



*True North In Canadian Public Policy*

# Straight Talk

January 2014

## *Straight Talk:* With Jeffrey Simpson

**In the latest instalment of *Straight Talk*, MLI spoke with *Globe and Mail* national affairs columnist Jeffrey Simpson about the challenges facing Canada's health care system. Simpson, who is author of a prize-winning recent book about medicare, *Chronic Condition*, says Canadians should not believe they have the best health care system in the world, and he suggests a number of areas where reform is urgently needed. The interview has been condensed and edited for clarity.**



Jeffrey Simpson is *The Globe and Mail's* national affairs columnist, and an author who has won many of Canada's leading literary prizes. In January, 2000, he became an Officer of the Order of Canada.

Mr. Simpson has published eight books – including *Discipline of Power* (1980); *Spoils of Power* (1988); *Faultlines: Struggling for a Canadian Vision* (1993); *The Anxious Years* (1996); *Star-Spangled Canadians* (2000); *The Friendly Dictatorship: Reflections on Canadian Democracy* (2001) and *Hot Air: Meeting Canada's Climate Change Challenge* (2007) co-authored with Mark Jaccard and Nic Rivers. His latest book – *Chronic Condition: Why Canada's Health-Care System Needs to be Dragged into the 21st Century* – in addition to winning the Donner Prize was nominated for three other book prizes.

Mr. Simpson has taught as an adjunct professor at the Queen's Institute of Policy Studies and the University of Ottawa Law School. He is now senior fellow at the University of Ottawa's Graduate School of Public and International Affairs. He is also a member of the executive committee of the University of Ottawa's Board of Governors.

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**MLI: Many Canadians consider our health care system to be the best in the world. Is it?**

**Simpson:** Well, for many years Canadians were led to believe by political people and health policy experts that we had the best health care system in the world, or at least among the best, and if you read the Romanow Report of 2002, he said our public health care system compares favourably with other public health care systems in the world. That was a staple of political discourse by people of all political parties. It wasn't true then and it isn't true now, but Canadians wanted to believe it. It made their hearts pump when they heard they had the best because they had elevated it to this great national symbol, and who doesn't want to believe that your most important national symbol is the best in the world?

Furthermore, it was either stated directly or it was assumed that not only did we have the best, but the Americans had a terrible system, and that appealed to our moral superiority vis-a-vis the United States, which is a terrible flaw in the Canadian character, but is rather deep. So, for all of those reasons we did think we had the best health care system in the world and I think that perspective now lies pretty much in tatters, but for a long time it was the defining framework for how we approached the problem.

**MLI: What does the evidence tell us now about how we rank in terms of health spending, and what we are getting for the money?**

**Simpson:** No one should look at any one study and hang a definitive conclusion on it because every study asks different questions, weighs the answers differently, uses different methodologies, etc. Some studies, for example, concentrate on patient satisfaction; others concentrate on outputs: how many of this and how many of that? How many operations? How many doctors, etc.? Others have a blend of questions, so I'm simply observing that if you look at all the international evidence, comparative evidence, the studies all tend to point generally in the same direction. That's from the Organisation for Economic Co-operation and Development, that's from the Euro-Canada Barometer, that's from the Commonwealth Fund in the United States, that's from the Bloomberg Fund, etc. They all say, if you leave the US aside, which I always do because it's based on a different set of principles of how to organize health care, we're in the top five from a spending point of view, which is no bad thing because we're a wealthy country. Wealthy countries always spend more on health care. That's not the problem. The problem is that when you look at these studies, they demonstrate that our outcomes in terms of quality and numbers put us somewhere in the middle of the pack. You've got this gap between the amount we spend and the outputs. The other big spenders in these surveys – Germany, the Netherlands, France, Switzerland, Denmark – they tend to get top of the line results. So, that's the problem. It's not that we're spending a lot on health care – although the rate at which we were increasing the spending was a problem until the last couple of years – it's that we weren't getting the outcomes that were commensurate or should be commensurate with the amount that we're spending.

