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(Accepted 7 September 2001)

The future of health care in Canada

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BMJ 2001;323:926–9

Canada's healthcare system, commonly known as Medicare, took shape in the 1950s and '60s. Founded on the principles of universality, accessibility, comprehensiveness, portability, and public administration, the system was considered the crown jewel of Canadian social programming and enjoyed both massive public support and international admiration. Its achievements seemed particularly impressive compared with those of its US neighbour, which realised none of these five principles despite much higher costs. The issue seemed settled, and health care ranked very low on policymakers' list of concerns, particularly at the national level.

Times have changed, and a decade of turbulence has transformed Medicare from icon of Canadian values and organisational know how to an apparent state of crisis.[1] A further blow to an already-shaken collective psyche was the publication of the World Health Organization report that rated Canada's healthcare system 30th in the world in terms of achievement relative to potential.[2] (The media chose to downplay its seventh place ranking in terms of goal attainment, further promoting the air of crisis.) Has Medicare gone wrong, and, if so, what went wrong?

Summary points

Canadians continue to favour a publicly funded, comprehensive healthcare system but seem pessimistic about whether it is sustainable

Increasing privatisation, in numerous forms, has crept into the system

Numerous reports have called for substantial reforms, but achieving a consensus based solution remains elusive

To date, the government has simply given more resources to the system, while largely ignoring calls to enhance its comprehensiveness and accessibility

Culture, context, and recent history

To understand the evolution of Canadian health care, one must understand its constitutional arrangements and political culture. Canada is a federal system whose powers are formally and sometimes contentiously divided between the national and provincial governments. Section 92 of the Constitution Act of 1982 confirms the British North America Act of 1867 assignment of responsibility for (most) health care to the provinces. The national government asserts authority outside its formally assigned realms through "fiscal federalism"—that is, money. Box 1 outlines the legal structure of Canadian health care.

The fiscal storm clouds that gathered during the 1980s intruded on the calm waters of Canadian health care. Anxious to get its fiscal house in order, the federal government in Ottawa accelerated its unilateral cuts to transfer payments to the provinces, which in turn faced severe pressures to balance their budgets. The history of sharing healthcare costs between Ottawa and the provinces is long and complex. Stripped to its basics, what began in the 1960s as in essence a 50-50 split in costs had by 1995, through a series of sometimes negotiated and sometimes unilateral changes, changed to a national government share of as low as 16% (according to the provinces) to 32% (according to the national government, which adds to its direct cash contributions the money that the provinces now collect as a result of the transfer of "tax points" from Ottawa).[3]

These cuts led the provinces to impose, for the first time, real restraint on healthcare spending—a small but real per capita decline for a four year period ending in 1996-7. This had a highly destabilising effect on a system accustomed to growing by 2.5% (in real terms) annually from 1975 onward.[4] In concert with this abrupt halt to spending growth the provinces, responding to a spate of high level reviews of the healthcare system conducted in the 1980s and early 1990s, launched massive structural reforms.[5] Chief among these was regionalisation that both devolved operating authority to subprovincial geographic area boards and consolidated or eliminated a large number of local programme specific boards.[6]

The privatisation challenge

The issue of privatisation in many ways encapsulates the often highly charged debates about health care in Canada. Historically, a minority of providers and citizens have advocated a private, parallel healthcare system, though this has never been publicly supported by any political party. But privatisation has many meanings, and the system has always been a

Box 1: The legal basis for Canada's healthcare system

- The Constitution Act (1982) assigns responsibility for most health care to the provinces (the national government retains responsibility for aboriginal populations covered by treaties, the armed forces, and members of parliament)
- The Canada Health Act (1984) consolidates and defines the principles of the publicly funded healthcare system, known as Medicare. The five principles are comprehensiveness, universality, portability, public administration, and accessibility
- The Canada Health Act requires that all hospital and physician services be (virtually) 100% publicly financed without user charges. Third party insurance for these services is prohibited. Physicians can "opt out" of their provincially operated Medicare plans, with no state financing of care. There are nuances in how individual provinces regulate this provision, but uptake is very small
- The Canada Health Act is silent on other services, resulting in a patchwork of coverage arrangements that varies considerably from province to province
- The federal government has long shared tax revenues and negotiated cost sharing agreements with the provinces. It used its fiscal levers to engineer the key legislation that created a national Medicare system in the 1950s (Hospital Insurance and Diagnostic Services Act 1957) and 1960s (Medicare Act 1966). Its ability to enforce provisions and penalties under the Canada Health Act is contingent on its power to withhold fiscal transfers to offending jurisdictions

public-private hybrid (see box 2). Delivery has been almost exclusively private, but mainly non-profit.

