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Insuring a Healthy Force: Centralization Remains Critical

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INSURING A HEALTHY FORCE: CENTRALIZATION REMAINS CRITICAL

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INTRODUCTION

The Canadian Armed Forces (CAF) health system, a federally controlled system, exists within Canada's complex, publicly funded health system that is at once the pride of Canadians and a hot button issue amongst politicians and health leaders. Debate about the health system often centers on its substantial cost with stakeholders continuously seeking efficiencies and improved stewardship of this precious piece of Canadian identity. There are myriad reasons for the CAF health system to remain distinct, including its exclusive federal funding.

While the current federal system may come at a premium price, the consequences of a shift to provincially and territorially insured services would be non-linear, difficult to predict and administratively burdensome. The current reliance on civilian health facilities already presents obstacles to continuity of care and this would be exacerbated by such a shift in funding.

Canada's constitutional history has set the conditions for the creation of a multijurisdictional health system that is continuously evolving and unlikely to perfectly integrate all subsystems in a way that will provide Canadians an equal level of care across the country. This paper asserts that the CAF health system should remain a distinct, centrally funded health system in order to satisfactorily serve the special health needs of its members and that it is improbable this requirement will change in the future.

HOW IT WAS MADE

Understanding the construction and evolution of Canada's health system is vital to effective policy development and implementation. The practice of benchmarking

against foreign health systems or within a complex system, such as Canada's, requires consideration of the historical context that might indicate the presence, or not, of necessary conditions for success of a policy change. Additionally, to create progressive programs, policy makers must appreciate the impetus for establishing principles as well as the health system trends that continue to reshape them.

Canada's health system is a system of systems. There are 13 provincial and territorial systems and the CAF"s health system is often referred to as the 14th system.[1] In fact, there are several, additional, federal systems that service some Indigenous peoples, federal inmates and some refugees.[2] These federal systems were not established to create different tiers of Canadians – albeit that may be the effect; rather, they emerged from Canada's constitution.

The Constitution Act of 1867[3] "is a complex mix of statues, orders, British and Canadian court decisions, and generally accepted practices known as constitutional conventions."[4] The provinces and territories (PTs) joined the Dominion of Canada, or were created, at various points since 1867 and are not all legislated equally.[5] For example, provinces have constitutional powers to govern their jurisdictions, but territories have only delegated powers from the Government of Canada (GoC).[6]

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[1] Chief Review Services, *Review of CF Medical Services,* (October 1999), 15, https://publications.gc.ca/collections/collection_2015/mdn-dnd/D58-75-1999-eng.pdf.: David Salisbury and Allan English, "Prognosis 2020: A Military Medical Strategy for the Canadian Forces," *Canadian Military Journal* (Summer 2003): 46, http://www.journal.forces.gc.ca/vo4/no2/military-militair-eng.asp.
[2] Health Canada, "Canada's Health Care System," last modified 17 September 2019, https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html.
[3] Legislative Services Branch, "A Consolidation of the Constitution Acts, 1867 to 1982," 1 January 2021, https://laws-lois.justice.gc.ca/eng/const/FullText.html.
[4] The Canadian Encyclopedia, "Constitutional History of Canada," 6 February 2006, https://www.thecanadianencyclopedia.ca/en/article/constitutional-history.
[5] *Ibid.*
[6] Government of Canada, "Provinces and Territories," last modified 19 November 2021, https://www.canada.ca/en/intergovernmental-affairs/services/provinces-territories.html.

The constitution vests all responsibility for the CAF in the Federal Government, including its healthcare.[7] The Canada Health Act (CHA or the Act)[8] legislates, and brings coherence to, Canada's health systems and has aspirational principles meant to overcome the inequalities stemming from the evolution of the constitution. Furthermore, the Act reflects Canada's national health policy. Although the CHA excludes CAF members, along with other special populations, as insured persons in relation to provinces and territories, their health and well-being matter equally in the Act as it pertains to the fairness and equity that underpin its five principles. Said differently, the stated primary objective "to protect, promote and restore the physical and mental well-being of residents of Canada…"[9] applies just as much to CAF members as all other Canadians.

