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Getting Beyond "Two-Tier" Gridlock:

What Do Canadians Really Want
from Their Health Care System?

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Thank-you for the invitation to be here. That kind introduction was long enough to give me time to wonder if I might have worded half of the title for this session somewhat better. “What do Canadians really want?” might lead people to expect some survey data. I don’t want to disappoint, but I’m a policy wonk, not a pollster.

I’m happier with the other part of the title: “getting beyond two-tier gridlock”. Earlier in this conference, you heard Michael Walker criticize the illusion that we can central-plan our problems away. You heard Reuben Devlin talk about the gaps between what we should be doing for patients and what we are actually doing. And Bill Orovan has told us about the looming shortages of service providers and other key resources.

These are important challenges to the goal of giving Canadians access to health care on reasonable terms over the long haul. And the sterile name-calling typical of any statement about health that contains the phrase “two-tier” is a huge obstacle to constructive thought.

So if this session moves us even a small step through two-tier gridlock with some ideas about better ways of sorting out what Canadians want in health care, and how public policy can help them get it, I hope you’ll forgive my bringing, not polling numbers, but policy wonkiness, to the platform.

Much of this conference already, and more of it today, will focus on specific problems in the health system. In the next half hour, I want to invite you to step back for a broader view of public policy in health care — not just here in Canada, but around the world.

Three Goals: Three Pillars

I’ll argue that asking a few simple questions about how we use public policy in areas such as health to improve our quality of life reveals not one monolithic approach, nor two tiers, but three main goals.

First, people want a safety net. People want to protect those who are down on their luck, or who have no prospects for supporting themselves, from destitution.

Second, people want insurance. People want insurance for themselves, and they also want others who can insure themselves up to some basic level to do so.

Third, people want to save. People want to put something aside for the future. They want a system that encourages saving, and ensures that when people want to draw on that saving in a time of need, they will be able to do so.

A safety net, insurance, and saving — simple ideas, but very powerful in understanding what drives social policy in Canada and around the world.

Think of income-support and maintenance programs, for example.

First, there is the safety net of social assistance or welfare. Its provisions differ from province to province, but all provinces have it. We debate how to make welfare work best, but the goal is clear. It’s a safety net to catch people who would otherwise fall through the cracks.

Second, there is employment insurance and workers’ compensation. The latter is also provincial with lots of variation, but

all provinces have it. People who are working and can afford a basic level of insurance to cover themselves do so.

Third, we encourage saving. Ordinary income taxes double-tax saving — both the amount saved and the return it gets. But in Canada, we tax important kinds of saving — for retirement, for buying a house — only once. So people are rewarded, not punished, when they set something aside for a rainy day.

You could think of these different programs as three pillars of income policy, each addressing one of the three goals.

Sometimes badly run programs miss their mark — if welfare becomes not a safety net but a hammock, or employment insurance turns into regional subsidies. But when the goal is clear, we can see more easily when a pillar needs work.

And when the pillars work well, they not only achieve their goals, but they reinforce each other. Insurance and saving, for example, relieve the strain that too many people falling into it would create for the safety net.

For another example, think of pensions in Canada.

We have a safety net. We have old age security, the guaranteed income supplement, and provincial programs the give basic support to elderly Canadians who never worked or suffered misfortune.

We have mandatory insurance. The Canada and Quebec Pension Plans oblige working people to contribute to a program that will replace part of their incomes when they retire.

And we have saving. Pension plans and RRSPs encourage people to save beyond the basic level of the CPP, so they can be self-reliant when they are older.

Pension gurus often call these programs the “three pillars” of pension policy that every good system should have.

Again, these pillars are not in perfect shape. Many of us have criticized the CPP, for example, for being unfair to the young. But we could make those criticisms and get a hearing because it is clear that the CPP is not a redistributive safety-net, but an insurance program. Because the different goals of the pillars are clear, it is easier to fix a program to meet the goal better.

What about health? If we look beyond our own borders, as some of you have done, we can see that other countries organize their health systems along these lines.

There is a safety net. Public funds everywhere — even in the much vilified United States — pay for treatments for those without resources of their own.

There is mandatory insurance. People who are in a position to contribute to plans that provide a basic level of coverage for themselves or their families are obliged to do so.