**MLI: How would you describe the fiscal situation in the provinces in terms of health care?**

**Simpson:** Well, the numbers are quite clear. Once Roy Romanow did his report and said we needed to spend a lot more money on health care to buy change, and once that diagnosis was accepted by the then Prime Minister Paul Martin and the premiers at the time, they decided to put \$41 billion, indexed at 6 percent a year I might add, into health care for the next 10 years. So, once that money started flowing we were spending from 2004 to 2010 about 7 percent a year more on health care, year after year. Then, of course, we had the recession of 2008 that was quite brutal, so all of the provinces' and the federal government's finances went from being in surplus, as it was when Mr. Martin signed that deal, to being in deficit, and in some cases substantial deficit. Governments responded [by saying] whoa, whoa, we can't just drive up health care spending as we have for years. So, now across the country on average it's going up by 2.5 percent. In Alberta they had a 9.5 percent increase in health care every year from 2000 to 2010 – so they doubled their health care budget.

Now, they had population growth to be sure; then there was inflation, so half of that was population growth and inflation, but still, every year they were pouring maybe 4.5 percent in real terms after inflation into health care; now it's down to 3.5 percent in total. In Ontario, tracking the national average, it was 7 percent and now it's down to two. In some of the Atlantic provinces it's zero. So, we now are increasing spending at 2.5 percent, but if you take population growth and inflation out, we're actually flat-lining.

The question at the moment is this: Can we put the health care system on a track whereby for the next 10 or 15 years we can keep health care growing at 2 to 3 percent a year? Because if we can, that's manageable and won't be damaging other parts of the provinces' spending pattern for education, roads, and so on. Or are we in a four or five year period of restraint and there will be a lot of built up pressure from provider groups like doctors' associations and from nurses and patient advocates and whatever? Then, after four or five years of restraint, boom, we'll be back up again where we were before? It's very important, therefore, right now that we bake into the system changes of assumptions, of procedures, of systems, and of governance that make sure we can hold this health care spending juggernaut to 2 or 3 percent a year; that's the great question at the moment.

**MLI: And that would be in line with federal health transfers as well, correct?**

**Simpson:** Well, the federal government under Stephen Harper basically said we don't think we can afford [Paul Martin's formula of transfers indexed at 6 percent for 10 years] so when we come to the end of [the agreement] we'll go to nominal GDP, which will probably be 3.5 or 4 percent – that's a guesstimate. Now, that doesn't sound like much, you're going from 6 to, let's say, 3.75, but that is a lot. If you do that year after year the provinces will be out multiple billions of dollars. It is interesting, the Parliamentary Budget Office in September of 2013 took a look down the road at federal and provincial fiscal situations and they said that the federal one was good. You don't know if there's going to be another recession or whatever, but on present assumptions it was quite good. There were going to be surpluses. But the provinces – this is the word of the Parliamentary Budget Office, not me – the provinces' fiscal situation as we move down the track was unsustainable. The principal reason why it was unsustainable, said the PBO, was this reduction in transfers from the federal government to the provinces for health care. So, I predict soon after or even before the expiration of this 10-year period, you'll see the provinces ramp up their demands that the federal government give them more money for health care.

**MLI: Is there also an opportunity there for the provinces in terms of implementing reforms, as the Harper government seems a lot less interested in how they deliver health care than the Liberals were? And if so, what reforms do you favour?**

**Simpson:** I believe that this reduction in spending we are seeing will actually produce more change and more reform than when you were pouring 7 percent more into the program [each year]. I've been all across the country many times since the book, *Chronic Condition*, came out and I've been in touch with many, many different groups and three things have happened, all of which are positive.