The CHA"s five principles are public administration, comprehensiveness, universality, accessibility and portability. Public administration requires that provincial health insurance plans operate under the authority of public officials on a not-for-profit basis. Comprehensiveness speaks to the delivery of medically necessary services - an inexact definition - provided by hospitals, medical practitioners or dentists. Universality entitles all residents, regardless of their location within their province or territory, to all insured services. Accessibility demands provision of all medically necessary services to all insured individuals without financial or other barriers. Finally, portability is the principle that guarantees coverage for Canadians as they move from one province or territory to the next.[10]

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[7] Legislative Services Branch, "A Consolidation of the Constitution Acts, 1867 to 1982…"
[8] Legislative Services Branch, "Canada Health Act," 12 December 2017, https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html.
[9] *Ibid.*
[10] *Ibid.*

A further characteristic of Canada's health system that results from its historical construction is the fact that provinces and territories must negotiate with physicians for their services because they are not in a position to impose policy.[11] The CHA replaced two previous acts: the Hospital and Diagnostic Services Act (1957), a federal, 50:50, cost-sharing policy with PTs for services delivered in a hospital setting, and then was later complimented by the Medical Care Act (1966), which incorporated a similar cost-sharing plan to cover physicians" fees.[12] The Medical Care Act was a national model of Saskatchewan's Medical Care Insurance Scheme, the first province to implement such a plan.[13] Its implementation was hard won, however, with physicians contending that public administration threated their professional autonomy and the rights of patients to choose their own doctor.[14] The hostilities culminated in a 23-day physician strike that settled on several conditions, including that a fee-for-service payment method was the only form of remuneration.[15] The origins of the Medical Care Act led to a national health system that was publicly funded but privately delivered. Subsequent policy evolutions have forced policy makers to proceed from this negotiation posture.

It is significant to note that Federal funding of health care is the mechanism used to enforce the CHA. PTs who contravene any of its five principles will receive reduced

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[11] Brian Hutchison et al., "Primary Health Care in Canada: Systems in Motion," *Milbank Quarterly* 89, no. 2 (June 2011): 257, https://web.s.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=1&sid=24affc7a-4b4c-4fc7-8a5f-15584c50e715%40redis.

[12] Malcolm C. Brown, "Health Care Financing and the "Canada Health Act,"" *Journal of Canadian Studies/Revue d'Études Canadiennes* 21, no. 2 (Summer 1986): 113–114, https://www.proquest.com/docview/1300019973/citation/4D3AADCD164E4515PQ/1.

[13] Anne Crichton, "Health Insurance and Medical Practice Organization in Canada: Findings from a Literature Review," *Medical Care Review* 51, no. 2 (1 July 1994): 151, https://journals.sagepub.com/doi/10.1177/107755879405100203.

[14] Jeffrey Simpson, "Saskatchewan and the Difficult Birth of Medicare," *Queen's Quarterly* 119, no. 2 (Summer 2012): 276, https://search.ebscohost.com/login.aspx?direct=true&db=31h&AN=78121590&site=ehost-live&scope=site.

[15] Anne Crichton, "Health Insurance and Medical Practice Organization in Canada…," 151.

funding.[16] While federal transfers started as a 50:50 cost-sharing arrangement, it has since evolved due to fiscal pressures. By the early 70s the federal government began transitioning to block funding out of apprehension that provincial and territorial health program costs were escalating.[17] Then, in 1996/97 the GoC introduced the Canada Health and Social Transfer (CHST) which combined block funding for health, post-secondary education and social services. Although it was meant to provide greater flexibility to PTs, it resulted in diminished federal oversight meant to hold PTs accountable to the CHA.[18] By 2003 this shortcoming was addressed by Bill C-28, which divided the CHST into a health care transfer and a separate transfer for social programs.[19]

A final attribute of Canada's health system and especially the CAF health system, is the moral obligation that developed when the world wars caused a paradigm shift in Canadian values. The world wars revealed the abysmal state of public health due to poor nutrition and physical fitness, apathetic uptake of immunizations to control the spread of infectious diseases and unhealthy lifestyle choices.[20] With up to half of new recruits rejected for substandard fitness[21] the Government of Canada began to realize that responsibility for the health of its population was a national matter.[22] This was an