And people are allowed to save on their own account, and to buy the medical services they want out of their own resources if they choose.

Three goals — three pillars: they make sense in income-support, they make sense in pensions, and they make sense in health care.

"Two-Tier" Gridlock

Inside our borders, however, we don't have a three-pillar plan in health care. We've got two-tier gridlock. And that doesn't make sense.

Over and over, we hear politicians, providers and pundits say that one tier is the way to go — that two, three, or twelve tiers means disease, disaster and doom.

The best interpretation I can give this rigid posture is that it's about having a safety net so broad and so deep that it is all we need. Any medical service required will be provided by the publicly funded system, and every expense incurred will be covered by general tax revenue. We don't need insurance and we don't need saving, because one big tax-funded system will cover everything.

Put that way, it's almost an attractive idea. At some abstract level, many people might like food, clothing and shelter in unlimited amounts at the taxpayer's expense. But there's no bottomless government cornucopia of food, clothing and shelter, and neither is there in health.

There are limits to government budgets, and — even if those limits are very generous — when we hit them, somebody decides what gets funded and what doesn't, and who gets treatment and who doesn't. That someone can't be the user of health services. It can't be a provider for whom the wellbeing of the user is an ethical imperative. It is going to be a bureaucrat.

And to make bureaucratic rationing work, we in Canada have gone one step further. We make it very hard for people to buy treatments that are covered by the public system. And we make it illegal for people to insure themselves for those treatments.

So even this best interpretation of the one-tier defense runs up against two things. It runs up against economic reality. And it runs up against the principle that people should be free to buy medical services that the public system won't provide.

And, not surprisingly, we don't really practice what we preach. We do supplement treatments in the public system out of our own pockets — the visit to the doctor may be free, but the drugs she prescribes aren't. We do allow parallel insurance for some things. Workers' compensation can move you through the public system faster. And you can buy a private hospital room if you want. We let people go south to buy treatments (sometimes from Canadian expatriates) that we won't let them buy here at home.

In fact, we have the outlines of a three-pillar system in Canadian health care. But two-tier gridlock makes it hard to see and politically dangerous to discuss.

And, speaking of political danger, there's another more troubling interpretation of the one-tier defense. For many people, especially for government employees, one-tier health care is health care delivered by government employees.

I'm sure you all remember the preposterous charges leveled at Bill 11 in Alberta — leaders of government-employee unions insisting that private provision of hospital services was a slippery slope to multiple tiers and disease, disaster and doom. The fact that most doctors are private entrepreneurs, the fact that drugs are made by private companies, the fact that laboratories are run for profit, the fact that all this happens in the publicly funded system — all those facts were drowned in a self-interested din.

So two-tier gridlock doesn't just make the outlines of a better health system hard to see and politically dangerous to discuss. It makes reform all but impossible by handing vested interests a slogan to shout as they defend their turf.

That's why we've got to get beyond two-tier gridlock. And I think one way of getting beyond it — or at least seeing through it and figuring out how to start the journey — is by focusing on the three key goals that Canadians have shown they accept in other social policies and that other countries explicitly identify in health. We want a safety net, we want insurance, and we want to encourage saving. And if we keep those goals in view, we can start imagining reforms that will give us a three-pillar system that achieves them.

The Safety Net

Let's start with the safety net. Every democracy makes provisions for people who cannot afford to buy health care on their own. Private charity meets some of that need, but in rich countries, governments meet most of it. That is true in Canada now, and it will always be true.

But let's be clear about how safety net programs work. They don't offer unlimited support — they can't. There will be limits. And those limits will change — depending on how wealthy we are and how much we want to spend on other things.

Having recently done some work on demographic change and health care costs — this is the first plug for my C.D. Howe Institute Commentary *Will the Baby-Boomers Bust the Health Budget?* published earlier this year — I have to point out that the limits on Canada's safety net will get tighter in the years ahead.

People age 65 and over use, on average, five-and-a-half times more publicly funded health services than people under 65. And as time goes by, the number of people age 65 and up compared to the working-age population — the people who pay the biggest share of the tax bill — is going to rise. There are currently fewer than two seniors for every ten people of working age. There will be closer to three for every ten in twenty years, and there will be more than four for every ten in forty years.

