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Mazankowski Report at 20

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Mazankowski: The man who had the prescription for medicare 20 years ago

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Introduction

The 20th anniversary of the Mazankowski report, *A Framework for Reform: Report of the Premier's Advisory Council on Health* (2001), is an appropriate time to assess the report's significant role in health care reform. Many of the report's ideas and recommendations were reflected in subsequent reports, health policies, and court judgments, but unfortunately some of the challenges highlighted 20 years ago remain unresolved today. As the country faces enormous pressure on health services caused by the COVID pandemic, it is particularly important today to reflect on Mazankowski's ideas for reform.

The Alberta government commissioned the report at a pivotal time in the 21st century history of Canadian health care. Its mandate, "To provide strategic advice to the Premier on the preservation and future enhancement of quality health services for Albertans and on the continuing sustainability of the publicly funded health system" (2001, 11), reflected growing public concern about the quality of health care that patients were receiving, especially the long wait times for treatment, and the equally important concern of governments about the long-term fiscal sustainability of the medicare system that had been created in the 1960s.

The report was also timely in that it coincided with other federal and provincial reports. Federally, the government commissioned the Romanow report, *Building on Values: The Future of Health Care in Canada* (2002), and the Senate released the Kirby report, *The Health of Canadians – The Federal Role* (2002). There were also provincial reports, such as Saskatchewan's Fyke report, *Caring for Medicare: Sustaining a Quality System* (2001) and Quebec's Clair Commission report, *Emerging Solutions: Report and Recommendations* (2001).

Interestingly, there were areas of common agreement among the various reports; for example, the general support for prevention, primary health care reform, changing the fee-for-service physician payment model, and improving information and accountability. However, there were major disagreements among the reports about critical issues like the sustainability of the health care system and the scope and nature of change required. Thus, this assessment will first consider the areas of common agreement with an analysis of the results achieved, then consider the more significant areas of difference.

Prevention, primary health care reform, and the role and compensation of physicians

The Mazankowski report, like other federal and provincial reports, argued that prevention was key to improving the health of Albertans and containing health care costs. It stated: "The best long-term strategy for sustaining the health system is to encourage people to stay healthy." The report added: "If we rely on simply treating people when they get sick, the increasing costs of new treatments and technology could bankrupt the system" (2001, 5). The analysis was based on population health: the report argued that the main determinants of health are education, income, employment, and environment. Hence improving people's health required a holistic approach that involved strategies like reducing poverty or curbing tobacco use (2001, 14).

As well as supporting prevention, all the reports endorsed some form of primary health care reform. The Mazankowski report described the benefits for patient care of a primary health care model that involved "multidisciplinary teams of health providers working together – doctors and nurses, nurse practitioners, dieticians, social workers" (2001, 33). However, the report also cited some major obstacles to moving to a primary health care model; for instance, many of the services that are part of a primary health care model are not funded by medicare and moving to such a model would require reforming the way physicians are compensated and their role in the health care system.

Structural problems with medicare

In the 20 years since the reports were released, there has been progress on investing more in prevention, moving to a primary health care model, and reforming the compensation and role of physicians, but the progress has been slow, primarily because of the way medicare was originally structured. In the 1960s when medicare was created, the health care system focused on treatment – doctors and hospitals – not on prevention. Thus, doctor and hospital services were fully covered by medicare but other services that are critical for primary health care were not. Doctors were paid on a fee-for-service basis and were the gatekeepers for patient access to the health care system, making it difficult to move to a primary health care model in which a variety of health care professionals work as a team.

Also, medicare services are funded from general revenue without any direct contribution by patients, meaning there is no restraint on demand. By fully covering doctor and hospital services, the government was funding the most expensive parts of the health care system. With no restraint on demand and the most expensive services being covered, the cost of medicare escalated well beyond projected costs, leaving limited funds available for preventative programs. Moreover, as the rate of increase in health care spending outpaced the rate of revenue growth, funding for health care crowded out funding for other areas such as social programs, which are fundamental to improving the overall health of the population.

Sustainability of the health care system

Though there was agreement on some issues, on others there were stark differences, notably the sustainability of the health care system, the seriousness of wait times, and the nature and extent of change required. On sustainability, the Romanow report stated that the health care system was as sustainable as Canadians wanted it to be and cited the fact that relative to Gross Domestic Product (GDP), Canada spent much less on health care than did the United States (2002, xxiii and 27). But comparing Canada's health care system to the American one is like a student comparing him or herself to the worst kid in the class.

The Mazankowski report made it clear that "Without changes, spending on health care is not sustainable" (2001, 27) and it provided a better way to measure sustainability. Unlike other reports that considered health care spending relative to GDP, the Mazankowski report focused on the share of provincial program spending that was spent on health care. The report stated that in 1990/1991, Alberta spent 24 percent of its budget on health care and 76 percent on all other government programs. But in 2000/2001 about one-third of the province's spending went on health care, leaving 65 percent for other government programs.