Number one, nobody thinks we have the best health care system in the world. Anybody who stands up on a public platform and says that just gets people in the white coats coming to escort them off the stage and into some institution somewhere. So, we now can have a frank conversation and that's very, very helpful. People in the system are having a frank conversation; observers are having it, and so are political people. I've heard ministers of health say that we don't have the best health care system in the world, that we have an underperforming system. I tell you, five to 10 years ago they were scared to say that publicly because they thought they'd be hung from a lamppost. Now they say it, so we can have a serious debate.

Secondly, the doctors know, the hospital administrators know, the government people know, the civil servants know we don't have the money to pour into the system. If you think you've got a problem

and you think the answer to that problem is to spend more money or use your collective bargaining agreement to get more money for yourself – forget it. That’s not going to happen, but that was the dynamic some years ago.

The third, which follows from the first two, is that you’re getting a whole lot of people who are saying, okay how do we improve quality if we’re not going to be able to buy it with a lot more money? How do we change the system to make it better for patients in a constructive way? In other words, there’s a lot more creative thinking going on right now on the ground than I’ve seen in the previous 10 or 15 years. It’s being forced by the fact that these other options – living in the la-la land that we had the best system and believing we could throw a lot more money at it and that would produce results – they are off the table now, so this is good.

I see evidence, for example, in simple things. You know the population is aging. People are transfixed by this now because if you’re over 80 years old the average amount of money that’s spent on you for health care is \$20,000 to \$25,000 as opposed to people who are 60 to 65, which is a few thousand dollars. We’re going to have a lot more people who are over 80 and even 90 in the years to come, so how do you prepare a system to deal with that? Well, one thing you do is you try to keep as many people as you can out of hospitals; being treated at home or in institutional settings, which is much less expensive and often better for them. So, now all the systems across the country are trying to do that; it saves the system money. If I don’t have to be in a hospital taking a bed, but can be treated at home, I’m saving the system a lot of money because to be in a hospital for a day is like \$1500. So, budgets, when you look at how they’re being allocated now, are putting the marginal dollar on community, that is to say local, care as opposed to in the hospitals.

So, that’s the kind of good thing that is happening at the moment and there are many others across the country. In Saskatchewan, we have this cascading wait time problem. You wait to see your general practitioner; then you wait to see the specialist. If you need surgery you have to wait to see the surgeon and then they have to wait to get the OR time – it’s a terrible problem except for acute situations. If you have a heart attack, boom, you’re on the operating table. The system is very good at that. So, Saskatchewan said, let’s try three things. Let’s put some more money into day surgeries here. Let’s get the surgeons to pool their lists. (I’ve got to tell you, this is so annoying: You’re a surgeon and I’m a surgeon, you’ve got your list and I’ve got my list. Your list is bigger than my list – a little bit of testosterone going on here). And thirdly, they are saying we are not going to do these surgeries in the hospital unless we absolutely have to. They are being farmed out to private clinics who will be paid by the state under contract.

One thing I found absurd, when I went and spent time in hospitals, is that you have these operating rooms, beautifully equipped and well-staffed, and the neurosurgeons are struggling with the oncological surgeons who are fighting with the orthopedic surgeons for operating time and the patients are backing up and waiting except for the emergencies. I couldn’t figure out why repetitive orthopedic surgeries, knee replacements, hip replacements and that sort of stuff, is being done in these ORs in big acute care hospitals. They should be farmed out to clinics in the big cities – you can’t do this in rural areas – where they do nothing but that under contract with the state and they’re privately organized. This is what other countries do. The patients don’t care whether they are getting it done in the hospital or whether they are getting it done in the private clinic as long as the quality is assured, which the state is capable of doing. So, these kinds of initiatives are creeping into the system, not in the province of Ontario where there’s still an ideological resistance to this, but it’s happening in other provinces and these are good steps.

