Stifling Innovation in Health Care: The Regional Health Authority System and Restriction on Private Actors

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I. INTRODUCTION

Manitoba has been travelling down the wrong path in several areas of policy, and it is time to re-examine the role the provincial government has in society. In health care we lag behind on most measurements, our public school system is restrictive and improperly funded, our universities are struggling, and innovation is generally stifled by overarching government interference. A society that values choice and originality without the need to seek government approval is one that is free to experiment and question whether the way things have been done in the past are the best. The province has become a "supplicant society" where the populace is dependent on government-funded and delivered services, while the government is rewarded for its inefficiencies through consistent federal transfer payments.

The province should not feel comfortably resigned to its "have-not" status—it should aim to be a society marked by vitality and pluralism. This goal can only be achieved if we explore options outside of complete government control.

II. THE REGIONAL HEALTH AUTHORITY SYSTEM

In Manitoba, the actual delivery of health care, as opposed to just its funding, has increasingly been placed under the command and control of government. Regional Health Authorities ("RHAs") have been a major instrument of these changes towards greater government control. RHAs were established under the Filmon government in 1997,[1] as in other provinces, with the idea of achieving greater coordination and efficiency in the delivery of health care and separating

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[1] Manitoba Health, *Report of the Manitoba Regional Health Authorities External Review Committee* (Winnipeg: RHA Review Committee, 2008) at 1, online: Manitoba Health <http://www.gov.mb.ca/health/rha/docs/report0208.pdf> [RHA External Review Report].

the administration of health care from partisan politics.[2] The theory was that a central authority could look at the broad picture of what different institutions were doing, define objectives, make system-wide plans, and look for means of achieving cooperation and efficiency.[3] However, this model has not improved the health care system or made it more efficient—perhaps we have been moving in the completely wrong direction.

There is a model of coordination that would be consistent with the "reinventing government" philosophy. Under this approach, the government would restrain or cut down on their involvement in the actual provision of services. Instead, it would define objectives and provide funding, but leave a wide variety of private sector operators to compete for contracts to deliver the services. This system can provide incentives for actors to deliver a service more efficiently, to find ways to maximize citizen satisfaction and minimize costs, which should be the goals for many government services.

The providers can be not-for-profit as well as commercial. In Manitoba, hospitals have historically been founded and operated by faith-based organizations, but this has been completely reversed and replaced by RHA ownership and control. The ingenuity, drive, knowledge, and values of a vast range of different individuals and organizations can be harnessed in the public interest. Government and the public can watch and learn from the froth of innovation and experimentation that takes place.

In 2002, the "Kirby Report" by the Standing Senate Committee on Social Affairs, Science and Technology recommended a "reinventing government" approach to health care. RHAs could continue to operate with the mandate provided by Canada's medical system. However, they should do so by funding various facilities—mostly nonprofit and allowing for commercial ones as well—to each year provide a given number of procedures.[4] Those facilities could compete for contracts leading to a more efficient system. There would then be government oversight of the quality of performance. In this model, the 'insurer' is separated from the 'provider' of care.

The strength of the "reinventing government" model includes restraining the growth of government and promoting the flourishing of a diverse society. Administrators, physicians, nurses, and other health care professionals could align themselves with organizations whose methods, objectives, and cultures best

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[2] *Ibid* at 13.

[3] *Ibid* at 18.

[4] Michael Kirby & Wilbert Keon, "Why Competition is Essential in the Delivery of Publicly Funded Health Care Services" *Policy Matters* 5:8 (September 2004) 1 at 15–17; Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role*, vol 6 (Ottawa: Standing Committee on Social Affairs, Science, and Technology, 2002) at 26–45, 70–74 (Chair: Michael JL Kirby) [Kirby Commission vol 6].

suit their own needs and the best interests of patients. Patients would gravitate towards the providers who can deliver the best outcomes and client satisfaction.

