Jeffrey Simpson has written a comprehensive, breezy and very readable book outlining the history of medicare in Canada[[1]](#footnote-1), how it stacks up with the healthcare systems of other countries, its virtues and defects, recommendations for reform and the fiscal consequences if we don’t act on many, if not all, of those recommendations.

The recommendations outlined are not new; rather they have been made by the many commissions established over the past couple of decades by the federal government and a number of provincial governments. They relate to reform of virtually all aspects of the health care system, ranging from the way hospitals are financed, to the organization of family care practices, to the payment system for medical doctors, to the use of non-physician professionals such as nurse practitioners, to the provision of out of hospital long term care for the incapacitated elderly, to a national formulary for drugs and more centralized drug purchasing, to the use of privately owned and operated specialized surgery clinics for repetitive surgeries like cataracts, and on it goes. Simpson recognizes that some of these are being implemented but at a snail’s pace – health care being the ‘third rail’ of Canadian politics. Politicians touch it at their peril!

The one commission report for which Simpson has little time – correctly in my opinion – is that produced by Roy Romanow for the federal government in 2002. That report was ‘unanalytical’ in the extreme, stating, for example, that the Canadian health care system compared “favourably” with those of other countries. As Simpson correctly points out, every cross-country comparison of the quality of health care systems ranks Canada’s among the lowest! Further, the key recommendation of Romanow was that our problems could be solved by more money. In fact, given the forthcoming demographic pressures on the system, that is the last thing we should be doing as virtually every other study points out!

Perhaps the most puzzling thing about our system is that, in the face of all the evidence about its deficiencies that garner a lot of press attention (wait times for surgery, the difficulty of finding family doctors, crowded emergency rooms, restricted availability of operating rooms, lack of adequate nursing care for the infirm elderly, relatively high generic drug prices, etc., etc.) a surprising number of Canadians believe, as Simpson points out, that our system stacks up well internationally! Referring to polling results on Canadians’ attitudes with respect to health care Simpson writes: “What emerges is a confusing mélange of passions, convictions, fears and mythologies. For example, Canadians are constantly being told medicare is the best in the world and, according to a 2006 Polara poll, 51 percent of Canadians believed it.” Ditto in a 2011 Deloitte survey: “… by margins ranging from five to one and twelve to one, with younger Canadians the most positive, respondents agreed that ‘our system works better than most systems in the world’, which of course has no basis in fact.”

Why this should be is a mystery, given the constant carping about the many issues noted above and the existence of numerous assessments – all publicly available and reported in the press – comparing Canada with other countries. It undoubtedly has to do, in part at least, with the fact that we’re next door to a country that, by most any measure, has among the worst systems in the world and the fear that any reforms, especially those having to do with private delivery of health services, will lead us down the slippery slope toward an American system.

In fact a major phobia of the Canadian system is that relating to ‘private’ medicine, this despite the fact that the share of total medical costs paid by the public system in Canada is among the lowest in the world – some 70%. This is because drugs, dental services and optometry services are not covered by the public plan. Moreover, Canada is alone among the industrialized countries of the Western world in not having significant numbers of physicians practicing outside the public system nor, with few exceptions, does the public system contract out the provision of medical services, cataract surgery for example, to privately built and run clinics.

The Canada Health Act, passed by Parliament during the Liberal administration in 1984, enunciated the principles under which the feds would continue their grants to the provinces. It was in response to a number of developments, such as ‘extra billing’ by physicians, that had occurred in the 1970’s. It has been argued that the Canada Health Act has been interpreted as prohibiting the establishment of the provision of medical services by for profit enterprises that are paid for by the public system. But, in an interesting and revealing discussion, Simpson argues that this is an overstatement of the intent of the Act. He states: “*public administration* has come to mean that only the government or someone directly employed by a public agency can deliver medical care, whereas what the Canada Health Act actually says is that health care has to be administered and paid for publicly, on a non-profit basis, but delivery by whom and how remains flexible. This misunderstanding has done much to choke off debate about the methods of delivery of health care, with defenders of the status quo insisting, wrongly, on a narrow definition that is not consistent with the wording of the act.” (page148).

Simpson has also discovered, or was provided, an‘interpretation manual’ written to provide material for federal civil servants in 1984. It says that the act “cannot be interpreted to mean that services cannot be provided on a ‘for profit’ basis. It simply states that the organization, commission, or agency that administers the provincial plan cannot record a profit on its operation.” And “The Act cannot be interpreted to mean that medical practitioners are precluded from making a profit or that hospitals providing publicly-insured health services cannot run a surplus or must be publicly owned and operated.” (page 149).

The provision of health services has been and remains a hot button issue in Canada even though most physicians, though they are paid by the public system mostly on a fee for service basis, are profit-making enterprises. Many (most?) are incorporated as ‘professional corporations’. However, as Simpson points out, if several physicians band together to create a for profit clinic to sell medical services to the provincial health care agency this is somehow incompatible with medicare!

There are difficult issues associated with the for profit provision of medical services having to do with equity and with the cost of private versus publicly provided services. For example a privately provided, for profit service will be more costly because of a higher cost of capital and the existence of a profit margin. And many health economists have used this as an argument against private provision. Offsetting the cost disadvantage, however, may well be more efficient and timely provision of services. Something will have to give in the Canadian system. As noted we have one of the more costly systems and we’re the only one that does not have a substantial private sector apart from that providing dental/drug/optometry services.

The other issue related to the private provision of physician services has to do with the ability of Canadians to buy private health insurance in this country. That is prohibited, according to Simpson, in Alberta, BC, PEI and Quebec. That prohibition as it applies in Quebec was challenged in a court case some years ago, referred to as the ‘Chaoulli Case’, and the Supreme Court of Canada ruled against the prohibition, a ruling that applies only to Quebec. It would be interesting to know the extent to which such insurance, which insures against costs associated with the provision of services by non-medicare providers, is in fact used by people in Ontario for example.

Simpson concludes:

“Canadians are so wedded to the medicare status quo, so fearful of change lest medicare somehow slip away and so ignorant of what other countries are doing that the political risks of candid talk, let alone serious reform, are intimidating. We are clinging to a system that exists nowhere else in the world: narrow and statist for hospitals and doctors, U.S.-style private and public health care everywhere else. Countries with largely public systems have been shaking up the statist approach for hospitals and doctors, while ensuring that public coverage extends beyond these services to other patient needs, especially elderly ones. That is the trade-off that other countries have made; that is the trade-off Canada needs.” (page 370).

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1. Jeffrey Simpson; *Chronic Condition: Why Canada’s Health-Care System Needs to be Dragged into the 21st Century*; Allen Lane, 2012. [↑](#footnote-ref-1)