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Straight Talk

True North In Canadian Public Policy

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Straight Talk: Reforming Canada's Health Care System

In this instalment of *Straight Talk*, MLI speaks to Janice MacKinnon, professor of fiscal policy at the University of Saskatchewan and former Saskatchewan finance minister, about proposals for much-needed reform of Canada's health care system. The interview has been condensed and edited for clarity.

Janice MacKinnon is a professor of fiscal policy at the University of Saskatchewan, a Fellow of the Royal Society of Canada, and a former Saskatchewan Finance Minister. She has an honours B.A. from the University of Western Ontario and a M.A. and PhD from Queen's. She is the author of three books, *The Liberty We Seek* (1983) published by Harvard University Press, *While the Women Only Wept* (1995), and *Minding the Public Purse* (2004). Between 1991 and 2001 she was a cabinet minister in Saskatchewan and held various portfolios including Minister of Finance, Minister of Social Services, Minister of Economic Development, and Government House leader. During her tenure as Finance Minister, Saskatchewan became the first government in Canada to balance its budget in the 1990s. She is Chair of the Board of Directors of the OmbudService for Life and Health Insurance, and she is on the Board of Directors of the Canada West Foundation. In 2009 she was appointed to the National Task Force on Financial Literacy. In 2010 Federal Finance Minister Jim Flaherty appointed her as Chair of Canada's Economic Advisory Council. She is also a public commentator on fiscal and political issues in Canada. In 2012 she became a Member of the Order of Canada.

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MLI: Should people be surprised that a former minister in a Romanow government would favour bold reforms to medicare, including forms of user payment and private delivery?

MacKinnon: I think when people think of private delivery, really it's only in Canada that private delivery of services is regarded as a right-left issue and actually, increasingly I wonder if it is. But, if you look at western European countries, which have a health system similar to ours in that they are public but actually they often have better results, they are socialist governments that consistently support private delivery of services.

It's just accepted, not only private delivery paid for by the government, but private delivery where you go and pay for your services. So, I think part of what we are missing here is that the system that was created by Tommy Douglas was a very good system for the 1960s. In the 1960s the idea was you got sick, you went to the doctor and the doctor fixed you. So, the focus was on funding hospitals and doctors because that's what the system consisted of. Only at the end of the 1960s was the idea beginning to take shape that, for example, if you smoked that was bad for your health; other lifestyle factors affected your health. So, I think that if Tommy Douglas were alive today, he very well may think – and probably more likely than not – that the system needs to be updated for a 21st-century system.

MLI: Now, the Romanow Commission Report has been characterized as mostly focussing on increasing funding. Is that fair?

MacKinnon: Well, I think part of what happens is if you do a report on health care like the Romanow Commission Report it's almost predictable what is going to happen because the biggest problem with changing the system in health care is you've got some very entrenched interests. You've got the doctors, you've got the nurses, you've got the unions, you've got academics who are committed to the status quo with only small variations. So, basically the report talked about change, but change at the margins, you know, primary health reform. Then, remember that report came out after the 1995 budget which made major cuts to all the social programs, but particularly hit health. Finance department people said putting money into the system actually prevents change, which is true if you look at what happened in Saskatchewan when the Romanow money came. The government – it was still an NDP government but it was a different one – said there's 25 rural hospitals that need to be closed. As soon as the money came from Ottawa they said, "oh by the way we're not bothering to close them". Why would you make a tough decision if somebody is going to give you more money to keep the status quo? Really the biggest waste was where that new money went, some $40 billion, to increase salaries for doctors, nurses, administrators, unions; all the people in the health system got better wages out of it. It was the biggest chunk of money, which is not at all what Canadians should expect.

MLI: With regard to compensation for health care professionals, you made the point in a paper for MLI that they are reasonably well paid by international standards. I think a lot of people worry about a health care brain-drain into the US; is that a reasonable concern?

MacKinnon: It used to be. The idea that the Americans would somehow or other attract our doctors was a problem in the past; it is not a problem today. In fact, if there is a flow, it is coming the other way – people coming into Canada. The only reason that we have such high salaries for health care professionals is a really unfortunate one – provinces compete with each other to try and attract nurses and doctors. Provinces have the tools they need to stop it though. Ontario kind of led the way with freezing salaries, and there are meetings now since the federal government decided it was not going to continue the 6 percent increase in health transfers into the future. Now the provinces are starting to say, "well, we have to kind of work together on compensation". I think they need to do more of that. Why are they competing with each other to drive up these salaries and costs? I mean, close to 70 percent of the whole cost of the health care system is salaries, so get a handle on that and you are going to start getting a handle on your costs.