Instead, the RHAs in Manitoba have adopted some of the worst habits of old fashioned bureaucratic government. They have used their mandates to take over the direct management and control of facilities and hospitals.[5] In exercising their coordinating and funding role, they are not detached leaders; they allocate resources between the remaining private sector operators and facilities that the RHAs operate themselves, to the detriment of the private operators.[6]

Several other jurisdictions have studied their centralized health care systems very recently and decided to go in the opposite direction—we would be wise to follow. In Alberta, a committee tasked with looking at the way legislation governs the health care system in that province concluded that the focus is aimed at the wrong target. Instead of focusing on what institutions and providers want, the health care system should aim to provide what the citizens want and need and it should also research the best available evidence.[7]

In the United Kingdom, a White Paper was released in July 2010 showcasing the opposite direction Manitoba has been and is headed.[8] The crux of the new plan for the National Health Service is to inject accountability into a publicly-funded health care system by increasing citizen involvement, providing autonomy for general practitioners and providers, and by making the bureaucracy smaller and more efficient.[9]

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5 Mia Rabson, "Centralization at hospitals moves ahead", *Winnipeg Free Press* (2 February 2006) A3; "A new prescription", Editorial, *Winnipeg Free Press* (3 February 2006) A10; "Grace Hospital timeline", *Winnipeg Free Press* (28 March 2008) B1. The Salvation Army handed over the keys to Grace Hospital on 1 April 2008.

6 The Catholic Health Association of Manitoba and the Interfaith Health Care Association of Manitoba both noted in their submissions to the RHA External Review that the increase in funding to the independent facilities has been grossly different to the increase in the WRHA budget and funding to the WRHA-managed facilities. See Submission of the Catholic Health Association of Manitoba to the External Review Committee at 5 [CHAM External Review Submission].

7 Alberta Health and Wellness, Putting People First, Part One: Recommendations for an Alberta Health Act by Fred Horne (Government of Alberta, 2010) at 2–4, online: Alberta Health and Wellness <http://www.health.alberta.ca/documents/Alberta-Health-Act-Report-2010.pdf> [Horne Report].

8 United Kingdom Department of Health, *Equity and excellence: Liberating the NHS* (London, UK: Her Majesty's Government, 2010).

9 *Ibid* at "Executive Summary".

III. RHAs: Separation from the Government, or Another Arm of It?

While the Health Authorities were supposed to achieve some detachment from high-level politics,[10] to some extent the opposite has happened. Board members and senior administrators owe their jobs—often very prestigious and/or highly paid—to the government of the day.[11] Board members are often appointed because of their favour with government, not their independent knowledge of health care administration.[12]

Recent events have shown how this plays out for the jobs of senior administrators. After 11 years on the job, the inaugural WRHA Chief Executive Officer Dr. Brian Postl announced his plan to resign from the position in September 2009.[13] The government-appointed WRHA Board conducted what they called "a national search" for a candidate, ultimately choosing Arlene Wilgosh, the deputy minister of health in Manitoba.[14] This is not to say that Wilgosh is unqualified for the job, but it is fair to question whether she will be willing to stand up to the government officials who facilitated her new position and raise in pay from the $124 000 she made in 2008–2009 as Deputy Minister to the $418 000 that Dr. Postl made as CEO in that year.[15]

In a number of comments that Dr. Postl made when he announced his resignation, he essentially stated that the WRHA is not an independent organization from the government, but one intimately connected with politics. Dr. Postl stated to the *Winnipeg Free Press*, "You didn't want to leave too close to an election."[16] A change in leadership at a truly independent administrator of health care would have no relevance in a provincial election, but it is clear that the health authorities are political. At the WHRA, administrators have taken public, partisan and disrespectful shots at opposition parties.[17]

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10 RHA External Review Report, *supra* note 1 at 13.

11 *Ibid* at 32–36.

12 *Ibid.*

13 Nick Martin, "WRHA president announces plan to resign in 2010", *Winnipeg Free Press* (9 September 2009) B3 ["WRHA president resigns"].