**MLI: Is there a perception that the *Canada Health Act* is more restrictive than it really is in terms of health reform?**

**Simpson:** Yes, absolutely, because of the defenders of the status quo over a long period of time. Medicare has a large ideological component to it. I’m quite agnostic. I’m not pro-a big expansion of



private care and I'm not adverse to public medicare. On the contrary, I just want to know what works. The *Canada Health Act* says that the system should be publicly administered. It doesn't say publicly delivered, it says publicly administered and financed. So, the *Act* is agnostic on whether you, I, and three or four other people sell our services to the government and raise the money to have a clinic, as long as it's paid for by the public sector and the public sector is administering the rules. They are agnostic on who is delivering. This is what they do in Sweden, which is a classic social democratic country.

The *Act*, properly understood, has within it a fair bit of flexibility. Unfortunately the defenders of the status quo in the past have had the upper hand and [they have argued private clinics] will cut corners because they have to make profits, so patient safety will be put at risk, and if you do that it'll be the slippery slope towards US-style medicine where they check your wallet before your pulse: "This is against Tommy Douglas, he'll be rolling in his grave". The deal that Tommy Douglas struck with the striking doctors of Saskatchewan – actually he didn't, his successor did, Woodrow Lloyd – was that we will have a public system in which the public purse will pay and access will be guaranteed on the basis of need, not money. You, the physicians, will continue to be privately organized individuals selling your services under a fee basis to the government. So, right from the beginning the doctors were private entrepreneurs, and most of them still are. If my doctor is billing the state as an individual entrepreneur, but five of them get together to do something collectively and sell their services to the state, all hell breaks loose and it's the end of medicare? I don't get it.

**MLI: Do you think there is merit to the idea that patients should pay some small portion of their care?**

**Simpson:** You know, that's a great question which has never really been debated in Canada. I thought about it a lot, I read a lot of literature about it. I spent some time in Sweden. I was very impressed by the Swedish system and in Sweden they've had the so-called user-fees or co-payments forever. It was interesting asking the Swedes, why do you have them? And as an old journalist I know when people are wondering "why waste my time with that question?" For them, it's a straightforward proposition that it deters frivolous use. They don't get a lot of money from user fees because once you exempt poor folks, the disabled, people with chronic conditions who absolutely have to use the medical system on an on-going basis such as diabetics on dialysis, once you exempt all of those people and then seniors over a certain age, you don't raise much money. So, it's seen as being a deterrent. I looked at that [idea] hard, but at the end of the day I said, you know, you don't raise all that much money; it's administratively cumbersome, or can be; physicians feel a bit uneasy about it because cheques are going back and forth (although in the modern age of computers you can get around that), but it presumes that there's a fair bit of moral hazard in the system, that is to say, the frivolous use of a free good. I have no doubt that there's some of that and that there's overtesting by physicians and that some patients overuse the system. But, you know, I don't think most people get up in the morning and say, "oh, it would be fun to go to the hospital and hang around today, that would be kind of the way I'd like to spend today". I just don't think there's that much moral hazard; therefore, I don't think the administrative hassle which, as I say only gets you a small amount of money, is worth it. But I respect the fact that the Swedes have done it – most countries don't.

**MLI: How did it come off the table in terms of something we could even discuss in Canada?**

**Simpson:** Well, it was never really there from the beginning. I mean, right from the beginning it was going to be a British National Health Service-style system in terms of no payment. Now, after the NDP in Saskatchewan that brought medicare to the province was defeated, the Liberal government of Premier Ross Thatcher introduced user fees. They proved to be politically very unpopular and when the liberals were subsequently defeated, the NDP took them off the table, and we've never really had any serious discussion about it since. We had a discussion in the 1970s about whether doctors should be able to charge extra fees to certain patients in individual specialties, but we've never had

a national debate about it. I think given the *Canada Health Act* it would be difficult because it does proscribe those sorts of fees.

