C.D. Howe Institute

Benefactors Lecture, 2010

Critical Condition:
A Historian's Prognosis on Canada's Aging Healthcare System

Michael Bliss
University Professor Emeritus,
University of Toronto

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Foreword

When a set of public policies fundamental to our wellbeing is so politically sensitive and shot through with conflicting real and perceived conflicts of interest as to produce paralysis, a smart and wise historian can often provide the long-term, evolutionary perspective required to find the more promising ways forward. Canadian healthcare is fundamental to our wellbeing and so politically charged that despite its widely perceived shortcomings, attempts at fundamental reform appear the electoral equivalent of touching the proverbial third rail on a subway track. Professor Michael Bliss is one of Canada's most able and eminent historians. The C.D. Howe Institute's 2010 Benefactors Lecture is his attempt to take stock of publicly funded healthcare in Canada in the light of how it came to be, and give his assessment of the right directions forward to ensure that it serves Canadians well in the decades ahead.

A good historian draws from many disciplines, and Professor Bliss's account draws on insights from medicine, political science, economics, and much else. His account of the development of what Canadians nowadays call "medicare" from provincial coverage of doctor and hospital services in the 1960s through the federal *Canada Health Act* in the 1980s and the alternating dips and boosts in spending in the 1990s and 2000s is clear and compelling. Without undue deference to any particular perspective, he argues convincingly that an economically advanced democratic society will devote a growing share of its resources to healthcare, and that Canadians' support for access to it is a fact of life that even medicare's more vociferous critics must accommodate in their reform proposals.

When it comes to his own advice for reform, Professor Bliss puts forward some propositions that will – like all changes to healthcare – inevitably be controversial. He draws on experiences with other major programs in the Canadian welfare state, family and old-age benefits in particular, to argue that reducing public commitments to the healthcare of Canadians who are able to pay their own way is both fiscally necessary and politically acceptable. Hence, he encourages the evolution of our health insurance system from providing universality of benefits onto a needs basis, preserving the core value of equal access. Economists and others concerned with the way income- and asset-related withdrawal of benefits from the better off have produced welfare walls and high effective marginal tax rates on modest-income people will have reservations about this proposal. If he is right that it is the way out of the chronic fiscal squeeze that otherwise looms, however, the challenge is to craft the most adept way to do it.

In an age of reduced deference to experts of all kinds, Professor Bliss's second recommendation – that Canadians accept that medical researchers and practitioners should play a more prominent role in determining what is medically necessary – will also raise objections. It may presuppose a level of confidence in professional expertise, and improved standards for research and practice that would justify that confidence, that medicine, like all fields, has yet to achieve. Yet the importance of specialized knowledge in determining what is likeliest to work is so critical in medicine that the problems of letting third parties, including health ministries, overrule researchers and practitioners in the field oblige us to take this advice seriously.

Professor Bliss's third observation is less about how to move forward than it is about not staying stuck where we are. Whatever the devotion of some Canadians and a handful of advocates abroad to a single-payer government monopoly model may be, he points out that no other developed country has imitated it, and none is about to. Canada's current approach is a product of specific Canadian circumstances, not least of which is its emblematic status as a differentiator of Canada from the United States – hardly a sound basis for determining how to provide and pay for the vast array of medical services that determine how healthy or sick we are, and even whether we live or die. His appeal to use more market mechanisms to harness the incentives of producers and patients in the service of better outcomes, rather than lamenting or denouncing them, is a general exhortation. In practice, it will require balancing against his other suggestions to abandon universality and defer more to medical expertise. Yet there can be no doubt that any reform that does not harness these incentives effectively cannot hope to succeed.

The C.D. Howe Institute's Benefactors Lecture is intended to encourage better understanding of major Canadian public policy challenges, and stimulate debate about how best to meet them. Many people besides Professor Bliss deserve credit for producing the 2010 version of the Lecture: I thank Pfizer for their financial support, the reviewers of earlier drafts for their comments, Barry Norris and James Fleming for their editing, and Bryant Sinanan for his page layout. As with all the Institute publications, the opinions expressed here are those of the author, and do not necessarily represent the views of the Institute's members or Board of Directors. I commend Professor Bliss for having ably responded to the challenge of addressing the condition of Canadian healthcare, however, and hope all readers will take from it his valuable insights about how we got where we are, and what can help us do better.

William B.P. Robson
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This is a historian's perspective on a current social issue. It is an attempt to stand back and take a long view of Canada's experience with health insurance in the context of Canadian culture and history. What lessons or conclusions can we discern that might help shape future policy?

After an overview of the evolution of our healthcare system through several stages, I suggest that (1) we reconcile ourselves to the fact of Canadians' demand for a high and probably growing level of healthcare expenditure in a predominantly public system; (2) consistent with our experience with other social programs once considered entitlements, we encourage the evolution of our health insurance system from providing universality of benefits onto a needs basis, preserving the core value of equal access; (3) more attention should be paid to appropriate divisions of responsibility in the management of Canadian healthcare; (4) hard questions be asked about the problems inherent in managing a complex "system" sheltered from market incentives, signals, and discipline.

The takeaway proposal, (2), is that reimbursement for healthcare in Canada now be on the basis of financial need, not universality.

The Historical Gaze

Society brings enormous expertise to bear on issues involving healthcare. We mobilize the physician's science, the economist's scholarship, the epidemiologist's and statistician's survey data, our personal obsessions with our inner rhythms and crotchets, and grandmother's recipes for chicken soup. This presentation is from the special perspective of a historian.[1] Historians are expected to tell us how we have reached the present in the hope of helping us better understand how to address the future. Historians are expected to show us where we have gone wrong so that we can avoid going there again. While historians seem eccentrically to be describing the world through the rear-view mirror of history, Marshal McLuhan noted that in today's society the rear-view mirror shows what is coming up on us.

So this is a historian's view of Canada's experience with health insurance, past, present, and, more tentatively, future. I concentrate on our 42 years of what was sometimes called socialized medicine, often called medicare (not to be confused with Medicare for seniors in the United States), now often referred to as our system of universal health insurance, or, more precisely, single-payer health coverage funded by government.

Medicare came to Canada in 1968 as a national shared-cost program, had been implemented in all the provinces by 1971, and quickly gained political currency as "the country's most cherished social program," and its most costly. It also became in some ways Canada's most contentious social program, but with the qualification that there was seldom open debate about its fundamental principles because they were so widely accepted. Indeed, the sacred cow status that Canadian medicare appears to enjoy often seems to preclude a range of possible changes to the

1 It has been prepared, however, with the benefit of research help from staff members at the C.D. Howe Institute and with helpful suggestions made by readers of earlier drafts: Philippe Bergevin, Colin Busby, Ben Dachis, David Laidler, Finn Poschmann, Bill Robson, Mark Stabile, and "Anonymous." The shortcomings of this final draft are, of course, my responsibility.

system, even as it encourages further change in certain approved directions. Prescriptions to improve Canadian healthcare are best formulated in the context of our record of hope, achievement, difficulty, debate, and constraint. When physicians confront a patient, the first thing they do is take a history.

Because history-taking is primarily patient specific, one of my concerns is to set the Canadian experience with healthcare in the context of Canada's distinctive social and political experience. Comparative study of social policy is always fundamental, a given, but any country's approach to an issue has also been shaped, conditioned, constrained – particularized – by its history. We need to understand this to appreciate, for example, the particular iconic status that medicare has attained in Canada, to appreciate the connotations of the language Canadians use to discuss their healthcare ("one tier, two tier," even the name *Canada Health Act*), and to appreciate the extent to which comparisons between Canada and the United States, following on the heels of deference to the British experience, tend to crowd out references to other countries' approaches to healthcare in setting the national agenda. As well, a national emphasis highlights the importance of setting health insurance in the context of the evolution of other Canadian social programs, notably support for children and the elderly.

Finally, the historical method, stressing distance and perspective, involves untangling themes and categories that get mixed up and confused in the hubbub of everyday life and chatter. Just as a physician has to sort out the issues presented in a patient's symptom complex, so the historian suggests, for example, that we differentiate such parallel, tangled developments as the evolution of modern healthcare, approaches to health insurance, political desiderata, and changing attitudes and expectations held by the Canadian people. We are better prepared to discuss the future after we have made historical sense of exactly how a set of situations became entwined in 1968 and continue to writhe and change as Canadians aspire to maximize their individual and collective health.[2]

The Evolution of Canadian Healthcare

Canadian medicare did not have an immaculate conception in 1968. Nor was it born the system the country now has. Canadians' approach to funding and organizing the delivery of their healthcare services has changed constantly, usually in the attempt to balance the two fundamental goals of accessibility and affordability. Other, parallel Canadian social programs have also changed markedly.

For the purposes of this discussion, the Canadian healthcare and health insurance experience divides into four periods: the long lead-up to the introduction of national health insurance; "classic" Canadian medicare in the 1970s; the era of "monopoly" medicare protected by the *Canada Health Act*; and the recent decade of medicare made more accountable by public pressure and judicial decree. The history of these developments, outlined in this section in some detail, may be skipped by those impatient and ahistorical readers who are interested only in the

2 Historians obsess about problems of objectivity and bias in interpreting the past. There is almost never complete agreement on what happened in the past, what lessons might be learned, and how the past should shape the future. Other historians may well disagree with both major and minor themes of this lecture. But that cannot be an excuse for simply lapsing into the chaos and silence that follows from complete historical relativism. Evidence-based and bias-conscious historical analysis will always be a precondition of the intelligent discussion of public policy.

lessons the past supplies. But readers who do not consider the evidence are bound, of course, to accept the validity of the conclusions on faith.