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[16] Malcolm C. Brown, "Health Care Financing and the "Canada Health Act…,"" 111.
[17] Provincial and Territorial Ministers of Health, "Understanding Canada's Health Care Costs," Interim Report, June 2000, 4, http://www.gov.pe.ca/photos/original/health_costs.pdf.
[18] Odette Madore, "The Canada Health And Social Transfer: Operation And Possible Repercussions On The Health Care Sector," accessed 2 March 2022, https://publications.gc.ca/Collection-R/LoPBdP/CIR/952-e.htm.
[19] *Ibid.*
[20] Christopher Rutty and Sue C. Sullivan, "This Is Public Health: A Canadian History," *Canadian Journal of Public Health*, accessed 1 March 2022, 5.1-5.14, https://www.cpha.ca/sites/default/files/assets/history/book/history-book-print_all_e.pdf.
[21] *Ibid, p.5.4.*
[22] Canadian Museum of History, "Making Medicare: The History of Health Care in Canada, 1914-2007," accessed 28 February 2022, https://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-1c08e.html.

important moment in history that drove national policy efforts, which materialised in the piecemeal fashion necessitated by the multijurisdictional nature of Canada.

CAF: A SPECIAL POPULATION

At the same time the GoC began to accept responsibility for the health of its population, it concurrently recognized a duty to care for CAF members as a special sub-group. It is informative to explore how the CAF"s unique characteristics have manifested in its health system.

The CAF population is distinct for several reasons. First, its members are highly mobile, and this challenges the Canadian Forces Health Services Group's (CF H Svcs Gp) ability to provide continuity of care, a pillar of patient care.[23] Continuity of care is of great importance to CAF leadership and was the issue that incited the Chief of Defence Staff to request the Chief of Review Services to conduct a review of the in-garrison care delivered by the CAF health system in 1999.[24] The report was released five years after a large restructuring that increased reliance on the civilian health system, at a time when the civilian system had itself restructured.[25] One of the major findings was that the regional differences in care across the country required enough flexibility in strategic policy to adapt to local circumstances.[26]

Second, CAF members are subject to unlimited liability and can be ordered into dangerous conditions that risk injury or death.[27] This substantial personal sacrifice and

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[23] Martin Gulliford, Smriti Naithani, and Myfanwy Morgan, "What Is "Continuity of Care"?," *Journal of Health Services Research & Policy* 11, no. 4 (October 2006): 248, https://search.ebscohost.com/login.aspx?direct=true&db=sih&AN=22458885&site=ehost-live&scope=site.
[24] Chief Review Services, *Review of CF Medical Services*, (October 1999), i.
[25] *Ibid,* i,9, 12.
[26] *Ibid,* 4.
[27] Department of National Defence, "Section 2: Fundamental Beliefs and Expectations," last modified 7 October 2019, https://www.canada.ca/en/department-national-defence/corporate/reports-publications/duty-

the impact it can have on health during and after a member's military career is the reason the Canadian Institute for Military and Veteran Health Research (CIMVHR) exists.[28] CIMVHR is "an independent research centre [that promotes and lobbies] for the recognition of veterans and their families by provincial and territorial healthcare systems as a unique population."[29] Carson argues that the distinct needs of military members and veterans require centralization.[30]

Lastly, aside from the effects on health of unlimited liability, there is also evidence to suggest that the types of care required by CAF members may be disparate from their civilian counterparts. A study conducted on Canadian veterans who released between 1998 and 2012 showed that veterans experienced greater rates of back problems, arthritis, depression, anxiety and high blood pressure in comparison to their Canadian counterparts.[31] A similar marked difference was observed in a study on the Australian Defence Forces that showed a proportionally higher presentation of musculoskeletal and mental health disorders in comparison to their civilian population.[32] While this study was not conducted on CAF members, it is logical to hypothesize comparable results would be

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with-honour-2009/chapter-2-statement-of-canadian-military-ethos/section-2-fundamental-beliefs-and-expectations.html.

[28] Scott A. Carson, "Innovation in Canadian Healthcare: An Essential Part of a System-Wide Strategy," in *A Canadian Healthcare Innovation Agenda: Policy, Governance and Strategy* (McGill-Queen's University Press, 2018), 10, https://www.deslibris.ca/ID/454264.