Three factors have combined to make the issue of privatisation more prominent. Firstly, the philosophical basis of the system, the five principles embodied in the Canada Health Act of 1984, has been eroded because of changes in patterns of care. The core requirement of the act is that hospital and physician services be essentially 100% publicly financed. As health care becomes less focused on hospital and physician care (together they comprise less than half of all expenditures) and more on community care and drugs (the latter now exceed physician costs), less and less service falls under the rules of Medicare.

Box 2: A taxonomy of private health care in Canada

- Most (70%) health care in Canada is publicly financed, but almost all is privately provided. Almost all hospitals are non-profit private societies or corporations. Most non-academic physicians are "fee for service" private practitioners. Long term residential care and home care are variously non-profit, state owned, or for-profit, with different mixes in different provinces
- About half of prescription drug costs are borne privately, either by patients themselves or through third party insurance. All provinces have drug plans that cover certain populations, such as elderly people and those receiving welfare or with special needs
- Recently, increasing numbers of private, for-profit clinics have appeared offering services such as magnetic resonance imaging, cataract and corrective eye surgery, and rehabilitation (particularly physiotherapy). Practices range from totally private transactions, to purchase of services by regional health authorities on behalf of their populations, to third party insurance purchase of rehabilitation services

Secondly, recent massive government reinvestments in health care have not (yet) restored confidence in or brought stability to public health care. In September 2000 the federal government agreed to provide $C21.5bn for health care over the next five years (a 7% increase to public sector spending), and $C2bn for child development programmes.[7] Increases in provincial health spending for 2001-2 average 9% (about 6.5% in real terms), led by Alberta's increase of 13.5%.[8 9] This is despite evidence that health status has improved[10] and rates of common surgical procedures, such as hip and knee replacements and cataract removal, continue to rise[11] in spite of fewer hospital admissions and shorter lengths of stay. Pessimists—some would say realists—observe that neither structural reform nor money seems able to restore equilibrium. As public expectations are unmet, technological advances and other drivers of higher costs proliferate, and traditional solutions prove unworkable, the discussion about privatisation takes on a new relevance.

Thirdly, new forms of privatisation have developed. Legislation[12] and public sentiment constrain some forms of overt privatisation (box 1). However, technology has led to creative, and to some subversive, erosion of Medicare principles. In the past decade high profile private clinics have sprung up to "cherry pick" lucrative, high volume, and low risk diagnostic and therapeutic services (such as magnetic resonance imaging, bone densitometry, cataract surgery, and arthroscopic surgery).

Another pathway to "privatisation by stealth" is to combine the provision of an insured service with a suite of non-insured additions, in which case the insured service acts as a sort of "loss leader" that brings patients into the shop. If inattentively managed this practice can lead to queue jumping: patients who book fast access to a non-insured service simultaneously gain access to the insured service, for which others will have to wait longer. Before the development of such strategies, doctors had to opt out of the public system in order to gain access to the private market—a high risk move given the small number of Canadians who would prefer to pay both taxes to support the public system and directly for their own services. Now, under some arrangements doctors do not have to opt out of the publicly funded system entirely to opt into a lucrative parallel market. Depending on how vigilantly the federal and provincial governments oversee these activities, such activities can lead to a two tier service.

Privatisation to date: flirtation, courtship, or impending marriage?

Do these developments portend a new era of privatisation and mark the end of commitment to the substantive principles of Medicare? Have Canadian values changed, or have people simply given up hope that a tax based system can meet their needs adequately, despite it being a third larger per capita than in Britain and soon to consume an unprecedented 10% of gross domestic product?