From the Individual to the State: The Coming of Medicare, 1867–1968

In the first half of the twentieth century, what was judged to be modern healthcare – the services provided by doctors and in hospitals – became effective enough that Canadians began to explore ways of making it accessible to everyone. As that happened, the issue of health insurance moved onto the national agenda.

In an earlier era, the state had had little involvement in healthcare, much of which was in any case often of marginal benefit because of the limitations of medical knowledge. In the 1860s, the Fathers of Confederation had no concept of health insurance or any other healthcare role for the state beyond providing quarantine stations and some limited provision for the care of paupers. Even the latter responsibility was to be shared between private philanthropists and health professionals – physicians, for example, were expected to treat the indigent as a professional duty, for which it was tacitly understood they would be compensated by the fees paid by their wealthier patients. In its delineation of the responsibilities of the federal and provincial governments, the *British North America Act* did not contain the word "health." For approximately two-thirds of Canada's modern history, paying for healthcare was considered the responsibility of individuals, with some backstopping from physicians, charities, and local governments.

Even in the nineteenth century, however, it was not uncommon to establish collective provisions for healthcare and/or death benefits for workers in frontier camps, members of fraternal benefit societies, and residents of small communities on the prairies (Naylor 1986). As modern medicine developed, as doctors became more effective at treating diseases, and as hospitals evolved from charity hospices into temples of diagnosis, delivery, and healing (see, for example, Porter 1997; Bliss 2010), the more important it seemed that individuals should have access to these services.

Canadian governments did not emulate early European experiments with state-provided health insurance, which began in Bismarck's Germany in the 1880s and became an important aspect of British social policy by 1910. But, in 1919, partly emulating British Liberals, the Liberal Party of Canada began advocating national health insurance as part of a comprehensive approach to social security, a proposal at first honoured mostly by neglect. In the Great Depression of the 1930s, however, the idea of a public role in insuring individuals against the costs of medical and hospital treatment moved swiftly up the public policy agenda, as did other social welfare concerns (Taylor 1978; Naylor 1992; Finkel 2006).

In a society in which many people still had to struggle for basic subsistence, it was as difficult to set aside resources to pay for sickness (or even the cost of having a doctor attend at childbirth) as it was to save for old age, feed extra mouths in a family, or accumulate reserves against being out of work. From the 1930s through the 1950s, the idea of insurance against the costs of

illness was discussed along with proposals to insure against unemployment and other periods of insecurity. The idea of the "welfare state," providing security for citizens from the cradle to the grave, developed in Europe and spread with the progressive movement to North America.

In Canadian healthcare, new systems of private health insurance, often pioneered by doctors' organizations, evolved out of the older fraternal society and employer-based schemes (Neilson and Paterson 1987). For many years, various levels of government had been involved directly in providing forms of healthcare through public health initiatives and municipal hospitals, but the crux of the public policy problem with healthcare seemed to be improving systems of payment rather than reorganizing the provision of services. At the provincial level, there was growing interest in the idea that the state should provide health insurance as part of its broad responsibility for social welfare or social security. As an Ontario family doctor put the issue in 1944, "Every day I see patients who are getting inadequate medical service, both diagnostic and curative, because they are unable to pay for it, or if they do pay they are left with insufficient money to provide a decent standard of living. Every such case is a demand, even though usually unexpressed, for some form of health insurance" (quoted in Bliss 2002).

By 1945, in the aftermath of the stimulus that World War II gave to broad schemes for social reconstruction, the Canadian debate on the future of health insurance had moved to the national level. There it became enmeshed in the thickets of Canadian federalism, notably the conundrum created by Ottawa's apparently abundant financial resources but little constitutional responsibility for basic healthcare. The courts effectively had determined that healthcare was the constitutional responsibility of the provinces, although they had limited and uneven resources. There followed years of discussion, conflict, innovation, experimentation, and the gradual expansion of the provision of health insurance by both provincial governments and the federal government.

The end of this beginning in the 1960s involved Ottawa's using its spending power – deemed constitutional even in areas of provincial jurisdiction – to steer the provinces into its offer to fund its version of health insurance on a shared-cost (originally roughly 50-50) basis. Several provinces, including Ontario, Quebec, and Alberta, had resisted dirigisme from Ottawa, and continued to have deep and sometimes bitter reservations about what seemed to be the national government's intrusive, possibly constitutionally abusive, foray into their domain. Other provinces, of course, led by the proudly socialist government of Saskatchewan, welcomed the national initiatives.

Not surprisingly, one of Ottawa's four conditions for beginning to pay a significant cost of provincial health insurance systems was that benefits be portable across the country. A second condition was that provinces not fudge their coverage by making it less than "comprehensive," a flexible term that in the 1960s was considered to include most doctors' services and hospital charges. To the disappointment of many interested parties, other large areas of healthcare, ranging from dental work to drug costs to midwifery and to almost all systems of "alternative" medicine, were not covered. Comprehensiveness was also considered to include first dollar reimbursement,[3] since experience indicated that even first dollar charges by doctors and hospitals were a disincentive to

3 These are the charges for first or basic consultation or treatment. Insurers then limited their liability by capping the numbers of procedures they would cover and/or maximum costs.

the poor. Deductibles, co-payments, user fees, and similar charges were thus excluded from Canadian medicare.

The problem of the poor was central to debate about the other two conditions Ottawa applied: universality and public administration of health insurance. Throughout Europe and North America, the traditional approach to problems stemming from indigence had been for the state to grant benefits on the basis of means tests. By the mid-twentieth century, means-tested aid was widely rejected by designers of social welfare systems who saw means tests as demeaning, cheese paring, humiliating, and invidious. Better to bypass the whole issue by giving benefits to all citizens as a matter of right, partly on the model of essential public services ranging from police and fire protection through primary (but not secondary or tertiary) education. As it emerged in twentieth-century Europe, with Canadians paying particular attention to such British proposals as those outlined in the landmark Beveridge Report of 1942, the modern social welfare state ideally offered the same benefits to all, without inquiry or tests to determine need.

In Canada, the principle of universality was applied in the state's approach to providing a measure of help in child-rearing and to the aged. The family allowances or "baby bonuses," introduced in 1945, and the basic old age pension, implemented in 1951, were given regardless of means as a universal benefit. Universality also was fundamental in Britain's National Health Service, introduced by the Atlee Labour government in 1948, a model that deeply impressed many Canadians. As in Britain, and as with baby bonuses and old age pensions, universal health insurance would cover everyone regardless of income, no questions asked (Bothwell, Drummond, and English 1981).

As a fourth principle of Canadian medicare, health insurance would be publicly administered. If the state offered universal and comprehensive coverage, it was reasoned, there would be no need for private insurers. Governments could do the job for everyone and, in the eyes of medicare's most passionate advocates, would do it more efficiently than the private sector because the profit motive and profit margins would be eliminated (Taylor 1978).

Accordingly, by legislation passed in 1966 and proclaimed in 1968, the federal government offered to provide 50 percent of the costs of any provincial health insurance program that met the four criteria of universality, comprehensiveness, portability, and public administration. By 1971, despite grumbles about the de facto coerciveness of Ottawa's use of its financial muscle, all provinces had plans that met these standards.

Individual reliance on Canadian medicare was not compulsory. Citizens would have to pay a share of the costs of health insurance either in taxes or, in provinces that levied them, healthcare premiums, or both. But they could opt not to take any benefits and arrange to get their healthcare privately, just as they could educate their children privately while also paying school taxes or decline to cash baby bonus or old age pension cheques. Similarly, physicians, whose associations had lobbied strenuously to maintain professional independence from government and who had fought the government of Saskatchewan to a draw in a bitter doctors' strike, could choose to practise outside the system, billing patients at whatever rates they thought the market would bear. In the 1960s,

however, it was widely believed that the vast majority of Canadians, patients and physicians alike, would be pleased to opt to participate in the new "socialized" approach to financing healthcare. Patients no longer had to worry about medical bills, and doctors would be assured of much higher levels of payment from government programs than from hard-pressed individuals or cost-conscious private insurers.

The movement to construct Canadian national health insurance had evolved gradually and fitfully over more than two decades from 1945. There was almost constant and ongoing disagreement between Ottawa and several of the provinces, and there had been intense lobbying by many interests, including private insurers and physician groups. During much of the period, the popularity of the health insurance initiatives in Saskatchewan taken by the socialist government of Tommy Douglas, who moved to the national level in the 1960s as leader of the New Democratic Party (NDP), made a strong impression on Canadian politicians. Building the welfare state, providing social security for all, and socializing the attack on poverty was politically popular in most of the affluent societies of the West during the quarter-century after World War II, and in this regard Canada was no different. At voting time in Parliament, as had been the case with baby bonuses and old age pensions, hardly anyone dared to appear to be standing on the wrong side of history. "Medicare was politically potent," J.L. Granatstein writes, "[and] no one could afford to be seen as opposed" (1986, 196). *The Medical Care Act* passed the House of Commons in December 1966 by a vote of 177 to 2; abstentions and absences from the tepid and timid would not count against them.

The initiatives of 1966–68 represented the formation of a consensus in Canada that access to necessary medical and hospital services should be guaranteed to all citizens, and that previous inequality of access had not been socially just. As Mr. Justice Emmett Hall had phrased it in his influential report of the Royal Commission on Health Services, broadly mandated to prescribe for the future of Canadian healthcare, the time had come 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" (Hall 1964, 97).

It is important not to denigrate other aspects of the organization of healthcare in the first century of Canadian history. In Canada, as in other advanced societies, the progress of modern medicine and healthcare in the twentieth century had produced spectacular benefits for virtually all citizens in terms of relief of suffering, increased quality of life, and striking increases in life expectancy. In pre-medicare Canada, a healthcare system had developed – responding to individual needs, market forces, and the support of governments – that was characterized by high levels of professional competence and dedication, high-quality hospitals, world-class research achievements, and a high level of public trust. It was both the triumphs and the shortcomings of pre-medicare healthcare that convinced the Canadian public and politicians that, as was often said in the medicare debate, healthcare had become too important to be left in the hands of doctors. In this respect, the old individual-based, market-driven, charity-reliant Canadian approach to healthcare had become a victim of its success (Porter 1997; Bliss 2010).

