How Canadians' deep affection for the status quo blocks health care reform efforts like the Mazankowski report

Jeffrey Simpson

In 2000, the World Health Organization (WHO) dropped a bombshell, figuratively speaking, on the Canadian health care system. By then medicare had already become a Canadian icon, a symbol of policy virtue, a publicly funded system for hospitals and doctors that had begun in Saskatchewan and became national in scope in the late 1960s.

When the WHO assembled data to compare "overall health system performance" in 191 countries, it shocked Canadians that their system ranked a miserable 30th (WHO 2000). Reaction was swift and predictable. Critics of the Canadian system seized upon the WHO report to justify their criticisms; defenders tore into the report's methodology.

Despite methodological controversies, the WHO report provided an indication that all was not entirely well with Canada's cherished medicare system. Part of the issue was funding, which remains a key flashpoint for debates about medicare reform. The Canadian economy was performing strongly when medicare became law in the late 1960s. Creators of the system as-

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sumed, as politicians often do in good times, that buoyant revenues would continue to pay *sine die* for this new health program. The 1970s, however, delivered the Arab-Israel conflict, a resulting oil embargo, and years of stagflation along with slow growth, double-digit inflation, soaring interest rates, high unemployment, and government deficits.

Still, medicare proved fairly impervious to significant reforms. By the time the WHO rankings came out in 2000, there was at least some appetite among officials for ideas to fix the problems. Reports piled up.

The first came in Alberta (*A Framework for Reform*) from an impressive group of experts from within and beyond Alberta under the leadership of former federal deputy prime minister Don Mazankowski (Premier's Advisory Council on Health for Alberta 2001). Others soon followed: the Romanow report commissioned by the federal government from Roy Romanow, a former Saskatchewan NDP premier (Commission on the Future of Health Care in Canada 2002); a multi-volume study under Senator Michael Kirby (Standing Senate Committee on Social Affairs, Science and Technology 2002); an examination of the Quebec system by Claude Castonguay, the health minister who had created the Quebec system (Task Force on the Funding of the Health System 2008); and another review of the national system by Kenneth Fyke, a former deputy minister in Saskatchewan and British Columbia (Commission on Medicare 2001). There were also smaller studies by interest groups, collections of essays by academics, and books.

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Many focused on how medicare should be paid for. Controversies over money between Ottawa and the provinces, and between provincial governments and providers (mostly doctors) had arisen soon after medicare's inception – controversies that continue to this day. Under fiscal pressure, Ottawa cut provincial health care transfers. Provinces in turn restricted their spending, including for health care, cuts that caused doctors to complain about the impact on their remuneration and assert that they intended to bill "extra" for procedures. The practice of "extra billing" threatened to introduce additional private payments into health care.

Thus was created the first confrontation between public-only payment – a principle at the philosophical and practical core of medicare – and the idea of introducing supplementary private financing.

The commissions that followed the 2000 WHO report grappled with that public-private debate. The Mazankowski report (and Claude Castonguay's in Quebec) went furthest in leaning towards more private payments. At the opposite end of the public-private spectrum stood the Romanow report that rejected all forms of private payment and argued for more public money to prop up and improve the existing system.

The Mazankowski approach slammed into political walls everywhere. Even Premier Ralph Klein, who had established the Mazankowski Advisory Council on Health, recoiled from the report's most controversial recommendations. Medicare, even in Alberta, was too firmly entrenched in the psyche of Canadians as a symbol of their citizenship. Canadians saw medicare as an example of equality and fairness. Its growing costs and evident weaknesses – the lack of consistently timely care and uneven access except for emergencies and life-threatening problems – could not shake medicare's grip. International comparisons long after the 2000 WHO report consistently showed Canadian medicare to be a poor-to-average system when compared to largely public health care systems in advanced industrial countries. Those comparisons never resonated with Canadians who, if they knew anything about another system, had heard only about the US health care system and wanted nothing like it.