The evidence from polls suggests that Canadians are unhappy with privatisation either by stealth or by policy. The great majority wants a single payer, comprehensive, publicly funded plan that works.[13] Alberta's recent legislation to allow the contracting of publicly funded procedures to private for-profit facilities elicited a public backlash that was seemingly not predicted by a conservative government in its fourth decade of continuous office (but returned with an even larger majority in March 2001). To appease the vocal opposition to the privatisation threat, the government tightened the provisions against extra billing and queue jumping. Ironically, Alberta's legislation, alleged by some to be the thin edge of the privatisation wedge, may have ended up, intended or not, as a bulwark against a two tier service and profiteering.[14]

Official opinion voices similar sentiments. The Canadian Medical Association, never the most reliable champion of Medicare, has argued for strengthening the public system with yet more funding.[15] While Canada's political spectrum currently extends from firmly right (the federal official opposition Canadian Alliance party) to moderate left (social democratic parties govern two provinces, arguably three if one defines the Parti Quebecois as social democratic), the traditional ideological cleavages are not reflected in official positions on health policy.

One interpretation, then, is that Canadians flirt with the privatisation suitor to rekindle the affections and performance of their chosen life partner, Medicare. Providers purvey gloom and doom scenarios to lever more cash, much of which ends up in their pockets: Alberta's physicians recently received pay increases of $C40 000, and its nurses are to get a 22% pay increase over two years. Major errors in planning and organisation (such as totally unmanaged waiting lists for elective surgery[16] and cancer patients in Ontario and Quebec being directed to US border cities) have raised concerns about the sustainability and competence of the system.[17] Medicare's philosophical critics have always declared that a free market approach, with health care as a commodity, is preferable. The real battle is for the hearts and minds of those sympathetic to Medicare's principles but less convinced than ever of its viability.

A renewed role for Ottawa?

As noted above, the federal government in Ottawa has attempted to buy back a meaningful role in the shaping of the healthcare system with cash, now that it is flush with multi-billion dollar surpluses. In the "First Ministers' Memorandum" in September 2000 the prime minister agreed to hand over the money more or less unconditionally, which can be seen as an implicit apology to the provinces still angered by the funding cuts in the 1990s. The "win-win" interpretation is that the provinces received a major increase in untargeted healthcare funding, while the federal government was seen as having addressed the main concern of most Canadians just before the general election in November 2000, which resulted in a Liberal majority government being returned a third consecutive time.

A potential problem resulting from this unconditional largesse is further fragmentation of a system that already shows considerable variation between provinces. (Although a requirement for "report cards" was included in the agreement, no one knows what this will mean in practice.) The Canada Health Act seems to be too imprecise and blunt an instrument to define and ensure comprehensiveness, accessibility, and quality throughout such a vast and diverse country. However, it could also be argued that the act's vagueness is also its strength, in a system where the responsibility for health care is legally that of the provinces. Interestingly, polls suggest that Canadians want both levels of government to be intimately involved in health care.[18 19] At present, both are involved in financing, but the provinces essentially decide on how to deliver care and allocate resources.

Home care and prescription drugs: crossroads for Medicare?

In 1997 the prime minister's National Forum on Health reported on the state of the healthcare system after 30 months of intensive consultation, deliberation, and research.[20] Among other things, the forum advocated that Medicare should also cover the costs of home care and prescription drugs, if not through legislation then through policy. It also called for the ratio of public to private coverage for health care to be restored to the historical 75:25 from the all time low of 69.8:30.2 reached in 1996-7.[21] In sum, the forum's central theme was to reverse the creeping privatisation of Medicare and to expand its scope.

As it turns out, both federal and provincial governments have steered clear of universal payment for prescription drugs, even while recognising appropriate drug treatment as a "medically necessary service" by any reasonable definition. They are sobered by history: no province has successfully controlled the costs of publicly funded drug plans, with annual percentage increases routinely in double digits. Saskatchewan, the country's most resolutely social democratic province (and birthplace of Medicare), implemented a universal drug plan in the mid-1970s that covered all costs except for a modest dispensing fee. By the end of the 1980s, it abandoned all public coverage except for certain high cost cases and for the poor. All provinces have faced the same pressures regardless of the exact configurations of their plans.[4]

With coverage for prescription drugs seen as desirable but financially risky, the focus has turned to home care. There is considerable public concern about imposing unreasonable burdens of care on citizens responsible for looking after elderly relatives. Home care accounts for only about 4% of total healthcare spending,[4] a figure widely perceived as inadequate either to meet real need or to substitute effectively for acute and long term institutional care. As a human service that evokes caring, compassion, and decency, it is politically attractive.

