24-PAGE SUPPLEMENT

# MENDING MEDICARE

ANALYSIS AND COMMENTARY ON CANADA'S HEALTH CARE CRISIS

A Joint Publication of the CCPA and the Canadian Health Coalition

CONTROLLING COSTS:

## Canada's single-payer system is costly—but least expensive

*By Armine Yalnizyan*

The big challenge for governments in health care is its affordability: how to pay for the things that keep everyone as healthy as possible, and how to make this level of payment politically feasible and attractive. "Social marketing" of the benefits of health care is important, but in the end governments' spending power determines the degree of access to health care that all citizens will enjoy.

Talk of affordability is often limited to the ability to pay. But beyond their ability to pay, governments also have the ability to manage costs. Government decisions affect both the public purse and individual wallets, and shape total health care spending in the economy. Public spending has greater potential to control costs and extend benefits than private spending, but that potential needs to be actively pursued.

Unlike individual consumers, governments can achieve economies of scale, streamline administrative processes, negotiate better deals, set rules, assess cost-effectiveness, and allocate spending to where the returns on investment are greatest. Each of these public policy levers requires thoughtful implementation and monitoring.

**"Single-payer systems have many advantages. With just one place to submit bills to and receive payment from, the system reduces duplication in the administration of different methods of payment. Americans pay three times as much per person for their multiple bill-paying procedures."**

### Single-payer systems

Over time, Canada's public spending on health care has become synonymous with the single-payer system. There are many advantages of single-payer systems. With just one place to submit bills to and receive payment from, the system reduces duplication in administration of different methods of payment. On average, about 1.8% of Canada's provincial and territorial costs for health care go to the structure that pays the bills. Comparative studies show that Americans pay, on average, three times as much per person for the process of paying bills for doctors' and hospital services, primarily because there is a multiplicity of payment systems and each of those has its own administrative costs. Multiple insurance systems in other countries where there are large public systems, but parallel private systems for enhanced benefits, also drive up administrative costs.

Beyond administrative efficiencies, single-payer systems also have a built-in advantage in their ability to negotiate better deals and extend purchasing power. Canadian jurisdictions have seen this advantage both used and ignored over time. Single-payer systems set fee schedules for doctors' services and rates for hospital budget-setting. Governments, as the single biggest purchasers of service, generally get better prices than individuals or private insurers do. The rule of thumb is the bigger the population base, the greater the economies of scale, which can open the door to volume discounts.

Setting fee-schedules, rates and prices in this kind of context is essentially a political process. There are better and worse eras of bargaining; much depends on the relative power of the people and groups trying to get a deal. Each round of negotiations depends on the different parties' points of view about what happened in the last round of bargaining, and the objectives for the new round of bargaining. Although cost controls are easier to achieve through single-payer systems, they are not always a high-priority objective.

### Drug costs

The power of single-payer systems could be used more effectively in our procurement systems, particularly in drug programs. Prescription drugs are the fastest-growing cost driver in health care spending, on both the public and private side. The provinces all have different ways of addressing the rising costs of drugs. Their policies also influence costs for private insurers. The following techniques have an impact on the development and pricing of new patent drugs, as well as on the share of the generic drug industry in the market for prescription drugs:

- **Generic substitution:** All of Canada's provincial drug plans have a policy to cover only the costs of a generic drug in place of a patent drug if they are basically, or chemically, the same. The effectiveness of this policy has been somewhat blunted by changes to patent law that limit the use of compulsory licensing. Individuals can opt to pay the difference between the cost of the generic and cost of a brand-name drug.
- **Reference-based pricing:** In a system introduced in British Columbia in 1995, the province controls what it will pay by grouping drugs that treat the same condition and are deemed to be therapeutically equivalent, whether they are chemically the same or different. The plan limits payment

*(Continued on Page 14)*

GUEST EDITORIAL:

# Medicare's core values

All around the world, Canada is held in high esteem for its approach to health care. Founded on the twin principles of universality and accessibility, the Canadian approach means, in theory, that the provision of care is based on need, not ability to pay. Canadian Medicare emerged in response to poverty, not plenty.

This was the founding vision of Tommy Douglas, widely acclaimed as the "Father of Medicare," and it has continued to serve and inspire Canadians, who rightly regard health care as their single most valued social program.

Since its inception half a century ago, however, Medicare's funding and delivery have been embroiled in conflict. Today there is friction about what services and drugs should be included in the basket of publicly-insured health care, and how distressingly long wait times for treatment can be reduced.

Many aspects of health care remain universally inaccessible, but our history still paints a clear picture: Over time, an ever-larger number of Canadians have benefited from an ever-larger scope of publicly-provided or subsidized supports, resulting in improved health and quality of life for every successive generation.

