Canadian Medicare 2017: Historical Reflections, Future Directions

Thursday, May 11th, 2017 – Public Keynote Lecture

The Past and Future of Canadian Medicare

Day 2: Friday, May 12th, 2017 – Invitational Symposium

Panel 1: Modernizing Medicare and Expanding Coverage Without Breaking the Bank: Lessons From History

Panel 2: Modernizing Medicare and Expanding Coverage Without Breaking the Bank: Lessons From Other Places

Lunch: Facilitator: Dot Pringle, Nursing, University of Toronto

Panel 3: The History and Future of Financing Medicare

Panel 4: Delivering on Medicare's Promise in the Delivery of Care

THURSDAY, MAY 11TH, 2017 – PUBLIC KEYNOTE LECTURE
THE PAST AND FUTURE OF CANADIAN MEDICARE

Facilitator: David Naylor, University of Toronto

Sally Sheard – Space, Place and (Waiting) Time: Reflections on Health Policy and Politics

Health systems have repeatedly addressed concerns about efficiency and equity by employing trans-national comparisons to draw out the strengths and weaknesses of specific policy initiatives. This paper demonstrates the potential for explicitly historical analysis of waiting times for hospital treatment to add value to spatial comparative methodologies.

Waiting times, and the size of the lists of waiting patients have become key operational indicators. In the United Kingdom, as National Health Service (NHS) financial pressures intensified from the 1970s, waiting times have become a topic for regular public and political debate. Various explanations for waiting times include: hospital consultants manipulate NHS waiting lists to maintain their private practice; there is underinvestment in the NHS; and available (and adequate) resources are being used inefficiently. Similarly, Canada has experienced ongoing tensions between the public and private delivery of universal healthcare in which national and trans-national comparisons of waiting times have been regularly used. The paper discusses the development of key UK and Canadian policies to explore wider issues including whether "waiting crises" were consciously used by policymakers, especially those brought into government to implement new economic and managerial strategies, to diminish the autonomy and authority of the medical professional in the hospital environment.

Gregory P. Marchildon – Can History Improve Big Bang Health Reform?

The professional skills of the historian are rarely relied upon when policies are being formulated. There are numerous reasons for this, one of which is the natural desire of decision-makers to break with the past when enacting *big bang* policy change. This article identifies the strengths professional historians bring to bear on policy development using the establishment and subsequent reform of universal health coverage as an example. Historians provide pertinent and historically-informed context; isolate the forces that have historically allowed for major reform; and separate the truly novel reforms from those attempted or implemented in the past. In addition, the historian's use of primary sources allows potentially new and highly salient facts to guide the framing of the policy problem and its solution. This paper argues that historians are critical for constructing a viable narrative of the establishment and evolution of universal health coverage policies. The lack of this narrative makes it difficult to achieve an accurate diagnosis of problems and, subsequently effective structural reform.

DAY 2: FRIDAY, MAY 12TH, 2017 – INVITATIONAL SYMPOSIUM

PANEL 1: MODERNIZING MEDICARE AND EXPANDING COVERAGE WITHOUT BREAKING THE BANK: LESSONS FROM HISTORY

Facilitator: Jeffrey Simpson

Erika Dyck – Bitter Pills: The Impact of Medicare on Mental Health

Medicare shifted the emphasis for mental health care away from large custodial facilities, that had been at the centre of the mental health system for decades, to out-patient psychiatric wings connected to general hospitals. This shift to care in the community expanded the patient population and, arguably, improved mental health care for many individuals who could now seek a variety of out-patient services rather than succumb to long-stay institutionalization. However, this shift also introduced new challenges: patients were increasingly expected to take responsibility for their own health care plans such as doctors' appointments and drug regimens, as well as sheltered employment, safe housing, and a social support network. An analysis of first-hand experiences suggests that despite the need for periodic clinical care, the major challenges to independence are political and economic. This paper examines some of these trade-offs and considers some of the historical lessons for continued discussions on public policy in the mental health care arena.

