Source of National Pride In Canada Now Causes Anguish

Will Canada's Health-Care System Meet the Challenges of the 21st Century?

It has evolved from a socialist's dream into an icon representing the soul of a country. It embodies the ideals of equality and inclusiveness long sought by the country, its people and its leaders. It has been a goal for groups in other countries—including the United States—who want universal, comprehensive health care for their citizens. It is the Canadian national health-care system called Medicare.

Evolution of a National Symbol

Before 1957 private sources covered expenses for the majority of health-care services in Canada. In 1946 Saskatchewan introduced public insurance to pay for hospital services for citizens of the province. In 1956 the federal government began a program to develop hospital insurance plans in all the provinces, in which the federal government would share the costs of hospital and diagnostic services. The first stage of Medicare occurred with passage of the Hospital Insurance and Diagnostic Act of 1957, which authorized the federal government to establish comprehensive, universal coverage for acute hospital care and laboratory and radiology diagnostic services. Under this legislation all provinces and territories provided universal coverage for at least inpatient care by 1961.

In 1962 Saskatchewan again led the way, this time introducing the predecessor to the second stage of Medicare: public medical insurance covering physician's services outside hospitals. The federal government inaugurated similar coverage in 1966 with the Medical Care Act, and by 1972 physicians' services were covered in all provinces and territories. Both the Hospitalization Act of 1946 and the Saskatchewan Medical Care Insurance Act of 1962 were introduced in that province by the New Democratic Party government led by Tommy Douglas, known as the father of Medicare. He later became the first leader of the federal NDP, the party founded in 1961 by the labour movement and the Canadian Commonwealth Federation.

Federal legislation determines the principles under which Medicare operates, but the day-to-day provision of health care rests with the provinces and territories. The provinces receive a subsidy from the national government to supplement their own health-care spending as long as their health policies meet the federally established criteria of accessibility, universality, comprehensiveness, portability and administration.

Initially, federal cost-sharing matched provincial spending approximately dollar for dollar. Ottawa altered this arrangement in 1977 through passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act. Instead of equal cost-sharing, the federal government transferred a lump sum to the provinces. Two years later the federal government found that doctors in some provinces were routinely charging patients extra to supplement the amount paid by the government. These "user fees" (also called extra billing) were creating an unequal system of health care in which access would be limited for low-income citizens. The Canada Health Act of 1984 was the Canadian Parliament's response to the concerns posed by user fees. The act reaffirmed the government's commitment to Medicare: that it be accessible, universal, comprehensive, portable and publicly administered. Under the act any province allowing extra billing would have its federal transfer payment reduced, dollar for dollar, by the amount patients paid.

Medicare's Growing Pains

Redundancies

During the 1980s and 1990s, provinces and territories, in their efforts to control costs and reduce their deficits, declared thousands of doctors' and nurses' positions redundant, reducing staff at hospitals throughout Canada. As a result, many doctors, nurses and nursing-school graduates moved to the United States or to other areas of Canada where jobs were available. In 1992 provincial governments decreased funding for positions in medical schools, which has caused shortages of these professionals in some areas of the country, especially in rural areas. Now, Nova Scotia lacks about 600 nurses; Calgary hospitals have 230 vacancies; Quebec is begging nurses to return.

Overcrowding, Long Waits

Many Canadians experience lengthy waiting periods before they can receive nonemergency medical treatments, especially if awaiting treatment by a specialist. Emergency rooms are overcrowded and often closed to patients with non-life-threatening emergencies. Hospital corridors are often crowded with severely ill patients for whom beds are unavailable. Basically, staffing levels are insufficient to meet the service demands of patients.

Few Alternatives to ERs

Jane has a sore throat and feels achy with a low fever. She calls her doctor; but it's after office hours, so an answering machine or service refers her to the nearest hospital emergency room. This is the 9-5 world of the Canadian health-care system. Most doctors' offices, clin-

ics, pharmacies and home care are available limited hours and on certain days. So, patients depend on the overburdened resources of health care's 24-7 universe, primarily ambulances and emergency rooms.

Priorities Change

The Canadian health-care system evolved during a period when providing acute care to critically ill patients was the driving concern. (Remember, the system began as a way to provide universal *hospital* care.) A person suffering a heart attack, the victim of a car crash, a patient with appendicitis—cases in which people suddenly need critical medical care—are the foundation upon which Medicare based its services and facilities. Changing population demographics have changed the types of health care required by patients and further swamped the ability of the provinces' programs to meet Canada's medical needs.

