



What Should Be Done About Medicare

by

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August 2000

ISBN 1-894598-10-5

The Caledon Institute of Social Policy occasionally publishes reports and commentaries written by outside experts. The views expressed in this paper are those of the author.

If I were still writing policy memoranda to the Prime Minister, as I did in the Pearson period, one would be like this (though a good deal shorter, since much of the argument could be taken for granted; and, thanks to secrecy, in places blunter).

August 1, 2000

To: Prime Minister

From: Tom Kent

Subject: Medicare

Medicare can be rescued and revitalized by your leadership; otherwise, it is likely to be eroded. The principal suggestions of this memorandum are:

- Replace the H of the CHST by a continuing commitment that, from this year on, the federal government will reimburse each province for at least 20 percent of the cost of its agreed medicare program.
- As the basis for such partnership in medicare, issue a joint declaration by all Canadian governments that the purpose of medicare is to make a consistent level of health care equally accessible to everyone according to his or her needs. For this purpose, agreed programs must be entirely tax-financed. The principle of care according to need rules out any muddling of public and private finance, any 'second tier' of privately purchased variations to, or queue-jumping within, medicare.
- Establish a joint, federal-provincial Canada Health Agency in order to provide regular consultation on health policies; to collaborate in defining the content of agreed medicare programs; to monitor the operation of the programs; to facilitate cooperation in improving the effectiveness of medicare and containing its costs; and to express accountability to the public by regular and full reports.
- Assign to the Agency the priority task of creating and operating a nation-wide health information system that enables all health treatments to be costed and related to the evidence of their benefits.
- Undertake that, as soon as the Canada Health Agency is in operation and its information system established, the federal government will increase to 21 percent its committed share of the costs of medicare.
- Agree to foster more awareness of medicare costs in the minds of both the providers and the recipients of care. For this purpose, provinces will provide an annual total of the costs of the medicare services received by each individual or family. A small part of the costs will then be recoverable through the tax system, on a scale that is related to income and does not deter access to needed care.
- Initiate consultations to define the improvements to medicare that are agreed to be desirable and potentially practicable over a period of a few years. While all the items will be agreed, each province can set its own priorities among them.
- Undertake that the federal government will facilitate these improvements by graduated increases in its share of each province's medicare costs, up to a ceiling of 25 percent. Timing of the changes will be determined by procedures that reconcile the provinces' freedom of selection with fairness among them and that also establish restraints on cost increases.

- Ensure that the federal financial contribution to the medicare partnership is made continually clear. This transparency is required not only for the credit of the present government but, equally, to protect the provinces against any future federal government thinking that it could cut its funding with little political penalty.

Background

The problems of medicare have been built, by neoconservatives and in the press, to terrify-ing size. In fact, these problems are by nature no worse than those we have to deal with in, say, national defence or immigration. The difference is that the politics of federalism hang over medi-care like a fog in which direction is lost.

There are, of course, many other govern-ment operations that require federal-provincial collaboration; most of it is conducted regularly and fairly successfully. Medicare's trouble is that it is too conspicuous and too popular for quiet diplomacy. Federal and provincial authorities vie to claim credit as its champions and to shift blame for its shortcomings. As the shortcom-ings have grown, posturing and recrimination increasingly have frustrated the needed discus-sion and decision.

The quarrel can produce no victors. It makes the public fed up with both sides, scepti-cal of spin doctoring from any quarter. Even the most combative of the Premiers and of your col-leagues must wish for a way out of the no-win situation. Faces have to be saved, however. To replace the fray by collaboration requires direc-tion-changing leadership from the top.

As with all such initiatives, there is some risk. You may fail to get agreement because two or three Premiers prefer to stop the battle after,

not before, the federal election. Nevertheless, while they could delay or deny you the triumph of saving medicare, they cannot prevent you from gaining by trying. Reasonable proposals will yield political credit for your government; it is not you who will be hurt by provincial intransi-gence.

Partnership in costs

Negotiations will go nowhere unless your federal colleagues and most provincial leaders have a common understanding of medicare and the partnership it requires. It is 'Canadian' in the sense that the provincial programs are closely similar, thanks to federal legislation defining their principles and to financial support from federal taxes.

The standard and good reason for such sup-port is that without it Newfoundland, say, could not afford much of what Alberta can. In the case of medicare, however, there is an additional, compelling reason. The principles of the Canada Health Act, the principles that the federal Parli-ament has laid down for provincial programs, are expensive to implement: so expensive that medicare is much the largest item in the budgets of all provinces, rich and poor. They took it on with the promise of federal reimbursement for 50 percent of the total cost. The ratio is no longer relevant, because of intervening tax shifts, but the principle is. Medicare could not have begun, as a similar service for all Canadians, except as a federal-provincial partnership. It can survive only as a partnership in which shared principles are backed by shared costs.