14 Larry Kusch, "New WRHA Boss from nursing front lines to city's top health post", *Winnipeg Free Press* (24 February 2010) B2.

15 *Ibid.*

16 "WRHA president resigns", *supra* note 13.

17 In Jen Skerritt, "'Brown envelope' gifts blasted: Critics want audit into over $20M in extras from suppliers to WRHA", *Winnipeg Free Press* (3 February 2009) A3. Dr. Postl's statement nearly mirrors the statement of a spokesperson from the Minister of Health contained in Joe Paraskevas, "Parties want heads to roll in HSC death: Grit, Tory leaders call for top health authority officials, minister to quit", *Winnipeg Free Press* (8 February 2009) A3.

The WRHA is also intimately connected with other organizations that have become increasingly influenced by the provincial government, such as the universities. While Dr. Postl's term as CEO ended on March 2010, it was announced on 5 April 2010 that he would be the new Dean of the Faculty of Medicine at the University of Manitoba.[18]

The RHAs have exhibited signs of becoming authoritarian and secretive, especially when it comes to controlling criticism. Dr. Larry Reynolds was a University of Manitoba professor through his position as head of the Department of Family Medicine, as well as an employee of the WRHA. In 2008 his post was not renewed in part, according to the admission of the WRHA, because he took his concerns about family medicine and the closing of a hospital service directly to the government, rather than going through the proper channels.[19] In 2008, Dr. Brock Wright, now Senior Vice-President of Clinical Services and Chief Medical Officer, commented that he viewed Dr. Reynolds' complaints to government and the public as "not really appropriate for someone in an administrative role – they're expected to bring their concerns right to us," and that he believed Dr. Reynolds was not a "team player."[20] The WRHA later said that there were concerns about Dr. Reynolds' leadership style, a statement in itself that breached their own policy of not publicly discussing personnel matters.[21] The problem not addressed at the time was that Dr. Reynolds also held a tenured position at the University of Manitoba.

The Canadian Association of University Teachers ("CAUT"), a national lobby group that represents about 65 000 academic staff through their respective faculty associations, released the results of a full investigation into Dr. Reynolds' situation in May 2010. They made several damaging findings against the University of Manitoba and the WRHA, including that Dr. Reynolds was "…subjected to coercion, initially to persuade him to agree not to stand for reappointment, then to withdraw his application, and finally to agree not to re-apply… ."[22] The CAUT then concluded that Dr. Reynolds was removed from his tenured professor position "…without due process and without any acceptance on his part of the termination of his tenure…" and in breach of his contract.[23]

18 "U of M names Postl dean of medicine", *Winnipeg Free Press* (6 April 2010) B2.

19 Jen Skerritt, "Physician lost job due to poor performance: WRHA", *Winnipeg Free Press* (29 November 2008) B1.

20 *Ibid.*

21 *Ibid.*

22 *Report of the Ad Hoc Investigatory Committee into the Situation of Dr. Larry Reynolds at the University of Manitoba and the Winnipeg Regional Health Authority* (Winnipeg: Canadian Association of University Teachers, 2010) at 18, online: Canadian Association of University Teachers <http://www.caut.ca> [CAUT Report].

23 *Ibid* at 19.

The CAUT has begun the process of censuring the University of Manitoba and WRHA, meaning that they will officially discourage professionals and academics from working for these organizations.[24] This is a serious, extreme, and embarrassing measure that has not taken place since 1979.[25]

Do we want a society where the professionals in a crucial and publicly funded sector are stifled? And where does a Dr. Reynolds go in Manitoba if he is on the outs with government bureaucrats? It is not as if there are a variety of independent institutions that can adopt someone with critical and different ideas and a willingness to speak about them in a forthright manner. We also cannot afford to lose good, dedicated people because they do not tow the party line.