It remains to be seen whether Ottawa and the provinces can work out a strategy for expanding home care, even with the extra federal money on the table. Ottawa favours, if not uniformity, at least some common principles and standards. This will require substantial compromise because current variations between provinces are so large. For example, there is more for-profit home care in Central and Atlantic Canada than in the west, and varying degrees of

emphasis on post-acute care versus other forms of care. Some workforces are highly unionised while others are not; a "homemaking" service that costs $C19 an hour in British Columbia may cost $C7 an hour in New Brunswick. The highest provincial per capita home care budget is three times that of the smallest (whereas total healthcare expenditures per capita are remarkably similar).[4]

How this plays out may indicate the extent of Ottawa's resolve to implement the "pay to play" principle of fiscal federalism, and the willingness of the provinces to adopt common approaches when beginning from different positions. Accommodating for-profit, private care providers within an expanded publicly funded home care system may prove especially contentious, notwithstanding precedents such as laboratory services.[22] So far the obstacles to expanding the scope of Medicare have proved more powerful than the will to achieve it.

Privatisation as red herring?

With the introduction of regionalisation, the 1990s saw dramatic organisational changes in health services, but the main elements of the reforms recommended in a series of extensive reviews in the 1980s have yet to be adopted. Fee for service remains the dominant payment method for doctors, despite widespread and longstanding recognition of its perverse incentives. Primary care remains fragmented, unevenly distributed, and disproportionately focused on reacting to episodic illness. The rhetoric of population health has yet to translate into successful multisectoral strategies for reducing disparities in health status, although the national children's agenda is a notable step forward. British style regionalisation is now the norm in all provinces except Ontario, but structural innovation in itself cannot change the culture of practice. Performance measurement is in its infancy; only in 2000 did the Canadian Institute for Health Information publish its first, crude, and embryonic overview of what healthcare services actually accomplish and how they do so.[11 23]

From this perspective, the privatisation debate, although it may be substantively important, is simply a distraction from the real business of system reform. Historically, adding more money without attending to the fundamental questions of organisation, management, division of labour, public expectations, and performance measurement at best bought temporary peace and in some cases reinforced the status quo. The current challenge is whether provincial governments are able to lever real reform with their—and Ottawa's—cash infusions.

Solutions may be elusive, but the Canadian appetite for further study seems undiminished. The appointed Senate (Upper House) has launched an extensive review of its own, expected to take up to two years. In April 2001 the prime minister appointed recently retired Saskatchewan premier Roy Romanow (a social democrat) as a one person royal commission to review and recommend on all options for revamping the system. In response, Ontario premier Mike Harris, who heads a conservative government with Thatcher-like inclinations, has announced his own review, justified partly on the grounds that changes must be made before Romanow reports in November 2002. The success of the Romanow commission will depend on its prospects for generating new and creative discussion and alternatives for enhancing rather than eroding the core principles of Medicare.

In light of recent history, one wonders whether the provinces' successful rebuff of federal government leadership has been a Pyrrhic victory. None has comprehensively implemented the key reforms that all have separately called for. Given the poor track record of a fragmented and province-centred approach, it may be strategically wise to cede to Ottawa the authority to require crucial reforms and policies as a condition of its cash contributions. Such a strategy would both transfer some political liability for unpopular measures to Ottawa from the provinces and allow Ottawa higher visibility and a share of political credit for achievements. There is little evidence that the provinces are inclined towards such subtlety. Regardless of the next step in the federal-provincial tango, the central question is whether any federal government will be prepared to invest more without also buying real change.

Funding: CD, CM, and GC are funded by the Alberta Heritage Foundation for Medical Research. CD is also a Canadian Institutes of Health Research senior investigator.

Competing interests: None declared.

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(Accepted 25 June 2001)