It mattered not to Canadians and their governments that after examining the international evidence, the Canadian Medical Association in 2010 (which at the time was led by Dr. Jeffrey Turnbull, a staunch supporter of public health care) concluded that "a case can certainly be made that Canada's health care system is not delivering value for money spent: Canada is one of the highest spenders of health care when compared to other industrialized countries that offer universal care … [but] Canada's health care system is under-performing on several key measures, such as timely access" (CMA 2010, 2-3). The Canadian Nurses Association, another strong defender of medicare, concluded in the same year that "Canadians are not satisfied with the capacity of the health system to provide them with timely access to care… The inability of Canadians to access appropriate and timely care is evidence of fundamental shortfalls in the health system" (Canadian Nurses Association 2011, 2).

The Mazankowski report, looking only at Alberta's system, had reached similar conclusions nearly a decade before, although the report did acknowledge that "there is much to be proud of in Alberta's health system," adding "people who receive care rate it highly" (Premier's Advisory Council on Health for Alberta 2001, 4). Nonetheless, the report recommended a substantial overhaul of the system, especially considering new methods of financing medicare. Twenty years after the report's publication, a balanced summary of its impact would be that some of the secondary recommendations (of the kind made in almost all the other reports on health care) have been accepted but few of the more controversial ones have been implemented. Put another way, the easy suggestions found favour; the difficult, radical ones did not.

Of the secondary recommendations, electronic health records are now more common, although not of the kind recommended in the report. Alberta launched a Healthy U campaign and a Tobacco Reduction Strategy to encourage healthier lifestyles (smoking rates have fallen sharply for many reasons across Canada except in Nunavut). The province shrunk the number of regional health authorities from 17 to nine and then to five (every province has re-arranged its regional health authorities in the last 10 to 15 years). The Alberta government promised that health policies would be based on a "patient-first" philosophy (the Mazankowski report called it "customers first"), a phrase every province adopted to the point of cliché. It urged primary-care physicians to group themselves into clinics with nurses, nurse practitioners, dieticians and other health care providers along with a changed model for physician remuneration based less on fee-for-service and more on blended models of pay. This idea, recommended in other reports, did take root although it remains far from a universal way for family doctors to practice and be paid.

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The Mazankowski report – and here it did plough new ground – encouraged private clinics to provide care under contracts with the provincial government. One example was the Calgary Eye Centre and other similar institutions, owned and operated by ophthalmologists who provide services under contract with the local health authority. These institutions flowed from the Mazakowski report's argument that if health care services are publicly funded and standards are in place, it should make no difference if the facilities that deliver the services are public, private, or non-for-profit. That approach did percolate outside the province, where such arrangements became somewhat more common, but still far from the norm. Today, the idea of private delivery for publicly financed services remains controversial for those who believe in all-circumstances-all-the-time public institutions – the irony being, of course, that the majority of doctors are private entrepreneurs paid on a fee-for-service basis by the public system.

Of the primary and most controversial recommendations, almost none were implemented, starting with the report's suggestions for injecting more private money into basic health care provided by doctors and in hospitals. The report argued against a completely parallel private health care system. It rejected user fees for health services, which are common in some G20 countries, observing "while user fees may reduce demand, they are also a much greater barrier to care for people with low incomes" (Premier's Advisory Council on Health for Alberta 2001, 55). It also rejected making health care services "taxable benefits." It spurned a dedicated health care tax.

The report did urge serious consideration of personal medical savings accounts. But it seemed to favour, above all other options, the creation of variable premiums as a co-payment for using health care services and a personal health care account in which all except low-income people would "pay a co-payment for a fixed portion of the health care services they use" (2001, 58).

Strangely, having placed these options in the policy window and described them in broad terms, the report did not provide models or offer details about how these significant changes might work. In any event, neither of these ideas ever received serious consideration by Alberta governments, or by governments elsewhere in Canada. The argument for private payment, as opposed to private provision for publicly financed health care, could not overcome in Alberta or anywhere else citizens' deep attachment to the health care status quo or, to put matters differently, fear of change.