The RHAs have also become self-promoting. Money that could be spent on providing services and saving lives goes to funding media relations experts to help the WRHA better communicate when scandals erupt,[26] and self-serving advertising by producing magazines.[27]

The government recently carried out an "external review" of RHAs. Astonishingly, the three person committee included a former WRHA board member and an advisor close to former Premier Gary Doer.[28] The committee was advised by six high-level insiders from government, the RHAs, and Manitoba Health,[29] and relied on survey results from mostly RHA employees and board members;[30] hardly an "external" process. Public input suggesting that the

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24 Canadian Association of University Teachers, News Release, "CAUT's national Council begins censure of the University of Manitoba and Winnipeg Regional Health Authority" (27 April 2010), online: Canadian Association of University Teachers <http://www.caut.ca>.

25 *Ibid.*

26 Jen Skerritt, "Health Authority to upgrade info policy", *Winnipeg Free Press* (28 February 2009) A8.

27 "Curtain lifting on new wellness magazine", *Winnipeg Free Press* (4 May 2009), online: Winnipeg Free Press <http://www.winnipegfreepress.com>; see also Winnipeg Regional Health Authority, News Release, "A "Wave" of Health and Wellness is Sweeping Winnipeg" (4 May 2009), online: Winnipeg Regional Health Authority <http://www.wrha.mb.ca/healthinfo/news/2009/090504.php>.

28 RHA External Review Report, *supra* note 1 at 87; see also CHAM External Review Submission, *supra* note 6 at 5.

29 RHA External Review Report, *ibid* at 127. Includes Randy Lock, Executive Director, Regional Health Authorities of Manitoba; Larry Hogue, Chair, Council of Chairs of Regional Health Auhotities and Chair of Brandon Regional Health Authority; Brian Postl, Chief Executive Officer of Winnipeg Regional Health Authority and representative for Manitoba Regional Health Authority Chief Executive Officers; Donna Forbes, Assistant Deputy Minister of Regional Affairs, Manitoba Health; Heather Reichert, Chief Financial Officer, Manitoba Health; and Joanna Plater, Manitoba Health (acting as coordinator).

30 *Ibid* at 6. Survey results comprised of 557 internal surveys and only 175 external survey responses, where the "internal" recipients were made up of 352 Regional Health Authority managers, 82 board members, 120 Regional Health Authority advisory council members and 3 health managers.

WRHA retreat from its takeover of command and control of hospitals and providers was ignored.[31] Although the report found that the RHA system has made some improvements to the health care system, it pointed out many areas where the government, through Manitoba Health, interferes and limits independence. One example is with closing sparsely-used rural hospital beds that would make the system more cost-effective, but is akin to political suicide. As a result, RHAs have been unable to act.[32]

Taking this report as a whole, it suggests that the RHAs have not created a separation between government and the delivery of health care, but instead are the vehicles that government uses. The *Winnipeg Free Press* called them "frustrated puppets",[33] and they are a convenient political cover. RHAs can be blamed when there are problems, like the death of Brian Sinclair in the Health Sciences Centre waiting room; but government can take credit for successes, such as the temporary lowering of wait times before the 2007 election.

It is easy for RHAs and the government to congratulate themselves on some successes, but much of this has been fuelled by "free" money from outside. The federal government provided massive increases to provincial health care funding in the past decade; some of these increases have been to general funding, some to address waiting lists.[34] The proof that federal transfers were the cause of success shows in the waiting times for MRIs, which were down to a five week provincial average in 2007 when federal support was at its highest, then the wait rose to 19 weeks in August 2009 after federal funding was cut.[35]

The problems with Manitoba's health care are not caused by insufficient government spending. Manitoba remains a place where health care spending per

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31 Interfaith Health Care Association of Manitoba, "Submission to RHA Review Committee; Sept 14, 2007" and CHAM External Review Submission, *supra* note 6.

32 "Department of Health fat", Editorial, *Winnipeg Free Press* (3 March 2008) A10.

33 *Ibid.*

34 CHAM External Review Submission, *supra* note 6 at 5. External Review mentions that increased Federal funding was not considered in their cost comparisons because of the higher than average concentration of Aboriginals in the province at 21. See federal statistics: Department of Finance Canada, "Federal Support to Provinces and Territories", online: Department of Finance Canada <http://www.fin.gc.ca/fedprov/mtp-eng.asp>, as well as HealthStats - MB Spending file collaborated from CIHI.