So even if use of health services by each person of a given age rose only at the same rate as productivity in the overall economy (which has not been true in the past), and even if inflation in health costs was the same as inflation in the overall economy (which has also not been true in the past), government health budgets would still rise steadily relative to Canadian incomes.

If you reckon the increase in health budgets relative to our incomes as an unfunded liability, as we do in pension plans, it comes to more than $500 billion. That's about the same size as the federal debt, or the unfunded liability of the Canada Pension Plan. And if health use outpaces overall growth and health inflation outpaces overall inflation even by a tiny fraction, the liability is hundreds of billions higher.

Put that kind of fiscal pressure on two-tier gridlock, and I worry that in most provinces — and, depending on the federal role, perhaps across the country — we will end up means-testing access to health care on a massive scale.

Lots of safety net programs are means tested. Provinces claw welfare back from people with savings, or when they get work. The guaranteed income supplement is clawed back, and so are the provincial supplements for low-income pensioners.

But even those clawbacks cause concern — in fact, they should cause more concern than they do. They cause concern about punishing work and saving, and hitting people of modest incomes with effective tax rates that can be over 100 percent.

Imagine what it would be like if clawbacks of health benefits affected, not just welfare recipients or very low-income seniors, and not just in some provinces, but masses of middle-income Canadians across the country. Reduce working and saving further, and — while I'm not in the business of prophesying disease, disaster and doom — the scenarios I just sketched and the unfunded liabilities could be much worse.

Suppose that instead we were up-front about wanting safety net programs. Suppose that instead of idealizing a one-tier national program covering everything from check-ups to sex changes all up to the last dollar, we let each province choose the package of core medical services it would guarantee to citizens unable to provide for themselves.

We wouldn't expose ourselves to unmanageable cost increases, and means-test the middle class into the underground economy or out of existence. We would shape safety nets that would guarantee core services that no-one in need would do without.

And we wouldn't expose ourselves to the charge that reform would close hospital doors to the poor, and lead to disease, disaster and doom. Putting sustainable safety nets at the core of a reform package would promise exactly the opposite: that there would always be services available for those in need.

Mandatory Insurance

Now let's talk about insurance. Just as with income support programs and pensions, a second pillar belongs in any well designed health-care system.

Why have a mandatory insurance pillar? One obvious reason is ensuring that people who can provide for themselves and their families will do so, and not strain the safety net and hurt their own prospects by falling into the safety net when they could have kept themselves out.

The premiums paid for employment insurance when people are working turn into payouts that, if they lose their jobs, keep them off welfare — which is good for the welfare programs, and good for them. The premiums people pay into the CPP when they working turn into pensions that raise their incomes above the level where they would draw on the GIS when they retire.

And the fact that social insurance programs come with their own premiums has other advantages.

Look at it from the point of view of the funder of health care. When a country faces a demographic squeeze, as Canada does, it isn't fair for today's workers to push the bill for their pensions and health care in old age onto tomorrow's workers. They should put something aside themselves.

Here's plug number two for *Will the Baby-Boomers Bust the Budget?* — if governments are smart, they can discipline themselves to set aside part of today's surpluses, while the boomers are still working and saving, to pay for tomorrow's health care once the boomers are retired. If governments find that too hard to do by running ordinary budget surpluses, they can set up special social insurance accounts, like the CPP, and save in them. And if the insurance coverage is from private companies, as it usually is in Europe, the insurers will pre-fund themselves so that when tomorrow's health bills come due, there will be money in the till to pay them.

And look at it from the point of view of the receiver of health care. Option one: pay taxes into one big pot of a consolidated

revenue fund and receive a vague promise of health benefits that a future finance minister can take away. Option two: pay premiums into a plan that specifies, in advance, what entitlement they buy and on what terms. Which is more secure?

Nothing is guaranteed in an uncertain world. But social insurance creates an explicit contract that is politically costly to break. Future health benefits in a second-pillar system might be attractive to Canadians who have learned to doubt the durability of political promises.

Canadians are comfortable with the principle of a second-pillar. I've already pointed out that we have them in income programs and pensions. Amazingly, we even accept them in health-related programs.

