

ADDRESS TO NATIONAL ROUNDTABLE ON WAIT TIMES

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Hello all you stalwart people who have been here all day. I've been asked to wrap up the events of the day and place them in context.

First I want to know something: How many of you folks were involved in the health system when Monique Begin passed the *Canada Health Act* back in 1984, over twenty years ago? Let's have a show of hands. How many people were involved in the health system a decade ago, when the cuts started hitting the system? (Show of hands.) And how many people got involved in the health system since 2000 – when the first 5-year deal came through to 'save' Medicare? (Show of hands.)

OK. Clearly more and more of us have gotten involved in health issues over time.

Me too. Twenty years ago, I was involved in what I'd say today are ways of keeping people healthy, but not by fighting to protect their health care.

I am an economist; so for that sin I'll have to face whatever penalties await me when I rise from this mortal coil.

Twenty years ago I got my first really interesting job at the Social Planning Council of Metropolitan Toronto where our mission was to support organizations that provide community-based services, services that keep people healthy, mentally, physically and socially. And for the next decade or so I worked with community-based coalitions, academic groups, and even politicians and departments of governments who were involved in the fight to keep people healthy by keeping them employed, by providing opportunities to train and upgrade their skills, by assuring decent housing for all, by making sure utilities like heat and electricity and phones remained affordable, by maintaining access to mental health services, physical recreation outlets, libraries and community centres ... Let me make a long story short. We lost every single fight.

In 2002, I had the incredible privilege and honour of receiving the first Award for Economic Justice from the Atkinson Charitable Foundation. They told me I could

do whatever I wanted with this award for the next 3 years. I was known at the time for my work on the growing gap between rich and poor in this country. But said I wanted to focus on health policy. They thought I was out of my mind.

The reason I wanted to focus on health policy rather than anything else was because, as an economist, I saw health policy as the one battle we *couldn't* afford to lose in the fight to hang on to basic human rights and collective rights. We needed a win, and while no-one a decade back anticipated that the principles of public health care would ever come under attack, this campaign still seemed more winnable than other battles. People understand the common sense and moral imperative behind the idea of universal access to health care. It seems obvious enough that such an approach is the only way to give all Canadians an equal chance to stay healthy and keep well for as long as possible. This one social program provides a concrete, visceral, experienced understanding that when we all stand by one another, we're all further ahead. We can protect each other from risk in a way that we cannot protect ourselves.

This morning Shirley Douglas talked to us about what was at stake at this stage of the battle for universally accessible health care. Shirley has the uncanny ability to name what is central in a fight. We have to keep focused on what we are fighting for. The fight is for nothing less than the recognition of the essentially equal nature of our humanity, and that we all have the right to health, not just health care. And that we need every single one of us, and all our wits, to fight this battle.

I am reminded of a story that the minister at our church told recently about a walk that the Devil took with a friend of his. They're going along the road and they see a fellow a little further up the road, picking something up off the ground, looking at it carefully and pocketing it. The friend asks the Devil "What did he find?" and the Devil says "A piece of the truth". The friend turns to the Devil and says: "That might be trouble for us. Are you going to let him hang on it?" "There's no problem with him having a piece of the truth," says the Devil. "I'll encourage him to make a belief around it. Before long, he'll bask in the vanity that comes with the realization of a discovery, and soon enough he will end up worshipping his own belief. Then he will become blind to all other truth." And the Devil laughed at his, shall we say, diabolical plan.

It strikes me that the struggle around Medicare is very much about NOT falling for *a piece of the truth*. The temptation is mighty great –on both sides of the battleline – to think we've got the pieces figured out, while losing sight of the big picture.

In my experience, against the backdrop of decades of battles for social and economic justice, it is a simple truth that nothing is more complex than the fight for Medicare.

As all of you in this room know, as we've heard all day long, there's not one single issue in this struggle that has a predetermined outcome, or contains an uncomplicated truth. And yet though the truth is complex; though there is no magic bullet to solve the dilemmas of wait times, though there no single answer to the problem of doctors who are "double-dipping" in the public and private systems, or straightforward ways to bench-mark outcomes, or incontestably superior ways to do this or do that, or even one single way to view the public-private mix, there ARE certain things that are very simple and abiding. And the simple and abiding truth is what people have been saying all along - for decades now - is the big picture of what they want the health care system to be in Canada.