Some of your colleagues and many Ottawa officials are not keen on cost-sharing. They will argue that the federal government has gained, not lost, by dropping other joint programs. Medi-care, however, is too popular to drop. And it is

too costly to continue, on consistent principles nation-wide, without consistency also in federal participation.

Many health costs will be driven upward by both technology and democracy. The impact can be moderated by attainable efficiencies, but those require steady planning of services and resources. Crisis-driven improvisations will not provide good health care efficiently. Partnership means more than immunity from arbitrary cuts in financing. It means more than sporadic negotiations of increases. Both efficiency and equity in health care require our commitment to a firm, continuing share in the costs of the programs that our Canada Health Act defines.

Canada Health and Social Transfer funding, by contrast, is jelly. It can be varied as we choose, spent however each province chooses. You will remember that in his 1995 Budget the Minister of Finance introduced it as the Canada Social Transfer, the CST. The H came in as a public relations afterthought. It was not any the less a disaster for medicare. But you can say that the full CHST was necessary to remove the deficit; with that done, you should take out the H and move on.

Renewal

The Finance Department, defending its CHST, will argue that cost-sharing is a move not forward but backward. So it would be, if the proposal were to restore cost-sharing as it originally was, with nothing learned from experience. The lesson of the past 30 years, however, is certainly not that medicare thrived as cost-sharing was eliminated. Quite the contrary. What experience shows is that medicare continues to require cost-sharing, but cost-sharing with a difference. That is my proposal: not restoration but renewal.

It may be helpful, for your less experienced colleagues and officials, to put the proposal into context.

A generation that had learned from economic depression and world war used three techniques to redirect Canadian federalism into the creation of national social programs. Inevitably, all three have since been blunted by use. One technique was constitutional amendment, which gave us unemployment insurance, employment services, Old Age Security and the Canada Pension Plan. Events in and since 1981 have put constitutional amendment far back on the shelf.

The second technique used the federal spending power to make social-purpose payments directly to individuals. Family allowances were the shining example. They fell victim to the 1980s reaction against universalism. The principle of direct payment has not been abandoned, however. It has been shifted to the selective form of refundable tax credits.

Cost-sharing with the provinces was the third technique. It drove the great improvements in postsecondary education and in social services and assistance, as well as in health care, which characterized the 1960s and 1970s. The design was in joint with the times. In the fiscal circumstances that ruled until the later 1970s, the sharing ratio had to be 50 percent. The provinces would not have been energized for less.

But the stimulant was distorting. Provincial governments kept a less tight rein on 'fifty-cent dollars' than on money they had to raise entirely on their own. The consequent extravagances, though much exaggerated by critics with other motives for objecting to medicare, were real enough.

This history helps to explain some present attitudes; it should not distort the reception of new ideas. What is proposed here is not fifty-cent dollars. The ratio for renewed cost-sharing will rise gradually to a ceiling of 25 percent. Three out of every four dollars of medicare spending will have to come from a province's own taxes. That is very different from one out of two. Provincial treasurers will not be motivated to relax their guards against careless spending.

Restraint is needed in any event. Three mechanisms for it are included with the proposal for renewed cost-sharing. First, there will be tax reporting to raise consciousness of costs throughout the medicare system. Second, there will be a federal-provincial agency to monitor the operation of medicare. Third, there will be specific procedures to contain cost increases. All three will be described later in this memorandum. The federal treasury will be far better safeguarded, to better purpose, than would be likely if medicare funding remained subject to political pressures on the CHST.

Credit

There is, however, another obstacle to moving away from the CHST. Cost-sharing has a bad name in Ottawa not only from the past 50 percent ratio but also from a lesson of political experience: The federal government gets credit when a joint program is begun, but once it is established the benefits become identified almost entirely with the provincial governments operating the program. Other politicians, often of other parties, get almost all the credit for services made possible by taxes that Ottawa levies.

This visibility issue led in 1977 to the Established Programs Financing (EPF) arrangement, shifting some of the tax burden for joint pro-

grams. That change, however, further weakened Ottawa's identification with the programs and greatly weakened its leverage to maintain their intended benefits. Many provinces reduced their expenditures on postsecondary education, making it less accessible by forcing fee increases, and the federal Health Department has turned a blind eye to provinces chipping away at the margins of the medicare principles.

