KATHERINE FIERLBECK

HEALTH CARE IN CANADA

A CITIZEN'S GUIDE TO POLICY AND POLITICS

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HEALTH CARE IN CANADA:
A CITIZEN'S GUIDE TO POLICY AND POLITICS

Health Care in Canada examines the challenges faced by the Canadian health care system, a subject of much public debate. In this book Katherine Fierlbeck provides an in-depth discussion of how health care decisions are shaped by politics and why there is so much disagreement over how to fix the system.

Many Canadians point to health care as a source of national pride; others are highly critical of the system's shortcomings and call for major reform. Yet meaningful debate cannot occur without an understanding of how the system actually operates. In this overview, Fierlbeck outlines the basic framework of the health care system with reference to specific areas such as administration and governance, public health, human resources, drugs and drug policy, and mental health. She also discusses alternative models in other countries such as Britain, the United States, and France. As health care becomes increasingly complex, it is crucial that Canadians have a solid grasp of the main issues within both the policy and political environments. With its balanced and accessible assessment of the main political and theoretical debates, *Health Care in Canada* is an essential guide for anyone with a stake in Canada's health system.

KATHERINE FIERLBECK is a professor in the Department of Political Science at Dalhousie University.

For Eleanor and Jack
Never stop asking why,
and remember
'because I said so' is never a valid reason
unless it comes from your mother.

Preface

In December 2008, a writer in the *Globe and Mail Report on Business* stated that 'my wish is that the Canada Health Act be amended so that Canadians have the same freedom to provide and to choose public or private health options that are enjoyed in every other developed country' (Morgan 2008). That provinces can, in fact, introduce private insurance or private services without amending the Canada Health Act was clearly not understood by the writer, the editor, or the fact-checker. They also did not grasp that Canada does *not*, as the article stated, 'outlaw privately funded purchasers of core health services': the government of Canada has no jurisdiction over how health services are funded, and indeed, many of the provinces do not 'outlaw' private health insurance for medically necessary health care at all.

Health care in Canada has an iconic status as a major component of Canadian citizenship, and it rightfully ought to be debated widely in the public realm. We cannot debate health care, however, if we do not understand how health care works. The very complexity of the issues underlying health care and health care reform stymies the attempt to place the discussion over health care reform firmly in the public sphere. Moreover, to the extent that reform is debated with reference to what other countries do, Canadians should also have a good sense of how other countries structure their health care systems. But if the *Report on Business* can't get it right, how are the rest of us to do so?

This book is an explanation of how the Canadian health care system works (and how it doesn't). But it is, more importantly, a discussion of the politics within which the health care system is enmeshed. Health care in Canada is highly political. It plays a major role in federal and provincial elections, constitutional debates, and the articulation

of Canadian identity. It figures in debates over trade policy, intergovernmental relations, and even international obligations. Health care touches the quotidian matters of most people's lives: can they see a physician today? Can they afford the drugs they need? What vaccinations should their children receive? What happens when their parents can no longer live independently? Health care is further politicized because of to the impression that it is in crisis and must be radically overhauled. But why are the discussions of solutions so interminable? Why can't health care just be fixed, once and for all?

Rather than simply a description of institutions and processes, this book is a discussion of the political and theoretical debates over health care in Canada. It examines why health care systems face the challenges that we read about in the newspaper, but it also explains why there is so much disagreement over what should be done. Why can't we just end waiting times, if other countries have done so? Why shouldn't we just leave it all up to the market? Or simply hire more doctors? The overarching argument of the book involves two very basic claims: first, health care reform can no longer be discussed simply as a binary choice between 'public' or 'private' options. This was the axis on which health care was debated in the 1980s and 1990s, but it is, for the most part, largely obsolete today. The choices are far more complex. There is more than enough evidence to show that simply privatizing health care is not a viable option. At the same time, a fully public health care system is not sustainable (one-third of Canada's health care spending already is in the private sphere). The harder choices involve selecting various ways of funding and providing health care, and trying to understand how to make all the pieces fit together most effectively.