Thousands of people told Romanow what they wanted the health care system to be, in spoken witness and in written testimony. And what they said is that care has to be universally accessible. What they want is that health care remains an expression of our essential equality in our society, and a manifestation of the principle that equal treatment is the right of all citizens.

We want everyone to have access to appropriate care, at the appropriate time. And we look at that not just in terms of treatment when we are ill, but the interventions that help keep us healthy. That means we want comprehensiveness of care too.

I've just listed three principles from the *Canada Health Act*. Accessibility, universality, and comprehensiveness. These three things are at the heart of what we are fighting for, and have been for decades. As Tim Sale pointed out at lunch, we fight for these things is never over, because attaining better health care, and better health, is a puzzle with thousands of interlocking pieces, and each piece has to contend with the timeless struggle for power, privilege and profit.

I have invoked the principle of comprehensiveness in the Canada Health Act, and that needs to be explored a little. The so-called "Canadian approach" to healthcare exists in a particular context, and displays a really unusual combination of strengths and weaknesses.

We're not strong, internationally speaking, on public spending for health care. Only seventy percent of all the dollars spent on health care in this country comes from the public purse. But that money covers virtually all the costs of doctors' and hospitals' services. We long ago decided to fund the system this way so that that people are not obliged to pay a penny up front for medically necessary care, so that care is provided on the basis of need, not ability to pay. That's a message that must be drummed into you by now. The way we guarantee that *individuals* get the care they need without relying on their individual ability to pay is by harnessing *society's* collective ability to pay, and we have chosen to do that, by and large, through taxes, not user fees or other "price tags" for care.

Access to doctors and hospitals are guaranteed, at no direct cost; but there are many aspects of care that *do* have a price tag at point of use, and for which we as a society provide no citizen guarantees at all. We don't guarantee access to medicines. We don't guarantee access to long-term care or home care. We don't guarantee rehabilitation and physiotherapy, or vision care, or dental care. So that's what's behind the other 30% of health costs – individuals paying to get access to these things, through insurance and through out-of-pocket payments.

It is precisely those elements of health care, the ones not guaranteed through public insurance, that have seen the most rapid escalation of costs. The costs of these more “privatized” aspects of health care are growing far more rapidly than categories of care that are funded virtually exclusively by the public purse.

Canadians are also seeing increasingly variability in what is covered by public insurance. What's inside or outside the publicly funded basket has become a real hodge-podge, a real patchwork. Where you live in Canada affects the services and forms of care you can access. And I don't just mean from province to province. Access varies by where you live *within* a given province as well.

We heard today how central the issue of integration of service is to getting a really well-functioning publicly-funded system that provides appropriate care at the appropriate time for all citizens. But the types of fragmentation I just mentioned are increasing, and they stand in the way of wide-spread progress.

In a sense, this isn't a new struggle. We've been dealing with blocks to progress in integrating services for decades now. In the 1970s, the Lalonde “doctrine” laid out the hows and whys for integrating our approach to care. The Lalonde report tried to shift the focus of our interests and interventions “upstream”. The Lalonde report stressed the role of more prevention. The Lalonde report named the importance of the determinants of health.

For the last three decades many medical and non-medical practitioners alike have tried to imbed these theoretical objectives in practice. Despite this awareness, the system has become more reliant on acute care as the way to get things done.

The centerpiece of what we fund publicly remains acute care. It is access to acute care which is universally available in this country, in theory and in practice, and in most instances with little delay. Our problems begin when we broaden our definition of health care or shift our approach to delivering health care. So long as we remain wedded to the doctor-driven, emergency-room back-up model, there is no friction.

Despite the value and the sheer common sense of the so-called “new” primary care reforms, the more critical life/death type care offered in hospitals continues to draw the most attention and money. Let us not forget both hospitals and doctors organizations have sophisticated and highly effective lobbies. Not so for the providers of services that can rehabilitate and improve one’s health, but not only through medical care, organizations like community health centres and CLSCs.

There are obstacles to improvements; but I want to stress the SUCCESS of what we do, and to highlight the factor that makes us unique in the world: that is, the importance we attach to the universality of access to doctors and hospitals. That principle is precisely why we are a beacon in healthcare around the world.

That said, we are very much laggards in other critical aspects of care – pharmaceuticals, long-term care, home care, mental health, rehabilitation...and of course the things that are determinants of our health, like the adequacy and affordability of housing; opportunities for education, jobs, and training; accessibility of high quality child care; water quality and other environmental safety concerns, etc. etc.