The report's arguments for opening the system to forms of private payments rested on philosophical (or ideological) and financial foundations. The report's philosophy was anti-statist, as in this early statement: "There are serious flaws in the way the system is organized. It operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of heath services. There is little choice or competition" (2001, 4). Later, the report contrasted what it called the "command-and-control" health care system with the education system, where "parents can choose which school they want their children to attend" and where "post-secondary institutions compete for students, introduce new programs to attract more students, and publish their results" (2001, 21).

Shopping for better products or services certainly applies in market economics, and it exists in certain European public health systems. Countries such as Germany and the Netherlands use a modern-day model of Bismarkian social policy in which competing health funds offer varieties of choice within a publicly financed framework. Canada, however, never bought into this kind of system, creating instead a variety of the British National Health System (NHS) with a centralized registry of services, doctors working for the NHS, hospitals run by the NHS, and patients provided with heath care cards for NHS billing. Nor for Canada the recent Swedish model where doctors and hospitals can establish their own clinics to compete with public ones, with public money following the patient to wherever she or he feels the best treatment can be found.

The Mazankowski report pilloried the province's NHS-inspired philosophy, complaining that "there's no competition and no incentive to provide the most efficient and effective services available… The system is organized around facilities and providers, not individual Albertans" (2001, 21). If "customers" are not satisfied, "They cannot take their business elsewhere so there is no incentive to keep improving service unless it is to save money" (2001, 21).

The patient-as-customer model has its attractions, and limitations. As in the Bismarkian-inspired systems and the Swedish reforms, competing plans or clinics can improve service as people move from one provider to another. But health care is not like a commercial product because there is usually considerable asymmetry of information between patients and medical practitioners. True, there is a plethora of information about diseases or medical problems online these days, but almost all the websites counsel users to check with their doctors. Therefore, the patient-as-consumer assumes a level of medical information that very few individuals would possess to put against the knowledge of health care providers and institutions.

The imperative of getting more private money into health care also arose from what the Mazankowski council believed to be medicare's fiscal drag on provincial finances. At the beginning of the report, the council rang the alarm bell: "Many have suggested – and the Council agrees – that without fundamental changes in how we pay for health services, the current health system is not sustainable. Spending on health is crowding out other important areas like education, infrastructure, social services or security. If health spending trends don't change, by 2008 we could be spending half of the province's budget on health" (2001, 4). Later on, the report correctly said that examining money spent versus health care outcomes in other countries demonstrated that "more money, if it not used effectively or in combination with other reforms, will not necessarily result in better health outcomes" (2001, 28).

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The Alberta budget of 2003, the year after release of the Mazankowski report, provided for a 7.5 percent increase in the health care budget, followed by increases of 4.3 percent and 5.5 percent in the next two years. In 2003, health care accounted for 30 percent of government spending, but the trend line was clearly up. This was the short-term context for the Mazankowski report's conclusion that "the current health care system is not sustainable if it is solely funded from provincial and federal government budgets" (2001, 53).

In those years the Alberta economy boomed. No balanced consideration of the "sustainability" argument can be made by only looking at the expenditure side of the ledger. On the revenue side of the 2003 budget, the Klein government bragged about Alberta having no sales tax, no payroll tax, no capital gains tax, Canada's lowest fuel tax, the country's lowest corporate tax rate, the lowest personal income tax rates, and a plan to eliminate completely the province's debt. These low tax rates were a cornerstone of what the government hailed as the "Alberta Advantage."

If Alberta did face a long-term budgetary challenge, it partly flowed from the province being a price-taker for its oil and natural gas or, as the report put it, "annual revenues to the province … can fluctuate significantly as the price of oil and gas swings up or down" (2001, 28). But it also flowed from the Alberta Advantage attitude to taxes, a philosophy the report was unwilling to challenge. It merely said: "Many Albertans would likely object to increasing taxes and there would be strong objections to any form of a sales tax, even if were dedicated to health care" (2001, 55). A realistic assessment perhaps, but certainly not a brave one.