Josée G. Lavoie – Medicare and the Care of First Nations, Métis and Inuit

More than 30 years after its adoption, Medicare remains culture-defining for Canadians. The purpose of the Canada Health Act 1984, which gave life to Medicare, was to frame the federal transfer of funding to the provinces and territories, and set out the obligations of the provinces (10) and territories (3) to abide by Medicare's key principles of universality, comprehensiveness, portability, accessibility, and public administration. Although contextual, the Act was and remains silent on the Indigenous health care system, Canada's 14th health care system. The Act has not kept pace with self-government activities that have since spread across Canada. Furthermore it has, unfortunately, crystallized the jurisdictional fragmentation that perpetuates health inequities, and has failed to clarify federal/provincial/territorial obligations towards First Nations and Inuit. The recent Daniels decision might extend this confusion to the Métis, as well.

This paper argues that to respect and operationalize the federal government's commitment to reconciliation announced by the Prime Minister in December 2015, and align with the Truth and Reconciliation Commission's calls to action, Medicare renewal must: make an explicit commitment to health equity; clarify jurisdictional obligations; establish effective mechanisms to address areas of jurisdictional dispute and/or confusion; and explicitly recognize First Nations and Inuit nations' health care services as integral yet distinct systems that must seamlessly work with provincial/jurisdictional health care systems to ensure continuity of care.

Katherine Boothe – Pharmaceutical Policy Reform in Canada: Lessons From History

Canada is the only country with a broad public health system that does not include universal, nationwide coverage for pharmaceuticals. This omission causes real hardship to those Canadians who are not well-served by the existing patchwork of limited provincial plans and private insurance. This omission also represents significant forgone benefits in terms of governments' ability to negotiate drug prices, make expensive new drugs available to patients on an equitable basis, and provide integrated health services regardless of therapy type or location.

This paper examines Canada's historical failure to adopt broad public pharmaceutical insurance, with a particular emphasis on the role of public and elite ideas about its supposed lack of affordability. This legacy provides novel lessons about the barriers to reform and potential methods to overcome them. The paper argues that reform is most likely to be successful if it explicitly addresses entrenched ideas about pharmacare's affordability and its place in the health system. Reform is also more likely to achieve universal pharmaceutical coverage if it is radical and addresses various components of an effective program simultaneously. An incremental approach is likely to fail for various reasons: it will not allow governments to contain costs and realize the social benefits that come with a universal program, and it forgoes the current promising conditions for achieving real change.

PANEL 2: MODERNIZING MEDICARE AND EXPANDING COVERAGE WITHOUT BREAKING THE BANK: LESSONS FROM OTHER PLACES

Facilitator: Carolyn Tuohy, Public Policy and Governance, University of Toronto

Bruce Rosen – Expanding the Breadth of Medicare: Possible Lessons from Israel

In Canada, there is an ongoing debate about whether to expand Medicare to include a universal national pharmaceutical benefit. On the one hand, this could make a major contribution to the health of Canadians; on the other hand, there are concerns about affordability particularly among some political leaders and government officials.

In Israel, the National Health Insurance benefits package includes a comprehensive pharmaceutical benefit while per capita pharmaceutical spending is well below that of Canada and the OECD average. This paper highlights six strategies that Israel has employed to constrain pharmaceutical spending some of which are already used in some parts of Canada. Others may be adapted by Canada and contribute to the affordability of a national pharmaceutical benefit.

The strategies are: 1) Prioritizing new technologies subject to a global budget constraint; 2) Using regulations and market power to secure fair and reasonable prices; 3) Establishing an efficient pharmaceutical distribution system; 4) Promoting effective prescribing behavior; 5) Avoiding artificial inflation of consumer demand; and 6) Striking an appropriate balance between respect for IP rights, access and cost-containment. While Israel and Canada differ in many ways, several of Israel's strategies for controlling pharmaceutical costs may be transferrable albeit with substantial adaptation at the tactical level. For example, HMOs play a central role in

promoting effective prescribing behavior in Israel, whereas HMO-free Canada would need other mechanisms to advance this important goal. While there are definitely opportunities for cross-national learning between these two countries, they must be pursued with due caution.

Stephen Duckett – Expanding the Breadth of Medicare: Learning from Australia

The design of Australia's Medicare program was adapted from Canada's scheme, taking into account differences in the histories and constitutional division of powers of the two countries. Key similarities include access to hospital services without charge and universal coverage for necessary medical services (albeit with a variable co-payment in Australia). Significant differences also exist between the two countries' health programs regardless of whether they are labelled as "Medicare".