[29] *Ibid,*10.

[30] *Ibid,* 11.

[31] Linda D. VanTil et al., "Understanding Future Needs of Canadian Veterans," *Health Reports* 29, no. 11 (November 2018): 23, https://www.proquest.com/docview/2154169489/abstract/E39E8CB76211444CPQ/1.

[32] Neil Westphalen, "Primary Health Care in the ADF," *Australian Defence Force Journal*, no. 202 (2017), 94, https://defence.gov.au/ADC/ADFJ/Documents/issue_202/Westphalen_July_2017.pdf.

found in Canada given its similarities with Australia that make country comparisons common.[33]

SYSTEMS THINKING

The historical context presents Canada's health care system as unequal but aspiring to be fair, publicly funded but privately delivered and morally obligated but fiscally bound. When considering whether the CAF health system, an exclusive system that reflects the separate needs of CAF members, should switch to provincially and territorially insured health care for its members, a systems thinking approach will be necessary to navigate these health system features.

The benefit of systems thinking is that it will pull policy makers out of the linear thinking Anderson and Johnson blame, in part, on Western language.[34] They explain that "basic sentence construction, noun-verb-noun, [that] encourages a worldview of "x causes y" [focuses] on linear causal relationships rather than circular or mutually causative ones."[35] Linear thinking is further reinforced within hierarchical bureaucracies, such as the CAF, where rigid policies meant to regulate and seek efficiencies prevent the institutionalization of successes realized on a small scale that are the product of systems thinking.[36]

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[33] Purple Pen Pharmacist, "Health Systems Comparison Analysis— Australia vs. Canada." *Medium* (blog), 10 February 2020, https://medium.com/@zacharysum/health-systems-comparison-analysis-australia-vs-canada-97b06a248395.
[34] Virginia Anderson and Lauren Johnson, "Systems Thinking Basics," (Pegasus Communications, Inc., 1997), 17, https://archive.org/details/systemsthinkingb00ande
[35] *Ibid,* 17.
[36] Aku Kwamie, Solip Ha, and Abdul Ghaffar, "Applied Systems Thinking: Unlocking Theory, Evidence and Practice for Health Policy and Systems Research," *Health Policy and Planning* 36, no. 10 (11 November 2021): 1716, https://doi.org/10.1093/heapol/czab062.

Understanding what systems thinking is and applying it on a practical level, however, has been lacking in health literature.[37] Some criticisms of systems thinking are that it is overly conceptual, few examples of its application are published, and terminology is used interchangeably with similar concepts resulting in an incoherent patchwork of theory definition.[38] To achieve a common understanding and language that is currently in use by CAF stakeholders, this paper will adopt its definition of systems thinking from the LEADS in a caring environment (LEADS) framework.[39] This is the framework the Canadian College of Health Leaders (CCHL or the College) has aligned their programs with[40] and since the Canadian Forces Health Services Group is in a strategic alliance with the College, it aims to integrate this framework through leadership training and development.[41] Figure one categorizes the 20 capabilities within the five domains of the LEADS framework.[42] Of particular note is this paper's adopted definition, namely, the systems thinking capability captured in the "S" of LEADS.

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[37] *Ibid,* 1715.
[38] *Ibid,* 1716.
[39] Graham Dickson and Bill Tholl, *Bringing Leadership to Life in Health: LEADS in a Caring Environment* (Springer Nature, 2020).
[40] The Canadian College of Health Leaders, "LEADS Framework," LEADS, accessed 6 March 2022, https://cchl-ccls.ca/site/pd_leads.
[41] The Canadian College of Health Leaders, "Partners - CHE Program Employers," accessed 6 March 2022, https://cchl-ccls.ca/company/roster/companyRosterDetails.html?companyId=20826&companyRosterId=32.
[42] LEADS Canada, "LEADS Framework," accessed 6 March 2022, https://leadscanada.net/site/about/about-us/framework?nav=sidebar.

