THE CANADIAN HEALTH CARE SYSTEM:
AN ASSESSMENT OF THE SYSTEM & THE CREATION OF THE HEALTH COUNCIL OF CANADA

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The Canadian health care system has been a work in progress since its inception. Reforms have been made over the past four decades and will continue in response to changes within medicine and throughout society. However, the basic principles remain the same - universal coverage for medically necessary health care services to be provided on the basis of need, rather than the ability to pay. Canada's publicly funded health care system can be best described as an interlocking set of ten provincial and three territorial health insurance plans. Known to Canadians as "Medicare", the system provides access to universal, comprehensive coverage for medically necessary hospital and physician services. Despite the slow improvement that has occurred, it has become clear that since the implementation of the Canada Health Act in 1984, Canada's health care system has been in decline and has fallen significantly behind nations like the U.K., Sweden and Finland[1].

The degradation of the Canadian healthcare system has been a gradual process, which has had many negative consequences. Despite negative indications, policy trend in Canada saw a decrease in transfer payments as a percentage of GDP from the Federal to Provincial governments as well as the vertical downloading of responsibility to maintain social services like health care and welfare[2]. Under this scenario, the Provinces control immense power over the quality of health care given to citizens of each respective province, and due to the regional inequality and diverging ideology of the various dominant political parties, health care between the ten provinces varies widely[3]. Furthermore, there has been a developing trend towards moderate levels of privatization

[1] "Raphael, Dennis. "Addressing the Social Determinants of Health in Canada: Bridging the Gap Between Research Findings and Public Policy". Policy Options. March 2003. Pg. 35
[2] ibid. 36
[3] Maioni, Antonia. "Romanow – A defence of Public Health Care, but is there a map for the road ahead. Policy Options. February 2003. Pg. 54

throughout Canada. Ontario has been allowed to operate over 900 private surgical, treatment and diagnostic clinics to work for-profit once they have satisfied the Provinces weekly requirement of public hours[4]. At the turn of the century, the Federal government recognized the many problems plaguing the Canadian health care system and attempted to fix the problem by creating the Health Council of Canada. Canadian health care was at a gridlock, where the system, something Canadians felt as a "defining aspect of their citizenship", could have either degraded to the point where this defining characteristic was nothing more than a fond memory, or could be improved and returned to its former stature among worlds top care systems.

From a general perspective, the increased costs that exist in the health care system could be attributed to societal trends that have developed since the beginning of the millennium. Many instances subsist where the aforementioned statement is proved to be true. First, labour shortages, which are the result of a decade of policy reversals, have driven up the cost of keeping doctors and nurses in the current system[5]. Second, the growing use of drug treatment to manage and prevent conditions has been a long-term trend that has astronomically increased the costs of maintaining the system[6]. Thirdly, due to the aging population, specifically the baby boomer generation, there has been a growing demand for resources and treatment[7]. Lastly, as the wealthiest generation in Canadian history are reaching old age, there is an increasing interest in the use of paid services and facilities. These general problems have been exacerbated by declining Federal health transfers to the Provinces, Provincial fiscal restraint, lack of accountability

[4] "Health Care in Canada 2008", Canadian Institute for Health Information: Statistics Canada, [Journal Online] 2008; available from http://www.cihi.ca. pg. 15
[5] ibid. 8
[6] ibid. 8
[7] ibid. 8

to the citizens of Canada and communication between the Federal and Provincial governments, lack of availability of rural and remote care and finally an increase in waiting times for diagnosis[8].

The Federal government has always been known as "a defender of Medicare", yet over the past decade they have worked to reduce their responsibility for the increased costs and changing expectations for this public system[9]. Furthermore, in the wake of the decline of the Canadian health care system, the Federal government in 2002 conceded 20 billion dollars in revenue to tax cuts, which was money that could have been used to maintain social services like health care[10]. This fact naturally leads to the issue of vertical fiscal imbalance and resource allocation, which has become a growing concern. The Conference Board of Canada (CBoC) claims that the problem stems from the Federal governments increased reliance on personal income (47% of revenue), which is the fastest growing source of revenue in Canada, and consequently is the Provinces primary source of income in the form of Federal transfer payments, which by nature are relatively slow growing[11]. The discrepancy between the provincial governments and the federal governments occurs on the expenditure side. The Provinces have a relatively large share of spending in the rapidly growing areas of social service, for example health care, education and old age security. Thus, due to the faster projected growth rate for provincial expenditures, at 3.5% over the next 20 years, and the comparatively lower

[8] "Health Care in Canada 2008", Canadian Institute for Health Information: Statistics Canada, [Journal Online] 2008; available from http://www.cihi.ca. pg. 10

[9] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. pg 3.