People from outside Canada look at us with no small degree of admiration for what we accomplish. But at home the chattering classes would have us believe that we are failures, and that other models of healthcare provision are better. It should be said that these critics never deal with the system as a whole, and mostly allege failures in acute care by referring to waiting times for elective surgeries.

Those who claim other countries “do it better” usually steer clear of the US and point to Europe. France and Sweden come up with great frequency as a superior approach. They are alleged to have “no waits” and, by golly, they countenance private insurance and/or user fees. Well, the fact is France, Sweden and most other European countries of the world publicly fund between 75 and 85 per cent of all health spending. It is true that they go beyond taxes to permit some instances of private insurance or user fees, and permit another tier of options for some aspects of care.....but they have a host of administrative and regulatory hoops to ensure that everyone gets access to basic levels of health service.

In Canada, with only 70 per cent of all health spending publicly funded, we still manage to provide that core nugget of acute care for *everybody*, and provide that care with over-head costs that are among the lowest in the world. That’s because single-payer systems can provide huge administrative efficiencies.

And all of us have stories about people who have waited for care. But we all know that people who are truly sick, truly in urgent need of care do not wait in our system – and they access care that is second to none, using the most

technologically advanced (and expensive!) techniques available in the world. One of the claims associated with the wait times debate is that we can no longer sustain the maintenance of both high quality and accessibility in public health care. Why?

We live next door to the United States, a nation that defines the cutting edge of technological possibility in health care. We live next door to a country that is awash in a culture of immortality; where it is commonplace to believe that you will out-live and out-perform all previous generations; where aging is widely viewed as an affront and indignity to our self-definition instead of a natural unfolding and development of who we are; where physical pain is viewed as something to be conquered and overcome quickly and is certainly not seen as an acceptable and normal part of the process of aging; where, with money, you don't need to age if aging means losing your looks, your hair, your ability to have sex.

“Forever young” is more than the title of a song. Now you can buy the dream, for a price. That's in part what the Chaoulli case, discussed earlier today, is about.

There is constant pressure to bring technological ‘advancements’ - be they technologies, procedures or drugs - into the fold of publicly insured care. We have big conversations ahead of us about what should be in or out of the publicly funded basket. They will not be easy decisions, as disputes over services for autistic children or access to cutting edge drugs for cancer patients have proven.

Yet, despite this turbulence in possibilities at the frontiers of care, we have remained steadfast in the stand for a basic right to care. We remain firm that urgent medical care should be available to all, not just those who can pay. We see timely primary care (like check ups, or access to vaccinations) as part of that right of citizenship too; though it is also true that we become less collectively assertive the further away from the medical model we get, for example in other aspects of primary care such as access to nutritional supports, or mental health services.

For the moment, the public debate over how to improve access to health care has been squeezed into one conversation, wait time guarantees. Its contraction has become “care” guarantees. It's a lovely turn of phrase except that it has such a thin, indeed anorexic, definition. It really only means speeding up the longest waits for a very short list of procedures.

The focus on wait times is relatively new, and has eclipsed a story that was much bigger a few years back and promises to re-emerge as a real issue in public health. Public health has taken on a renewed vitality and significance because of the threat of global pandemics. It re-emerged as a serious aspect of public service that governments had to provide, couldn't offload, partly because of how SARS shook up our world; partly because of the anthrax scare right after 9-11; partly because of

the devastation of the HIV/AIDS pandemic; partly because of the impact of mad-cow disease; partly because of the emergence of the West Nile virus; and partly because of the fear of a new pandemic erupting on a global scale, whether that is avian bird flu or some as-yet unidentified virus.

For whatever set of reasons, the “new normal” in our world is in some ways very similar to the world as it was 100 years ago. Much of the context in today’s definition of maintaining public health is framed by the looming reality of communicable, and avoidable, diseases – things that *can* be controlled, but can also very quickly, explosively, get *out of control*.

So we’re back to the future. Back to the conversations of the 1970s. Then as now, the conversation about intervening “upstream” includes, but is not limited to, vaccination and immunization, healthy lifestyle choices and, more rarely, addressing inequalities. Back to conversations of a hundred years ago. Then as now, public health initiatives that seek to contain communicable and preventable disease include, but are not limited to, addressing tainted water supplies and waste disposal, crowded shelters, hungry children and other “at-risk” populations.