Therefore, necessary though it is for medicare, renewed cost-sharing is politically attractive only if you find a way to get from it what your predecessors did not: steady identification with the benefits, not the woes, of medicare.

That is entirely possible. It is possible because it is also the way to overcome the provinces' distrust of Ottawa, their experience-generated fear that commitments to them will always count for little beside the vagaries of federal politics and finance. That fear will be overcome, cost-sharing will be reliable, if this time we set it up in a way that gives future as well as present federal authorities the assurance of continuing political credit for their money, and thereby discredit if they take it away.

In short, the federal need for recognition of funding and the provincial need for security of funding are not in conflict. Both parties are winners if, instead of jousting, medicare financing is set up in a way that makes the partnership continually clear to voters nation-wide. That will be the effect of this package of proposals.

It does not mean that all provinces will leap for joy because you offer renewed cost-sharing. When the Minister of Finance slashed transfers to them in 1995, he threw out a consolation bone: The CHST is free from any conditions as to how it is spent. Some provinces may now see, at the end of the tunnel, the best of both worlds. Concern for health care gives them the political clout

to get, and probably for some time to go on getting, more federal money. If it continues to come through the CHST, they can use it how they like. They can cut their taxes, or whatever, and for a time still attribute health care woes to Ottawa not coming up with all the money they claim it should.

That is, of course, a viewpoint possible only for politicians of limited foresight, indifferent to the stability of later funding. There are among the Premiers wiser heads and hearts more concerned about medicare. The fatter cats may stir up some side issues; they will earn nothing but public scorn if they try to mount a denunciation of your offer to provide both immediate help and stable, long-term collaboration for medicare.

The politics of the matter do require, however, that the help be both immediate and substantial. A reasonable first move would be to offer to reimburse each province for 20 percent of the cost it incurs for its medicare program in the present fiscal year. Of the current \$15.5 billion CHST, about \$9.5 billion is attributable to the health component (the rest being some compensation for the previously cost-shared 'social' programs). The exact amount of the 20 percent share of medicare costs will not be known until after the end of the year, but it will be about \$12 billion. Replacing the H of CHST by the cost share will therefore provide about an additional \$2.5 billion to the provinces this year. That does not exactly meet, but it is close to, their demands for transfers restored to the 1994, pre-cutting levels.

The Canada Health Agency

Partnership requires embodiment. Hitherto, it has been ethereal. Ottawa has spoken from on high, insisting that it is both the investigator and the sole judge of how faithfully the provinces adhere to the principles of the Canada

Health Act. The provinces have kept their distance from federal officials they suspect of trying to interfere in program management. The prevailing acrimony has not been allayed by ministerial meetings and only occasionally and temporarily assuaged by the bargaining of First Ministers.

Collaboration will not become established unless there is organization for it. There should be a Canada Health Agency. The purpose is neither to manage the provinces' programs nor to impair Parliament's responsibility for the Canada Health Act. It is to provide a mechanism for regular consultation within the medicare partnership.

An outline of the proposal to the provinces would be that they and the federal government appoint, by consensus, a health advisory council – the Canada Health Agency – embodying a wide range of expertise. It would be the employer of the agency's staff, which thereby would be neither federal nor provincial. The advisory council itself would report to a ministerial committee responsible for directing the agency in its function of assisting governments in all the areas where they may cooperatively advance their joint interest in improving the quality of medicare programs, in increasing effectiveness and containing costs. Both the ministerial committee and the advisory council would enhance government accountability to the public by regular and full reports on their findings and recommendations.

The creation of such an agency would be entirely in the spirit of the Social Union Framework Agreement.

To know what we do

The agency, if established promptly, could be in charge of the most urgent of all reforms. It is to bring health care into the information age.

Much medical data is still little more than a by-product of the record-keeping doctors need in order to make their fee-for-service claims. It often gives virtually no account, readily usable by other doctors and nurses, of a patient's health problems and treatments. Even more rarely is there any precise record of the results, if any, of the treatments.

The benefits of an adequate data system would be most immediately apparent in hospital emergency rooms. Their staffs would not have to waste time getting from new arrivals information for diagnosis that could be immediately accessible from a family doctor's data bank but is obtainable only vaguely, if at all, by questioning the patient.

More broadly, the poverty of health information means that we lack the empirical evidence for systematic assessments of medical practice and for measuring the cost-effectiveness of alternative procedures. It would be folly to pour out more tax money without instituting a nation-wide information system capable of providing full data for the efficient development of health care. That purpose requires a publicly operated information system, independent of drug companies and other interests.

