

Threatening Inequality: The Struggle to Maintain Canada's National Healthcare System

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Abstract

Canada's national healthcare system—Medicare—is a patchwork of mandatory provincial healthcare insurance plans covering most acute care hospital- and physician-based healthcare services. Many Canadians also have private insurance to help pay for services not covered by Medicare, such as dental care, homecare, nursing home stays and the cost of out-of-hospital pharmaceutical treatment.

Healthcare costs have increased steadily since Medicare began. Insured services now account for 6.8%, and private expenditures 2.4%, of Canada's gross domestic product. So far, governments have not found popular or, at least, tolerated ways to reduce this public economic burden.

Disease risks, incidence and outcomes vary with the wealth and educational attainment of Canadians, as do access to and utilization of insured and uninsured services. These inequalities increase the need for healthcare, add to the costs of Medicare, and worsen queuing or waiting times for already scarce resources.

Access to healthcare services can be a sensitive indicator of these inequalities, the economic burden of Medicare and the gap between healthcare needs and supply. Access has been examined from three perspectives: *patients* who need and use Medicare services; *professionals* who provide them; and *purveyors* of those services that pay, or are paid, for making them available. It shows a need for *rules of access* whereby utilization of insured services will be fair and efficient; *rules of medical necessity* whereby deciding what services are necessary and insured will be clear and open; and *rules of provision* whereby boundaries between public and private provision and public and private funding of healthcare services will be demarcated and clarified.

Introduction

Medicare—Canada’s national healthcare system—is less a national healthcare programme than a patchwork of provincial health insurance programmes stitched together by two major federal initiatives—the *Canada Health Act* of 1984¹ and federal financial contributions. It is reinforced by federal-provincial-territorial agreements and input from national associations such as the Canadian Medical, Nursing, and Hospital Associations. Medicare began in 1957 when the federal government agreed to share the costs of hospital-based healthcare services with the provinces.² In 1968, it agreed to share the costs of physician-based healthcare services. By 1972, each province had implemented a health insurance programme that fully paid for insured services.

This paper examines the origin, evolution and present functioning of Canada’s healthcare system(s), inequalities in access to and use of insured services, and ways whereby the system might be improved, from the perspectives of (1) patients who need healthcare, (2) professionals who provide that care and (3) governments that pay for it.

You get what your government, or you, pays for...

Medicare coverage predominantly includes acute care hospital-based and physician-based services. These vary slightly from province to province due, in part, to local or regional needs, diversity in the populations served, economic disparity, provincial autonomy and political pressure.³

Insured services are free-of-charge and cannot be purchased privately, unlike uninsured ones that most Canadians must pay for, unless they belong to particular populations such as the elderly and indigent. These uninsured, or ‘extended’, services include dental care, homecare, nursing home stays and out-of-hospital pharmaceutical treatment.⁴ 70% of Canadians have private health insurance that covers some of the costs of uninsured services, particularly the cost of out-of-hospital pharmaceutical treatment.⁵

In terms of 1997 constant Canadian dollars, the healthcare sector grew from \$40 billion, or \$1,715 per capita, in 1975 to \$96 billion, or \$3,089 per capita, in 2001. Almost one-tenth of Canada’s economy is now devoted to healthcare, with public and private expenditures amounting to 6.8% and 2.6% of gross domestic product, respectively.⁶

Medicare has gone through four phases of development: *implementation* through 1975; *expansion* ending in 1990; *constraint* following the

economic downturn of 1990-1992; and, *renewal* beginning in 1998. Between 1975 and 1991, public healthcare spending rose 11% each year, outstripping Canada's gross domestic product and inflation.⁷ Between 1992 and 1996, constraint reduced that growth to 0.5%. From 1996 to 1998, public healthcare spending did not change but, by 1999, it had risen by 4.2% and it is expected to grow by 7.9% in 2001.⁸ Provincial and federal governments disagree about the amount of funds lost to Medicare between 1992 and 1998, but none dispute the impact of constraint.⁹ It led to downsizing, service delays, consumer and provider frustration, widespread dissatisfaction, and loss of public confidence.¹⁰ As a result, hospital beds decreased by 30%,¹¹ there is a looming shortage of physicians¹² and nurses,¹³ and stock purchases by retail pharmacies dropped dramatically.¹⁴ Meanwhile, private healthcare expenditure increased steadily, seemingly unrelated to changes in GDP or in healthcare fiscal constraint, downsizing or shortages. (Fig. 1)¹⁵

Renewing Medicare: re-funding an impossible dream?

By 1998, Medicare was widely perceived to be badly under-funded and in growing disrepair,¹⁶ with shortages of manpower, insufficient or outdated technology and physical resources, and a system that was unable to meet the necessary health care demands, as well as expectations, of the public in a timely manner. Medicare was widely perceived to be in crisis,¹⁷ a claim that has been strongly disputed.¹⁸ A national survey found 78% of Canadians perceived their healthcare system(s) to be in crisis, yet almost as many reported they were "confident that if they had a serious medical condition, they would get the healthcare services they need."¹⁹

Medicare may or may not be in crisis, and it may or may not be severely short of resources, but there is no shortage of opinions and proposals on how to improve it. The suggestions range from proposals aimed at saving Medicare to those aimed at dismantling it. Some would strengthen the current publicly funded, one-tier system; others would permit or promote a two-tiered mix of public and private funding; while others would replace Medicare with a privately funded system.²⁰

Privatization proposals might seem heretical, but an increasing proportion of Canadians report they would tolerate such changes.²¹ Few Canadians, however, purchase healthcare outside Canada. Last year, they spent \$1.5 billion abroad—less than 1.5%, of Canada's total healthcare expenditures.

In its 2000, end-of-the-year cover story, Maclean's magazine—a national weekly publication—reported that there had been a profound shift in responses to its annual public opinion poll.