All these conversations stress the importance of health promotion, and the age-old wisdom that “an ounce of prevention is worth a pound of cure”. The promotion of health reminds us of the weight and import of the elements that create healthy lives. It acknowledges, for example, that safe housing is a greater determinant of your health than health care is, whether that’s safe houses for women and children who are facing violence, or affordable housing that is warm and dry and provides a little breathing space for every person. This view is still not commonplace in how our policy makers view the way to better health, but with enough activism and repetition, many of us hope it is simply a question of time.

Still, we need to remember the public purse is not infinite. For more money to flow to housing or anything else, including health care, we better make sure we are getting the best value possible out of our public spending.

As an economist, I was taught that all the activities that we engage in, paid and unpaid, rely on a particular “recipe” to create a good or service. Each activity has its own combination of “ingredients”. Instead of recipes, economists call these relations between ingredients a “production function”. All output is a “function” of the amount and quality of three key inputs: labour, capital and a certain technique, or technology.

We have a shortage of all three inputs in health care today. In fact, most of these shortages are manufactured crises – but they are still crises.

We face a shortage not just of doctors, but of nurses, radiologists, technicians, physiotherapists, nutritionists, all manner of health workers. Those shortages are only going to become more accentuated in the next 5-10 years as the wave of retirements accelerates. And even though we've seen this slow-moving train coming down the track, demographically, for the last 10-15 years, we still have no clear plan on how to replace the people that are leaving the labour force in the health care sector, let alone meet the emerging demands on the health care system.

Well, I should not say we have *no* plan. Some provinces, such as Manitoba, have been expanding training spots for years. Some other provinces, such as B.C. and Alberta, have extensive and ambitious recruitment plans. But there is no cross-country, co-ordinated strategy designed to respond to a supply shortage that is chronic, significant and threatens to undermine the whole enterprise of publicly insured healthcare in a few years.

At the federal level, and for many provinces, the 'plan' is to import more doctors. Both federal and provincial leaders have offered to increase immigration of physicians and speed up their accreditation when they get here. That is *not* a solution our labour shortages for health care. The shortage is not just about doctors, and the shortage is not just about us. The shortages across a broad range of health care professions are GLOBAL shortages. The resolution requires augmenting the supply of health professionals, not simply redistributing them.

The only way to augment supply is to train more people. No doctor or other health professional graduates without significant investments of public resources. Tuitions cover only a portion of training costs. So every time one jurisdiction decides to "import" their way out of a supply shortage (of doctors, or nurses, or technicians), another jurisdiction is left robbed of returns on its public investment. In other scenarios it would be called freeloading.

When this practice extends between nations, and the nations that gain workers are richer than the nations that undertake the investment to train the workers, this amounts to poaching on the public resources of jurisdictions that have a much tougher time rustling up public resources at all. That means Canada's domestic labour strategy in health care actually undermines its foreign assistance and international development policies, policies that stress the importance of health care as part of human development. Not only is that incoherent policy formation. It is, to put it bluntly, unethical.

The fact is that Canada has more public resources than most countries in the world. Canada is the only advanced industrial nation in the world that has had back-to-back fiscal surpluses for 8 consecutive years, and that forecasts budgetary surpluses for as far as the eye can see. We are rolling in resources, giving away

billions in tax cuts; yet we can't seem to find the money to expand training spots, fund residencies, offset tuitions, and generally make sure enough people are graduating so that we can at least replace the people who are retiring.

We could even view training health professionals as a form of foreign aid, to help address looming health labour shortages around the world. Other countries do it. For heaven's sake, poor Cuba trains "extra" doctors, bringing them in from other poor countries on condition that they return and serve their native land upon completion. If Cuba can export expertise and produce doctors, why can't we? Is the extra cash burning holes in our pockets? We are squandering our wealth, becoming net importers and net consumers rather than using our capacity to become net exporters and net producers - net generators of wealth.

Training more people, and using them to their full scope of practice, just happens to be a key strategy to deal with the current "priority" issue in health care - wait times - in a cost-effective way. Labour accounts for roughly 80% of the costs of providing health care. We are facing a labour shortage. If you do nothing about the supply problem, you will end up paying more just to hang on to the people you have. That doesn't solve the problem of a shortage AND it drives up the costs, raising fears, yet again, that public health care is unsustainable.

