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MEDICARE 2.0

Fixing holes in our healthcare
system that hurt Canadians

BY

Drs. Danyaal Raza, Amina Jabbar,
Jeffrey Ansloos, Kofi Hope, and Gregory Marchildon

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Introduction

As Canadians, we are rightly proud of our health care system. In 2004, the “Father of Medicare,” Saskatchewan politician and visionary Tommy Douglas, was crowned in a CBC poll as the Greatest Canadian, and more than a decade later, he and the system he helped create continue to define Canada. More than a set of interlocking provincial and territorial health insurance programs, Medicare has become the highest expression of Canadians caring for one another.¹ Our public health care system touches us at all stages of life: from the day we were born, attended by doctors, nurses, and midwives; through our infancy, with the immunizations and check-ups our primary healthcare team gave us then; through our adult years, when we were supported by emergency care and regular appointments at the family doctor; and to the last days of our lives, when medical professionals will provide us with compassion and empathy in palliative care.

Yet flaws are readily apparent in this system that we all rely on, and they were made all the more apparent during the global COVID pandemic. Among these critical gaps are access to prescription drugs, long-term care (LTC), community-based mental health, and dental care—and differential access based on race, gender, geography, or immigration status. Pre-pandemic, the role of public health was invisible to many Canadians. That is,

hopefully, no longer the case. Though public health is outside the traditional conception of Medicare, it can no longer be seen as the poor cousin of the health care system.

So is our pride in our Medicare system misplaced? No—but, it mustn’t stop us from imagining a better one, a truly comprehensive health system that spans acute to chronic care and hospitals to community-based services and public health, and that covers residents in Canada from the cradle to the grave. It must not merely provide access to an insurance program and medical services; it must provide access to programs and services of the highest possible quality. Right now too many Canadians have to choose between essential medication and being able to afford nutritious food, too many go for months or years suffering from tooth decay because they can’t afford to visit a dentist, and millions suffer within the depths of depression because they cannot gain access to therapy or counselling.

Looking Back to Look Forward

In fact, this was always the vision. Medicare today is a shadow of what it was intended to be. Its story begins in Saskatchewan, immediately after World War II. Even then, Douglas had a much more sweeping vision of what Medicare was supposed to be, of what “much further” should look like.

The initial iteration of Medicare, introduced in 1947 by the Co-operative Commonwealth Federation (CCF) government led by Tommy Douglas, included universal public insurance for hospitals that focused on acute care, diagnostic care, and in-patient drug therapies.

In the late 1950s, the federal government introduced cost sharing for health services, and Douglas seized on the opportunity. His government expanded universal coverage to physician-based care, but the relatively low amount of cost sharing prevented his government from doing much more than this.

In the 1970s, Douglas described the next stage of Medicare as not only an expansion

of insured service to areas like pharmacare, home care, long-term care, and mental health, but also a reform of the delivery system itself. Unfortunately, his ideas were not adopted by either the federal government or other governments in Canada. Advocates to this day continue to refer back to this as the unfinished business of Medicare.

But the expansion of universal health coverage will not be not enough to fulfill Douglas’s dream. We also need to change the delivery system so that health care is truly a social service rather than a commodity to be bought and sold. Many possible paths can be taken to move forward to this second stage. Here, we focus on three prominent areas highlighted by the pandemic: community mental health, long-term care, and pharmacare. Each is at its own stage of policy development, with unique opportunities and hurdles. And each fits into this unique moment in time when we can bring transformational change to our health care system.



Community Mental Health

There is a growing need for the development of Canadian public policy that addresses the rising rates of mental health illness and addictions in this country. Current population health estimates suggest that one in five Canadians currently experiences mental health challenges² and that approximately one in three will experience mental health challenges within their lifetime.³ Unaddressed mental health challenges can be linked to poorer health outcomes, higher mortality rates, and profound disparities in social welfare. They can also have costly effects on the economy.⁴ While some public health services are available to Canadians, they are limited and specialized, in addition to still being widely stigmatized.⁵ And these services are often inaccessible. During the last few years, with initiatives like Bell's Let's Talk, we are seeing more and more awareness about the realities of mental health issues and the need to combat the stigma attached to them. But our neighbours, friends, and family members suffering from mental health challenge need not only more understanding, but also access to the array of mental health services that help people get better.