MLI: How would you characterize the fiscal condition of the provincial health systems?

MacKinnon: Well, the biggest problem with health care in Canada is that it has been growing at a faster rate than the growth of revenue coming into governments, it has been taking a bigger and bigger share of the spending pie. In Ontario it is over 40 percent of spending and in some provinces half of the money being spent is going to health care. Well, that's not really a healthy future because

if you think about what affects people's health it's also the social programs you have, the poverty levels, education levels, the environment, and all of these other things that are being squeezed out just to fund the system. But these other things are actually in the long run more important to having a healthy population. So, I think that's our biggest problem that we have to deal with and if we don't deal with that we can spend more on health care but we'll have Canadians who aren't as healthy.

MLI: You mentioned that at the origins of medicare in the 1960s, health care was largely hospital-based care. To what extent do we rely too much on hospitals now and what are some of the solutions?

MacKinnon: We rely far too extensively on hospitals. Part of the problem is that for Canadians, the only free health care is hospitals and doctors, right? So, if you are going to use health care, you are going to go to the hospital or see a doctor. The problem is that they are also the most expensive part of the system and so the most expensive place to have anything done is in a hospital. Our goal should be to move as much as possible out of hospitals that doesn't have to be done in hospitals. So, in my paper I looked at Saskatchewan where they took 34 procedures that are performed in hospitals and they said we are going to use private clinics. They had a tender, there was bidding. A Calgary-based company, a private company, won the tender and it established clinics in both Regina and Saskatoon in which they did these procedures. They did things like cataracts, simple procedures, not complicated heart surgery, but simple procedures that had been done in hospitals but didn't need to be. The standards were set by the province, by the physicians, so the standards were the same. What they found is it was 26 percent cheaper to do these procedures in the clinics rather than in the hospital. My public health students will tell you very quickly when they look at a clinic, if you want to get a procedure done go to a clinic where the only thing they do is that procedure because they are going to be better at it than in the hospital where maybe they do that every so often. So, they are less expensive and easier for patients. These clinics you just drive up, there's a parking lot. Hospitals are big complicated places to get into and you can get some pretty bad infections just by being in the hospital, which is not as true of the clinics. So, there's one example of cost savings and better service, just by moving something out of the hospital. It is still paid for by the government.

MLI: The difference in the costs between public and private clinics seems to contradict a lot of what you hear about the dastardly profit motive. Can you tell us a little bit about that?

MacKinnon: Well, there are the factors I just mentioned and there is the fact that hospitals in Canada are heavily unionized. So, it's not that the clinics are paying lower salaries – they actually are not, but it's the administrative problem of trying to juggle the contracts of five different unions and members claiming "I get every Friday off, I don't work past this hour, I have this requirement, I have this grievance" ... In the clinic, the salaries would be the same, maybe even better, but the workforce is completely flexible. You can say to them, "we have a lot of patients coming in after five; you stay to seven tonight, but take tomorrow morning off." You can't do that with the unionized environment. You talk about the profit motive in clinics, which is certainly there, but there's a huge administrative burden if you have a unionized environment. The number of people that are required to manage the contracts, the agreements, and decide on how you move the workforce around, is extremely expensive and the clinics don't have that cost.

MLI: Unions have a strong incentive of course to advocate for an increase in public investment in health care. What effect have they had on the debate in general?

MacKinnon: Well, it's interesting. The Saskatchewan government did a very good job because they didn't actually approach it from a cost perspective; although, I'm sure that was a big motive. They

said, “look we have a waiting list problem and we’re going to establish these clinics so that you can get your procedures done more quickly”. How are people going to say, “well I don’t want the waiting list reduced”? The unions came out and said, “don’t use the clinics, spend $14 million more and build a new public facility”. Well, taxpayers can pretty quickly see why the unions would want to do that. I really wonder if private delivery beyond certain entrenched interest groups is a right-left issue in Canada anymore. I would say a lot of people in Saskatchewan who really would have wondered about private clinics have been to them now and they kind of say, “I’m not sure I see what the issue is here”. It’s good service, it’s easier, it’s cheaper – why aren’t we doing it?

MLI: How can hospital funding models cut costs?