Figure 1. The LEADS in a Caring Environment capabilities framework

In their study about how systems thinking was used during the initial phases of the COVID-19 pandemic, Graham et al represented it as a leader's ability to shift their approach depending on various contexts that arise in complex adaptive systems such as the Canadian health system.[43] Complex adaptive systems are marked by their sensitivity to events that prompt changes in distinct, unpredictable and often nonlinear ways, their adaptability that derives from a learning capacity, their behavioral patterns that can bring stability but intermittently change in unexpected ways, and lastly, their interconnectedness through positive and negative feedback loops.[44] Unfortunately, the CAF health system operates within the hierarchical and bureaucratic CAF institution,

[43] Graham Stewart Dickson et al., "The Relevance of the LEADS Framework During the COVID-19 Pandemic," *Healthcare Management Forum* 34, no. 6 (n.d.): 326, https://pubmed.ncbi.nlm.nih.gov/34496640/.
[44] Tamara Galkina and Irina Atkova, "Effectual Networks as Complex Adaptive Systems: Exploring Dynamic and Structural Factors of Emergence," *Entrepreneurship Theory and Practice* 44, no. 5 (1 September 2020): 966–967, https://journals-sagepub-com.cfc.idm.oclc.org/doi/full/10.1177/1042258719879670?utm_source=summon&utm_medium=discovery-provider.

which presents a challenge to policy makers seeking flexibility and non-linear solutions that systems thinking requires.

The various contexts and associated approaches Graham et al consider are listed in Table one. What is essential about their definition of systems thinking is that leaders, and by extension, policy makers must have the flexibility in policy to adapt to changing circumstances. The complexities detailed in the historical construction of Canada's health system and their interconnectedness with the political system demonstrate the dynamic nature of systems that need continuous iterations of policy reviews and updates to maintain the objectives shaped by Canadian values.

Table 1. [45] A Leader's Framework for Decision Making

Context	**Characteristics**	**Approach**
Simple	Stability, clear cause-and-effect relationships, shared understanding	Best practices
Complicated	Multiple right answers, not everyone can see cause-and-effect relationships, expertise required	Good practices
Complex	Whole is far greater than sum of its parts, unpredictability, flux	Emergent practices

[45] David J. Snowden and Mary E. Boone, "A Leader's Framework for Decision Making," *Harvard Business Review*, 1 November 2007, https://hbr.org/2007/11/a-leaders-framework-for-decision-making.

Chaotic	No manageable patterns exist, turbulent, constant change	Novel practices

WHAT WOULD PROVINCIAL COVERAGE LOOK LIKE?

Given the distinct health needs of CAF members and the federal duty to assure their welfare, in accordance with constitutional definition and moral charge, central regulation and funding affords the most confidence in achieving adequate care delivery when complemented with a systems thinking approach. The centralized control over the CAF health system ensures coherent advocacy for nationally dispersed members at risk of divergent care if left to navigate PT systems themselves, which would negatively impact CAF operations. While the federally regulated system with its existing infrastructure and health care providers could still have provincially insured services, there would be an undeniable loss of control, with unpredictable outcomes, as the federal government's oversight would amount to imperfect financial mechanisms that allow provinces to retain prerogative in care delivery. There is benefit, however, in exploring what decentralized insurance would look like to reveal areas for improvement that can be fulfilled by supplementary policy.

The most obvious difference that would be seen with the inclusion of CAF members in the Canada Healthcare Act is the issuance of provincial or territorial health care cards. Immediately recognizable PT health care cards extend seamless access to civilian health facilities providing insured services that would eliminate any

administrative barriers that are currently in place to permit integration with the CAF health system.

Another advantage of possessing a PT health care card is ease of access to the health system for family members and other services or programs linked to PT health care numbers. In Quebec, for example, service couples are unable to register their children on the provincial waitlist for a family doctor because they do not meet the condition of having a Quebec health insurance card.[46] Moreover, in Ontario, organ donation registrants must identify themselves with a health care card number.[47]

There are substantial administrative encumbrances, however, that come with PT insured services. The variance across the 13 provincial and territorial systems in insured services currently disadvantages CAF family members and would create a complicated patchwork of supplementary insurance coverage plans that would be needed to maintain the comprehensive spectrum of care[48] required by CAF members. For instance, CAF members often reside outside their home province due to organizational needs making interprovincial travel while on leave commonplace. If a family residing in Quebec travels to Ontario and a dependent requires hospital services during the trip, the patient would be

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[46] Gouvernement du Québec, "Guichet d'accès à Un Médecin de Famille," accessed 16 March 2022, https://www4.prod.ramq.gouv.qc.ca/GRL/LM_GuichAccesMdFamCitoy/fr.