Most existing publicly funded services for mental health care are intensive and crisis oriented (e.g., in-patient psychiatric units), specialized clinical services (e.g., out-

patient psychiatric or psychological care), or preventive services provided by health, social, and educational systems with a focus on screening, early intervention, and harm reduction. Broader, community-based services and other mental health professionals are less often publicly funded, yet they make up the largest service delivery context for mental health. Treatment for mental health is costly, and while private insurance companies have developed relevant benefits for some of the labour force, coverage is far from universal.

The financial investment gap is significant: while 20% of the Canadian population experiences challenges associated with mental health, only 7% of health funding in Canada is designated for mental health.⁶ Over 85% of Canadians indicate that mental health is underfunded, and there is broad support (86%) for federal expansion of mental health coverage to match that of other health services.⁷ There is also evidence to suggest that substantial investment in services in the long term will bring cost savings to the Canadian economy.⁸

In 2019, the Canadian Mental Health Association recommended that in order to ensure that existing services could keep pace with national demands and to support the broader expansion of mental health

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coverage, there should be a 2% increase in public health spending on mental health.⁹ While these services would bolster existing intensive and specialized services, increased coverage for community-based mental health support is needed, and the case for universal coverage is stronger than ever. In the wake of the COVID-19 pandemic, the Government of Ontario has advanced an initiative that would provide online mental health services at no cost.¹⁰ This universal approach, while still being evaluated, should be considered for nationwide expansion, at least in terms of national funding.

The World Health Organization (WHO) defines universal mental health coverage as the guarantee of mental health services, including prevention, promotion, treatment, rehabilitation, and palliative care, without the risk of financial hardship to the person needing care.¹¹ To achieve this end, we suggest that the Canadian government should examine and implement one or a combination

of the following approaches: (1) the expansion of free public mental health services and (2) a public insurance guarantee for community-based services.

The government should move to introduce legislation that clarifies that mental health (including psychological, cognitive, and social health) services are considered within the scope of medically necessary services—and specifically, that insured health services should include mental health services provided by mental health professionals operating within hospital, extended, or community-based settings. While implementation would look different in different parts of Canada, legislation like this would provide a standard for all 13 provinces and territories.

There is clear evidence that social determinants of health, including social and economic factors, play a substantial role in mental health disparities.¹² Independent of legislation intended to broadly expand

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universal access to mental health services, we suggest that immediate guarantees of coverage should be established for population groups facing heightened ecological risks and known health disparities (e.g., Black, Indigenous, and other people of colour; immigrants and refugees; children and youth; disabled people; LGBTQ2S+ people, and older adults). Given the need for increased mental health service provision among population groups like these, the federal government should consider enhancing educational funding and providing guaranteed tuition coverage for students entering the mental health professions. In response to a broader shortage of physicians, a number of provinces have launched publicly funded programs to support tuition reduction and to develop highly qualified professionals. Similar investments in the education of mental health professionals would promote public mental health service contributions.



Treatment for mental health is costly, and while private insurance companies have developed relevant benefits for some of the labour force, coverage is far from universal.



Long-Term Care

Pre-COVID-19, long-term care homes were largely invisible to society. Now the virus has laid the realities within LTC homes so bare that it's impossible to turn away from the need for reform. In Ontario, the military was deployed to help manage devastating outbreaks in five homes, where they discovered, and reported on,¹³ abysmal conditions, including rotting food, pest infestations, and residents who hadn't been bathed in weeks.

The conditions described in the military report wasn't representative of those in all LTC homes before the virus. However, the report did underscore how thinly resourced the sector is, such that major stressors on the system substantially increased the likelihood that the safety and well-being of residents would be endangered.

The Canadian long-term care sector houses many of the frailest and most medically complex adults in the country. However, frontline workers, families of residents,

unions, and academics have long warned¹⁴ about serious shortages in staff, resources, and funding in these institutions. Efforts to prepare for COVID-19 focused largely on hospitals,¹⁵ yet over 82%¹⁶ of COVID-19 deaths in Canada occurred in LTC facilities. Few decision makers considered the potential needs of LTC homes—needs related to infection control, access to personal protective equipment (PPE), and supports for families and frontline workers, among others.

