", initiatives that called for a massive change in the social support structure in Canada. Going far beyond health, the Green Book Proposals were a broad, ambitious restructuring initiative that affected a large number of areas including federal/provincial powers, welfare and taxation.

Under the "Green Book" proposals, health care was to be financed through a set tax on the population based on a percentage of income. The cost of the program was to be shared

between the federal and provincial governments, with the federal government contributing a maximum of 60%, and provinces 40%.

After more than a year of extensive and heated debates over proposals and counter-proposals, an agreement on the Green Book recommendations could not be reached. One of the most serious objections was a decrease in provincial taxation authority in return for larger transfer payments from the federal government. This was viewed as a direct reduction in provincial authority and financial discretion. Although the Dominion proposals did not come to pass, the idea of a national health system was now firmly entrenched in the minds of Canadians.

The failure of the Dominion proposals deeply disappointed the Saskatchewan Government, which had been supportive of their development. In a surprise move, the Saskatchewan Liberals introduced "A Bill Respecting Health Insurance" on March 31, 1944, very late into the legislative session and on the eve of an election.

The bill proposed that a Commission be established to govern and administer a health insurance program for the province. The Commission would be responsible for outlining benefits, establishing insurance regions and making preliminary agreements with hospitals and professional organizations. In a dramatic series of events, the bill went unaltered through its first and second reading on the same day and passed unanimously the following day, on April 1, 1944. The bill did not, however, save the flagging fortunes of the Liberal government, as the June election brought Mr. Tommy Douglas and the Cooperative Commonwealth Federation to power.

Mr. Douglas continued to implement the provincial health insurance plan over the next two and a half years. The plan went into effect January 1, 1947, and became the first universal comprehensive health insurance program of its kind in North America. The main characteristics of the plan were that it was:

Universal	– the plan covered every resident of the province
Compulsory	– every resident was required to be part of, and pay into the plan
Comprehensive	– the plan covered all essential services provided by hospitals

The program was paid for via a flat "premium" on every adult or child in the province, amounting to $5 per person, per year, to a maximum of $30 per family per year. Despite the added cost of insurance premiums, in general the public tolerated the extra cost and the program continued to develop and gain support of the population. Public pressure quickly mounted on the other provinces and the federal government to implement a similar plan for the remainder of Canadians.

After strenuous debate, a consensus was reached that the first step towards a national health insurance program should focus strictly on hospital and diagnostic services. Subsequently, in 1957 the Hospital Insurance and Diagnostic Services Act (HIDS Act) was introduced in the House of Commons. The primary component of the plan was that the federal government would provide matching grants to provinces for the funding of the program, provided that the following specific conditions were met:

- Universality – the plan covered all residents of the province
- Comprehensiveness – the province insured all the services listed in the Act

- Public administration – the plan was managed by government appointed administrators
- Portablility – insured residents would be entitled to receive care in all participating provinces

In one of the few instances in Canadian history, the vote held on the HIDS Act (Bill 320) was passed unanimously in the House of Commons by a vote of 165 to 0. Mounting public pressure, plus the incentive of significant federal funding, had overcome the reservations of many provinces.

From Hospital to Medical Insurance

When Saskatchewan joined the national hospital insurance plan on July 1, 1958, the addition of federal funding for hospital services left the province with a considerable excess of revenue. Without requiring higher taxes or premiums, attention inevitably turned towards medical insurance. The public mood was vastly different from the scenario faced by government during the implementation of hospital insurance in 1946. Residents of the province now enjoyed full hospital coverage, which eliminated considerable public anxiety over potential health costs. By February of 1962, Saskatchewan had implemented the first universal medical insurance plan of its kind in North America and calls to introduce similar plans across Canada were soon heard.

While Saskatchewan was busy leading the charge for medical insurance, the Canadian Medical Association maintained its support for a tax supported medical insurance system for all Canadians, passing a resolution stating:

> *That the CMA … Executive approach the Federal Government to ask them to establish a committee to study the existing and projected health needs and health resources of Canada; and to study methods of ensuring the highest standard of health care for all citizens of Canada* (Taylor, 1982, p. 335).

This resolution was forwarded to the Prime Minister's office on Dec 12, 1960 and on December 21st the Prime Minister announced that a Royal Commission on Health Services would be appointed to investigate this issue. The mandate given to the Commission was:

> *… to inquire into and report upon the existing facilities and the future need for health services for the people of Canada and the resources to provide such services, and to recommend such measures, consistent with the constitutional division of legislative powers in Canada …* (Royal Commission, 1964).

The Royal Commission, chaired by Justice Emmet Hall, required almost three years to complete its report, holding more than three months of public hearings, commissioning numerous studies and completing several visits to other countries to examine their health care systems. The final report was released on June 19, 1964, and was one of the most comprehensive and detailed studies on health care in Canada ever completed, encompassing two volumes and several thousand pages. The Hall Report is considered as one of the foundations of modern Canadian health care policy.

The main conclusion of the Commission was direct:

> *As we examined the hundreds of briefs with their thousands of recommendations we were impressed with the fact that the field of health services illustrates, perhaps better than any other, the paradox of our age, which is, of course, the enormous gap between our scientific knowledge and skills on the one hand, and our organizational and financial arrangements to apply them to the needs of man, on the other.*
>
> *What the Commission recommends is that in Canada this gap be closed, that as a nation we now take the necessary legislative, organizational, and financial decisions to make all the fruits of the health sciences available to all our residents without hindrance of any kind.*

In order to achieve this vision, the Commission recommended that a Health Charter "be accepted as an objective of national policy for Canada". Due to its historical importance and scope, the charter has been included here in its entirety (Royal Commission, 1964, p. 11,12).

HEALTH CHARTER FOR CANADIANS

The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive, universal Health Services Programme for the Canadian people,

IMPLEMENTED in accordance with Canada's evolving constitutional arrangements;

BASED upon freedom of choice, and upon free and self-governing professions and institutions;

FINANCED through prepayment arrangements;

ACCOMPLISHED through the full co-operation of the general public, the health professions, voluntary agencies, all political parties, and governments, federal, provincial and municipal;

DIRECTED towards the most effective use of the nation's health resources to attain the highest possible levels of physical and mental well-being.

1. "Comprehensive" includes all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide.

2. "Universal" means that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors.

3. "Health Services Programme" consists of legislative enactments and administrative arrangements to organize comprehensive universal health care including prepayment arrangements for financing personal health services

introduced in stages. Such a programme will provide complete health care with due regard to human factors and the spiritual, social, economic and regional forces intrinsic in the Canadian way of life.

4. "Canada's evolving constitutional arrangements" take into account the primary jurisdiction of provincial governments with respect to health matters including staging, scope and administration of health services, as well as the necessity for federal financial assistance to enable each of the provinces to implement a comprehensive, universal Health Services Programme.

5. "Freedom of choice" means the right of a patient to select his physician or dentist and the right of the practitioner to accept or not to accept a patient except in emergency or on humanitarian grounds.

6. "Free and self-governing professions" means the right of members of health professions to practise within the law, to free choice of location and type of practice, and to professional self-government. With respect to "institutions" it means academic freedom for medical, dental and other professional schools, and for hospitals, freedom from political control or domination and encouragement of administration at the local level.

7. "Prepayment arrangements" means (a) financing within a province by means of premiums, subsidized premiums, sales or other taxes, supplements from provincial general revenues and (b) by federal grants taking into account provincial fiscal need.

8. "Full co-operation" means

   (a) the responsibility of the individual to observe good health practices and to use available health services prudently;
   (b) the responsibility of the individual to allocate a reasonable share of his income (by way of taxes or premiums or both) for health purposes;
   (c) the methods of remuneration of health personnel – fee-for-service, salary or other arrangements – and the rates thereof should be as agreed upon by the professional associations and the administrative agencies and not by arbitrary decision, with an appeal procedure in the event of inability to agree;
   (d) the maintenance of the close relationship between those who provide and those who receive health services, safeguarding the confidential nature of that relationship;
   (e) the provision of educational facilities of the highest standards and the removal of financial barriers to education and training to enable all those capable and desirous of so doing to pursue health service careers;
   (f) the adequate support of health research and its application;
   (g) the necessity of retaining and developing further the indispensable work of voluntary agencies in the health care field;
   (h) the efforts to improve the quality and availability of health services must be supplemented by a wide range of other measures concerned with such matters as housing, nutrition, cigarette smoking, water and air pollution, motor vehicle and other accidents, alcoholism and drug addiction;

(i) the development of representative health planning agencies at all levels of government, federal, provincial, regional and municipal, and integration of health planning.

The Hall Commission paved the way for the introduction of a national medical care plan. In July of 1965, a federal/provincial conference was held to discuss "the way in which federal and provincial action can most effectively contribute to programs that will provide health services to Canadians on a comprehensive basis" (Shillington, 1972, p. 151). The initial proposal for medical insurance, as outlined by then Prime Minister Lester Pearson, was based on the same set of principles as the HIDS program, namely, universality, comprehensiveness, portability and public administration.

The reaction from the majority of provinces was largely skeptical as, "there were a number of provincial governments who were balky about being forced to introduce a measure which not only represented a heavy strain on their financial resources, but was fraught with all kinds of administrative and political headaches, while the government at Ottawa got all the bouquets" (Shillington, 1972, p. 153). Indeed, at first only three provinces (Saskatchewan, Newfoundland and New Brunswick) openly supported the proposal. However, following a period of intense negotiation and discussion, the federal Medicare Bill (C-227) was introduced in the House of Commons on July 12, 1966.

Despite a turbulent period of debate and controversy, the bill passed its final reading on December 8, 1966 by a vote of 177 to 2. Under the bill the federal government agreed to contribute, to each participating province, 50% of the national average per capita cost for each insured residents of the province. The target date for implementation was July 1, 1968. While required to adhere to the general conditions outlined in the Act, the administration and operation of the medical plans was largely left to the provinces. However, on the commencement date of July 1, 1968, only two provinces, Saskatchewan and British Columbia accepted the program. It was not until 1972 that all provinces and territories were participating in the plan.

The LaLonde Report (1974) – Expanding the Scope of Health

In 1974 a report entitled "A New Perspective on the Health of Canadians," prepared by Mr. Marc Lalonde, Minister of National Health and Welfare was released. This document is credited for expanding the efforts of government health policy beyond strictly illness care. The report outlined three determinants of health; lifestyle, environment and human biology. In a speech entitled "Beyond a New Perspective" made to the 104th Annual Meeting of the American Public Health Association on October 18, 1976, Minister Lalonde reflected on the implications of his report:

> *Its central message was that improvements in the environment and in lifestyles will now be the most effective means of reducing mortality and morbidity. In Canada, as in most other industrialized countries, the major current causes of illness and death are linked closely to lifestyle and the environment. This list is long and disturbing; lack of exercise, excessive drinking, poor eating habits, careless driving, cigarette smoking, the mental and physical stresses of the work environment, of the urban environment, and so on* (p. 4).

However, Minister Lalonde also recognized the reasonable limitations of these efforts:

> *Preventive health measures and promotion of healthy lifestyles are not an alternative to the health care services needed by a person who is actually ill* (p. 3).
>
> *Finally, we must develop a realistic appreciation of the practical limitations of prevention and promotion programs, This includes not only the question of program effectiveness, but also the basic questions of political and social ethics inevitably posed by government programs of regulatory or persuasive natures* (p. 6).

The Shifting Focus of Ability to Pay – The Established Programs Financing Act

The early years of health insurance in Canada were ones of accelerated costs, as health expenditures through the late 1960s and early 1970s escalated rapidly. Part of the problem, from the federal government's perspective, was the use of per capita cost sharing arrangements in the funding of health services. In this regard health budgets appeared to be "open ended" with no real incentives to curtail provincial expenditures. Indeed, the Economic Council of Canada in its 1970 review stated that, "if the rate of increase of the past five years (1964-1969) were to continue unabated, these two areas of activity (health and education) alone would absorb the entire national product before the year 2000" (Taylor, 1987, p. 423). Whereas the first three-quarters of the century had sought the removal of ability to pay considerations for patients in need of care, the focus was now on societies capacity to financially support the public program.

The concern over the government's collective ability to fund was the first of many such discussions to come over the next three decades. Many of the poorer provinces wanted to retain the 50-50 cost sharing, while the wealthier provinces wished to move to an increased percentage of tax transfers, minimizing or eliminating federal cash transfers. The solution, according to the federal government, was to move towards a "block-funding" approach that set a specified limit on federal transfers for specific social programs. Agreement was reached on the block funding approach with the passage of The Established Programs Financing Act on April 1, 1977. The Act provided for a transfer of the value of certain tax points to the provinces and guaranteed provincial flexibility in their use between health and education programs. Shared funding for health programs were no longer limited to only those specified by federal legislation.

In the eyes of both the federal and provincial governments, the EPF Act was seen as a victory:

> *The federal government obtained greater predictability and stability over its health expenditures; the provincial governments achieved greater flexibility in determining their health services program priorities* (Taylor, 1990, p. 155).

The future funding liability of the federal government was constrained by formula, tying the growth of expenditures to population and economic growth, as opposed to sheer spending volume. Although the EPF arrangements appeared to be satisfactory at the time, the

continuing cost pressures associated with growing medical capability and increasing public expectations were not as controllable as provinces had hoped. As a consequence, in the coming years the prevalence of user fees in hospitals and extra-billing for medical care increased.

1984 - The Canada Health Act

As of 1983, provincial hospital and medical insurance plans had been functioning together for over a decade. The plans experienced growing pains at both the federal and provincial level, as both levels of government continued to struggle with cost increases and regulation of the growing and expanding health system. A particularly sore point for the federal government was the issue of patient-pay charges. From the late 1970's and into the early 1980's, user charges and extra-billing by hospitals and physicians were a common occurrence. Patients would be charged a small user fee at the point of service. Federal policy advisors felt that this created a significant access problem for lower income Canadians and proposed the introduction of the Canada Health Act to eliminate this practice. As stated by Health Canada, the purpose of the Canada Health Act was to:

> *"establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made."*

In essence, the federal government would agree to hand over cash to the provinces if, and only if, certain conditions were met. The conditions created by the CHA were adherence to the former principles of universality, portability and public administration, a modified principle of comprehensiveness to include non-physician providers where permitted by the provinces, and an added principle of accessibility. The principle of accessibility was such that the provinces, "must provide for insured services on uniform conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons" (Canada Health Act, 1984, S 12.1.a). The accessibility principle effectively eliminated the application of user fees in the provinces, since for every dollar so collected, the federal government would reduce their cash contributions by the equivalent amount.

The CHA was not introduced without controversy. Provinces were significantly opposed to what they saw as a direct intrusion by the federal government in an area of provincial authority. The federal government was now in a position to shape health care policy, without being directly accountable for the implications arising from that policy. Consequently, the principles of the CHA, particularly the comprehensiveness and accessibility revisions introduced in 1984, remain among the mostly fiercely defended (and attacked) elements of the health policy debate in Canada.

Federal Withdrawal From Medicare

The combination of the Canada Health Act and the Established Programs Financing Act placed the federal government in a strong and unique position. The EPF allowed them to constrain the growth of funding, while the CHA permitted that funding to be withheld if the

provinces violated the CHA principles. However, the degree of influence maintained by the federal government was directly tied to the size of the funding contribution made.

