Healthcare Choice In Canada

Innovative policy solutions to improve Canada's failing healthcare system

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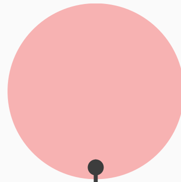

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INTRODUCTION

We need a new conversation about healthcare in Canada

**Christine van Geyn, Canadian Constitution Foundation*

We are so thrilled to bring you this book about healthcare choice in Canada and innovative policy solutions to improve Canada's failing healthcare system.

Healthcare in Canada is a topic rife with sacred cows and national mythology. But these dogmas are getting in the way of desperately needed reforms. The COVID-19 pandemic revealed many of the frailties of Canada's government monopoly healthcare system, and nationwide data suggests that the surgical backlog created by the pandemic remains today. The pandemic underscored the urgency for the need for reforms, and the reforms suggested in this book are a step in that direction.

In this book, we feature essays from some of Canada's thought leaders on healthcare reform who are not afraid to challenge entrenched ideology. We begin with our own expertise: the courts. And examine how deeply entrenched values about the role of Canada's healthcare system seemed to have stopped the courts from doing their duty to uphold the constitutional rights of Canadians suffering and even dying on government-controlled wait lists. This book features essays about how we measure Canada's healthcare performance, and how novel thinking around preventative healthcare and aging in your own home can reduce costs on the taxpayer funded system. We also consider how patient choice can drive quality in medical care, just as we know it does in other areas of our life, and how comparisons to the American healthcare system are misplaced, and Canada can look to Europe for models of reform.

We hope that this book will expand your beliefs about what types of changes are possible to improve Canada's healthcare system and improve lives for patients. And we'd love to hear your ideas for reform. If you have ideas you would like to share, please send them to me, you can contact me personally by email: cvangeyn@theccf.ca

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HEALTHCARE CHOICE THROUGH THE COURTS

*Christine Van Geyn, Canadian Constitution Foundation

When the government leaves patients languishing and even dying on long state-controlled medical wait lists it has legal consequences in Canada – or at least it was supposed to. In 2005, in a case called Chaoulli v. Quebec [1], the Supreme Court concluded that Quebec prohibitions on private-pay insurance violated the guarantees against government deprivations of the right to life, liberty and security of the person.

One would think this fact that Quebeckers have different rights from the rest of Canadians would create some conflict in the law. Some patients and medical clinics in British Columbia certainly thought so.

In that case, then-Chief Justice Beverley McLachlin observed that "access to a waiting list is not access to health care." Since that time, Quebeckers and visiting patients have enjoyed access to a growing number and modestly enhanced range of private facilities.

But what about the rest of Canada? Unfortunately, the Chaoulli decision does not apply outside of Quebec. Even though the principles at play – the guarantees of life and security of person – are protected by the Canadian Charter of Rights and Freedoms, the Chaoulli case was decided under the Quebec Charter. The Quebec Charter has the same protections but is only binding in Quebec.

The trouble is, all Canadians should be able to access healthcare. Government action anywhere in Canada that prevent patients from making choices about their health and which could - and do - cause Canadians to die, should be struck down as unconstitutional.

One would think this fact that Quebeckers have different rights from the rest of Canadians would create some conflict in the law. Some patients and medical clinics in British Columbia certainly thought so, which is why fourteen years ago they brought a legal challenge to BC laws that were substantially identical to the laws in Quebec that had been struck down in Chaoulli. The case was called Cambie Surgeries v British Columbia (Attorney General) [2].

"access to a waiting list is not access to health care."

The patients in the case had tragic stories. One was an 12-year-old boy when the litigation started who had a severe curve in his spine. Because of long waits on government lists, he was left paralyzed and wheelchair bound. Other patients involved in the case had pediatric knee injuries, cancer, required eye surgeries – all serious medical conditions where time really matters. In Chaoulli, the Supreme Court found that the rights of patients to security and person and even life were engaged by the government enforcing a healthcare monopoly and failing to let patients seek out care when the monopoly system fails. The Cambie litigation asked a simple question: does Chaoulli's reasoning apply to the rest of Canada?

The BC Court of Appeal contorted itself to find that the similar laws to what had been struck down in Chaoulli were constitutional in Cambie. Although the majority found that long wait lists engaged those fundamental rights of life and security of person, they bizarrely found that deprivations of life were consistent with the principles of fundamental justice.

The Supreme Court of Canada's decision to refuse leave in the Cambie matter is a shocking dereliction of the Court's duty

Some more recent cases have found unconstitutional certain prohibitions on assisted suicide, brothels and safe injection sites for hard drugs. But allowing a mother to pay for her child's spinal surgery in time to prevent him becoming a paraplegic? No, that prohibition stands in the name of an increasingly dysfunctional government healthcare monopoly.

The concurring Appeal judgment by Justice Fenlon held that the BC laws are not consistent with the principles of fundamental justice, but that the limits on these patients right to life and security was justified under section 1 of the Charter. "A law that causes patients to wait beyond a medically determined benchmark and thereby to incur an increased risk to life and limb in order to preserve a system intended to provide timely necessary care based on need is a law whose effects are inconsistent with its purpose and is, therefore, arbitrary in respect of those patients," she wrote.

But Justice Fenlon ultimately found that the violation was justified, based on deference to the "complexity" of balancing social and legislative priorities within the public care system. She deferred to the trial judge's findings that the importance of barring a private health care system was necessary to protect the public system, and more broadly, the "common good".

Laws that violate the right to life will almost never be justified under section 1. This is because the right to life is the most serious deprivation one can face. The only precedent for such a finding involving the right to security of the person is a 2016 Ontario Court of Appeal decision, R. v Michaud [3], which was denied leave by the Supreme Court of Canada. This should have served as a bad omen for the patients who brought the claim in Cambie.

In April 2023, the Supreme Court declined to hear the appeal. In doing so, the highest court dodged their opportunity to clarify the law so that the rights of Canadians are protected from coast to coast, and not just in Quebec. They refused to remedy a glaring inconsistency in the law between Cambie and Chaoulli. They left open the opportunity for future governments to impose policies that violate Canadians' right to life, and justify such action under the balancing test in section 1 of the Charter.