The second shortage is the short supply of capital, and that too is a manufactured crisis. It is manufactured for two reasons. The cuts to services about 10 years ago came on top of another type of cut. Starting in the mid 1980s, governments of all political stripes started to defer maintenance and expansion of public infrastructure. That has only recently been changing, as a wave of upgrading, maintaining and building new capacity occurs across the country for the first time in a generation.

The recent infusion of public funds for health care is primarily focused on operating budgets, and though most governments are now in a balanced budget or surplus situation, the extra cash is not going to capital investments. Governments have decided that private sector cash is a better bet for financing the development of free standing clinics, or new hospitals, or renovations. Why? Because finance ministers at both the federal and provincial levels are captured by the notion, promulgated by the International Monetary Fund, that debts should be paid down now, before baby boomers retire en masse.

Even though we have urgent infrastructure needs, even though interest rates are at the lowest rates they've been in 40 years, even though every way of financing infrastructure other than borrowing publicly costs taxpayers more, governments will not entertain the option of keeping the level of debt constant, by rolling over

debt that comes up and re-investing in the future. If public borrowing is ruled out, we are saddled with higher borrowing costs, and consequently higher taxes.

That makes absolutely no sense. There is no shortage of capital available to the public sector. Ideology, not fiscal reality, is the reason we, as taxpayers, are going to spend billions of dollars on unnecessary financing costs over the next few decades, billions that could be buying so many other public goods, like affordable housing, or training more nurses. We need to confront our elected leaders with the questionable wisdom of these artificially inflated costs if we are going to fend off the “sustainability” bogey-men and meet our needs in the coming years.

We face a third shortage, and this is in the area of appropriate and efficient techniques and technologies, the way we get things done in the field of health care. Other speakers have referred to one aspect of this earlier in the day by calling for the better integration of all parts of the system of care. That’s crucial, but the problem is not limited to better interfaces between types of service – it’s also about improving the *management* of the resources we’ve got.

Better management is at the heart of what Michael Rachlis just spoke to as he discussed the many ways of improving systems flows. Better management also could mean taking our purchasing power in health care seriously and making the most of our clout. For example, we could use that clout to better contain the soaring costs of pharmacare, and even plough those savings right back in to expand access.

This year Canadians will spend about \$18 billion on prescription drugs. About half of that spending flows through the public purse. There is no question that we could be doing much more to manage and control those expenditures. For example, it is simply inexplicable how governments pay for prescription drugs that are covered by publicly insured drug programs.

Anyone who’s bought lots of one particular item has probably asked themselves “Why pay retail?” It’s common to find price breaks if you buy in high volume. I guess no-one who pays the bills for drug programs has ever shopped at Price Chopper or Costco or Walmart. Despite the fact that governments foot a \$8 billion a year bill for prescription drugs through public programs; despite the fact that much of this expenditure is for the same drugs every year; our governments still pay retail prices on every single pill that is bought in this country.

This is passing strange. Public policy, generally speaking, has drifted towards increasingly market-oriented practices over the past two decades. Unbelievably, the logic of one of the most common dynamics of the marketplace – saving costs

by bulk-buying – hasn't entered the procurement process of one of the biggest examples of bulk-buying in the country.

It does not need to be this way. There is a very telling story from a few years back about how Canadians harnessed the power of bulk-buying through their government to protect everyone *and* save money. After the 9-11 disaster there was an anthrax scare in this country and in the U.S., and concerns were raised about how prepared we were to counter bio-terror emergencies. The Canadian government decided on the antibiotic Ciproflaxin as the first line of response in the event of an outbreak of anthrax, a lethal virus that is airborne on microscopic spores. To be prepared for such an emergency it needed to distribute quantities throughout the country to ensure that an affected population could be treated quickly nomatter where such an event might occur in the country. It needed to bulk purchase the drug. So the federal government went to the patent holder of Cipro and tried to cut a deal. The manufacturer responded that production at such scale was not possible to supply in the required time frames; so the government invoked an escape clause in federal patent legislation that permits governments to override patents in the case of emergency, and asked a generic company to produce the drug in volume. You may remember that this led to a particularly tough public relations fight where both producers and the government tried to pass on the bad karma to other parties, like a hot potato. But I'll cut to the chase. In the end we saved \$3.50 on every pill that we bought! We saved millions and millions of dollars on one drug! If we can do that with Cipro then we can certainly do it with the most commonly prescribed drugs that are used all over this country, year after year, in huge quantities. That's just what any good manager of a multi-billion dollar system would be doing, given that chronic care needs are emerging as a huge driver in system costs.