[47] Government of Ontario, "ServiceOntario," accessed 16 March 2022, https://www.services.gov.on.ca/wps85/portal/s2i/!ut/p/z1/dYuxDoIwFAD_qK-AAo7IoJNCitF2IQ-oTQN5JYKQ-PUimyaOd7kDBTdQhJM1OFpH2C0sVVjGBx76ycY7nYvLjudbfvTyLAp4GoBcguhvIDwQoEAJ3-6xbguXodEga2SOmHETG3zL-sUx1zyYpbv71B2SAanp67xaatz8-86rXe9hxPE5gNBUpgn0LVYvXcVvWcyc-Q!!/.

[48] Department of National Defence, "About the CAF Spectrum of Care," last modified 15 January 2019, https://www.canada.ca/en/department-national-defence/services/benefits-military/pay-pension-benefits/benefits/medical-dental/information-management.html. Spectrum of care consists of six parts: comprehensive medical care, supplemental and occupational health care, preventive medicine, health promotion, and comprehensive dental care.

responsible for most of the cost.[49] If the CAF adopted three tiers of health care benefits, namely, basic, supplementary, and occupational,[50] similar to the Royal Canadian Mounted Police (RCMP) since their inclusion in the CHA as of 2013,[51] then it would need 13 tiered packages to account for the differences in each province and territory. Additionally, each benefit package would require coverage during interprovincial travel, whether the member is travelling for training, exercises, leave, or any other business purpose. A decentralized insurance model is more complex and will create more opportunities for errors or gaps in coverage.

Finally, there are financial factors in a decentralized model that warrant examination. When CAF members access health services outside of the CAF health system the billing rate is higher than the billing rate used for provincial or territorial residents.[52] In 2019 the Department of National Defence (DND) suddenly implemented new billing rates that matched the rates used for residents of the same province or territory in which services were delivered but quickly back tracked after multiple hospitals projected millions in shortfalls.[53] While it is prudent for the DND to responsibly

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[49] Royal Bank of Canada, "Understanding Your Out-of-Province Government Medical Coverage," accessed 16 March 2022, https://discover.rbcinsurance.com/understanding-your-out-of-province-government-medical-coverage/.

[50] Royal Canadian Mounted Police, "AM - Ch. XIV.1. Health Care Entitlements and Benefits Programs," Access to Information Request Number A20208937 - Release Package (30 July 2015), 1.

[51] "Canada: RCMP Will Soon Receive Basic Health Coverage From The Province." *MENA Report*, (26 March 2013), https://www.proquest.com/docview/1319522277/abstract/9F144D584D824BE9PQ/1.

[52] Mercedes Stephenson and Amanda Connolly, "EXCLUSIVE: Federal Government Cuts Reimbursements for Military Health Care, Hospitals on the Hook for Millions," *Global News*, 30 March 2020, https://globalnews.ca/news/6007117/military-health-care-cuts/.

[53] Department of National Defence, "CAF POC 6 - Medical Services - New Benefit Code Modifier," October 2019, http://pub.medavie.bluecross.ca/pub/0001/PublicDocuments/CAF%20POC%206%20-%20Medical%20Services%20-%20New%20Benefit%20Code%20Modifier%20-%20October%202019%20-%20V1.pdf: Department of National Defence, "CAF POC 05 , 06 - Changes to CAF Program (QA) Updated," 2019, http://pub.medavie.bluecross.ca/pub/0001/PublicDocuments/CAF%20Program%20of%20Choice%20(POC)%2005%20%2C%2006%20-%20Changes%20to%20CAF%20Program%20(QA)%20Updated.pdf: Department of National Defence, "CAF POC 5 - Bulletin," 1 April 2019, http://pub.medavie.bluecross.ca/pub/0001/PublicDocuments/290317%20CAF%20POC%2005%20Bulletin

exercise financial stewardship, there has to be consideration given to whether those higher billing rates provide an added service and if such preferential treatment aligns with the principles of the CHA. For example, an Alberta report noted CAF members may receive expedited services due to "differential status…under the CHA."[54] If any preferential treatment can be addressed through policy amendments, in this case adjusted billing rates, and this would improve health equity, then the adjustments should be made. There may be justification for expedited service, however, if there is an operational imperative.