The Supreme Court of Canada's decision to refuse leave in the Cambie matter is a shocking dereliction of the Court's duty to provide legal clarity across the country. The role of the Court is to hear cases that raise legal issues of national importance, and given the growing crisis of wait times across Canada as well as the complex and contradictory state of the law, it is inexplicable and stunning that it elected not to hear this challenge.

The editorial boards for the Globe and Mail, National Post and even the Toronto Star criticized the top court for failing to hear this case. The Globe and Mail wrote "Looking at this tangle, the Supreme Court said: Nah, we're good. The court had an opportunity last week to finally resolve those contradictions, but

inexplicably chose not to."

The National Post editorial board wrote that the "Supreme Court can't be bothered to fix the health care chaos it created" and that "Canadians have a right to have doctor end their life, but no right to pay for the level of care actually needed to save life." The National Post board went on to say "We now live in a country where, if the substandard medicare system has left you in pain and suffering, you have a right to opt out by getting a doctor to pump your veins full of poison and end your life, but have no right to pay for the level of care you so desperately need. More importantly, in terms of legal consistency, we find ourselves in a situation in which the court has said that unnecessarily long wait times infringe the rights of Quebecers, but not those living in the rest of Canada."

The Toronto Star editorial board wrote "The Supreme Court's washing of its hands of this challenge will not bring consistency to provincial rules regarding the private-public mix and it will do nothing about the two-tier system already in place, in which patients can use private employer-funded health care to receive treatment."

This is unlikely to be the last legal battle over Canada's government monopoly on healthcare. Other provinces have similar legislation to what was struck down in Quebec and upheld in BC. There may be future opportunities for litigation in other provinces. But in the meantime, politicians could resolve part of this issue themselves. These laws that prohibit access to private care go beyond the Canada Health Act. The Supreme Court has affirmed that the federal law "does not prohibit private health care." If the courts will turn their eyes from the deaths resulting from Canada's monopoly health care system, politicians can stand up to defend these patients and address a decades long crisis head on. By allowing patient choice and a flourishing private sector for healthcare service.

ENDNOTES

[1] Chaoulli v. Quebec (Attorney General), 2005 SCC 35 (CanLII), [2005] 1 SCR 791.

[2] Cambie Surgeries Corporation, et al. v. Attorney General of British Columbia, et al., 2022 BCCA 245.

[3] R v. Michaud, 2015 ONCA 585.

"A law that causes patients to wait beyond a medically determined benchmark and thereby to incur an increased risk to life and limb in order to preserve a system intended to provide timely necessary care based on need is a law whose effects are inconsistent with its purpose and is, therefore, arbitrary in respect of those patients,"

PATIENT CHOICE DRIVES QUALITY IN MEDICAL CARE

*Dr. Shawn Whatley, Senior Fellow, MacDonald-Laurier Institute

It seems strange to defend an idea that most people take to be self-evident for everything else in their lives. Individuals know what works best for them. People know what kinds of service they need. Choice drives quality by rewarding those service providers who improve service to meet the needs of those they serve. But strangely, when it comes to healthcare, these basic common-sense principles need to be explicitly defended. Those principles are consumer choice driving quality, and the dangers of monopoly power.

All professionals, including accountants, lawyers, dentists, and doctors, can adjust their service based on clients' needs. The crux is whether or not professionals will improve service, when they see the need to change. While professionals cannot compromise professional standards, they can and do find creative ways to offer more, better, or different service than their competitors.

Canada used to have competition between doctors, in the 1970s and 1980s. Clinic schedules and service delivery had to be built around patient needs, not provider preference.

In 2001 while president of the Ontario Medical Association, Dr. Albert Schumacher said, "When I began practicing medicine nearly twenty years ago, the very idea of waiting for care in Ontario would have seemed far-fetched... How the world has changed—waiting lists have become the norm rather than the exception" [1]. The Fraser Institute only started studying wait times in the early 1990s and published its first "Waiting your turn" report in 1993 [2]. Wait time benchmarks did not even exist, until the Wait Times Alliance created them in 2005 [3].

Today, more than 2.2 million patients cannot find a family physician in Ontario [4]. If patients do not like their family doctor's service, they cannot easily leave the practice – because they might not find another.

Lack of choice removes a major impetus to improve service. Without choice, patients can only grumble to the office staff or write a formal letter to the medical regulator. Neither approach improves service. If anything, it might make service even worse.

What happened? In the early days of medicare, family physicians competed for patients. If you did not like your doctor, you could easily find a new one, in all but the most remote communities.

Today, more than 2.2 million patients cannot find a family physician in Ontario

Unless a patient chose to not have a family doctor, unattached patients simply did not exist until the 1990s. Doctors dared not go on holidays when their pregnant patients were due. Another doctor might deliver the baby and steal both the mom and baby away to join his or her own practice.

Competition for patients meant patients could expect far more than they can today. It was normal for doctors to provide house calls, take after-hours on-call duties (instead of signing out to a phone service), see their patients in hospital, assist in surgery, and care for family members in long-term care. Every office ran at least one evening clinic; many doctors offered multiple evenings as well as Saturday clinics.

Into the late 1980s, a young doctor could not start a practice by simply opening an office. New doctors had to work in an emergency department to slowly build a practice over many years, or they could buy a practice – a list of patients – from a retiring doctor. As late as the early 1990s, in Ontario buying a practice could cost several hundred thousand dollars. Even after buying a practice, new doctors needed to provide the same level of service (or better) than the doctors they replaced or risk losing a large percentage of their patient list to the competition.

In many communities today, a new family doctor can open an office and be full within a week, while offering appointments only between 9:00 am and 3:00 pm. Governments have to force doctors to work evenings and weekends, with increasingly detailed contracts and agreements. Retiring doctors find it hard to give their practices away, including all their office equipment, for free. In some places, physicians can have a full roster before they even move to a community and open a clinic to see their first patient.

Although Canada has more doctors per capita than forty years ago, we have far fewer in comparison to other countries. In 1970, Canada had "the second-highest ratio among 20 OECD countries for which data were then available," according to the Fraser Institute. By 2005, Fraser also noted that Canada ranked 23rd out of 28 countries [5]. In 2023, Canada ranks 27th out of 37 OECD countries for physicians per 1000 population [6]. Canada has controlled costs by rationing the number of doctors available.

