

Health Care In Canada: Incrementalism Under Fiscal Duress

Fiscal constraints have eroded Canadians' enthusiasm about their single-payer system, but their commitment to universal coverage is holding firm.

by C. David Naylor

PROLOGUE: Canada's health insurance system, the nation's most popular publicly financed service, has for years demonstrated a capacity to deliver universal, high-quality medical care for considerably less per patient than is the case in the United States. But now new strains are testing Canada's commitment to maintaining its treasured system. Over the 1990s, as Canada sought to eliminate its soaring budget deficit, the federal government reduced its financial commitment to the provincially administered health insurance plans. The plans, in turn, sharply squeezed their spending on hospitals, sorely testing physicians' and nurses' tolerance for major change. In sharp contrast with the United States, which has increasingly relied on market-driven methods to achieve the modest reductions in hospital capacity that had been recorded, Canada used a combination of fiscal and regulatory initiatives to radically restructure its hospital sector. In this paper David Naylor, a physician-scientist who also is well regarded as a student of the system, discusses the evolution of the provincial health plans.

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ABSTRACT: Driven by fiscal pressures in the 1990s, Canada's provincial Medicare systems cut inpatient care, expanded community services, and consolidated hospitals under regional authorities in nine of ten provinces. Public confidence has been badly shaken by the transition. No province has successfully integrated services across the continuum of care. Home care and prescription drug coverage vary from province to province. Efforts to reform physician payment have stalled, and capacity to measure and manage the quality of care is generally underdeveloped. Thus, for the next few years, policymakers must stabilize the acute care sector, while cautiously pursuing an agenda of piecemeal reforms.

FOR YEARS, PUBLICLY FINANCED health care has drawn high approval ratings from Canadian citizens and been widely regarded as the nation's most cherished social program. Administered in the ten provinces and two northern territories, the twelve nonprofit Medicare plans have common elements as a result of federal funding conditions. Each plan offers universal first-dollar coverage of necessary medical and hospital services, including long-term care; none impedes the patient's free choice of physicians; and all cover drug benefits for senior citizens, albeit with copayment provisions. Unlike other industrialized nations, Canada has essentially no parallel private system, because investor-owned carriers are barred from covering any services that are publicly insured. In a nutshell, Canada has embraced private delivery of services by both nonprofit and investor-owned providers, while insisting on public financing to contain costs and maintain equity.

Canadian governments at all levels have wrestled over the past decade to balance operating budgets and reduce massive public debts. Health care has been financially squeezed and restructured to an unprecedented degree across the nation, and Canadians' confidence in their Medicare program has ebbed. As governments return to fiscal health, the key questions have become: Can Medicare be strengthened? And if so, how?

In this essay I briefly sketch the backdrop for Canada's current federal-provincial/territorial health care systems and then provide an overview of some current issues. The goal is not to analyze specific policy issues in depth, but rather to provide a descriptive update for American and international readers. However, some themes do recur. First, as is true in other confederations such as the United States and Australia, health system reform in Canada continues to reflect a balancing act between national uniformity driven by federal funding and regional pluralism arising from provincial administrative autonomy. Second, Canadian provincial experience illustrates how, in contrast to market-driven downsizing in the United States, a combination of fiscal and regulatory initiatives in a publicly fi-

nanced system can radically restructure the hospital sector. Third, Canadian policymakers are actively seeking to integrate services and strengthen community care, in part with a view to cost containment, but also to offset the downsizing of the institutional sector. Last, in common with every other industrialized nation, Canada is struggling with how to optimize the “impossible triad” of health care objectives: quality, accessibility, and affordability.

■ **Background.** The cornerstone for a national system in Canada was arguably laid in 1957, with federal legislation for coverage of hospital care and related diagnostic services.¹ In accordance with the Canadian constitution, the federal government provided cash transfers to any province that agreed to operate a universal hospitalization scheme with first-dollar coverage. Medical insurance was added in 1968, again with conditional cash transfers to the provinces. By 1971 all of the provinces and northern territories were participating fully in the combined medical and hospital services program that came to be known as Medicare.