Today, the growing demand for medical services is in chronic care. People are living longer and relatively healthier lives. But millions of people are coping with chronic conditions like asthma, diabetes or arthritis. Medicare cannot efficiently treat people with such conditions when the system continues to prioritize emergency-room treatment of acute episodes instead of providing round-the-clock services for early diagnosis of conditions and for management of chronic diseases. Thus, many patients with chronic conditions occupy hospital beds which in previous decades would have been taken by more critically ill patients.

Can We Salvage The System?

Two major difficulties confront Canada's health-care system: how to fund sufficient, comprehensive care for all citizens, and how to create a system which fulfills the medical needs of all its patients—the chronically ill as well as the acutely ill.

Michael Decter, former deputy minister of health for Ontario, has some suggestions for adapting the system:

Provide service by telephone in which nurses can answer health and treatment questions without having to send patients to the emergency room or the doctor's office.

Provide home care on a 24-7 basis, and add quick-response teams to emergency rooms. These teams could determine when a noncritically ill patient can utilize home care instead of spending the night in a hallway waiting for a bed.

Establish a system of 24-7 primary care, including funding doctors and nurses in urgent-care clinics.

Designate some pharmacies as 24-7 and close to certain population centers.

The other major difficulty is funding, for several reasons. First, the federal government's decision in 1977 to go from 50-50 cost-sharing for *Medicare* to a global grant plus tax points to the provinces for *social programs.* Second, the Mulroney government's decision in 1993 to extend the term of drug patents as part of the free-trade deal, thereby substantially increasing health-care costs to Medicare and individuals. Third, the Liberal government's decision in 1995 to cut the provinces' grant portion for social programs by $6 billion. Even with some restoration of these cuts, today the federal government's cash grant covers less than 15 percent of Medicare nationally. Fourth, conservative provincial governments have also cut services and now want a greater role for private firms.

For example, Alberta's Conservative government, led by Ralph Klein, has introduced a bill to permit private clinics to treat patients for certain surgical procedures on an overnight basis. If this bill passes, according to a legal opinion obtained by labour, it will open the whole Canadian Medicare program to foreign for-profit firms. These companies tend to make their profit by lowering the wages of staff and referring costly, less-profitable services like emergency care to the public sector. The federal government so far has refused to take any concrete action, partly because in 1996 it signed a 12-point agreement with Klein that allowed the private sector a strong presence within the public sector health-care system.

A poll conducted in late January determined that 72 percent of Canadians rate health care their No. 1 budget priority, well ahead of the much-ballyhooed tax cuts that Finance Minister Paul Martin has offered. A majority of Canadians also want money restored wisely to a health-care system which needs reform. Perhaps Prime Minister Jean Chretien was heeding their wishes when he refused to conduct a quick health summit with the provinces' premiers, saying, "We need thoughtful approaches to improving a system which is still serving Canadians well. [But] a long-term commitment from governments is not simply about more money for health care."

Chretien wants Health Minister Allan Rock to conduct speedy negotiations with the provincial health ministers on how to overhaul delivery of health care. The ministers will meet in early May, and Chretien expects a report on their progress in early June. Chretien expects to call a first ministers meeting toward the end of 2000 to take final action on a national health plan.

The Canadian Labour Congress and the Canadian Health Coalition (comprising groups representing unions, seniors, women, students, consumers and health-care professionals across Canada) advocate a six-point agenda for salvaging Medicare:

- Rescind the Alberta-Canada 12-point privatization agreement.
- Pass emergency legislation to stop Klein's plan to spin off some services to for-profit clinics.
- Restore federal grant funding to at least 25 percent of public health spending.
- Expand Medicare, as originally intended, to include a national system of home and community care.
- Exclude health and social services from all trade agreements.
- Involve the public in decisions on Medicare (no back-room deals).

IBEW members can help in the fight to stop two-tier Medicare by writing or faxing their MPs in support of this campaign. This is easily done at the CLC web site www.clc-ctc.ca. The "FAX your MP" section of the site will use a member's postal code to match him or her with the appropriate MP and will fax the message to that MP's office in Ottawa.