What's worse, doctors care for far fewer patients than the average doctor did years ago. A full-time practice may have only 1200 – 1500 patients, whereas practices of 2500 and larger were considered full time in the past. Not only that, today's doctors offer less care themselves and can offer only a fraction of availability they could

Monopolies never provide as good service, because they are immune from competition and can provide inferior service without fear of losing business.

years ago. While this change has happened worldwide, Canada has not kept up with changes in medicine itself.

Part of the issue is that Canada has a system of monopoly healthcare. Consumer choice drives service providers to tailor services to match individual needs. Monopolies never provide as good service, because they are immune from competition and can provide inferior service without fear of losing business.

Following this logic, monopoly government healthcare will always offer worse care than if patients had choice within the system. Long wait lists, rationed care, and overcrowded hospitals are exactly what we should expect from a monopoly.

Defenders of medicare will note that simply having government pay for services (a monopsony) does not mean we must have rationed care. Governments make the choice to ration, which brings out all the bad aspects of a monopoly.

They could choose to offer more access, which would recreate competition inside the system that we had in the 1970s. We could have our single-payer, "free", universal, government-run monopoly and patient choice at the same time. Simple!

As former Prime Minister Margaret Thatcher famously said, "Socialist governments do make a financial mess. They always run out of other people's money" [7]. Canada spent 7 per cent of its GDP on healthcare in 1975 [8]. We spent 13.8 per cent of GDP on healthcare in 2020 [9]. even with heavy rationing of medical providers, technology, and hospital beds [10].

All things being equal, monopolies tend to focus on what works best for the monopoly, not what works best for those the monopoly is supposed to serve. This happens by necessity, not because monopolies are uncaring by intention. Whether through arguments about costs or appeals to quality-in-uniformity,

monopolies usually settle on a one-size-fits-all approach, or at best, a short list of choices, which do not inconvenience the monopoly. One-size-fits-all too often becomes one-size-fits-none.

Many things have changed since the start of medicare. One of the most prominent has been the elimination of patient choice. Until we can build a system big enough to allow patients the opportunity to change providers, based on the service they receive, we will continue to have long waits, inflexible service, and schedules that work best for providers, not patients. We need to rebuild that patient choice.

monopolies usually settle on a one-size-fits-all approach, or at best, a short list of choices, which do not inconvenience the monopoly. One-size-fits-all too often becomes one-size-fits-none.

ENDNOTES

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[10] note, spending dipped in the pandemic to 12.2% of GDP in 2022

MORE PREVENTION TO EASE HEALTHCARE DEMAND IN THE FIRST PLACE

*Colin Craig, SecondStreet.org

There's an old parable called The River Story that helps illustrate a major problem with health care in Canada. The story involves a young man named Alan who is walking along a river walk one day when he sees a man drowning. Alan dives in, pulls the man to shore and revives him with CPR.

Seconds after Alan helps this man get back on his feet, he hears a woman drowning in the river. So, Alan dives in again, pulls her to shore and provides CPR ... only to hear cries from a third person drowning. This happens again and again. Alan is so busy helping these victims that he doesn't have time to figure out the cause of the problem – a decrepit bridge upstream that is in desperate need of repair. The bridge is in such bad shape that it keeps crumbling as people try to cross it. If only Alan could warn people about the bridge, he could prevent the danger.

Today in Canada, provincial governments spend a significant portion of their health care budgets on treating patients with entirely preventable illnesses and conditions caused by lifestyle decisions – a poor diet, a lack of exercise, smoking, etc.

What if that changed?

If Canadians lived as healthy as, say, the Swedes, the French or the Japanese, then demand for health care services would ease and the system could use more of its finite resources to help patients with unavoidable health problems, including those with genetic conditions.

To be sure, Canada would still need health reform. Prevention alone is not a magic solution. As other authors in this book have shown, there are plenty of ways our system can and should improve to deliver better results for taxpayers.

But prevention deserves more attention from policymakers than it currently receives. The preventable illness numbers are staggering.

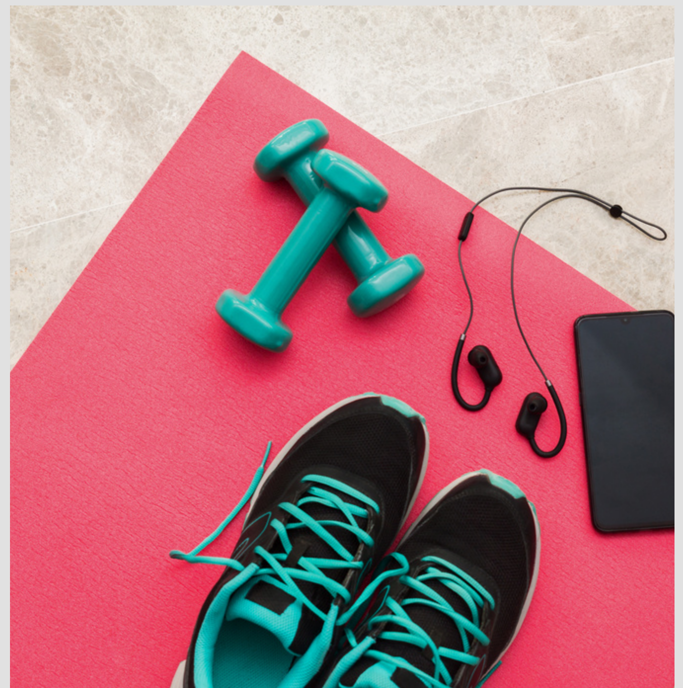
The Chronic Disease Prevention Alliance of Canada (CDPAC) estimated that the cost of treating diet-related disease in 2015 was approximately $26 billion [1]. For perspective, governments in Canada spent about $153 billion on health care that year.

Similarly, Diabetes Canada notes that the disease "impacts more than 11.7 million people across Canada and costs the healthcare system almost $50 million to treat every day."[2] This works out to approximately $18 billion on an annual basis. Some of these cases are caused by genetics, but a sizeable portion can be prevented with positive lifestyle choices.

It's not just poor dietary choices that are causing untold billions of dollars' worth of costs to the health care system. Few Canadians get enough exercise. According to a 2018 bulletin from the Public Health Agency of Canada, only 18 per cent of adult Canadians [3] get enough exercise each week. A lack of exercise contributes to many significant health problems, such as diabetes, hypertension (high blood pressure), heart disease and more.