The obstacle to creating such an information system is familiar in public finance, federal and provincial: Immediate needs crowd out money for investments that yield their benefits over time. Some of the costs of the information system will be federal anyway, but you may expect suggestions – particularly from your own Health Department – that you also should provide special funding to help the provinces with their costs.

Superficially, the case is quite strong. It is, however, short-sighted. Nation-wide prin-

ciples for medicare require partnership, not domination. They in no way remove the responsibility of each province for the management of its program.

Recently, for example, the widespread need for more home care has led to the proposal that we provide special funding for it. We should not. The effect would soon be to over-expand home care relative to other health services, to waste money by distorting the allocation of resources. It would be inequitable as well as inefficient, because the extent to which home care is more needed than better community facilities, for example, varies among areas and among provinces. Such priorities are matters for management within each provincial program. Special federal funding of bits and pieces of medicare would be neither efficient nor fair. Our partnership role is to support the program as a whole.

Certainly the information system is a prime and urgent need. To get it going now is worth our money. But there is a better way than special funding. It is to say to the provinces that when the Canada Health Agency is established and running, as soon as it has got the information system organized, then Ottawa will raise its permanent share in their total medicare expenditures, including the new costs, from 20 percent to 21 percent.

Such a commitment would consolidate the turn from confrontation to partnership. Far more than special grants, it would give provinces security for long-term planning of their health policies; and, equally, it would better assure continuing public recognition of the federal contribution to medicare.

For the same reasons, the same technique – the offer of progressive small increases in the committed federal share of costs – is the way in

which you can lead Canada to improve health care. There are, however, efficiencies to be achieved first.

Reform through collaboration

Ending confrontation does not mean shrinking from challenges to the provinces. In their jurisdiction, health care has been slower than most activities in its response to the information revolution and to the social changes of recent decades. The reason, however, is not that provincial authorities need federal lectures on what should be done. It is, chiefly, that they lack the clout to overcome strongly established interests. Empowerment could come through collaboration.

The clear, major example is the organization of primary care. When medicine was simpler, when it changed little from decade to decade, when patients were fewer and their expectations lower, the traditional family doctor was the best regarded of caregivers. Scientific advances and social changes have combined to make it increasingly difficult for the physician in sole practice, or even for partnerships of two or three, to provide the quality of primary care now possible. In urban communities, a common response is to confine the practice as much as possible to office hours, five days a week. One consequence is the clogging of hospital emergency rooms.

For many people, group practices could provide better care more efficiently. Many doctors know this, but fee-for-service remuneration gives them little or no incentive to do the necessary organizing and lessen their independence. The doctors' trade unions therefore tend to be dominated by those who are dedicated to the concept of themselves as entre-preneurs, deserv-

ing good fees for their services but hampered by bureaucrats and ill-used by politicians.

Doctors are people of influence. While provincial governments occasionally have fought and won, they are generally reluctant to press bargaining with medical associations to the point of battle. Fee-for-service remuneration continues to be modified little, if at all, by the element of capitation that would facilitate group practice.

Collaboration through the Canada Health Agency could shift the balance of power. A provincial government would be able to say to its doctors: "This is the process for encouraging improved delivery of health services that all the provinces and the federal government agree to be fair to you as well as beneficial for the public." A common front would make resistance to reform considerably weaker, politically, than a province encounters when it acts alone.

More group practice not only would be helpful in itself. It also would facilitate a broader reorganization. At the beginning of medicare, a department of the provincial government was superimposed on all the separate organizations – public, private, charitable, volunteer – that were financed in various ways to deliver particular health services, in large part independently of each other and of physicians. Medicare, establishing a single payer for much of the activity, has the potential to make it more effective by coordination. But that will not be done by direction from the provincial capital. It requires decentralized, on-the-ground area managements tuned to the particular needs of varying communities.

In most provinces that change has been slow to come and is partial at best, not least because physicians have been too little involved in the process. They could play a considerably

more effective role in a better integrated, decentralized delivery of health services if more were themselves working in group practices.

This is one of many ways in which medicare cries out for more efficiency. It is not in your power to ensure improvements but you will make them appreciably more likely if your leadership does indeed secure the collaboration that hitherto has been submerged by political conflict. A wider range of pilot projects will be feasible. Containing drug costs will be a little less difficult. Provinces cooperating more, with each other and with the federal government, will find sharing ways to use scarce resources more effectively.

In this context, we should recognize that public agencies are often slower to adopt new techniques than private enterprises seeking profits. Health authorities pressed to meet desperate current needs are particularly likely to sacrifice capital investments. Hence the waits for scanning, by expensive equipment, that can be done promptly if paid for privately. The Canada Health Agency should increase the chances of foreseeing and coping with such problems, by interprovincial sharing and perhaps by spreading the costs of loan funding for major investments.