BENEFITS OF THE FEDERAL SYSTEM

With an appreciation gained for the problems decentralized insurance would bring to the CAF population, there are a few critical benefits to outline that further endorse the current centralized funding framework. First, the CAF health system has earned a reputation respected by Canada's only professional body that offers credentialing for health leaders, the Canadian College of Health Leaders[55]. In addition to their strategic alliance with the CF H Svcs Gp that facilitates greater system-wide understanding of the special health needs of CAF members and veterans, CAF health leaders are asked to share their experiences at conferences and local chapter events in the interest of collaboration and sharing of best practices.[56] Admittedly, strategic alliances would be

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%20May%201%20EN.PDF: Mercedes Stephenson and Amanda Connolly, "EXCLUSIVE: Federal Government Cuts…": Janet French, "Federal Government Reverses Changes to Military Health-Care Reimbursements," *Ottawa Sun*, 15 December 2019, https://edmontonjournal.com/news/politics/federal-government-reverses-changes-to-military-health-care-reimbursements.

[54] John Z. Vertes, "Health Services Preferential Access Inquiry - Alberta," August 2013, 106, https://hqca.ca/wp-content/uploads/2018/05/HSPAI_Final_Report_Volume_2_Complete.pdf.

[55] The Canadian College of Health Leaders, "What We Do - CCHL – CCLS," accessed 17 March 2022, https://www.cchl-ccls.ca/site/about/college/whatwedo?nav=sidebar.

[56] Canadian College of Health Leaders, "BC Health Leaders Conference Program," 2017, https://cchl-ccls.ca/uploaded/web/BCHLC/2017/BCHLC_2017_Program_Final.pdf: The Canadian College of Health

possible under a decentralized insurance model, though, not without risk of reputation erosion if innovation is hampered by disjointed funding and increased administrative barriers to partnership.

Second, the CAF health system offers centralized advocacy for health matters that impact operational effectiveness. The COVID-19 pandemic is a recent example of such an occurrence when the dispersed and mobile nature of the CAF population required a dedicated planning team to roll out the vaccination campaign as part of Operation VECTOR.[57] Already complicated by understanding and adhering to variances in PT public health measures, the campaign could have been further complicated by disordered delivery of vaccines if PTs scattered CAF members into 13 civilian campaigns.

Third and last, is the protection CAF members retain from inherent volatilities in a system of 13 systems. When Ontario announced an end to out of country emergency service coverage, a breach of the CHA, a legal battle ensued before Ontario backed down.[58] Furthermore, the debates about and growth in privatization threaten Canada's treasured public system.[59] Understanding the impacts of fundamental changes to the public health system on CAF members would be difficult and inclusion in the CHA as insured persons would limit federal ability to mitigate them.

Leaders, "Eastern Ontario Chapter Event," accessed 16 March 2022, https://www.cchl-ccls.ca/viewEvent.html?productId=8010.

[57] Department of National Defence, "COVID-19 Vaccines for Defence Team Members," last modified 9 December 2021, https://www.canada.ca/en/department-national-defence/campaigns/covid-19/covid-19-vaccines-for-canadian-armed-forces-members.html.

[58] Health Canada, "Canada Health Act Annual Report 2019-2020," 22 February 2021, 22, https://www.canada.ca/en/health-canada/services/publications/health-system-services/canada-health-act-annual-report-2019-2020.html.

[59] Connor Forbes and Erica Tsang, "Healthcare in Canada: Privatization and How to Contain It," *UBC Medical Journal* 4, no. 1 (n.d.): 4–5.: Nancy Olivieri, Michael Hurley, and Natalie Mehra, "Doug Ford's Government Is Quietly Privatizing Health Care," *The Toronto Star*, 15 March 2022, sec. Contributors, https://www.thestar.com/opinion/contributors/2022/03/15/doug-fords-government-is-quietly-privatizing-health-care.html.

