# HEALTH CARE FOR MORE THAN JUST ONE GENERATION

I am not an employee of the government.

Nor have I been commissioned by the government to study the health care system.

But I am a taxpayer paying for the health care system. And I am a user of the health care system. And I am a health care professional.

This essay is my attempt to make Canada's health care system the envy of the world – something to be proud of not just for one generation, but for many generations to come!

## THE PROBLEMS

> *"Nobody dares to solve the problems – because the solution might contradict your philosophy, and for most people, clinging to beliefs is more important than succeeding in the world." State of Fear, Michael Crichton, 2004*

We hear regularly that the main problem with Canada's health care system is waiting lists. Other problems such as reduced eligibility for services and low morale among health care workers (which then causes lower quality and contributes to the "brain drain") are also mentioned to a lesser extent. But waiting times are the most disturbing to Canadians, and for good reason.

We know that, while waiting for needed intervention, many conditions deteriorate. Physically, a condition can deteriorate to the point of excessive pain or inability to complete activities of daily living. It can put a person at risk for other physical problems (e.g., while waiting for a knee replacement, an individual is at high risk for falls, which can then cause other injuries). The emotional tolls are just as high and perhaps higher. If unable to move, individuals can become socially isolated which can lead to depression and other disorders. The simple act of waiting can create enormous worry and stress, especially waiting for diagnostic tests to determine the cause of a problem or waiting for time-sensitive treatment such as radiation therapy. And we haven't even begun to tally the economic cost. Employees working with injuries and poor health have reduced productivity. Employees who are off work with pay are costly to employers. Employees who are off work without pay aren't contributing to the tax base. And as conditions worsen, the costs to assess and treat the problems escalate.

So first we hear that waiting lists are the problem, then we hear a myriad of solutions, most related to improved data collection and higher funding. How many times have we heard that we have to put patients first, provide better information, work smarter not harder and increase accountability? We've heard this for 30 years, but each year we seem to be in a worse situation than the year before. How can this be?

The problem is in the problem. When we identify that waiting lists are the problem and then start generating solutions, we have missed a crucial step in the process. We have neglected to ask <u>why</u>

we have long waiting lists. Waiting lists are a symptom, not a cause. Until we identify causes, our solutions will be wrong at worst and random at best. If I show up at my doctor's office with a fever and she doesn't attempt to find out what's causing the fever, she may turn out to be lucky in prescribing a medication to bring the fever down. But she may equally prescribe a medication that does nothing or one that actually worsens the fever. We expect our doctors to accurately diagnosis a cause before attempting to treat a problem – we don't want them flipping a coin when our health is at stake. Yet that is exactly what we are allowing our politicians to do.

So problem #1 is that we are not seriously evaluating the causes of the problems.

And problem #2 is that we are afraid to seriously evaluate the causes of the problems.

## FEAR OF THE UNKNOWN – OR WORSE, OF ANYTHING AMERICAN

Before I discuss some of the underlying causes of waiting lists and spiraling costs, I want to assure you that it's OK to debate this issue – it's not anti-Canadian to question our health care system.

In so many other areas, Canadians are known for their creative solutions, their out-of-the-box thinking. Countless inventions and medical breakthroughs have come from within our borders. Yet the minute someone dares to explore causes and solutions to our health care system, we immediately put a stop to it with one of two comments:

"Medicare is what makes Canada Canada. We can not alter a system that defines us as a nation."

"So, what – you want the U.S. system? You think that's better, where the rich get good health care and the poor go without?"

Now the gloves come off and the debate heats up – but the debate focuses on the pros of the Canadian system and the cons of the American system. I could write a whole other essay on the realities of the American system, because Canadians tend to have a gross misconception of it, but the point of this essay is to focus on what will work for Canada, so we'll stick with that.