Public and private money

Whether such improvements are realized will depend on how well collaboration is sustained through the natural tensions of politics. You cannot create guarantees. You will increase the chances of success if you obtain now a joint declaration, clear and precise, of what medicare is.

The principles of medicare are now defined by federal statute alone. The provinces that pro-

vide the service are bound to the definition not by that legislation but, loosely, by federal finance and, strongly, by public opinion. That opinion compels all politicians to come to praise. Only a few would prefer a quiet burial of medicare. Many, however, are uncertain – along with much of the public – in their understanding of the principles that the Canada Health Act necessarily states in arcane legal terms. Particularly uncertain, because it is particularly controversial, is the relation between medicare and private payment.

The uncertainty is not about services medicare does not cover. If it excludes, say, eyeglasses you need, you will pay for them, either directly or through private insurance, if you can; if you cannot, you will either go without or manage with non-prescription glasses from the drug store. This is poor public policy, but until it is changed no one will challenge the right of those who can afford to buy.

Nor is that right removed for the services that medicare does provide. If you prefer to stay out of it, if you can afford private care instead, the principles of medicare are not an obstacle. There may be practical difficulties: The market for some types of care may be too small to bring out private entrepreneurship conveniently located; the restrictive practices of the medical trade unions may make most private medicine unattractive for its potential providers. But there is no issue of principle on which devotees either for or against universalism can mount their high horses. As long as we have with us not only the poor but also the very rich, lavish health cures will be available on the Cayman Islands if nowhere else.

Indeed, this issue is virtually ignored for public services that have been longer established, such as education. Those who do not like the tax-financed school system are free, if they can

afford, to send their offspring to Upper Canada College or wherever.

Confusion of principle does not arise, in short, from separate private financing. It arises if public and private financing are mingled. Private schools as such are not the threat to the public system. It is endangered if some schools within it, receiving the normal tax financing, are allowed also to charge fees in order to cover the costs of more teachers, smaller classes, better equipment. The articulate middle class, the people who have most influence on politicians, then become less concerned for the quality of the schools in general. Fewer teachers for other people's children would not greatly distress most of the people who could buy better teaching for their own children with fees covering the marginal cost. But that combination would be disastrous for the equal-opportunity society almost all of us profess to want.

Health care is a parallel case. You can dismiss private care, without any public financing, as unimportant. What is incompatible with the principles of medicare is the introduction of privilege within the public system. Health care is tax-financed in order to provide it according to needs, not pockets. The purpose is lost if fees can buy preferential treatment, jumping of queues, additions to the care that taxes provide.

Though advocates of 'two-tier' medicine in Canada are generally shy about exactly how it would work, its intent and its effect are not in doubt. With well-to-do people buying better service, political interest in the standard level of care would be lessened, funding for it restrained. The gap between the two tiers of care inevitably would widen, with the upper tier promptly providing the benefits of advancing medical science and the lower tier lagging increasingly far behind.

Few politicians would welcome this outcome but many are capable of seeing no harm in small concessions to rich supporters and business interests, in allowing a growing penetration of tax-financed health care by elements of private financing. Privilege can creep far more effectively than socialism used to be alleged to do.

This moment of intense concern about health care provides your opportunity. You can act decisively to stop the erosion of medicare. My proposals for collaboration, for more federal funding, can be conditional on a joint statement of commitment to the principles of medicare, a statement clear and firm enough to put to rest all ambitions to undermine those principles by mixing private payments into medicare programs.

Private enterprise

To obtain unanimity, however, you will need to make it equally clear that the issue is how health services are paid for, not the extent to which they are delivered by public or by private organizations, for-profit or not-for-profit.

The principles of medicare require singleness of payment, not monopoly of provision. They do not require the use of a public institution if a private enterprise can be contracted to use the same or less public money to provide more efficiently the same services on the same terms: according to need, without any fees for special treatments. If those conditions are met, specialized testing and scanning procedures, for example, can be contracted out as appropriately as a hospital's laundry.

In that case, principle is not at issue. The practical problem is that the difficulties of monitoring may create grey areas, or worse. Premier

Klein's determined promotion of private clinics is the notable example. The efficiencies he claims are obscure. The supposed absence of fees is suspect. If the clinics are indeed limited to the medicare compensation that hospitals receive for the same services, where will profits attractive to private capital come from? Will ways be found to add on fees for faster or supposedly better treatment? The extra policing that federal Health Minister Rock plans will be a regrettably necessary diversion of money that could otherwise be put to better use.