The refusal to contemplate, let alone implement, a provincial sales tax sets Alberta apart from all Canadian provinces, most US states, and all European countries. It defies what almost every economist believes to be sensible tax policy. But in Alberta, the population has come to believe that to live without a sales tax is a kind of preordained right of citizenship. And although various think tanks, editorialists, and economists have argued for a sales tax, politicians of every stripe believe it to be the "third rail" of Alberta politics: touch it and you die.

So the idea of using private money to pay for some health care was driven in part by the report's acceptance of the Alberta Advantage low-tax philosophy. If raising every general tax – personal, corporate, sales – were ruled out, then some other form of revenue might be needed, namely some form of private payment for health care. Or the government could run deficits, which Alberta did when fossil fuel revenues fell.

By 2019-2020, the government was running huge deficits thanks to a combination of slumping oil prices and the early pandemic expenditures – and health care was taking 36 percent of spending ($21 billion), a far cry from the Mazankowski report's prediction that health could consume 50 percent of the budget by 2008. Still, health care had grown in real terms following the report, such that Alberta's spending on health became the second highest per capita in Canada, behind only Newfoundland and Labrador.

The Mazankowski report made only passing references to international comparisons, perhaps because apart from the controversial WHO report, few comparative studies were then available. As some emerged, the weaknesses of the Alberta system (which mirrored those across Canada) were reinforced. Canada's health care spending was among the highest for countries with largely public systems – 11.5 percent of GNP in 2019 – but the results were far from the best.

The Commonwealth Fund's reports based on surveys of patients and practitioners in 11 countries consistently rank Canada's system at or near the bottom (Commonwealth Fund 2021; CIHI 2017). As the Mazankowski report underscored, an enduring weakness of the Alberta (and Canadian) system was timely access. This flaw was reflected in the Commonwealth surveys. For example, among countries with public systems, Canada ranked second last in

the time lag for getting an appointment with a doctor, last in finding medical care in the evenings, weekends, or holidays, second worst for time taken to see a specialist, the highest use of hospital emergency rooms, and the second longest wait times for non-emergency surgery. The Organization for Economic Cooperation and Development (OECD) studies showed a mixed record for Canada, despite per capita spending on health care having risen from $5240 in 2010 to $6666 in 2019.

Mixed record or not, as the Mazankowski report pointed out, Albertans (like other Canadians) were reasonably satisfied with their health care system overall. In the latest Commonwealth survey, 63 percent of Canadians said their system was "very good" or "good." This level of approval, while sounding impressive, was the second-lowest among the 11 countries surveyed, with Norwegians, Swiss and Germans reporting satisfaction levels above 80 percent. Australians and New Zealanders reported levels in the high 70s, an interesting finding for Canadian health care academics who are usually quick to decry the private payment elements in the systems of those countries. Their more mixed systems apparently attract higher levels of satisfaction than the Canadian system. The 2021 Commonwealth Fund report ranked Canada last among countries with public systems on performance compared to spending.

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The majority's satisfaction level within Canada for the existing health care system partly explains why recommendations for wholesale changes, as in Mazankowski (and Castonguay), fell flat. As does the good quality of care, once accessed, and the fact that Canadians do not know other, better systems. There is also the fear of the unknown, since this is the only system Canadians have experienced. No political party in Alberta or elsewhere has dared to question the essential structure and method of financing medicare, and importantly there are only a few centres of criticism among think tanks or university professors.

