

By Cynthia Martin

Born in Italy, raised in France and Portugal, speaking engagements in India and across North America – how does travel make you appreciate healthcare in Canada (beside the fact you were a federal Minister of Health and architect of the Canada Health Act)?

I recall how terrified Canadian students in Paris in the early sixties were of falling sick or having an accident! I was doing my doctoral studies at the Sorbonne. French hospitals, which are now state-of-the-art, were so dirty and so primitive in our eyes that each of us had instructed our respective closest friends to take us to the American Hospital in Neuilly, whatever the cost! But it is in Côte d'Ivoire and in other African hospitals, in the past 20 years, where I was most shaken by the conditions of healthcare delivery. Professionals and others were missing the most basic elements to operate or to treat sick people. Whatever our healthcare system problems, our medicare is serving Canadians rather well!

Pierre Trudeau's death must have brought back much thought about the era and your relationship with him; what do you most remember about those years?

Pierre Trudeau's death shook me deeply, much more than I thought it would ... It brought back so many memories. Compared to the world we now live in, 15 years later, anywhere in Canada, what was very special for me as a cabinet minister (or before, as a backbencher) is that the notion of governing, under Trudeau, did include discussing ideas, ideals and values.

You called the erosion of medicare and issues such as extra-billing and user fees the "tiny crack in the dam that leads to major flooding." Why is the foundation and universality of healthcare so crucial to our values as Canadians?

I wish I had the answer to your question! It seems to me that people in Canada like to perceive themselves as members of a classless society; so universality as a value comes naturally so to speak. The dream of being an egalitarian community, of having equal opportunities, equal chances, is deeply rooted in our political culture as a country. It must go back, among other causes, to our difficult beginnings as a country, faced with a crazy geography and a most challenging climate. We read about stories of wonderful local solidarity in pioneer times. In addition, and contrary to the United States, in Canada there has been an old European socialist tradition and ideology that became an intrinsic part of our political life for almost a century now.



MONIQUE BÉGIN

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Were you surprised by the collapse of that most newsworthy private health clinic in Toronto and the financial abuse by its founders, such as in phony MRI sales?

I was flabbergasted! It looked like a parody of a worse case scenario of privatization!

Have your warnings about free trade, vested interests and two-tier health systems, as you saw it in the late 1980s, illuminated the perils of privatization?

I am just one voice with (some) credibility adding to the public forum. So what I do is use it to signal to concerned citizens and to people in general whenever I see trouble ahead. I try to inform, explain and motivate. This being said, it always was very clear to me that medicare will remain if the public so decides. It's in their hands.

Has Alberta's agreement with the federal government reinterpreted the Act? How can the Act be flexible while keeping peace with the provinces?

In fact, Alberta's role towards privatizing the healthcare system goes back to 1996, well before Bill 11 in 2000. The official endorsement by the federal government, on May 17, 1996, of the Twelve Provincial Principles Underlying the Alberta Healthcare System is, in that respect, profoundly shocking. With the complete lack of accountability of our system, we all learned of it years after the fact! What should be done is a clarification and, yes, a contemporary interpretation of the five conditions/principles of the Canada Health Act; in particular of the role of public administration. Our "private/public" debates are sterile and dogmatic. We need to think not-for-profit/for-profit and establish new boundaries that will make the system efficient and sustainable, while preserving its universality and accessibility. It could be done by a royal commission with a clear, focused mandate (I would see Ed Broadbent doing it), or by a task force of provincial and federal experts together with capable citizens.



You've proposed this with the National Council of Citizens; how would this be able to provide a key voice in preserving our public healthcare system?

In reality, no one is in charge of our Canadian healthcare system. Its governance is rooted in the constantly renegotiated and fragile equilibrium among three of the major stakeholders: the provincial governments, the federal government and organized medicine. None is over and above the others; none has the control of the system. Each can disrupt it seriously, yet all are needed to make it function smoothly. Nowhere in this hierarchy is the citizen, as patient, considered seriously, except as passive recipients of healthcare services.

A serious impediment to proper accountability in healthcare services is therefore the major imbalance of its power structure. Right now, there is no balance between the power of those who have a direct professional vested interest in the health system and those whose vested interests are to be its users and taxpayers.

Even though figures include overhead, doctors essentially operate like any small business but have guaranteed public "customers" paid out of public funds. Should doctors – as noted in a January 2001 *Globe and Mail* article – be able to bill more than half a million dollars a year?

In Canada, the culture of the medical profession turns doctors into a mentality of entrepreneurs, so well captured by C. David Naylor's book *Private Practice, Public Payment: Canadian Medicare and the Politics of Health Insurance, 1911-1966*. Let's be clear: physicians must receive reasonable and fair compensation. Fee-for-service, however, is not the best mode of remuneration; it rewards the process only and has many other weaknesses. We should design mixed modes of remuneration, with built-in incentives towards outcomes of health maintenance, evidence-based practice and teamwork.