Classic Medicare, 1968-84

The high quality of Canadian medical and hospital services seemed to get even higher in the heady early years of medicare. Patients were delighted to find that money no longer was an impediment to access to doctors and hospitals. The whole grubby business of paying doctors' and hospital bills had suddenly faded away. No Canadian family would be ruined or even inconvenienced by basic medical costs. Some provinces still charged health insurance premiums, but these were quickly adjusted to income and in most cases gradually faded into general taxation.

The contrast between the apparently total healthcare security available to Canadians, thanks to government action, and the ongoing anxiety millions of Americans suffered about finding affordable private insurance was striking, and was seen immediately as a new and important factor differentiating the two North American democracies. A popular and distinctive approach to healthcare in a country whose sense of history and identity had always involved finding rationales for remaining separate from the United States quickly took on a dimension that far transcended transactions in doctors' offices and hospital wards.

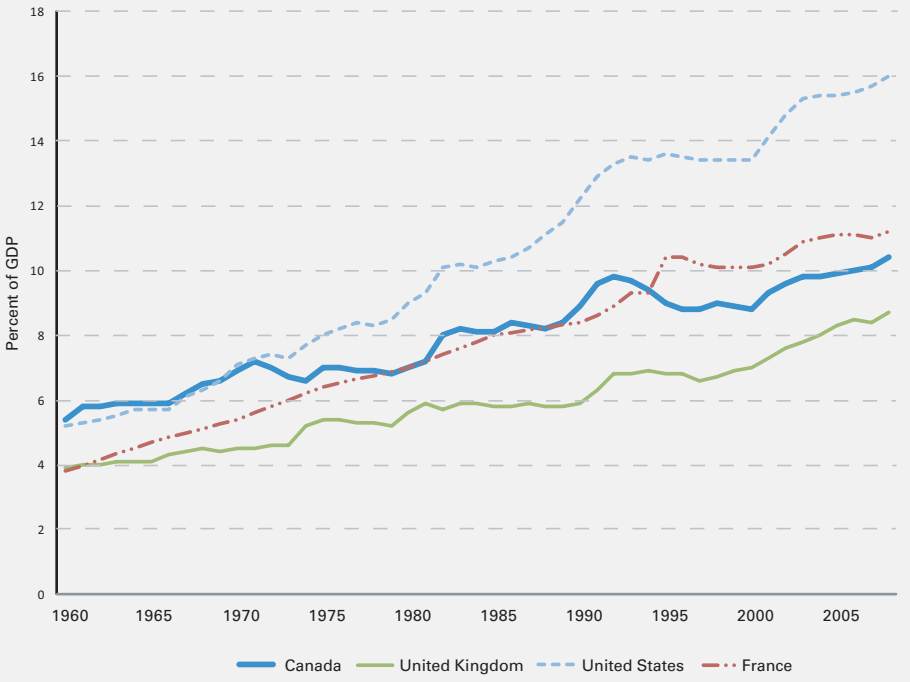
Medicare was considered by its champions to be a great Canadian progressive achievement. Sometimes mentioned in the same breath as family allowances and the welfare state generally, Canadian public health insurance, they argued, was a mark of national progress. Canada, it seemed in the late 1960s and early 1970s, was maturing into modern nationhood at a time when its affluent, dynamic neighbour often seemed to be losing its way in several areas of social policy. Having experienced what Antonia Maioni calls a "Parting at the Crossroads" from the United States, Canadians were now said to be showing Americans the way even in healthcare (Maioni 1998; see also Bothwell, Drummond, and English 1981).

Enthusiasts for Canadian medicare now began characterizing it as a reflection of Canadian values, as an expression of Canada's long-sought – now found! – identity. Thus medicare almost immediately assumed iconic status in Canada. With the possible exception of Great Britain in the early years of the National Health Service and Cuba in the early Castro era, no other country asked its public health insurance system also to serve as its major benchmark of national excellence and achievement. Already entrenched in the popular consciousness as extremely effective, the Canadian approach now began to take on the trappings of an untouchable sacred cow. Politicians would tamper with medicare at their peril.

With payment systems socialized on a national basis, Canadian healthcare was increasingly seen or conceptualized as a "system." Instead of being driven by a diversity of signals, forces, initiatives, and incentives, in a complex of decentralized markets, healthcare would now be "managed" by those responsible for funding it. The fact that funding responsibility was divided between Ottawa and the provinces would always muddy this situation, generating frequent frictions and confusing voters and politicians alike. It was not always clear which governments were in charge of Canadian healthcare, but there was no doubt that the genus, government, had stepped in to make fundamental decisions.

Total healthcare costs, however, rose relentlessly – and faster than national income – from less than 6 percent of gross domestic product (GDP) in the 1960s to more than 10 percent today

Figure 1: Total Healthcare Spending as a Percentage of Gross Domestic Product, Canada and Selected OECD Countries, 1960–2008.

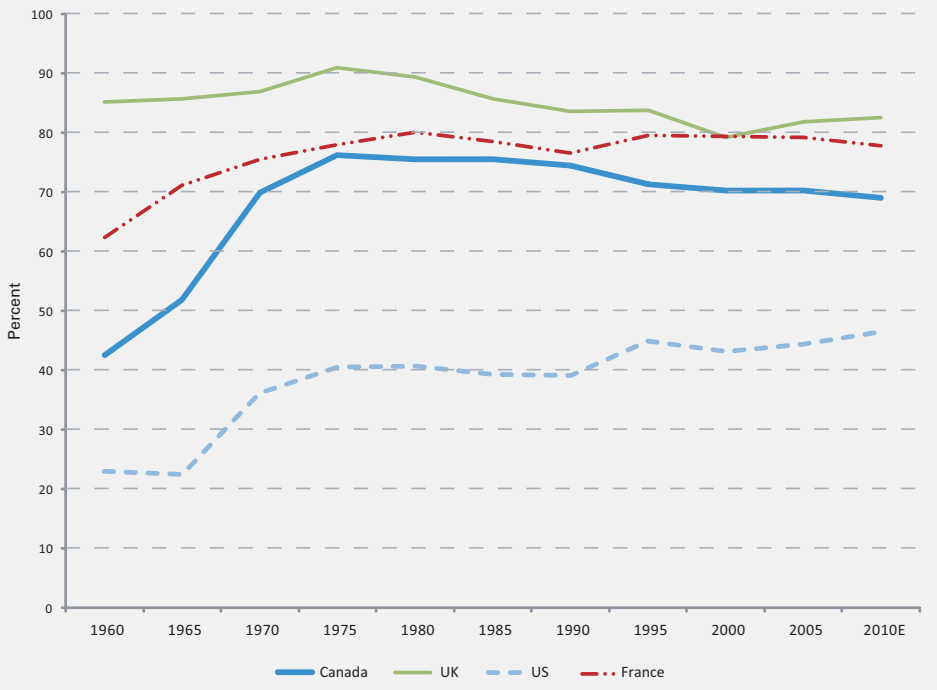


Source: OECD 2010.

(Figure 1). Canadians liked their healthcare, and now that cost hindrance had been removed at the point of service for basic healthcare, they wanted much more of it, and they also had the resources vastly to increase their spending on uninsured forms of care. Very quickly after medicare's introduction, all Canadian governments began to be concerned about the affordability of the commitments they had made. As usage and public costs soared (see Figure 2), and critics began to wring their hands about the unlimited propensity to consume a free service, alarmist projections issued about the capacity of healthcare to take over practically the whole tent of government spending (Gray 1991). If the central problem before medicare had been to make modern healthcare accessible to all Canadians, the central problem after the introduction of medicare was how to pay for it. It has continued, into the present, to be a central problem.

In 1968 and immediately afterward, Ottawa and the provinces launched a number of studies of healthcare. Most aimed at finding ways to manage the cost-benefit puzzles created by generous guarantees to fund services that were constantly evolving, often multiplying, in ways that involved greater expense and in the context of apparently unlimited patient demand (Gray 1991; Vayda and Deber 1992). Doctors and other professional care givers, who had the clearest mandate to make decisions in the best interest of patient health, were required to share control of the

Figure 2: Public Healthcare Spending as a Percentage of Total Healthcare Costs, Canada and Selected OECD Countries, 1960–2010E



Sources: OECD 2010; and author's calculations.

agenda/system. Accountants, economists, bureaucrats, politicians, and myriad interest groups now contributed to discussions of how best to "manage" medicare.

The domains of care providers and cost controllers necessarily overlapped, fudged, merged, and conflicted, generating sometimes acrimonious debate. As ultimate legislators and funders of the system, politicians found themselves torn between the recommendations of their hired experts and their sense of accountability to Canadian voters. The previously diverse, fragmented, market-driven system was becoming bureaucratized, politicized, and increasingly subjected to research microscopy – even as ongoing developments in healthcare made it more complex and expensive.

The effort to contain the costs of medicare was part of governments' general concern that the social welfare commitments made and entitlements created in the optimistic years of the 1940s, '50s, and '60s had to be contained in the rollercoaster, slow-growth '70s. Previous assumptions about growth rates and the reliability of long-term planning now came into question.[4] Major proposals to further enlarge the scope of the Canadian welfare state were shelved in the 1970s, when Ottawa decided against trying to give all Canadians a guaranteed annual income and the provinces rejected giving university students free tuition (Bliss 1997).

4 These caused Prime Minister Pierre Trudeau to announce sternly that "the government is not Santa Claus," a view he at times later seemed to forget.