During the mid 1980s and early 1990s the federal government began to take steps to address its budget deficit and debt problems. The result was that over the course of the next 15 years, the federal government consistently reduced its financial contribution to health care while continuing to demand provincial adherence to the principles of the Canada Health Act.

In 1983, as part of a cost reduction strategy, the Liberal government under Pierre Trudeau, reduced the level of federal contribution. Subsequently, current and future calculations of the EPF transfer no longer matched the growth of the economy. Later in 1986 the Conservative government, under Brian Mulroney, changed the level of EPF transfers even further so that annual growth was constrained to 2% less than the growth in the economy (GNP). As Canada entered the 1990's, transfer payments from the federal government were composing a smaller and smaller piece of the health care budget. The outcome of this federal policy placed the increasing burden of financing health care squarely on the shoulders of the provinces.

By 1991 Canada was in the midst of a recession, with both provincial and federal governments struggling with increasing deficits and debts. As part of the federal response, Brian Mulroney passed the Federal Restraint Law which froze EPF transfers for both 1990-91 and 1991-92. Later this freeze was extended a further three years, up to and including 1994-1995. By 1995, both provincial and federal governments were calling for a revised method of funding programs, as the EPF proved to be a too rigid and complicated process.

In response, the Liberal federal government established the Canada Health and Social Transfer (CHST) program in 1996. While the EPF was designed to provide block funds for specific programs, the CHST created a single fund that permitted provinces the flexibility to allocate funding among various programs. However, the new CHST mechanism did not provide the funding panacea sought by the provincial governments. Total federal cash transfers for health (estimated) fell from $18.5 billion to $12.5 billion between 1994/5 and 1998/9 – a decrease of almost 33% over four years. This reduction was implemented on top of the reductions that already had occurred since 1983. Despite their public defense of the health care system and the Canada Health Act, federal financial support for health care had plunged.

Closer to Home

Although it may have clarified the federal role in health care, the Canada Health Act did nothing to alleviate the concern of those who felt that the health care system was no longer sustainable, and calls for reform remained prominent over the latter half of the eighties. Several provinces, including British Columbia, responded with Royal Commissions to examine the policy questions and options. In 1991, The British Columbia Royal Commission on Health Care and Costs released its report entitled "Closer to Home". This report was prepared by a six-member Commission, and was chaired by Justice Peter D. Seaton.

The Seaton report was intended to include a comprehensive review of BC's health care system, and included meetings and discussions in many BC communities over a period of 18 months. The basic conclusion of the report called for a movement away from the acute care

system, and instead to focus on providing care in the community "closer to home," addressing prevention, health promotion and the determinants of health.

The Commission made 301 recommendations spanning a wide range of topics including hospitals, long term care, ambulance services, home care, substance abuse, mental health, drugs, laboratory services and native health. Many of the recommendations of the Seaton Commission were implemented, while many others were not. However, the basic objective of providing services "closer to home," with its consequent plethora of interpretations, continues to be a major focus for many groups in the health care system.

Unfortunately, the ideals that motivated the Commission have become distressingly blurred in the aftermath of their work. Indeed, the report of the Commission served to exacerbate the problems in the health care system rather than resolve them.

First, the report paved the way for the introduction of the regionalized governance structure that is in place in the province today. Notwithstanding the relative merits or demerits of "regionalization," the mechanisms to introduce such a concept were not well developed, nor particularly well communicated to the managers charged with the implementation responsibility. Consequently, regionalized health care remains at the fore of much discontent in the province.

Of further and equal concern was the recommendation made by the Commission with respect to the funding source for many of its initiatives – primarily through cuts to the acute care system. The Commission based this erroneous conclusion on the premise that the investment in community services would directly reduce the utilization of acute care services. They stated,

> *"This recommendation is based on the premise that "25% of the acute care days provided in 1989/90 in BC could have been provided in other facilities or through other programs, or were not needed at all. At an occupancy rate of 80%, these unnecessary acute care days required about 3,000 acute care beds"* (B-96).

The BCMA was deeply concerned with this recommendation at the time, and in 1992 indicated:

> *One of the major thrusts of the report, which is to render care that can be appropriately provided otherwise, outside of the acute care setting, is to be applauded. But to theorize that sufficient funds can be redirected (from acute care) in this way to finance the many extremely costly proposals in the report is, frankly, dreaming* (BCMA, "The Response of the BCMA to the Report of the Royal Commission on Health Care & Costs, Page 2).

Physician concerns were largely ignored, however, and the budgetary attack on the acute care sector was relentless through virtually all of the nineties.

The National Forum on Health

The early 1990's saw a considerable amount of Canadian interest expressed in health reform, demonstrated by many provinces regionalizing the provision of health care services. This period was also marked by more dramatic events such as hospital closures and budget cuts across health care that focussed public attention. The result was an increasing level of public concern over the health care system and how it was developing. In response, in October of 1994, Prime Minister Jean Chretien called for the creation of a National Forum on Health. The mandate of the Forum was:

> *"to involve and inform Canadians and to advise the federal government on innovative ways to improve our health care system"* (National Forum 1997, p. 7).

The Forum was an advisory body of 24 volunteer members composed of professionals, consumers and other advisors. The Prime Minister served as Chair, with then Health Minister David Dingwall, serving as Vice-Chair.

In their final report, "Canada Health Action: Building on the Legacy", the National Forum on Health reached four primary conclusions:

1. We believe that the health care system is fundamentally sound (p. 11).
2. We believe we spend enough money on health care (p. 12).
3. We believe the system can be improved. There is ample evidence that resources could be used more effectively (p. 12).
4. We conclude that Canadians want to preserve the fundamental principles of Medicare (p. 13).

Further to these main recommendations, the Forum concluded that the following key features of Canada's health care system must be preserved and protected to ensure the integrity and sustainability of the system (National Forum, p. 20):

1. Public funding for medically necessary services;
2. The "single payer" model;
3. The five principles of the Canada Health Act; and
4. A strong federal/provincial/territorial partnership.

Had the Forum stopped at this point, there is a strong likelihood that their report would have been well received by Canadians. However, they went further, suggesting that the scope of services provided through the public system be expanded:

> *"Preserving medicare, however, also means adapting to new realities by: expanding publicly funded services to include all medically necessary services; and, in the first instance, home care and drugs; and reforming primary care organization and delivery"* (p. 20).

In the face of substantial evidence to indicate that the existing acute care system was approaching the breaking point, the Forum recommended that the home care initiative "should be funded by reallocation of savings from reductions in the institutional sector" (p. 23). Surprisingly, the Forum also recommended "tax increases, premium increases, or both" (p. 23) to fund the national Pharmacare program. These thoughts, which flew in the face of both reality and public opinion, have seemingly relegated the Forum's rather high profiled work to the recycle bin.

The Resurgence of Federal Interest in Health Policy

By 1998, health care clearly had become the number one issue in the minds of Canadians, as it remains today. Long wait lists for surgery, crowded emergency rooms, lack of hospital beds and a shortage of nurses focused a national sense of urgency on health care. As stated by the federal Health Minister:

> Canadians are worried about the future of health care. They worry about waiting hours in an emergency room. About waiting months to see a specialist. About waiting a year for a long-term bed. About waiting for what seems an eternity for someone to answer the call button in an understaffed hospital ward.
>
> - Health Minister Allan Rock, Feb 19, 1999

Mr. Rock got it right, of course, but tracing the cause for concern invariably leads directly back to the actions of his own federal government.

By the late 1990's, Canada was entering into an time of economic recovery and expansion. For the first time in almost thirty years, the federal government had controlled its deficit problems and was debating what to do with a budget surplus. However, it was also becoming increasingly difficult for the federal government to ignore concerns over health care expressed by provincial governments and the public. This was particularly sensitive when the government was in a surplus position.

In response to public concerns the federal government, which had stated one year earlier that the system was fundamentally sound and sufficiently funded, presented the 1999 Federal Budget as the "Health Budget". This budget reflected the federal government's new objective to reinvest in and restore the health care system.

The main thrust of the budget was the infusion of $11.5 billion, specifically for health care over five years. This included an immediate $3.5 billion supplement, available in 1998/1999. The remaining $8.0 billion was to be distributed over the next five years. The second part of the "Health Budget" included an additional $1.4 billion over the next three years to be spent on health research, health information systems, First Nations and Inuit health, disease prevention and health promotion.

Although sorely needed, the injection of $11.5 billion over the next four years was insufficient to address the multitude or previous cuts to provincial transfers. By 2002/03, the final year of the four year injection, the total federal funding will only have been returned to its 1995/96 level, and this level will not contain any adjustment for demographics or inflation over that time.

It was clear that the federal government desires an expanded role in health care. Yet, provinces remain cool to the notion of any federal intrusion into health care delivery issues – particularly in light of the transfer cuts of the early and mid 1990's. However, the federal government has repeatedly indicated that it will not introduce significant increases in health care transfer payments without a clear plan for improving the system – a plan which includes a role for the federal government. The public will be watching with great interest as the two levels of government tangle over this issue.

Health Policy in Transition

The Canadian Health Care system clearly faces a multitude of resource and distribution issues. Canada is not alone in this regard; virtually every nation in the world is searching for ways to make its health care system more effective and efficient. There is no easily recognizable solution; rather just a series of the "latest attempts" at system reform, as nations literally exchange failed ideas, with the view that recycled initiatives are better than no initiatives at all. Canadians have witnessed several such attempts, with no indication that the health care system is improving. Indeed, there is evidence we are headed in the opposite direction.

Canadian history of health policy development over the past century has demonstrated an unyielding commitment to a strong and prominent public program; a system that places equal access to care as its cornerstone. That goal is in jeopardy, not only in Canada, but elsewhere as well.

In 1978, the World Health Organization (WHO) defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease". While it is difficult to object to the philosophical base of this definition, it has been controversial in so far as many consider this as a too broad and inherently expensive goal to be funded by a public program. Today, it appears that WHO has recognized some of the difficulty in achieving this goal. In their discussion of reform in the 1999 Annual Report, WHO argues that the pursuit of providing universal access to all possible services has been an unrealistic goal:

> *"Efforts to provide all services to all people have led to arbitrary rationing, inequities, non-responsiveness and inadequate finance for essential services"* (p. xiv).

Consequently, the 1999 WHO report focuses on balancing the scope of services provided against the ability of a nation to finance those services:

> *"This report advocates a "new universalism" that recognizes governments' limits but retains government responsibility for leadership, regulation and finance of health systems. The new universalism welcomes diversity and, subject to appropriate guidelines, competition in the provision of services. At the same time it recognizes that if services are to be provided for all, then not all services can be provided"* (p. xv).

The statement from the WHO provides a potential avenue for exploration, but it is only one possibility. Whether or not it is the right avenue for Canada remains to be seen, but it is

certain that we are at a crossroads. There are many possible paths to follow. Choosing the right path for Canadians requires a clear understanding of the issues and an enlightened debate concerning the available policy options. The framework for that debate follows.

Chapter 2 The Health Care System Today – An Intricate Weave of Decision Processes

Increasingly, Canadians are hearing calls to undertake health care reform in order to save Medicare. In this context, health care reform is intended to provide a means to protect and preserve our Canadian health care system. However the term "health care system" describes a vast and complex array of services and providers. Indeed, very few Canadians have adequate knowledge as to how the health care system actually works. A more complete understanding is a prerequisite to identifying necessary reform initiatives.

The Myth of a National Health Care System

A misconception in Canada is the notion there is a single national health care system. As outlined earlier, the Canada Health Act is the cornerstone of federal health care policy. Interestingly, however, it is not an Act that has health care delivery as its primary purpose, and it is not a prescriptive piece of legislation that binds the provinces of Canada. At its fundamental level, the CHA simply is a regulatory framework for federal funding. The CHA lays out specific conditions under which federal cash transfers will be made to the provinces for the purpose of health care delivery. Thus, it is intended to persuade the provinces to adhere to certain principles (universality, portability, accessibility, comprehensiveness, and public administration) in the development of their individual health care systems and structures.

Canada's health care system is actually a collection of thirteen independent health insurance plans administered by provincial and territorial governments, with the federal government retaining responsibility for providing health care to certain specific groups, including war veterans, native Canadians living on reserves, military personnel, inmates of federal penitentiaries and the Royal Canadian Mounted Police. There is also a distinct insurance system for providing care to injured workers through the Workers' Compensation Board (WCB) within each province and persons injured in motor vehicle accidents with coverage of the latter, in British Columbia, provided by the Insurance Corporation of BC (ICBC).

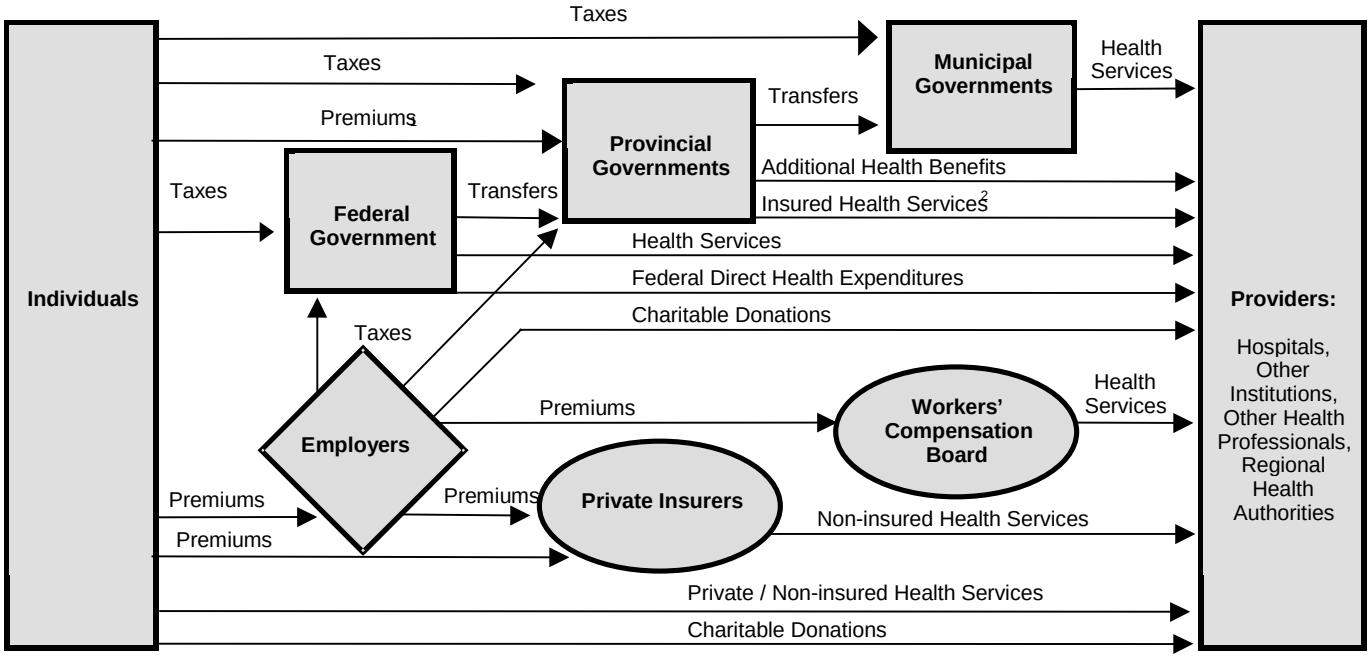
In addition to these plans there exist a variety of extended private insurance plans that assist with the costs of a variety of services such as drugs, dental services, glasses/contact lenses, life, travel and disability insurance etc. These extended health insurance plans charge premiums which are paid for either by employer based groups or individual Canadians. One of the most common examples is Blue Cross. And finally, of course, there are many services for which patients must pay directly out-of-pocket.