[10] Yalnizyan, Armine. "Paying for Keeps: Securing the future of public health care – Beyond Romonow: Why $3.5 billion is not enough". Canadian Centre for Policy Alternatives. [Journal Online] 16 December 2002; Available from http://www.policyalternatives.ca/publications/payingforkeeps1.html.1.

[11] Ibid.

growth rate for Federal transfer payments, at 2.2% over the next 20 years, it is inevitable that the provinces will be left in severe debt and the Federal government will have an estimated surplus of 126 billion dollars by 2025[12]. This lack of transparency with respect to federal contributions is not only causing dysfunctional intergovernmental relations, but is also hampering the process of health care reform.

Secondly, the issue of Provincial restraint, coupled with declining Federal health transfers has caused immense problems. Theses problem have been accentuated in two ways. The first is due to the approach taken by several provincial governments, for example the former governments of Alberta and Ontario. The second is the simple fact that some of the "have not" provinces have been forced to curb spending in order to meet the unresponsiveness of Federal transfers. In both scenarios this has resulted in the delay of much needed investment in the supply of health human resources, for example doctors nurses and technicians, and physical infrastructure, such as MRI and CAT scan machines[13].

Thirdly, a lack of accountability to the citizens of Canada and communication between Provincial and Federal governments has promoted irresponsible spending habits, which has led to dysfunctional relations between the levels of government. This scenario can be best exemplified by the Medical Equipment Fund, which called for a 1 billion dollar investment by the Federal government in 2003. However, due to the lack of communication and accountability, the money that left Ottawa was enormously misused. In New Brunswick, for example, the fund was used to purchase lawn tractors, icemakers

[12] St-Hilaire, France and Lazar, Harvey. "He Said, She Said: The Debate on Vertical Fiscal Imbalance and Federal Health-Care Funding". Policy Options. February 2003. Pg. 61-63.
[13] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. Pg. 3.

and floor scrubbers for the hospital, which is equipment that is neither geared towards diagnosis or treatment equipment, which was what the funds were originally designated for[14]. Despite this clear flaw in the system, Provincial governments have rejected the movement towards building accountability mechanisms into the system. In contrasts they have continually argued for more flexibility with respect to funding[15]. This scandal, along with others like the Canadian blood scandal have created a general mistrust of government action by the citizenry, which can be partially accountable for the decline of deference that has begun to occur in Canada.

Fourthly, the general lack of availability of rural and remote care has become a serious problem in Canada for many reasons. This problem presents many problems in maintaining equality in the system since communities exist where no doctors live. Therefore, the lack of these basic social services are partially responsible for destroying Canada's rural communities as it is forcing families and elderly to move to urban settings to ensure medical attention and treatment[16]. Consequently this current model, without placing pressure on rural health care, has hurt rural society and health, while heightening the pressure on urban population growth and government spending to maintain urban social services.

Finally, the trend of increasing waiting times for diagnosis has come to be a serious problem, as they have doubled in the last decade[17]. Currently, the average waiting time from referral from a GP to actual treatment is 17.7 weeks, which percent jumped 7%

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[14] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. pg 48
[15] Ibid. 48
[16] ibid. 48
[17] Kirkey, Sharon. "Hospital Waiting Times Jump 7% in One Year". The National Post. 14 November 2004

from 2003-04[18]. To further demonstrate the disparity and lack of equality in the current system, Saskatchewan has the longest waiting time at 29.9 weeks and Ontario has the shortest at 14.3 weeks, which is a 15.5 week disparity[19]. When doctors were polled by the Fraser Institute, 90 percent of the 3000 doctors from 12 specialties believe the delays are unreasonably long[20]. This is a simple exemplification of the deterioration of efficiency in the heath care system as the current equipment and quantity of human resources are clearly inadequate to deal with mounting demand.