Governments also began to move away from universality in the provision of certain social services – most clearly, family allowances. In 1978, the federal government introduced the income-tested Child Tax Credit as a complement to the Family Allowance and the existing tax exemption for dependent children. In the 1980s, growth in the dependent exemption was limited and income testing was introduced for the Family Allowance. In 1992, both the Family Allowance and the dependents exemption were eliminated and the Child Tax Credit rolled into the fully income tested Child Tax Benefit. Universality thus disappeared from federal child benefits programs. The demise of Canadians' once-sacred entitlement to "baby bonuses" happened with little or no long-term political cost.

The thrust of reform in medicare throughout the federation was to try to limit spending without affecting entitlement. The federal government replaced its open-ended medicare commitment in 1977 with block funding under Established Programs Financing provisions. Provincial governments used their financial and legal position to tighten control on fees paid to physicians and grants to hospitals. Experts in management suggested many organizational changes that might reduce costs. Not surprisingly, cost controllers in government were attracted to the ideas of those healthcare "reformers," some within the care-giving professions, who believed that the "system" was heavily and unnecessarily marbled with overtreatment, conflict of interest on the part of providers, and misplaced emphasis on high-tech, curative procedures (Gray 1991, 107-08; Vayda and Deber 1992). Perhaps Canada could do more with fewer physicians, hospital beds, laboratory tests, intensive-care units, and heroic surgical interventions. Could fee-for-service payment be usefully abandoned, as it had been in Britain's National Health system? Could an emphasis on environmental and lifestyle change and other forms of preventive medicine produce a healthier population at lower cost? A healthy population would surely need less healthcare than a sick one. To insurers everywhere, public and private, these were attractive ideas.

Governments proved more interested in finding immediate cost savings and/or new sources of revenue than in sweeping proposals for root-and-branch healthcare change. Most provinces froze or reduced reimbursement rates. Some provinces, most notably Alberta, proposed to challenge the tradition of first dollar coverage in health insurance by instituting what were variously called user fees, deterrent fees, deductibles, or co-payments.

Among healthcare providers, governments' constraints on reimbursement led to dissatisfaction that was expressed in widespread opting out and/or extra billing, particularly by specialists. By the early 1980s, there were areas of Canada in which healthcare was becoming reprivatized in the sense that it was impossible to find providers – ophthalmologists and obstetricians in large parts of rural Ontario, for example – who worked entirely within the public system.[5] With provinces themselves moving towards implementing forms of direct extra billing, classic Canadian medicare appeared to be eroding at a quickening rate. The era in which Canadians enjoyed access to their healthcare system without any form of financial hindrance seemed to have been short-lived.

5 Doctors had always been thin on the ground in rural areas, a problem that would continue to plague healthcare delivery outside of Canada's major cities and be a constant rebuke to the notion that Canada had achieved anything like complete equality of access to healthcare.

Monopoly Medicare, 1984-2000

Even as the system evolved, arguably failing by the criteria of 1968, all surveys showed that Canadians believed deeply in entitlement to healthcare without impediment, which seemed to many to have worked well since 1968 and had been heralded so often as a mark of national identity. A vigorous debate developed about how best to "save" Canadian medicare. In the early 1980s, the Trudeau government announced that a fifth vital principle of the Canadian system, accessibility, which had been implicit from medicare's beginning, was threatened by private and public extra billing. It moved to eliminate this alternative by penalizing provinces that permitted the practice by withholding funds on a dollar-for-dollar basis. Practices and procedures would continue to differ slightly from province to province, and pockets of private care would remain, but the effect of the proposed *Canada Health Act* would be to create a single-payer state monopoly in the funding of Canadian health insurance. The safety-valve alternative of expansion into the private sector, previously available to physicians, patients, and governments, would no longer be a practical – in some provinces, even a legal – alternative. Parliament hoped that the *Canada Health Act* would assure Canadians of equal accessibility to universal, state-provided comprehensive coverage of their necessary medical and hospital services.

An important "crossroads" opportunity to debate the fundamental principles of Canadian health insurance, particularly the concept of universality, was forgone in the early 1980s: medicare was too popular to be fundamentally reconsidered. The Trudeau government positioned itself, with full support from the NDP and leadership from a particularly dynamic minister of health, Monique Bégin, as medicare's defender. Their Progressive Conservative opponents, who had regularly criticized confrontational and coercive tactics in federal-provincial relations and were thought to be somewhat friendly to the privatization of government enterprises, supported the *Canada Health Act*. It was passed without dissent in the House of Commons in April 1984. In the general election that summer, the act was not an issue. As Brian Mulroney outlines in his memoirs, there was perceived to be absolutely no political capital to be gained by supporting anything that smacked of extra billing ("a live grenade for us") or private or for-profit healthcare (Mulroney 2007, 280-81). After the election, the minister of health in the new Mulroney Progressive Conservative government announced that medicare was "a sacred trust" (Gray 1991, 126), and began to apply the provisions of the *Canada Health Act*.

By contrast, after several stops and starts, the Mulroney government did succeed in limiting eligibility for the previously universal old age pension, which since its inception also had enjoyed the aura of inviolability. In 1989, Old Age Security entitlements were made income dependent. The development of the Canada Pension Plan in the mid-1960s, the growth of private-sector pensions, the deindexing of benefits, Ottawa's introduction of Registered Retirement Savings Plan allowances, the phasing out of universal family allowances, and the skilful use of a three-year phase-in period all helped to make this transition politically feasible.

Provinces gradually fell into line with the *Canada Health Act*. Alberta abandoned its proposed user fees, and Ontario's ban on extra billing survived a serious, bitter doctors' strike in

the summer of 1986, sponsored by the Ontario Medical Association. With the safety valve of private medicine apparently legally welded shut, the managers of Canadian medicare appeared to face fewer impediments to applying more stringent cost-control measures. A combination of serious recession in the early 1990s and a major fiscal crisis in the middle of the decade was a further stimulus to efforts to reduce or at least to hold the line on healthcare costs.

The healthcare experts who tended to have the ear of cost-conscious governments were those who suggested that patient demand for healthcare was to some degree generated by suppliers, leading to misplaced priority for curative and high-tech treatments and overservicing to increase provider income. In the early 1990s, basing their policies on recommendations in what became the notorious Barer-Stoddart report (1991), which expressed many of these assumptions (along with caveats that were immediately ignored), most provinces acted directly to try to reduce the supply of providers. They reduced enrollments in medical and nursing schools, limited openings for residency training, and continued to reduce hospital beds and the number of hospitals themselves. Ministries of health began to encourage reliance on paramedical personnel such as nurse practitioners and midwives. Bureaucrats and their political masters required closer scrutiny to billable procedures and hesitated adopting expensive innovations in imaging and diagnosis, including CT scanners and MRI machines. Efforts continued to reduce the incidence of disease by encouraging preventive attitudes to ill health, to generate efficiencies through organization reform and the application of information technology, and to challenge the perceived wastefulness of fee-for-service medicine. In some reformers' ideal systems, all healthcare providers would be salaried employees of provincial ministries of health. And with the savings generated by squeezing fat from medical and hospital services, it would be possible to expand Canadian medicare into areas such as pharmacare.

By the late 1990s, one effect of a decade of relative rationing of resources for Canadian healthcare was to generate public and professional concern that the quality of healthcare was being jeopardized by cost containment. The visible effect of limits on supply was the emergence of shortages characterized by growing queues for access to family physicians, emergency room services, and several kinds of specialized care. Media "horror stories" about lack of timely healthcare for the less fortunate and queue jumping by the privileged (including Members of Parliament and some senior government officials) were both cause and symptom of declining public confidence (see particularly the essays in Gratzer 2002).

Debate again flared about the effect of maintaining equality of access through equality of rationing/deprivation and whether or not a constrained system was undercutting its own principles. Critics from both right and left seemed to agree that Canadian healthcare contained such nonfinancial impediments to accessibility as shortages of service in rural areas. Nothing short of a lottery-like approach to healthcare rationing could prevent the well educated and savvy from doing a superior job of gaming the system on behalf of themselves, their families, and their friends - and even then the rich would still be able to jump the queue by crossing the border.

Critical private think tanks began tracking waiting times for diagnostic and medical and surgical services. Critics claimed that the quality of Canadian healthcare was now falling below both

US and European standards. Long-simmering concern by market-oriented economists and political theorists that a managed system developed the inefficiencies associated with socialist command economies was reflected in increasingly harsh criticism of Canadian medicare as comparable only to the Cuban and North Korean systems. Why not get over the obsession with being different from the United States and learn lessons from the mixed private-public healthcare systems of countries such as Sweden, France, and even Britain (whose venerable National Health System had always had to compete with private medicine)?

Debate expanded to include the possibility that the managers of the system, understandably inclined to present to government the ideas that government wanted to hear, had misread underlying public demand for health services. New questions were being asked about incentives to innovation in Canadian healthcare. Were healthcare planners properly attuned to the development of such long-term issues as the impact of demographic change, including declining birth rates and increased life expectancy (Robson 2001)? Market-oriented critics suggested that it was generally desirable, for both efficiency's and equity's sake, to subject a managed monopolistic system to the breezes of change generated by competition.

