



## 1. WHY CARE?

Our public system of health care is in trouble. These days it seems we can't watch television, listen to the radio, log onto the Internet, or read a newspaper or magazine without encountering some horror story. This week comes news of a cancer patient in desperate need of a drug not recognized or covered by the public system. Last week it was an elderly woman who couldn't find a doctor, and the week before that an elderly man had to wait a year for hip surgery. The week before that it was an athlete with torn ligaments who couldn't get an MRI. Tomorrow it might be an infection acquired in the hospital by a new mother. Next week it might be someone who can't get an appointment with a specialist.

Even the Supreme Court of Canada has entered the fray. In 2004, in what became widely known as the Chaoulli case, the Court agreed to hear a case about the alleged failure of the public health system—what we call medicare. It heard experts testifying about major shortages in the public system. Four out of the seven presiding judges concluded that the system was indeed in trouble, at least in Quebec.

While we hear story after story about how the system fails individuals, we are increasingly warned that worse is yet to come. All those babies born after World War II, when the soldiers came home and prosperity returned, are growing old. These aging baby boomers, we are told, will put heavy pressure on the public health-

care system, risking bankruptcy for us all. Not only are there a lot of them, but they are also likely to live longer than the previous generation. Moreover, new technologies and drugs come at ever higher prices—prices that the public purse will not be able to handle. Radio, television, magazines, and the Internet carry constant talk about new pandemics, while a lot of noisy advertising tells us about yet another worrisome health problem coming our way.

For some time now, given this barrage of bad news, Canadians have been expressing concern, even panic, about their public health-care system. Indeed, “be scared” seems to be the message. The personal stories bring the problems home, suggesting, “This could be me.” The constant weight of all these stories—and especially the threat of too many old people, combined with more expensive drugs and more illness—suggests that the public system is no longer sustainable, that public care is a luxury we can no longer afford. The need to do something seems to be increasingly urgent.

What is this public system that’s in the news so much? At its core, medicare covers the costs of much of our health care when we need it, and it does so without direct charge. We don’t personally pay the hospital or the doctor that provides us with care. As a result, financial barriers almost never prevent us from seeking care for ourselves or our family members. Instead, the costs are met by governments—we pay through our taxes. As a society we pool the risk of encountering ill health, which means that the healthy and wealthy foot most of the bill, rather than the unhealthy and poor. It also means that some of the healthy and wealthy want to reduce or even eliminate this pooling of health risks, and their voices are often powerful.

Despite this power, and despite all the turmoil surrounding it, medicare remains Canada’s best-loved social program. For many people it is also a defining feature of our country. It represents our commitment to shared responsibility and our recognition of shared vulnerability. Losing it would mean much more than losing access to care; it would mean losing a symbol that is the essence of the

Canada that emerged from World War II committed to democratic and solidaristic means of achieving our right to care. Still, we are right to be afraid, although not necessarily for the reasons given in the stories.

Canadians are being offered a variety of solutions to these troubles, all of them advertised as saving public care. But to assess these solutions, we must dig more deeply into the past, present, and possible future makeup of the system. We need to find out what the evidence tells us about what works for whom, along with who benefits most from the solutions being offered. We need to examine the claims that the system is now in crisis, rather than assuming that this is the case. Given that we have a public health-care system, we all have a stake in the system. It belongs to us, and it is up to us to determine its future. We can do this only if we know what we have—including where it has come from—as well as what we don't have. We need to look at what we need, what we could have, and what we could lose if we let it all somehow drift away.

We need, too, to look more closely at the manufacturing of dissent on the health-care front, and especially at the possible solutions being put forward: private insurance and the right to buy care, along with for-profit delivery and management. As we shall see, the evidence does not support these forms of privatization as viable solutions. Instead, we need strategies developed through the public system to further improve quality, access, efficiency, and equity. In other words, we need collective, democratic strategies for care. We need these strategies not only to protect health care but also to protect our understanding of Canada as a place that puts shared solutions above the individual's right to buy and profit from care.

Like the United Nations, the authors of this book see health care as a human right, which means that necessary health-care services should not be a source of profit. This is not just our opinion. As Roy Romanow, who headed the Commission on the Future of Health Care, put it in 2002 after examining the evidence and consulting Canadians widely, health care is about our values and it

is as sustainable as we collectively want it to be. He called his report *Building on Values*, emphasizing the centrality of values in seeking solutions. Our health-care system is fundamentally about democracy, and democracy can work only with a public that is both involved and informed. It will also work only if those who participate in the debate make their values explicit. We intend this book to contribute to the democratic process by offering the tools needed for informed involvement in the shaping of public care.