**MLI: Is there any room for private insurance in Canadian health care?**

**Simpson:** Seventy percent of the money that we spend on health in the country is public and 30 percent is private, so there's already lots and lots of private insurance. Two-thirds of all the drug costs in this country are private and only one-third is public or roughly 63/36. I like to tell folks that if we cross the street and get hit by a car, and, let's say for the sake of argument fracture our pelvis or something, the ambulance comes and you pay. Then you go into the hospital and you're covered while you are in the hospital. You leave and all of the sudden, depending on what drug plan you have, you've got private insurance or no private insurance for your drugs. Then, you get some crutches to hobble around on – you pay for those. You need physio – you pay for that. So, there's lots of private insurance in the system. The question really is, should we have private insurance for what are defined as core services, for example, in the hospital or for doctors? The answer there is probably no because the international evidence – and I looked at this pretty carefully – about having a kind of parallel private system where within a hospital there's a private wing or doctors work both private and public, which happens in Australia and in New Zealand, the international evidence is quite mixed as to what it brings. It does bring advantages for those who use private facilities. It reduces your wait times quite a bit. It can produce quality improvements in the sense that there's money flowing into a particular part of the system; however, it can also take health workers out of the public system and that makes the collective wait time problem worse. So, it's a kind of mixed bag, let's put it that way. You can read ideologically into that whatever you want and people do; in my case, I've tried to look at the evidence, which is mixed.

**MLI: What impact do you think the *Chaoulli* decision has had and will have on Canadian health care?**

**Simpson:** You know, the *Chaoulli* decision is one of the great mysteries of Canadian health care because it's been on the books now from the Supreme Court for some years. The majority of the court essentially said because of the right to “security of the person” in the *Charter*, if the state can't deliver timely service to you or service on a timely basis and, therefore, imperils your health or comfort, you should have the right to buy private insurance. I thought, and so did many other people who came out and made comments after that, that would kind of open the door to more private insurance for these basic medical services of doctors in hospitals. That has not happened; *Chaoulli* is sitting there on the books and nothing has happened. In fact, in the province of Quebec, where they did have a little more private delivery than elsewhere, governments have actually closed some clinics under contract with the state. I have friends who tell me that there are some court cases winding their way up through different provincial court systems that are using the *Chaoulli* precedent and, of course, Brian Day who runs a private clinic out in British Columbia is behind or participating in one of these appeals and that it may come back; therefore, the door may open again. In theory it's open because the Supreme Court made the decision that it did in *Chaoulli*, but it's been very interesting that no provincial government and no group of physicians has chosen to go through this open door.

My opposition to *Chaoulli* was quite different. I don't think the Supreme Court should even have touched the case. This issue of health care has been the most debated and most discussed perhaps in an inconclusive and unsatisfactory way, of any issue I have known in the last 20 years. We've had commissions, we've had legislative committees, we've had election campaigns, federal and provincial, that have featured this – we've had a huge amount of public discussion about health care. As I say, maybe we haven't been able to come to good and satisfactory conclusions, but the political process largely has certainly discussed this at great length. I don't think it's a legal question at all. I think it's a political question, I think it's an economic question, I think it's a social question, and the court had no particular expertise to bear on this. It's a classic example in the age of the *Charter* where

you legalize, essentially, a non-legal question and that's what they did. I think that was a mistake because they overturned the lower court and the Court of Appeal who had spent weeks looking at the health care evidence and then in their judgments they just kind of cherry-picked pieces of the international and domestic evidence that suited where they wanted to go and I've actually had the occasion of saying to them in a certain way – I won't say how – I said, look, you know, you're very smart people. The nine of you are very smart people whom I greatly respect, but you are not experts in health care. I've got a whole drawer full of people who know a lot more about health care than any of you do and I would frankly count on their judgment about what to do with the health care system rather than yours. What you did, because someone appealed under the *Charter*, is you put this in the Procrustean bed of the *Charter* because you feel comfortable with that. Well, it doesn't fit.