Canadians appear to be prepared to entertain new means to address their concerns. We now find half the population reporting some measure of acceptance of either moderate user fees or a private system alongside medicare as possible solutions to maintaining our health standards. But make no mistake, it is our health standards that the population values and not user fees or private medicine. The problem to date has been that political leaders have been unable to convince the electorate that they share Canadians' understanding as to what are ends and what are means. If anything, the political discourse has left the electorate feeling that those who advocate solutions have their priorities reversed -- valuing user fees or a private system rather than the preservation of an honoured past.²²

More importantly, none of the respondents reported healthcare to be their top concern in 1995, whereas 35% did so in 2000. The poll posed a bewildering conundrum: 66% of respondents rejected raising taxes to pay for growing healthcare needs and demands; at the same time, almost 80% per cent rejected reducing the services that were available at the time. Nearly half of the respondents rejected a two-tier healthcare system (53%) or user-fees (46%) to help control escalating publicly funded healthcare costs.²³

It is unclear who wants Medicare turned into a 'two-tier' system. The public may have become increasingly tolerant of such proposals, but it does not seem enthusiastic for them.²⁴ On the other hand, a one-tier, two-tier polarized debate suits the media, supporters of privatization²⁵ and, possibly, some politicians²⁶.

Who, then, is promoting such changes? Surprisingly, there appears to be a paucity of empirical data to answer this question. One likely answer is the media, as suggested by the Canadian Institute for Health Information.

[It] noted a sharp distinction between the satisfaction of Canadian users of medicare and the fears of the public at large. In 1998, 54 per cent of Canadian users reported that the care their family had received in the previous 12 months was "excellent" or "very good"—and yet the public felt anxieties about the system's viability. The discrepancy between user satisfaction and

perceived systemic trouble, the CIHI's [Canadian Institute for Health Information] research suggests, is in part because "individuals' ratings of the health-care system seem most influenced by the media when their own experience provides little guidance."²⁷

'Fixing' Medicare has become a very prominent national issue, and it was the number one concern of voters in pre-election polls during the 2000 federal election.²⁸ There was a surprisingly strong endorsement of Medicare by all of the candidates running for the office of Prime Minister. At the time, federal and provincial governments agreed to a seven-point plan to renew Medicare.²⁹ In doing so, Canada effectively rejected a two-tier healthcare system.³⁰ They chose to relax fiscal constraints on the system, restore some of the funding that was reduced between 1992 and 1998, and try to renew the system. The objective of this renewal was "to promote and protect the health of Canadians, and to ensure that they have timely access to quality care."³¹

Beyond any improvements to Medicare that might be possible with better management and greater efficiency, there are only four possible ways to improve Medicare: 1) free up and re-allocate resources, either by excluding some individuals or communities from some services or by eliminating some services despite demand for them; 2) reduce the quality of some (or all) services in order to increase their quantity; 3) maintain the *status quo* with a corresponding growth in waiting times; or 4) add new public funds to the system. Few, if any, Canadians would be likely to find the first two alternatives acceptable. The scenario likely to appeal to Canadians would be 'fixing' Medicare with better management, greater efficiency and more funding. Most people familiar with Medicare would agree that as an interim measure, at least, the system needs more resources—human, capital, and technological. Also, few people would disagree that the system could be improved by restructuring it. The problem, of course, is what to change. A survey of Canadian Chief Executive Officers, for example, found Medicare to have deteriorated, lacked leadership, was poorly managed and needed overhaul, but there was no consensus about what might best repair it.³²

One response to these problems that remains very much in vogue has been to review provincial Medicare programmes and try to find ways to improve them. Ontario released its report in March 2000,³³ Quebec in January 2001,³⁴ Saskatchewan in December 2001,³⁵ and Alberta in January 2002.³⁶ Two interim reports of federal studies have been released: one by a Senate Committee was released in September 2001,³⁷ and one by the 'Romanow' Royal Commission was released in February 2002.³⁸ A Toronto newspaper

columnist provides a strong—if not cynical—view of these enquiries and their potential impact:

Many of my friends are worried about the stealth neocon[servative] program to undo medicare.... They can relax. In fact, they might as well send the Mazankowski [Alberta] report, the Romanow [Federal Commission] report, the Kirby [Senate] report, and all the rest of those reports straight to the recycling bin. Nothing much is going to happen. The entire system is rigged against it. The reason is that politicians and bureaucrats run health care. This means that the system is highly politicized and that innovation is almost impossible.... People keep saying that what we need is more "debate" over health care. We've had an awful lot of that. What we really need is to understand why even the best ideas for "reform" are useless because they can't be executed.³⁹

By 2000, the federal government was transferring billions of dollars to provincial governments, to be used to refund and renew Medicare. The transfer hardly quieted opposition against a single-tier healthcare system and demands for even more federal funding. The transfer brought changes, mostly short-term, catch-up ones, but it did not bring provincial cooperation and determination to preserve Medicare and to solve or eliminate many of the problems that necessitated its re-funding and renewal.⁴⁰ The federal government has, so far, refused to allocate further funding transfers, beyond the five-year \$25 billion commitment that both federal and provincial governments had agreed to. The Alberta and Ontario governments, meanwhile, are claiming Medicare is no longer sustainable without major restructuring and new means of funding.⁴¹

The many healthcare burdens of inequality

One issue has received relatively little analysis in the debates on how to 'fix' Medicare is the healthcare burden arising from inequalities among Canadians. This healthcare burden includes increased risks for, prevalence and outcomes of disease, and greater need for, access to and use of healthcare services.

Determinants and indicators of health vary widely across Canada and within its different communities and populations.⁴² Some of these differences are associated with—or, possibly, are attributable to—such factors as age, gender, geography, wealth and educational attainment. Canadians with the least resources are often the least healthy. They are

more likely to have a shorter lifespan, increased risks for and rates of disease, and a correspondingly greater need for health care services. Yet, their access to healthcare services is likely to be less, waiting times for the services they need are likely to be longer.