35 Tom Brodbeck, "Always an excuse; NDP spin on wait times is nothing but pathetic", Editorial, *The Winnipeg Sun* (18 August 2009) 5; see also federal statistics in the rows "Direct Targeted Support – Wait Times Reduction" and "Major Transfers" contained in "Federal Support to Provinces and Territories", online: Department of Finance Canada <http://www.fin.gc.ca/fedprov/mtp-eng.asp#Manitoba>.

Note: the most recent wait times available at time of print showed that the provincial average for MRI scans was 16 weeks as of April 2011. See "Manitoba Wait Time Information", online: Manitoba Department of Health <http://www.gov.mb.ca/health/waittime/diagnostic/mri>.

capita is among the very highest of any province,[36] and by some measures, outcomes are among the very worst.[37] The problem is therefore the system, and the increased centralization takes us in the opposite direction.

When scandals erupt, such as the death of Brian Sinclair in the Health Sciences Centre waiting room after waiting for 34 hours,[38] the search for remedies can easily be too narrow and focused on individuals. Reform cannot be confined to scolding or replacing this or that employee at the bureaucracy. More fundamental questions have to be asked, such as how can health care administration and diversity provide far more freedom, innovation, and responsiveness to diverse talents and interests? How can we move away from turning Manitoba into a place where citizens must look to government for employment, contracts, subsidies, or services from central government authorities, with all the accompanying stultification of innovation, experimentation, diversity, and freedom of expression?

In the health care sector, ending the system-wide takeover by RHAs is part of the answer. There is a major role for public authorities in defining objectives, and funding coordination of delivery of health care. However, a restoration of the independence and flourishing of private sector institutions that deliver care—both non-profit and commercial—should be a primary objective of reformers.

IV. ROOM FOR PRIVATE-SECTOR HEALTH CARE: WE ARE NOT ASKING THE RIGHT QUESTIONS

The government needs to consider limited and thoughtful ways to permit and take advantage of private sector institutions that wish to operate, at least to some extent, outside of not only direct government management but outside of public funding. Unfortunately, the tough questions of incorporating alternatives into Manitoba's healthcare system are not being explored honestly, regardless of the possible benefits that could be gained for all of society.

The *Canada Health Act* provides that there must be equal availability to the public, at no cost to the consumer, of insurance for all services that a

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[36] Canadian Institute for Health Information, *National Health Expenditure Trends 1975-2009* (Ottawa: CIHI, 2009) at 148; see also Canadian Institute for Health Information, *Health Indicators 2009* (Ottawa: CIHI, 2009) at 126 [*Health Indicators 2009*].

[37] See *Health Indicators 2009*, *ibid* at 98 ("Wait Time for hip fracture surgery"), 124 ("Number of family and specialist physicians"); see also Canadian Institute for Health Information, *Health Indicators 2008* (Ottawa: CIHI, 2008) at 48, 50 (Wait time for hip fracture surgery); Canadian Institute for Health Information, *Health Indicators 2007* (Ottawa: CIHI, 2007) at 50.

[38] "Sinclair fiasco telling", Editorial, *Winnipeg Free Press* (16 June 2009) A10.

province chooses to insure.[39] In the service of this model, there are sometimes legal restrictions placed on your ability to buy services outside of those insured by the province. In Manitoba, for example, a doctor operating outside of the medicare system cannot charge more for services than the medicare schedule pays doctors within the system—removing the financial incentive.[40]

The strength of the "single tier" model is in promoting equality and dignity. A patient's ability to pay should not, in principle, impair access to most services involving physician or hospital care. Another strength is that equality can in some respect promote quality. The medicare system does not directly guarantee: that the listing of services will be sufficiently broad; that it will include services that are state of the art and deliver the best outcomes; or that care will be available reasonably promptly. However, a theory behind medicare is this: if everyone in society, including the rich and influential as well as the less advantaged, must use the same public health insurance system, there will be sufficient political pressure to ensure that the services it provides are of high quality and accessible. If the elite can obtain their own services privately, they will not want to put their tax money into the system funded for the general public.