Our societal disregard for LTC homes reflects the low value we have ascribed to the lives of the vulnerable elderly. This attitude is attributable in part to the historical foundations¹⁷ of the sector. The earliest LTC homes in Canada were actually “poorhouses.” In the 1940s, for example, the City of Toronto needed residences to house poor and vulnerable people discharged from hospital. The city made private arrangements with homes, and responsibility for these homes was eventually taken on by the Province of Ontario.

Frontline workers, families of residents, unions, and academics have long warned about serious shortages in staff, resources, and funding in long-term care institutions.

Long-Term Care

However, privatization of LTC homes across Canada has proliferated over time. Throughout most of the country today, 40% to 60% of all long-term care homes¹⁸ are operated as for-profit enterprises. This trend has unfortunately reduced the quality of care. This isn't surprising, given that, fundamentally, for-profit organizations are beholden to their shareholders. In other words, for-profit LTC homes will always direct money¹⁹ away from internal operations that would improve residents' quality of life if management views those expenditures as reducing their shareholders' return on investment to an unacceptable degree. This dynamic has played out in the operation of actual for-profit LTC homes. For example, residents in for-profit LTC homes receive fewer hours of direct care²⁰ than do residents in not-for-profit homes—a result of fewer hires and under-resourcing. Between 2017 and 2018, the Seniors Advocate²¹ in British Columbia found that for-profit homes failed to deliver 207,000 hours of care based on the public funding they received. Not-for-profit homes, in contrast, over-delivered a total of 80,000 hours beyond what they were funded for and spent 24% more per year on resident care.

Work within for-profit LTC homes also tends to be more precarious. Frontline workers, such as personal support workers (PSWs), generally

earn less²² than PSWs working in not-for-profit homes. For-profit LTC homes²³ are more likely to hire employees on a casual or part-time basis and are therefore less likely to provide benefits. As a result, PSWs are often forced to work multiple jobs, which further increases their employment precarity as well as their risk of being exposed to COVID-19 or other contagious diseases, and carrying those diseases from one home to another. Race- and gender-based disparities are ever present within the LTC sector. Racialized and immigrant women²⁴ represent a disproportionately large number of the sector's workforce. For example, up to 80%²⁵ of LTC workers within the Greater Montreal Area are racialized women. In addition, family members—for those residents who have family who are able to care for them—have been increasingly forced to assume caregiving responsibilities to fill in gaps in care. Women represent the majority of those family members who are unpaid caregivers within long-term care homes.²⁶

Overall, residents living in for-profit LTC homes also tend to have poorer health outcomes. For example, residents in for-profit homes are more likely to develop pressure ulcers.²⁷ They are also more likely to be transferred to hospital for conditions such as anemia, pneumonia, and dehydration.²⁸

Long-Term Care

The specific shortcomings of for-profit LTC homes, some of them listed above, are well documented. These homes should therefore become not-for-profit institutions by being brought into the fold of Medicare. This transition will present challenges. However, it should not be dismissed as impractical. On the contrary, as we know from other parts of the health sector, continuing down the path of privatization²⁹ makes care more expensive.

Government rules and regulations don't eliminate the impetus among for-profit LTC homes to put their highest priority on being accountable to their shareholders. If we decide to depend on more and stronger regulations to improve standards within both for-profit and not-for-profit LTC homes, governments will be forced to develop complex, deterrence-based mechanisms³⁰ (e.g. an intensive monitoring and reporting regime) to ensure that those standards are being met. Those enforcements will increase government administrative costs. At the

same time, in response to increased regulations, for-profit long-term care homes will need to find other ways in which to increase their margins, thereby further increasing the costs of care. We have evidence of a similar "death spiral"³¹ in other parts of the health care system, including private health insurance.

The tragedies of COVID-19 can give way to opportunities for transformational change. If we are to finally acknowledge that the long-term care home sector is an essential part of universal health coverage, then the only option is to bring LTC homes into the fold of Medicare and to fund them in the way that we fund hospitals and physicians.