Disease outcomes vary inversely with income, whether measured by infant mortality,⁴³ life expectancy, or death rates from circulatory diseases, lung cancer, injuries or suicide.⁴⁴ Many chronic diseases exhibit this same relationship, some of which also are associated inversely with educational achievement.⁴⁵

Healthcare use varies inversely with wealth. For example, the repeated use of physician services by Canada's lowest income population is twice that of the highest income population. Emergency room use is also higher.⁴⁶ Residents of the poorest Winnipeg, Manitoba, neighbourhoods spent 83% more days and had 40% more hospital admissions than residents of the highest income neighbourhoods.⁴⁷

Access to healthcare services also varies inversely with wealth. An Ontario study found wealthier Canadians with myocardial infarction had better access to healthcare services and better health outcomes—including survival. Even after controlling for variations in the severity of illness, there was a 23% increase in the use of coronary angiography and a 45% decrease in waiting time among patients with the highest incomes when compared with those with the lowest incomes.⁴⁸

Many Canadians have insurance that pays for some of the services not covered by Medicare. 27% are insured through government-run programmes and 49% through private insurance programmes. The proportion of Canadians who are insured privately is related to income and employment status.⁴⁹ Dental insurance coverage is also strongly associated with household income. Fifty-six percent of Canadians have private dental insurance, but only 31% of lowest income group has coverage compared with 75% of the highest income group.⁵⁰

Explanations for these differences are not obvious. For instance, does being wealthier and/or better educated facilitate access to Medicare services? Or, does being poorer impede access to and use of these services? Does influence 'buy' access? Or, is it possible that poorer people self-exclude themselves from access to and use of services? Certainly, money, alone, cannot 'buy' better access, since Medicare prohibits purchasing healthcare services privately. Physicians, as gatekeepers of Medicare services, can affect access but, as an Ontario study found, access to cardiac healthcare

services was overwhelmingly driven by healthcare need, and less than 10% of differences in access were attributable to physicians.⁵¹

Regardless of the explanation of these differences, reducing inequalities can improve the need for, access to and use of healthcare services. When federal and provincial governments agreed to refund and renew Medicare, in 1999, they opted for *equality of access*. In doing so, they opted for medical necessity as the ‘coinage’ of access and, once again, prohibited user-fees, two-tier healthcare, and financial influences that could differentially benefit some Canadians.⁵²

This paper examines the impact of inequalities among Canadians on access to and utilization of healthcare services and suggests possible ways that this impact might be lessened or remedied. It does not address reducing inequalities – or increasing equity - among Canadians that give rise to some of these healthcare inequalities. Whatever is done to increase the efficiency of, or reduce inequalities in, the healthcare system, however, should not be perceived as allowing an increase in inequities among Canadians that, sometimes, drive these changes.

Three perspectives: three conclusions

Until substantive changes are made to Medicare, or federal and provincial governments –unilaterally or jointly—agree to increase its resources, especially its funding, the challenge will be to ‘manage’ the present healthcare system better, in particular finding ways that can help (1) decrease the demand for healthcare services, (2) curtail the increasing costs of the services provided by the system, and (3) increase the efficiency of the system, while not impairing the health of Canadians, not reducing the quantity and quality of services that are available, and not breaching the five principles of the *Canada Health Act*.⁵³

These concerns can be examined from three perspectives, namely that of *patients* who need and use the services, that of *professionals*—in particular *physicians*—who provide the services, and that of the *governments* which pay for the services. In the analysis that follows, the patients’ perspective primarily concerns their access to healthcare services they need; the professionals’ perspective primarily concerns the scope of the services they authorize or provide, based on the medical necessity of those services; and the governments’ perspective primarily related to cost containment.

From the patients' perspective: *rules of access*

Most Canadians consider the biggest bottleneck to healthcare is timely access to the medical services that they need. Access to healthcare services can be framed as a problem of finding a balance—if one can be found—between rationing healthcare services and queuing for them. Access to some services has been restricted, such as insured nursing home stays and out-of-hospital pharmaceutical treatment while others may be practically unavailable, such as some new chemotherapy regimens and MRI scanning in some locales. Most of the time, healthcare services are available, but people must wait to obtain them. Queuing or waiting for healthcare services is a reality for most Canadians, and waiting times and waiting lists have become measures of accessibility to healthcare services. Efforts to reduce them have become disputed and confusing goals of Medicare,⁵⁴ as a team of Canadian researchers found:

The waiting-list "nonsystem" in Canada is a classic case of forced decision-making in the absence of good management information. There is a surfeit of nonstandardized data and a dearth of usable, policy-oriented information about waiting lists. The most serious consequence is that information and management defects are almost always prematurely diagnosed as financial shortages.⁵⁵

An editorial in the *Canadian Medical Association Journal* asked: "Is the allocation of Canadian health care fair?"⁵⁶ The answer it gave was a resounding 'yes', acknowledging, at the same time, that access to healthcare services is not perfectly equitable nor is it immune to influence.⁵⁷ As Canadians wait for scarce services they need, what determines, or reassures them, that their wait is a fair one? In other words, what are the 'rules of access' whereby they can secure the scarce healthcare resources they need as efficiently—and as fairly—as possible?

These 'rules' include *macro* level ones that involve national and provincial norms or standards guiding or governing access; *meso* level ones that involve policies, procedures, processes and normative practices applicable to a region or a particular institution, such as a hospital; and *micro* level ones governing individual patient-physician decision-making and individuals access to healthcare services.

Explicit 'rules' governing access to most healthcare services appear to be lacking nationally.⁵⁸ An exception to this paucity of explicit rules is triage assessment and management of queuing for emergency room services.⁵⁹

Provincial approaches to access often focus on (1) improving healthcare system efficiency, (2) containing costs involved in delivering healthcare services, and (3) trying to manage queuing and waiting.⁶⁰ Ontario, for example, is developing a normative approach to improve access to healthcare services such as coronary arterial bypass grafting⁶¹ and hip and knee arthroplasty.⁶² Improving efficiency can have considerable impact on equity in the delivery of healthcare services, even though the equity implications of such initiatives are seldom subjected to careful evaluation.⁶³ Physicians appear to have an important role in managing queuing. As an Ontario study of queuing for radiotherapy treatment observed:

Participants [in the study] felt that government and administrators of cancer services should be accountable for waiting lists. However, the physician may be legally liable. Hospital legal counsel advised radiation oncologists that they were responsible for patient outcomes on waiting lists. The Canadian Medical Protective Association, in response to a letter written by a concerned physician, advised that "sound medical judgement [*sic*] within the accepted standards of practice for similar communities must always guide the physician's treatment and care of patients and take priority over cost restraints." In response to a patient's letter on delays to starting radiation, a Ministry of Health official indicated that responsibility for timeliness of treatment rests with the individual physician. While no action has been taken against a radiation oncologist for delayed treatment, in a mock legal case involving the cardiac surgery waiting list, a judge concluded that the physician was liable and the government was not.⁶⁴

Formulating 'rules' of access—even implicitly—poses questions about the initial presumption(s) governing access. For instance, should access to scarce services be based solely upon greatest need, greatest benefit for the person needing the acts or services, greatest benefit for society in general? Should access be on a strictly random (*e.g.* lottery) basis or on a first-come first-served (*e.g.* queuing) basis? Or, should it be some mixture of these different approaches? Furthermore, are exceptions allowed and, if so, under what circumstances, and who should make them?

There is a risk that rules of access, whether national, provincial, institutional or individual, could make access bureaucratic and inefficient. This could occur when gatekeepers of scarce resources find themselves having to defend their opinions and decisions about medical necessity, waiting times, and resources needed to support the provision of scarce

services. As advocates of the best interests of their patients, physicians could face conflicting interests between supporting their patients (as well as other patients, in general) who are competing for scarce resources and being accountable for and guardians of those scarce resources.

Rules of access also raise the issue of political sensitivity. For example, one can imagine the CEO (Chief Executive Officer) of a huge multinational company, or even a provincial Premier, waiting in line for a CT or MRI scan, alongside a comatose infant with meningitis, a homeless prostitute unconscious from an illicit drug overdose, and a police officer shot trying to stop a bank robbery. This illustrates an important aspect of the access problem: is it feasible to prohibit influencing access, other than by medical necessity?

From the physician's perspective: *rules of medical necessity*

Provincial governments are constitutionally responsible for providing healthcare services and, hence, responsible for determining what services will be insured. Insured healthcare services are, in general, those for which practitioners are remunerated for providing or authorizing them, or those, such as hospital services, that the provincial government make available, free-of-charge, to those needing them. Uninsured (*i.e.* extended) healthcare services—like dentistry, homecare, nursing home stays and out-of-hospital pharmaceutical treatments—are paid for by individuals needing them directly, through third parties such as private insurance providers, or by provincial governments for a *mélange* of specific populations and services. Momentum is building for universal, comprehensive coverage of out-of-hospital pharmaceutical treatments, but, at the moment, coverage varies widely across the country.⁶⁵

The scheduling of healthcare services as insured ones results from negotiations between Ministries of Health and professional associations.⁶⁶ The negotiations include what constitutes the act or service, any qualifications or restrictions agreed to in providing the act or service, and remuneration the provider receives for providing or authorizing it.

Surprisingly, there is no uniformity (or consensus) across the country as to what services are medically necessary, are insured, and what constitutes (or defines) those services. There are, however, national and provincial professional training, performance, and auditing standards that impose some uniformity. The *Canada Health Act* does not impose uniformity on the services that are insured across the country, since it does not specify what services are medically necessary, or required, and hence ones that

provincial governments must insure.⁶⁷ As the Canadian Bar Association concluded in 1994,

Much of the debate over Medicare in Canada revolves around the definition of what services are medically required. By not including a definition of this term in the CHA [*Canada Health Act*], the federal government seems to have left it up to each province and territory to establish its own definition. ...[T]he provinces have also chosen not to provide a substantive definition, and the scope of medically required services and indeed, all insured health services, is a policy decision.

The approach...[is] to simply list those services which are medically required and will therefore be publicly insured.... A presumption is therefore created that whatever is not on the list of insured services is not medically required. Where circumstances warrant, new services may be added to the list, just as services may be de-insured. While this procedure is flexible, it is arguably susceptible to political and economic winds, as it does not seem to be grounded in any principled definition.⁶⁸

The British Columbia Medical Association (BCMA) has interpreted what it considers to be necessary or required healthcare services:

While the Canada Health Act defines services provided by doctors as medically necessary, the BCMA does not believe there are any objective clinical criteria that would in themselves enable the development of a priority preference list of services. A decision to restrict the scope of services covered under health insurance must ultimately be a policy choice implemented by government, based on economic factors, public opinion, and medical input. This decision is one of economic rationing, not medical necessity.⁶⁹

The Nova Scotia Appeal Court has taken a similar position, finding that the Nova Scotia government has discretion to decide what healthcare services it considers to be medically necessary or required, what services it will insure, and that its decisions can be economic ones (as opposed to medical ones).⁷⁰

The process, whereby governments determine what healthcare services are medically necessary and listed as insured ones, is, in general, neither a visible one, nor is it open to the public. Indeed, there appears to be no

analysis of this decision-making process, those who are involved in making the decisions, their accountability for the decisions made, or variations in decisions across the country. One can easily imagine that those involved in deciding the necessity and insurability of healthcare services, and in negotiating physicians' incomes—whether on the side of government or the side of professionals—would not want their deliberations widely publicized. Also, one can easily appreciate how conflicts of interest can become an inextricable part of this process when governments want to control healthcare growth and costs; when professionals desire to enhance their repertoire of professional services, and their incomes; and when patients desperately seek new or improved treatments or interventions.