This paper discusses four areas where Canada could potentially learn from Australia in a positive way. First, Australia has had a national Pharmaceutical Benefits Scheme for almost 70 years. Second, there have been hesitant extensions to Australia's Medicare to address the increasing prevalence of people with chronic conditions. Extensions include some payments for allied health professionals, "care co-ordination" payments, and exploration of "health care homes". Third, Australia has a much more extensive system of support for older people to live in their homes or move into supported residential care. Fourth, Australia has gone further in driving hospital efficiency than Canada. Finally, the paper examines aspects of the Australian health care system that Canada should avoid, including the very high level of out-of-pocket costs, and the role of the private sector in providing acute inpatient services.

LUNCH: FACILITATOR: DOT PRINGLE, NURSING, UNIVERSITY OF TORONTO

Virginia Berridge – Why Policy Needs History (and Historians)

Policy makers like the idea of new initiatives and fresh starts unencumbered by – even actively overthrowing – what has been done in the past. At the same time, history can be pigeonholed as fusty and antiquarian, dealing with long past events that are of no relevance to the present. Academic historians are sometimes bound up in their own worlds. The debates central to academe may have little direct relevance to the immediate concerns of policy making.

This paper argues that history, as the evidence-based discipline par excellence, is as relevant as other approaches to evidence-based policy making. Case studies can show us the nature of that relevance. How history can influence needs discussion. The relationship is not straightforward and will vary by time and place. History is an interpretative discipline and not just a collection of "facts". This paper discusses how historians work and why it is important for policy makers to engage not just with history but with historians, as well. For their part, historians need to think about the value of bringing their analysis into policy.

PANEL 3: THE HISTORY AND FUTURE OF FINANCING MEDICARE

Facilitator: Michael Decter

Richard B. Saltman – The Impact of Slow Economic Growth on Health Sector Reform: A Cross-National Perspective

This paper assesses new health sector reform strategies adopted across Europe since the 2008 financial crisis. The paper begins with an overview of continued economic pressures on public funding for health care services, particularly in tax-funded Northern European systems. While economic growth rates across Europe rose slightly in the last year, they remain well below levels needed to expand public health sector revenues.

The paper then presents a conceptual overview of health sector reform strategies across Europe, locating recent efforts within broader overall health system patterns. Social Health Insurance (SHI) funded systems have focused on stepwise structural adjustments to funding health care systems (e.g., how funds are raised and distributed to health care providers). In contrast, tax-funded health systems have almost exclusively focused on re-structuring public sector providers on the production side of health systems. There are two notable exceptions to this pattern: Ireland – a tax-funded system – considered and rejected moving to an SHI funding model and the Netherlands – an SHI-funded system – changed funding levels and structural delivery characteristics in home care and long-term care services for the elderly.

The paper briefly reviews specific country approaches, flagging new mechanisms that have been introduced and which potentially could be reshaped and adopted in other national health sectors. Given Canada's tax-funded health system, the preponderance of cases focus on tax-funded countries (Norway, Denmark, Sweden, Finland, England, Ireland), with brief assessments of recent changes in SHI-funded health systems in The Netherlands and Germany. The paper concludes by suggesting that recent European reforms, while valuable, may not be sufficient to address core financial dilemmas.

Mark Stabile and Maripier Isabelle – Rising Inequality and the Implications for the Future of Private Insurance in Canada

Income and wealth inequality have risen in Canada from their low point in the 1980s to the present. Over the same time period, the amount that Canadians spend on privately-financed health care – both directly and through private health insurance – has increased. This paper explores the relationship between these two trends using both comparative data across jurisdictions and household-level data within Canada. The paper then outlines the implications for the future of private insurance in Canada. The starting hypothesis is that the greater the level of inequality, the more difficult it becomes for publicly-provided insurance to satisfy the median voter. Thus, we would expect increased pressure to access privately-financed alternatives as inequality increases. In light of these implications, the paper offers some guidance on how Canada can continue to offer comprehensive universal coverage and counter this trend.

Colleen M. Flood and Bryan Thomas – Constitutional Challenges to Canadian Medicare: What Policy Options Do Provincial Governments Have in the Wake of a Successful Charter Challenge?