There is also a lurking danger to have in mind. The protections of investment that are burgeoning in the guise of free trade make it possible that, once a transnational company has got its toe into a public service, it may be able to claim a right either to further inroads or to compensation for profits denied. That, however, would be an attack on democratic government against which all public services would require defence. It is an issue broader than present medicare policy.

Taxable benefits

In the past, medicare has been challenged by some politicians wanting to limit access through user fees, and by some doctors wanting to extra-bill. There are now slightly subtler proposals. Voucher schemes can be given some appearance of fairness, though their effect would be to stigmatize the unhealthy poor and to give the healthy rich another concealed tax break.

The chief threat to medicare now comes, however, from the propaganda that, by emphasizing ever-rising costs, prepares the way for further economies in the basic, tax-financed service in combination with fees for extra and faster service. It cannot be too strongly emphasized, in response to such propaganda, that freedom for

the politically dominant middle class to buy better service would progressively lower the relative level of tax-financed service. Medicare and private financing will not mix any better than oil and water.

Other hard facts have, however, to be recognized. Health care is extremely difficult to operate fairly and efficiently. Costs are great and rising. So are expectations. Patients have little consciousness of costs. Doctors, harried by some patients and consulted too little and late by others, have to make dauntingly difficult decisions about what should be done for whom. They have little incentive – to some degree, indeed, a reverse incentive – to take costs into account.

In short, the ideologues of market economies are right, in the sense that pressure to exceed reasonable needs is inherent in tax-financed health care. Medicare does require a way to contain its costs without breaching the principle of universal access.

There is a way appropriate for you to propose, a way well grounded in Liberal precedent since it was suggested in the decisive resolution on medicare adopted at the party's Policy Rally of January 1961.

It is that the costs of the medicare services provided to an individual or family should be calculated, as can now be readily done through a computer program, and totalled for the year. The amount would then be reported on the equivalent of a T4 slip, as are other tax-financed benefits. Such reporting would in itself create more awareness of costs throughout the medicare system, in the minds of the prescribers and providers of care as well as of its recipients.

The medicare reporting slip might look like other T4s but it would not have the same meaning for everyone's tax bill. However large the

benefit reported – however great the cost of treating a serious illness might have been – the most taken into account, in calculating tax liability, would be a small percentage addition to the taxpayer’s income. The percentage could vary, with family size and income level, between – say – five and ten percent.

The ‘clawback’ of medicare benefits therefore would be small. For people on low incomes, paying little or no tax, the addition would be little or nothing. Suppose, however, that a middle-income family, earning \$50,000 a year, encounters illness so serious that its treatment shows on the T4 as a cost to the medicare system of some thousands of dollars. The maximum that would be taken into account for tax liability would be five percent of \$50,000 – that is, \$2,500. At the marginal rate for such a family (now 24 percent), this would mean additional federal tax of \$600 for the year.

For a middle-income family, that is an extreme case. For upper-income people, the dollar amounts could be, of course, a good deal larger. But however great the medicare benefit received, the clawback of it would never be more than the taxpayer’s income divided by ten and multiplied by the top tax rate (currently 29 percent); that is, the additional federal tax would be at most 2.9 percent of income.

As a further protection against hardship, there could be provisions that the payment of extra tax might be deferred, without penalty, in cases of prolonged illness.

Even so, there will be protests: from people who object to any tax, however fair, and also from those universalists who believe that social benefits should always be free of tax, however higher other taxes then have to be. Neither kind of criticism will resonate strongly with a public well aware that medicare is severely stressed. Few people may realize how much their own care

costs, but all know that medicare in total is expensive, that it is in some respects inefficient, sometimes abused. The ordinary sense of fairness is not offended by the idea that people should make some direct contribution to the cost of the service, according to how much they use it and how much they can afford.

That is exactly what is not done by crude devices, such as user charges or extra billing, but will be achieved by medicare T4s. And thanks to other provisions of the tax system, relating to overpaid benefits and to Old Age Security, clawback by tax recovery is not a strange idea. You will have little trouble winning the political debate about a sound and fair proposal to preserve the health care people want.

Limits

Essential though it is for fairness and for efficiency, greater consciousness of costs will not in itself solve the most difficult problem of tax-financed health care: setting its limits.

The Canada Health Act is intended “to facilitate reasonable access to health services without financial or other barriers.” Each of us may like to think that this should mean, for herself or himself, any service that may be of benefit at any time. It does not. “Reasonable” cannot mean “regardless of public cost.” There are always necessary qualifications of principle by practicality.