I find it interesting how we accuse Americans of being myopic, not being able to see beyond their own borders. Yet when it comes to the health care debate, we Canadians forget that there is a big world out there and we instead focus all our energies on debating the American system. Ask the average person on the street what they think about American-style health care, and you're guaranteed to get a response. But what if I were to ask about the health care system in Singapore? Or the one in China? What about the system in Sweden? Generally, the only guaranteed response to these questions is a blank stare.

In her presentation at the 2012 Ivey Global Health Conference, Dr. Anne Snowdon reported that Canadians are in the top tier of OECD countries in terms of generating novel ideas and conducting pilot projects for innovative new approaches. Yet we are in the bottom tier when it comes to actually implementing these new ideas and approaches!

So let's make a deal. For the next several minutes, let's think like the creative Canadians that we are. Let's look with interest at what is causing the problems in our health care system. Let's get past our obsession with the United States. And let's turn the corner to see if we can actually implement some innovative solutions!

## THE REAL CAUSES

At the risk of being called a simpleton, I am going to boil all our problems down to 4 causes:

- Demographics
- Technology
- Bureaucratic decision-making
- Lack of real accountability

(Please rest assured that I do realize the many complexities in the system; for thorough discussions on much of what I will be discussing, interested readers are referred to the books Code Blue and Better Medicine, by David Gratzer.)

### Demographics

When Medicare was created in the 1960's, Canada was a country of 20-somethings. Many articles and books have described the effect of the baby boom generation (see, for example, Boom, Bust & Echo by David Foot). At the same time, it is estimated that 75% of health care dollars are spent on people over the age of 50. So in the 1960's we had an almost limitless supply of workforce-aged Canadians paying taxes into the health care system. But there were very few people over the age of 50, so there were no pressures on the system. Lots of tax money, very little to spend it on.

These days, Canada is a country of 50+, with ever-increasing health care needs. But who is there to pay for these services? Our tax base of people in their 20's and 30's is incredibly small relative to the huge numbers of aging baby boomers. Very little tax money, lots to spend it on.

### Technology

Every day there are new advances in the medical professions, and many of these involve technology. Technology is wonderful – what did we do before we had MRIs and lasers? But it comes at a significant cost. MRIs aren't cheap by any stretch of the imagination. Nor are lasers. Nor is the equipment for arthroscopic knee surgery. Technological advances can help significantly reduce the effect of disease and injury – but the up front costs are high.

### Bureaucratic Decision-Making

Spend it or lose it! When I worked in a hospital, I looked forward to February and March each year as this was the end of the fiscal year when managers were wanting to get rid of any money left in their budgets. If they didn't spend everything, it would be interpreted that they didn't need as much, so their budgets would be cut the next year. So if I wanted some new equipment, late

February was the time to ask! This is just one example of bureaucratic decision-making. Other examples abound.

Most of us live on budgets and every month we have to make difficult decisions about how to spend our limited funds. This requires balancing needs versus wants and balancing the needs and wants of one person against those of another person. This is an enormous task for one person or for one family. Imagine trying to do it for millions of people.

This is what we ask of the Ministry of Health. A family of four might very well hire a financial planner to help manage competing demands. So you can imagine how many "financial planners" the Ministry of Health must need! How do you decide which hospital is more deserving of an MRI? How do you decide which is more important after a stroke - speech therapy or physical therapy? How do you decide how many visits a home care nurse should provide for people with cancer?

Thousands of people are hired at all levels of government to make these decisions. We have enormous management teams in hospitals and Community Care Access Centres. We have District Health Councils (now replaced by Local Health Information Networks). We have the provincial and federal Ministries of Health. We have government-funded think tanks. And most of these people are very skilled people who genuinely want to improve our health care system. So why does it get worse each year, despite spending more and more every year?

(Yes, some people may find it surprising, but we are spending more per capita now than we ever have.)

Let me answer this question with an analogy. Most families spend a considerable amount of their disposable income on food – doing groceries and eating out. Food is a basic necessity and the types of food we choose to consume often dictate how healthy we are. So buying food is an important decision.