Professional associations, the courts and the public can potentially influence what services are insured. National associations and organizations promote uniformity through the universality of professional, scientific and international standards, such as evidence-based medical practice, clinical research, professional education and institutional and professional accreditation.⁷¹ Legal challenges have forced provincial governments to make available or pay for healthcare services that the government has refused to insure or make unavailable.⁷² Individuals have successfully gone to court to obtain the act or service they need, or have purchased it outside Canada and, then, sought reimbursement.⁷³ The public, too, can influence this process by demanding government insures particular services. HIV community or interest groups are one example⁷⁴; another is the successful request for the treatment of Gaucher's disease.⁷⁵

The paucity of information about, and visible standards for, the deciding what healthcare services are necessary and insured includes whether there is public input into this decision-making process, the evidence on which decisions are based (e.g. scientific, economic, cost-benefit, political, need), accountability, appeal and review procedures, and how conflicts of interest are resolved. In other words, explicit, open, public, 'rules of medical necessity' are lacking. One innovation that could change this situation is the plan of the Alberta government to use a committee of experts that would determine if there should be changes in the coverage in the healthcare services that the government now insures or that it might insure in the future.⁷⁶

From the payer's perspective: *rules of healthcare provision*

The third perspective of Canada's healthcare system to be examined here is an economic one. It is the perspective of governments that make healthcare services available and pay for them, and of individuals and third parties—

such as private insurers, employers, and non-profit and charitable organizations—that pay for non-publicly insured services.

Healthcare expenditures have steadily increased since Medicare began and provincial governments are worried that Medicare will become unaffordable, as it is now structured and funded. At a recent First Minister's meeting, provincial Premiers described a variety of Medicare problems that need to be addressed, a variety of ways that their healthcare systems could be improved—even permitting private funding—and an agreement to try to 'restructure' their healthcare systems independently of the federal government.⁷⁷

One reason for the concern about affordability and sustainability of Canada's healthcare system(s) is that Canada is the only country among the G-8 and almost all OECD countries with a healthcare system that prohibits purchasing insured (*i.e.* publicly funded) services with private (*i.e.* non-public) funds. One consequence of this 'closed' or single-tier healthcare system is a seemingly relentless struggle to find an acceptable or popular balance between a sustainable taxation burden and the scope and volume of insured services that are affordable and can meet the public's needs, demands and expectations for healthcare services. An interim report from the federal government's Romanow Commission suggested four potential solutions to this dilemma:

Medicare needs more money and this should come from public investment.

1. Medicare needs more money but any new investments should come from individual Canadians through co-payments or user-fees.
2. Allowing more private sector participation (non-profit and for-profit) would increase consumer choice and relieve pressure on the public system.
3. The system needs fundamental reforms to increase efficiency, not more money.⁷⁸

At the heart of this dilemma are three concerns, namely (1) who or what organizations or agencies should be permitted to provide insured healthcare services; (2) how should those services be paid for; and (3) who, or what agency, should decide this.

Although there are exceptions, governments in Canada do not provide healthcare services directly; they pay healthcare professionals and

institutions to provide them. Over 90% of Canadian hospitals are owned and operated by public, non-profit corporations or organizations—most of which predate Medicare. The ‘public administration’ criterion of the *Canada Health Act* requires that

...the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province....⁷⁹

The *Act* does not explicitly prohibit or restrict for-profit organizations or entities from providing healthcare services (as opposed to administering or operating the insurance plan itself). There are numerous precedents or examples of public funds paying private entities to provide insured healthcare services. This includes most non-salaried (*i.e.* fee-for-service) healthcare professionals.⁸⁰ Several provincial governments have sent patients to the U.S.A. for radiotherapy when treatment capacity at home was insufficient.⁸¹ The Ontario government contracted with a private agency to manage insured cancer treatments after normal working hours.⁸² And, the Alberta *Health Care Protection Act* authorizes the provision of limited healthcare services by private (for-profit) hospitals.⁸³

In order for private purveyors of healthcare services to make a profit, they will have to provide the same services as publicly provided ones, but provide them more efficiently, that is, at a lower cost. They would have to accomplish this without reducing the quality of those services provided. They could, perhaps, do so by: (1) improving management practices; (2) lowering operating costs, such as by outsourcing and hiring non-union employees,⁸⁴ or (3) excluding sicker individuals or those requiring more complex, costly care and treatment. Increasing efficiency may be an elusive goal, however, as the Ontario government discovered recently. The Provincial Auditor investigated outsourcing cancer care when demand for government-run services exceeded the services available, and press reported that

[t]he privatization of an Ontario cancer care clinic has not shortened long waiting lists and has cost significantly more than a public alternative, the provincial auditor says.... Patients treated at the privately run clinic cost the system \$3,500 each -- \$500 more than at publicly run clinics....^{85,}

This does not mean the private sector does not have a potential role in providing healthcare services, but it suggests that the private provision of

healthcare may not be cost-saving for—when private provision is paid by public funds. This may not be the case when services are paid for privately. Then, presumably, the price of the services would increase. In other words, improved access would cost more. Rapid access to MRI and CT scanning in private clinics is an example where this is already happening in Canada.⁸⁶

There are four alternatives for providing and funding healthcare services in Canada. These can be easily visualized in a two-by-two table (Fig 2) that helps to distinguish and demarcate each funding and provision alternative. The table shows that public funding can be used to pay for insured services that are provided by public (not-for-profit) entities and by private (for-profit) ones. It also shows that private funding—whether by out-of-pocket, private insurance or charitable payment—could be used to pay for insured services that are provided by public and by private entities. The table shows that many of the current debates on restructuring Canada's healthcare system(s) are focused on publicly funded, private sector provision of healthcare services. On the other hand, there is increasing public and governmental acceptance of private clinics that provide, otherwise insured, diagnostic services such as MRI and CT scans. The number of these clinics is growing. The services they provide are paid for privately, often by private healthcare insurance. Whether future initiatives will move in this direction is unknown. There are, certainly, proponents of greater privatization of Canada's healthcare system(s).⁸⁷

What public-private arrangements will be prohibited, permitted or promoted is unclear at this time. The process whereby this will be decided is also unclear, including on what basis decisions will be made and by whom. For instance, will the decisions be political, economic, popular (referenda, national elections, etc) ones? Will they be national, federal or provincial ones? Certainly, a national consensus will be needed, if Medicare as a national healthcare programme is to survive. 'Rules' that would help to arrive successfully at these decisions would be helpful, if not essential.

For now, federal officials and much—if not most—of the public seem happy to try to preserve Medicare, as defined (or protected) by the values articulated in the *Canada Health Act*. However, as the debates intensify over preserving or dismantling Medicare, rules will be increasingly needed that can clarify the positions being debated and can explain them to the public.

