



## Notes from the Editor-in-Chief

FROM TIME TO TIME, there is a healthcare issue so compelling to politicians, policy-makers, healthcare providers and the public that it warrants a special report from the publishers and editorial board of *HealthcarePapers*. What we should do in terms of healthcare reform in Canada is a critical issue worthy of extensive debate. There are many different perspectives, and *A Framework for Reform*, the recent report of the Premier's Advisory Council on Health in Alberta, chaired by Donald Mazankowski, has provided added incentive and momentum.

In the summer of 2000, Duncan Sinclair, Chair of the Ontario Health Services Restructuring Commission from 1996 to 2000, provided a thoughtful article in *HealthcarePapers* on the sustainability of medicare in Canada. Along with 10 commentators, Sinclair concluded that for medicare to be sustained it was likely that more funding would be necessary, and this would most likely come from the private sector. In addition, Sinclair and others acknowledged the extent of rationing of health services as it exists in Canada and made a series of suggestions for cost savings through efficiencies, realigned incentives and information management. So what has happened since then? Why has there been so little action?

Several provincial commissions have been held as well as two important federal projects – the Kirby Senate Committee on Health Care and the Commission on the Future of Health Care in Canada headed by Roy Romanow. These initiatives brought together the most well informed thinkers and experts across the country and have advocated for modernization of the Canada Health Act. But it is clear there are no easy solutions. The Romanow Commission, appointed by the federal Liberal government, is not due to report until November 2002, but has now embarked on a public consultation process. Funding of healthcare, always a high-priority item, is outlined in terms of four options: provide more money from current sources (taxation) for healthcare, introduce co-payments for users of healthcare, allow greater participation by private sector organizations and increase the efficiencies by which the services are now provided.

Well, how big a problem is out there? Some observers would argue not much. Some armchair experts see the problem as one created for political purposes to pit one level of government against another. Others suggest that this is a media game – that a “crisis” in health services is a controversial public interest story that attracts attention and sells newspapers. But Canadians are not alone in the dilemma; all Western societies are facing similar problems of how to provide access to quality health services at a reasonable cost, and are looking to each other for magic solutions.

The Mazankowski Report published in January 2002 recognizes that healthcare is an emotional issue. For sure, all Canadians pay taxes and no one wants to pay more. Access to services is a key issue that is not helped by the Canadian geography, an aging population, advancing medical technology and predicted human resources shortages.

The report recommends a number of important strategies, including helping Canadians to stay healthy, improving the service ideal of customer first, redefining the meaning of comprehensive services, investing in medical technology and information systems, and diversifying revenue streams for healthcare. As you will read in this volume, there is no shortage of individuals with opinions who are willing to offer serious and thoughtful commentary on the Mazankowski Report.

Lewis and Maxwell commend the report for its focus on the mainstream issues of health and healthcare, including the promotion of healthy lifestyles and the need for better information management for providers and consumers. They do not share the Report's pessimism about the prospects of internal healthcare reforms, many of which have already been tried. They are, however, skeptical about the success that could be achieved in defining what are "essential" services as opposed to "medically necessary" services as currently defined by the Canada Health Act. While the Mazankowski Report does not advocate an American-style market-driven healthcare system, Lewis and Maxwell recognize that the principles of this philosophy are only lightly veiled under the guise of patients' choice.

Deber too comments on the emphasis in the report on the determinants of health. In fact, the majority of the report places a great deal of philosophical responsibility for health on the individual and his or her lifestyle. Deber, however, challenges the report for its description of the current system as "command and control" and points out that the system is actually quite decentralized, giving professionals such as physicians a great deal of autonomy. She also suggests that critiques of the report have tended to focus on some of the "sillier" (her words) recommendations that have less potential for success.

The recommendation that appears to have drawn the most attention is the diversification of revenue streams. Part of the interpretation here is seen as a code for private-sector sources of funding, which seems somewhat at odds with the approximately 25 to 40% of funding for health services in healthcare currently provided through the private sector. Marshall, who is with the Canadian Union of Public Employees, is critical of the report, suggesting that, if implemented, the recommendations would move healthcare away from being a "right" for all Canadians. McMahon and Zelder at the Fraser Institute, an independent Canadian economic and social research and education organization, argue that Canadians do not get the benefits of choice of medical innovations because services are rationed.

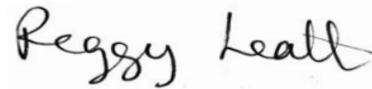
The report has evoked a lively discussion of Medical Savings Accounts. The idea here is that basic costs of services are covered and there is an accompanying insurance against catastrophic medical events. Shortt, Canada's leading expert on this topic, responds that being informed about utilization of services has not historically resulted in less utilization.

Maynard, providing an "outside" perspective, sensibly points out that the report is not based on facts or evidence. He points out the extent to which physicians ration health services and that perhaps the trust the public places in physicians may be

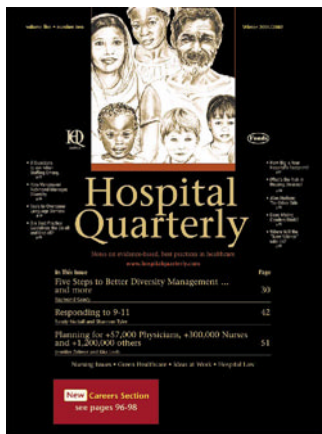
misplaced. Clinical decision-making shows an alarming variation in practice, and there is very little in place at the moment to change that. Physicians and rationing decisions is a topic covered earlier in *HealthcarePapers* (Vol. 2 No. 2, July 2001, [www.healthcarepapers.com](http://www.healthcarepapers.com)), and I encourage anyone interested in the topic to review this issue.

One of the ways to solve some of the dilemmas suggested in the report is the creation of a permanent independent expert panel that would make decisions about what services should be covered by medicare. Flood argues that this is one of the most important parts of the report, although it may be difficult to operationalize. Medical associations may be reluctant to give up their power to negotiate with provincial governments about what gets funded and at what price. The creation of such a panel, however, would make the decisions more transparent.

In summary, the Mazankowski Report has opened up many avenues for discussion. It has recognized that there are no quick fixes and that Canadians want fair and equitable access to services. The report places a great deal of responsibility for health in the hands of individuals and suggests that choice of when and how services are provided is important to consumers. For Alberta, Mazankowski promotes the health sector as a dynamic contributor to the economy, but in order to be successful healthcare reform is past the simplistic notion of cutting the fat and reducing services and expenditures. Every province will need to set its own directions.



Peggy Leatt  
Editor-in-Chief



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