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Pharmacare

As has become apparent, Medicare is long overdue for structural change. As a consequence, Canada has earned the dubious distinction of being the only high-income country in the world with a universal health care system that does not include a universal drug plan.

More than one in five Canadian households³² still have trouble filling prescriptions because of cost. Nearly a million³³ people in Canada are cutting back on food or turning down thermostats just to pay for the prescription drugs they need. And these access challenges do not affect everyone equally. In Ontario, 25- to 34-year-old workers who have part-time jobs or who are recent immigrants, racialized, or millennials are all less likely to have medication coverage. Four in ten workers who³⁴ have recently immigrated do not have any medication coverage at all.

Many businesses, especially small ones, are finding it increasingly challenging to pay for the drug plans many of their employees need. As the cost of private drug plans rise, employers are responding by shifting cost sharing onto employees through increased deductibles or co-pays and the use of annual or lifetime maximums. A universal public drug plan would eliminate these trade-offs, for businesses large and small. Recent estimates place cost savings at \$750 per employee.³⁵ The cost burden of necessary medications is not borne solely by families, households, and businesses. The price of medications in Canada is a macro-crisis. On a per-capita basis, Canada pays more for drugs than Australia, New Zealand, and almost every European country. Only the United States and Switzerland pay more. For many individual drugs, Canadians pay three to four times more than other countries—sometimes ten times more or higher.

A patchwork approach to coverage not only exposes individuals, households, and businesses to significant financial risk; it also undermines our collective purchasing power when negotiating with drug manufacturers for competitive international prices.

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New Zealand offers a stark comparison, and a look at the price of two particular drugs³⁶ in each country is instructive. For one hundred 80-mg tablets of atorvastatin, a common medication for high cholesterol, New Zealand pays CAD\$6.58. In Canada, the cost is more than 3.5 times as high, at CAD\$23.42. For a common medication used to treat schizophrenia called olanzapine, one hundred 10-mg tablets can be purchased for CAD\$5.35. In Canada, the cost is 13 times higher, at CAD\$70.80.

The reason for these differences is no secret. Medicare in Canada effectively ends as soon as a patient receives a physician's prescription. Depending on the jurisdiction in which they live, Canadian residents have access to either a public plan, a private drug plan, or nothing at all. With over 100 public prescription drug plans and over 100,000 private plans,³⁷ Canada's hybrid system of coverage is complex. This patchwork approach to coverage not only exposes individuals, households, and businesses to significant financial risk; it also undermines our collective purchasing power when negotiating with drug manufacturers for competitive international prices.

Major commissions since the 1960s have all recommended an expansion of Medicare to include universal, public drug coverage. The

latest, the federal Advisory Council on the Implementation of National Pharmacare,³⁸ led by Ontario's former Minister of Health Eric Hoskins recommended yet again, in 2019, the same approach: a universal, nationwide, public drug plan.

Canada spends well over \$30 billion a year on prescription drugs. Depending on the design and size of a chosen formulary, a fully realized universal public plan could reduce national spending on drugs by \$4 billion to \$7 billion³⁹ annually while extending access to all. Net savings would be realized through the reduction of out-of-pocket and private insurance costs while increasing public investment to between \$1 billion and \$3.5 billion per year.

This investment would support three mechanisms predicated on international best practices: evidence-based drug formularies, systemic tendering, and bulk buying. From an international health systems perspective, none are policy innovations. From a domestic perspective, bringing these elements together as a way of advancing toward universal coverage represents a leap forward. The Canadian Agency for Drugs and Technologies in Health (CADTH) and the pan-Canadian Pharmaceutical Alliance (pCPA) are already doing much of this work for existing public

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drug plans, and the 2019 federal budget included⁴⁰ funding to establish the Canadian Drug Agency (CDA) to “take a coordinated approach to assessing effectiveness and negotiating prescription drug prices on behalf of Canadians.” Although it’s still unclear how much progress has been made toward this goal, it’s evident that the institutional infrastructure now exists to make the leap to universal public prescription drug coverage.