Conclusion

Medicare—Canada’s cherished but threatened patchwork of provincial healthcare insurance plans is, once again, undergoing scrutiny as an affordable, effective and sustainable healthcare system. It does not provide coverage of all healthcare services. Dental care, nursing home stays, homecare and out-of-hospital pharmaceutical treatment, for example, are left to individuals to arrange for personal coverage. As a consequence, many Canadians already have supplemental, private insurance to help pay for those services that are not covered by Medicare. Publicly insured healthcare services now consume 6.8% of Canada’s gross domestic product. Private expenditures account for another 2.4. Governments have been unable to find popular or, at least, tolerated ways to reduce this public economic burden.

Inequalities add to this economic burden. Disease risks, incidence and outcomes vary with the wealth and educational attainment of Canadians, as do access to and utilization of insured and uninsured services. These inequalities increase the need for healthcare, add to the costs of Medicare, and worsen queuing or waiting times for already scarce resources. Federal and provincial governments, with popular (although by no means universal) support, have opted to continue Medicare as a single-tier, inequality-averse, nationwide healthcare system.

A sensitive indicator of these inequalities is the access Canadians have to the healthcare services they need. It is also a sensitive indicator of the economic burden of Medicare and the gap between healthcare needs and supply. Analysis of access to healthcare services can be examined from, at least, three perspectives: that of *patients* who need and use healthcare services, in particular Medicare ones; that of *professionals* who provide those services; and that of *purveyors* of those services—governments, organizations and agencies that pay, or are paid, to make those services available. Analyzing access to healthcare services from these three perspectives shows there is a need for: *rules of access* whereby utilization of insured services will be fair and efficient; *rules of medical necessity* whereby deciding what services are necessary and insured will be clear and open; and *rules of provision* whereby boundaries between public and private provision and public and private funding of healthcare services will be demarcated and clarified. Such rules would help to eliminate or reduce some of the inequalities, and their consequences, that challenge Canadian healthcare today.

**GDP, public & private healthcare expenditures
1975-2000
(1992 constant \$)**

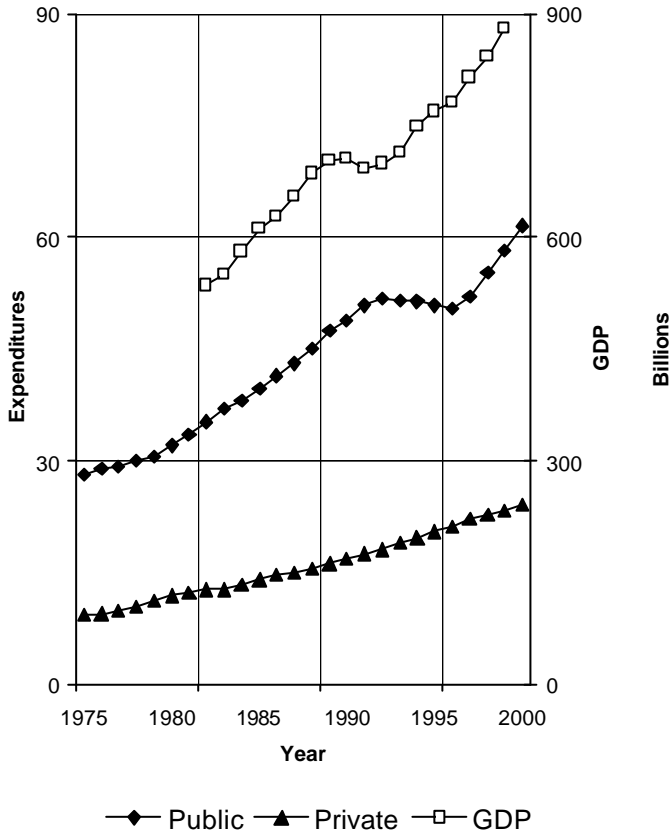


Figure 1. Relationship between gross domestic product (GDP), public and private healthcare expenditure and time. Data are expressed in 1992 constant dollars. Least squares regression analysis showed a strong linear relationship between private expenditure and time ($Y = 6 \times 10^8 X + 8 \times 10^9$; $r^2 = 0.9891$), public expenditure and time ($Y = 1 \times 10^9 X + 3 \times 10^{10}$; $r^2 = 0.9686$) and GDP and time ($Y = 2 \times 10^{10} X + 4 \times 10^{11}$; $r^2 = 0.9592$).

Canadian healthcare services funding options

	Insured services delivered by public system	Insured services delivered by private system
Services funded by public \$	Required by <i>Canada Health Act</i>	Radiotherapy in USA ¹ Ontario cancer treatments ² Alberta private hospitals ³
Services funded by private \$	Prohibited by <i>Canada Health Act</i> (e.g. extra-billing and user charges) ⁴	MRI & CT scans ⁵

¹ See Paszat LF, Mackillop WJ, Groome PA, Zhang-Salomons J, Schulze K, Holowaty E: note 81 *supra*

² See, Cancer Care Ontario: note 82 *supra*

³ See Government of Alberta: note 83 *supra*

⁴ Extra-billing is defined in *The Canada Health Act* as: “the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province....” User fees are defined in the *Act* as "user charge" as “any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing.” [*Canada Health Act* (R.S. 1985, c. C-6 (2), at <http://laws.justice.gc.ca/en/C-6/text.html>)

⁵ see, for example, Pinker S: Private MRI clinics flourishing in Quebec. *CMAJ* 2000; 163(10): 1326, at <http://www.cma.ca/cmaj/vol-163/issue-10/1326a.htm>

Endnotes

¹ According to *The Canada Health Act*, each province must comply with the five conditions in order to be eligible to obtain federal healthcare contributions (<http://www.hc-sc.gc.ca/medicare/home.htm>). These five principles are:

Public Administration: requires that the administration of the insurance plan of a province be carried out on a non-profit basis by a public authority.

Comprehensiveness: requires that all medically necessary services provided by hospitals and doctors be insured.