So we can see that shortages in the key input of technology - techniques used to make health care "happen" - is not just about what equipment we use, or what drugs we prescribe, or how we integrate care, or how we address system flow. These are all important. But how we manage the system is an equally important "technology". It's simply good management to continually reassess how resources are allocated throughout the system and see if there's a way of recalibrating parts of the process to produce better results. That's were more investments in preventive care kick in.

Michael provided us with a great example of this when he referred to a disease management model for diabetes used in Edmonton at Capital Health. So many of the emerging success stories in this country pin their strategy on early detection and early intervention. A pro-prevention focus can save so much, in both dollars and cents and in human costs. Problems caught early have a much greater likelihood of responding quickly to simple measures earlier in the cycle (often

measures that aren't even "health care" *per se*). Good prevention practices mean there are fewer problems that require medical treatment down the line. That's another, effective way to deal with wait times, *and* with the desire to promote healthier outcomes.

As Tommy Douglas stressed decades ago, it's about keeping people healthy, not fixing them when they get broken. That approach doesn't cost as much and you don't need as many doctors and specialists to achieve good outcomes. And if we do more of that kind of "healthy" work we can have much better integration of elements that include the entire spectrum of care - right from the beginning and our understanding of what it means to be healthy - right to the end and the way we live our final years and months.

We've heard about the potential and pit-falls of many different ways to address wait times. The three real problem-solvers are a) using the whole spectrum of care, seamlessly and appropriately; b) implementing primary health care reforms that use all our existing resources to their maximum potential and facilitate better practice of early intervention; and c) addressing the shortages we are confronting (particularly: labour, capital, and gutsy management techniques of the system) so we don't manufacture *failure* over the next 5-10 years with our eyes wide shut.

It is a daunting little list, but it is not an impossible set of tasks, and progress is being made on all fronts. But instead of focusing on these real problem-solvers, many elected leaders across this country have reduced the problems and solutions in health care to a single metric - *time*; and particularly wait time guarantees.

That approach is about as thoughtful and sophisticated as *Pizza Pizza* policy if you ask me. "It's 30 minutes or it's free", now that's a pretty amateur way of managing a \$100 billion public chequing account. And it does nothing to strengthen the system for the real tasks we're assigning to it.

Let's keep our eye on the big picture. We want everyone who needs medically necessary care to get it, and we want to make sure people stay as healthy for as long as possible. That's a totally different proposition than getting care as fast as possible, whether you need it today or not. Our vision is not a pipe dream. We've methodically moved closer towards that goal.

Let's think for a moment about the magnificent arc of history in this country. For a century we have been moving towards the big picture - despite our politicians, sometimes with their assistance, despite our doctors, sometimes with their assistance. What's kept us on track is people's vision of *what we want*.

Almost one hundred years ago, beginning in 1912, we saw the first round of major health reforms start to sweep the big cities. Public officers of health were talking about ways to reduce common sources of disease, and they started introducing sewers and water treatment plants. The rate of infant mortality and maternal mortality plummeted. By 1922 Toronto boasted the lowest mortality rate in North America. The public health movement rippled across the country in other municipalities, big and small.

Around that time, in 1915, a group of destitute prairie farmers pooled together enough cash to offer a small annual stipend to hang on to their local doctor, who was considering leaving the town of Holdfast, Saskatchewan to find a place with a bigger population, so he could be sure of paying his bills. If he left they knew they'd be witnessing more of their wives die in childbirth, more senseless infant and children's deaths. They launched the first collective experiment in healthcare in Canada, acting in concert to give each individual a better chance, to reduce the incidence of the intolerable and the avoidable.

By 1916 Saskatchewan's legislation permitted the pooling of property taxes across municipalities to form union hospital districts, and a flurry of municipal experiments took place across the prairies.

By 1929, Saskatchewan introduced the first program to offer universal access to free tuberculosis treatment, funded by provincial income taxes.

Within five years, in the depths of the Depression, all the legislative changes that had been brought in to enhance the municipalities' powers to increase revenues for the purposes of health care needs, and pool risk across wider geographic zones, were for naught. Too many local areas could not ensure their residents that they would be able to raise enough money to provide for their needs, and the province stepped in to support the funding of health care costs in all parts of Saskatchewan.