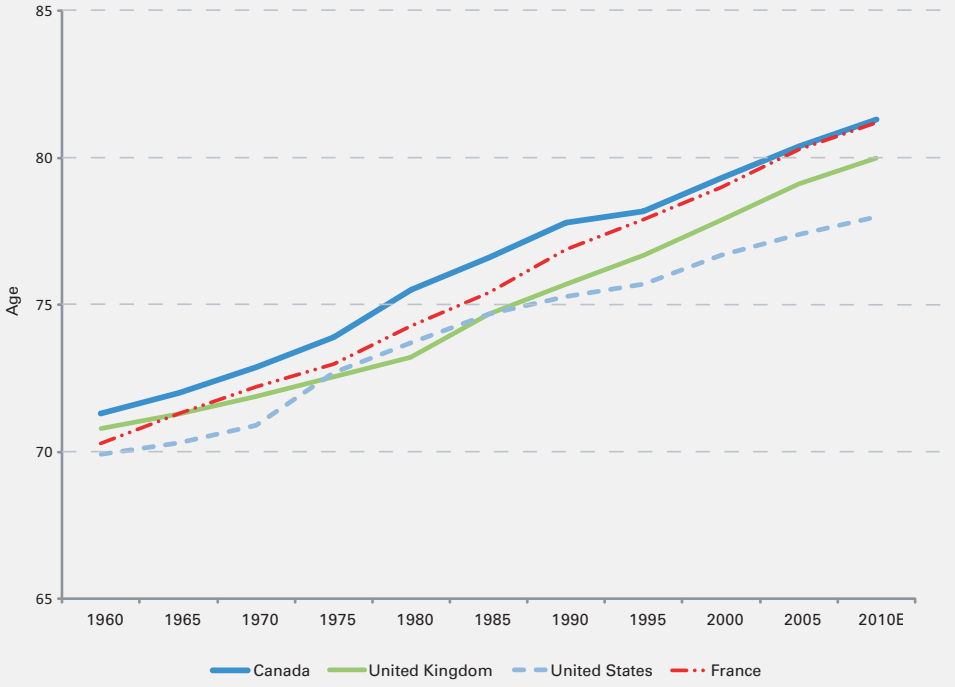
Defenders of the system, ranging from the prolific Dr. Michael Rachlis to the influential health economist Robert Evans, attacked critics' motives, credentials, and statistics, urged further reform, decried private-sector medicine as inefficient and expensive, and resisted any relaxation of *Canada Health Act* constraints as likely to lead to unequal access without compensating benefits. They argued that many alleged shortcomings of Canadian medicare were in fact problems germane to all modern healthcare systems. In any case, if money could buy queue jumping or other forms of preference through resort to an expanded private sector, then Canadians no longer would have equal-access, single-tier healthcare. Their system no longer would be significantly different from or better than US healthcare. Canadians would not be treated equally or fairly.

As the perception developed that Canadians were losing confidence in their healthcare system, terms like "unsustainable" entered the discourse. Politicians and healthcare bureaucrats began privately to confess to something like existential healthcare despair.[6] The late 1990s and early 2000s generated another round of inquiries, commissions, and proposals. Think tanks, stakeholder organizations, provinces, and the federal government again focused their attention on the future of Canadian healthcare (see Boothe and Carson 2003).

The two national inquiries were the Royal Commission on the Future of Health Care in Canada, chaired by former Saskatchewan premier, Roy Romanow, and the Senate Study on the State of the Health Care System in Canada, chaired by Michael Kirby. Both reported in 2002. The Romanow report stressed the importance of retaining and expanding a *Canada Health Act* system, a legislated single-payer monopoly perceived to be in accord with fundamental Canadian values. The Kirby committee was more inclined to encourage exploration of greater reliance on certain forms of private delivery of healthcare, but made only tentative suggestions for reconsidering the constraints of the *Canada Health Act*. Both reports, as well as other provincial studies, advocated

6 My correspondence from those years contains letters from prominent politicians expressing these feelings and encouraging me to write further critical pieces. Most well-placed healthcare providers had numerous stories of being approached for help in queue jumping, sometimes by some of medicare's most vociferous advocates.

Figure 3: Life Expectancy at Birth, Canada and Select OECD Countries, 1960–2010E



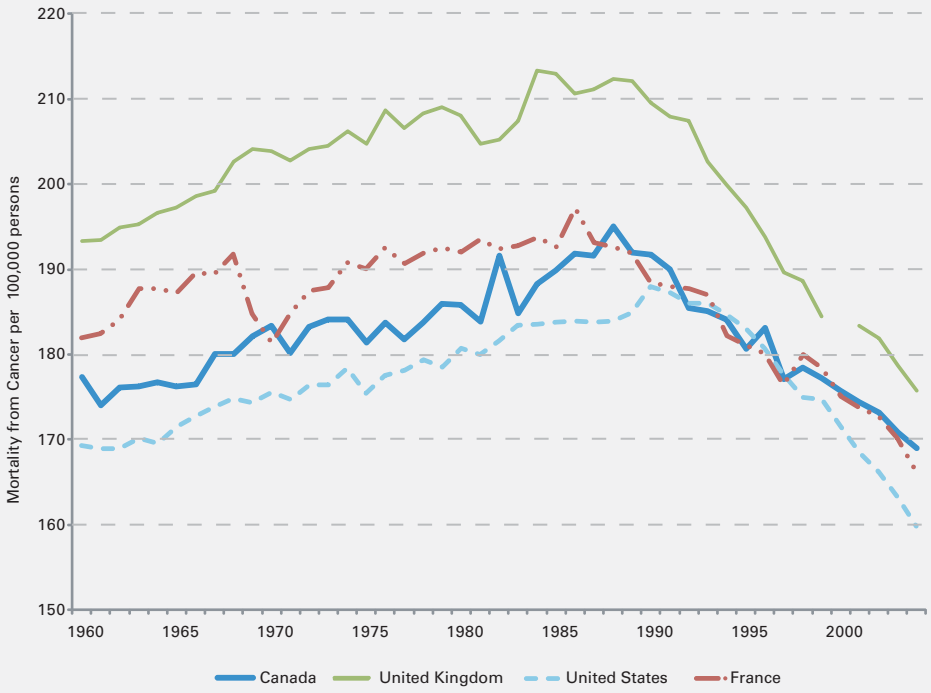
Sources: OECD 2010; and author's calculations.

more attention to primary care reform, improved organization, and an increased emphasis on health promotion and preventive medicine. In much of the discussion underlying these studies, however, there appeared to be less confidence that public demand for healthcare was manipulable or suppressible, or could be contained without significant increases in spending. It was possible that governments had been misled by eager (and in their own way, self-interested) cost cutters who had misjudged the extent to which Canadians' demand for world-class healthcare could be suppressed and satisfied on the cheap.

Accountable Medicare in the Chaoulli Era, 2001-10

Although confidence in Canadian health insurance appeared to be waning, there was little support for radically changing the system. Physicians, for the most part, were unwilling to abandon fee-for-service payment (the traditional piecework approach) for a salary or capitation system. Governments were hesitant to resort to coercion. Despite the constraints of the *Canada Health Act* in severely limiting the sphere of private practice, doctors, like other providers, enjoyed the significant power flowing from their personal mobility. Canadian policy always had to be cognisant of the continental aspects of the labour market in healthcare providers.

Figure 4: Mortality Rate from Cancer, Canada and Selected OECD Countries, 1960–2004.



Source: OECD 2010.

The Canadian public similarly resisted significant reallocation of funds away from acute care, still seemed to prefer family doctors to nurse practitioners, and lessened its indulgence in some unhealthy habits, such as smoking, only to indulge in other unhealthy habits, such as overeating. Even as Canadians in fact did become healthier – as measured by virtually every index of morbidity and mortality (Figures 3 and 4) – they relied as heavily as ever on traditional healthcare providers. They also supplemented these services with increasing private spending on uninsured healthcare services, including both prescription and nonprescription drugs, dental and vision services, and a wide range of nontraditional or "alternative" therapies.

Citizens who were freed from old ways of becoming sick and needy found they had new healthcare needs, some of them related to new and higher expectations. Baby boomers needed less treatment for lung cancer and heart attacks, more treatment for their torn ligaments and worn-out joints. They wanted public funding to pay for expensive and experimental procedures, including best-practice procedures, both within and without the country. Preventive approaches to illness involved significant expense in monitoring, counselling, and actively treating people who previously had been deemed healthy but were now judged vulnerable because of "risk factors." Prevention

now involved the expense of attempting to vaccinate the whole Canadian population against even mild strains of influenza. Conditions that previously had been viewed as normal or nonmedical, ranging from short attention span to anxiety and the senility of old age, were now understood as requiring medical intervention (Conrad 2007; Rosenberg 2007). Every kind of biomedical research and clinical investigation was thought by one group of another to have high and ongoing priority. Social scientists and reformers urged further costly interventions to try to even out disparities in health outcomes they believed were determined by socioeconomic status. If the future of healthcare in an era of unprecedented longevity was to be ever more patient-centric and individualized in the new world of twenty-first century genomics, ever more reliant on high technology, ever more an attack on aging itself, it was perhaps wishful thinking to imagine that total healthcare costs could be held constant as a proportion of national income, let alone actually decrease in the way that advocates of preventive and curative care had hoped.[7]

On the other hand, Canadians offered little support for reform proposals that seemed to presage the growth of two-tier medicine on a widespread or visible basis. Political trial balloons about user fees or other financial deterrents generated no enthusiasm. Suggestions to reduce the comprehensiveness of coverage were more than counterbalanced by lobbying campaigns to insure new and sometimes extremely expensive forms of treatment. There appeared to be no public support for changing the Canada Health Act to permit the expansion of private-sector medicine. But nor was there political will or support to expand the system to provide, for example, universal drug coverage on a national (and portable) basis. In this respect, governments were perhaps sensitive to history's lessons about the problems of cost escalation.