Universality: requires that all residents of the province be entitled to public health insurance coverage.

Portability: requires that coverage be maintained when a resident moves or travels within Canada or travels outside the country (coverage outside Canada is restricted to the coverage the resident has in his/her own province).

Accessibility: requires reasonable access unimpeded by financial or other barriers to medically necessary hospital and physician services for residents, and reasonable compensation for both physicians and hospitals.

² Among the major laws passed by Parliament were:

Hospital Insurance and Diagnostic Services Act, 1957 established cost-sharing between federal and provincial governments of hospital-based healthcare services;

Medical Care Act, 1968, established four of the five Medicare principles or 'standards', namely comprehensiveness, universality, portability and public accountability, and extended cost-sharing to include physician-based healthcare services;

Federal-Provincial Fiscal Arrangements and Established Programs Financing Act, 1977, changed the cost-sharing model of financial support for health care to one of block funding, consisting of tax transfers and cash payments to the provinces based on each province's gross domestic product (see <http://medicare.ca/tools.html>);

Canada Health Act, 1984, added the principle of accessibility to Medicare 'standards', thereby prohibiting user-fees;

Canada Health and Social Transfer Act, 1996 established block funding of health and social services to be used at provincial discretion

³ With regard to the distinction between needs and demands, see Picard A: Patients requesting advertised drugs. *The Globe and Mail* (Toronto), February 2, 2002, p A8

⁴ Iglehart JK: Restoring the status of an icon: a talk with Canada's Minister of Health. *Health Affairs* 2000; 19(3): 132-140, at p. 132, quoting Health Minister Rock who stated that the federal government currently covers about 23% of total healthcare expenditures, provincial governments cover about 45% and non-public sources cover about 31%. (accessed at

<http://managedcare.medscape.com/projecthope/HA/2000/v19.n03/ha1903.03.igle/ha1903.03.igle-01.html>

⁵ Statistics Canada Catalogue 82-003, Health Reports, Winter 1999, vol. 11, No3, pages 91

⁶ Canadian Institute for Health Information: National Health Expenditure Database in *National Health Expenditure Trends, 1975-2001*. Ottawa, Canadian Institute for Health Information, 2001, in particular Table A.1, at <http://www.cihi.ca/indicators/tables.shtml>

⁷ *Ibid*, Tables A.1, Appendix A.1, Appendix B.1. Data are in current dollars

⁸ *Ibid*, at pp. 6-7 and Tables A2.1 to A2.5.

⁹ Finance Canada. Federal Support for Health in Canada, at http://www.fin.gc.ca/activity/pubs/health_e.html; Understanding Canada's Health Care Costs. Final Report. Provincial and Territorial Ministers of Health. August 2000, at <http://www.scics.gc.ca/cinfo00/850080017%5Fe.html>

¹⁰ Statistics Canada, Catalogue 82-003. Health Care Services-Recent Trends. *Health Reports*, Winter 1999; 11: 91-112

¹¹ Iglehart JK: Revisiting the Canadian health care system. *New Engl J Med* 1997; 342: 2007-12

¹² <http://www.cma.ca/advocacy/taskforce/index.htm>

¹³ Ryten E. A statistical picture of the past, present and future of registered nurses in Canada. Ottawa. Canadian Nurses Association, 1997

¹⁴ Anonymous: *Drug Monitor, Insights into Health*, Montreal, IMS Health Canada, undated, at http://www.imshealthcanada.com/htmen/3_2_3.htm.

¹⁵ Canadian Institute for Health Information: 6 *supra*, at pp. 6-7 and Tables A2.1 to A2.5.

¹⁶ Provincial and Territorial Ministers of Health: Understanding Canada's Health Care Costs. Final Report. August, 2000. Accessed at <http://www.scics.gc.ca/cinfo00/850080017%5Fe.html>.

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January 2001, at p. i. (accessed at <http://www.tommydouglas.ca>); See Chwialkowska L: Money alone not the answer, Romanow says. *The Globe and Mail* (Toronto), 7 February 2002, p. A4, and Commission on the Future of Health Care in Canada accessible at <http://www.healthcarecommission.ca/>

¹⁹ Angus Reid Group: Health Care in Canada. Results of a National Public Opinion Poll (13-20 Jan 2000). Toronto, Angus Reid Group, 02 February, 2000.

²⁰ Shrecker T: Private health care for Canada: North of the Border, an idea whose time shouldn't come? *J Law Med Ethics* 1998; 26: 138-148, at p. 140

²¹ Marshall R: Paying the Price. User-fess and two-tier. Are Canadians ready for fundamental changes to health care? *Maclean's*, 25 December, 2000.

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²³ Marshall R: note 21 *supra*

²⁴ Picard A: Health care not so bad: survey. *The Globe and Mail* (Toronto), 27 November 2000, p. A 11

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²⁸ Wickens B, Demont J, Branswell B, McClelland S, Bergman B, MacQueen K: Divisions over health care: Would you be in favour of a two-tier health-care system? *Maclean's* 13 November, 2000.

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³⁰ Rock A: Presentation to the Canadian Medical Association at its 133rd Annual Meeting, Saskatoon, Saskatchewan, 14 August, 2000. Referenced at <http://www.hc.gc.ca/english/archives/speeches/14aug2000mine.htm#obj>

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³² Vieira P: Health care in crisis, says business. *Financial Post* (Toronto), 21 January 2002, p. F P1

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³⁴ Commission d'étude sur les services de santé et les services sociaux: *Les Solutions Émergentes. Rapport de la Commission d'étude sur les services de santé et les services sociaux*. Québec, Gouvernement du Québec, December 2000 (released 17 January 2001; accessed at http://www.cessss.gouv.qc.ca/page1_f.htm)

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³⁷ The Standing Senate Committee on Social Affairs, Science and Technology : *The Health of Canadians—The Federal Role. Interim Report. Volume 4: Issues and Options*. Ottawa, Department of Supply and Services, Government of Canada, September 2002, accessed at <http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/SOCI-E/rep-e/repintsep01-e.htm>