This analysis correctly diagnosed the sustainability problem: because health care spending was increasing at a faster rate than growth in the economy, it was cannibalizing other program spending. With health care taking up an ever-growing percentage of provincial program spending, it was crowding out spending on other important areas like education, infrastructure, social services, and security (2001, 28). And, of course, education and social programs were critical to improving overall population health. Thus, a major achievement of the Mazankowski report was to provide a comprehensive analysis of the reasons why the health care system was not sustainable.

Health care coverage

While many of the ideas in the Mazankowski report influenced subsequent policies, some of its recommendations did not produce significant changes. The most notable is the report's recommendations on health care coverage which are central to addressing the unsustainability of medicare. It argued that there should be a review of "what can and should be covered by Medicare" because, "the system was never designed to cover all aspects of health services, but people have come to expect that it will – and at no cost to individuals" (2001, 5). The idea never gained traction and in fact, rather than discussing ways to curtail coverage, the discussion in Canada has been more about adding programs such as home care, long-term care, or pharmacare to the list of covered services.

Funding the health care system

Another significant point of departure between the Romanow and Mazankowski reports centred on the funding of health care. The Romanow Commission's main recommendation on funding was that the federal government increase its contribution to health care to finance reforms and enhanced services. The Mazankowski report related funding to the sustainability challenge. Health care funding was already taking up a disproportionate share of provincial spending, and with an aging population and new treatments and drugs becoming available, the problem would only worsen. Finding efficiencies and streamlining services were necessary but would not be "sufficient to offset increasing demands and rising costs." The report continued, "If we depend only on provincial and federal general revenues to support health care, we have few options other than rationing" (2001, 7). Hence, the report was adamant that new sources of revenue needed to be found and it established some basic principles for revenue options (2001, 4-7). Finding new sources of revenue for health care would limit the crowding out of funding for other programs that were essential to overall population health and would provide a direct link between patients using the system and its costs. As economist Jack Mintz finds in his upcoming contribution to this series, reform of health

care funding is still required 20 years after the Mazankowski report.

Wait times for health care

Without new sources of revenue, rationing of services would be necessary, which in turn meant long wait times for care. The Mazankowski report saw wait times for care as a serious problem. The report stated: "We can't sustain a system where people are told: these services or treatments are available, they will diagnose health problems, cure illnesses, and make your life better, but they cost too much so you can't have them." It continued: "Waiting times are too long for many procedures and this causes Albertans to worry about whether the health system will be there when they need it" (2001, 4). The report also made specific recommendations to tackle wait times: patients should be given a 90-day guarantee of access to services and wait times should be reduced by introducing centralized booking, posting wait times on a website, and allowing people to access services from any physician or hospital (2001, 6).

Thus, while the Romanow Commission argued that the health care system was sustainable and essentially working well, the Mazankowski report provided a convincing diagnosis of its two main problems: fiscal sustainability and long wait times for care.

Reducing wait times for care

The Mazankowski report had some influence in the area of wait times. Its recommendations for reducing wait times by introducing centralized booking, posting wait times on a website, and allowing people to access services from any physician or hospital formed the core of the 2010 Saskatchewan Surgical Initiative's report, *Sooner, Safer Smarter: A Plan to Transform the Surgical Patient Experience*, which led to a dramatic decline in wait times for elective surgeries.

Ideology, competition and the private sector in health care

Having diagnosed the health care system's two major problems, the Mazankowski report recommended solutions. One necessary change was in ideology. The report stated that Canadians should move beyond the common practice to "just rehash the rhetoric of old arguments." Instead, it argued that all ideas needed to be up for consideration (2001, 30).

In contrast to the Romanow report, the Mazankowski report stated boldly

that "More spending is not the answer." It cited studies and international comparisons showing that "above a certain amount of basic funding, there is no direct relationship between spending on health care services and the overall health of the population" (2001, 30). Instead, making the health care system sustainable and addressing long wait times for care required major structural changes.

The most important structural change that the Mazankowski report recommended was to introduce more competition and private service delivery into the health care system. These ideas were fundamentally at odds with the Romanow report, which argued that the single-payer Canadian health care system was less costly than the American private system. The problem with this reasoning is none of the Canadian reports in fact favoured getting rid of the single-payer health care system. Instead, they were supporting private delivery of services; the *Canada Health Act* requires public administration of health care, but not public delivery of services. The Romanow report distinguished between the private delivery of ancillary services, such as laundry services, which it supported, and private delivery of health care services, which it rejected on the grounds that quality could not be assured and that private companies would cream off the least complicated procedures, leaving the public system burdened with the more complicated and costly ones (2002, 7).