The other provinces watched; some tried similar things. By the 1940s every province was negotiating with the federal government to get some additional funding. It had become clear that without federal support there would be no equal access to care for citizens in different parts of the country, given the starkly different capacities to meet these needs in different parts of the country. By 1966 legislation was in place to provide federal support for universal health care across the country, a vision that was only implemented by all provinces by 1972.

So within 50 years we moved from small groups of people, to municipalities, to groups of municipalities, to provinces, to a national project. That's not a small accomplishment; that is a huge success. No other nation has done it quite this way.

Not only did we broaden the sweep of who was included over time, we kept expanding access to services. In 1971 Alberta became the very first province to introduce a drug insurance scheme to cover seniors and elderly. Other provinces followed suit with their own versions of pharmacare.

We forget that it looked like it was over when the Depression gripped the prairies in the 1930s. It was *not* over. We forget that it look like it was over when federal-provincial talks stumbled in the 1950s and doctors struck in the early 1960s. It was *not* over. We forget that it looked like it was over in the early 1980s, as we fought to prohibit user fees as a condition of access to care. It was *not* over. Almost every decade has seen a fight over the principle of universal access. Each fight was followed by expansion in the range and sophistication of health care services. The 1990s has been no exception, though I admit this fight is grave and long.

Many think that the period of progress is over, but it is *not*. In 2004, the federal budget introduced the first national immunization program for children. 2004 was the year that launched the Public Health Agency of Canada – the first time public health issues of communicable diseases was discussed, importantly, as a pan-Canadian concern that needed a coordinated pan-Canadian response. The Public Health Agency is also playing a critical role in the arena of chronic care and disease management, both at home and abroad. This includes strategies to prevent the avoidable proliferation of chronic disease. For example, our made-in-Canada approach to reducing the use of tobacco is being copied world-wide and has the potential of averting millions of deaths every year.

These are huge advancements. We may think we are losing the battle – and indeed, we *are* under attack, make no mistake. But, at the same time, we are also making progress in the right direction.

To throw in some shameless self-promotion here, the Canadian Centre for Policy Alternatives will soon be releasing a book that I've been requested to write for CIDA - the Canadian International Development Agency. They wanted something to answer the question commonly posed by developing nations with whom they work in partnership: "How do you do what you do in health care in Canada?" That question is asked with admiration and envy.

Many who live in poorer nations see a very tight relationship between health reforms and human development, for good and for ill. We should too. We have lessons from both sides of the ledger over the years: successes and failures in health reforms, encouraging signs and things to avoid.

It is to our peril that we have, of late, been ignoring the lessons of the last 100 years. We should remember that the struggles of the last few years are not representative of all we have accomplished.

It takes years for the seeds of change that are planted today to come to fruition. A potent example of that truism is the Chaoulli case, discussed earlier here today.

The Chaoulli decision turned on facts as they existed in the mid 1990s. The conditions that triggered the case were direct results of the only period in our history when public funds for healthcare were actually cut. The logical consequences of those cuts erupted with this case more than a decade later.

Since the events of the Chaoulli case took place, we've had at least 5 years of re-investment from the federal level for equipment, primary health care reforms, and health information technology, and almost a decade of provincial initiatives. Some bad things have happened, but many good things are also unfolding. We are making progress. And that progress will be more obvious in another 5-10 years. And we can make lots more progress if we keep our eyes on the prize and keep pushing our politicians to do the same.

The fight's not over. As Tim Sale made very clear to us earlier today, the fight is *never* over. So don't give up and don't give in.

We are the keepers of the flame. We do that by showing the examples of where things *are* working, where things *can* work better, why things *must* work better.

Our job is not to speak *the* truth, but to speak *a* truth. Consistently. Over and over and over again.

We join our voices to the river of people who have been arguing for the better part of a century the hows and whys of making it work, for every last one of us.

Today we've revisited a simple truth. Better health care is not just about faster access to care, but better access to appropriate care, and better management of our collective resources. We want a system that treats illness compassionately and efficiently. That means also preventing avoidable illness, creating more wellness.

It is not enough to focus on models that promote quicker service for patients. We want a model that promotes healthier citizens.

That goal is entirely within our grasp. Thanks to every one of you who believe it is possible, and who are willing to join the struggle to make it so.