Medicare reform

Retaining Canada's health care system as a global public good

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This is the seventh and last in a series of essays in which notable Canadians give their perspectives on the future of medicare.

Although countless technical issues must be tackled in shaping the future of Canada's health care system, the interim report of the Romanow Commission on the Future of Health Care in Canada[1] has correctly situated the question of *values* at the heart of the matter.

Public opinion in the year 2002 echoes what Canadians have been telling pollsters for over 3 decades: we are committed to health care equity. We should indeed be proud of this commitment. The principle of universal access based on medical need rather than on ability to pay speaks both to our sense of fairness and to our sense of community. Canadians have accepted a vision of social justice that sees health care as a fundamental human right. Within this tradition every citizen, regardless of ability to pay, is viewed as part of the same social community. The principle of social justice in health care was incorporated into the UN General Assembly Covenant on Economic, Social and Cultural Rights,[2] which Canada ratified in 1976. Artitle 12 of the Covenant affirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," in part through "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."

It has been repeatedly noted that we Canadians regard our public health care system as a defining attribute of our national identity. Our perhaps somewhat idealized self-assessment emphasizes that, in achieving quality care, we have preserved universal access. However, in ensuring the provision of services we have not lost sight of the other determinants of health. When the influential Lalonde Report,[3] released in 1974, emphasized the importance of not only biological factors and health care, but also of lifestyle and the environment, it was heralded internationally as setting a framework that advanced our understanding of how to preserve and promote health in Canada and internationally. Canada has continued to play a leading role in the discussion of health determinants, a role that was evident in the drafting of the Ottawa Charter[4] — the outcome document of the First International Conference on Health Promotion, which Canada hosted in 1986.

Celebration of the balanced comprehensive approach that has produced medicare and the Ottawa Charter stands in stark contrast to models that have produced pockets of excellence alongside profound disparities, as in the United States and elsewhere. Our strained capacity to sustain the *balanced* objectives of addressing the full range of health determinants, including high-quality medical care on one hand, and maintaining social justice and hence universal access on the other, is precisely why the Romanow Commission is so important and so timely today.

Globalization, the worldwide trend to greater interconnectedness in economic, technologic, demographic and cultural domains, has introduced a qualitatively new set of pressures and opportunities. On the one hand, there has been an explosion of knowledge and technologic advances that empower us to more effectively intervene to improve health. These developments can of course also influence — or skew — expectations of what *can* and *should* be achieved. On the other hand, pressures to maintain our competitive position globally reinforce the reality that we must conduct our affairs in a financially prudent way to support the lifestyle we elect to maintain. Although polling data confirm a high level of support by Canadians for universality in health care, these data also suggest that political support for medicare is likely to erode substantially if people come to believe that preserving equal access will, because of escalating costs, undermine the quality of care provided. The need to understand what is driving up these costs is thus crucial. There is strong empirical evidence that medicare is significantly less expensive and more efficient than the US model. Indeed, it is not administrative costs or doctors' fees that have been escalating so dramatically; rather, it is those costs arising from within the private sector that are now tipping the balance.

This is precisely because the operating environment in which we manage health in our country has changed dramatically from half a century ago. Initiatives such as the General Agreement on Trade in Services now provide an emerging set of rules governing the choices we make in shaping our future. The case of pharamaceuticals is an illustration of how this can operate and why we must carefully appraise these policies. In the late 1960s provisions for compulsory licensing were modified in Canada to al-

low broader access to generic drugs. By 1983 this resulted in an estimated saving of at least $211 million in a total market of $1.6 billion.[5] As a consequence of, first, the Free Trade Agreement in 1987 and, subsequently, the North American Free Trade Agreement in 1994 and the Trade-Related aspects of Intellectual Property Rights (TRIPS) agreement in 1995, the Canadian government first limited and then abolished compulsory licensing for pharmaceuticals. Until the anthrax scare after the terrorist attacks of Sept. 11, 2001, and the global emergence of the drug-patent issue with respect to the access of developing countries to inexpensive drugs, we heard little of these provisions. In the interim, we have arrived at a situation where the price of pharmaceuticals has itself become the major driver of increased costs, exacerbated by an increased reliance on drugs in treatment and prevention. We must stake out a public policy position that places our trade policy in line with our values. Otherwise, we not only compromise our values, but we further threaten the sustainability of the things we hold most dear.

Exaggerating the shortcomings of our health care system has led some to throw up their hands and look for radical changes where more measured approaches are more appropriate. We should recognize that some who wish to dismantle the public character of our health care system have a proprietary interest in doing so. But there is, to reiterate, no evidence base to suggest that user fees or privatization will provide greater efficiencies, let alone ensure access for vulnerable people. The burden of proof rests on those who would pursue radical restructuring. That being said, we should be imaginative in finding ways to improve organizational and administrative efficiencies.

To take the widest perspective on the stakes involved, it should also be noted that in the eyes of others internationally, our balancing of excellence and equity in health care has earned us great respect. We should acknowledge this asset more explicitly. We should also consider whether we have done enough to build on it. If, in fact, the Canadian health care system can be considered as a "global public good" insofar as it provides an example of how a balanced approach can be pursued, then the stakes are even higher as we decide how to proceed.

The challenge of providing quality health care is being confronted in other countries across the globe. We are not unique in this respect. But, just as our values in the past have guided us to distinct achievements that have produced great benefit for Canadians and made a mark internationally, we now have the opportunity to build a sustainable future and, in so doing, to set a positive example for others.

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