Health Canada has a useful diagramatic presentation of these many participants, available on their web site[2] and reproduced below as Figure 1 (with the addition of a "charitable donations" category, which was omitted in the source document, along with some additional refinements).

[2] http://www.hc-sc.gc.ca/datapcb/datahesa/E_sys.htm

Figure 1

FUNDING STRUCTURE OF CANADA'S HEALTH CARE SYSTEM*



1 Two Provinces, British Columbia & Alberta, levy health premiums.
2 Medically-necessary hospital & physician services
* Based on charts prepared by Health Canada 1999

This diagram is a somewhat busy, yet relatively descriptive, depiction of the funding structure for Canadian health care. It clearly identifies the multitude of individuals, agencies and governments involved in the day-to-day management of the health care system. However, while this depiction is useful, it masks the many complex and intricate inter-relationships which exist between legislation, management and care delivery. These inter-relationships often generate a national tension and competing interests between the participants.

For example, the principles of the Canada Health Act are relevant for those services covered under the public program and funded by the provincial government, yet generally do not affect those services under the authority of municipal governments, WCB, or private insurers. Even those services funded directly by the federal government do not explicitly fall under the CHA and the principles thereof are applied only by choice, not by reason of a legislative framework. Clearly, those administering these other programs can, and frequently do, operate under different sets of principles than those of the CHA. This can provide somewhat of a dilemma for hospitals and providers who are present to serve the entirety of the health care system demand when they, without the benefit of clearly enunciated health care policy, must make decisions with respect to allocating their limited resources amongst these competing interests.

Visualizing, let alone recording, these myriad of inter-relationships is a difficult task. Yet it is possible to think of a simplified systems approach to describing the health care financing and delivery structure, as outlined in Figure 2.

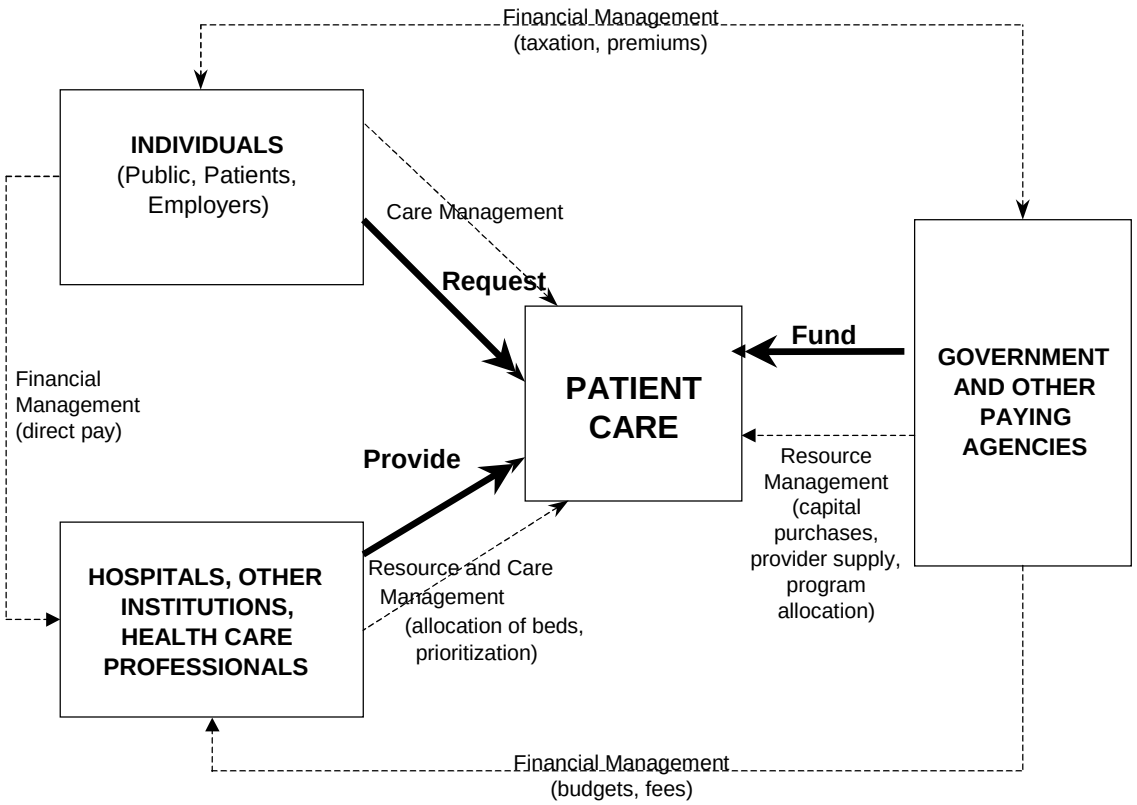


Figure 2: Health Care Financing, Delivery and Management Interactions

Patient care is at the centre of the health care system. Patients seek health care when they need it, institutions and health care professionals provide that care and, in the majority of instances, governments and other paying agencies fund the resulting service provisions. But also depicted in Figure 2, via the dotted line connections, are the additional management decisions that are required with each interaction involving care delivery and/or resource/financial allocation. These management decisions fall into three general categories:

a) Financial Management - Each participant engages in financial management activities, either directly or indirectly. Governments and paying agencies provide operating budgets, or set fees, for example. They also tax individuals and businesses as a source of revenue. Hospitals and providers interact financially with individuals in cases where some co-payment is involved, or where services are not covered under the public program.

b) Resource Management - These management activities occur at the government/agency and institution/provider levels. At a macro-level governments and agencies make resource decisions such as which capital purchases are made, allocations of budgets between health care areas and decisions which regulate the available supply of professionals such as doctors and nurses. At the more micro level, institutions allocate beds and determine hours of operation for diagnostic equipment, for example, while

providers make decisions about how they will allocate their own time between competing activities.

c) Patient Care Management - Individualized care management is generally left between the patient and providers (either individually or collectively, working as a team).

If one can visualize the hundreds of thousands of patient care interactions that occur each day, in the hundreds of institutions, across 45 health authorities, involving several different levels of government and other paying agencies, one can begin to glimpse the complexity of this process.

In an ideal world, with perfect knowledge of all decision makers and instantaneous response on their behalf, the health care system could operate efficiently. But in reality, each level of decision making is independent of the next, frequently un- or ill-informed of the other, slow or unable to react to changing circumstances, and labouring under financial constraints.

The fact is, we do not enjoy a health care system where patient need dictates the allocation of resources and, ultimately, the associated financial requirements. Contrarily, our health care system first sets financial constraints, from which resource allocation and patient care decisions are expected to flow. Not surprisingly, bottlenecks occur and all too frequently, patient care is jeopardized.

If we are going to reform our health care system, Canadians will need to ensure that the management of decisions noted above are made objectively and that they focus on the need for patient care as their primary goal. This objective raises a number of policy questions, examples of which are summarized in Table 1. The list is not exhaustive, but rather reflects the expanse of issues involved. There are no easy solutions, but Canadians need to have a clear understanding of the intricate nature of the puzzle.

Table 1
Policy Considerations from the Management of the Health Care System

Management Area	Organizations/Individuals Involved	Types of Decisions Taken	Examples of Policy Questions Arising
Finance	Federal Government	Transfer Payments	▪ Is the federal gov't contributing enough funds? ▪ Should federal funding be unconditional? ▪ Is there sufficient accountability for spending? ▪ Is a national core set of services required?
	Provincial Government	Budget Allocation	▪ Is enough spent on health care? ▪ Is spending relative to need? ▪ Is the scope of insured services correct? ▪ Is spending sustainable? ▪ Is there sufficient accountability?

Management Area	**Organizations/Individuals Involved**	**Types of Decisions Taken**	**Examples of Policy Questions Arising**
		Sector Negotiations	▪ Are settlements fair and sustainable? ▪ Are settlements adequately funded?
		Revenue/Premiums	▪ Are premium levels responsive to need? ▪ Should premiums be set by an arm's length agency?
	Regional Authority Institutions	Program Allocation	▪ Do programs reflect the community demand? ▪ Is there accountability? ▪ Is program funding responsive to need?
	Other Agencies	Revenue/Expenditures	▪ How should the service needs associated with responsibilities of the agency be compared to those of the general public? ▪ Should price competition exist?
	Providers	Fees/Wages	▪ Do fees and wages reflect the relative worth of the service/activity? ▪ Is there accountability?
	Individuals	Direct Payment	▪ Are co-payment charges fair and reasonable? ▪ Should individuals be allowed to purchase care directly? ▪ Is there accountability?
Resource	Provincial Government	Capital Expenditures and Acquisitions	▪ Does the physical plant capacity meet the expected need? ▪ Should available capacity reflect peak, normal or low demand periods? ▪ What role should the private sector play?
		Social Policy	▪ Do policies reflect and support resource allocation needs (e.g. provider supply)
	Regional Authorities/Institutions	Bed Allocation	▪ What is the appropriate mix of emergency, acute, chronic and continuing care beds? ▪ Who should decide allocations? ▪ Are the allocations responsive to need?

Management Area	Organizations/Individuals Involved	Types of Decisions Taken	Examples of Policy Questions Arising
		Support Staff Allocation	▪ Are the right people being trained and employed in the most efficient manner? ▪ Does the availability of support staff align with program expectations?
	Providers	Time Allocation	▪ Do providers allocate the appropriate amounts of time to the right activities? ▪ Are the number of hours worked consistent with quality patient care?
Patient Care	Providers	Service Use	▪ To what extent are "best practices" followed? ▪ Does the health care system infra-structure support the services required? ▪ Is there accountability?
	Individuals		▪ To what extent do individuals have choice of care alternatives? ▪ Is there truly equal access? ▪ Are individuals accountable for what they demand?

How Much Does Health Care Cost?

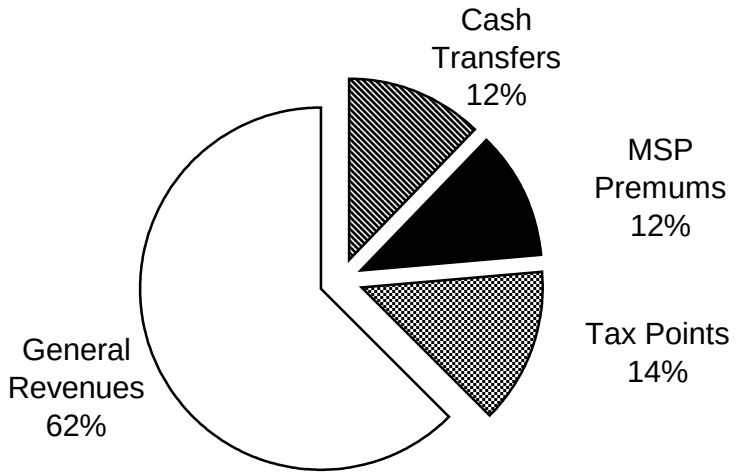
On occasion, Canada's health care system has been described as a "free" public service. In reality, health care is a significant expense both in terms of taxes and out of pocket expenses. From a national perspective, in 1997, Canada spent 9.2% of its Gross Domestic Product on health care – meaning for every $100 earned or generated within Canada, $9.20 of it was spent on health care, including all private and public dollars spent. Among developed countries, Canada ranks 5th in the world in terms of GDP spent on health care, behind the United States (13.9%), Germany (10.7%), Switzerland (10.0%) and France (9.6%) (OECD 1999). Canada has seen a steady decline in the percentage of GDP spent on health care from its peak in 1992 at 10.2% of GDP.

For a nation that prides itself on providing a universal public system, it is important to point out that the proportion of public funding is steadily decreasing. In 1987, for every dollar spent on health care in Canada, $0.75 was public, and $0.25 was prviate. By 1997, less than $0.70 was spent publicly and more than $0.30 was spent privately. The percentage of public spending on health care today has not been this low since before 1970.

Public health care in BC is funded primarily through a combination provincial and federal taxes and health care premiums. In 1998/1999, the BC provincial government spent $7.58 billion dollars on health care – 36.5% of the total provincial budget (Source: BC Financial and

Economic Review, 1998). The relative importance of these sources is depicted in Figure 3 below:

Figure 3 - 1998/1999 BC Health Budget Revenue by Source



Source: Department of Finance Canada, BC Financial and Economic Review, 1999

The federal contribution to health care (called the Canada Health and Social Transfer) is part of a block of funding provided to the province for health care and post-secondary education and welfare. In 1998/1999, the federal government provided approximately $920 million to British Columbia for health care in the form of cash transfers.[3]

In addition to this cash contribution, the federal government also provides the provinces "tax points". The transfer of tax points means that the federal government agrees to lower their tax rate so that the provinces may raise their taxes by the same amount. The net effect is that an individual's taxes don't change, but that the provinces collect additional tax revenue.

Direct taxation is not the only way health care is funded in British Columbia. British Columbia also collects monthly premiums to assit in the financing of the system. BC and Alberta share the distinction of being the only two provinces in Canada to collect premiums for their health plans. Current monthly premiums in BC are (Medical Services Plan, February 2000):

- $36 for a person without dependents
- $64 for a family of two
- $72 for a family of three or more.

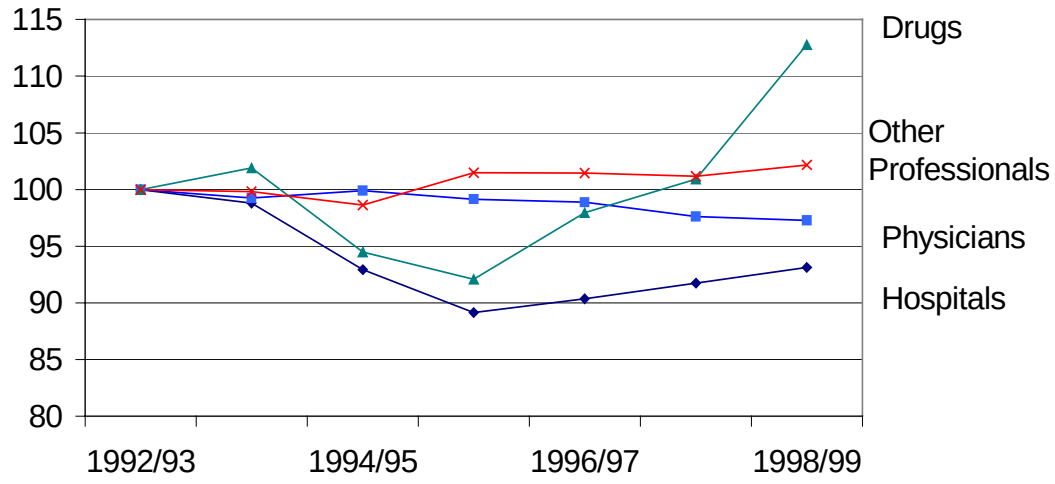
In 1998/1999, BC collected $876 million dollars in Medical Services Plan premiums. While this seems like a large sum, closer analysis reveals otherwise. In 1998/1999 physicians

[3] The CHST does not identify an amount for health care, therefore, the health care component has been estimated using the 95/96 distribution. In this year federal transfers for health care amounted to 46.73% of total CHST cash transfers.

provided services to British Columbians totalling $1.45 billion dollars. Therefore if applied totally to physician services, medicare premums would fund only 60%[4] of physician services, and represents only 11.5% of total health care expenditures in British Columbia.