What if we therefore asked the government to determine which food we should buy? They could hire hundreds of consultants to study food consumption patterns across the province and compare that to the available research documenting the nutritional value of various foods. With all this data, they could then create a list of foods that we are allowed to purchase and restaurants that we are allowed to visit. You're probably all laughing now – why would we want the government making this decision? They're not going to know my individual tastes or how I'd like to split my money between vegetables and cookies!

This is the inherent problem in bureaucratic decision-making and it is why we are in trouble in Canada and why the HMOs in the United States are such a problem. We ask a group of people to make decisions for the population as a whole. It is hard enough to make decisions for a family of four and keep everyone happy. Making decisions for millions of people is all but impossible. And we would consider it wholly unacceptable, even laughable, for the government to dictate to us which foods we can eat. Yet we sit back and give them the go ahead to dictate which health services we can purchase with our tax dollars. An example from 2004 is when the government decided that we could no longer purchase physiotherapy, chiropractic or optometry with our tax

dollars. I don't have many problems with my legs, back or eyes, so maybe I think that's just fine. But if you are in need of these important services, you probably have a very different opinion!

Lack of Real Accountability

I have noticed that "accountability" is the latest buzzword in health care circles. At a meeting I attended recently, I stopped counting how many times it was used because I was starting to need a calculator. One committee was accountable to another committee who was accountable to another committee. Everyone was incredibly accountable. But nothing had changed in the sector they were asked to manage and in fact many things had worsened. They were successful, however, in getting funding from the government to hire another bureaucrat who would be accountable to them.

What does "accountable" mean? To answer this question, let's consider another analogy.

I used to take my car to a local garage for servicing. Their prices were reasonable and their service was excellent. I was a happy customer. Then the quality of their service started to deteriorate. I continued to go there thinking it was just an anomaly. But after the third bad experience, I spoke to their service manager and explained my concerns. He was apologetic, said it wouldn't happen again and gave me a coupon for a free oil change. After two more bad experiences, I switched to another garage.

To me, this is accountability. I am the paying customer. If I am not a happy customer, the company must figure out what it can do to make me happy or risk losing my business to another company. And if they keep losing customers to competitors, they will go out of business. In a competitive environment, customers "vote with their feet." You can't get much more accountable than this.

In our health care system, the government takes our money in the form of taxes and they decide how to spend it. So when I show up to see my family doctor, her accountability isn't really to me. If I don't like the service I'm getting, does it matter to her? It may be that she is simply a nice person so of course she cares if I'm happy or not. But her job certainly isn't on the line if she has a series of dissatisfied patients, because her patients don't pay her directly. They can't take their wallets down the street to someone else if they're not happy.

So if not accountable to patients, is she then accountable to the government? We've already discussed how ineffective a government is in making individual health care choices for us so we know that this "accountability" is not real. In fact, how my family doctor is paid generally depends on the latest greatest idea that again will have nothing to do with her individual performance. An incredibly skilled physician is not allowed to bill any more than any other physician. The government simply decides that all family physicians will get paid X. So even the doctor-government relationship doesn't encourage true accountability.

Health care professionals and their patients simply do not have an accountable relationship with each other. Canadians have no problems despising monopolies (former examples being Air Canada

and Bell Canada) for the lack of accountability that ensues. Yet for some reason we accept the biggest monopoly of them all, Medicare.

What about patient accountability? Knowing that we all pay for each other's health care, are we therefore very careful about how we spend our neighbour's money? No. We still fill doctors' offices when we have runny noses. We still smoke knowing that our future emphysema or cancer will cost our friends and neighbours tens of thousands of tax dollars.

Not having a direct payment relationship distorts how we make decisions. If it doesn't cost me anything and I have a choice between a CT scan and an MRI, you can bet I'm going to demand the MRI even if it's clearly overkill for my particular needs. If the government covered the cost of cars, sales of Mercedes would increase dramatically and you probably would never see another KIA on the street – it's just human nature. Many people were outraged when the government required us to wear seatbelts – it's my life, let me do with it as I please. I suppose it's easy to feel this way when you know that it isn't you on the hook for your acute care bill when you're injured in a car accident.