We have sickness benefits under EI — you pay a premium; you're entitled to a payment. We have workers compensation — you pay a premium; you're entitled to payments, and medical services.We have disability benefits in the CPP — you pay a premium; you're entitled to a payment. There are health insurance premiums in two provinces, and premiums for pharmacare in another.

I think we are ready to build on those foundations. In Quebec, the Clair Commission recently advocated pre-funding the kinds of health care an older population will need. Our medical associations have designed plans for universal private health insurance. And several people have proposed medical saving accounts — which would work as a second pillar in health care just as individual retirement accounts could work in pensions.

The challenge, again, is to show Canadians how insurance in strong second pillars can make their health systems more sustainable, and their benefits more secure.

Private Saving

What about the third pillar: a friendly environment for individuals and families to save on their own? Here, there's some good news and some bad news.

The good news is that when it comes to saving, Canadians are most of the way there. We already have pension plans and RRSPs that help people set something aside.

We could do better. We could raise the limits on contributions. We could liberalize the rules for withdrawals so funds in these plans would be easier to use for health services. And we could provide better ways for lower-income people to save, as my colleague Finn Poschmann and Jon Kesselman who spoke to your earlier conference in Vancouver have proposed.

But Canadians are already believers in the virtues of saving. So the good news is that here too, there's a solid foundation to build on.

The bad news isn't on the saving side. The bad news is that two-tier gridlock has convinced many Canadians that, however much people save, and however much they would like to use their savings for health services, we have to make sure that there is nothing they can buy.

And because so many Canadians believe that buying health services as individuals leads inevitably to disease, disaster and doom, we have waiting lists for diagnostic equipment that sits idle because the budget to run it is exhausted, we have pets getting treatments that human beings cannot, and we have doctors on the golf course, or in the United States, because they

have maxed out their billings, while people who would pay for their services if they could sit, undiagnosed, and untreated.

The challenge here is to help Canadians see the absurdity of that idle equipment, those queue-jumping cats, and those emigrating doctors. The challenge is to help them see that two-tier gridlock, and predictions of disease, disaster and doom get us no closer to a solution.

And when we put it like that, I'm not sure the bad news is really all that bad.

For one thing, the key obstacles to buying health services aren't federal. Sure you can read the Canada Health Act to find a mandate for government insurance — but though I confessed I'm no pollster at the outset, I do know that when Canadians are asked how much they value the various principles of the Canada Health Act, public administration comes last.

It is the provinces that actually create and maintain the obstacles to individual purchase of health care. And it is the provinces that can — and should — remove them. As Canadians learn more about the absurdity and human cost of two-tier gridlock, I think provincial governments will liberalize their systems.

A wise federal government will encourage those reforms. That is how we can encourage saving — the third pillar of a sound health system.

Summary

In closing, let me highlight again that the three goals of a good health system — a safety net, insurance, and saving — complement each other. People will support individual saving and purchase more readily if they are confident that a well crafted safety net will be there for those who need it. And people will support a well crafted safety net if they are confident that those who could provide for themselves up to a basic level of protection will do so. As in income policy and pensions, the three goals and the three pillars in health work best together.

Do I know exactly what ought to be in a first-pillar safety net? I do not. Health is primarily a provincial responsibility. I am sure that each province will have its own priorities, and that those priorities will change over time.

Do I have a precise design for medisave insurance? I do not. There are many examples to draw on in designing second pillars. Some provinces would opt for rich ones with drug, eyewear and dental benefits, but others would not. Most provinces would probably opt for public monopoly plans, but some might want competing private ones.

Do I have detailed plans for reinforcing the third pillar — liberalizing private saving for and purchasing of medical services? I do not. Some of the necessary tax changes could be done federally, others provincially, and the task of loosening restrictions on private transactions differs from one province to another.

But there's one thing I do have. That's a conviction that we need to get past two-tier gridlock, and predictions of disease, disaster and doom, and look as hard and thoughtfully as we can at the key goals of a good health system, and the reforms that will achieve them.

So I congratulate you for organizing this conference. And I hope that my outline of three key pillars of a sound health system — a safety net for those who need it; insurance for those who can afford it; and private saving for those who wish it — will help us move ahead.