The five cornerstone conditions of the 1968 legislation have endured: universal coverage of all provincial residents on uniform terms and conditions; public nonprofit administration; portability of benefits among provinces; comprehensive coverage of all “necessary” services provided by medical practitioners and hospitals; and maintenance of reasonable access to insured services, “unprecluded or unimpeded, either directly or indirectly, by charges or other means.”²

By the late 1970s inflationary pressures led provincial governments to take an increasingly hard line in collective bargaining with organized medicine. With price inflation, caps on fee increases, and rapid growth in physician supply for some urban markets, real medical take-home incomes began to decline. A sizeable minority of medical practitioners responded by levying extra charges to patients above and beyond the negotiated fee schedule. This led to widespread concern that Medicare’s accessibility principles were being eroded. The federal government responded in 1984 with the Canada Health Act, which consolidated previous health insurance legislation and reduced federal transfers to provinces that allowed hospitals to levy user fees or doctors to charge patients more than negotiated tariffs. Within two years, despite vigorous protests by organized medicine, all provinces passed legislation to abolish these charges.³

The system that emerged in the late 1980s was therefore characterized by highly monopsonistic public financing coupled with private delivery mechanisms. The vast majority of physicians remained in fee-for-service (FFS) private practice but were tied tightly to

negotiated fee schedules. Almost in parallel, general hospitals typically were structured as private nonprofit corporations but were funded primarily by annual global budgets determined through negotiations with provincial ministries of health.

All of the provinces have grappled with the question of how far to extend coverage beyond physician services and general hospital costs. The Canada Health Act applies only to physician and hospital services, leaving room for both cost sharing and variation in the provincial coverage of other services. Thus, whereas virtually all general hospitals are publicly owned, ownership and management in the long-term care sector has been diverse. Nursing homes are often privately owned and operated, drawing a blend of public and private funds, whereas chronic care and rehabilitation hospitals rely almost exclusively on public funding and management. Long-term care accommodation and overhead costs are usually charged back to the resident, whereas all health service and drug costs are insured. Dental coverage commonly includes only inpatient surgery, whereas optometric coverage is usually limited to refractions and partial payment for corrective lenses. Four provinces offer nominally universal Pharmacare plans; outpatient prescriptions in the other plans are publicly insured only for senior citizens, social welfare recipients, and persons with certain communicable and/or chronic diseases when special provisions have been made. Most Canadians have some form of supplemental private insurance, most commonly for prescription drugs or dental services. Public coverage for community-based care is growing, and most of the provinces already provide at least partial funding for both transient postacute home care and chronic home support services. However, the menu of home care services varies widely across the provinces.

A Decade Of Incremental Changes

■ **Reduced federal contributions.** Over the past three decades the federal government has supported provincial health plans by direct cash transfers, by allowing province-specific taxes within the national income tax program, and by so-called equalization payments designed to smooth out the interprovincial differences in average per capita income (and concomitant variations in provincial tax bases). What matters, however, is that federal support for health, postsecondary education, and social services has been steadily reduced as successive governments have struggled with deficit financing and massive national indebtedness.

The proportion of provincial health expenditures provided as a direct cash transfer from Ottawa fell from 30.6 percent in 1980 to 21.5 percent on average in 1996 and to much lower levels in richer

provinces. The provinces, meanwhile, were facing their own fiscal problems and struggled during the 1990s to make up for the federal shortfall. In consequence, the public share of total health spending has been declining, from 75 percent in 1986 to 70 percent in 1996. However, the proportion of such spending varies substantially across categories, with a particular concentration of private spending on drugs and nonphysician professional services (Exhibit 1). As Gerard Anderson and Jean-Pierre Poullier report elsewhere in this volume, Canadian per capita health spending between 1990 and 1997 grew at 2.7 percent per annum, below the Organization for Economic Cooperation and Development (OECD) median of 3.8 percent per year.⁴ In the same period per capita spending, adjusted for purchasing power parities (PPPs), rose from US\$1,696 to \$2,095, and the percentage of gross domestic product (GDP) spent on health declined from 9.2 percent to 9.0 percent. On both of the latter indices, Canada moved from second- to fifth-highest among the OECD nations.

In 1998 the federal government achieved a balanced budget and pledged an end to cuts in the provincial transfers. With a budgetary surplus looming for 1999, the new issue is not whether the federal government will increase transfers to the provinces but, rather, the terms and conditions for those transfers. Most provinces also have achieved a stronger fiscal position; thus, growth in public spending is inevitable in the near future.

■ **The rise of regionalization.** Driven in part by a desire to decentralize the burden of coping with fiscal restraints, nine provinces and one northern territory have moved toward some form of regionalized governance of health care during the 1990s. Ontario, Canada's largest province (population 11.8 million), is a conspicuous exception.