The Federal government's primary interest is to make "the Canadian health care system the best in the world and Canadian people the healthiest in the world"[21]. This primary objective could have been realistically obtained by renewing the foundations of Medicare, by ensuring that equality, accessibility and transparency are primary tenants of the reformation. Once the internal objectives have been completed there is a desire to move beyond Canadian borders to consider Canada's role in improving health standards around the world. Finally, the Federal government believes that relying on the status quo is not a feasible option and have committed to investing money to stabilize the system in the short-term by enduring change in the long-term.

The Provincial governments have similar objectives as the national government, yet they do not have the same unified vision in the successful reformation. To generalize, the Provinces are not interested in conceding control and sovereignty to the Federal government in order to achieve the goal of health care reformation. Thus, on the Federal level there is the hidden agenda of helping reunify provinces and the 'Canadian identity'.

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[18] Kirkey, Sharon. "Hospital Waiting Times Jump 7% in One Year". The National Post. 14 November 2004
[19] ibid.
[20] ibid.
[21] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. Pg. 4

While on the Provincial level, they simply desire additional funding and support from the Federal government to improve on individual progress in order to meet the needs of constituents, despite the potential lack of equality and solidarity.

From a non-governmental standpoint, there are many interest groups that are lobbying to promote various dimensions of the health care system. One specific example of a lobbyist advocating against the public system and a more privatized option is Pierre Lemieux. Before becoming an MP in 2006, he believed those who opposed the idea of some individuals being allowed to use money to purchase better health care and instead preferred everybody have less, provided equal care, are foolish[22]. He went further and claimed that while pursuing the highest moral standard of equality for the health care system we are inherently sacrificing individual liberty and property rights[23]. Yet, for every group or individual who is lobbying against public health care there are an equal number that are lobbying for an egalitarian system for all Canadians coast to coast. Thus, this is an extremely broad and well excavated issue that is addressed from all sides.

From the most individualistic standpoint, nearly two thirds (61%) of Canadians ages 12 and older said, "their overall health and satisfaction with the concept of a publicly funded system was very good"[24]. Furthermore, 78% of Canadian said that they have visited a family doctor in the last year, which demonstrates that a majority of Canadians utilize the service provided[25]. Thus, all Canadians are directly affected by any decisions and modifications made to the current system, and is in everyone's interest to

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[22] Kreptul, Andrei. "Canadian Health Care". Ludwig von Mises Institute. [Journal Online] 30 August 2000; available from http://www.mises.org.
[23] ibid.
[24] "Health Care in Canada 2008", Canadian Institute for Health Information: Statistics Canada, [Journal Online] 2008; available from http://www.cihi.ca. pg. 6
[25] ibid. 6

ensure that system is updated to meet current and future needs of the aging Canadian population.

It is important to acknowledge the transition at this point in the report from dealing with broad issues pertaining to the health care system to more specific issues of reformation taken half way through the first decade of millennium. At the turn of the century the Canadian health care system was at a crossroads as reformation was needed. The options included: continue, in post-modernist fashion, to use dialogue and roundtable discussions in cities across Canada to determine the problems and solutions for health care; absolve the governments responsibility for Medicare, whereby relegating their position to merely fund givers, which would have enables provinces to chart their own course and individually determine areas of problem and improve them as they see fit; continue on with the status quo and do nothing; move to a two-tier system, which would have allowed for private support for the ailing system, permitting the free market and other alternative pressures to define the future direction of the health care system. As a final option the federal government commissioned Roy Romonov to compile a report outlining the future of the health care system in Canada.

After analyzing all of the reformation options, the most feasible option was to follow the Romonov Report in order to ensure the future of the health care system was modeled after the egalitarian system that helped define and unify Canadians for decades. Much of the early attention was paid to the recommendations with respect to the financing of health care in Canada and especially transfers from the federal government to provincial and territorial governments[26]. The report set the stage for another round of

[26] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. pg 14

federal-provincial/territorial bargaining leading to a significant agreement in September 2004 whereby the Government of Canada agreed to transfer an additional $41 billion over the next 10 years in support of Romonov's action plan[27]. The report outlined 42 recommendations proposing sweeping changes to ensure the long-term sustainability of Canada's health care system. One of the recommendations called for the creation of the Health Council (HC) to foster accountability and transparency by assessing progress in improving the quality, effectiveness and sustainability of the health care system[28].