Indeed, it is one of the ironies of health care discussions that the institutions best equipped to provide robust critiques of any status quo – universities – are populated with medicare's most ardent defenders. Many health care professors in these institutions might critically nibble at the margins of medicare's structure and financing model but they do not advance anything like the substantial overhaul proposed in the Mazankowski report. If anything, these experts often want the funding and structure of medicare expanded to incorporate all prescription drugs (pharmacare), long-term care, home care, and perhaps even dentistry. Medicare-plus is their preferred model for

change. The Canadian health care model that ranks near the bottom of international comparisons is the one they prefer for expanded coverage.

Might it happen, as the Mazankowski report predicted in 2002, that inexorably rising health care costs will "squeeze out" spending on other important government programs? Those costs have certainly been rising. An aging population will cause them to rise faster still because more people, especially women, will be living beyond age 80, and even 90, with the attendant health care costs that aging brings.

The "squeezing" effect has happened, is happening, and will happen, but at what rate and with what results? A decade or so ago, the amount governments spent on health care eclipsed for the first time the amount spent on all levels of education. Since the largest sums for health are spent on the older cohorts of the population, whereas education is mostly for the younger cohorts, an inter-generational transfer of resources is occurring. And since the share of the population in the older cohorts is growing, and since older people tend to vote in higher proportions than younger people, the political imperatives of health care spending are unlikely to be attenuated.

Under Prime Minister Paul Martin, who promised a medicare "fix for a generation," federal transfers rose by $40 billion over 10 years. Martin insisted this money would bring "transformative change." It proved to bring nothing of the kind. Some of the extra money was promised for procedures disproportionately used by older people – radiation, hip fracture surgery, cataracts, and joint replacements. The new money did indeed buy more of these procedures, and wait times went down for a while – except that demand kept rising so that the wait times rose again.

What happened to much of the new federal money is a lesson in public finance. As could have been predicted, the providers (mostly doctors) who are organized and targeted in ambition grabbed a disproportionate share of the money. Patients, by contrast, present to the health system as individuals. They are not organized and face the asymmetrical disadvantage of lacking the knowledge of providers. Hospital administrators did well too, as their salaries rose. Federal transfers, then as now, patch but have not fundamentally altered the system; in part because Ottawa has few if any powers to direct how federal transfers will be spent, health being a provincial jurisdiction.

Alberta will face substantial pressures on its health care system unless it dusts off the Mazankowski report and tries one of the private options for payment, which no political party will apparently do. Alberta has a large deficit arising from a drop in oil and natural gas prices, the province's failure to build a large rainy-day fund when fossil fuel royalties were abundant, and its refusal to introduce a broad-based sales tax. It now confronts a long-term decline in the demand for oil and natural gas, the revenues from which successive Alberta governments so unwisely and for so long excessively depended.

In retrospect, the Mazankowski report was ahead of its time, but that time never came – at least for its more radical proposals of introducing private payments into the public system. Nor did the time arrive for a 90-day "guarantee of access to selected heath services" (2001, 6), a target neither Alberta nor any province has come close to achieving. The idea did spread for electronic health records, but not ones that would show patients how much their treatment had cost the system each year – an idea tried by the Tony Blair government in Britain that subsequent analysis showed had no effect on patient behaviour. Nor was the report's recommendation taken up for a review of what should be covered by medicare, the report's inference being that it had been extended willy-nilly to services not initially contemplated but now considered essential by citizens.

Some day, maybe, the already stretched Canadian health care system will so alarm enough Canadians who wait too long for access that Mazankowski-type changes in the private/public mix might find some receptivity. Alberta and the rest of Canada are not there yet.

About the author

Jeffrey Simpson is an Officer of the Order of Canada, was *The Globe and Mail*'s national affairs columnist during which time he wrote about almost all the major Canadian public policy issues, and many international questions. He wrote seven books, one of which won The Governor-General's award; another, titled *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century*, won the $50,000 Donner Prize for the best book on public policy. He has received eight honorary degrees, lectured at several dozen universities in Canada and abroad, and is a member of the Trilateral Commission. He was on the Board of Governors of the University of Ottawa for nine years and is now an emeritus senior fellow at the Graduate School of Policy and International Affairs at that university.

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