Given these constraints, governments at the beginning of the twenty-first century maintained and strengthened the Canadian medicare system mainly by increasing their spending. "If there is a unifying theme to the past decade in Canadian Health care," the Canadian Institute for Health Information reports in its major 2009 retrospective, "it is abundance.... [T]he last decade has seen the biggest sustained increases in health care spending since the dawn of medicare" (2009, 107, 119). Spending increases already had begun before the prime minister and the premiers reached an agreement on healthcare renewal in 2003 to add 17.3 billion in additional funding (First Ministers 2003), followed by their $41 billion plan to strengthen healthcare in 2004 (First Ministers 2004). Allowing for double counting, the total spending increase was to amount to approximately 60 percent in real terms over the decade from 1999 to 2009. There was new money available for diagnostic equipment, for a sustained attack on waiting times, for hospital emergency services, for many kinds of research, and for the expansion of Canada's supply of healthcare providers. Having cut the output of doctors and nurses in one decade, healthcare planners sharply increased it in the next.

7 A complex debate developed over the impact of longevity on healthcare costs. Sixty-year-olds in 2010 tended to be healthier and incur less in the way of healthcare costs than did 60-year-olds in 1960. The problem was that 90-year-olds still had proportionately the same need for help in 2010 as their grandparents had in 1960, there were many more of them, and their expectations for help in the way of joint replacement, organ transplant, and end-of-life care far exceeded those of the innocent old folk of the past. On the other hand, it was still at least theoretically possible to posit breakthroughs that enabled most people to live very long and disease-free lives until they reached some natural limit, whereupon they would expire quickly and cheaply, like the collapse of Oliver Wendell Holmes's marvellous one-horse shay. Legalization and widespread acceptance of euthanasia would also be an effective healthcare cost-containment measure. The longevity debate took on different dimensions when reframed to include the economic consequences of declining birth rates.

One of the major themes of this era in both politics and healthcare was an increased emphasis on the idea of accountability. Years of physicians' interest in "evidence-based" medicine now blended with consumer discontent, political pressures, and other factors to generate movement to measure health outcomes and waiting times more accurately, to develop electronic health records, and to create other forms of benchmarking to help governments and voters evaluate the costs and benefits of their system and make it more responsive (see, for example, Manuel et al., 2009).

Elections are the ultimate mechanism for holding governments accountable for their stewardship. But one result of frustration with the health insurance monopoly legislated by the *Canada Health Act* was litigation aimed at holding governments legally accountable for carrying out their healthcare commitments. In June 2005, the Supreme Court of Canada ruled in the case of *Chaoulli* v. Quebec that it was contrary to Quebec's Charter of Human Rights and Freedoms for governments that do not provide timely healthcare effectively to forbid its purchase from private suppliers.

The *Chaoulli* decision, which came as a considerable surprise to many supporters of Canadian medicare (but had been anticipated in the Kirby report), generated a flood of both favourable and unfavourable commentary. It specifically applied only to Quebec, but in general appeared to set a framework for what Patrick Monahan (2006) has called the introduction of accountability as a sixth principle of Canadian healthcare. As of 2010, *Chaoulli* has sparked a significant expansion of private healthcare alternatives in Quebec – where it is not clear the *Canada Health Act* effectively still applies - while casting a long shadow over the healthcare systems of other provinces (Cousins 2010). If the courts are prepared to see access to healthcare as a constitutionally protected right and to make binding rulings about what might be called medicare malpractice, the *Canada Health Act* structure has become dependent on satisfactory accountability as determined by judges. The single-payer approach to Canadian healthcare is broken in Quebec and vulnerable in all other provinces. Cost control by rationing supply probably is no longer possible.

In 2010, in the aftermath of the traumatic recession of 2008/09, Canadians again have begun to experience national frissons of anxiety about the future of healthcare. It does not seem possible to imagine that heavily indebted governments could continue to make larger investments in healthcare than real economic growth or the state of their revenue seems to warrant without retrenching on other desirable forms of social spending. But nor does it seem possible that an aging population with constantly increasing expectations of entitlement to first-class modern healthcare would accept less than first-class healthcare in the age of *Chaoulli* and other forms of accountability. Yet there seems to be no political will to change the status quo. There seems no basis of political support for cutting back on medicare benefits, refunding the system through substantial tax or premium increases, or expanding private sector healthcare. How can Canada's most expensive and most popular social program, now showing many of the strains of its own aging, be sustained?

Lessons

Canada's 42-year experience with national health insurance suggests to this historian two major conclusions, or lessons, and two minor ones that might help to guide public policy in the future.

Get Used to It

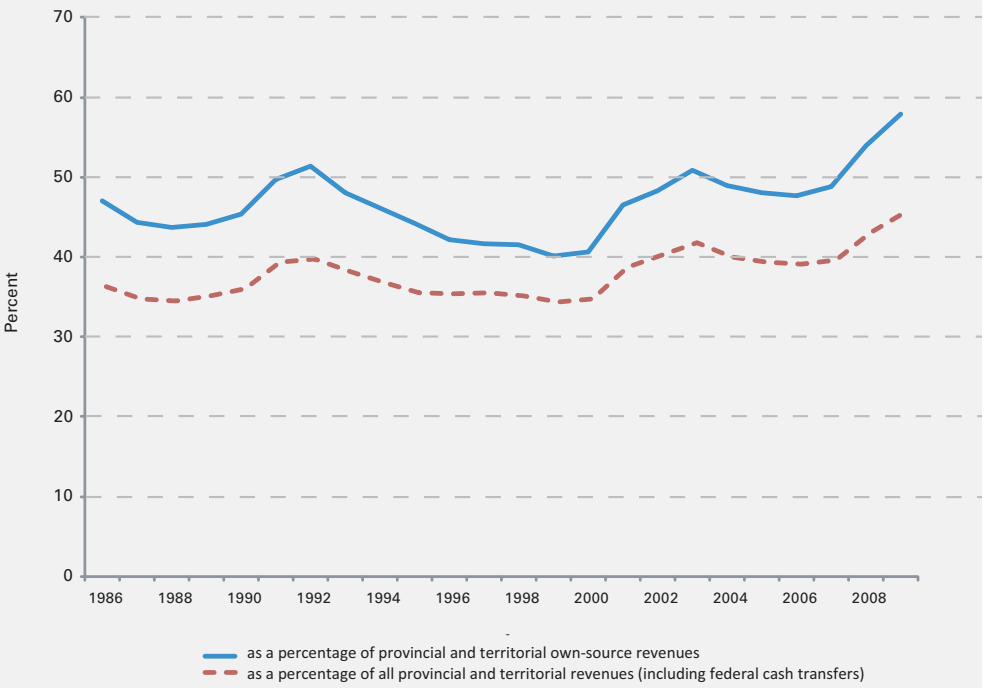
In the second half of the twentieth century Canadians continued to value modern healthcare services highly. They did not seem particularly distressed by increased costs or increased government spending on healthcare, and they continued to support the ideal of equality at the heart of the medicare vision. They wanted more and better healthcare services, but most voters were wary of privatization initiatives in this field.

Doctors' offices and hospital wards had become very different places from those of the 1960s – in fact, by the twenty-first century, there were no longer hospital wards per se – and many different procedures were carried out using once-unimaginable diagnostic, surgical, and electronic technology. The evolution of modern healthcare, driven by an enormous global research effort, would have taken place whatever Canada's health insurance arrangements had been. The Canadian healthcare economy probably would have grown faster than national income, as it has in all advanced countries, and probably would have reached roughly the same size and generated similar problems and debates. Citizens everywhere believe in the efficacy of modern healthcare. Healthcare industries have become the largest sector of all advanced economies. Every affluent country wrestles with healthcare issues near the top of its public policy agenda. In these regards, Canada is not and never will be distinctive.

The record of attempts to curb the growth of healthcare spending in Canada, which sometimes seems like a chapter in the biography of King Canute, suggests that significant reductions in the burden of healthcare are unlikely. Healthcare spending is not apt to shrink as a percentage of GDP or of government income; it is more likely to continue to grow. It may be that the US experience of an affluent, politically egalitarian democracy generating constantly increasing citizen demands and expectations in the realm of healthcare is not so much an international anomaly as it is a harbinger. As in many other social trends, the United States probably is setting the pace to which the rest of the world, not always knowingly, aspires. North of the forty-ninth parallel as well as south of it, pressures to expand the supply of the highest quality of healthcare, and to resist rationing, will continue to be relentless.

In the long view of history, the growth of modern healthcare and most healthcare spending is surely cause for celebration rather than hand wringing. Outcomes in terms of increased longevity and reduced pain and suffering have been magnificent. When rich societies spend a growing proportion of their wealth on health and education, as opposed to guns and gewgaws, they surely have sensible priorities. Modern tut-tutting by economists and other cost controllers about healthcare spending sometimes seems to reflect a view from olden days that healthcare drains resources from more productive uses. If only we did more healthy things, whisper the puritanical spirits of our ancestors, we would not be wasting all this money on doctors' bills. For most people

Figure 5: Public Healthcare Expenditures as a Percentage of Total Provincial and Territorial Revenues, 1986–2009



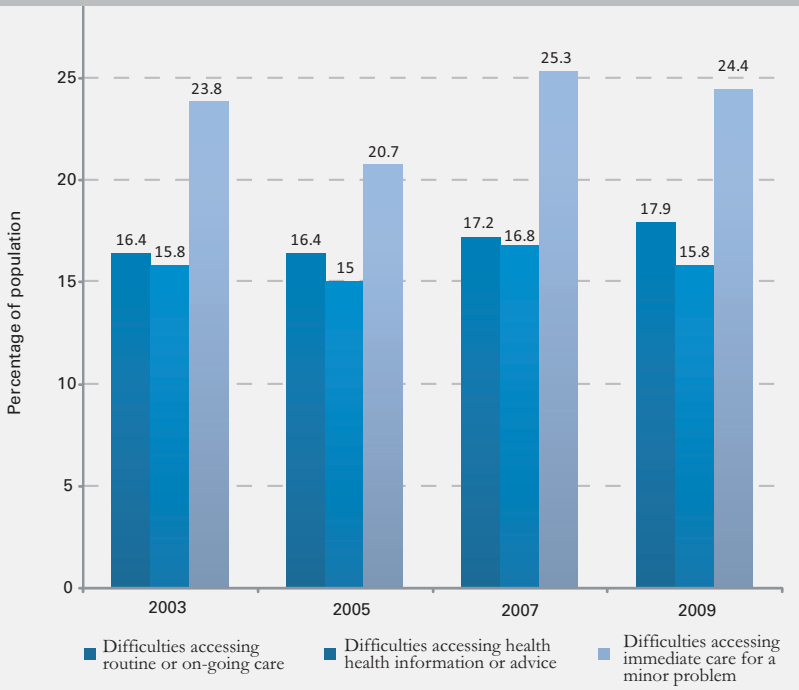
Sources: Canadian Institute for Health Information 2009, "National Health Expenditure Trends, 1975 to 2009;" Finance Canada Fiscal Reference Tables; and author's calculations.

in the real world, though, healthcare expenditures are one of the best uses of resources on their behalf (an attitude that mocks insurers' concept of simple moral hazard).[8] It is no drain on Canadian society to have a large, flourishing, innovative, efficient, and expanding healthcare sector. The problem is not to spend less, but rather to spend better.