The Public Health Agency of Canada noted in its Preventing Chronic Disease Strategic Plan 2013-16 [4] that if Canadians exercised enough each week, ate healthy and didn't smoke, 80 per cent of premature heart disease, 80 per cent of type 2 diabetes cases, and 40 per cent of cancers could be prevented.

Just imagine having a type of cancer that is genetic. As you languish on a government waiting list, suddenly 40 per cent of the people ahead of you in line vanish. It can't be overstated that a healthier Canadian population could do wonders for patients stuck on waiting lists.



There are countless examples around the world that show even small financial incentives can lead people to make healthier choices, like exercising more, eating healthier, or quitting smoking.

So, what can the government do? "Prevention" has been a buzz word for years, but it has yet to take flight in terms of policy. It's also tricky for governments to navigate – no one wants the state to regulate how much we eat or how much we exercise.

Under normal insurance models, those who pose higher risks, pay higher premiums. For example, drivers who receive more speeding tickets pay more for their insurance each year.

But health care in Canada is not a normal insurance model. There is no connection between the risks posed by a patient's behaviour and the amount they pay for health care services. We all pay excessive taxes that end up in a giant government pot and we're promised "free" health care in return.

Some have argued in favour of user fees in the health care system. Regardless of what you think of the idea, it appears to be an unrealistic option for the foreseeable future. Consider that the top issue in Canada right now is inflation and the rising cost of living. It's doubtful that a governing party would dare introduce user fees anytime soon. And even if a provincial government wanted to, such fees would also likely require Ottawa to change the Canada Health Act.

But what about the opposite? What if the government incentivized healthy living?

There are countless examples around the world that show even small financial incentives can lead people to make healthier choices, like exercising more, eating healthier, or quitting smoking.

The former CEO of Safeway, a U.S. grocery store chain, described in a 2009 Wall Street Journal column [5] how he introduced financial incentives for employees who met healthy targets when it came to weight, blood pressure, cholesterol levels and for not smoking.

Employees could save upwards of $1,560 on the cost of their health insurance premiums each year if they reached their goals. As Safeway's employees began shifting their behaviour to earn those savings, the company's cost for providing health insurance to its employees essentially froze over a four-year period while "most American companies' costs ... increased 38%" over the same time frame.

Insurance giant Manulife takes a different approach. Through its "Vitality" program [6] it uses technology to measure plan members' daily physical activity. Plan members wear FitBits or Apple watches and their daily activity is tracked. If they meet their targets, they can earn discounts on their life insurance or receive rewards such as gift cards for Tim Hortons and Indigo. The company claims its Vitality program has helped improve users' health [7].

Manulife has indicated that its Vitality program has helped improve users' health: "11 per cent [of Vitality users] improved their body mass index into a healthy range, 23 per cent did so with their cholesterol, 28 per cent with their glucose readings and 29 per cent with their blood pressure."

No one would want the Canadian government to monitor our steps or manage a program to hand out Tim Hortons gift cards. Governments tend to struggle with even simple activities. However, provincial governments should be encouraged to run pilot projects to see if there is a way to incentivize healthy behaviour without creating a bureaucracy to micromanage peoples' lives. Such programs should of course be voluntary. And if a government program showed positive results, it could then be scaled province-wide.

One thing is clear, if we can find a way to ease demand on the health care system in the first place, then the system will be better positioned to treat those with unavoidable conditions.

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MEASURING MEDICARE'S PERFORMANCE

a first step towards greater accountability

*Mackenzie Moir, the Fraser Institute

Canada's healthcare system is clearly in crisis. The media is awash with stories of overworked physicians, overcrowded hospitals, and underserviced patients. However, it can be difficult to separate out the direct effect of the recent pandemic and associated government action from systemic issues that have plagued our healthcare system for decades.

As governments consider potential solutions to our current predicament, it is more important than ever to objectively measure and communicate the performance of Canada's healthcare system across a comprehensive set of indicators relative to our international peers. Doing so is a crucial step toward identifying areas for improvement, increasing transparency, and restoring accountability.

In 2022, Moir and Barua compared Canada's health care system to a group of 30 other high-income countries that provide universal health care [1].

The study used a "value for money" lens to contrast two factors: i) the cost of the current system and ii) what Canadians got in return for their spending and found an overall imbalance between the two.

The study looked at two indicators for spending, thirty-nine for performance, and five for health status for a total of forty-six. Not all countries reported data for every indicator, however, meaning some had less than thirty ranked countries.

For the sake of comparability, most data were adjusted to account for the fact that some countries have significantly older populations than others (for example, 12.1 per cent of the Israeli population was over 65 compared to 28.6 per cent of Japan's in 2020), as we know there are differences in how health care resources are used based on age. For example, in 2019, Canadians over 65 consumed 45 per cent of public health care spending by provinces and territories while making up 18 per cent of the population [2].

The relative differences between the amount countries spent on health care were examined on two indicators - total health spending as a percentage of gross domestic product (GDP) and health spending per capita.

at 13.3 per cent, Canada was the highest spender on health care as a percentage of the economy

In 2020, the study found that Canada, at 13.3 per cent, was the highest spender on health care as a percentage of the economy, higher than the Organisation for Economic Co-operation and Development (OECD) average of 10 per cent. When spending per capita was examined, Canada ranked 8th out of 30 countries (at $5,988 USD PPP), significantly higher than the OECD average ($4,627 USD PPP). The results suggest that Canada spends more on health care than the majority of other OECD countries with universal health care.

