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Executive Summary

Health care is the number one social policy challenge for the next decade. However, the debate on health care has been dominated by surrogates who have diminished the complexity of health care reform down to facile bi-polar country comparisons and left vs. right ideological disputes. Despite this obfuscation, Canadians yearn for an ideas-based discussion about **all** possible options for health care reform.

Canada spends $95 billion – 9.3% of its GDP – for public and private health care. With health costs consuming 62% of all new budget expenditures in the provinces over the last three years, it is clear that health care is a taxpayer issue.

The Canadian Taxpayers Federation (CTF) has entered this debate and believes that:

- Health care is in a state of crisis;
- Canadians are ahead of their politicians on the need for reforms;
- Health care is a shared jurisdiction between Ottawa and the provinces;
- The *Canada Health Act* is not the Bible;
- It is impossible to measure health systems by numbers alone;
- The present debate is too continental, it must become global; and
- Quality and excellence must be the primary focus, not cost containment.

The development of health care policy in Canada over the past century reveals that Canadians can handle exhaustive and sometimes painful debate. So we owe it to ourselves to mirror and build on this history by objectively considering all options for reform without needless rhetoric and hyperbole.

The logical starting point is with a review of the *Canada Health Act* (CHA), since it is the de facto standard by which reform options are judged. Scholars and medical practitioners agree that the CHA stifles innovation, constrains provincial initiatives and its core principles are often in conflict with each other. Meanwhile, Canadian public opinion reveals a thirst for fundamental changes, even if these changes contravene some of the CHA's existing principles.

While the fight between Ottawa and the provinces over historic and more recent funding levels is partly inherent to our federal system, it is clear that this tension is now counterproductive. Yet, across the country, provincial officials continue to play the Ottawa "blame game" and demand more money, even though the public has expressed its displeasure with this approach as witnessed by the national collective yawn in response to the Premiers' demands for an additional $7 billion in health care funding in the summer of 2001.

Spending growth in health care is now unsustainable. Some provincial health ministers have stated as much. On the other hand, these same ministers abandon economic reality in favour of good politics as health care spending continues to ramp up at rates that double or even triple annual revenue growth.

If spending continues unabated, today's tax cuts vs. more spending debate will quickly give way to tomorrow's MRIs vs. school books dilemma. With tomorrow coming as soon as 2007 for provinces like B.C. and Newfoundland when health care is projected to consume 50% of all provincial spending. Similar fates await Alberta, Manitoba and Saskatchewan in 2012, 2014 and 2019 respectively.

At the root of this problem is medicare itself and its flawed economics. Funding flows from taxpayers though a variety of intermediaries (governments to insurers to other governments to service providers) and insulates patients (read: consumers) from the financial ramifications of their consumption decisions. As a result, we are left with a patchwork system of perverse incentives for patients, doctors, bureaucrats and politicians. This perversion only serves to drive up costs and vaccinates the health care system against innovative options that improve quality and health outcomes.

This has led some observers to conclude that our system never really did work and that we only covered over this gaping flesh wound with generous and periodic applications of heavy gauze in the form of massive cash infusions. Even more damaging is the blunt assessment by the World Health Organization which rated the health care systems of 191 countries: Canada ranked 30th. As a WHO official put it, "Canada does not have the best health care system in the world."

The lesson is clear, we should emulate or at least learn from the best practices (financing, organization and service delivery) of some of the countries that finished ahead of Canada: the sooner, the better.

Demographic pressures are already upon us and by 2020, almost 60% of health care expenditures will be consumed by those aged 65 or older compared to 45% today. Yet according to the Auditor General, the federal government (and presumably others) is still not prepared to measure or plan for this eventuality. Moreover, technological advances – while welcome – usually just improve upon existing technology instead of replacing it (i.e.: x-ray, CT scanner, and MRIs), thereby driving costs further in an upward spiral.

Pharmaceuticals now consume more resources than physician billings. With new and aggressive drug therapies in the works to treat a variety of chronic conditions from cancer to Parkinson's disease, costs will only escalate. Amidst these pressures, patient demands and expectations for "right here, right now" services will only magnify. Taken together, demographic, technological, pharmaceutical and patient expectation pressures are termed as the "gang of four."

So far, reforms in the Canadian health care system have been supply side driven, from regionalization of service delivery to province-wide disease networks to cost containment to structural integration. While some economies have been found, patient demand, patient responsibility and the perverse incentives inherent in our medicare system have been ignored as focal points for reform. The process bears a striking similarity to the shuffling of deckchairs on the Titanic.

Health care is complex and it is clear that there are no magic bullet solutions to address its many shortcomings. However, key principles do exist that should be employed both in legislation and in restructuring service delivery which would put Canada on the proper road toward patient-focused, sustainable reforms.

At the legislative level, a modernization of the *Canada Health Act* is long overdue. Its current principles should be replaced in favour of:

- Public governance;
- Universality;
- Quality;
- Accountability;
- Choice; and
- Sustainability.

At the structural level, guiding principles for reform include:

- Individual accountability and responsibility (this could include co-payment);
- Intergenerational fairness (pre-funding of health care is key which could include health care savings allowances or accounts); and an
- Embrace of innovative approaches (including flexible and workable public-private partnerships in capital construction, service provision and technology renewal as well as provincial experimentation in financing and service delivery).

The principal and laudable aim of medicare was to provide health services without hindrance. Now, the greatest hindrance to reform is the intransigence of those who refuse to accept that the problem with health care is the system itself.

Its present global funding configuration is unsustainable and its orientation must change to place the patient at the centre of every interaction. The sign of a healthy democracy is one that finds fault with itself, for if it cannot, it has ceased to be a democracy.

An honest, open and thorough debate on the future of health care is needed. Anything less would constitute a disservice to those who went before us and an abdication of our responsibility to those who will follow us. We must leave them a better country than that which we inherited.