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Many believe that women's health needs are still not adequately served by the current healthcare system. Why is a multidisciplinary specialty in women's health a good thing?

Medicine and medical research, although scientific, have never been neutral and objective. The developing multidisciplinary study of women and their health will benefit both women and men for a host of reasons, and foremost because it questions pre-conceived ideas held as universal truths. Let me give just a few areas of benefits. Women's health is conscious of the need to consider the whole person. It tries to apply a full spectrum of "determinants of health," including factors other than strictly biomedical and genetic. Those suffering with "soft" non-glamorous diseases/health conditions such as depression, chronic fatigue, migraine, musculoskeletal problems or arthritis should benefit immensely from women's health research.

Your willingness to share conditional responsibility for Canada's tainted-blood scandal came with a blow to your personal pride, moral beliefs and ethics. Is ministerial responsibility possible given portfolio sizes and delegation?

It's like democracy: the least bad system we know! Yes, ministerial responsibility does and must exist.

After being in government, you became active in teaching; was this fulfilling?

When I started teaching after politics, I had the feeling at first that my new job as a professor served no purpose. Here I was, with some 30 students in front of me, when achieving a position and effecting change as a Minister could affect the lives of thousands, even millions in Canada! Then I slowly understood that touching the life of just one, two or three of these students was for life. When you teach, you often don't know how your words, knowledge or encouragement affect others until much later. Having received some moving testimonies, I now know this to be true and I treasure the positive effects I've had. From the quantitative to the qualitative certainly.

What are you doing now?

Right now, I'm exploring how to put changes and real reforms to healthcare delivery (not just downsizing and amalgamation) into motion, at all levels. I enjoyed tremendously working with the little team that Hugh Segal, of the Institute for Research on Public Policy, put together last summer to try to rethink medicare outside of the box. I think our Letter to the First Ministers of last September, the result of our summer work, has a few great ideas! And I am back into teaching, at the Masters Program in Health Administration, with Doug Angus, at the University of Ottawa. I want our students – tomorrow's hospital CEOs, assistant deputy ministers of health, managers of home-care agencies, healthcare consultants – to be leaders embracing change as the new norm of work; rewarding excellence and evidence-based practice everywhere; giving back to communities and regional health authorities the full budget (including doctors' payment) for everything "health"; making sure their provincial ministry stops micro-managing the system (and cutting by at least half their own staff); developing a patients' charter; and connecting with others, technologically and psychologically!

What books are you reading?

A Social History of England, by Asa Briggs, *The Tale of Murasaki*, by Liza Dalby and *The New York Trilogy*, by Paul Auster.

What's your desert island CD?

A Bach cantata or good jazz, such as Louis Armstrong.

What do you do for fun?

Watch a Fred Astaire or a Katharine Hepburn movie. Travel and exchange with friends. Spend time in nature.

You've received a whack of honorary degrees; at the event at Memorial University of Newfoundland, did you look at comedians Mary Walsh and Cathy Jones, who also received honorary degrees, and think you might have wanted a different career?

I love Mary Walsh and Cathy Jones, and told them so in St. John's! I feel I survived my years in elected politics – which I loved – thanks to the metaphor of a traveller into foreign, at times exotic, new lands, full of new people and new discoveries, but where the locals are pretty bizarre. And, I think I have a good sense of humour ...



Monique Bégin is perhaps best known for her work within the Canadian healthcare system, implementing the Canada Health Act in 1984. Born in Rome, raised in France and Portugal, she came to Canada with her family during the Second World War. She received her MA (sociology) at the University of Montreal and undertook her doctoral studies at the Sorbonne in Paris. She was the first woman in Quebec to be elected to the House of Commons, in October 1972. Mme. Bégin was re-elected in 1974, and again in 1979 and 1980 with the largest majorities in Canadian history. She served as Parliamentary Secretary to the Minister of Foreign Affairs, was Minister of National Revenue, and Minister of National Health and Welfare for seven years before leaving politics in September 1984. In 1986, she became the first holder of the Chair in Women's Studies, jointly at Ottawa and Carleton universities. She is now Professor Emeritus at the University of Ottawa and Visiting Professor at the Masters of Health Administration Program, a Fellow of the Royal Society of Canada, and has received several honorary doctorates. In 1998, Mme. Bégin was invested as an Officer of the Order of Canada. As a volunteer, she chairs the Canadian Institute for Radiation Safety and sits on the boards of the Ottawa Heart Institute, the Clinical Research Institute of Montreal and the National Cancer Institute of Canada.

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