Two core Canadian values have infused most health reforms over the past 100 years: fairness and pragmatism. It needs to be said that, despite almost constant squabbling at the political level, these values have stood the test of time.

Public confidence in the system has been regularly tested: before the advent of Medicare in the 1930s during the Great Depression; in the 1950s when negotiations failed to secure the federal government's participation; in the 1960s when Medicare's introduction in Saskatchewan was opposed by a doctors' strike; and in the 1980s when the system was weakened by the imposition of "user fees." Each time, the "right" to health care as a basic right of citizenship was challenged, and each time the fundamental values prevailed.

Canada's history and experience display a steadfast desire for equal treatment, revealing in the process important lessons about the interface between the health of individuals and the health of their society. We have learned that equity pays off. We have learned that striving for equity means making sure everyone gets access to the same timely and best available care, but that sometimes it means that interventions need to be targeted to the most vulnerable groups.

Publicly-insured services have continued to expand in scope—from public health, to doctors and hospitals, to expansion of public drug programs, to more supports for long-term care, home care, and rehabilitation. Public commitments to spending on health care are growing at a rate that outstrips any other service that governments provide. Yet even today some parts of our society are falling behind in their access to health care. Uncertainty festers about what is or should be publicly supported, resulting in the current ill-advised attempts by some provinces to turn more services over to private, for-profit operators.

The push for more private insurance reflects a growing emphasis on individual benefit, and as such defies the simple logic and strength of extending collective benefit. Nothing is less costly to provide on such a scale than a publicly-insured system. Nothing is more powerful than a single-payer system to control costs and allocate funding so that treatments provide the greatest benefits to those in the greatest need.

Health care is the most solid manifestation of the principle of solidarity, and we are confident this deeply-held Canadian value will prevail over the latest and most aggressive efforts to undermine the most cherished of our country's social programs.

*—Armine Yalnizyan.*

REALITY CHECK:

# Delivery matters

*"It does not matter who delivers health care, it matters that everyone can receive it."*
*—Stephen Harper (May 10, 2004)*

**Reality Check: For-profit health care facilities—**

**a) have higher death rates than not-for-profit facilities** (1,2,3);

**b) cost more** (4);

**c) provide lower quality services**(5);

**d) engage in schemes to cheat taxpayers** (6,7,8);

**e) compromise access to public services** (9); and

**f) provide less nursing care than not-for-profit nursing homes** (10).

**Don't trust a politician who says it doesn't matter who delivers your health care!**

References:

*(1) Devereaux, P.J., et al, "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals", Canadian Medical Association Journal, May 28, 2002; Vol. 166, No. 11 (2) Thomas, E., et al, "Hospital Ownership and Preventable Adverse Events", Journal of General Internal Medicine, April, 2000 (3) Devereaux, P.J., et al, "Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centrers," Journal of the American Medical Association (JAMA), November 20, 2002; Vol. 288, No. 19 (4) Woolhandler, S. et al, "When Money is the Mission - The High Cost of Investor-Owned Care", New England Journal of Medicine, August 5, 1999, Vol. 341, No. 6 (5) Schneider, E. et al, "Quality of care in for-profit and not-for-profit health plans enrolling Medicare beneficiaries," The American Journal of Medicine, vol. 118 No. 12, December 2005 (6) Eichenwald, K., "Hospital Chain Cheated U.S. on Expenses, Documents Show," New York Times, December 18, 1997 (7) Steward, G., "Public Bodies, Private Parts: Surgical Contracts and Conflict of Interest at the Calgary Regional Health Authority," Parkland Institute/University of Alberta, March 5, 2001 (8) British Medical Journal (May 15, 2004), "NHS overcharged for private surgery." (9) Canadian Health Services Research Foundation, "Myth: A parallel private system would reduce waiting times in the public system," 2001 (10) Harrington, C., "Does Investor Ownership of Nursing Homes Compromise the Quality of Care," American Journal of Public Health (September 2001)*

## Canadian Health Coalition calls for Pharmacare

*By André Picard*

With a new government in place, a coalition of social groups and labour unions is renewing calls for a national Pharmacare program, saying that paying for essential prescription drugs is a fundamental step in the evolution of Medicare.

"Universal first-dollar coverage for cost-effective, safe drugs will save money and lives,"Kathleen Connors, chairwoman of the Canadian Health Coalition, said in a letter to new federal Health Minister Tony Clement.

"Canada has a big drug problem," she said, citing the $18-billion in annual prescription drug spending and the large number of medical errors related to prescription drugs. (An estimated 12,000 deaths annually are attributed to the misuse and overprescription of drugs in Canada.)

Connors said prescription drugs are the health expenditure that is growing most quickly, and the way to rein that in is with improved management and use of medication. But, at the same time, a growing number of Canadians are being denied access to medically necessary drug treatments.