MacKinnon: Part of the problem in the past has been that hospitals just get a global amount of money: “Here’s your money, and it’s 2 percent more than it was last year” or whatever. So they actually see patients as a cost. You come in and you are going to cost the system more money so the way they deal with their budget is to close beds or something to restrict access. If you actually change the funding to something like activity-based funding – and that’s where they had to move to compare with private clinics – you get a certain amount of money for each procedure that you perform. Well, then, there’s a competitive notion. Now you want patients through your door because it’s based on activity. So, changing the funding model, and Ontario and British Columbia have started to do that, I think is a really important factor. Don’t just say, “here’s your money, go do what you have to do”. Say, “we will give you money on the basis of some assessment of the activities that are being performed in the hospital”.

MLI: One of your potentially more controversial recommendations is that taxpayers pay for a portion of their care. Can you address Canadians’ attitudes to that idea to begin with, and then perhaps explain the model that you would advocate, which doesn’t include user fees, correct?

MacKinnon: One of the problems with the health care system, if you compare it to other programs, there’s no link at all between the services and the costs. So, the patient has no idea what the cost of the service is. The doctors really have no incentive to restrict costs; in fact, they are paid on a fee-for-service basis so if there is an incentive it’s to see more people and therefore prescribe more treatments. But, Canadians have a very entrenched idea that they pay for health care through their income taxes, which they don’t really. User fees have been advocated as one solution: you pay for the use of the system depending on what services you consume. The problem with the user fees is, in the past anyway, they have been paid right at the point of service and can deter people from seeking treatment. They might say, “I feel bad today, but I don’t have the money so I’ll wait until tomorrow when I’m really sick”. But many European countries, left-wing European countries, have user fees.

What I suggested is a model that is not a new idea at all – it just riles Canadians because they think “why would I have to pay for this?” – is to use the income tax system. So, first of all it’s based on ability to pay. You don’t actually pay when you go to access the service, so you are not going to be deterred, and there are different ways you can do it. You can make it a taxable benefit or you can make a co-payment so that certain services you are going to claim under your income tax or you are going to have to pay for certain services. The other thing about using the income tax system is you can be very selective. What I really was suggesting that is different than others is to start charging people for the doctor and hospital services to even it out because the problem is so many people are staying in the hospitals now because it’s the only free place to be. Long-term care you pay for; other facilities you pay for, but it’s a hard sell with Canadians.

I think the other problem that nobody really thinks of – well there are two. If you actually say a certain part of the increasing costs of health care comes directly from people, the problem of squeezing out other services is alleviated. Health care isn't growing, isn't taking an increasingly bigger part of the spending pie, so it's not squeezing out funding for education or social programs. There's also an issue of intergenerational equity if you like. The baby-boomers are coming along. The projections of the taxes the young people are going to have to pay if they want to keep the same health system are just out of this world. I can't imagine anybody actually paying those levels of taxes. So, if you get some way for people to pay for part of their health care, the baby-boomers, who can afford it, are going to be paying some share of their health care and creating less of a burden on the younger generation. We are going to have to end up there anyway.

MLI: Is one benefit to a user pay system a reduction in demand for services?

MacKinnon: You have to say, "why are you doing this?" You are doing it to raise some revenue for the reasons that I suggested, to curtail the crowding out and to be sure that the baby-boomers are paying some part of their own health care. But, in fact, all the studies show that if you do that there will be a reduction in demand and you will save money on the demand side as well. Some people will just not go to the doctor. Ask any family physician honestly behind closed doors, are there people here who should not be here and they say "oh yes it's true". So, you do want to detour some of those people from just going to the doctor for a visit.

MLI: A lot of people assume there is no elasticity in demand for health care services. Doctors will simply prescribe what's necessary and people will go to the doctor only when they truly need to. Would you say that is the case?

MacKinnon: No, if you look at the studies, and these are not my studies, any time you do put some charge, even a minimal charge, there is a reduction in demand. There are some people who say, well you know, maybe if my head cold feels bad today it might get better tomorrow and why should I put that on my income tax; there is a reduction in demand, but you know, that's not the main focus. The reason to do it is because the system needs more money and you can't just keep getting it from general taxpayers, you have to get it from the older people who are going to use it more who have the money because there are a lot of prosperous baby-boomers out there.

MLI: You have referred to the success Canadian policy-makers have had in reforming other systems of social services – education and that sort of thing. Can you talk a little bit about that and talk about why medicare has been so resistant to that kind of reform?