Relatively high spending has to be taken in the context, however, of what's provided. A high-cost system can generate high value. Unfortunately, Canada did not fall into this category. In fact, of the four performance categories that were evaluated, Canada's system had mixed results on its use of resources and its clinical performance and quality, while

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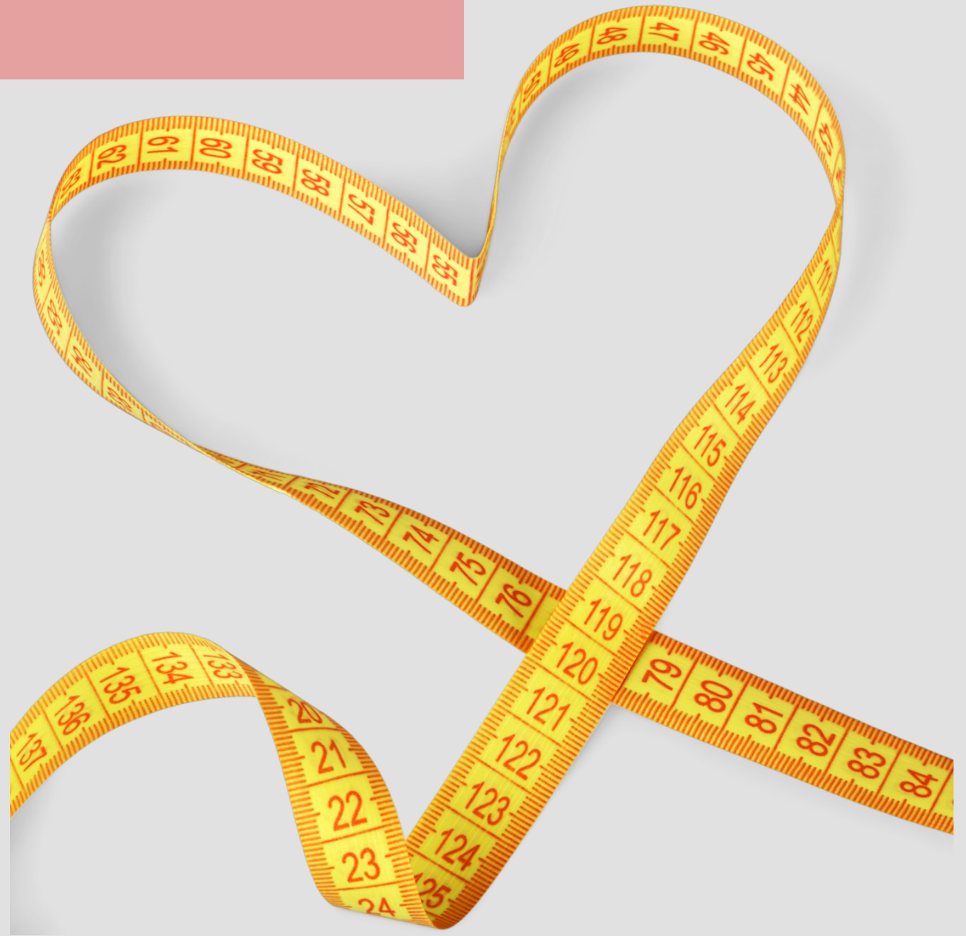

doing poorly on resource availability and access.

All health care systems rely on some combination of health care providers and physical resources, like hospital beds and diagnostic technology, to provide care. The availability of these resources is, therefore, a crucial performance measure. When the relative availability of physicians was examined, the study found that Canada ranked 28th out of 30 countries, with 2.8 physicians per 1,000 people. In contrast, Norway, ranking 3rd, had 5.3 per 1,000 people. Canada however did perform better when nursing availability was examined, ranking 15th of 30 countries.

When physical health resources were examined, Canada ranked 23rd out of 28 countries on care beds, with 2.2 beds per 1,000 people – whereas Germany, which ranked 3rd, reported 6 beds per 1,000 people. On psychiatric beds, Canada ranked 22nd out of 29 countries while ranking 7th out of 17 countries on long term care beds (unadjusted).

Canada ranked 9th of 10 on the ability to get a same day appointment when sick, 8th when it came to how easy it was to find after hours care

Canada also performed poorly on the availability of diagnostic technology, ranking 26th out of 29 countries on MRIs, with 10.3 units per million people and 27th out of 30 for CT scanners, with 15.0 units per million people. For contrast, Japan (ranked 1st), had over four times as many MRIs per million people, while Australia (ranked 2nd) had nearly five times as many CTs. For PET scanners, Canada ranked 20th out of 25 countries and 14th out of 23 countries for mammographs – while, in contrast, doing quite well on Gamma cameras, ranking 3rd out of 24 countries. Overall, Canada performed below the OECD average on 7 out of 10 measures of resource availability.

The report also found that Canada had mixed results on the use of its available resources, performing better than the OECD average on two thirds of the thirteen utilization indicators. For example, Canada performed well on its provision of doctor visits, ranking 8th out of 27, but performed poorly on hospital activity (as measured by the volume of discharges), ranking 26th out of 27 countries.

When clinical performance and quality were examined, Canada performed better than the OECD average on five indicators (doing particularly well on some cancer survival rates and the timeliness of hip-fracture surgery), while performing no different or worse than the average on the remaining six. Notably, Canada ranked dead last (20th) on two measures of obstetric trauma during birth.

The report also evaluated the access patients had to medical resources for 10 high-income countries. Of these, Canada ranked 9th of 10 on the ability to get a same day appointment when sick, 8th when it came to how easy it was to find after hours care, and 7th on experiencing an access barrier due to cost. However, it performed particularly poorly when timely access to specialist (under 4 weeks) and elective surgical care (under 4 months) were evaluated – ranking dead last on both measures. For example, while only 38 per cent of Canadians reported timely access to specialist care, 69 percent of Dutch reported the same (ranking the Netherlands 1st). For elective surgical care, 99 per cent of Germans (ranked 1st) reported timely access compared to 62 per cent of Canadians. Overall, Canada was below the OECD average on 4 of 5 measures of timely access.

In summary, despite being one of the highest spenders, Canada only outperformed the OECD average 41 per cent of the time on performance indicators (16 out of 39 variables). This suggests an imbalance between Canadian health care spending and the value they get in return from their health care system – based on its performance.

This imbalance has real world negative implications for patients who, on the whole, have few viable alternatives for seeking medically necessary treatment. Further, this current "crisis" in Canadian Medicare cannot be solely attributed to relatively recent shockwaves created by the COVID-19 pandemic. Rather, it has been years in the making and the result of

deliberate policy choices. However, options for reform are severely restricted due to the existing arrangement between the provinces and the federal government.

This restriction is because there's an ever-looming threat of a withholding of federal cash transfers due to a perceived violation of the Canada Health Act. As a result, premiers are often hesitant to experiment with what would otherwise be a more complete range of potential reforms that are common in more successful universal healthcare systems around the world. This has entrenched public systems that routinely underperform in their provision of medically necessary care.