The evidence and the values of most Canadians are both on the side of keeping medicare public; indeed, they are both on the side of expanding its public scope and character. But the powerful forces favouring privatization are not disappearing quietly into the night. They keep finding new ways of promoting their interests. To defend and to improve our public system require at least as much vigilance on our side. This book is intended as a contribution to the democratic and continuing fight on behalf of medicare.



## 2. HOW DID WE GET HERE?

“My name is Sally. I work in intensive care, and I’m benefited,” a California nurse told us in the late 1990s when asked to describe her job. We were doing group interviews with nurses in the United States, and nurse after nurse said much the same thing. Although we had been interviewing Canadian nurses for years, that was the first time we heard the term “benefited”—and for good reason, as it turns out. What this California nurse meant was that, in her job, she had health insurance. In a country in which health-care costs are the leading cause of personal bankruptcy, and where most of the people who have health insurance get it through employment, the matter of “benefits” is among the first questions asked by people seeking a job. And “benefits” mean, above all, health insurance in various forms.

In Canada health-care coverage is not tied to employment, and few health-sector workers would describe their work in terms of health benefits. Indeed, many of the Canadians we have interviewed have no idea what is covered under their supplementary health

“Critics of government-run health care are either rich hypochondriacs who want to buy more medical services than the state will allow them, or lousy economists.”

—Columnist Eric Reguly, *Globe and Mail Report on Business*, February 6, 1999, p. B2.

plan, when they do have one. After close to fifty years of public care Canadians take basic coverage for granted, even in the face of the growing panic. How did we get a public health-care system while the richest nation in the world leaves more than forty-seven million people without health-care coverage, and many more with inadequate coverage? To understand our quite different trajectories, we have to look back as far as the early part of the twentieth century.

### **Depressions and Wars, Economics and Ideas**

The Great Depression and World War II were both critical to the introduction of public health care in Canada. The stock market crashed in 1929, signalling the failure of free-market capitalism. Governments across Canada responded to the subsequent dramatic rise in unemployment by following classical economic theories that said, “Leave the market alone.” Governments provided a modicum of public relief for people who were defined as the most deserving and vulnerable. Widows with children were most likely to receive this charity, although it was dependent upon the close inspection of their lives. Others were eligible for workfare—very low-wage, back-breaking labour that went mainly to men deemed employable. Many were left to ride the rails in search of employment or to beg from door to door for food. Protests were inevitable, and were just as inevitably put down. People paid their doctors and hospitals in food and services, or not at all. Many simply went without care.

As the Depression both continued and deepened, governments began to listen to a new theory being put forward by a British economist, John Maynard Keynes. Simply put, he challenged two supposedly common-sense notions. The first is that governments should not interfere in the marketplace, leaving the economy instead to business to run. The second is that governments should stop spending when their supply of money is low. Instead, Keynes argued that governments should spend in bad times, creating demand for both employees and products. They should borrow in order to purchase

public goods like roads, schools, and hospitals, and they should put money into the hands of the unemployed. In good times governments should save in ways that would allow them to protect workers and their purchasing power from excessive inflation. With money to spend even when they are unemployed, people would sustain the demand for goods and services and thus promote employment. Keynes also argued that a healthy, skilled labour force was both critical to the economy and a government responsibility. Many Canadian policy analysts—most notably social scientist Leonard Marsh<sup>1</sup>—promoted similar ideas and even more government-sponsored programs to support a healthy, educated labour force.

World War II reinforced Keynes's views. When Canada entered the war in 1939, governments were not in good economic shape. Nevertheless, they invested heavily in everything from guns to day care. Employment and training expanded enormously, including in the health-care sector, where large numbers of women found work. Recruitment and conscription brought many people directly into government service. However, a health survey found that too many Canadians did not make the grade for entry into military service, laying the groundwork for future government intervention in health issues. War also meant heavy investment in the development of new drugs, technologies, and techniques to deal with the casualties. Some of these, like antibiotics and plastic surgery, transformed treatments, while the recruitment of so many workers transformed care. Together these developments in health services contributed to the need for large hospitals where the complex equipment could most efficiently be utilized.