Regionalization invariably involves a combination of decentrali-

EXHIBIT 1
Private Share Of Health Expenditures In Canada, By Category, 1996

Category	Private share of health expenditures
Hospitals	12.3%
Other institutions	31.9
Physicians	1.0
Other professionals	85.7
Drugs	64.8
Capital	27.6
Public health	0.0
Other	47.4
Total	30.1

SOURCE: Health Canada, "National Health Expenditures in Canada, 1996" (annual fact sheet).

zation and centralization. Even as provincial ministries devolve some administrative authority and budgetary elements to regions, the emergence of regional authorities centralizes administrative control at the expense of individual institutions and agencies within a region. General hospitals have been particularly affected by this transformation. Countless hospital boards (and their hospitals) have been consolidated under regional governance mechanisms. In the past provincial governments used supplemental funding for capital renewal or support of specialized programs to encourage regionalization of high-technology services such as open-heart surgery, organ transplantation, and nuclear magnetic resonance imaging (MRI) capacity. However, each institution faced pressures from local citizens and its medical staff to be “all things to all people.” The rationalization of hospital-based services has been a key accomplishment of regional health authorities in several provinces.

There is interprovincial variation in how regional boards are appointed or elected, in the population size within regions, and in the extent to which regions have integrated health services, let alone integrated health with social services. Budgeting for the authorities has been a challenge. At one extreme, Saskatchewan has developed a population-based funding formula, in which authorities receive a budget based on population, adjusted for age, sex, and indicators of need such as standardized mortality ratios. Such population-based funding theoretically couples fiscal and clinical accountability. At the other extreme, two provinces have created regional boards but have not actually devolved budgets to them.

Debate continues about Canada’s experiment in regionalized health care administration.⁵ I later consider one administrative issue, touted by some as a key advantage of regionalization: improved integration of services across the continuum of care.

■ **The shrinking hospital sector.** The 1990s also have seen a profound transformation in the institutional sector, with massive reductions in hospital bed days. The driving forces behind the shift to outpatient care, fewer admissions, and shorter lengths-of-stay are the usual ones: new technologies, fiscal pressures, and better management. Between 1986 and 1994 the decrease in staffed beds for short-term care units in all categories of public hospitals was 30,023, or 27 percent, despite ongoing population growth and aging.⁶

Exhibit 2 illustrates the proportionate decline for general and specialty hospitals, even as long-term care facilities and home care programs have captured an increasing proportion of Canada’s health spending.⁷ Budgetary changes for general hospitals were particularly rapid in the 1990s. From fiscal years 1991 to 1994 the average annual change in hospital operating expenses was –2.4 percent, even with-

EXHIBIT 2**Comparison Of Health Care Spending In Canada, By Category, 1987 And 1997**

Category	1987	1997	Percent change
Hospitals	40.6%	33.6%	-17.2%
Physicians	15.6	14.4	- 7.7
Other professionals	10.4	11.3	+ 8.7
Drugs	10.4	12.6	+21.2
Other institutions	9.2	10.1	+ 9.8
Capital	4.4	4.0	- 9.1
Home care/public health	9.4	14.1	+50.0
Total	100.0	100.1	

SOURCE: Canadian Institute for Health Information.

NOTES: 1997 percentages are forecasts. Hospitals include general, psychiatric, and rehabilitation facilities. Long-term care facilities are covered under "other institutions."

out adjustment for population growth or aging.⁸

Data from Ontario provide further insights. Between FY 1984 and FY 1994 the age/sex-adjusted acute care bed days per thousand population fell by more than 40 percent—driven by both falling lengths-of-stay and reduced hospitalization rates.⁹ As the trend continued, about 10,000 acute care beds were inactive by 1996. In the absence of regionalization, and with virtually no voluntary closures, the government appointed a Health Services Restructuring Commission in 1996 and gave it wide-ranging powers to rationalize hospital services. Partway through its mandate, the commission has ordered forty of 139 institutions reviewed to close or merge.

Nurses, physicians, other health professionals, and hospital administrators across Canada have done a remarkable job of transforming practices without conspicuous adverse effects on patient outcomes. Their tolerance for change, however, has been sorely stretched by the pace, scope, and scale of institutional downsizing. Moreover, the wave of hospital closures and cutbacks has been profoundly disturbing to the public. General hospitals are not only visible symbols that care is accessible around the clock; they also contribute to local economies, particularly outside urban areas. Politicians and bureaucrats point to rising expenditures on drugs and home care as the logical offsets to this downsizing of the institutional sector, but the public remains unsettled.