These revenues are converted into expenditures and allocated amongst the variety of programs. Of some interest, as depicted in Figure 4 below, the per capita allocation to physicians and hospitals (primarily for acute care purposes) has been declining during the decade of the nineties, while spending for other health sector areas has been increasing.

Figure 4:
Change in BC Government Health Care Expenditures per Capita Adjusted for Inflation



SOURCES: CIHI, MSP, BC Stats and Statistics Canada

These allocation decisions reflect both an expanding array of publicly funded services and programs, as well as a conscious decision to re-allocate funding acute and chronic care to health promotion and illness prevention activities. The consequences of this policy direction are addressed in some detail in the following section.

[4] Source: Medical Services Plan Claims Data, 1999

Chapter 3 What are the Problems in the Current System?

Canadians are concerned about their health care system. A national poll conducted by the Angus Reid Group in February, 2000 showed that health Care was the number one issue on the minds of Canadians by a significant margin. The poll showed that over 55% of Canadians "believe political leaders should make the health care system the number one priority", exceeding all other expressed concerns combined (National Post, Feb 7, 2000).

A Top-Line poll of 1,500 Canadians conducted by Angus Reid in May 2000 showed that 75% of Canadians thought the health care system is currently facing a major funding crisis.[5] The nature of people's concerns are complex, as the current situation represents an evolution of interconnected issues, decisions and contributing factors. Some of these factors were preventable, others were not.

Factors Influencing Canada's Health Care Policy

This paper identifies five major factors which have a significant impact on how health care has evolved in Canada. More importantly, these factors will continue to challenge how health care is provided to Canadians in the years to come. These factors include:

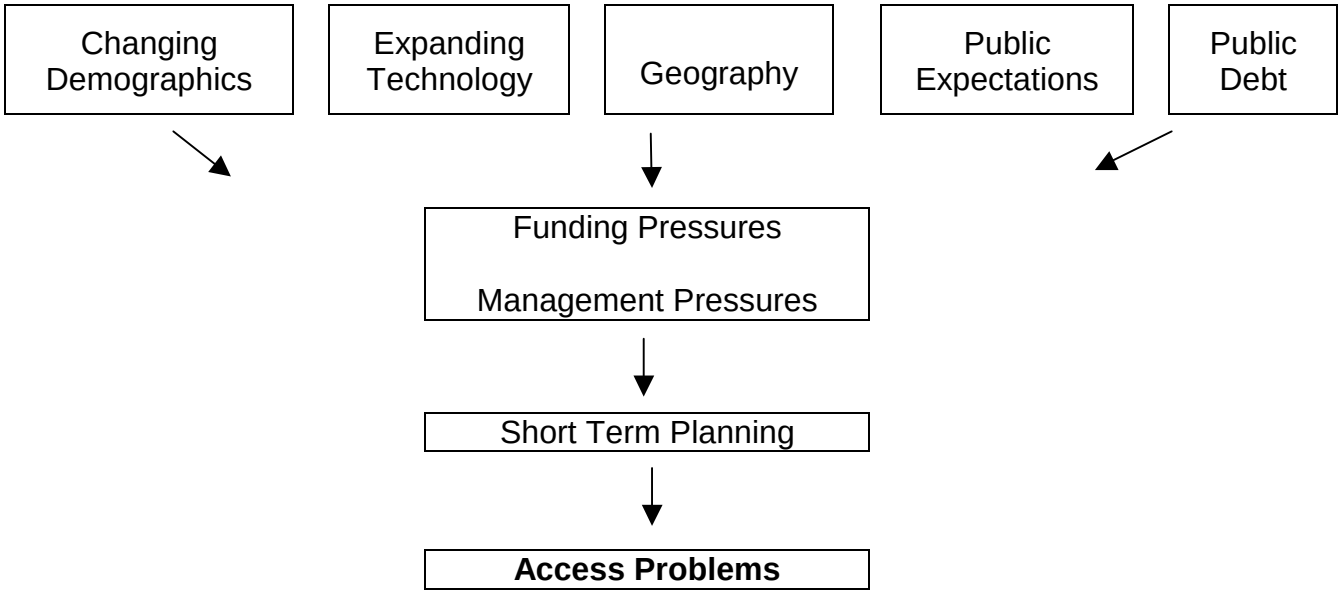
- Changing Demographics
- Expanding Technology
- Geography
- Changing Expectations and Attitudes
- Public Debt

There can be no doubt that this combination of social, economic, demographic and scientific variables has created unprecedented pressure on the system, pressure focussed both on funding and management decisions. Various governing agencies have responded to these pressures through a variety of decisions which have, frequently out of necessity, been transferred on a short term solution to what is invariably a long term problem. The unfortunate result has been an exacerbation of access (e.g. home care, wait lists) and capital infrastructure (e.g. hospitals and equipment) problems.

Clearly, the health care system is not sustainable within this type of issue/response framework. Some fundamental changes are required.

[5] National random sample of 1,500 Canadian adults and has a margin of error of ± 2.5 percentage points 19 times out of 20

Figure 5
Pressure Points – Factors Influencing Canada's Health Care Policy



1. Changing Demographics – Canadians Come of Age

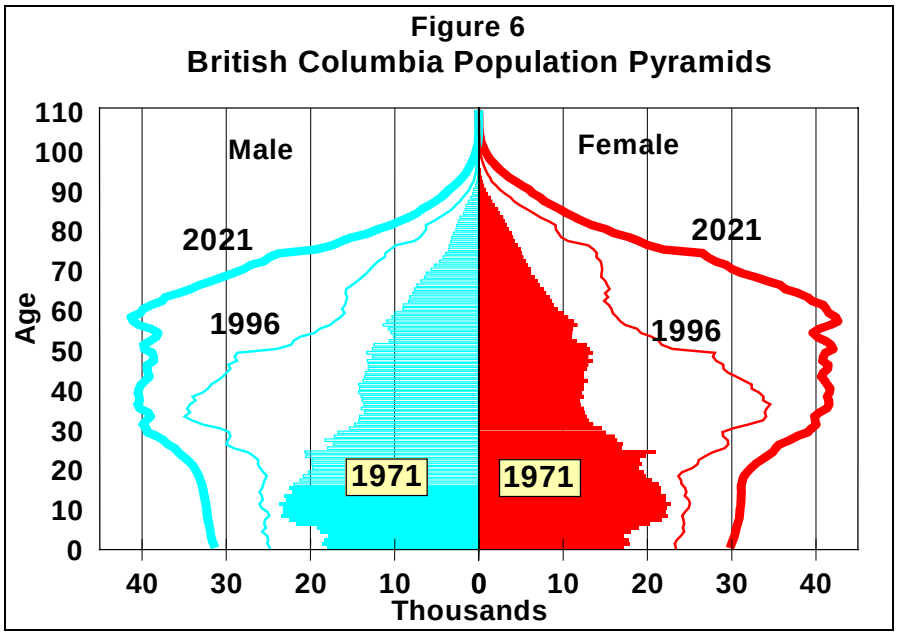
Canada's aging population is at the forefront of the challenges facing the health care system. In general we all realize that the "greying" of the population will place increasing pressure on the health care system. However, the true magnitude of the problem is not succinctly defined in the current debate. This issue is portrayed as something that will happen "in the future" at some unknown time down the road. In reality, demographic changes are already taking their toll on the system – and will only increase in the coming years.

The aging of Canada's population presents a two-pronged problem for the health care system. First, "baby-boomers" will have a significant impact on the cost of running the health care system as they will both expect and use more services as they get older.

> "Expect the baby boomers to dramatically alter health care and its delivery systems just as they have dramatically changed every social institution as they reached each benchmark in life."
>
> The Health Care Revolution
> The Global Network, 1998

According to the Urban Futures Institute in 1998, one out of three Canadians was over 45 years of age, while one out of eight Canadians was over 65 years. In 2040 they predict that one out of two Canadians will be over age 45 while one out of four will be over 65 (Baxter, 1998).

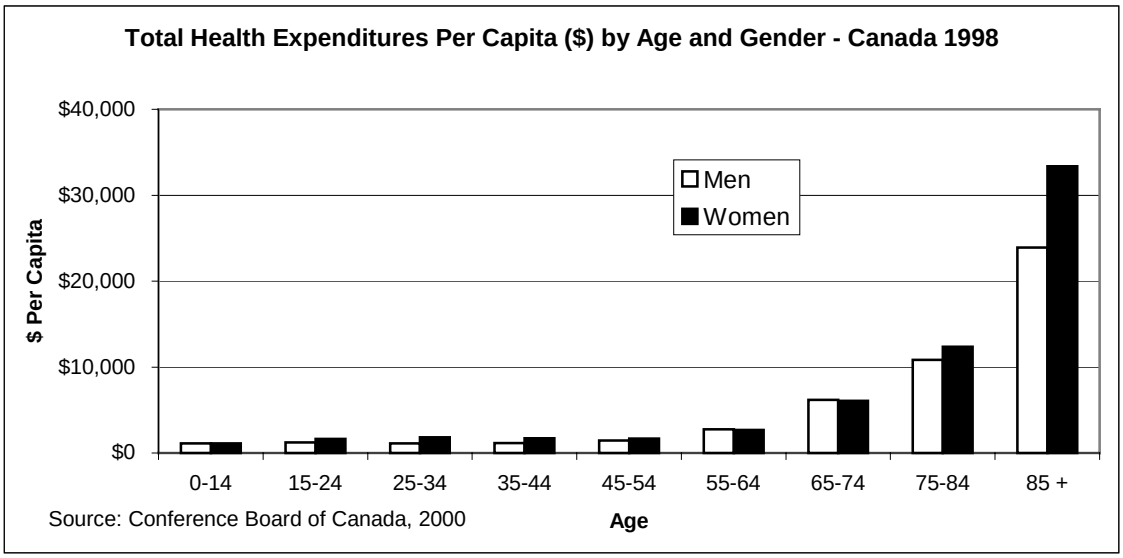
Figure 6
British Columbia Population Pyramids



SOURCE: BC Stats

Figure 6 paints an expensive scenario. It is well known that older people tend to use more health care services. The conference board of Canada estimates that the average man aged 25-34 spends a total of $1,128 per capita on health care in Canada while a woman of the same age spends a total of $1,831. In contrast a man aged 65 to 74 spends $6,198 and a woman $6,076 – more than five times their younger counterparts. For those over age 85, the average costs for a man are $23,895 and a woman are $33,381 per capita (Conference Board of Canada, April 2000, p. 15).

Figure 7



The second, and equally important, issue is that the aging population will leave a smaller number of taxpayers to pay for a system which has a growing number of high end users. In the foreseeable future, BC and the rest of Canada face a scenario where the cost of providing care may completely overwhelm the tax paying population's ability or willingness to pay for the system. Recently the Health Conference Board of Canada estimated that if current trends continue, health care in British Columbia will require 53% of provincial government revenue in 2020 (The Future Cost of Health Care in British Columbia, April, 2000). In dollar terms real provincial costs will rise from $7.1 billion in 1999 to $16.2 billion in 2020. In order to provide this level of funding to health care, provincial governments will need to forego spending in other areas and programs to sustain the health care system.

This problem has been characterized as the "unfunded liability" of Canada's health care system. Unlike regular insurance plans, Medicare is not required to set aside a pool of funds to offset future liabilities or sudden emergencies. In reality, today's taxes are paying for today's health care. Neither the federal nor provincial governments are setting aside funds to address this future problem. If we consider that we are involved in a funding crisis today in BC, what will happen in the future when the proportion of Canadians in the population over age 65 doubles?

2. Expanding Technology – Increasing Possibilities … and Costs

The 1980s and 1990s have been described as the "information age" in which computers became a part of people's everyday life. The 21st century is heralded as the dawn of the "biotechnology age" in which incredible developments such as the Human Genome Project are emerging. The central theme in both these times is the expanding use of technology in our lives – including health care.

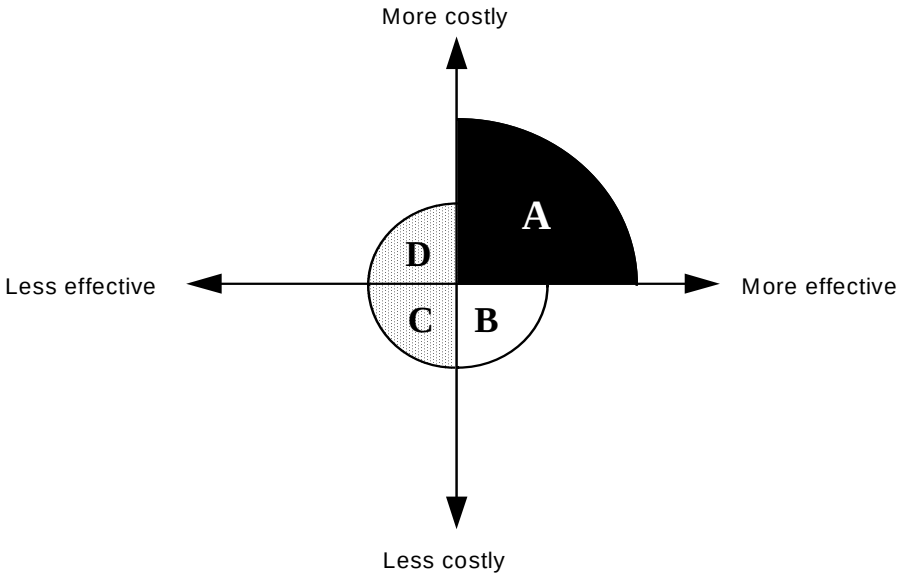
New technological breakthroughs seem to be happening at an accelerated pace. Canada faces the difficult task of accommodating an ever expanding scope of services offered within limited amounts of funding in our public system.

Whether benefiting the elderly or other age groups in society, new technology in health care has been appropriately defined as "advances in knowledge and technique that have been translated into improved diagnostic, therapeutic and rehabilitative procedures and/or equipment" (Ginzberg, 1990). In this sense, advances in "technology" in health care include examples such as drugs, new surgical devices and techniques, and new diagnostic equipment.

Laupacis et. al. (1992) described four potential impacts which a new technology can have on the provision of health care in terms of expense and effectiveness. This spectrum is represented in Figure 8 below, with "expense" being a function of both cost per procedure and volume of service provided. In general a new technology can be:

- more effective and more expensive (quadrant A);
- more effective and less expensive (quadrant B);
- less effective and less expensive (quadrant C);
- less effective and more expensive (quadrant D).

Figure 8
Impact of New Technology



The dominant academic opinion is that new health care technology most often falls into quadrant A, increasing overall costs to the system. Numerous studies conclude that new technologies contribute significantly to increased medical costs.[6] Researchers cite advances in surgical procedures, diagnostics and pharmaceuticals that improve the quality of care, e.g. care for premature babies. Through new technology, previously untreatable illnesses become treatable and the health status of the population improves. However, by expanding the realm of interventions, costs invariably rise. Consider the following examples:

[6] Altman, S. H. and S. S. Wallack. 1979. Banta, H. David, Clyde J. Behney, and Jane Sisk Willems. 1981. Fineberg, Harvey V., David Scadden, and Lee Goldman. 1984. Fuchs, V. R. 1972. McKinlay, J.B. 1972. Mendelson, D. N. and W. B. Schwartz. 1993. Scitovsky, Anne A. and N. McCall. 1976. Showstack, Jonathan A., U.S. Congress, Office of Technology Assessment. 1984.