The second claim is that the contemporary discussion has gone beyond the dyadic public-private debate to whether we face zero-sum choices or positive-sum choices. In other words, will we have to choose between the kinds of qualities we want our health care system to have, or is there a way of changing the way in which things are run so that we can achieve all (or most) of the objectives to which we aspire? Like the health care systems of all modern countries, the ideal Canadian model is premised on the perfect balance between several major components, including cost containment, equity, efficiency, universality, comprehensiveness, and responsiveness. In practice, moving too far in securing one objective (such as choice) will generally undermine one or more of the others (such as cost containment). To a large extent, then, it seems that we face a trade-off between health care goals: we cannot have it all. Or can we?

Those who advocate a positive-sum model argue that the choices aren't so stark. They look at developments in integrating health care services, in data systems, in comparative efficiency research, and in health promotion strategies, and assert that we can have a system with greater choice and efficiency that does not undermine its equity or ability to contain costs.

These discussions have been articulated in the health policy literature for some years now. But they are not easily accessible to the general public. To make reasoned policy choices Canadians must understand how their health care system works and what, therefore, the reform options are. Despite the trend in public administration towards transparency, accountability, and democratic governance, Canadians cannot be expected to engage fully in the debate over health care unless they can comprehend how the system works dynamically in both its policy and political environments. Thus part of the task here is thinking about political interests: who is pushing what option, and for what reasons? Who has an interest in blocking (or delegitimizing) any particular option? The health care system should not simply be seen as a large mechanism with various interlocking cogs and gears, but also as a battlefield of competing interests with varying levels of influence. Even the most sensible health policy will not be enacted if there are powerful agents who don't like it (as health reform in the United States has shown). Identifying some of these interests, and what they have to gain or to lose in any particular health policy debate, should enable us better to evaluate the arguments for or against specific policy options (if, say, Bernie stands to inherit most of Grandma's property, we should probably look hard at his argument to take her off life support).

This book is intended to be a critical overview of the Canadian health care system. It is not simply a description of the system itself, but a discussion of the intellectual debates and political dynamics involved in health care policy. It is not comprehensive: there are a number of important health policy issues that are not included here that could have constituted discrete chapters. These include policy discussions over home care and long-term care; Aboriginal health care and health policy focusing on other vulnerable or unrepresented groups; rural health care; bioethics; orphan diseases; and so on. Many of these issues are briefly mentioned in the context of the larger debates presented in the following chapters.

This book is also about the health care system's intransigence to change, and its capacity for vital reform. One of the most influential works on how to understand the dynamics of change in health care is

Carolyn Hughes Tuohy's *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada,* which examines health care policy from the perspective of 'historical institutionalism.' This perspective holds that all policy decisions are constrained by the institutional environment within which they are articulated. Health care in Canada, for example, is constrained by a federal system, in which sustained political agreement must be achieved by numerous political actors, often with competing interests, before any significant political change can occur. This explains why so little radical change took place in the past several decades. In contrast, the health care system in the United Kingdom is much more centralized, and has been subject to a number of significant policy reforms throughout the past two decades.

Tuohy points out that this trajectory of 'path dependency' can, however, be recalibrated by 'windows of opportunity' which open at certain times: a pattern of timing that derives 'from factors in the broader political system, not the health care arena itself' (Tuohy 1999: 6). Like most social science, this model is better at explaining why changes happened in the past than at predicting how they will manifest themselves in the future. It is, nevertheless, helpful in obliging us to understand that health policy reform is not purely arbitrary or historically determined, but rather strategic and political. Health policy analysts saw the election of Barack Obama as a critical juncture in shaping health policy in the United States – until the collapse of the banking system in 2009. As this window of opportunity began to close, American political debate became an intense struggle to see what possible changes could be achieved (or prevented). The result was much less than proponents of reform had hoped for, but it was reform nonetheless. Thus, health care policy is constructed and constricted.