Clearly, increased public investment in prescription drugs is needed to achieve net savings and universal coverage. To put this in perspective, at present, overall health care spending amounts to \$245 billion per year,⁴¹ while overall drug spending amounts to \$34.3 billion per year.⁴² Both figures are expected to increase with time, with or without a universal public drug plan. However, the rate and sustainability of the change will depend on decisions made today. This is the context in which \$1 billion to \$3.5 billion per year of public investment is required to

achieve overall savings in the amount spent on prescription drugs in Canada. The challenge at present does not appear to be one of developing sound health and fiscal policy but of increasing the political will needed to make the necessary changes.



A fully realized universal public plan could reduce national spending on drugs by \$4 billion to \$7 billion annually while extending access to all.

Concluding Summary of Recommendations

Canada’s public health care system is due for a transformative upgrade. We have focused on three areas where both expansion and reimagined delivery are warranted.

ESTABLISH COMPREHENSIVE MENTAL HEALTH SERVICES

The shutdowns, isolation, grief, loss of work, and other stressors exacerbated by COVID-19 have taken a toll on our mental health, yet for many, professional counselling and support are not easily accessed because of high cost and low availability.

We recommend that the government introduce legislation to include mental health services among the medically necessary services that are insured and to stipulate that these services may be provided by mental health professionals operating within hospital, extended, or community-based settings.

Immediate guarantees of mental health coverage should be made for population groups facing heightened risk and disparities (e.g., Black, Indigenous, and other people of colour; immigrants and refugees; children and youth; disabled people; LGBTQ2S+ people, and older adults). Given the need for increased mental health service provision, the federal government should also consider enhancing funding for mental health education and guaranteed tuition coverage for those studying to enter the mental health professions.

Concluding Summary of Recommendations

MAKE LONG-TERM CARE PART OF MEDICARE

Over 82% of the deaths due to COVID-19 in Canada occurred in long-term care homes, and this has become one of the most heartbreaking stories of the pandemic in this country. Sadder still is the fact that many of these deaths may have been prevented with a better-funded long-term care system that relied more on public and not-for-profit delivery, as opposed to for-profit delivery focused shareholders' returns, sometimes at the expense of proper care for residents of homes.

The tragedies of COVID-19, however, can lead to opportunities for transformational change. When we finally acknowledge that the LTC sector is an essential part of universal health coverage, then the only option will be to bring LTC homes into the fold of Medicare and to fund them in the way that we fund hospitals and physicians..

PHARMACARE

The case for universal public pharmacare has been made multiple times in Canada, but we are still the only high-income country in the world without such a program. The evidence is clear that a universal public pharmacare program built on evidence-based drug formularies, systemic tendering, and bulk buying will cost less than the patchwork system of partial insurance that exists now—and such a program will significantly improve health outcomes.

Canada's health care system is experiencing its greatest challenge since the creation of Medicare. COVID-19 is testing the system's ability to manage a widespread pandemic and all of the resulting direct and indirect health impacts. Though Canadians can be proud of many aspects of our health care system's response, serious deficiencies that were already evident to some before the pandemic have now been laid bare for all to see. We are reminded that Tommy Douglas, the father of Medicare, never envisioned universal health coverage stopping when Canadians left the doctor's office or hospital. Now we have the opportunity to more fully realize his original vision by providing Canadians with expanded coverage in key areas and in so doing, improve health and well-being of our country.

About the Authors

DR. DANYAAL RAZA

Chair, Canadian Doctors for Medicare

Dr. Danyaal Raza is a physician, academic and advocate. He is a family physician with the Department of Family & Community Medicine at St. Michael's Hospital, Assistant Professor at the University of Toronto and serves as Chair of Canadian Doctors for Medicare, an organization dedicated to evidence-based, values-driven health care reform. His leadership and advocacy work focus on health policy, including access to prescription medication and the interface of public/private healthcare.

Dr. Raza holds a Masters of Public Health from Harvard University, completed as a Frank Knox Fellow. He is also a former Fellow in Global Health at the University of Toronto's Department of Family & Community Medicine. He completed his post-graduate medical training at Queen's University, and holds a Medical Doctorate and Bachelor of Engineering Science from Western University.