Table 2

Type of New Technology	Specific Example
Creation of a new service.	Prenatal surgery, prenatal ultrasound, and genetic surgery
Creation of a complimentary service which does not completely replace old technology.	Coronary angioplasty and coronary artery bypass surgery
Technology which may prolong life and consequently increase potential future utilization.	Triple therapy for AIDS treatment extends life from 10 to 17 yrs.
Technology which may allow or extend treatment of previously untreatable patients.	Care for premature infants from 1500 to 1000 g
Technology which may increase average costs of treatment, but also increase effectiveness.	Hospital-based hemodialysis
Technology which provides high volume diagnostic tools with low positive detection rates.	Mammograms where significant majority of reported abnormalities are non-malignant, but still require full scope of tests.

The cost of drugs in Canada is another poignant example of how new treatments can impact health care costs. In 1975 drugs made up a total of 8.8% of total health expenditures in Canada. By 1999 it was estimated that drug costs rose to more than 15.2% of total expenditures.

Technology is, furthermore, being applied at all levels of medical care treatment. Although virtually all existing technology assessment efforts are focused towards highly publicized and expensive diagnostic and surgical techniques such as CT scan, MRI, and bypass surgery as pointed out by Scitovsky (1979). However the smaller tests and procedures play a significant role in the overall costs of technology. As Scitovsky states “the less dramatic changes that have occurred in the treatment of the common, everyday illnesses that make up the bulk of medical care have received relatively little attention. Yet taken together, these changes may well have had as important effect, if not a greater one, on medical care costs than the most spectacular innovations.”

Furthermore, a significant amount of new technology is directed at the first and last year of life. Mendelson and Schwartz (1993) discuss the growth in health care costs as “explained by the ongoing development of new medical technology and the disproportionately heavy use of new advances among elderly and newborns.” As noted in the section on demographics, an increasing number and proportion of the elderly in Canadian society will have significant cost implications for health care’s future.

New technology represents an exciting array of opportunities in health care. Advances in medical procedures, drugs and equipment will continue. Patients will continue to demand access that may improve outcomes and quality of life. In the future, physicians will be able to provide better, higher quality services to a larger scope of needs as a result of technological improvements. These services will be demanded by older and better-informed patients. However these services will not be without significant cost. The question is how to ensure

that Canada's health care system can best adopt these technologies in order to continue to provide effective high quality care to patients.

3. Geography – Providing Care "From Far and Wide"

In discussing the health care system, geography does not typically enter into everyday conversation. However, Canadian geography has been, and will continue to be, a major influence on how health care is organized and delivered.

Canada covers a total area of 9,970,610 square kilometers, and is the second largest country in the world. In contrast, Canada has a relatively small population, 30,491,300 people in 1999. Consequently, Canada has one of the lowest population densities among developed nations in the world. The following table prepared by the Organisation for Economic Co-operation and Development (OECD) illustrates the dramatic difference between Canada and other G7 countries.[7]

Table 3
Population Density Among G7 Countries

Country	Persons per Square Km	Total Population
Canada	**3.0**	**30,491,300**
France	107.2	58,608,000
Germany	229.8	82,610,000
Italy	189.2	57,520,000
Japan	334.8	126,166,000
United Kingdom	242.0	59,090,000
United States	28.7	266,792,000

Source: http://www.statcan.ca/english/Pgdb/People/Population/demo01.htm; Organisation for Economic Co-operation and Development. *Labour Force Statistics, 1978-1998*, Paris, 1999 Edition.

The reality is that other G7 countries manage their health systems based on providing health care to a much larger population across a much smaller area. One can imagine that if Canada were one tenth of its current size, our health care system would be structured somewhat differently and would, undoubtedly, cost less.

The difficulty in Canada's public system is in ensuring the right balance of services and infrastructure to meet the needs of the population. When communities are relatively small and separated by large distances, the cost of maintaining necessary infrastructure is multiplied many fold.

One of our most well known challenges is providing health care services to rural communities across Canada. These challenges range from resource allocation decisions to ensuring a

[7] In 1998 the G7 officially became the G8 and included Russia as a full participant. For the purposes of discussing Westernized health care systems, the original G7 nations were used.

sufficient supply of health care professionals. Rural communities are often required to provide services to a wide geographic area with a limited number of providers and resources. Physicians in these communities often work long hours and have few opportunities for time off or vacations.

4. Public Sophistication and Expectations – Right Here, Right Now

When Medicare was first introduced, its intent was to provide universal coverage for hospital and medical services. Since that time the scope and intensity of services available in health care have expanded far beyond those original boundaries. Likewise the public's knowledge and expectations of medical care have expanded as well.

Today's patients are better educated and better informed than ever before. The dissemination of health information and growing use of the Internet provide patients with unprecedented access to technology. Patients are researching and becoming more knowledgeable about the care choices available to them. More and more, patients demand that every technically possible intervention be pursued, without regard to costs on the system. This "technological imperative" to do anything possible for a patient is a major influence on the use of new technology (Altman, 1979, Kressly, 1981). Both years of education (McKinlay, 1972; Andersen et al., 1976) and the age of a patient (Mendelson and Schwartz, 1993) have been shown to influence a patients demand for technology. As technology evolves, older and better-informed patients will increasingly demand access to interventions with the potential to improve outcomes and quality of life.

Some Canadians are also showing a desire to expand the scope of services available to them under public health insurance. A recent survey by Angus Reid showed that 42% of surveyed Canadians thought that the health care system did not cover enough services and programs. Only 9% believed the system covered too many services and programs. 47% believed that the service and program coverage of the publicly system was about right. (Angus Reid, CMA Poll, April, 2000).

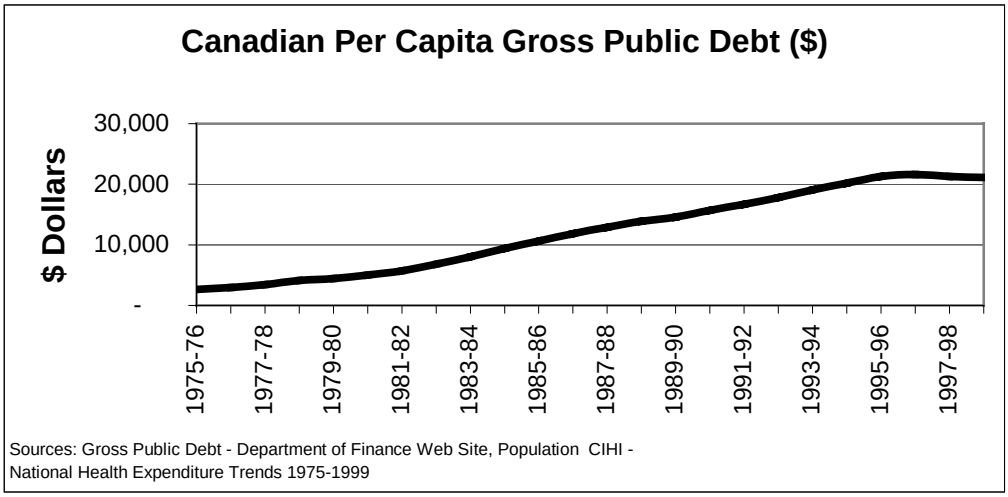
5. Canada's Public Debt – Tomorrow's Tax Dollars Spent Today

Canada is deeply in debt. This particular debt does not pertain to mortgages or credit cards of individual Canadians, but rather the public debt that the federal and provincial governments hold as a result of past government spending.

Canada's public debt has risen dramatically over the past twenty five years. Between 1989 and 1999, the national debt rose by more than 61%. Gross public debt has risen to more than $640 billion in 1998/1999, although it has leveled off in recent years.

A useful way to visualize the magnitude of this debt is to consider on a per capita basis. In 1975, the public debt per person in Canada was $2,635. As of 1998/1999 the public debt amounted to $21,132 for every man, woman and child (Figure 9).

Figure 9

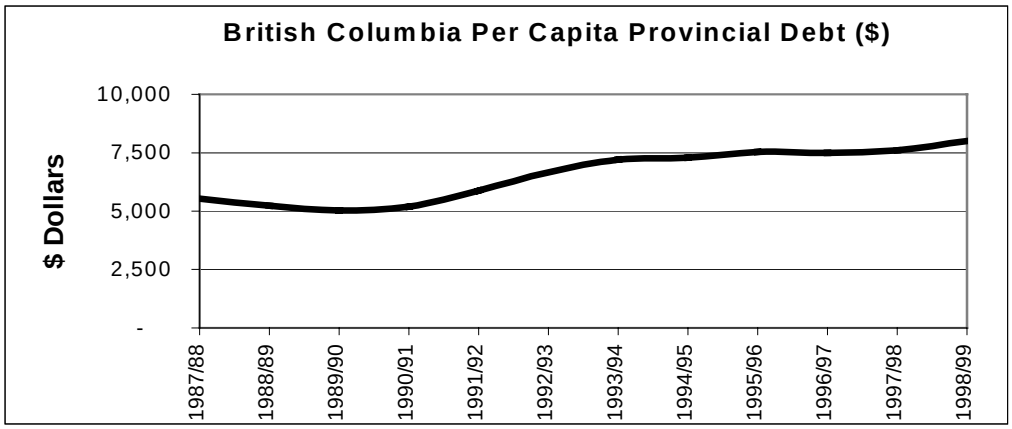


In 1975, the national debt was approximately 35% of Canada's GDP. By 1995 this figure had more than doubled, to over 77%. This meant that for every dollar generated in Canada in 1995, the federal government owed 77 cents to debt. Since 1995 this figure has dropped slightly as the Canadian economy has improved, and in 1998/1999 fell to 71% of GDP. This drop was largely the results of two factors: a booming Canadian economy and the federal government cutting costs and reducing transfer payments to the provinces.

The reported total provincial debt for British Columbia in 1998/1999 was more than $32 billion. This is almost double what the provincial debt was in 1988/1989 ($16.4 billion). British Columbia is expected to continue to run deficits for the next few years.

On a per capita basis, BC's provincial debt was $7,997 per person in 1998/1999 (BC Financial and Economic Review, 1999). The provincial debt per capita has risen 44% in the last 10 years, approximately the same rate as the national per capita debt.

Figure 10



While the Medicare program is one of Canada's most remarkable achievements, that program has been partly responsible for increasing the national and provincial debts. As

governments ran deficits, public programs such as health care consumed a considerable sum of public dollars.

A consequence of these large public debts are the interest charges that must be paid on those debts. Finance Canada reported that for every dollar spent by the federal government in 1998/1999, 27 cents went towards interest charges on the public debt. In this sense, money that must go towards debt interest charges and/or pay down the debt cannot be used on program spending.

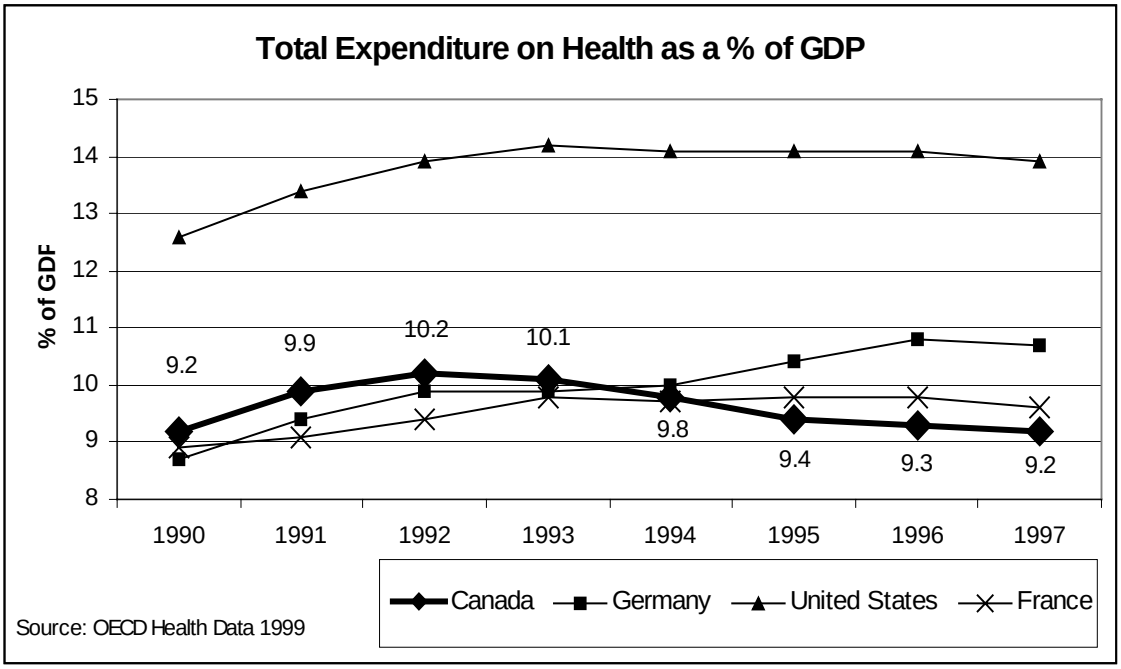
While most governments in Canada have eliminated their deficit financing ways (although not yet in British Columbia), the consequences of our past will continue to haunt us. Our cumulative debt is going to be around for a long time. Regardless of future economic conditions, federal and the provincial governments must continue to pay interest charges on their debts, and if possible, pay down the debts themselves. Every dollar that is spent on debt financing is a dollar less for health care and other key social and capital programs.

Funding & Management Pressures – Less is Not More

The combination of the preceding factors has created a challenging environment in which the health care system has evolved. It is important to recall that the 1990's were a time of increasing financial pressure. Federal transfer payments to the provinces for social programs (the CHST) were cut from $18.7 billion in 1994/1995 to $12.5 billion by 1998/1999, a drop of 33% in four years. In British Columbia, federal cash transfers totaled $2.24 billion in 1994/1995. By 1997/1998 this amount had dropped to $1.70 billion. This represents a cumulative loss of more than $536 million in federal funding over four years (BC Ministry of Health Performance Plan, 2000/2001, p. 29). The mantra accompanying these cuts called on the health care system to do "more with less".