RECOMMENDATIONS

Despite the stance of this paper that the CAF must preserve its health system's extant, federal funding scheme, there are several enhancements that naturally fall out of this analysis. First, the CAF system relies on and is inextricably linked to the civilian system, which requires deliberate, strategic attention to find and permit opportunities to educate, share and collaborate with civilian stakeholders. The alliance with the CCHL is exactly the type of formal partnership that achieves this goal and similar arrangements should be sought with other reputable groups. Honorary appointments within CF H Svcs Gp could be leveraged to support this aim.[60]

Second, full implementation of systems thinking in policy development processes is needed to avoid narrowly centered policy that lacks a mechanism for adjustments. The reduced billing rates DND swiftly implemented without consultation or warning to PTs illustrates the risks of linear thinking. Complex adaptive systems call for resilient strategic policy that create space for local, tailor made solutions to ground truth circumstances.

Third, it is essential to establish and socialize reporting channels for members who experience gaps in services, which can then be addressed. For example, there is no reason the Blue Cross card CAF members carry can not be used to register their children on Quebec's family doctor waiting list. The 32 Military Family Resource Centres

[60] Royal Canadian Medical Service, "Honorary Appointments," accessed 17 March 2022, https://www.royalcdnmedicalsvc.ca/rcms/honourary-colonels/.

(MFRC) located near bases across the country are logical places to house this function as it aligns well with their objectives.[61]

The fourth recommendation is closely tied to the third. The health of CAF family members, much like members themselves, is affected by the demands of the military lifestyle. Frequent moves disrupt access to care and long separations have mental health impacts. While DND recognizes CAF families as a special population,[62] there is insufficient policy to ensure they are no more disadvantaged with respect to the CHA than Canadians who choose which province to live in and when to live there. There are a variety of solutions that could address this shortfall. For instance, routine vaccines like influenza vaccines could be provided to family members at the same location as CAF members. Local agreements could be set up with family doctors in the community to accept CAF family members as patients, which should not see significant growth if a similar number of families are posted in as out in a given location. If relocating CAF family members are receiving medical treatment and that same treatment is not immediately available at their new location there should be travel entitlements until such time that services can be transferred. These are but a few examples.

The final recommendation is a suggestion for future research. There are innovative provincial examples to launch from that could improve financial stewardship while better meeting the five CHA principles. For example, Quebec's Family Medicine Groups could be expanded to include CAF members and their families:

> In Quebec, Family Medicine Groups have been associated from the outset with a set of contractual agreements between accredited clinics and

[61] Chief Review Services, "Evaluation of Military Family Support Programs and Services," audit, January 2013, 4, https://www.canada.ca/en/department-national-defence/corporate/reports-publications/audit-evaluation/evaluation-military-family-support-programs-services.html.
[62] *Ibid, iv.*

> other health institutions at the local, regional, and provincial levels. These contractual agreements formalize the collaboration and sharing of resources among and within primary care clinics. In addition, regional and local departments of family medicine have been established in Quebec (Département régional de medicine générale). These departments, composed of elected representatives from each local area's pool of general practitioners, have a mandate to coordinate the supply and planning of primary care services and to work in close collaboration with regional health authorities and local health centers. For example, these departments control the entry of new general practitioners into the area and determine where these newcomers will perform their mandatory emergency room or long-term care service requirements. As such, they represent one of the first attempts at integrating general practitioners into the governance of Quebec's health system.[63]

CONCLUSION

The CAF health system has earned a reputation that renders CAF members visible in the civilian system in a way that promotes better care and addresses their specific health needs. CAF members benefit from centralized advocacy that also protects them from the innate unpredictability of the 13 PT systems. Any advantages gained by including the CAF population as insured persons under the Canada Health Act can be pursued through other means.

Policy makers must understand that Canada's healthcare system is a complex adaptive system which will not respond as expected to narrow, linear thinking in policy changes. A narrow focus on cost to drive policy will have wider impacts that may far outweigh any financial savings. Policy must instead consider the whole system and its interconnectedness with other systems – systems thinking.

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[63] Brian Hutchison et al., "Primary Health Care in Canada: Systems in Motion," *Milbank Quarterly* 89, no. 2 (June 2011): 270-271.

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