A similar debate exists in Canada: the issue of sustainability in a period of economic contraction forces us to think ever more clearly about how long we can go without fundamental reform, while the abysmal health record of the United States makes us realize that the simple debate of public versus private is no longer tenable. The health care system must be fixed; but the shape it should take is unclear. For those confused about why the system is so difficult to fix, this book is a guide for the perplexed. It does not offer simple solutions; it explains why they do not exist. But for those wishing to make changes, it is a road map of how the system is truly an interlinking set of paths, processes, and power struggles.

If health care systems are highly political, so is the study of health care systems. I received a grant to write a book on the politics of health care in 1992. Had I done so then, instead of tending other gardens, it would have been a much different book. It would also have been less interesting (and much thinner). The economic turmoil of the 1990s meant that many of the developments in health policy were discouraging ones. While the seeds of change were sown in this dismal field, it was the economic expansion and theoretical innovation that occurred thereafter that made health policy such an engrossing subdiscipline. Once primarily the province of economics, health policy has become a truly multidisciplinary field of study. Debates once grounded firmly within economics and interest-group politics now encompass ideas presented in public administration, sociology, comparative politics, law, philosophy, and other disciplines.

It is difficult to write about the politics of health care in the present tense. Practices and institutions become quickly outdated, and changes of government also bring changes in policy direction. Merely describing how the system works entails working on shifting sands. What remains constant is the resolutely political nature of the broad debate over health care. This is as true for the *study* of health politics as it is for health care itself. Even as the study of health care becomes more multidisciplinary, funding for the study of health politics has been removed from the sphere of the social sciences (Science and Humanities Research Council of Canada, SHRCC) and relocated to that of the medical sciences (Canadian Institutes of Health Research, CIHR). In 1992, a researcher wishing to investigate the political dynamics underlying health politics would apply for funding from a research agency designed to encourage the analysis of power dynamics underlying contemporary social relations. That the results of such investigations might be exasperating, irritating, or threatening to those holding the balance of power was not only accepted, but generally counted in one's favour. In 2010, a social scientist engaged in the examination of political dynamics within the field of health care would have no option but to compete for funding with medical researchers, who generally operate within a completely different intellectual culture. This is one that largely builds on the status quo rather than opposes it. It is also one that does not tend to ask whose interests are being served by following one direction rather than another. Scientific neutrality, not the bias of scepticism, is the intellectual baseline. But this does not mean that the structure of scientific research is itself necessarily apolitical. Given

that CIHR has explicitly articulated the commercialization of health research as one of its fundamental goals and that senior drug company executives are involved in governing this funding body, for example, one is led to wonder about the extent to which any research project that questioned the appropriateness of health care commercialization would be given serious consideration.

The critical evaluation of the Canadian health care system may or may not be affected by the way in which researchers are funded. But the first step in developing any accountable and responsive system is simply having a solid understanding of how the system works. As health care becomes increasingly complex, it is important to ensure that everyone with a stake in the health care system – either as decision maker, health care consumer, health care provider, or taxpayer – is able to understand why things work the way they do, what the obstacles are to change, and what the potential trade-offs are for competing policy directions. I am most fortunate and grateful to have received the advice and criticism from colleagues across a number of disciplines, not only in political science but also in public administration, medicine, law, nursing, pharmacy, and medical anthropology. I would also like to acknowledge the assistance of individuals within various branches of Health Canada (specifically Public Health Agency of Canada, Patented Medicines Prices Review Board, and Health Products and Food Branch), as well as officials within provincial departments of health who took the time thoughtfully to explain how their particular corner of the health care field worked. The patience and professionalism of those at the University of Toronto Press have been exemplary; they are a pleasure to work with. Special thanks are due also to Peter Aucoin, Kate Baltais, Sarah Binder, Gerry Boychuk, Louise Carbert, Annette Daley, Jocelyn Downie, Mary Fierlbeck, Albert Fierlbeck, Gordon Forsyth, Judy Garber, Adam Gibson, Elaine Gibson, Janice Graham, Barb Greschner, Jim Houston, Paula McKay, Norma Kinnear, Jeff Scott, Ingrid Sketris, Steven Tomblin, Gail Tomblin-Murphy and, of course, all of the anonymous reviewers who provided so much thoughtful and constructive advice.