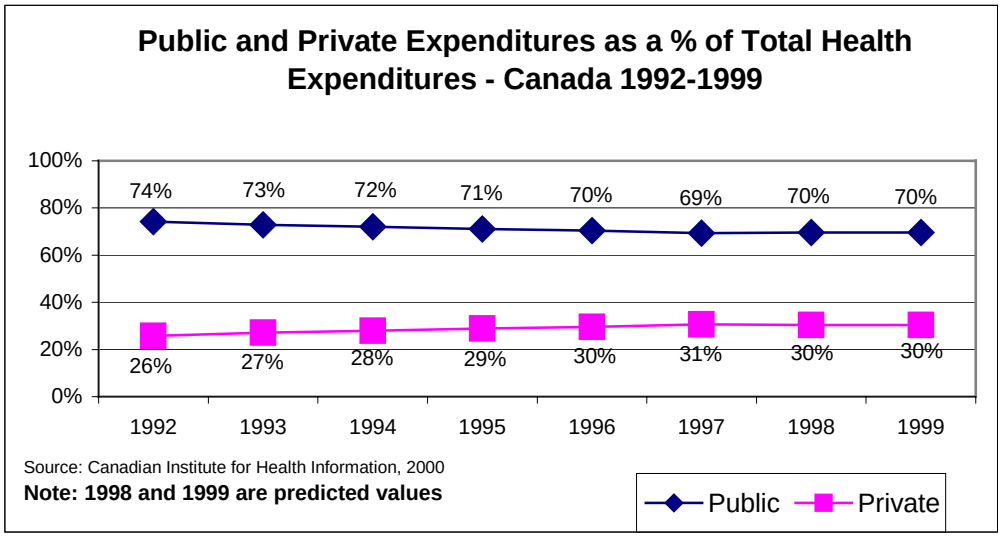
Two important trends in health care spending emerged between 1992 and 1999. First, total expenditures on health as a percentage of GDP began to fall. In 1992, Canada's total health care expenditures reached an all time high of 10.2% of GDP, however by 1999 this had fallen to 9.2%. Canada, which once ranked second in the world in percentage of GDP expenditures on health, had fallen to fifth, as shown in the Figure 11:

Figure 11



The second trend revolved around the proportion of private spending on health care. For the first time since the inception of medicare, in 1997 public spending on health care dipped below 70% of total health expenditures.

Figure 12

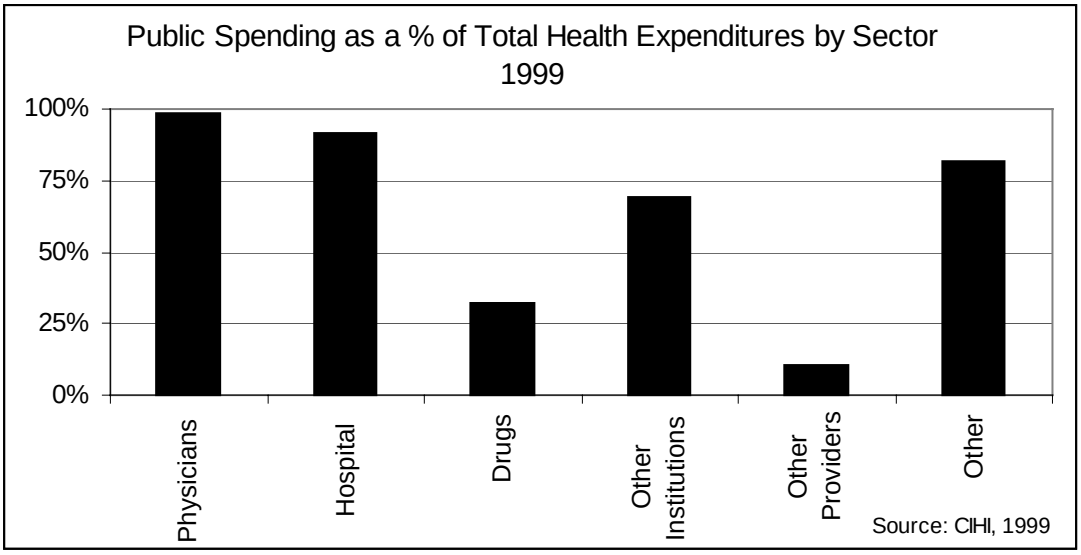


The Canadian Institute for Health Information indicates that in 1999 public sector health care spending in BC ranked fourth compared to the other provinces in Canada. BC ranked first in

1997. In the year 1999, BC spent about seven percent less per person ($2,097) than Manitoba ($2,250). Total health expenditure per capita for BC is also down, with BC ranked fourth in Canada ($2,872) behind Saskatchewan ($2,950) Ontario ($2,989) and Manitoba ($3,025).

However, while public expenditures as a percentage of total health expenditures are falling, it is important to note that these reductions are not occurring evenly across all spending sectors, as the following chart illustrates:

Figure 13



Public spending on physician services represents 98.8% of total physician payments in 1999. This sector is where private spending occurs the least. Indeed, the proportion of public expenditures on physicians has remained above 98% since 1975. Hospitals rank second at just under 92% of total expenditures occurring in the public sector. The vast bulk of private spending occurs in the pharmaceutical and other health care provider areas.

It was within this challenging environment of funding and management pressures that provincial health care plans attempted to cope.

Short Term Planning – Solving Today's Problems at Tomorrow's Expense

The combination of financial, scientific, and demographic pressures on the system proved to be simply unsustainable for many agencies. Consequently, provincial and regional governing agencies responded in a variety of ways. Many of these efforts, sometimes out of sheer necessity, focussed on balancing budgets and managing resources in the short term. Other efforts were based on ideological arguments of the day. Despite the claims of some advocates, there did not appear to be any single reform or plan that could address the wide array of challenges facing the system.

1. Funding Adequacy and Announcements – Band Aids and U-Turns

There is perhaps no better example of the type of short term responses than commitments made by the federal government over last two years with respect to transfers and short term injections of funds. This is particularly relevant given that in 1997, The National Forum on Health, chaired by Prime Minister Jean Chretien, stated:

> … *in Canada we spend enough money on health care.*[8]

This observation was made despite the growing anxiety among provinces that the system was in trouble. However, less than two years later the Prime Minister announced an increase in CHST transfers to the provinces of $11.5 billion over the following five years. Health Minister Allan Rock described this increase as "the largest single investment this government has ever made" (Good Health and Quality Care... Moving Forward Together, University of Toronto, February 17, 1999).

At this time the federal government also set up a $3.5 billion Trust Fund which the provinces could access specifically for health care between 1999 and 2001. This amount was over and above the added transfer payments.

While these additional funds were welcome, there was no commitment towards their long term continuation and application. A key ingredient of any health care system is a stable funding base. Ongoing scenarios of issue/response management, without a focus on the long term sustainability of the system, are not conducive to operating efficiency.

2. Acute Care Reductions & Community Programs – Cutting the Safety Line

One of the most pronounced changes during the 1990's was the significant pressure to reduce costs and create efficiencies in the acute care sector. As budget pressures increased, governments turned to the sector which consumed the majority of public dollars – the acute care system and its hospitals. British Columbia was no exception, and throughout the 1990's there was a steady reduction in the number of acute care beds in the province, as well as a reduction in the overall length of time patients stayed in hospitals. Other provinces such as Ontario, Saskatchewan and Alberta also embarked on significant hospital bed closures.

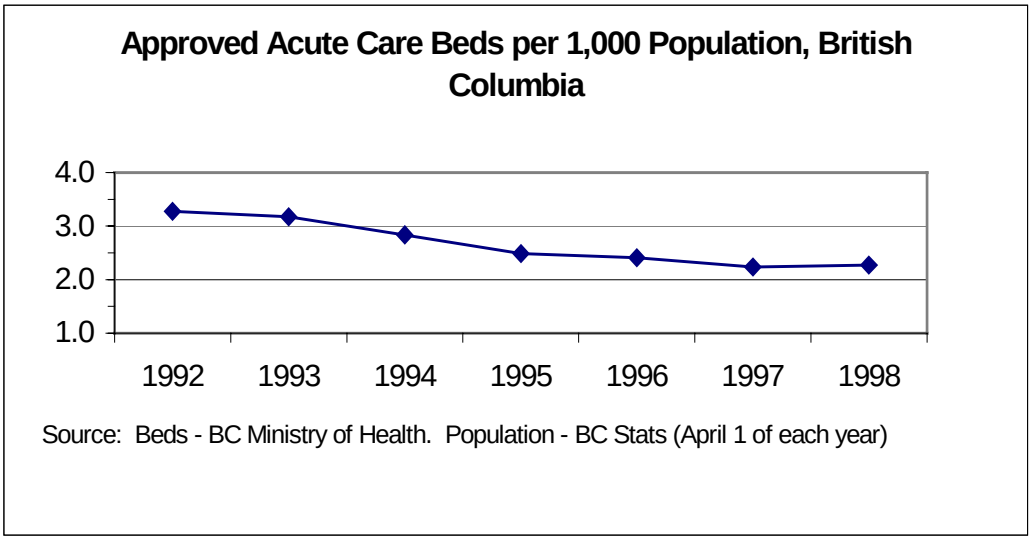
The impetus behind these cuts was the belief that many people staying in hospitals did not require that level of care – and subsequently would be more effectively cared for in the community at a lower overall cost. This belief was articulated in the Seaton Commission report entitled "Closer to Home" released in 1991. In its report the Commission recommended that:

> The Five Year Plan of the Ministry of Health be revised to establish a provincial average of 2.75 acute care beds per thousand population to be reached by 1995 (*Closer to Home*, The Report of the British Columbia Royal Commission on Health Care and Costs, 1991, B-100).

[8] National Forum on Health, 1997, *Canada Health Action: Building on the Legacy - Volume I: Final Report of the National Forum on Health,* (Ottawa: National Forum on Health).

However, reductions went far beyond the Seaton Commissions recommendations. By 1998 BC had only 2.27 acute care beds per 1,000 population.

Figure 14



A critical error in this planning was that following the reduction there were delays in the construction and implementation of the proposed community support programs needed to support the reduced acute care sector. Indeed many of these programs have yet to be put in place due to a combination of fiscal pressures and implementation problems. In BC there are two areas where implementation failures have become particularly problematic: long term care and mental health.

As the number of persons over age 65 increases, BC will require more long term care capacity. BC has insufficient capacity to meet current bed demands, let alone the increased demand coming in the near future. Many regions across BC already have significant waits for people requiring publicly funded long term care. In November, 1999 the Ministry of Health estimated there were 16,707 continuing care and 8,000 extended care beds which were publicly funded (Ministry of Health, "Minister Vows Renewal of Continuing Care System" Nov 19,1999). These beds primarily serve seniors, of which there were 509,200 in BC in 1998. By the year 2010, BC is estimated to have 150,000 more seniors – almost a 30% increase over 1998 levels. In order to keep the same proportion of publicly funded long term care capacity to the number of seniors in the population, BC will need to build more than 7,200 long term care beds in the next ten years. Given the current fiscal environment, this will be a significant challenge.

Mr. Murray Martin, CEO and President of Vancouver Hospital and Health Sciences Centre, has recommended that tax incentives be granted to allow the private sector to build 10,000 new long term care beds over the next 15 years to assist with this growing demand (Sustaining the Canadian Health Care System, presentation to the Vancouver Board of Trade, April 6, 2000).

The second example of delayed community program implementation lies in Mental Health. In the past, a significant amount of institutional care for the Greater Vancouver area was provided at Riverview Hospital. Since 1980 the number of beds available at Riverview Hospital has been cut by more than half to just over 800. The eventual full closure of Riverview Hospital was to be replaced with a series of smaller regional and community facilities. The BC government announced in 1998 that it would contribute $125 million dollars to implement its Mental Health Plan. However, despite this announcement, the funding was never included in the budget, and by May 2000 only a fraction of the money and services had been implemented.

The necessary support for those mental health patients displaced out of facilities such as Riverview, and moved into the community, is simply not in place. Vancouver Hospital estimates that the number of psychiatric admissions in its emergency department has tripled in the past five years.

Unfortunately, the responsibility and cost for caring for these individuals sometimes switches from one public agency to another, as many patients may wind up in the care of the justice system. In March 2000 it was estimated that 2,600 people with mental illnesses were waiting for supported housing units, with an average wait time of 3.5 years to get in (The Province, March 12, 2000, A12).

3. Medical School Reductions and Physician Supply Planning – Unheeded Warnings

Over the past few years a serious problem has emerged with respect to an increasing shortage of physicians. Communities and hospitals around the country are clamoring to deal with these shortages, and even traditionally well supplied urban areas are experiencing difficulty in attracting and retaining physicians in certain specialties. The current shortage was predicted and indeed potentially avoidable, the result of a combination of demographic changes and short-sighted policy decisions that have occurred over the past ten years.

A considerable amount of attention has been paid to the fact the population is aging, however, a large proportion of health care providers are also part of the “baby-boom” generation. BC doctors are aging – in fact they are older than the typical baby-boomer. In 1999 one in four physicians in BC was over the age of 55. As the following table demonstrates, the situation is significantly more serious is certain specialties:

Table 4

% of Doctors Over Age 55 In BC (1999)

42% - General Surgeons
40% - Urologists
40% - Neurosurgeons
39% - Obstetricians/Gynaecologists
37% - Ophthalmologists

Source: BCMA

These individuals are highly specialized physicians requiring over ten years of training. Given the average ages of these physicians, BC can expect a significant number to either retire or scale back their workload over the next ten to fifteen years. Medical schools in British Columbia are in no position to replace this magnitude of retirees. Indeed BC produces the fewest number of medical graduates per capita) in the country (only 120 graduates per year for a population of 4.1 million). The UBC medical school is not expected to significantly expand its capacity in the short-term.

Given attrition, BC requires approximately 300 new physician registrants each year to maintain current levels of supply, not taking into account our growing and aging population. In the short and medium term, BC will be forced to rely on importing physicians from other jurisdictions to maintain an adequate supply of physicians

The national picture is just as bleak. In 1998 the Canadian Medical Association released new projections estimating the future shortage of physicians in Canada.

Table 5
Physician Supply in Canada
1998 - 2021

Year	Total Physicians	Population per Physician	% Age 55+
1998	55,896	550	21.0
2006	56,272	598	29.6
2016	55,101	674	45.4
2021	52,525	737	46.8

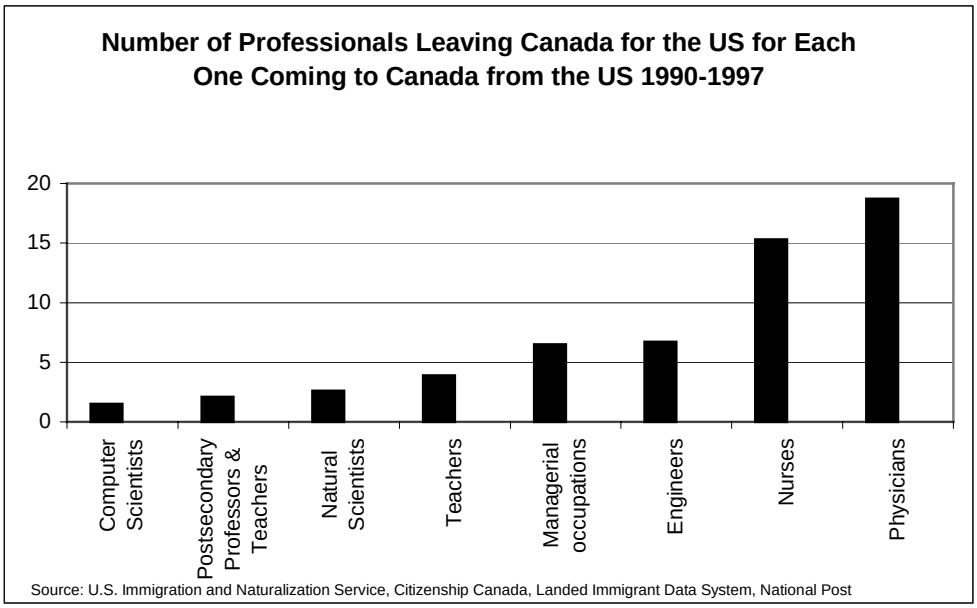
Source: CMA Physician Resource Evaluation Template, 1998

Despite the warnings of the medical profession, in 1993 medical school enrolment was decreased by 10% across Canada, resulting in fewer younger physicians potentially available to enter the system as Canada's population continues to grow and age.