The sacrifices of war were promoted on the grounds of solidarity with Britain, the protection of freedom, and the promise of a better world to come. The war itself encouraged feelings and programs of solidarity, bringing people together through both deprivation and action. Countries such as Canada and the United States emerged from World War II with a commitment not only to peace and prosperity but also to human rights. Indeed, a Canadian official took the

lead in drafting an international declaration of human rights at the United Nations. Increasingly, shared responsibility for what were understood as shared risks was a notion that underlined Canadian government activities, rather than the idea that most people got what they deserved in a market economy and must be held responsible for themselves.

The legacy of the war was a significantly expanded state, a sense of common cause, and expectations of government intervention to both provide and protect. The war also left a significant proportion of the population with military experience, creating the possibility of a formidable opposition. Governments remembered the major protests that followed World War I, and feared a repeat. Unions and women's groups, religious organizations, and community groups became increasingly active in demanding public health care. Governments were already heavily involved in providing health services for the military and for veterans. Services for those who had sacrificed at home seemed a logical extension.

The end of World War II also signalled the return of economic prosperity, thanks in large measure to government intervention. Governments had spent a great deal on the goods and services needed to fight the war, in the process reviving many businesses that had failed during the Depression. Governments also limited the right to buy during the war in order to save materials and labour for the war effort. When the war ended, they continued to spend on housing, health care, and education for returning veterans. As a result, there was lots of pent-up demand for houses, cars, furniture, and frivolity as well as lots of money to buy them with, thanks to forced wartime saving and rising postwar employment. Although governments still had debts from the war, prosperity meant that rising tax revenues went along with the increases in employment levels.

## Politics and People

It took more than popular demand and good economic times, new economic theories and the positive experience of government intervention to get public care. It also took political will on the part of both individuals and governments. The most famous of these individuals was Tommy Douglas. He may be the grandfather of the popular TV and movie actor Keifer Sutherland, but years after his death Douglas remains justly famous in his own right. In 2005 he was voted the greatest Canadian ever in a major CBC television program poll.

Tommy Douglas had an infection in his leg when he was young, and he would have lost that leg if he had been forced to depend on his family's ability to pay for care. His family had no insurance, and it was only by accident that a doctor decided to offer his services while using the boy to demonstrate a technique that saved his leg. Douglas vowed then to work hard to ensure that no one's health depended on charity and accident. Unlike most of us who make pledges in our youth, he followed through on his when he became premier of Saskatchewan in 1944. Even though Saskatchewan was heavily in debt and one of the poorest provinces, he carried out his promise. In 1947, just two years after the end of World War II, his social-democratic government introduced the first public hospital insurance plan in Canada. This plan became the model for our public health-care system and a key element in his vision of a better, fairer Saskatchewan and Canada.

The hospital insurance plan certainly had its opponents, with many critics expressing fear about government intervention and the loss of private control. At the time, however, hospitals in Canada were almost all owned and operated by non-profit charitable or religious organizations. Many of them were in deep financial trouble because so many patients could not pay for hospital services. To survive they needed government money, though they also wanted to remain independent. When patients did have insurance, it was mainly from

non-profit organizations, such as Blue Cross, formed by hospitals themselves. So these insurance companies were protecting hospitals, not profits. Employees of the hospitals were supportive. They had an interest in stable government funding, rather than uncertain insurance-based support. In any case, most of the employees were low-paid women who were not then represented by unions and thus were not very influential in the decision-making process. Employers outside health care were starting to face unions that were demanding that they provide hospital insurance, so they too were not strongly opposed to some government payment. A public plan means costs are shared across the population, relieving pressure on employers to pay.

What the Saskatchewan government under Douglas offered was a public insurance plan that covered everyone in the province. Payment came from taxes while the hospitals were left mainly to run themselves. Those who could, paid premiums. But the same hospital care was available to all, regardless of ability to pay.

Douglas was successful in part because we have a parliamentary system of government. In Canada the party with the majority forms the government. Given that governments can be forced out of office if they lose a vote, strong party discipline pushes all members of the governing party to support the government in a vote. This in turn makes it harder for opponents of a measure to influence votes by influencing individual members of parliament.

This political system contrasts with the United States. As anyone who watched the U.S. TV show *The West Wing* knows, individual members of Congress can be pressured by companies and organizations opposed to a piece of legislation to vote against it without threatening their party. Private interests thus have more direct power. Even a president with a majority in Congress can therefore find it difficult to pass health-care legislation, as Bill Clinton found in the early 1990s when he was president.

Douglas's plan for Saskatchewan was a success. Even those who had initially opposed the plan came to see the benefits of a program