In September 2016, a case went to trial to test the constitutionality of provincial laws in British Columbia that: i) ban private health insurance for medically necessary hospital and physician services; ii) ban extra-billing (physicians cannot charge patients more than the public tariff); and iii)) require physicians to work solely for the public system or "opt out" and practise privately. All provinces have similar laws and, thus, a finding of unconstitutionality of one or more of these laws could have a very significant impact on the future of public medicare. However, should the court find that a particular law is not in compliance with the *Canadian Charter of Rights & Freedoms*, the baton is then passed back to the government. The ultimate impact of any successful *Charter* challenge to laws protecting public medicare from privatization will depend on how Canadian governments respond. Provincial governments could permit privatization to undercut equity and access or they can respond creatively with new legal and policy solutions to improve equity and access, defending the human rights and dignity of all.

This paper provides an understanding – grounded in comparative health systems evidence – of law and policy options available to Canadian lawmakers for limiting two-tier care in the wake of any successful challenge to existing laws. The paper presents the results of a large inter-disciplinary, comparative study, started in 2015, that systematically reviewed the legal and broader regulatory schemes used to regulate the public/private divide in 18 OECD countries.

PANEL 4: DELIVERING ON MEDICARE'S PROMISE IN THE DELIVERY OF CARE

Facilitator: Andre Picard, Globe & Mail

Jacalyn Duffin – Doctors as Stewards of Medicare or Not: CAMSI, MRG, CDM, DRHC and the Thin Alphabet Soup of Physician Support

Canadian physicians have had a fraught relationship with many aspects of the health care system, especially Medicare. Beginning in 1944 with the earliest efforts to bring Medicare to Saskatchewan, opponents and supporters formed separate camps that culminated in a three-week doctors' strike in 1962. The doctors lost. Similar bitter divisions greeted the Canada Health Act in 1984 provoking another lengthy, devastating doctors' strike in Ontario. Again, the doctors lost the strike and popular respect, too. Physicians have regularly supported job actions when they are dissatisfied with their fee schedules. Some, like Dr. Jacques Chaoulli and Dr. Brian Day, have resorted to the courts. The recent rejection of the Physician Services Agreement in Ontario is another indicator of disaffection, as are the calls to abolish Medicare and/or introduce two-tiered health care.

Statistics Canada and OECD data show that health outcomes in Canada are far better than in the United States. Duffin's research shows that Medicare has benefitted average physician income. Physicians' intransigence over working with each other and with governments to fix income disparities within the profession abrogates the much-touted "competencies" valued in medical education: it proclaims a lack of collaboration, communication, and advocacy for the social

determinants that would improve population health. Small activist groups of lesser-paid physicians have argued for fixing the system from within, using evidence to define problems and find solutions; yet, their voices are hard to hear, drowned out by the hypocrisy of their colleagues.

Anne Marie Rafferty – Nurses as Change Agents for a Better Future in Healthcare: The Politics of Drift and Dilution

Nurses as change agents have been most effective when responding to a crisis. Responses have included engaging in campaigns and leveraging change by lobbying or goading governments into doing what they would not do if left to their own devices. This paper considers the conditions under which change has been possible. It draws on a range of historical examples from different national and international settings that exemplify the role of leadership in mobilizing change at the political, educational and clinical levels. The paper analyses the roles played by political regimes, culture, and structural factors such as race, class and gender on the empowerment of nurses. This analysis prompts the related question of leadership, and explores reasons for the persistent perceived gap between the demand and supply of strong leaders (or at least their visibility in a system that often presents nurses as invisible). The paper concludes by reflecting on the role that history can play in creating a counter narrative, one that provides a more nuanced framing of the question, sees nursing as part of the solution to health systems challenges, and repositions nursing for the future.

Carol Propper – Competition in Health Care and Lessons From the UK

The use of competition and choice in health care is a popular reform model adopted by many governments across the world. It is also a hotly contested model with opponents seeing it, at best, as diverting energy or a luxury and, at worst, as leading to health care inequality and waste. The paper scrutinizes the use of competition and choice in health care. It begins by examining the theoretical case and then argues that only by looking at evidence can we understand what works and when. The main body of the paper examines the evidence for the United Kingdom. For 25 years, the UK has been subject to a series of policy changes which have introduced and then reversed the use of competition in health care. Consequently, this makes the UK a very useful test-bed since it is possible to draw out causal inferences from changes that have been implemented. The paper presents the UK reforms followed by a discussion of the evidence which includes changes in outcomes such as quality, productivity and the effect on the distribution of health care resources across socio-economic groups. Possible mechanisms that could be leading to these changes are identified. Finally, the UK reforms are put into the context of reforms taking place in similarly centralized and heavily regulated healthcare systems.