As governments continue to grapple with public frustrations with their provincial health care systems, the measurement and communication of their performance will continue to be a crucial tool for system transparency, improvement and accountability.

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AGING IN YOUR OWN HOME

How European Cash-for-Care Models can reduce institutionalization

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Long-term care in Canada is heavily skewed toward institutionalization. Yet seniors generally prefer to age at home if they can. Moreover, the greying of the Canadian population will put increased pressure on our long-term care institutions in the coming years. Already, the share of the population aged 65 or older had risen to 19 per cent in 2022, up from just 14 per cent a dozen years ago, and is projected to hit 22.5 per cent by 2030 [1].

cash-for-care models give seniors purchasing power through direct public transfers, which can be used to support care at home.

One way to shift the focus from institutionalization to home care is by giving seniors a larger say in what services they receive, and where. European cash-for-care models provide that choice, favouring the development of care markets [2] and reducing reliance on institutional care [3]. These models give seniors purchasing power through direct public transfers, which can be used to support care at home. In contrast, most seniors in Canada have very little control over where and how they receive services [4].

Cash-for-care models vary from country to country, with transfers taking various forms: direct payments, care allowances, personal budgets, self-directed care, attendance allowances, or individual budgets [5]. Seniors generally have a choice between purchasing professional services or compensating informal caregivers [6].

In countries where cash-for-care is well developed, there is relatively higher spending on home care, in contrast with Canada's heavy institutional spending. In the Netherlands, for instance, almost a quarter (23 per cent) of government and compulsory insurance spending on long-term care in 2017 was for home-based care. In Germany, a whopping 57 per cent of such spending was for home care. In Canada, this number was just 11 per cent [7].

MORE CHOICE AND AUTONOMY FOR SENIORS

In both Germany and the Netherlands, seniors can choose between in-kind services or cash to spend on market services for their own care arrangements, including the compensation of informal caregivers [8].

most seniors in Canada have very little control over where and how they receive services

In Germany, cash benefits can be transferred directly to seniors who then arrange (with the assistance of care coordinators) the care that best suits their needs. Individuals who choose the cash option, though, receive a smaller subsidy than those who receive care in kind [9] Research shows positive welfare effects for seniors following the introduction of this system in Germany, due to their added autonomy and greater self-determination, [10] which tend to lead to better health and better adjustment to increased care needs [11].

In the Netherlands, a formal employment contract is required between caregiver and recipient [12]. Not coincidentally, proportionally fewer recipients have opted for cash payments compared to Germany, [13] likely restraining growth in informal care markets. This may also help explain why the proportion of overall spending on home care is higher in Germany. Nonetheless, the Dutch system is well tailored to the needs of users, and seniors' needs are often taken care of at home unless institutionalization is a necessity [14].

In Canada, there is little choice over the basket of services available [15], and home care support is lacking, leading to over-institutionalization. A recent study found that one in nine Canadians newly admitted into institutional care could have stayed at home with adequate support [16].

With a third of those who provide informal home care in Canada reporting being distressed, there is a need to improve home care services and community supports so that caregivers are better equipped to provide the proper care for those who wish to remain at home [17].

one in nine Canadians newly admitted into institutional care could have stayed at home with adequate support

This is all the more important given that an estimated 70 per cent to 75 per cent of home care in Canada is provided informally by relatives [18]. Being able to use long-term care funds to pay informal caregivers could help ease their burden, encouraging them to continue providing care and thus avoiding unnecessary institutionalization.

QUALITY AND COST: ADDRESSING CONCERNS ABOUT CASH-FOR-CARE

While cash-for-care models give users flexibility and a voice in how and where they receive care, there are potential risks to increasing the proportion of home care in Canada using such models. In particular, there are concerns related to quality control and to the containment of public spending.

First, the use of unqualified workers can lead to poor care quality, which can significantly impact recipients' health [19]. Yet this is far from an unsurmountable challenge. Safeguards can be implemented, such as a training program for informal caregivers, covered by health insurance funds [20]. Periodic visits of care recipients can also be made to ensure the adequacy of their overall situation at home [21].

countries with better-developed home care tend to experience lower public expenditures in the long run.

Second, there is the issue of spending growth with increased access and uptake [22]. In fact, countries with better-developed home care tend to experience lower public expenditures in the long run. Evidence from multiple jurisdictions shows long-term cost savings following the expansion of home and community care, which makes sense as it is generally more cost-effective than institutional care [23].

In the short term, however, evidence regarding the impact of cash-for-care models on public spending is mixed [24], and there might be short-term increases in spending following implementation [25]. For example, when the Netherlands first adopted its cash-for-care system in the 1990s, there was an initial sharp increase in public costs, and multiple reforms were needed in order to reel in expenditures [26]. These resulted in the provision of institutional care to those who really need it, while others were able to age at home, and just recently, between 2015 and 2019, there was an 86 per cent decrease in the number of seniors requiring low levels of care in institutions [27].

By enhancing choice and developing care markets, cash-for-care models can foster the development of home care, thus reducing the overreliance on institutional care.

CONCLUSION: LEARNING FROM WHAT WORKS

The historical reliance on institutional care in this country has kept many elderly Canadians from reaping all the well-documented benefits of aging in their own homes. Just maintaining control over their daily lives instead of having to adhere to a rigid schedule in a long-term care centre is a boon. Living in a familiar environment can also be beneficial, and the preservation of autonomy can have a positive impact on quality of life and sense of well-being.

By enhancing choice and developing care markets, cash-for-care models can foster the development of home care, thus reducing the overreliance on institutional care. Best of all, there is no need to reinvent the wheel. Public authorities in Canada can emulate such models in countries like Germany and the Netherlands in order to help more of our seniors spend their golden years in the comfort of their own homes.

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POLITICIANS AND HEALTH CARE

Lead, follow, or get out of the way

*Susan Martinuk, Frontier Centre for Public Policy

Health care has long been used as a political strategy to gain votes at the federal and provincial levels of government. In the beginning, that connection was mutually beneficial, and governments offered innovative policies to serve the health care needs of their citizens.

In the 1940s, Tommy Douglas used the promise of socialized medicine to gain a majority government in Saskatchewan, while Prime Minister Lester Pearson used the first national Medicare program as election bait to stay in power some 20 years later.