Politicians and administrators, however, are understandably reluctant to admit, publicly, to the limits of reasonableness; and unacknowledged limits commonly result in rationing by delay. To some degree for some purposes, that may count as reasonable. But it is often inefficient, adding to costs; quite often, it prolongs suffering; sometimes it brings premature death.

One of the important, if less obvious, benefits of collaborative health care would be to make it easier to develop guidelines, at least informally, about what not to do. No practicable increase in medicare funding will remove the necessity for difficult choices. Collective consideration through the Canada Health Agency may, however, make sensible decisions easier to reach and should certainly make them less controversial to implement.

The T4 proposal will raise a different kind of question about when to stop. It will in any event require the collaboration of the provinces; their organizations will have to be geared to provide, by the end of February each year, the figures for the T4 slips. Do they stop there? My proposal applies to federal income tax only, but the provinces may be interested in applying it to their taxes also. If all or most wished to do so – the decision, of course, is theirs – the ratios of five to ten percent that I have used, to illustrate the operation of the scheme, might be excessive; further consideration and negotiation would be required.

Moving on

In any event, the tax provision rounds out this comprehensive set of measures to rebuild medicare as a firm partnership, to enable improving health services to be delivered more promptly and fairly, by greater efficiency to contain the growth of costs. But all this is, in a sense, house-keeping. It is not the promise of goodies soon that many of both your colleagues and your opponents see as the core of any political program.

The electorate today knows better. A majority of people want good health care more than they want anything else from government. They know from experience that this means, first,

prompter, more efficient delivery of the services medicare already offers. Grand talk of expansion, of more services, will carry no conviction, will be seen as irresponsible spending, if it comes from politicians who show no evidence of fixing the existing problems first.

First, but not alone. People do want to move on. Collaboration must replace conflict. There must be realistic measures for improving, in collaboration, the housekeeping. But with that, you also can make responsible and credible proposals for the health care policy of the new century.

Vision, however, has to be tempered by federalism. A health policy cannot be announced from Ottawa. It can begin only as suggestions for discussion with the provinces. The vision, the enthusiasm of a dynamic government, have to be expressed not in pre-fixed policy but in the leadership that translates policy discussions into agreed action plans.

The aim would be to give practical definition to the additional services, wholly or partially excluded from existing medicare programs, which would make health care according to need a full reality for Canadians. The wish list generally starts with pharmacare but goes on to home care, dentistry, eye care, environmental protections and community services of many kinds. There can be more than a wish list provided that existing services are demonstrably improving in effectiveness and efficiency.

The proviso is necessary, but it cannot be allowed to make your health policy appear tentative, suspect as mere electioneering. Vagueness will be avoided, the provinces will be brought into serious consideration of action plans, if your initiative includes a definite offer of more federal funding as agreed improvements to health care are implemented.

You already will have offered to follow a 20 percent share of costs this year by a rise to 21 percent when the Canada Health Agency and its information system are operative. The same partnership style is needed for the further stages of your health policy. You will establish the incentive and the means for a full revitalization of medicare if you announce now that the federal government is prepared to continue to raise, by careful steps, its share of funding. Responsibility and credibility require a firm limit and a timetable: by the fiscal year beginning April 2005, a maximum of 25 percent of each province's expenditure on its agreed medicare program.

So direct an announcement would be deliberately unconventional. It underlines the sharp break from medicare conflict. It provides the lead time, equally required, for careful planning and implementation of major program changes. In itself, of course, it establishes only the context for cooperative program development. That requires unanimity on the broad outlines of acceptable programs. Beyond that, each province must be free to establish its own order of priorities, to arrange what it thinks best for its people.

Such necessary diversity creates, however, what could be one of the more difficult problems that have to be wrestled with through the Canada Health Agency. With provinces implementing somewhat different programs in different ways at different times, what are the criteria that will determine, fairly, the points at which their scales of program implementation entitle provinces to steps up in their ratio of federal funding? This is the kind of technical problem that need not be of great moment if recognized early but is liable to create much frustration, or worse, if unconsidered until late in negotiations.

The criteria for program development and implementation have an important significance

besides fairness among provinces. You cannot embark on a constructive medicare policy unless you are prepared for its call on federal expenditure to increase substantially: in ballpark figures, from \$12 billion this year to \$20 billion in 2005. That is entirely reasonable for a program that does so much for so many, that is a principal mark of the Canadian society built through federalism. But 'so far, so good' cannot be allowed to mean 'and yet more.' Nothing is at present more important than putting medicare into shape; once it is, there will be other national purposes to emphasize. The criteria for program development to which you would agree with the provinces now need to be fully compatible with program consolidation later.