MacKinnon: If you look back into the 1990s, most of our social safety net was in trouble. It was expensive and outdated and needed to be changed. The welfare system, the post-secondary system, the Canada Pension Plan – all these things had to be changed, and they were changed successfully. The only one we didn't successfully change was health care. If you look at it, it's because of some of the structural problems we talked about. Canada Pension Plan you could reform because there was a link between the cost and benefit. You know that if you want more benefits – well, you're going to pay more. Family Allowance used to be universal, but we can't afford to give everybody money, so we are going to target it to those in need. You could also introduce competition, like in post-secondary education. But part of the problem in health and making those kinds of changes is the entrenched interest groups – the unions, the doctors, the nurses. At the end of the day when we tried in the 1990s to reform our health system, those interest groups eventually turned on the government because they realized they were going to be affected. They claimed that what the government was

trying to do is bad for your health. The public always listens to the doctors and the nurses rather than the government. So, it makes it very difficult for governments to actually want to take on those interest groups.

MLI: How can the federal government and the various provinces work together better to improve the system?

MacKinnon: One of the structural problems of the health system was that when it was created the federal government had the money and the provinces had the jurisdiction and so you had a really bad policy start. So, there's always been tension with the federal government saying "I'm putting this amount of money into your system, therefore I'm going to tell you how to run it; I'm going to set the rules". "Well," the provinces say, "I run the system, these rules don't work for me". Really, in 2004 when the federal government decided to increase health spending by 6 percent a year every year for 10 years, which is a huge amount of money, it did so because the provinces basically ganged up on the federal government, got the public behind them and said "we need this money for health care". But it's really a very bad relationship.

So, I thought one of the most significant moves was when the federal government in late 2011 said "we're going to have to renegotiate this health accord". The provinces wanted 6 percent or more back into health again and all the interest groups were out there and they were going to take on the federal government and there was going to be this great big rally and they were going to drag the federal government kicking and screaming to put more money into health; everything else was going to suffer. The Minister of Finance went to the provinces and said, "this is what you are going to get and it's done". It was actually quite generous: Until 2016, they continue to get 6 percent, and after that the money going into health will grow with the rate of growth in the economy and will never go below 3 percent.

But, what was really interesting was all of the sudden the provinces sat there and looked at each other and said, "now what are we going to do?" because the whole focus of the ministers of health had been to badger the federal government for more money. What they have never really done is what they need to do; they then have to co-operate. Only they can restrict health professional salaries and they began – they had been to some extent already – but they began working together on drugs. Why don't we buy drugs together so we can get lower prices? They started to do that. They need to do more of that; they should be working together and they should be looking more at best practices: "That really worked here, we're going to have to import it". But it's a new road for them. It'll take them some time, but it's a more realistic road than just battling the federal government. I always tell my students that health care has been like a car. The federal and provincial governments are trying to steer it, and when we have two drivers at the steering wheel, it always goes into the ditch.

MLI: What effect do you think the current federal government's approach, beyond the health transfer arrangement, will have on things? They appear to be taking their hands off the wheel, at least to some extent.

MacKinnon: What I think has always been one of the fallacies about the health system is that it's the federal government that had prevented the change in the provinces. I still remember Paul Martin saying he was going to really take on Ralph Klein and tell him that he is not going to do that with the health system in Alberta. The people in Alberta were quietly laughing because the federal government paid a very small part, less than 10 percent of the cost of the Alberta health system. That wasn't a realistic threat. What stopped Ralph Klein from making the changes was the public. His own public

didn't want to pay for the system, didn't want to make those sorts of changes. So, I think that it wasn't the federal government that prevented change. I think what prevented change was the money coming from the federal government to the provinces. Why would you change your system and make tough choices if you can just tell some other level of government, "give me money so I don't have to close these hospitals or I don't have to have a doctor strike". It was the money that was coming that was preventing change not the big tough federal government.

MLI: Do you think this message, coming from Saskatchewan New Democrat, rather than a Ralph Klein-type, might have more of an impact with Canadians?

MacKinnon: I don't really think about it that way. I think that particularly the younger generation, I have a lot of graduate students who feel this way. They do not have all of these old ideas, they can't figure out why we don't have a private system: "I can buy anything, why can't I buy health care. This is crazy!" So, they are quiet about it now because they know this isn't standard Canadian practice. You shouldn't be thinking these things, but they do. So, the system is going to change because the young people are not going to be set in some of these old ways about the way the system should operate. This is where we are heading.

Recommendations

1) Divert more people from hospitals to less expensive and more appropriate facilities.

2) Change the funding model so there is a link between the use of the system and its costs.

3) Provinces need to co-operate to deal with rising costs such as health care professional salaries and prescription drugs.

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