Health System Transformation Lecture
The Healthiest Nation
Second Panelist—Dr. Gregory Marchildon

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Richard just asked me if he took all my time, and I told him he did. We're quite a bit behind schedule. I'll try to be as short as possible, and hopefully I'll try to bring you better news than Richard brought you. But I do agree with him in one respect. It's all about implementation. And what I'm going to talk about is precisely that, in terms of the Canadian case. I'm going to go through the milestones that we've experienced in Canada to summarize health systems transformation, but in terms of implementation. I'm going to focus on public health, and I'm going to focus on the much—the more upstream health services rather than downstream healthcare.

Now, from 1974 on, we've all known what to do. In the Lalonde Report, it was set out very clearly. Figuring how to do it has been the challenge for all countries. And, see? In terms of Lalonde, as you all know, it's split into four quadrants, in terms of the kinds of interventions needed to, in a sense, improve the health status of a country. Healthcare, of course, is one of them, but only one of them. And as you know, there's a debate ongoing—Richard's mentioned it—whether that's responsible for 10 percent or 25 percent or somewhere in between that. We also know that lifestyle behaviors are extremely important, the environment in which you live, and of course, your biology. All of these combine, in terms of producing a certain health status.

In practice, however, figuring out what to do is very difficult, and the Lalonde Report actually had a pretty interesting history in Canada in that the first initial reaction politically to the Lalonde Report was that this was produced by the federal government as an excuse to get out of healthcare spending. And in fact, they were going to reduce transfers to the provinces by showing or demonstrating that healthcare had very little to do with health outcomes. So, that was the initial political debate in the country over the Lalonde Report. After time, however, everyone settled down a bit and realized, of course, that we needed to work on all four quadrants and that we had systematically underestimated the importance of environment and lifestyle in terms of health outcomes.

I'm going to now talk about two areas where the reforms have attempted to be implemented. One is in terms of regional health authorities and the establishment by provinces because healthcare is very decentralized in Canada, the ministries of health in Canada decided to move from what were basically passive public payment systems to actually managing the system in such a way to ensure that wellness was introduced on a much more systematic basis. This didn't happen until the early 1990s. So that meant greater public control in a fundamental way. It meant moving public health from where it had been, largely in cities and small municipalities that often could little afford the kinds of services needed for a proper public health infrastructure, to these much larger, geographically based units called regional health authorities. And public health began to be funded much more substantially, and in fact as a share of total health expenditures, went from

three percent in the early 1990s to six percent in the first part of the twenty-first century, so that you can see, although it sounds small, it's fairly significant when you look at this kind of a shift.

The other aspect is that the regional health authorities received wellness mandates in which they were to focus as much on wellness as on the illness care system. This was part of the philosophy behind this major reform. They were to, in fact, manage the continuum of care from or to wellness from/to illness care, and it can go either way, as everyone knows. So, they were required to, in a sense, figure out what were the on ramps and the off ramps. And they were charged with actively changing resource allocation - moving resources from acute care downstream care to upstream care. In reality, it was proved very, very difficult to do that. People do not like hospital beds being shut down or hospitals being closed, even if there's less need for them. And they like the security of an acute care system even if it isn't always needed. So, it proved very difficult, but there were some achievements over the last 15 years in shifting resources to the wellness area. So, these regional health authorities, in effect, became the vehicle--the public vehicle--for this enormous shift.

The next area is in terms of public health care. There was one big exception, in terms of these regional health authorities, and that was physicians and the way in which physicians were paid which continued to be controlled by the ministries of health because the organized medicine basically wanted it that way and felt it was in a better position to negotiate, in terms of the ministries of health. So, there was opposition to the idea of moving those budgets to the regional health authorities. The end result? Primary healthcare, which is actually the nexus—the practical nexus between disease care and wellness within a system—the nexus was, in fact, outside the regional health system and remains outside the regional health system.

There was an attempt by the federal government to encourage provinces, as well as a Major Royal Commission—Mr. Romano, the Chair of that Royal Commission, is here with us today—in which it was recommended that funding be tied, in terms of shared costs, funding from the federal government to provinces to really push major reforms to move from this singular physician care to clinics and to 24/7 care in which you would have a team of providers, basically across the spectrum, ensuring that there was proper wellness care, as well as proper early diagnosis.

This has proven extremely difficult, even though there have been some successes in some of the larger pilot projects, but there are no simple answers. And every time we begin to take another step down this road, we run into two new problems that were unanticipated, including the very difficult business of getting a range of health providers to work together given a certain legal system—a medical malpractice tort system which encourages doctors to take control mainly because they're still held liable, and numerous other issues that we have to deal with.

And finally, the business of the rural—the health authorities and their ability to provide primary care in rural and remote areas. Canada is the second-biggest country in the world. There are vast areas that have to be served with very small populations. This is extremely expensive and ensuring proper primary care in those areas is a huge challenge.

So, so far, there has been, I would say, little change in this area. I don't feel particularly bad about that given that no other country has made major changes and given the fact that in some areas, we've actually scored some successes relative to other countries. So, it's going to be a long journey and we accept that it's going to be a long journey.

Finally I'd just like to say that the true mother of policy change is crisis. And health system transformation, in particular, because of the strength of the stakeholders and the interests at stake, it's very difficult to do anything major without there being a crisis behind it. And we had such a crisis in 2003 with the SARS outbreak in Canada, largely in Toronto. And as a consequence of that, we built for the first time a Public Health Agency of Canada, and for the first time we began to have some national direction in terms of public health. You've had this in the United States for a very long time. In a highly decentralized federation like Canada, it was debatable whether we would ever have it. And I think this has proven to be very positive. Now, the strength of a decentralized federation is that we have the Provincial Ministries through these regional health authorities taking direct responsibility, managing wellness, managing, hopefully in the future, primary healthcare. What you lack, though, is the central push, in terms of the federal government. And that we can possibly achieve through the Public Health Agency of Canada, but it will be slower because it will have to be with the negotiated agreement of the various provinces in the country. It just will take us a little bit longer.

And I note that Dr. Gerberding mentioned the importance of measuring health and what the impact would be if we would actually do that. And I would say that Mr. Romano, since he left the Commission, has been involved with a select group of people working on a Canadian Index of Well-Being, which is a pioneering effort to do precisely that. And hopefully this idea is going to spread in a number of countries, and once we're able to, in fact, have this kind of a systematic and rigorous index, we're going to be able to place even more emphasis on resourcing wellness properly.

Thank you very much.