But politicians no longer seem to have the big ideas or vision that are needed to save health care. They make election promises to “fix” it, yet never present a coherent plan for change and instead seem content to pour vast amounts of money into a broken system. But that is not sustainable in the long term and, frankly, it is never enough in the short term.

The turn-over of political ideals and priorities that occurs every four years or so, at both levels of government, has made it difficult to plan, fund and sustain major innovations or infrastructure projects. As a result, politics has ostensibly crippled systemic change. Our medicare system is now out-dated, and health care has become an expensive, overly-bureaucratic and highly-fragmented government monopoly.

It's time to rethink how we deliver health care, so here's an idea for our political leaders: lead, follow or get out of the way.

LEAD

The first step to systemic renewal is for federal politicians to take a leadership role and revise the Canada Health Act (CHA) to remove all impediments to innovation.

The CHA establishes five ideological principles that each province must meet to receive federal transfer payments for health care. These so-called principles do nothing to improve access to health care or enhance health care outcomes. They do not, in any way, promote or restore the health of Canadians.

Yet, these intangible principles must be upheld; they govern health care delivery in each province/territory and dictate that it falls within a narrow scope of acceptability. Any deviations from these principles (no matter how beneficial they may be to patients or the health care system) are punished via federal government claw backs from transfer payments to the provinces.

In practice, the CHA prohibits innovative and beneficial policy changes that would allow for better delivery of health care, as has been successfully demonstrated in a host of other countries that have world-class health care systems.

For example, it keeps the provinces from implementing policy changes that allow private citizens to pay (fully or partially) for their own care – even when they have the means to do so. It also prevents private health care entities from delivering publicly-funded care. The latter is particularly galling since many provinces, in a shameless display of hypocrisy, pay private surgical facilities to help them eliminate long surgical wait lists. In other words, our equivocating politicians will pay for or use private clinics when they need them – but try to shut them down when they don't.

The CHA is supposedly a guarantor of universal care. But the realities of its constraints coupled with a system that routinely rations care mean that the only real guarantee Canadians have is that they will be placed on a wait list.

In practice, the Canada Health Act prohibits innovative and beneficial policy changes that would allow for better delivery of health care

FOLLOW

The provinces and territories administer and manage their health care systems. By amending or getting rid of the CHA, the federal government will be giving them the flexibility and the tools that they need to make strategic changes that will work best in each province.

But large-scale innovation will only come about when federal and provincial stakeholders (politicians, administrators, members of the health ministries, health authorities, health care workers and patients) stop playing the political blame game, admit that the status quo isn't working and stop looking to money as the only solution. The answers won't come in a brief one- or two-day meeting. It will probably take months of honest, substantive discussions to identify and agree on a cohesive national vision of health care and a redesign of provincial systems.

Federal and provincial stakeholders need to talk to each other, share knowledge, forget ideology and focus on the practicalities of delivering timely health care. Consider how we can best rebuild health care to create an integrated, progressive, high-tech system that works and will serve the needs of Canadians will (an aging population, chronic conditions, mental health issues, and long-term care) both now and in the future.

It's time for our leaders to follow. Look to other provinces to see what they are doing in the short-term to deal with issues like access to primary care, human resource shortages and waitlists. Look to other countries that have successful health care systems to determine long-term policies to deal with hospital funding, multidisciplinary/community clinics, technology, hybrid systems and sustainability.

We now have a unique opportunity to look at the best systems in the world, consider what could work for us and then incorporate those practices here.

GET OUT OF THE WAY

Our current health care system is inextricably linked to politics. When Canadians look at health care today, they see a system that is more concerned with protecting political ideology than treating patients. As Nietzsche wrote, "The most basic form of human stupidity is forgetting what we are trying to accomplish" [1]. It's time to get back to a system of health care that puts patients before politics.

For decades, provincial and federal politicians have made promises and assured us that health care is working – even as it is obvious that it is not. They have commissioned dozens of reports on how to improve healthcare at various levels of government, yet little has changed. Our political leaders have failed to manage our health care system and now people are dying because it is in disarray – and that is not acceptable.

If politicians won't step up to create positive change, then itis time to separate politics from health care and create independent, non-political governing bodies/agencies of stakeholders (administrators, patients, health care workers) to administer health care and oversee the revitalization of Canada's health care system.

Perhaps we need to remind ourselves that sometimes good governance means getting out of the way.

CREATING CONDITIONS FOR IMPLEMENTING CHANGE

This essay is not so much about solutions as it is a road map to get to the place where we can implement short-term fixes and look at long-term solutions.

In short, Canada needs two things to save and reconfigure its health care system:

First, it needs bold, innovative and creative politicians who are willing to put politics aside and work with other health care stakeholders to create a health care system that works best for Canadians.

Second, we need to educate Canadians about the myriad possibilities that exist if we are willing to look to successful models of health care in Europe and elsewhere. They have already solved the problems that are now overwhelming our medical system. Only then can we have a reasoned public conversation on health care change.

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We now have a unique opportunity to look at the best systems in the world, consider what could work for us and then incorporate those practices here.

EUROPEAN UNION POLICY COULD HELP CANADIAN PATIENTS AND REDUCE WAIT TIMES

**Colin Craig, SecondStreet.org*

A policy from the European Union (EU) called the Cross Border Directive could immediately help Canadian patients who are languishing on long government waiting lists. Best of all, it could be implemented relatively easily and wouldn't break governments' budgets. ,

SecondStreet.org looked into the EU policy after speaking with Manitoba patient Max Johnson. Johnson had made headlines in 2021[1] for billing the Manitoba government for the cost of his knee surgery in Lithuania: $14,431. Johnson decided to seek surgery in Europe after the Manitoba government told him he'd be looking at a 2-year wait[2] to have the procedure in Winnipeg. Go figure, he didn't want to sit on the sidelines of life for a couple years while the government got around to providing the care he needed.

Upon his return from surgery in Lithuania, Johnson looked up what it would have cost the government to provide him with the surgery at a hospital in Winnipeg and was startled to find it was about $21,000. Considering that was roughly $7,000 more than the procedure cost in Lithuania, it would have been a steal for the government to pay for Johnson's surgery.