DR. AMINA JABBAR

Chair of the Progress Toronto Board of Directors

Dr. Amina Jabbar is a geriatrician in the Greater Toronto Area. With a focus on populations that have been traditionally marginalized, Dr. Jabbar has facilitated anti-homophobia workshops in schools and community organizations with Teens Educating and Confronting Homophobia, delivered sexual health services at Planned Parenthood Toronto, and created tools to research neighbourhood-level health issues at the Centre for Research on Inner City Health.

Dr. Jabbar earned a Bachelor of Social Work from Ryerson University (2007), a Masters of Science in health research methodology from McMaster University (2009) and a Doctor of Medicine from University of Toronto (2013). She is pursuing a PhD in Health Policy at McMaster University.

About the Authors

DR. JEFFREY ANSLOOS

Canada Research Chair and Assistant Professor Indigenous Health and Social Policy at the Ontario Institute for Studies in Education at the University of Toronto Broadbent Institute Fellow

Dr. Jeffrey Ansloos is Canada Research Chair and Assistant Professor in Indigenous Health and Social Policy at the Ontario Institute for Studies in Education at the University of Toronto. He also chairs the Indigenous Education Network, an educational forum which convenes ongoing public scholarship, organizes progressive social action and promotes positive change for Indigenous communities across Canada. Dr. Ansloos' research focuses on social, economic, political, cultural, and environmental dimensions of health, as well examines community-based and systems-level change processes needed to advance social and health equity within Canada, with a particular focus on Indigenous rights. Dr. Ansloos also researches the role of emergent technologies at the intersection of community mobilization and social change. He is a fellow of the United Nations–Alliance of Civilizations, which promotes intercultural dialogue and cooperation in the areas of education, youth, migration, media and women's rights.

Dr. Ansloos serves on a number of non-profit and community boards, and is a policy advisor with various branches of federal, provincial, and territorial governments, as well as First Nations governments. Dr. Ansloos is Nehiyaw (Cree) and is a member of Fisher River Cree Nation (Ochekwi-Sipi; Treaty 5).

KOFI HOPE

Senior Policy Advisor, Wellesley Institute

Kofi Hope is a Rhodes Scholar and has a Doctorate in Politics from Oxford University. He is the co-founder and CEO of Monumental, a new start-up focused on supporting organizations work towards an equitable recovery from COVID-19. He is an emeritus Bousfield Scholar and current adjunct professor at UofT's School of Geography and Planning. He also serves as a Senior Fellow at the Wellesley Institute and is a board member at the Atkinson Foundation. In 2017 he was winner of the Jane Jacobs Prize and in 2018 a Rising Star in Toronto Life's Power List. Kofi was the founder and former Executive Director of the CEE Centre for Young Black Professionals. In 2005 he established the Black Youth Coalition Against Violence, which became a leading voice for advocating for real solutions to gun violence in Toronto and led to him being named one of the Top 10 People to Watch in Toronto in 2006 by the Toronto Star.

About the Authors

GREGORY MARCHILDON

Ontario Research Chair in Health Policy and System Design at the University of Toronto's Institution of Health Policy, Management and Evaluation

Prior to this, he was a founding member of the Johnson Shoyama Graduate School of Public Policy at the Universities of Regina and Saskatchewan. In addition to being a faculty member and research chair, Greg regularly provides advice to governments and international organizations on health reform. He also sits on the editorial board of the European Observatory on Health Systems and Policies. Greg received his PhD from the London School of Economics, after which he taught for five years at Johns Hopkins University's School of Advanced International Studies in Washington, DC.

In the 1990s, he served as deputy minister of intergovernmental affairs and subsequently as deputy minister to the premier and cabinet secretary in the Government of Saskatchewan. From 2001-2002, he was executive director of a federal Royal Commission on the Future of Health Care in Canada, known as the Romanow Commission. Greg is the author of numerous journal articles and books on Canadian history, comparative public policy, public administration and federalism, including a survey of the Canadian health system for the World Health Organization and the European Observatory on Health Systems and Policies that has gone through two editions.

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