The lesson is not to give up on sensible measures of healthcare cost control. Rather, it is to recognize that, in a broad sense, modern healthcare has moved fully into the tent of our social spending, and will always take up a large and probably a continually increasing share of the available space (Figure 5). We should welcome it, get used to it, and celebrate it, even as we wrestle with the problems it unintentionally generates. As a mischievous physician friend commented to the author, the tent is not being taken over by smelly camels, but rather by choirs of ministering angels. Healthcare is a major social good, jostling pushily in the consciousness of all of us with the other social goods we want our politicians, and our own pocketbooks, to support. The problem is how to welcome and nourish and support our caregivers while recognizing the legitimate claims of the suppliers of other social programs, from education to antipoverty measures, some of which in fact have a major positive impact on the health of the population.

8 As the patient rebellion against Health Maintenance Organizations in the United States in the 1990s seemed to show (or as most males asked to ponder the controversial psa test for prostate cancer realize), the case for the "extra" test or doctors' visit seems very different for the individual worried about his or her health than it is for the insurer's economist applying hindsight to delineate and excoriate unnecessary procedures.

Figure 6: Self-Reported Difficulty Accessing Health Services, Health Information or Advice, or Immediate Care, Canada, 2003, 2005, 2007, and 2009



Source: Statistics Canada, Health Services Access Survey.

Canadian healthcare history also suggests that policymakers should get used to citizens' insistence that healthcare be available to everyone without financial hindrance, and with as few other hindrances as possible (Figure 6). It is unlikely, for example, that provincial governments can implement point-of-service fees or even tax-based clawbacks if they are provocatively described as user fees (as the Quebec government learned while this essay was being drafted). The very idea of user fees has come to be widely perceived by Canadians as involving unfair discrimination against the poor and the sick. Experience also seems to rule out as politically unacceptable such changes to the system as thoroughgoing privatization, because of suspicion that it would enable significant queue jumping by the economically or politically or geographically privileged.[9] On the other hand, the use of monopoly power under the *Canada Health Act* to attempt to ration scarce healthcare resources has been rejected in both the court of public opinion and the Supreme Court of Canada. Unimpeded access to high-quality healthcare is effectively seen as a human right in Canada. Most basic healthcare in Canada will continue to be delivered by an expensive public system that offers easy and equal access to all citizens. Canadian medicare as we have known it since 1968 may be reformed, improved, expanded. It will not be dismantled.

Nor will the confused division of responsibilities in Canada's federal system be neatly sorted out. Given that Ottawa's proportionate contribution to medicare as it now exists apparently

9 The consequence of creeping privatization was the perceived problem that inspired the movement to create the *Canada Health Act* in the first place, and explains why many advocates of a parallel system of private healthcare, somewhat like private school systems, realize that it might be necessary to follow the model of some European countries by developing controls on how providers divide their time between public and private systems. The important history of this issue noticeably was not considered by the Supreme Court of Canada in its *Chaoulli* decision.

has declined substantially since 1968 (the exact size of the federal contribution is fiercely contested; the arguments and the calculations are almost hopelessly complicated), given continued provincial resistance to federal attempts to steer the healthcare agenda, and given what sometimes appears to be a significant decline in political enthusiasm for a highly centralized approach to social policy, it might be tempting to suggest that one "solution" to healthcare as a national issue is simply for Ottawa to get out of the business and let the provinces go their own way. Decentralization and diversity and competition among the provinces might generate better practices, healthy emulation of excellence, and eventually some new forms of interprovincial coordination.

But history does not suggest that voters and politicians would let these flowers bloom. With Quebec perhaps excepted, it is difficult to see how political support could be mobilized to defend Ottawa's effective withdrawal from the lead role in Canadian health insurance. Canadians do look to Ottawa as their national government. Rightly or wrongly they think of medicare as a national social program. Rightly or wrongly they expect significant portability of benefits across provincial boundaries. Outside of Quebec, provincial governments have had little political support for experiments with approaches to healthcare that seem to offend the principles Ottawa has upheld. Nor has there ever been provincial agreement on funding mechanisms that do not involve a significant federal role. The confusions and frictions incident to the workings of federalism in Canada, as in most federations, are messy, constant, and sometimes maddening. But they are a basic political reality, a fact of Canadian life since 1867, and cannot be wished away.

The point of "getting used to it," however, is not glumly to accept the status quo, but rather to discard politically impossible panaceas, however desirable they might be in theory, in order to focus on a realistic range of possibilities for changing and improving the system.[10] The most intriguing of these possibilities is to slow or even reduce the growth of public funding for medicare by reconsidering the definition of universality.

Revisit Universality

Most of the anxiety about the future of Canadian healthcare stems from a political judgment that democratic governments cannot contain the demand for service, will be unable to raise new revenue to pay the bills, and therefore have to starve other vital areas of social and economic spending.

Even assuming that political resistance to general tax increases in Canada may have strengthened since the 1960s – it may not have – it does not necessarily follow that Canadians oppose taxes earmarked for causes they cherish. Polls usually suggest otherwise. Historically there does not seem to have been implacable resistance to the levying of healthcare premiums by provincial governments, nor have recent experiment's such as the Ontario Health Premium been received with devastating hostility. It is very possible that governments can mobilize the political support they need to introduce more flexibility in health financing.

10 Also, it should be said, to encourage the discarding of the elitist and very Canadian habit of berating the citizens of a democracy for their self-interest and alleged intellectual shortcomings in clinging stubbornly to views of the desirability of cheap and accessible healthcare, and thus having priorities not shared by policy wonks and politicians.

On the other hand, Canada's experience does suggest that alternatives involving point-of-service fees, extensive delisting of insured services, or unrestrained expansion of private-sector medicine are politically unacceptable. Canadians insist on ease and equality of access to first-class healthcare. This appears to be what is currently understood to be the meaning of "universality" in Canadian medicare: universal access on an equal basis.[11]

It may well be possible – as it has been historically with other Canadian social programs – to retain that concept of universality in healthcare while revisiting the idea of a universal entitlement to full payment for necessary hospital and medical services. The simple, politically realistic, and philosophically important phrasing of the question is this: Why should government continue to pay for the healthcare of the well-to-do? Why should the state pay for the banker's coronary bypass, the retired hockey player's hip replacement, elbow reconstructions for the ladies who lunch? And so on. Does the state entitle everyone to all the healthcare they need, or does it entitle the economically needy to the benefits of modern healthcare?

As we have seen, the primary historic rationale for universal entitlement was to avoid the public stigma of means testing in healthcare and the other social programs that were the foundation of the welfare state in the first half of the twentieth century. Universality was not so much a goal of public policy as it was a means to deliver what was perceived to be fairness or equal treatment at a particular time in the evolution of social services. By the 1970s, however, governments came to believe that, through the use of the tax system, they could withdraw from the expense that universality and the implicit entitlement to it entailed and move social programs onto a needs basis. Learning to use language carefully and to introduce changes gradually, they managed without political upheaval to phase out both the universal baby bonus and the universal old age pension. It was not necessary, and no longer even worth defending politically, to send baby bonus and old age cheques to the affluent. The wasteful or redundant connotations of universality had always been the Achilles' heel of the concept of cradle-to-grave social welfare.

Experience therefore seems to suggest that it would be possible to phase out universality of entitlement in Canadian healthcare without political upheaval. This might well have happened in the 1980s if either the Trudeau or the Mulroney governments had not chosen to try to use the force of law to experiment with the possibilities of monopoly medicare. A generation later, with that experiment having floundered in the face of public and judicial resistance, and in a climate of even greater anxiety about the long-term implications of rising healthcare costs and responsibilities, it seems time to consider taking Canadian health insurance in this new direction. It clearly would lighten the burden on governments if reimbursement for healthcare expenses could be on a modernized means basis.

One immediate response to any proposal to change a policy is to demand details. How exactly is it to be done? Insistence on pre-clearing all details before initiating any change is, of course, a common resistance or delaying tactic in politics, perhaps particularly so in conservative Canada. As most politicians understand, however, there have to be horses before there are carts, which is to say that a determination to make changes then drives the development of detailed proposals.

11 Some suggest that Canadians may not be as resistant to user fees for healthcare as it is commonly assumed. As often happens with tax or fee increases, once they are implemented citizens do adjust, and many other countries have such fees or co-payments. The Canadian record so far, however, is that politicians have found it particularly difficult, indeed virtually suicidal, even to advocate bringing in user fees. Canadians are distinctively determined to guard this characteristic of what they see as their distinctive healthcare system.