Persisting And Emerging Issues

■ **Scope of coverage.** Throughout much of 1998 the federal and provincial governments were engaged in public posturing and private negotiations about spending the growing federal budgetary surplus. The provinces sought major increases in cash transfers without new terms or conditions. The federal Liberals, however, wanted visible "wins": new programs that might cement their popu-

larity with voters. In this respect, the two programs that garnered greatest attention were universal Pharmacare and national home care.

Pharmacare. The case for Pharmacare rested on more equitable sharing of the costs of prescription drugs, while ensuring better access to drugs that are life prolonging or enhancing and may even be cost saving. As Exhibit 3 shows, the distribution of private coverage for prescription drugs remains highly skewed by income.¹⁰ Although four provinces have nominally universal plans, various cost-sharing provisions mitigate the equity-enhancing impacts of these programs. Those four provinces would welcome federal support for their existing plans but are wary of new drug entitlements. For the other provinces, universal Pharmacare has even less appeal. In effect, the provinces are seeking redress from past cutbacks before accepting the economic hazards of major new entitlements supported by what could be transient federal support. The extent of existing private coverage and employer subsidies for drug benefits poses a further political complication. For now, the federal government has shown little inclination to move ahead with a national drug plan.

Home care. Home care, in contrast, has garnered strong political support from the federal health minister, Allan Rock, and a wide array of stakeholders. Home care expenditures have grown at an average annual rate of 21.3 percent in Canada over the past two decades, greatly outstripping overall health spending and general inflation.¹¹ Provincial approaches to home care vary. For example, in Saskatchewan private home care has little role. Instead, a comprehensive publicly funded and delivered program covers nursing care, homemaking services, and occupational and physical therapy. In Ontario the system also is publicly funded, but delivery is in the hands of a wide range of private and public agencies. Services range from nonprofit “meals on wheels” to home care nursing services run by investor-owned groups.

Community-based services are vested under ministries of social services or health, depending on the province, but most provinces have moved to bridge the health and social service sectors by creat-

EXHIBIT 3**Private Drug Insurance In Relation To Income, In Canada, 1995**

Annual income	Proportion with private coverage
More than \$60,000	75%
\$40,000–\$60,000	68
\$20,000–\$39,999	42
Less than \$20,000	7

SOURCE: National Forum on Health; see Note 10 in text.

“The provinces have been cool to the concept that the government might grade the performance of their health care systems.”

ing “one-stop shopping” for seniors and chronically disabled persons. Local agencies hold budgets, serve as a single access point for a range of services, advocate for community programs, compile data based on standardized assessment protocols, and coordinate care across a continuum of needs.

Nonetheless, evidence from the National Population Health Survey suggests that many persons living in the community and identified as requiring assistance with activities of daily living (ADLs) do not receive home care, and a Saskatchewan audit showed that 60 percent of hospitalized patients deemed likely to benefit from home care did not receive it.¹² Home care’s potential benefits are particularly pertinent in the light of falling hospital lengths-of-stay, the rapid rise of ambulatory care, and an aging population. In 1996 about 10 percent of Canadians reported that they were providing informal care to someone with long-term health problems.¹³ These factors all add to the political and practical case for earmarked federal support for home care.

Research and information. The federal government also is considering moderate-cost but high-impact investments in health research and health information. For example, a large multistakeholder group has been pressing for a major increase in funding for medical and health research. In addition, both the health minister and the prime minister have called for a national report card on health and health care. The strategic advantage of a series of national report cards is plain. System-status reports in different regions of Canada could temper the rhetoric of providers and provinces, draw the provinces into a useful examination of each other’s policies and programs, chart best practices for emulation nationally, and increase the federal government’s moral authority as national standard setter. Although the provinces have accepted the principle of better national reporting, they have been understandably cool to the concept that the federal government might be given a mandate to grade the performance of their health care systems and share the results with all Canadians.