**MLI: How do we proceed from here? You have mentioned all of the commissions, all of the talk. Practically speaking, how do we fix the system?**

**Simpson:** What would I do? Well, the first thing about what to do is to get straight that this is an immensely complicated system with many different pieces to it. It is a public system and it involves two levels of government, so that adds another layer of complication. Anybody who thinks there is a silver bullet that if we only did this, things would get magically better, doesn't know what they are talking about. It requires a lot of changes over many aspects of the system.

The good thing at the moment, as I've said before, is there's now an understanding that change has to come not from spending a great deal more money, and that change must come. This is partly because the public demands it, and partly because the population is aging, and partly because there isn't a lot of money to sort of salve everybody's conscience, because what happened was people said: "How come we spent all this money when the system is not materially better?" One of the reasons is the providers helped themselves and did very well, thank you. The physicians and the nurses did extremely well as could have been predicted, but unfortunately wasn't. So, that's not going to happen again.

You need to do a whole bunch of things and I'll tick four or five off. Let's look at the federal government for example. We have at the moment among the highest drug prices in the world, okay, for generic drugs and for brand name pharmaceuticals. One of the reasons for that is that every province has its own formulary and they go out and negotiate with the drug companies the prices for the drugs that the formulary needs. Well, there are fewer than one million Nova Scotians, but there are 35 million Canadians. We would get a better price if we had one purchaser for pharmaceuticals as other countries, including federal countries, do. Their drug prices are lower so we should have one federal agency that buys the drugs.

Second thing, and this is not any secret, if you are a provincial premier you know that the cost for your seniors' drug plan is going to go up sharply because you're going to have more seniors – a lot more. So, what are you going to do about your drug costs? If you continue to finance drugs the way we have in the past you'll just raise the tax dollars for it, but what happens in five, 10, or 15 years is you have more people taking drugs and fewer people in the workforce to tax, so you're shifting the burden inter-generationally onto your children. So, we need to have a social insurance mechanism so that people pay throughout their life the way they do for pensions for drugs they're going to need when they are seniors, because 85 percent of seniors take drugs.

You have to have an understanding with the physicians and nurses that this sort of shooting up of their salaries and then a period of restraint, shooting up and restraint, is not fair to them; it is not good for the state. Here's the deal: For the next decade if we're going to keep health care at 2 to 3 percent your income is going to go up at the rate of inflation adjusted for population – no more, no less. We're not going to slice you back, we're not going to give you big raises – this is what we can afford. Everybody got that? Doctors say, "we're going to go to the States". Bye. See you later, okay? You like the mess down there? Good luck. We have a lot of physicians coming to this country who are

pretty well trained who we can train up to high levels and the labour market, the way it worked in doctors' favour for getting wage gains in the 1990s, doesn't work anymore and the same for nurses. So, don't use that scare tactic that the Ontario Medical Association and others sometimes resort to.

Third, at the margin, all the provinces should be putting additional money into community care, not hospitals.

Fourth, we do need private delivery of publicly-paid for services on a more flexible basis, with quality, timing, and cost being monitored, obviously.

But, the point being: that there's no one thing that needs to be done. There's a wide range of things that have to be done to make this system better, commensurate with the money that we are spending which, I repeat, is at the high end of the world's scale.

### **RECOMMENDATIONS:**

- 1) Adopt a single, federal drug formulary to reduce pharmaceutical costs.
- 2) Constrain growth in the salaries of health professionals.
- 3) Invest more in community care rather than hospitals.
- 4) Allow more private delivery of care, for example doing repetitive procedures which should be done outside of hospital where possible.





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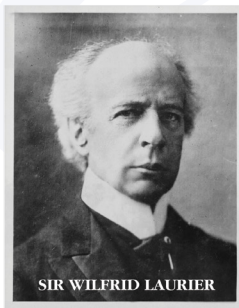
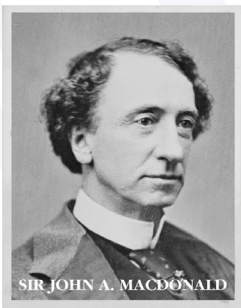
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