Dr. Snowdon reported in her 2012 White Paper on a curious discrepancy between Canadians' values for a health care system and the values for health care in other OECD countries. We Canadians seem to be more distanced from active involvement in the process. We seem to value "excellent care" and "collaboration among providers" whereas people in other countries value "healthy, active living", "patient choice and equity", "health literacy" and only then "quality health services." Somehow we Canadians have become divorced from the idea that we as patients are central to the system – that we have an active role to play in our health and that at the end of the day, our actual health outcome is what matters, not whether our doctor is considered an expert and collaborated with other professionals. We are disconnected from our health and I believe this is due to how our health system has evolved over the last several decades.

In a similar vein, I have participated on committees whose members bring forward all the possible pockets of funding they've found that they would be eligible to access. Many questions are asked about how to access these funds, but one critical question is never asked – will whatever we do with these funds really make a meaningful difference or would the money be better spent elsewhere? One talk I attended recently infuriated me. The speaker spoke with great excitement about the $6.5 million government grant they received to determine that teams are an effective way to deliver health services. They gladly spent the money and wrote the report without ever questioning whether this was what taxpayers would really want to spend $6.5 million on. So again, thinking becomes distorted without that direct payment relationship. If everyone on the committee had to personally open their wallets and write a cheque to fund their latest greatest initiative, they would scrutinize their plans considerably more carefully. But when the pot of money is distanced from us, it becomes easy to forget where it came from. And when we all pay such high taxes, we can't help but think we're going to "get our fair share" whether we need it or not.

In our current health care system, we are divorced from the normal buyer-supplier relationship that naturally builds accountability.

Demographics+Technology+Bureaucracy+No Accountability = The Trouble with Canada's Health Care System. The only thing worse than bureaucratic decision-making alone is bureaucratic decision-making when there is limited money to go around and no accountability to the people who matter. This is where we find ourselves today. It's bad enough knowing that you have to rely on someone you've never met who knows nothing about you to decide whether or not you get speech therapy after your stroke. But to think that that person is having to manage funding requests that greatly exceed what's in the bank is enough to make you have that stroke in the first place. And to further think that one bureaucrat's accountability is usually to another bureaucrat and not you the individual taxpayer is simply a recipe for disaster.

## "SOLUTIONS" THAT AREN'T

### More Money

What we have heard in the media is that we need more money – billions more every year. Different groups cite different dollar amounts, but does anyone really know how much more we need? Of course not, it's impossible. If a hospital identifies that they need more radiologists, how many is enough? With all the problems we discussed above, there is no way of knowing what we really need. We can predict some health trends, knowing cancer rates for instance. But with the accountability and bureaucracy problems, we can never calculate with any remote certainty how much of any health service or product we need. So we really don't know how much to ask for.

And even if we did, where would we get it from? Which of you feel like you aren't paying enough tax?

In Code Blue, David Gratzer reports that in the mid-1990's, the Office of the Superintendent of Financial Services attempted to calculate the tax rates needed to continue offering the same level of service as they were then (which wasn't great) taking into account the aging demographic. In 1995, the average family paid a tax rate of 48%. Projecting forward, the needed tax rate to sustain services as they were in 1995 becomes 58.5% by 2010, 74.5% by 2025 and 94.5% by 2040.

Yes, you read that right. To maintain the current system as it is, but with an older less healthy population, we would have to hand over 94% of our earnings to the government by 2040.

More money is not the solution.

### Privatization

Before we go further here, we should ensure that the various meanings of "private" health care are clarified. "Private" could mean that hospitals and clinics are privately owned but are still paid by the government. It could also mean that Canadians would pay for some services directly or with insurance, commonly referred to as "two-tier."