Concerns about "two tier" have considerable force. Experience in places like the United Kingdom show that the "publicly insured tier", even in an advanced country, can operate poorly alongside a far superior privately funded system.[41]

On the other hand, research by the Kirby Commission found that in many countries, a privately funded system can operate alongside a good quality public system.[42] Kirby warned in 2002 that if the public system resulted in excessively long waiting times for care, sooner or later citizens would win constitutional cases based on their right to make their own private arrangements.[43] To some extent, this occurred in the 2005 *Chaoulli* decision of the Supreme Court of Canada.[44] A Québec doctor won the right to pay for and accept private

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39 *Canada Health Act*, RSC 1985, c C-6, ss 10, 18–21; Colleen M Flood & Tom Archibald, "The illegality of private health care in Canada" at 826–827, online: Social Science Research Network <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1147667> ["Illegality of Private Health Care"].

40 *Health Services Insurance Act*, CCSM c H35, s 95(1); "Illegality of Private Health Care", *ibid* at 827.

41 Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role*, vol 3 (Ottawa: Standing Committee on Social Affairs, Science and Technology, 2002) at 38–39 (Chair: Michael JL Kirby) [Kirby Commission vol 3].

42 *Ibid* at 65–70.

43 Kirby Commission vol 6, *supra* note 4 at 102–108

44 *Chaoulli v The Queen* [2005] 1 SCR 791.

insurance payments to cover costs for receiving care outside the public system in Québec.[45]

Other indexes have consistently shown that Canada cannot compete against European countries that have incorporated a degree of private insurance and delivery into their health care system. The Euro-Canada Health Consumer Index measures health care system performance from the perspective of the consumer/citizen[46] as opposed to the wait-times and spending levels that governments in Canada frequently point to. The report found that while Canada spends amongst the highest per capita amongst comparison countries,[47] it performs poorly, ranking 25th out of 34.[48]

Countries with a Beveridge healthcare system, where multiple different insurers compete with each other and separate from the providers of healthcare, consistently outperform those that follow the Bismarck model, where financing bodies and providers completely or partially operate within a single system with no competition.[49] Bismarck countries take the top spots on the index along with the small Nordic countries that follow the Beveridge model. The larger Beveridge countries of Italy, Great Britain, and Canada rank near or below the middle.[50] Therefore, the system is the problem, and the only way to improve is to ask whether having the single insurer/single provider system is worth dealing with sub-par performance.

The Romanow Report[51] avoided any hard and original thinking about many issues by appealing to "Canadian values." The value principally relied on was "solidarity"—the notion that we are all equal and care about each other. However, there are other Canadian values including freedom of choice for patients in managing their own health care and looking after their own well-being. This value is asserted even in controversial areas such as the rights of

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45 *Ibid*. See also Patrick J Monahan, "Chaoulli v. Quebec and the Future of Canadian Healthcare: Patient Accountability as the "Sixth Principle" of the Canada Health Act" (C.D. Howe Institute Benefactors Lecture, Toronto, 20 November 2006).

46 Ben Eisen & Arne Björnberg, "Euro-Canada Health Consumer Index 2010" 89 *FCPP Policy Series* (May 2010) at 5, online: Frontier Centre for Public Policy <http://www.fcpp.org/publication.php/3286> [Euro-Canada Index 2010].

47 *Ibid* at 19. Of the 34 countries analyzed only Norway, Switzerland and Luxembourg spend more per capita on healthcare than Canada.

48 *Ibid* at 14.

49 *Ibid* at 18.