While the Manitoba government balked at Johnson's reimbursement request, patients in the European Union have the right to reimbursement for surgery they pay for in other EU countries.

Passed in 2011, the EU's Cross Border Directive [3] gives all EU citizens the right to travel to another EU country, pay for surgery and then be reimbursed by their home country. Reimbursements cover up to the same amount the government would have paid to provide the surgery locally.

If an EU patient decides on a surgical facility that charges more than their home government's reimbursement rate, the patient is responsible for covering the difference. On the other hand, if the surgery costs less, then the patient's government reimburses the lower amount and actually saves money.

Considering Canada's health care system is in crisis, implementing this type of policy could help ease a lot of Canadian patients' suffering right now.

Figures obtained by SecondStreet.org through Freedom of Information reveal there are approximately 2.9 million patients [4] waiting for surgery, a diagnostic scan or to meet with a specialist in Canada.

However, as the figures provided by provincial governments are often incomplete (e.g. British Columbia does not have estimates for the number of patients waiting to see a specialist or receive a diagnostic scan), the true figure is likely closer to 4.7 million. Put simply, one in every ten Canadians are on a waitlist.

If Canada implemented an EU-style policy, and even a fraction of the patients on waitlists decided to pay for surgery abroad, the travelling patients would not only benefit from having surgery faster, those behind them on the waiting list would also benefit as they would get to move up a spot in line.

Ultimately, the EU's Cross Border Directive turns health care on its head. Instead of bureaucrats controlling access to health care, patients are put in the driver's seat. Patients become empowered like consumers to find the best service that works for them. Have a sister in Barcelona that you can stay with while recovering from hip surgery? This policy would give you the flexibility to take those kinds of considerations into account when deciding on where to go for surgery.

A second benefit is that this policy is especially helpful for lower income patients. Right now, wealthy Canadians, and even many in the middle class, have access to resources to travel abroad for surgery and avoid long wait times in Canada. However, low-income Canadians often lack such resources and get left behind.

the EU's Cross Border Directive gives all EU citizens the right to travel to another EU country, pay for surgery and then be reimbursed by their home country. Reimbursements cover up to the same amount the government would have paid to provide the surgery locally.

They're completely dependent on the government and its long wait times. The EU policy changes that dynamic by providing all patients with more timely access.

So how could this policy work in Canada?

First, it would have to be completely voluntary like it is in Europe. Some patients will never feel comfortable with the idea of travelling abroad for health care. That's fine. As noted above, those who remain in Canada would also benefit as this policy could reduce pressure on waiting lists.

A second consideration for provincial governments concerns which jurisdictions patients should be allowed to travel to for surgery and then seek reimbursement.

One solution, at least initially, would be to let patients expense procedures from other OECD nations. This would help ensure patients receive treatment from providers which have to meet high standards. Oddly enough, a 2019 bulletin [5] from the Canadian Institute for Health Information suggests that it might actually be safer for Canadians to receive care abroad than it is to receive it in Canada. The bulletin notes: "rates of avoidable complications after surgery, such as lung clots after hip or knee surgery, are 90% higher [in Canada] than the OECD average."

In addition to letting patients seek reimbursement for surgical costs abroad, it would of course make sense to let patients seek reimbursement for care provided at private facilities right here in Canada.

Some readers may wonder if the EU policy complies with the Canada Health Act.

In short, the answer is yes. In fact, provincial governments will sometimes cover the cost of treatment abroad right now. Such instances are usually for rare procedures and typically require approval ahead of time. Reimbursement rates can vary greatly. That being said, there have been cases where governments have reimbursed patients for routine procedures abroad.

Ultimately, the EU's Cross Border Directive turns health care on its head. Instead of bureaucrats controlling access to health care, patients are put in the driver's seat.

For instance, in 2004, the CBC reported on Alberta patient Aruna Thurairajan [6] and the three-year wait she faced for spinal surgery. Thurairajan decided to travel to India for treatment and was reimbursed by the Alberta government for "almost the entire cost of the surgery."

In 2017, CTV reported on Bob Bridger [7], a retired RCMP officer in Alberta who traveled to Montana for hip surgery in order to avoid an 18-month wait. Bridger was only reimbursed about $1,900 of the $32,000 he spent abroad.

These two examples show governments have the discretion to operate a program like the EU's Cross Border Directive.

One key difference between the EU policy (at least how it operates in many member countries), and how reimbursements work in Canada right now, is that in Europe it is often a standardized process. In many EU countries, patients can look online for their government's reimbursement rate, book the procedure abroad, pay for it and then seek reimbursement upon their return. This is an important distinction as, in order to be effective, a Canadian version would need to be set-up to handle large volumes of patients.

Finally, provincial governments would need to consider how to finance a potential rush of patients seeking reimbursements from abroad. In theory, this policy would merely shift expenses over time. Instead of paying for John Doe's hip surgery next year, the government pays for it this year. It's essentially cost neutral in the medium term. To account for any interest costs on funds borrowed to pay for a rise in expenses in the short term, governments could set reimbursement rates at, say, 95 per cent instead of 100 per cent. The 5 per cent "savings" could then be used to cover public debt finance charges.

To be sure, copying the EU's Cross Border Directive won't solve all of Canada's health care problems. This policy would, however, immediately help ease the pain and suffering of thousands of patients. And isn't that what the health care system is supposed to do?

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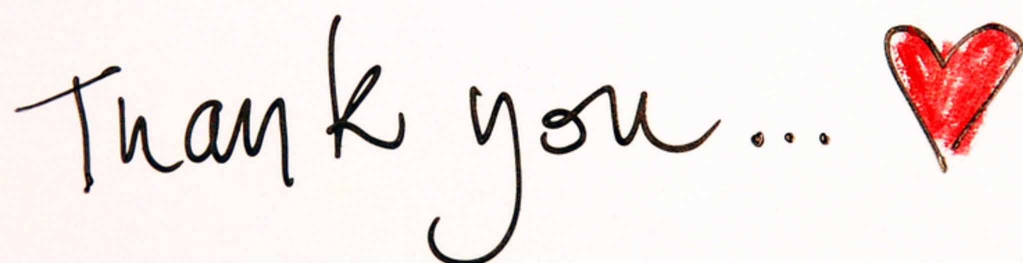

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