³⁸ The Commission on the Future of Health Care in Canada: note 18 *supra*

³⁹ Wentz M: Why health care will never be reformed. Toronto, *The Globe and Mail*, Tuesday, 15 January 2001, at p. A17

⁴⁰ The Commission on the Future of Health Care in Canada, at note 18 *supra*, and Laghi B: Premiers decide to go it alone. *The Globe and Mail* (Toronto), 26 January, 2002, p. A4

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⁴² Canadian Institute for Health Information: Health Indicators: note 6 *supra*

⁴³ Statistics Canada, Catalogue 82-003. Health Status of Children. *Health Reports* 1999;11, no 3, pages 25-34

⁴⁴ Mackillop WJ. Association between community income and cancer incidence in Canada and the United States. *Cancer* 2000;89:901-12

⁴⁵ Statistical Report on the Health of Canadians 1999, Table 53 Federal, Provincial and Territorial Advisory Committee on Population Health, Ottawa, 1999, and Statistics Canada, Catalogue 82-003. Health in Mid-life. *Health Reports* 1999; 11 (3): 25-34

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⁵⁹ Canadian Association of Emergency Physicians: The Canadian Triage & Acuity Scale (CTAS) for Emergency Departments. Ottawa, Canadian Association of Emergency Physicians, 2001, at <http://www.caep.ca/002.policies/002-02.ctas.htm>

⁶⁰ Queuing is, perhaps, most evident over the past few years in the tension between government-required cut-backs in services leading to bed closures, staff downsizing, including early professional staff retirement, hospital closures and mergers, on the one hand, and the need to secure services outside the province, or even outside Canada, because services are unavailable, are in such short supply, or demand for them is so great that waiting times become unacceptable medically. Another indicator of this problem has been emergency room overcrowding—so severe, at times, that Montreal hospitals have resorted to reporting emergency room bed (over)occupancy rates. (see, for example, Foss KA, Picard A: ER crisis deepens across country. Flu, holidays and scarce resources get the blame. *The Globe and Mail* (Toronto), Jan 5 2000, at http://www.benefitsworld.com/AA/GovBen/PHC/ER_Crisis-010500.asp)

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⁶⁴ D'Souza DP, Douglas K Martin DK, Purdy L, Bezjak A, Singer PA: Case report Waiting Lists for Radiation Therapy: A Case Study. *BMC Health Services Research* 2001; 1: 3, at <http://www.biomedcentral.com/1472-6963/1/3>. Footnote omitted. The reference in the text is: Mock trial shocks guilty docs. *Medical Post*, November 3, 1998, (author and page not cited)

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⁶⁷ For example, the *Act* states that hospital services "...means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability..." and physician services "...means any medically required services rendered by medical practitioners"

(emphasis added; *Canada Health Act* (R.S. 1985, c. C-6 (2), at <http://laws.justice.gc.ca/en/C-6/text.html>).

⁶⁸ Canadian Bar Association Task Force on Health Care Reform: *What s Law Got To do with It? Health Care Reform in Canada*. (Ottawa, Canadian Bar Association: 1994), at p. 31, 37

⁶⁹ British Columbia Medical Association: *Issues and Policy: Establishing "Medically Required" and Core Services*. Victoria, British Columbia Medical Association, April 2000, at <http://www.bcma.org/IssuesPolicy/IssueBackgrounders/medicallyrequired.asp>

⁷⁰ See *Cameron v Nova Scotia* *Cameron v. Nova Scotia*, [1999] N.S.J. 33 (N.S.S.C.); [1999] N.S.J. 297 (N.S.C.A.), at <http://mail.nsbs.ns.ca/dbtw-wpd/exec/dbtwpub.dll>. In its majority opinion, the Court held that medically required or necessary services “are limited at least to treatments that are medically necessary or medically required in the judgment of those who administer the scheme—in this case, the Department in consultation with the medical profession and ultimately, the Minister.... Of necessity, what is or is not medically required must be judged by those placed in charge of the administration of the [government’s decision-making] policy. The judgment call requires an appreciation not only of medical procedures, but the availability of funds to finance them...”

⁷¹ See for example, the Canadian Medical Association’s website at http://www.cma.ca/cma/menu/displayMenu.do?pMenuId=1&pSubMenuId=0&pageId=staticContent/HTML/N0/12/where_we_stand/policies.htm and the Canadian Council on Health Services Accreditation, at http://www.cchsa.ca/index_1.html

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⁷⁵ Clarke JTR, Amato D, Deber RB: Managing public payment for high-cost, high-benefit treatment: enzyme replacement therapy for Gaucher's disease in Ontario *CMAJ* 2001; 165(5): 595-6

⁷⁶ See, for example, note 17 *supra*

⁷⁷ Laghi B: Premiers decide to go it alone. *The Globe and Mail* (Toronto), 26 January, 2002, p. A4, and Mackie R, Mickleburgh R, Mahoney J, Foss K, Capannelli H: Provinces not persuaded to delay making changes. *The Globe and Mail* (Toronto), 07 February 2002, p. A5

⁷⁸ *Commission on the Future of Health Care in Canada: Commission on the Future of Health Care Interim Report*. Ottawa, Health Canada, 6 February 2002, at <http://www.healthcarecommission.ca/default.asp?DN=cn=679.cn=15.cn=3.cn=2.ou=Stories.ou=Suite247.o=HCC>

⁷⁹ *Canada Health Act*, R.S.C. 1985, c. 6, s. 8 (1) (a)

⁸⁰ This would include physicians, dentists and pharmacists when paid for providing insured services.

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⁸⁴ Mickleburgh R: Huge job cuts loom, B.C. health document says. *The Globe and Mail* (Toronto) 5 March, 2002, p. A9

⁸⁵ Elliott L: Privately run cancer clinic no faster, more costly than public: auditor. (Canadian Press report). C.health at Canoe.Ca, 13 December 2001, at http://www.canoe.ca/Health0112/13_cancer2-cp.html

⁸⁶ Pinker S: Parallel universe. As public health system bogs down private testing facilities are seeing healthy demand. *The Gazette* (Montreal), 24 February, 2002, page C1

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