Under the most prevalent goals of the Health Covenant, the objectives of universality, equity, solidarity, responsiveness, efficiency, accountability and transparency, were used to restore Canadian faith in the system and the system itself[29]. As a subset of the Health Covenant, the HC's primary objective is to establish indicators to measure the performance of the health care system and establish benchmarks in order to improve quality, access and outcomes[30]. Thus, by properly utilizing this system the HC allows the Federal government, with support from the Provinces, to determine how serious the erosion of the health care system is in Canada. Furthermore, the HC does not strictly evaluate the system itself, but rather evaluates the mechanisms that facilitate the operation of the system, such as dysfunctional intergovernmental relations and lack of mechanism for public input[31].

The HC was created by the provinces, excluding Alberta and Quebec, the territories and the federal governments and functions as a regime which operates not-for-

[27] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. pg 48
[28] Ibid. 48
[29] Ibid. 48
[30] Ibid. 52
[31] ibid. 54

profit at arm's length from government[32]. While the council officially reports to its members – the health ministers of the participating jurisdictions – it provides an independent assessment of health care renewal in Canada. The HC acts as the middle man between the Canadian government and its citizenry. It monitors and reports governments' progress in meeting their commitments to health care renewal agreed in 2004[33]. The HC is composed of: 3 representatives from the public, 4 representative of the provider and expert community, 7 governmental appointees (1 appointed by consensus by the Territories, 1 appointed from the Western Provinces, 1 appointed by Ontario and 1 from Quebec, 1 appointed by the Atlantic Provinces and 2 from the Federal government), summing a total of 14 members[34]. These representatives are accountable to the public through reports to both the provincial and federal health ministers and in an Annual Performance Reports. These are designed to determine the net result of the year's reformation efforts[35]. Finally, 10 million was set aside to fund the operation of the council[36].

Since the release of Romonov's Report, there have been many challenges to the creation of the HC. The most prevalent issue is the transformation of the Romonov concept of a 14-member board existing at arms length, to a 27-member board consisting of a chairperson, 13 members from inside various levels of government and 13 from outside. This change prompted ex-premier Ralph Klein to back Alberta out of the deal, claiming "the health council is not a representation of what was discussed and agreed

[32] "About the Health Council of Canada" Health Council of Canada. [Journal Online] 2008; available from http://healthcouncilcanada.ca/en/index.php?option=com_content&task=view&id=235&Itemid=3. Pg. 2
[33] ibid. 2
[34] Romanow, Roy J. "Statement on the release of the Final Report of the Commission on the Future of Health Care in Canada". Commission on the Future of Health Care in Canada. 28 November 2002. pg 55
[35] ibid. 56
[36] "Health Ministers Agree to Form National Council". CTV.ca. 5 September 2003; Available from http://www.ctv.ca.1.

upon by the PM and Premiers last February [2003]"[37]. Furthermore, many other analysts have criticized this change because its unwieldy size facilitates failure and due to the fact that the non-governmental seats are handpicked by the government, transparency and governmental control could prove to be problematic[38]. To compliment this critical problem, issues of public mistrust of government exists as the creation of the commission and HC can be seen simply as means for the Federal government to lessen responsibility for the health care crisis.

However, despite such interpretations, the HC in actuality has helped create a viable plan to retain the viability of the health care system in Canada. By enacting this policy laid out in the Romonov Report, the Canadian government sent many messages to their citizens. Firstly, that Canada is a nation with a well-developed welfare state and is unwilling to allow its citizens to live in an environment where the citizenry's well being is compromised by a lack of commitment on the part of the Federal government. Secondly, the creation of the HC helped resolve has since been called a 'democratic deficit' in Canada. Thus, by creating more transparency the government has encouraged more participation and focuses on the actions of the government on the part of the citizenry.

[37] "Ottawa and Provinces Reach Agreement on National Health Council". Canadian Press Newswire. October 2003; available from http://8590-webspirs.micromedia.ca.proxy.lib.uwo.ca:2048/western.1
[38] ibid.

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