50 *Ibid.*

51 Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: Government of Canada <http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf> [Romanow Report or Romanow Commission].

women to obtain abortion services without undue government hassle, such as being required to obtain these services in hospitals rather than clinics.[52]

What about the value of having independent medical professions being free in practice to offer the services that their own values, judgment, and experience lead them to believe are the best for patients? What about the value of free enterprise? Of having governments allow reasonable space for consumer choice and provider ingenuity in addressing it? Reconciliation of different values requires some realism and practicality; these are the facts that we must accept.

First of all, as the Kirby report points out, we do not have a single tier system. Many health services are not covered by medicare,[53] including dental care or prescription medicine, which amount to 30% of all health expenditures being outside the publicly funded system. Furthermore, even physician care and hospital services are not "single tier." There is a huge exception under the *Canada Health Act* for Workers Compensation systems.[54] In practice, those who are willing to pay can access care in other countries, including the United States. The well-connected obtain expedited and often superior service from the publicly funded system.[55]

Second, several-tiered systems operate in many areas of public service Canada, and appear to have no ill effect. An example is private elementary and secondary schools in Manitoba that are only partially publicly funded. Has their existence drained the quality or prevalence of the public school system? Absolutely not.

Third, experience in some other countries provides both warnings that privately funded systems can damage the public system and that sometimes it does not.[56] As a result, we should be studying what works and what does not, rather than closing our eyes to possibilities. There are many examples to study since Canada is the only major industrialized country without a private hospital and doctor system operating parallel to the public system.[57]

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[52] *Doe v Manitoba* 2004 MBQB 285, 2005 MBCA 109, 2006 SCC leave refused, 2008 MBQB 217.

[53] Senate, Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians - The Federal Role*, vol 5 (Ottawa: Standing Committee on Social Affairs, Science and Technology, 2002) (Chair: Michael JL Kirby) [Kirby Commission vol 5]; Kirby Commission vol 6, *supra* note 4.

[54] Kirby Commission vol 6, *supra* note 4 at 302, also *Canada Health Act supra* note 39, s 2. "Insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation"

[55] Kirby Commission vol 6, *supra* note 4 at 302.

[56] Kirby Commission vol 3, *supra* note 41 at 65–70.

[57] Kirby Commission vol 6, *supra* note 4 at 302; Kirby Commission vol 3, *supra* note 41 at 65–66.

Fourth, we cannot arrive at the best policy choices simply through study of other models and abstract analysis. To some extent, we have to learn from practical experimentation and experience. What can we learn from the experience in provinces such as Québec, Alberta, Ontario, or British Columbia, where there are clinics operating outside of the system? What can we learn from providing more room for experimentation right here in Manitoba?

Fifth, command and control by government, no matter how well intended or clever, cannot entirely replace the benefits of freedom, competition, and choice. Look at how we have dealt with the "waiting list problem." Governments identify a few key procedures, such as hip replacements, and try to set acceptable average and maximum wait times. Yet how do we know that there are not better alternatives to some of these procedures? Or better ways of doing them? How do we also know that resources are not being diverted from hundreds of other procedures to address the procedures that have been targeted by government?

At the philosophical level, we should ask more subtle questions than which principle wins: solidarity or freedom of choice. We could explore this question: how can we find ways in which the existence of non-medicare services actually enhances the quality of the public system? A purely private clinic might draw top doctors out of the public system, or it might attract and retain physicians to the province who want to make more money or offer services that the public system has not yet recognized or cannot afford. Can we find models in which we encourage some of these talented professionals to contribute their time and ideas to service at both privately and publicly funded clinics? Can tax revenues, or even special surcharges, generated by non-medicare providers in the province be used to help fund the public system? Can those innovating in the non-medicare side be encouraged to share their techniques and methods with those within it?

In health policy, conflicting values and the need to ration resources in one way or the other means that we never achieve perfect solutions. However, if we can ask ourselves better questions, we can come up with answers that will better promote the health of individuals, our society, and our system of government. Instead of deciding that the direction we are taking will improve if we remain steadfast, we would be wise to follow Alberta's advice[58] and look for the best available evidence.

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[58] Horne Report, *supra* note 7 at 4.