Though they will not take effect until the planned expansion is complete, it will be wise to suggest some procedures well in advance. One might be that if, in 2006 or later, a province increased its medicare spending at a significantly faster rate than the national average, there would be a consultation, through the Canada Health Agency, about the circumstances. If no satisfactory reasons for the increased spending were established, the margin of extra cost could be excluded in applying the 25 percent ratio for shared cost.

The more general procedure would be an annual review, by the Canada Health Agency, of the rate of increase in total medicare spending relative to other social programs and to the GNP. If this indicated need for special action to contain the growth of costs, collaborative measures would be developed; if those did not work, the federal government would be entitled, after due notice, to make specified reductions from the amounts on which it provided its 25 percent reimbursement.

Such provisions would require detailed technical examination before they were made

final, but it is important for genuine collaboration that the policy considerations be broached early, not late.

Health at the start

What will be needed five years and more hence will depend chiefly on circumstances now unforeseeable, but it will be shaped also by the emphasis within health policy now. Traditionally, health care has meant the treatment of illness. Increased understanding is leading to more emphasis on preventive care, on combatting the causes of illness. The most effective prevention is healthy development in childhood. And that development is crucial for the national economy.

Despite their rage against taxation, even extreme neoconservatives nowadays recognize that government has to invest in the decisive resource of a high-tech economy: people. Productivity and growth depend, above all, on the quality of the workforce, which is largely shaped in childhood and adolescence; and ability to learn is greatly influenced by health.

The federal government's responsibility for national economic policy therefore gives it a special concern for health care in childhood and youth. You will provide leadership in the most constructive of public investments if, in your contribution to the discussion of health policies, you stress the national interest in putting children first. We cannot dictate to the provinces. Medicare programs are theirs to operate. But national priorities are yours to articulate.

Medicare will not be complete and fair until it includes pharmacare for all. That is, however, one of the services most notoriously exposed to much waste and abuse. The T4 clawback will make its administration easier, but even so pro-

vinces will be wisely hesitant to move into full-scale programs. Coverage of prescriptions for, say, ages 0 to 12 might well be a good way to begin, a pilot project that would develop administrative experience and lead in time to full pharmacare.

There will be, of course, many other suggestions for child and youth services: prenatal and post-natal clinics; parental counselling; nutritional supplements; 'school' lunches (including kindergarten and nonprofit day care); regular check-ups, including eyes and teeth; dental treatments; corrective aids such as eyeglasses. There are now elements of such services in different forms in various communities across the provinces, and there is no reason why their further development should be the same in Hamilton and Moose Jaw. It is entirely appropriate, however, that the Prime Minister should articulate, as a collaborative aim, the creation in time of a Canada-wide network of child centres, varied in character with their communities, but providing for each a focal point where caring and developmental services are accessible to all children.

You would make it clear that this is not a federal prescription for the provinces. It is a national project that the Prime Minister has the responsibility to articulate for the consideration of all Canadians.

Conclusion

The stakes involved in this whole set of proposals are high. The troubles of medicare will not diminish, will probably mount, if governments continue to squabble and to improvise. There will be no effective change without your leadership. With that, however, there is a historic opportunity for the taking.

About the Author

Tom Kent is one of the chief architects of postwar Canadian social policy. He played a key role in shaping the policies of the Liberal party during its 1957-63 opposition years and, as Policy Secretary to the Prime Minister and a Deputy Minister, was equally active in the implementation of those policies – including medicare – by the Pearson government.

Mr. Kent was born in Stafford, England, and graduated from Oxford University. He began his multi-career life in British military intelligence during World War Two, as a code-breaker on ‘the ultra secret.’ After the war he went into journalism, working on the editorial staff of the *Manchester Guardian* and as Assistant Editor of *The Economist* before coming to Canada to serve as Editor of the *Winnipeg Free Press*. Following his years in Ottawa as chief policy advisor to the Prime Minister and senior public servant, he ran Devco and Sydney Steel, headed a royal commission on the press and served as a dean at Dalhousie University. Since his retirement, he has been an adjunct professor of public administration at Dalhousie and fellow-in-residence at the Institute for Research on Public Policy, and is now associated with the School of Policy Studies at Queen’s University. Mr. Kent has written several books and articles on political and economic subjects, including *Social Policy 2000: An Agenda* published by the Caledon Institute of Social Policy in January 1999. He was named an Officer in the Order of Canada in 1979.