As of early February 1999 there appeared to be a new federal/provincial accord, not just on health care, but on the broader terms for shared support and administration of social programs (generally termed the “social union”). Ottawa will gradually restore the funding that it has withdrawn from health care, without onerous terms and conditions or new entitlements, provided that the provinces

agree to continue to uphold the terms of the Canada Health Act. Any national accountability framework, including report cards, will be developed by the provinces in concert with federal agencies. Perhaps most importantly, there is agreement in principle that Ottawa must obtain the consent of the majority of the provinces before introducing any new programs or changing the terms for existing programs. Quebec, now governed by the separatist *Parti Québécois*, has already rejected the terms of the accord. More generally, it remains unclear how long this fragile consensus will survive.

■ **Private practice, public payment.** A wide range of health care professionals tap Canada's health insurance systems as independent FFS providers. Physicians are a key group. Global increases across medical fee schedules are negotiated between each provincial government and medical association. Negotiations have frequently been acrimonious, with occasional withdrawal of nonessential medical services during disputes and unilateral imposition of settlements by provincial governments.

Some specialists circumvent provincial fee schedules by making extra charges for services that might otherwise be considered routine but are not expressly described in the benefits schedule (for example, telephone consultations, letters for employers, photocopying of records, or even, in the extreme, booking operating room time) and can therefore be categorized as "uninsured." The sums involved range from trivial to substantial, and governments generally have turned a blind eye to this entrepreneurship.

The small-business mode of FFS practice was enshrined in the 1964 Royal Commission report that set the stage for Canada's contemporary Medicare programs. It avoids burdening governments or regional health authorities with responsibility for establishing and managing clinics for physicians across a vast, thinly populated geography. However, since the 1960s Canadians have debated the merits of organizing physician payment around the FFS mode.

Among the perceived drawbacks to FFS for provincial governments has been steady growth in per capita use of physician services, particularly items of a potentially discretionary nature such as follow-up visits and in-office diagnostic tests.¹⁴ The standard policy responses have been to cap outlays to physicians by limiting payments to a quarterly basis or pro rating payments once annual billings exceed a specific ceiling. However, the combination of a volume-driven incentive system with a fixed pot of funds has proved to be a prescription for conflict and frustration.

Both the public and the medical profession acknowledge that "practice churning" for revenue maximization occurs. Furthermore, a Gallup poll in 1995 showed that 43 percent of Canadians favored a

flat salary system for paying general practitioners/family physicians (GP/FPs), while 24 percent supported capitation, 24 percent favored FFS payment, and 10 percent had no opinion. There were sharp regional differences: Support for salary ranged from 56 percent in Quebec to 32 percent in Ontario.¹⁵

Movement away from FFS payment, however, has been slow. Starting in the 1970s the Quebec government attempted to blanket the province with primary care centers staffed by salaried professionals. Family physicians in the FFS sector organized rapidly into groups and fought successfully to retain a significant market share. About 140 *Centres locaux de santé communautaires* (local community health centers) remain, structured to integrate health and social services. In other provinces salaried or capitated primary care is less developed than in Quebec. In Ontario there are only fifty-five Community Health Centres—nonprofit, multiservice agencies, typically with community boards, that pay general practitioners on salary and offer comprehensive primary care services. Nationally, about 90 percent of all primary care is provided by FFS providers, and the proportion of specialty services provided by FFS is even higher. Only a few academic centers have converted their physicians to alternative payment schemes.

■ **The continuing quest for integration.** Canadian policymakers are attracted to the concept of integrated delivery systems (IDSs) or networks, as defined by Stephen Shortell and colleagues: “a network of organizations that provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served.”¹⁶ One of the potential advantages of regionalization with budgetary devolution is the creation of such integrated systems in the Canadian context.

Regionalization has indeed been associated not only with improved rationalization of the acute care hospital sector, but also with improved integration of acute, long-term, and community-based care. However, integration remains limited in many respects. Ontario, with more than one-third of Canada’s population, has rejected regionalization, and two other provinces have set up regional authorities without devolving budgetary responsibilities. No province with devolved budgets has brought physician services or drug benefits under the regional funding envelopes, and some provinces also have left specialty hospitals and cancer services outside the control of their regional authorities. Without modifications to traditional FFS practice, integration of physicians will continue to be a challenge.

At this stage, however, the potential advantages of greater service

integration for Canada may have more to do with quality than with costs. Three decades of centrally capped budgets and a decade of unprecedented constraints have wrung much of the fat out of Canada's hospital systems. American IDSs capitalized on excess hospital bed capacity and low occupancy rates; neither condition holds any longer in Canada. American IDSs could drive down costs by switching to primary care providers and away from specialists. Canada already has almost half GP/FPs; residual gains in Canada, if any, may lie in switching to nonphysician providers, but governments and regional authorities seem unlikely to take that step.