We have seen an (imperfect) example of this in the recent US experience with reforming a vastly more complicated healthcare system than Canada's.

The key is to understand that changing Canadian healthcare is ultimately a political choice. The despair felt by many in the policy community about changing the healthcare system is not warranted. Politicians should take heart from the realization that the iconic status of Canadian medicare is not a barrier to sensible reform. We do have the experience and the vocabulary to initiate and to explain and defend changes that can strengthen the system while preserving its fundamental values. Canadians expect that those who need healthcare will get it, without financial hindrance. Past experience suggests that they will also accept the view that citizens of means should pay a progressively increasing portion of their healthcare bills – just as they pay for the care of their children and save for their retirement. Icons and entitlements only appear to be set in stone: so long as their basic function is preserved, they can be and have been moved around, reconstructed, modernized.

Developing the exact mechanisms involves choosing from a menu of options, each of which has articulate and passionate champions. The starting point I favour is to consider expanding upon the de facto means testing of health insurance costs implicit in the levying of designated and progressive premiums, as part of the income tax assessment, as in Ontario and now, in a small measure, Quebec. The costs incurred by individual use of the system then might be factored gradually into the equation as partially taxable benefits. Other forms of healthcare premiums, medical savings accounts, compulsory catastrophe insurance, and a policy of designating healthcare expenditures as the individual's partial responsibility in progressive proportion to income (see, for example, Furman 2007) also might be considered. The extensive and apparently successful use of phase-in periods for important tax and other policy changes now used by governments seems highly pertinent to any discussion of the practicality of loosening logjams created by a traditional sense of entitlement.

It almost goes without saying that there are many complexities to be wrestled with, much devilment in any attempt to specify details. To a historian, this aspect of the problem seems secondary, a plumbing issue. Would-be reformers' past tendencies to offer highly detailed proposals without considering their political practicality in the Canadian setting have been a recipe for irrelevance. Changes that might work in Sweden, France, Switzerland, Botswana, Cuba, or Ayn Rand's Erewhon have to be saleable to Canadians – keeping in mind the lessons of our past.

The basic proposal is to recognize that many Canadians can afford to meet a significant proportion of their healthcare needs out of their personal incomes. It would lighten the burden on government and on the tax system – and, so long as total healthcare costs remained constant, would not involve a new burden on the economy. Of course, a redesigned system would have to take into account such issues as income variability, disincentives, start-up costs, phase-in times, intergenerational equity, and other matters, but these are all part of the normal process of making considered public policy.

The question of whether a new balance between the public and private sectors in the provision of health insurance is desirable intersects with the means issue. In view of our history, though, it seems distinctly secondary. Canadians are too suspicious of private insurers, queue jumpers, the idea that wealth should confer privilege, and other practices common in the United

States to acquiesce easily in a major expansion of private-sector health insurance or healthcare. They would be more comfortable, at least in the short term, with the idea of significant reform within the borders set by the *Canada Health Act*. Such reform is possible, has precedent, and ought to appeal to politicians who are crafting platforms aimed at protecting the flexibility of the public purse.

Re-emphasize Medical Necessity

Canada's historical experience of the interactions of interest groups that express the viewpoints of healthcare providers, consumers, provincial governments, bureaucracies, and other stakeholders underlines the old maxim that, by the mid-twentieth century, healthcare had become too important to be left in the hands of doctors. At the beginning of the twenty-first century, most Canadians would endorse the view that healthcare is also too important to be left in the hands of politicians, bureaucrats, and economists. The decline of deference to elites and authority was a constant theme of both medical and political history in the last third of the twentieth century. It may have been furthered, rather than arrested, when Canadians began to perceive that, in the new healthcare system, governments appeared to be confusing cost control and healthcare concern in their attempts to suppress patient demand. Cost control was being attempted in the guise of good medicine, but often with neither the cooperation nor the approval of the professionals most qualified to practise good medicine.

The overall erosion of confidence in the system and its managers is unfortunate. The lesson appears to be that decisions shaping the excellence of the healthcare system should be made primarily by experts in providing healthcare, and only secondarily by governments. This does not preclude constant efforts to use resources efficiently. But governments and economists might remember that their mandate is limited to finding ways to pay for the very high levels of healthcare that modern medicine has made possible and that the Canadian people clearly expect to receive. Diagnosing and treating our sicknesses is mainly the job of doctors, interacting with patients' perceptions of medical need. The notion that physicians' economic self-interest – under, say, fee-for-service payment – constantly overrides their professionalism, idealism, "real" patient needs, and other considerations also might reflect the prejudices, self-interest, and penchant for intellectual reductionism of groups that are contesting for power and influence within the system. Not to say that this notion is wrong, but the real world of healthcare today seems too complex and too fast moving to be explicable in simple pejoratives.[12] The need for groups to work more smoothly and harmoniously, with more trust and mutual respect, within the healthcare system seems palpable.

12 While the argument that supplier interest was important in expanding healthcare spending in the first two-thirds of the twentieth century may have some superficial merit (debatable merit, for convincing historical analysis of the issue does not seem to exist), it is difficult to see how the model easily holds today. Patient lobbying for more spending on everything related to healthcare seems to be a more powerful influence on governments than the more reasoned pressures from healthcare professionals, who in fact are often resistant to unproven practices. As a case in point, while this essay was being written, neurologists in Canada, along with the research establishment, were resisting intense pressure from multiple sclerosis patients, aided by the media, to have resources poured into testing procedures advocated by a single maverick Italian surgeon. In virtually every other area of healthcare, from diagnostic testing to flu vaccination to spinal and open-heart surgery, professional opinion was either divided or cautious in the assessment of proposals to increase spending. The US Congress passed the most sweeping healthcare reforms in the history of the United States with widespread professional support, including that of the American Medical Association, in the teeth of public concern about the establishment's rationing agenda.

Professional healthcare providers are also inclined to notice how seldom opponents of fee-for-service payment acknowledge the disincentives to efficiency that accompany remuneration by salary or capitation or other forms of fixed payment. Ironically, the notion of remunerating hospitals according to the number of services actually performed, sometimes called activity-based reimbursement, but actually fee-for-service hospital care, recently has enjoyed a revival. More generally, the most important economic determinant of incentives to healthcare workers is surely the amount of competition in the medical marketplace.

Revitalize the Healthcare Marketplace

In a way that Canadians do not like to recognize, modern history has already passed stark and sobering judgment on Canadian medicare. Despite the system's popularity and iconic status; despite the belief by many Canadian health experts that the *Canada Health Act* system, a single-payer government monopoly, is the best way to deliver modern healthcare; and despite years of nationalist proclamation that Canadian health insurance ought to be a model to the world (and especially to the United States), no country has adopted the Canadian model. In the eyes of the world, Cuba and North Korea perhaps excepted, Canadian medicare is not a model. The vast majority of global healthcare experts – led, of course, by those who designed healthcare reform in the United States – do not consider the Canadian system to be a practical ideal. While Canada is widely perceived as a high-achieving global participant in many areas of biomedical research – a capacity that predated and has developed largely independently of the medicare system – it is not clear that there is parallel respect and demand for other areas of Canadian healthcare expertise. Canada has not stood particularly high in various attempts to rate the quality of national healthcare systems, ranging from the World Health Organization's highly controversial standings through recent comparisons that have us vying with the United States for bottom status (World Health Organization 2000; Davis, Schoen, and Stremikis 2010). Put more bluntly, since 1968 Canada does not seem to have generated much in the way of exportable health insurance excellence.

To a historian this suggests that the distinguishing feature of Canadian healthcare since 1984 – the attempt by government to maintain a single-payer monopoly – appears to be problematic. It raises important issues of individual liberty and freedom of choice, so far only partly resolved by the *Chaoulli* decision of the Supreme Court of Canada. As an administered system, with personnel, pricing, and supply decisions abstracted from market signals, it may well be prone to serious inefficiencies and misallocation of resources that are difficult to correct, sometimes even to identify. Mainstream economists' critiques of protected monopolies in other areas generally have been considered substantially accurate, and came to underlie the movement towards retrenchment and privatization in the last third of the twentieth century.

It is difficult to see why the Canadian approach to health insurance, once proudly labelled socialized medicine, should continue to be insulated from the forces of competition in the supply of care and/or insurance – either competing private alternatives, or at least some fresh winds of internal competition.[13] The hubris of politicians, civil servants, economists, and managers who believe their expertise is generally superior to market forces in dictating the allocation of healthcare resources does not seem to be supported by either the experience of other countries or the record of Canada's distinctive healthcare history. While history seems to support the view that Canadian public opinion resists injections of market forces in healthcare, and in this regard will be hard to change, there does seem to be good reason to urge that attempts be made to encourage flexibility and experimentation. And it ought not to have to be said, but unfortunately does, that no healthcare system, private, public, or mixed, will perform optimally without an adequate long-term funding plan.

On the other hand, the notion that large doses of competition, market prices, and other liberalizations of the Canadian system would mean major cost savings may be somewhat of a

13 See, for example, the conclusions of Bloom et al. (2010) with respect to hospitals in the United Kingdom.

chimera. While it is certainly good to use resources as efficiently as possible, the historical growth of healthcare spending around the world seems to be a function of rising wealth, rising consumer expectations about healthcare, and technological and scientific innovation. No Western countries appear to have been able to contain the growth of healthcare spending to rates less than the increase in their national wealth. In the United States, the country where healthcare and health insurance markets function with the least amount of government involvement, healthcare spending as a share of national income has risen to its highest figure in history. This seems to be further evidence that, in any prosperous democracy, citizens' demand for high-quality healthcare will be hard to satisfy or contain. The main social spending in wealthy countries will continue to be aimed at improving the quality and length of citizens' lives. This is not such a bleak prospect. In the long view of history it might even be cause for celebration.

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