What is startling is that these reductions have not yet been felt in the system. Physicians require a minimum of six years of training. At the time of this report the first class of reduced medical school graduates is now just entering practice. Therefore, the current physician shortages are occurring prior to the impact of the enrolment reductions being realized.

What many policy advocates did not predict was the impact that changes in health care system would have on a physician's desire to remain in Canada. Indeed a recent report by Statistics Canada shows that doctors and nurses are the two professions leaving Canada in the highest proportions, compared to those coming into Canada. These statistics show that between 1990 and 1997, Canada has lost 19 physicians to the United States for every physician that comes to Canada.

Figure 15



As noted by Dr. Hugh Scully, President of the Canadian Medical Association, the reason physicians leave is not because of greater financial reward, but rather "the opportunity to practice medicine well, the way they have been taught to do it, with access to good technology and good therapy for their patients" (National Post, Thursday May 25, 2000).

4. Reduced Nurse Training and Staffing Levels – Health Care on Overtime

As noted earlier, the 1990's was a period of significant downsizing in the acute care sector in an effort to reduce and control costs. As the number of beds and average length of stay were reduced, so were the number of health care professionals working in hospitals. The exact number is not known, but across the country literally thousands of nurses had their positions eliminated or reduced in the 1990's, replaced through the increased use of "casual" and/or part time positions.

A "casual" nurse is not a full time employee of a hospital or facility, but is called in on an "as needed" basis. Even in the situation where a nurse may be working full time hours (or more), the position is still considered casual. Casual employees do not receive the same level of benefits as do full time employees in most situations, therefore, cost savings result for the host institution. In a casual position, a nurse also has no guarantee of set hours per month. However given recent nursing shortages, many nurses in these positions have been working overtime.

The use of casual positions in the health care system is considerable. The Registered Nurses Association of British Columbia (RNABC) have indicated that in 1998 only 47% of registered nurses in BC had full-time employment; 27.4% worked on a casual basis and 25.4% worked part-time (http://www.rnabc.bc.ca/, April 2000). More than 50% of BC's nurses do not have a guaranteed full time position.

An error made by administrators and policy makers has been the assumption that there would be a continuing supply of nurses to be called upon to fill positions as needed. Over time, nurses have proven fully capable of leaving British Columbia and Canada in search of full time positions, better pay and better working conditions. As noted earlier, among professionals, nurses are second only to physicians in the proportion leaving Canada as opposed to those coming to Canada. Between 1990 and 1997, more than 15 nurses left Canada for each nurse entering the country. According to Statistics Canada, 3,000 nurses graduated in Canada in 1995. Of those 3,000 about 800 of them left Canada for the United States alone– approximately 27%.

The resulting nursing shortage manifested itself in rural communities first. However as time went on, urban communities and hospitals also began to encounter problems. In November of 1999 a shortage of nurses caused the closure of two operating rooms and 39 hospital beds in Vancouver (Globe and Mail, Nov 5, 1999).

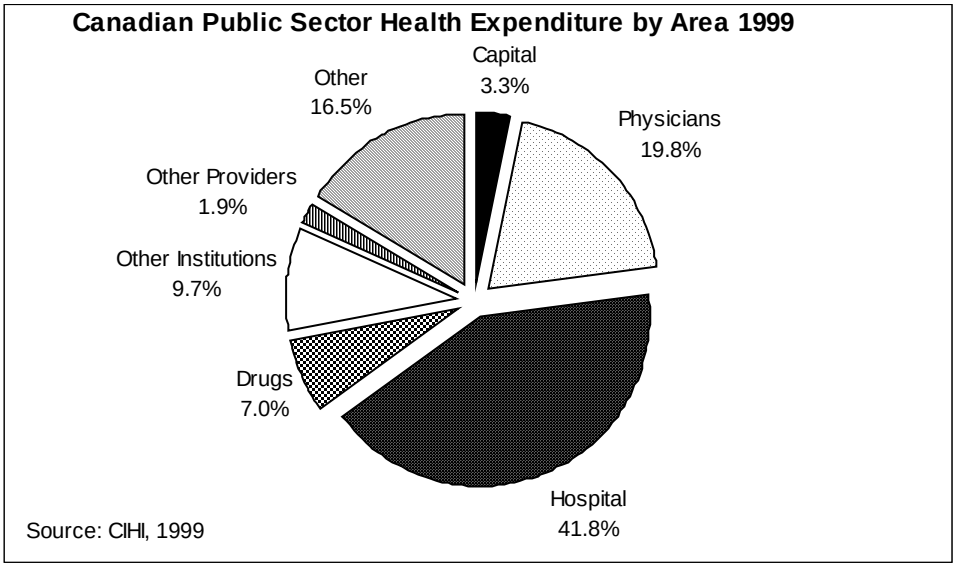
Similar to physicians, BC fails to train enough nurses to be self-sufficient and relies heavily on recruiting nurses from other jurisdictions. In 1999, British Columbia had the capacity to graduate 567 nurses per year, down from 839 in 1993. However, the RNABC states that over 13,000, or 48%, of BC's registered nurses are currently between the ages of 45 and 65. Of this group approximately 4,000 are eligible for retirement today. By 2011 the RNABC indicates that more than 9,000 BC nurses will be eligible to retire.

The situation across Canada is just as dire. The Canadian Nursing Association predicts a national shortage of at least 59,000 nurses by the year 2011, given current training and population growth

5. Insufficient Capital and Infrastructure Reinvestment – Pennywise, Pound Foolish

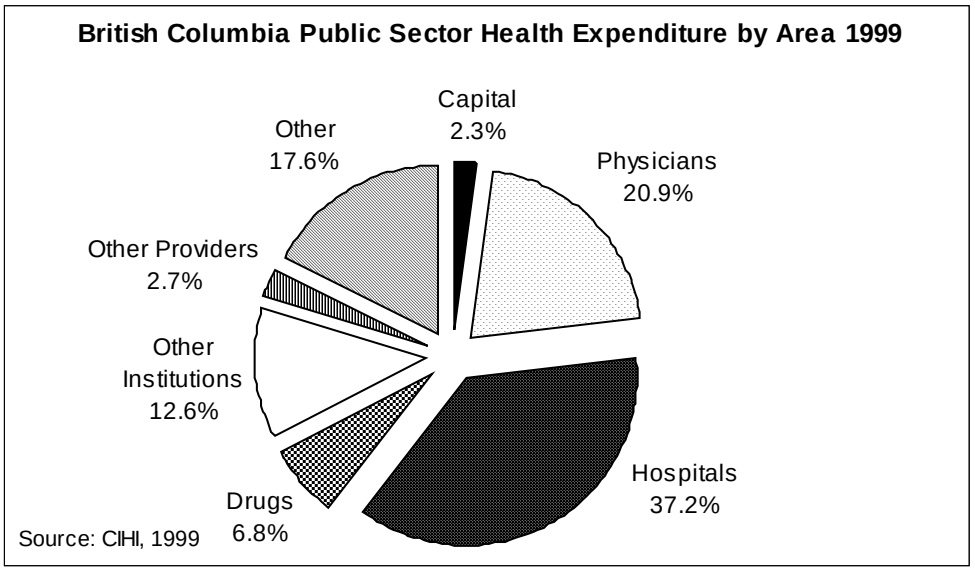
The capital and infrastructure requirements of the health care system encompass a dizzying array of equipment from hospital beds, to advanced diagnostic equipment, to computers to the actual hospital buildings themselves. However, as part of the cost cutting and acute care reductions in the 1990's both capital and infrastructure expenditures across Canada ground to a halt. By 1998, a mere 3% of public sector health expenditures in Canada went towards capital investment, as shown in the following table:

Figure 16



Looking specifically at public health expenditures by the provincial government in British Columbia, capital expenditures are just over 2% for 1999.

Figure 17



In many instances a significant number of these necessary investments were delayed and put off until more funding was available – which often did not happen. Perhaps the single most visible example of this situation are the ongoing delays in the completion of the Laurel Pavilion at Vancouver Hospital. Many hospitals across BC are aging, and no longer meet current seismic requirements. Plans to replace or upgrade many facilities across BC are slow in progress or non-existent.

The result of delayed capital investments have serious implications on the delivery of health care. As one example only, we are significantly short of advanced diagnostic technologies like Magnetic Resonance Imaging (MRI). According to the Organization for Economic Cooperation and Development (OECD), Canada has only 1.7 MRI units per million population. Among the 29 OECD countries, only Poland, Greece, Hungary and the Czech Republic report fewer MRI units per million than Canada (OECD Health Data 1999). Developed countries like the United States and Japan have significantly greater diagnostic capacity.

Many people within the system believe that the lack of reinvestment has reached critical levels. Mr. Murray Martin, CEO and President of Vancouver Hospital and Health Sciences Centre has recommended "a one time cross-Canada catch up investment in system infrastructure of $5 billion over the next three years, cost shared equally between the federal and provincial governments and distributed on a per capita basis. The major focus of the program should be on equipment replacement and facilities upgrading" (Sustaining the Canadian Health Care System, presentation to the Vancouver Board of Trade, April 6, 2000).

Mr. Martin estimated that current requests for equipment replacement in BC alone is $1 billion dollars. However, Mr. Martin stated that only $15 million has been allocated for capital equipment purchases in the province this year. The result of these types of allocations has resulted in the unfeasible "100 year depreciation" plans hospitals have described on equipment.

An unfortunate side effect of reduced capital budgets is the increasing reliance of the public system on the charitable donations of Canadians to fund the purchase of essential equipment. According to the Vancouver Hospital Foundation, over $11.6 million was received last year from private donations to fund research, education, patient comfort and equipment needs.[9] The St. Paul's Hospital Foundation also raises more than $4,000,000 each year "to fund important medical research, to upgrade or purchase new equipment, and to support health education for both patients and staff".[10] These figures raise a startling reality. The combination of funds raised by these two hospital foundations is larger than the $15 million reported by Mr. Martin as that set aside by the provincial government for equipment purchases for the entire health care system in British Columbia.

However, hospital foundations are not the only means by which equipment is being purchased. On February 29, 2000, BCTV aired a story describing how over the past five years, physicians at Burnaby Hospital have donated more than a half million dollars of their own money to replace aging equipment. Indeed, 90 percent of the new medical equipment bought at Burnaby General are purchased through charitable donations, and not government funding (BCTV, February 29, 2000).

The generosity of Canadians must be credited for preserving the ability of hospitals to provide care through these trying times, but such a situation cannot continue. Hospital foundations were originally intended to supplement public dollars for equipment purchases – not replace them. It is inappropriate for a critical social program such as Medicare to rely so heavily on charitable donations to meet basic equipment requirements.

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[9] http://www.vanhosp.bc.ca/foundation/promo/page_one_info.html.
[10] http://www.stpaulshospitalfdtn.com/.

As new technological advances appear and new treatments become available, there will be increasing pressure on the health care system to adopt them. By delaying a considerable bulk of equipment needs over the years, the system faces an unpalatable possibility of large capital investment being needed right away.

Accessibility Problems – Cracks Into Crevices

The preceding list of contributing factors and planning decisions are by no means complete. However, the delivery of health care must be considered in the context of these elements interacting with one another. It is the combination of these environmental, financial and planning decisions which culminate in the system's ability to provide care to patients when they need it. Unfortunately, Canadians no longer perceive that their needs are consistently being met, as system problems have forced the health care debate into the public arena. According to an April 2000 survey of 1,500 random Canadians (Angus Reid, April 2000):

- Only 37% of Canadians say that Medicare is working fine the way it is now.

- 65% of Canadians believe that the quality of healthcare in their province over the past five years has gotten worse

For Canadians, the most visible signs of problems in the health care system relate to their ability to access services for Canadians, waitlists are the most recognizable indicator of access problems, and most perceive these lists in terms of surgery. Unfortunately this is but one of the many examples of waiting lists in Canada. Access and waiting problems exist in a variety of areas in the current system, including access to:

- Surgery
- Hospital beds
- Diagnostic tests
- Emergency department treatment
- Long term care beds
- Home Care
- Adoptions of new technologies
- Adoption of new drugs
- Ability to access a physician

The majority of research on access issues in recent years has focused on surgical wait lists. Several organizations and agencies have conducted research into wait lists and, in general, these studies show wait times in BC are increasing over time. For example, the Ministry of Health's own Waitlist Registry has shown dramatic increases in wait times over the past year (Ministry of Health Surgical Wait List Registry):

Table 6
BC Ministry of Health Wait Times – Surgical Wait List Registry July 1998 – Dec 1999

Procedure	July 98	Dec 99	% Increase
Vascular surgery	2.0 weeks	2.9 weeks	45%
Neurosurgery	3.0 weeks	4.4 weeks	47%
Cataract surgery	6.6 weeks	9.7 weeks	47%
Knee Replacement	13.0 weeks	22.0 weeks	69%
Hip Replacement	10.6 weeks	20.1 weeks	90%

A 1999 MarkTrend survey of 700 BC residents found that 25% thought that long waiting lists were the biggest problem facing health care in BC, while another 25% cited lack of funding. The same survey showed that 85% of those surveyed thought that all people in BC should have equal access to doctors and hospitals. In contrast only 37% thought that all people in BC currently do have equal access.[11]

As described earlier, barriers to access of health care services is a multifaceted issue resulting from numerous factors and policy decisions. Unfortunately there have been several solutions advanced as a panacea to improve access – among them primary care reform, alternative remuneration methods for physicians and private/public partnerships. In general none of these proposals should be interpreted as a "cure-all" for accessibility problems in Canada on their own – and each should be carefully evaluated on their own merits.

[11] A Public Assessment of Medicare, MarkTrend Research, 1999, p. 8-10

Chapter 4 Restoring the Foundation of Medicare

Medicare has evolved considerably over the past three decades. It is no longer the "simple" insurance scheme envisioned by Tommy Douglas, designed to protect Canadians from the unexpected costs of catastrophic illness. From its beginnings as a hospital and physician program, equally cost-shared by the federal and provincial governments, it has developed a much broader health care focus, incorporating many additional treatment, prevention and promotion components. However, while this program has evolved, the relative level of funding support from the federal government has diminished.

Health care in Canada is at the proverbial crossroads, and there are many important decisions to be made. It is clear that the status quo is not sustainable and that our long term problems require long term planning, not short term reactions.

Bringing about change to Canada's health care financing and delivery system will not occur without stress. Many institutional and emotional obstacles will need to be overcome. The most appropriate place to start this process is to open a public dialogue and engage the people of Canada in helping to determine how the foundations of Medicare can be effectively restored.

The Regulatory and Fiscal Environment

Canada's public health care program has been irrevocably shaped by the principles of the Canada Health Act; universality, comprehensiveness, accessibility, portability and public administration.

Arguably, without those principles health care delivery would look quite different than it does today. So critical is the perception of these principles that the British Columbia government has copied them into the provincial Medicare Protection Act. The mere suggestion of system change, such as occurred recently in Alberta with the government's expanded private delivery bill (Bill 11), brings about a flood of public concern and anxiety.