Low population density compounds the problem. Many natural monopolies exist—catchment areas with 150,000–500,000 people and a well-defined hierarchy of referrals. But only three or perhaps four metropolitan areas are large enough to sustain competing IDSs.

The next logical step in most provinces is for larger authorities and networks of smaller authorities to foster vertical integration, both as purchasers of diverse professional services and as facilitators of strategic alliances. Whether costs of physician services and drug benefits will be integrated into regional budgets remains uncertain.

■ **Quality.** Quality of care is an amorphous concept; what drives consumers' perceptions of quality may have little to do with quality as conceptualized by providers, payers, or researchers.¹⁷ However, both providers' and consumers' confidence in Canadian health care unquestionably dropped as cutbacks took their toll in the past few years. National polls show that six of ten Canadians assessed the health care system as "excellent" or "very good" in 1991. By 1996 only four of ten made those ratings, while one-quarter of respondents rated the system as "fair" or "poor."¹⁸ In a 1998 international survey, Robert Blendon and colleagues found that about 18 percent of Americans believed that recent changes had harmed their system's quality of care, as opposed to 46 percent of Canadians.¹⁹

These polls emphasize the extent to which the public equates high-quality health care with access to a stable hospital system. Most physicians and administrators have anecdotal evidence of patients suffering as a result of nursing cutbacks, delays in diagnostic or therapeutic maneuvers, or poor coordination among overstretched facilities. To date, however, analytical studies have generated little hard evidence to prove that hospital restructuring has had major adverse impacts on health care delivery. Noralou Roos and colleagues have documented the fact that despite downsizing of the Manitoba hospital sector, surgery volumes rose dramatically, utilization fell least for patients who were particularly sick or poor, and short-term mortality outcomes for a set of tracer conditions were improving.²⁰ In Ontario analyses of a variety of medical diagnoses

have shown no meaningful relationship between lengths-of-stay and rates of urgent readmission for related problems.²¹

The public is nonetheless clear on its sources of unhappiness. A poll in Ontario in late 1996 showed that only 42 percent of respondents were satisfied with waiting times in emergency rooms. Only 34 percent were satisfied with specialized surgical services or advanced diagnostic tests. Dissatisfaction appeared to be especially high in relation to waiting periods for specialized surgical services such as cardiac and orthopedic surgery.²²

Hard data on cardiac and orthopedic surgery, however, highlight the complex realities behind the public's perceptions. Examination of clinical selection criteria for hip and knee replacements in high- and low-utilization areas has yielded *prima facie* evidence for rationing in some Ontario regions.²³ Data also show that patients awaiting joint replacement face lengthy waiting times with major and reversible reductions in functional status and quality of life.²⁴ On the other hand, age-adjusted rates of both hip and knee replacements are rising steadily in Ontario, and neither referring physicians nor the public are given surgeon- or even center-specific information about the severity-adjusted waiting times for surgery.²⁵

For cardiac surgery, the facts again refute any simple story line of cutbacks and arbitrary rationing with poor-quality care. Postoperative mortality rates after coronary artery bypass graft (CABG) surgery in Ontario are low, and center-to-center variation is small as a result of regionalization and volume controls.²⁶ Waiting lists for CABG are a source of anxiety for patients, but, fortunately, fewer than one of 250 patients die while awaiting this procedure in Ontario—a death rate lower than expected for cardiac patients in general.²⁷ Ontario also operates a comprehensive waiting list management system, with explicit queuing guidelines; analyses confirm that clinical indicators of severity and urgency are closely correlated with shorter waiting times.²⁸ When CABG queues have grown to unmanageable lengths (as in 1990 and 1997), the ministry of health has responded with major capacity expansions that have quickly reduced the number of patients waiting and their waiting times.

Rates of revascularization by angioplasty or bypass surgery do run at or below half the corresponding rates in the United States, but age/sex-adjusted revascularization rates have risen by more than 40 percent in the 1990s alone.²⁹ Comparative studies show that American cardiac patients enjoy some quality-of-life advantages that are probably related in part to more aggressive revascularization strategies, but the self-rated overall health and work status of Canadian patients is similar to that of their American counterparts.³⁰ No comparative study has shown survival advantages with

the more procedure-intensive and expensive U.S. approach.³¹ So both Canadians and Americans can defend their service profiles, and determining the “right rate” of tertiary cardiac procedures may have as much to do with values and context as it does with evidence per se.