"It's time to replace our patchwork, U.S.-style insurance plans that drive up spending and leave millions without access," Connors said.

The 28-page report, "More For Less: A National Pharmacare Strategy," argues that Canadians should have access to all drugs "necessary for healthy living" free of charge, regardless of income or where they live in the country.

The coalition recommends that a national formulary be created that includes drugs that are medically necessary and cost-effective. Under the plan, an independent agency would determine what drugs are placed on the list. Currently, each province has its own drug formulary, but there are attempts to co-ordinate the lists through an agency called the Common Drug Review.

In its report, the Canadian Health Coalition argues that a national Pharmacare plan would reduce costs for provincial health plans, but it would benefit employers even more, extending the "competitive advantage" that Medicare already offers.

Currently, Canadian employers spend more than $6.7-billion annually in drug insurance premiums, but 42% of workers are not covered by work-based plans, according to the report.

---

*(André Picard is the public health reporter for the* ***Globe and Mail,*** *where this report was first published.)*

## INDEX Pharmaceutical Drugs

- Amount spent on prescription drugs in Canada in 2004 (excluding hospitals): **$18 billion**
- Amount spent on drugs in hospitals in 2002: **$1.37 billion**
- Increase in prescription drug costs in Canada between 1994 and 2004: **62.3%**
- Percentage of new, more expensive drugs in Canada (2000-2004) that offer no improvement over existing drugs: **97%**
- Amount of prescription drug costs in Canada covered by the federal government: **2.9%**
- Number of drug prescriptions filled in Canadian pharmacies in 2004: **382 million**
- Adverse drug reactions as ranked among the leading cause of death in Canada: **between 4th & 7th**
- Canadian per capita drug expenditure in 2003 (estimate): **$620**
- Pfizer's profit on $48 billion worth of business in 2002: **$9.1 billion**
- Amount spent by Merck in 2000 on direct to consumer advertising for Vioxx (U.S): **$160 million**
- Estimated number of extra patients (U.S.) that experienced heart attacks from Vioxx use: **88,000 to 139,000**
- Number of sales representatives for pharmaceutical companies in the U.S. alone in 2000: **83,000**
- Estimated amount spent by the pharmaceutical industry in Canada on promotion in 2004: **$2.1 billion**
- Estimated increase in total antidepressant drug costs (mostly SSRIs) from 1993 to 2000: **347%**
- Scientists at the U.S. FDA who lack confidence in their agency's ability to monitor drug safety: **2 in 3**
- Percentage of 2003 budget for Health Canada's drug approval agency that comes from the drug industry: **56%**
- Percentage of the Canadian population that have 100 % coverage for drug expenses: **under 10**
- Number of Canadians who are not insured for prescription drugs: **1 million**
- Number of Canadians that have some type of protective cap on out-of-pocket drug expenses: **1 in 3**
- Annual increase in employer health benefit premiums: **15%**
- Number of Canadians who have inadequate drug insurance: **4.3 million**
- Annual administrative costs of the private drug insurance system in Canada: **$670 to $800 million**
- Canada's prescription drug costs as a percentage of OECD average: **30% higher**
- Australian Pharmacare savings on new patented drugs compared to Canada: **9%**

---

***SOURCES:*** *Canadian Institute for Health Information (1, 2, 3, 5, 8); CMAJ, 161-3, 1999 (7); PMPRB (4, 13); IMS Canada (6); Fortune 2003 (9, 12); IMS Health, Integrated Share of Voice and CMR, 2001 (10); Lancet, 9458, 2005 (11); Currie, J., Women & Health Protection, 2005 (14); Harper's Index, March 2005 (15); Health Canada, 2003 (16); Applied Management & Fraser Group Tristat, 2000 (17, 18, 19); Hutty, S. 2002, Third Party Issues (20); Applied Management et al (21); Palmer D'Angelo, 1997 (22); Lexchin, J., CCPA, 2001 (23); Productivity Commission, Australia, 2001 (24).*

# Gov'ts fail to use their bulk-buying power to lower drug costs

*(Continued from Page 11)*

to cover the full cost of the least expensive alternative, or the "reference" drug in a therapeutic class. Doctors can prescribe a more expensive drug, but if patients covered by the public plan opt for that choice, they must pay the difference between its price and the reference price.

- **Direct price controls:** At the federal level, the PMPRB (Patented Medicine Prices Review Board) sets price controls on the wholesale prices of new patent medicines coming onto the Canadian market. Generic drugs are not covered by its mandate. There are three guiding criteria for pricing patent drugs, which together ensure that Canadian prices of patented medicines will never be the highest in the world:
  - New patented drugs that fall into an existing therapeutic class have their prices limited so that the cost of therapy is in the range of other existing drugs that are used to treat the same disease and sold in Canada.
  - Breakthrough drugs have their prices limited to the median of the prices for the same drugs charged in other specified industrialized countries, as set out in the Patented Medicines Regulations. These reference nations include France, Germany, Italy, Sweden, Switzerland, Britain, and the United States.
  - Existing patented drug prices cannot increase by more than the Consumer Price Index (CPI).