The Mazankowski report made a strong case for introducing more competition and private services in delivering health care. The Canadian health care system was described as an "unregulated monopoly where the province acts as insurer, provider and evaluator of health services" (2001, 4). Rather than the existing highly regulated system, the report declared "It's time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice." The province, according to the report, should establish multi-year contracts with health authorities "setting out performance targets… and budgets," and the health districts should contract with public, private, and non-profit service providers with the goal of getting the highest quality services at the best price (2001, 5).

Another of the Mazankowski report's major recommendation was that the health care system needed to become patient focused. It argued, "the focus is more on hospitals and health providers and less on people [who] have little choice but to go where the public health system points us and wait in line if we need to" (2001, 4).

Patients first

The Mazankowski report's ideas were reflected in subsequent reports on health care. The 2009 report on Saskatchewan health care, For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health, took up the Mazankowski report's theme of making the health care

system more patient focused. The report stated that the interests of stakeholders – doctors and other health care professionals, unions, management, and government departments – dominated the health care system at the expense of patients. Hence, the report called for a fundamental cultural change that would focus the system on patients. The report argued that patients should play a greater role in managing their own health care and have more of a voice in managing the system. It also stated that focusing on patients would help break down the silos in the health care system and result in more integrated, coordinated care.

The *Chaoulli* case

The diagnosis of the problems in the health care system and the recommended solutions in the Mazankowski report influenced court decisions, subsequent health care reports, and government policies.

The similarities between the Mazankowski report and the 2005 Supreme Court decision in the *Chaoulli* case are striking (*Chaoulli* v. Quebec (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35). The case involved a challenge to the power of the Quebec government to enforce its monopoly provision of medicare services by preventing citizens from buying private health insurance for services covered by medicare, while failing to deliver services in a timely way. The majority decision was that "prohibiting health insurance that would permit ordinary Canadians to access health care, in circumstances where the government is failing to deliver health care in a reasonable manner, thereby increasing the risk of complications and death, interferes with the life and security of the person as protected by s. 7 of the Charter" (*Chaoulli* v. Quebec 2005, par. 124).

Especially interesting were the comments the Justices made about the Canadian health care system. Their consensus was that wait times for treatment were serious and resulted in compromised quality of life and in some cases death. The long wait times were also linked directly to the structure of the health care system and to ideology. One Justice commented that waiting lists were "intentional" in that they resulted from government policy decisions and they represented a "form of rationing." The Chief Justice challenged the idea that the Canadian monopoly for medicare services resulted in a superior system. She wrote, "Many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada" (*Chaoulli* v. Quebec 2005, par. 39, par 142, par 1423, par. 140). The decision also cited the role of ideology. One Justice stated that evidence of the negative effects of wait times had been available

for some time but that governments had failed to address the problem; the debates had focused on "a socio-political philosophy" so that governments had "lost sight of the urgency of taking concrete action" (par. 96).

Conclusion

The Mazankowski report had a significant influence on health care reform in Canada. It provided a succinct and insightful analysis of two of the main problems with the Canadian health system: its sustainability and long wait times for care. As well as providing an astute diagnosis of the problems in Canadian health care, the report made a compelling case for structural change. It argued persuasively that more competition and private delivery of health care services would lead to more choice and innovation. Moreover, the report's diagnosis of the problems and recommended solutions had an influence on future court decisions, health care reports, and government policies. In the *Chaoulli* decision, for instance, some of the analyses by the Supreme Court Justices of the structural problems in Canadian health care mirrored ideas in the Mazankowski report. Subsequent reports echoed the idea that patients – not stakeholders – should be the focus of the health care system. The changes recommended in the Mazankowski report to reduce wait times were reflected in subsequent provincial strategies to reduce wait times.

In short, the report was insightful when it was released, and its impact was felt well beyond the first decade of the 21st century.

About the author

Janice MacKinnon is a Fellow of the Royal Society of Canada, a member of the Order of Canada, and a former Saskatchewan Finance Minister. She has a PhD and M.A. from Queen's University and an Honours B.A. from the University of Western Ontario She is the author of three books and many articles on public policy issues. She has also served as the Chair of the Board of the Institute for Research on Public Policy, as a board member of the Canada West Foundation and is currently on the advisory board of the Global Affairs Institute. As a cabinet minister in Saskatchewan, she held various portfolios including Minister of Finance, Minister of Social Services, Minister of Economic Development, and Government House leader. From 2010 to 2015 she served as Chair of Canada's Economic Advisory Council. In 2017 she was appointed to the federal advisory panel on NAFTA and the environment. In 2019 she chaired the Blue-Ribbon Panel on Alberta's Finances. She is on the Board of Governors of the University of Alberta, is an Executive Fellow at the University of Calgary School of Public Policy and Professor of fiscal policy at the School of Public Health at the University of Saskatchewan.

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