Abbreviations

ACCESS	A Convention on the Canadian Economic and Social Systems
ACHDHR	Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources
ACO	accountable care organization (U.S.)
ACT	assertive community treatment
AHIP	America's health insurance plans
ALLHAT	Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial
AMSA	American Medical Student Association
BSE	bovine spongiform encephalopathy
CADTH	Canadian Agency for Drugs and Technologies in Health
CER	comparative effectiveness research
CGPA	Canadian Generic Pharmaceutical Association
CHA	Canada Health Act
CHB	community health board
CHC	community health council
CHI	Commission for Health Improvement (U.K.)
CHSRF	Canadian Health Services Research Foundation
CHST	Canada Health and Social Transfer
CIHI	Canadian Institute for Health Information
CIHR	Canadian Institutes of Health Research
CME	continuing medical education
CMHA	Canadian Mental Health Association
CMU	Couverture Maladie Universelle (Universal Health Coverage Act, France)
CMU-C	Couverture Maladie Universelle Complémentaire (France)
CNIB	Canadian National Institute for the Blind

COMPAS	Canadian Optimal Medication Prescribing and Utilization Service
CPHI	Canadian Population Health Initiative
CPHO	chief public health officer
DFAIT	Department of Foreign Affairs and International Trade
DGF	diagnostic-group financing
DHA	district health authority
DRG	diagnostic-related group
DSEN	Drug Safety and Effectiveness Network
EMA	European Medicines Agency
EPF	Established Program Financing
EU	European Union
FDA	Food and Drug Administration (U.S.)
FDAAA	Food and Drug Administration Amendments Act
FFS	fee for service
FMAP	federal medical assistance percentage (U.S.)
FP	for profit
GATS	General Agreement on Trade in Services
GDP	gross domestic product
GP	general practitioner
GSK	GlaxoSmithKline
HAS	Haute Authorité de Santé (France)
HCC	Health Council of Canada
hcs	health care spending
HiAP	Health in All Policies (EU)
HIE	health insurance experiment
HMO	Health Maintenance Organization
HSRC	Health Services Restructuring Commission
ISRCTN	International Standard Randomized Controlled Trial Number Register
IT	information technology
KOL	key opinion leader
LHIN	local health integration networks (Ontario)
MD	medical doctor
MHCC	Mental Health Commission of Canada
MHITF	Mental Health Implementation Task Force (Ontario)
NAFTA	North American Free Trade Agreement
NDP	New Democratic Party
NFP	not for profit
NHS	National Health Service (U.K.)

NICE	National Institute for Clinical Effectiveness (U.K.)
NIH	National Institutes of Health (U.S.)
NOC/c	conditional notice of compliance
NPDUIS	National Prescription Drug Utilization Information System
NPM	new public management
OECD	Organization for Economic Co-operation and Development
OHA	Ontario Hospital Association
OHIP	Ontario Health Insurance Plan
OMA	Ontario Medical Association
P4P	pay for performance
PACs	political action committees (U.S.)
PBS	Pharmaceutical Benefits Scheme (Australia)
PCG	primary care group (U.K.)
PCT	primary care trust (U.K.)
PFP	private for-profit
PHAC	Public Health Agency of Canada
PhRMA	Pharmaceutical Research and Manufacturers of America (U.S.)
PHU	public health unit
PMPRB	Patented Medicines Prices Review Board
PNFP	private not-for-profit
PPACA	Patient Protection and Affordable Care Act (U.S.)
PPP (or P3)	public-private partnership; also purchasing power parity
PROCTOR	Public Reporting of Clinical Trials Outcomes and Results
R&D	research and development
RAND/HIE	Research and Development Corporation / Health Insurance Experiment
RHA	regional health authority
RN	registered nurse
Rx&D	Canada's research-based pharmaceutical companies
SARS	severe acute respiratory syndrome
SDOH	social determinants of health
SHI	statutory health insurance
TPD	Therapeutic Products Directorate
VA	Veterans Affairs, Department of (U.S.)
VHA	Veterans Health Administration (U.S.)
WHO	World Health Organization
WMD	wet macular degeneration

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