On the negative side of the ledger, waiting lists for many procedures remain lengthy and inconsistently managed.³² The true extent of underservicing and implicit rationing is still unknown, in part because systematic audits have not been carried out. Health regions and provincial ministries simply do not routinely compile and report on a variety of indicators that most American managed care plans would regard as routine. In effect, quality-of-care monitoring across Canada remains too inconsistent for any generalizations to be drawn. There also is a paucity of systemwide accountability mechanisms. Provincial bodies for professional self-governance are driven by complaints about individual practitioners, while hospital-based quality assurance activities focus on only one aspect of a complex continuum of care. Canadian governments have failed to emulate, as but one example, the myriad initiatives in clinical quality improvement now being launched in Britain’s National Health Service. Selective reinvestments no doubt are needed to palliate some problem areas in the acute care sector, but the key quality concerns are arguably best remedied by more systematic assessments and audits, together with strengthened public accountability and enhanced service integration.

■ **The status quo versus two-tier care.** The unsettled state of Canada’s health care system has rekindled a long-standing debate about the ban on private insurance for publicly insured services. Alberta, Newfoundland, Nova Scotia, and Manitoba allow semi-private clinics to charge facility fees, while practitioners working in them bill for publicly insured services. In general, however, Canada’s restrictions on private insurance are uniquely stringent among the OECD nations. Arnold Aberman, dean of the University of Toronto medical school, minces few words on this issue. Asked how he would change the Canada Health Act, he states: “Decriminalize medical acts between consenting adults and allow patients to purchase more medical care than the government provides.”³³

Critics of the Canada Health Act note that multitier care is a fact of life. Provinces that eagerly barred extra-billing by physicians have been equally quick to impose large copayments for public drug plans. Meanwhile, workplace safety and compensation boards in each province provide parallel public insurance for occupational illnesses and injuries and have institutionalized queue jumping by block-purchasing time for MRI scans at public hospitals, providing accelerated rehabilitation programs through either their own clinics

or private practitioners, and arranging with semiprivate clinics for fast-track arthroscopic procedures. Critics also argue that some Canadians already seek private and expedited care by traveling to the United States. (According to the 1994–1995 National Population Health Survey, only 0.5 percent of respondents reported receiving health care treatment in the United States in the preceding twelve months, and only 0.1 percent went there specifically for treatment.)

Opponents of two-tier care reply that if a parallel private sector is truly able to provide superior access to essential services, then Canadian health care would by definition become less equitable. A private tier of service might be parasitic: It could limit itself to highly remunerative services, while luring away some of the best and brightest clinicians from the public sector. It is also argued that as long as upper-middle-class Canadians must rely on the public system, they will agitate against its deterioration, advocate for adequate funding, accept higher taxation levels, and support the system through personal and corporate donations. Thus, while exponents of a parallel private system call it a “safety valve,” their ideological opponents claim that this policy change would “let the canaries out of the coal mine” and erode support for publicly funded health care.

The equity argument carries particular weight in Canada. Available data suggest that although the well-to-do still make more use of ambulatory specialist care and receive more preventive services than the poor do, universal first-dollar coverage indeed has led to more equitable access to health services and greater spending on care for those in lower socioeconomic strata.³⁴

The public’s reactions are mixed. A 1996 national poll asked whether “it would be okay if Canada developed two levels of health care service: a basic one that government funded for everyone, and another under which those who could afford it paid the full amount and received whatever kind of services they wanted.” Almost 60 percent of Canadians rejected this concept, whereas 70 percent of doctors supported it.³⁵ But much depends on wording. In the same year Gallup found that 44 percent of respondents favored a two-tier system (described as government insuring basic services, with private insurance or direct payment options available for further coverage). With this formulation, even supporters of the nominally socialist New Democratic Party registered a 42 percent level of support for a two-tier plan.³⁶

The support for some form of parallel private coverage seems to be related less to fundamental beliefs about civil liberties and more to fears that the public system is deteriorating. With future increases in public spending on health care a certainty, and with most provinces accepting that new federal monies remain conditional on

compliance with the Canada Health Act, Canada's parallel private system seems destined to remain south of the border.