I believe this debate is largely futile. Does private ownership of hospitals change anything if they still have a guaranteed revenue stream from the government? We have many privately owned MRI

clinics in this country – have they improved access to service and reduced waiting times? No. Why? Because the government still pays for the services, so they still dictate how much they're going to pay. True, the entrepreneurs who started the clinics invested some of their own money to get the clinics started, so perhaps that saved the government a few dollars. But if the owners don't make enough money from their government revenue to cover their costs, they're going to close down. It's a catch-22. And it changes nothing.

The same holds true for Ontario's home care system. A number of years ago home care was "divested" such that individuals and privately owned companies would contract with a Community Care Access Centre to provide various services such as nursing, speech therapy, physical therapy, etc. This was to be a great solution. But, as for the privately owned MRI clinics, it has changed nothing. In fact, access to services is more restricted than ever.

What about de-listing some services, such that the same health professional is providing both OHIP-covered services and non-OHIP-covered services? Again, it doesn't solve the problem. I required a medical procedure a number of years ago that was no longer covered by OHIP. So I paid my doctor $300 for it. But I was on the same waiting list as everyone else. I waited 3 months for the procedure and on the day of the procedure, I had to wait 3 hours beyond my appointment time because the doctor was running late. Did paying $300 solve the waiting list crisis? No. In fact it made me more angry that I had to pay and then was still subjected to the same poor service!

Two-tier health would certainly reduce the burden on the publicly funded system, no question. Those with insurance or who could afford to pay would buy their services privately. This could happen in one of two ways. The private system could be entirely separate from the public system – separate hospitals, separate clinics, separate physicians. Or there could be "queue-jumping" in the hospitals, such that if you were paying directly, you would get bumped to the front of the line. This latter option is clearly inappropriate and I doubt many Canadians could stomach the unjustness of it (although this is actually already going on). The separate private system seems better, but it still doesn't seem to quite fit with Canadians' moral desire for equal access to health care regardless of income.

Now, here I have to clear up some mistruths about our Canadian health care system. We have a two-tier system already. Every time a government de-lists a service, that service must then be offered privately. The government will no longer pay for your eye exams or hearing tests – does that mean the professions of optometry and audiology just pack up and leave the province? Of course not, you just now have to pay for these services yourselves. And if you have money and don't want to wait to access a listed service, you can go to the States to buy it. Our current system, far from preventing privatization, is actually ensuring that the rich get better care.

We also have queue jumping in our system. Do you think that if the Prime Minister required a hip replacement that he would wait the standard 18-24 months? Of course not. It is common practice in our health care system to allow "important" people to move to the front of the line and to obtain more services – ask anyone who works in a hospital. I saw it happen regularly.

I have heard this referred to as "creeping privatization." I like this term because it reflects that our governments are pretending that it isn't really happening. Rather than dealing with the issues at hand, we are turning a blind eye and letting our health care system fall apart.

User Fees

User fees are often recommended because they serve two purposes. First, by requiring some level of direct payment, they should encourage patients to think twice about accessing a service, thereby reducing demand, thereby reducing waiting lists. Second, they put some money back into the system.

I don't disagree with either of these – they are both quite accurate. But there are three downsides to user fees. First, they disadvantage the poor because they will be less able to afford the user fees. Second, they require lots of consultants to determine what level of user fees to set for which services. More money spent on bureaucrats, fewer services available to the poor – not an ideal solution. And third, they still don't provide the consumer with any choice.

## AT LAST, AN INNOVATIVE NEW SOLUTION

If you're like me when I read David Gratzer's first book, Code Blue, at this point I was feeling helpless. I understood the cost drivers in the health system and I understood why so many of the proposed solutions didn't work. So what are we to do – it seems hopeless!

But David Gratzer and many others have proposed quite an interesting solution, called Medical Savings Accounts or MSAs. My solution is based strongly on this concept.

Little Ticket vs. Big Ticket Health Care

The first step in understanding this new concept is to recognize that there are different types of health care. There are more "routine" needs and there are "catastrophic" needs. Getting your eyes checked, having an annual physical, going for speech therapy, meeting with a dietitian to help you lower your cholesterol – these are all lower cost, more routine services. Bypass surgery, hip replacement surgery, cancer care – these are all higher cost, more catastrophic services.