Yet, as difficult as it may be to openly discuss these principles, today's reality demands that this be done. The principles of the Canada Health Act remain basically sound; but they were written for a different day and a different environment. They must be subjected to serious review, not so much with respect to what they say, but more with what they fail to say.

When it comes to health care, Canada can no longer afford to be all things to all people. Some hard choices need to be made. These choices will undoubtedly alter the face of medicare as we know it, but they do not have to be choices which will destroy the public program. On the contrary, they must be choices which ensure that the program is placed on a stable footing for the future, so that it will be there for everyone, when they need it.

In the Conference Board of Canada report, "The Future Cost of Health Care in British Columbia, Challenges to Sustainability", it is identified that by the year 2020, fifty three cents of every tax dollar will be needed for health care in the province. This is a sobering thought; and the downsizing implications for other social programs and the provincial capital infrastructure are significant. The Conference Board report provides four possible responses

to this scenario. Two of them, increasing taxes and increasing the public debt are considered highly undesirable, and likely impossible under the political environment for the foreseeable future. Of the remaining two, increased federal transfer payments to the provinces and reduced public sector expenditures, not surprisingly, the former is garnering the majority of the provincial political attention at the present time.

If, in fact, adequate levels of financing can be found within the existing federal fiscal environment, that is a bonus. However, to avoid the fifty three cent scenario identified above, according to the Conference Board the increase in federal transfers would have to significantly exceed 5% per year over the next two decades, and come to the provinces with no conditional spending constraints. While possible, the probability is small. The long term federal fiscal situation is uncertain and particularly sensitive to interest rates and the subsequent effect on debt servicing. In addition, the federal government is under significant pressure to reduce taxes which would, of course, directly impact on their ability to increase transfer payments. It is also extremely unlikely that the federal government will entertain a long term funding commitment without having some say in how that funding is utilized, particularly given their stated interest in primary care reform and a national home care and pharmacare strategy.

In summary, while the federal government may be the source of some relief, provincial governments cannot realistically expect this avenue to lead to a restoration of the health care system. Canadians must turn their attention to a serious look at the options for reducing public health care expenditures.

These may be summarized into three general categories; a) delivering the existing scope of care with increased efficiency, b) reducing the scope of publicly insured services and c) increasing the role of private financing and delivery.

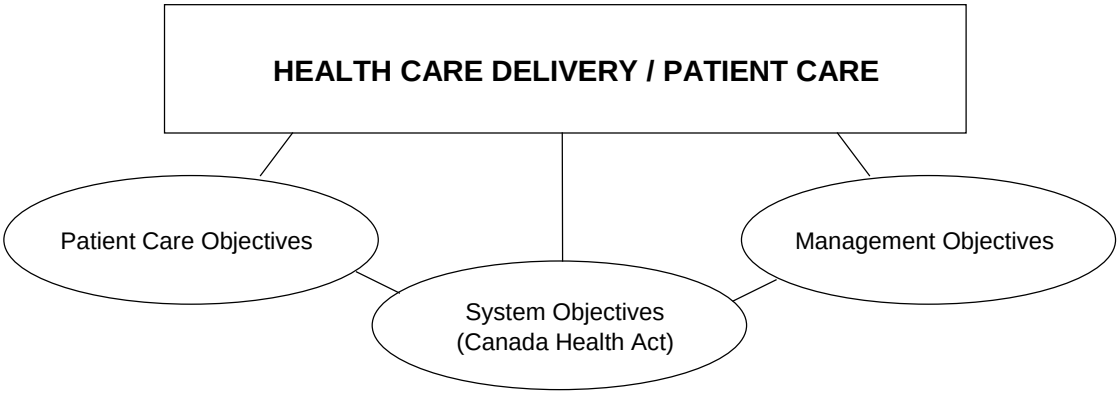
A subsequent paper will address these options in a more comprehensive way, but in general they are all implementable, each comes encumbered with a host of associated issues and difficulties and none are mutually exclusive, but rather are inter-related. In any case, for the purposes of the current discussion it is critically important to realize that regardless of the options pursued, the principles of the Canada Health Act will be affected one way or another.

In the final analysis, it will not be a question of ***if*** we amend or re-interpret those principles, but one of ***how*** they will be modified to reflect the needs and expectations of the Canadian public.

Shaping the Health Care System

The future may be uncertain, but change is inevitable. That change can take on many faces and the challenge before health care planners is to define a clear set of objectives. These objectives should be formulated within a triumvirate of categories, possessing equal measures of system, patient care and management direction, and integrated into a coherent support structure for a re-defined health care system.

Figure 18
A Framework for a Sustainable and Accountable Health Care Program



1. SYSTEM OBJECTIVES – As previously noted, the principles of the Canada Health Act remain basically sound. They provide the necessary set of system objectives by which the health care program should be structured. Universality, accessibility, comprehensiveness, portability and public administration remain key components of the public program. However, those principles are insufficiently defined and have been subjected to many different interpretations by the various governments in Canada. Further substance is required through the addition of patient care and management objectives.

2. PATIENT CARE OBJECTIVES – Much of today's health policy debate reflects a distinction between illness prevention and/or health promotion on the one hand, and the management of illness on the other. "Population health", or the "determinants of health" are attracting the attention of health care planners and funders. While the determinants of health are important components of defining a healthy population, one cannot neglect the treatment requirements of those needing medical and hospital care. To that end, the introduction of a set of patient care objectives is timely. Ultimately, patient care objectives need to be articulated by the Canadian people, but it is expected that they should look something like this:

a) Patient focused – those who use and pay for the healthcare services must be more involved in determining what they want and expect from their health care system. Providers and administrators can assist in that process, but patients must have the right to choose the type of care and the appropriate provider.

b) Available – necessary health care services should be readily available to all residents of the province, regardless of location of residence. Where it is not reasonable for services to be made directly available, adequate transport services should be provided.

c) Timely – patients should expect to receive all necessary care without undue delays which cause physical or mental anguish.

d) Continuity of Care –health care services should be effectively coordinated to provide seamless care over the entire treatment regime. Gaps in the availability or timeliness of care should not occur.

e) Quality of Care – health care services should consistently be provided at a high level of quality. Quality care is founded upon the best available evidence, focuses on outcomes and reflects the need for appropriate equipment and resources.

These objectives speak directly to the patient experience and could reasonably be woven into a carefully delineated "patient charter." The charter could focus on what patients, as well as taxpayers, could reasonably expect from the publicly funded program and could include such components as a guarantee of the availability of emergency care at any time, or definition of maximum reasonable waiting times for diagnosis and treatment.

Such a statement of patient rights would effectively bolster the principles of the Canada Health Act, particularly with regard to the principle of accessibility. With the creation of a patient charter, Canada would attain a clear statement of objectives related to patient care and provide the second leg of support for a re-defined publicly funded health care program.

3. MANAGEMENT OBJECTIVES – An effectively functioning and equitable public program can only be maintained if it incorporates three fundamental management principles:

a) Planning – British Columbia and Canada desperately need a well articulated, comprehensive plan for the health delivery system which the public, not the bureaucracy, accepts and supports. The planning process needs to define a multi-year time horizon and be continuously monitored and reviewed. The process must incorporate a mechanism to assess the public demand, need and expectations, and compare those elements to the existing (or planned) capacity of the system.

b) Sustainability – public health care expenditures must reflect government's ability to pay. As technology expands the array of treatment applications, choices will be required with respect to the scope of services covered under the public program. If universality is to be maintained, service limitations will be necessary to ensure that other government priorities (e.g. other social safety-net programs) can also be sustained.

c) Accountability – accountability is about ensuring that the system provides for the right service, at the right time, in the right place, by the right individual, at the right price. This is paramount to creating a transparent and equitable approach to health care delivery and financing. The public, providers and the government (including regional health authorities) share a joint responsibility in ensuring that Canada's health care system maintains a quality standard of the highest level.

- The health care system should be outcome driven, not process driven
- The public is accountable for ensuring their access of the system is appropriate.
- Providers are accountable for ensuring that only appropriate and beneficial services are provided, in a cost-effective manner.

- Government is accountable for ensuring that services insured under the public program are clearly defined, that the necessary support resources and infrastructure required to deliver those services (including information systems) are in place and that the funding is adequate to support that service level.

The application of these management objectives would further enhance the system principles of the Canada Health Act, particularity with respect to the principle of comprehensiveness, while at the same time establishing a degree of transparency and clarity that has lately escaped the public program.

Notwithstanding the mounting list of problems associated with health care funding and delivery, there exists a universal interest in restoring what was once an excellent system. It is not too late, but the remedy must be applied relatively quickly if further deterioration is to be avoided. A new structure, founded on complimentary system, patient care and management objectives must be created.

Turning the Tide

The challenge is monumental. Canadians will no longer accept "solutions" crafted behind closed doors by the bureaucracy and policy advisors. Effective change will only come about through an iterative process of public dialogue, assessment and more public dialogue. The May 11/12, 2000 invitational forum on Medicare, co-sponsored by the British Columbia Medical Association, the Canadian Medical Association, the Health Association of British Columbia and the Registered Nurses of British Columbia was a small first step in this process.

Many opportunities to advance the level of discussion and debate will present themselves over the coming months. Premier Romanow, of Saskatchewan, has initiated a full scale review of Medicare in his province. The Canadian Senate is currently conducting a review of Canada's Health Care system under the chair of Senator Michael Kirby. In the very near future, there will be both a British Columbia provincial and a Canadian federal election, with health care issues topping the list of priorities. In 2002, the Social Union Framework Agreement, a little known (and lesser understood), yet exceedingly important document for health care will be renegotiated between the federal and provincial governments.

Canadian leaders must not shrink from their responsibilities to educate the public with respect to both the current and coming deficiencies in health care delivery. Platitudes and false promises will not serve a useful purpose. The opportunities exist to more actively engage the public in understanding, and in a determination of what they expect from their health care system.

The British Columbia Medical Association is committed to communication and dialogue and will be actively engaging the public at the community level, while encouraging other health care provider organizations across Canada to do likewise.

Problems in health care access, infrastructure and staff shortages are situations chiefly resulting from a systemic deterioration. Attempting to address these problems, without dealing with the underlying issues, simply treats the symptoms, ignores the underlying

unease in health care delivery and preserves the status quo, which is not meeting the demands and expectations of individuals in need of care. The health care system must be stabilized to set it on the road to recovery and sustainability. The introduction of patient care and management objectives are key initiatives.

This discussion document represents a pivotal piece in the health care reform debate by clearly enunciating a revised set of core objectives for health system planners – objectives which protect and enhance the principles of the Canada Health Act. These key objectives provide a framework for developing a more sustainable and accountable health care environment. Reform activities and other "solutions" to the problems identified in this paper need to be assessed against their adherence to this framework. A BCMA assessment of potential initiatives will follow in Part II of this paper.

Reference List

Altman, S. H. and S. S. Wallack. 1979. Is medical technology the culprit behind rising health costs? The case for and against. In: Altman, S. A. and R. Blendon (Eds). Medical technology: The culprit behind health care costs? Washington, DC: U.S. Government Printing Office, 24-37.

Banta, H. David, Clyde J. Behney, and Jane Sisk Willems. 1981. Toward rational technology in medicine: considerations for health policy. New York: Springer Publishing Company, Inc.

Baxter, David, Smerdon, Jim, "Without Care? – Demographics and Health Spending in British Columbia 1999 to 2040", Urban Futures Institute, 1999

British Columbia Medical Association, "The Response of the BCMA to the Report of the Royal Commission on Health Care & Costs Entitled Closer to Home", 1992

BC Ministry of Health, BC Ministry of Health Performance Plan 2000/2001, 2000

Conference Board of Canada, "The Future Cost of Health Care in British Columbia", April, 2000

Fineberg, H. V., D. Scadden, and L. Goldman. 1984. Care of patients with a low probability of acute myocardial infarction: cost-effectiveness of alternatives to coronary-care-unit admission. New England Journal of Medicine 310: 1301-1307.

Fuchs, V. R. 1972. The growing demand for medical services. In: Fuchs, V. R. (Ed). Essays in the economics of health and medical care. New York: National Bureau of Economic Research.

Ginzberg, Eli. 1990. High-tech medicine and rising health care costs. JAMA 263(13): 1820-1822.

The Global Network, "The Health Care Revolution", Global Network Inc., Washington DC, 1998

Kressley, K.M. 1981. Diffusion of high technology medical care and cost control - A public policy dilemma. Technology in Society 3: 305-322.

Lalonde, Hon. Marc, "Beyond a New Perspective", speech made to the 104th Annual Meeting of the American Public Health Association on October 18, 1976. (Obtained from BC Ministry of Health Web Site http://www.hlth.gov.bc.ca/guildford/html/019/00001932.html)

Laupacis, A., D. Feeny, A. S. Detsky, and P. X. Tugwell. 1992. How attractive does a new technology have to be to warrant adoption and utilization? Tentative guidelines for using clinical and economic evaluations. Canadian Medical Association Journal 146(4): 473-81.

MarkTrend Research, "A Public Assessment of Medicare", Public Opinion Poll, MarkTrend Research, 1999.

Martin, Murray, "Sustaining the Canadian Health Care System", notes from presentation to the Vancouver Board of Trade, April 6, 2000.

McKinlay, J.B. 1972. Some approaches and problems in the study of the use of services . . . an overview. Journal of Health and Social Behavior 13: 115-152.

Mendelson, D. N. and W. B. Schwartz. 1993. The effects of aging and population growth on health care costs. Health Affairs 12(1): 119-25.

National Forum on Health, Canada Health Action: Building on the Legacy - Volume I: Final Report of the National Forum on Health, Ottawa, 1997

Organisation for Economic Co-operation and Development (OECD), "Health Data 1999 – A Comparative Analysis of 29 Countries, OECD, 1999

Rock, Hon. Allan, "Good Health and Quality Care... Moving Forward Together", Speech to the University of Toronto, February 17, 1999.

Royal Commission on Health Care Costs, Closer to Home, The Report of the British Columbia Royal Commission on Health Care and Costs, 1991.

Royal Commission on Health Services, Royal Commission on Health Services – Volume I, Government of Canada, Queen's Printer, Ottawa, 1964

Scitovsky, Anne A. and N. McCall. 1976. Changes in the cost of treatment of selected illnesses, 1951-1964-1971. DHEW Publication No. (HRA) 77-3161. Washington, DC: U.S. Government Printing Office.

Shillington, C. Howard, The Road to Medicare in Canada, Toronto: Del Graphics Publishing, 1972.

Showstack, J. A., S. A. Schroeder, and M. F. Matsumoto. 1982. Changes in the use of medical technologies, 1972-1977: a study of 10 inpatient diagnoses. New England Journal of Medicine 306: 706-712.

Taylor, Malcolm G., Insuring National Health Care - The Canadian Experience, Chapel Hill, NC: University of North Carolina Press, 1990.

Taylor, Malcolm G., Health insurance and Canadian public policy - The seven decisions that created the Canadian health insurance system and their outcomes (Second edition), Kingston: The Institute of Public Administration of Canada and McGill-Queen's University Press, 1987.

U.S. Immigration and Naturalization Service, Citizenship Canada, Landed Immigrant Data System, 2000

World Health Organization, "The World Health Report 1999 – Making a Difference" Annual Report, 1999