Tomorrow's Incrementalist Agenda

Canada's publicly funded health care system is more than a social program; it is a unifying force, a national obsession, and, not least, one of the few features that allows Canadians to differentiate themselves from their neighbors to the south. Medicare's successes are clear: It has knocked down the financial barriers to access to care for the less privileged in Canadian society, even as its single-payer mechanism has kept costs at an acceptable level.

Although recent fiscal pressures have catalyzed important reforms in Canada's health care system, many Canadian citizens and more than a few policymakers pine for greater stability in health care. Indeed, today's would-be health care reformers are chastened by the fiscal crisis of the 1980s and 1990s, hobbled by intermittent federal/provincial squabbling, confused by the tension among interest groups that advocate diverse spending priorities, and confounded by the growing interprovincial pluralism in administrative arrangements for delivering health services. Some reinvestments indeed are needed to heal the wounds of a decade of rapid restructuring in the acute care sector, but much else remains to be done. Among the piecemeal reforms required are improved integration of regional services; wider adoption of blended compensation mechanisms for physicians, with particular emphasis on primary care reform; strengthening home care services and managing them better; more equitable coverage of prescription drugs through carefully structured public/private partnerships; and major investments in health information-gathering and quality-improvement initiatives. Governments, of course, may be loath to fight on so many fronts simultaneously. But the dogged pursuit of this incrementalist agenda now appears to be the best way that Canada's single-payer health care systems can be rendered more accountable, integrated, and sustainable in the next millennium.

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NOTES

1. See M.G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created the Canadian Health Insurance System* (Montreal: McGill-Queen's University Press, 1979); R.F. Badgley and S. Wolfe, *Doctors' Strike: Medical Care and Conflict in Saskatchewan* (Toronto: Macmillan, 1967); and C.D. Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance*,

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2. Canada Health Act (1984), *Revised Statutes of Canada*, 1985, c. C-6.
 3. S. Heiber and R. Deber, "Banning Extra-Billing in Canada: Just What the Doctor Didn't Order," *Canadian Public Policy* (March 1987): 62–74; and C.J. Tuohy, "Medicine and the State in Canada: The Extra-Billing Issues in Perspective," *Canadian Journal of Political Science* (June 1988): 267–296.
 4. G.F. Anderson and J.P. Poullier, "Health Spending, Access, and Outcomes: Trends in Industrialized Countries," *Health Affairs* (May/June 1999): 178–192.
 5. See, for example, J. Abelson et al., "Does the Community Want Devolved Authority? Results of Deliberative Polling in Ontario," *Canadian Medical Association Journal* 153, no. 4 (1995): 421–424; and the series of papers by Jonathan Lomas and colleagues in *Canadian Medical Association Journal* 156 (1997).
 6. P. Tully and E. Saint-Pierre, "Downsizing Canada's Hospitals, 1986/87 to 1994/95," *Health Reports* (Spring 1997): 33–39.
 7. The disparities between the numbers in Exhibit 2 and those in the paper by Anderson and Poullier (Note 4) are explained by the fact that the inpatient database for the OECD analysis by Anderson and Poullier covers hospitals and "other institutions." Hospitals include acute care but also some chronic and rehabilitation facilities as well as specialty hospitals. Other institutions include homes for the aged and a variety of residential facilities for mentally and physically handicapped persons and substance abusers. This also accounts for the higher length-of-stay reported by Anderson and Poullier; for the acute care sector per se, the average Canadian stay is about six days.
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 9. Ibid.
 10. S. Lewis et al., "Directions for a Pharmaceutical Policy in Canada," in *Canada Health Action: Building on the Legacy. Synthesis Reports and Issues Papers* (Ottawa: National Forum on Health, 1996), 1–20.
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 13. *Who Cares? Caregiving in the 1990s*, Cat. no. 11-612E (Ottawa: Statistics Canada, 1997).
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 34. See, for example, R.F. Badgley and S. Wolfe, "Equity and Health Care," in *Canadian Health Care and the State*, ed. C.D. Naylor (Montreal: McGill-Queen's University Press, 1992), 193–237; and W.J. McIsaac, V. Goel, and C.D. Naylor, "Socio-Economic Status and Visits to Physicians by Adults in Ontario, Canada," *Journal of Health Services and Research Policy* 2, no. 2 (1997): 94–102.
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