The concept of insurance is typically used for more catastrophic needs. When you buy house insurance, it is to cover you against fire, theft or natural disaster. It is not to pay for lawn cutting or house painting. When you buy car insurance, it is to cover you against serious damage or personal injury. It is not to pay for oil changes and gas.

So, for our innovative solution, we need to recognize the need for two systems – one for catastrophic health care needs and one for more routine needs.

The Health Care Debit Card

This is my term for Medical Savings Accounts. We all carry health cards and Canadians are big users of debit cards – hence, Health Care Debit Cards.

Under this system, we would still pay our taxes to the government. But instead of the government hiring analysts to decide what services should be made available to us, they would give us an annual amount to spend on routine health care on our Health Care Debit Cards. If we used up the money on the card, we would have to pay for any additional services ourselves or buy private insurance. And we would decide where we wanted to spend our health care money. When we'd go to see the family doctor of our choice, before we'd leave we'd pay for our visit with our Health Care Debit Card. If we needed speech therapy because of vocal nodules, we'd see the speech therapist of our choice and pay for the service with our Health Care Debit Card. If we needed to consult with a dietitian to reduce our cholesterol to prevent a heart attack, we'd see the dietitian of our choice and pay for the service with our Health Care Debit Card.

The philosophy behind this system is two-fold – first, the choice is left to the individual, rather than a team of bureaucrats, about which services they want to purchase from whom; second, the individual must rationalize their spending, rather than a bureaucrat, to ensure their health care money for routine services lasts the full year.

This system is also self-equilibrating. The government will immediately know if they have over- or under-funded the cards if everyone runs out of money early in the year or if everyone has lots left over at the end of the year.

However, there are 2 common arguments against this type of system:

- People aren't smart enough to make decisions about their health care
- If people have to rationalize their spending, they won't seek out needed care and will therefore be sicker

On the first point, it is definitely true that our bodies and minds are incredibly complex. However, there are many other complex things that we are trusted with making decisions on (e.g., buying a house, choosing a career). With the Internet, we are able to research things so much more easily than in years past. But if we feel particularly vulnerable, we make sure we hire someone we can trust to help us make these decisions. Plus, we spend 24 hours a day, 7 days a week with ourselves – our family doctor spends a matter of minutes, and bureaucrats spend no time with us. Who knows our needs best?? Aristotle once said, "If you really want to know if the shoe fits, ask the person who wears it, not the person who made it." And finally, not all health care is complex – a broken arm is a broken arm and there aren't many complicated treatment decisions to make. So I think bureaucrats aren't giving us enough credit – we are smart enough to make these decisions. Indeed, there are already many health services offered privately and all those individuals using those services are making these decisions – and with their own money rather than tax dollars.

The second concern has been disproven in many studies (see Gratzer's books for full details). The studies have actually found equal or better health outcomes, and for lower cost, when the individual had a set amount of health money they had to decide themselves how to spend. And if you consider that the alternative is waiting lists, people will definitely be healthier simply by not having to wait and worry for months on end.

The concept of Medical Savings Accounts, what I am calling Health Care Debit Cards, is actually already in use in various forms in other countries (e.g., Singapore, China). Even some innovative employers have implemented this concept instead of health benefit plans for their employees. The results are always the same – better health outcomes, happier health consumers, lower cost.

So just how could this work in Ontario? Some features of the Health Care Debit Card that I envision include:

- Ontarians could purchase health services from any regulated health provider – this would allow Ontarians to access many alternative therapies such as naturopathy, and would allow Ontarians to access many services that have been de-listed (like audiology and optometry) or services that were never listed to begin with (like speech-language pathology, massage therapy, dentistry, prescription medications, etc.).
- Health providers could work for the government or for privately-owned facilities – the government could continue to operate clinics, but when their only funding comes from Health Care Debit Cards or direct from consumers and they are in competition with privately-owned facilities, they will have to offer a far superior service to stay in business.
- If you don't spend all the money available on your Health Care Debit Card, it would be rolled over into the next year – this works nicely as we age, recognizing that in our 20's we'll probably spend very little so it would be nice to "save" these funds for when we are older and have greater health needs.
- Employers could contribute to the Health Care Debit Cards of its employees instead of purchasing expensive benefit plans – this way employees can spend the money on any health service of their choosing and not be limited to the particular plan the employer purchases on their behalf.
- One family member could choose to use their Health Care Debit Card to help pay for services needed by another family member.
- Unlike many health benefit plans (which allow, for example, $500/year for physiotherapy, $500/year for speech-language pathology, $500/year for psychology, etc.), you could spend all of your money on one service if that is what you happen to need a lot of in any given year – if you had a knee replacement done one year, you would probably need lots of physiotherapy and no speech therapy, so you could spend all your money on physiotherapy; if another person had a stroke and lost their speech, they could spend all their money on speech-language therapy – the choice is theirs.

We could even implement a fun element to this system by offering incentives for healthy decisions. People could submit their receipts for joining a health club to be entered in a draw for a weekend getaway. People could submit their before and after blood test results showing the effect of lowering cholesterol with healthy eating, exercise or medication – the person with the greatest decrease could win free groceries for a week.

See how invigorating it can be thinking out of the health care box? Starting to get excited about health care in Canada again?

Catastrophic Insurance

The other component to our new, improved health system is insurance to cover the big ticket items. This insurance could be purchased through the government with tax dollars. Or it could simply be mandated by the government but up to individuals to purchase such insurance from the insurance company of their choice. This component would be very similar to our existing system.

## GETTING FROM HERE TO THERE

So we have the makings of a great health care system for Canada, utilizing the concepts of Health Care Debit Cards coupled with Catastrophic Insurance! But how on earth do we make the transition to this new world?

First we need to recognize that change is difficult, even with a bright light at the end of the tunnel. It takes some time to get used to new ideas. So we should implement it gradually.

Step 1

The Ministry of Health needs to start sending Ontarians annual statements of what was billed to the Ministry on their behalf. This will help us get accustomed to the idea that health care is not actually "free." During this time period, health care analysts also need to start determining what dollar amounts would be allocated to Health Care Debit Cards and if some factors would increase the base amount. For example, should larger amounts be allocated to children under the age of 4 and adults over the age of 60? Should individuals with certain diagnoses receive higher amounts?

Step 2

The Ministry of Health should provide 12 months' notice of a Health Care Debit Card trial in a few different communities. This would allow government-run facilities time to get prepared for a competitive environment, and time for privately owned clinics to start up. During this time period, the government should also allow two-tiered health to occur. Privately owned clinics and hospitals could open up where patients could pay directly for services. This provides some immediate cost relief to the public system, allows time for interested health professionals to start businesses, allows government-run facilities time to prepare to become competitive, and allows insurance companies to develop catastrophic insurance products.

Step 3

The Ministry of Health would implement the Health Care Debit Card and Catastrophic Insurance system in selected communities across the province. They would gather data on health outcomes, consumer satisfaction, access to service, waiting lists and, of course, cost.

Step 4

The Ministry of Health would utilize the data to make any modifications to the system and begin rolling it out across the province.

## SO, WHAT NOW?

If you think these ideas have merit, talk to people about them. Talk to your MPP and MP about them. Write letters to the editor. Write to the Ministers of Health. Send emails.

If you don't think these ideas have merit, generate other ideas. Read books and studies. Think about which aspects of this model you do agree with and how you could alter the others to be better. Be creative!

The critical thing is to act and act now. We have a small window of opportunity to save our health care system.

I am not an employee of the government. Nor have I been commissioned by the government to study the health care system. But I am a taxpayer paying for the health care system. And I am a user of the health care system. And I am a health care professional.

I am just one person. But the word can spread. Let's make Canada's health care system the envy of the world – something to be proud of not just for one generation, but for many generations to come!

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