**"Health problems are much easier to deal with, and less costly, if you catch them early. So one goal of the primary care reform movement is to move more care 'upstream'."**

In general, Canadian governments do not use economies of scale to push for better deals in supplying drugs, even when they are on public formularies and known to be dispensed in huge and rising quantities every year. Everyone essentially pays the retail cost for every pill, even when hundreds of millions of pills are dispensed annually.

Some hospital groups and large pharmaceutical retail chains have figured out the benefits of bulk-purchasing, and both Saskatchewan and Ontario have attempted price-volume contracts with pharmaceutical suppliers, with varying degrees of success; but this remains a limited option. In contrast, in the United States, although unit prices are higher, large insurers such as the Veterans Administration are more likely to strike price-volume deals.

## Returns on public investments

All budgets may be limited, but there are still choices to be made about what to spend on. If improving health is the goal, what should we be buying? Demographics are an important factor in how much we spend on health care and where that spending is focused.

With fertility rates having peaked about 60 years ago, and low birth-rates today, Canada's population is aging. As a result, the country's health needs are now less centred on infant and maternal mortality and control of infectious diseases than they were a hundred or even 50 years ago. Thanks to generations of investment in public health and growing prosperity, most Canadians now enjoy longer life-spans, and general population health has improved. These trends have shifted what we do in the name of health care, influencing both what is publicly insured and the associated costs.

Demographic realities have led to an increased interest in how to extend coverage of pharmaceuticals and long-term care or home care. And an increasing proportion of health spending goes to care for diseases that are not limited to but are largely associated with the elderly. Cancer care, cardiac care, vision care, and joint replacements are among the health services most in demand. An aging population is looking to improve and extend not just life expectancy but also its quality of life, which leads in turn to an intensified interest in health promotion and the reduction of preventable illness.

The allocation of public resources, which are always too scarce to meet all needs, is a task fraught with difficulties. Increasingly, technological approaches to care mean that the bulk of public spending on an individual's health care is now consumed in that person's last six weeks of life. These heroic measures come at a high price. Sometimes simpler, less costly, and earlier interventions have a more beneficial impact on population health. Unfortunately, there is no simple formula to calculate the best return on public investments. The decisions are guided partly by evidence, partly by politics.

For example, some Aboriginal communities have brand-new health facilities, equipment and computers, but no one to operate the technology, and no physicians. Meanwhile, many of these communities lack proper sanitation systems for water and waste, which, if in place, would have a greater impact on health than all the technology combined. A number of reserves, struggling with rates of alcoholism, have become "dry" communities, and people coming into the community are checked for alcohol. That kind of policing can make a great difference to community well-being and health, even more than the availability of new equipment and surgery. So can a community dedicated to reducing violence against women.

Even when cost-benefit evidence is compelling, it doesn't always turn the tide. Politicians are more likely to have to field complaints about access to tertiary care (specialists, or surgeries, for instance). Even if the greatest impact of public spending comes from investments made in health promotion rather than health care—such as campaigns targeted to reducing smoking, or improving the practice of safe sex—that is not what individuals say they want from the public system. They want better, faster care for what ails them now.

Chronic health problems—illnesses such as diabetes, asthma, cardiac disease, and other long-term conditions—are increasingly likely to be what ails Canadians, and treating

*(Continued on Page 15)*

# Cost of health problems are lower the earlier they're caught

*(Continued from Page 14)*

them is becoming more and more costly. Because drugs can now prevent, manage, and treat disease, their use is expanding rapidly. What has *not* changed are the lessons to be learned from history: that there are irreplaceable gains from public health interventions that provide better sanitation, offer health promotion, and work to prevent communicable diseases.

Canada's spending within the health-care "envelope" has gradually aligned with some of these realities.

## Reallocating health spending

The allocation of resources faces two key challenges:

- balancing investment in the treatment of disease with initiatives to address the determinants of health; and
- balancing investments in primary care, acute care, and tertiary services.

Today, doctors and hospitals account for less than two-thirds (62%) of public spending, a steady decline since 1975, when doctors and hospitals accounted for over three-quarters (77%) of public spending on health. Drugs now take up 9% of public spending, up from 1.8% in 1975. Home care, medical transportation, and health research are also growing areas of expenditure, especially more recently: between 1975 and 2005 they grew from 1% to 5% of all public spending.

Canada's approach to public health is another key to overall health spending. Public health interventions — such as food safety inspections, health promotion, prevention of communicable disease, and community mental health — accounted for about 3.5% of all public spending on health from 1975 to the early 1990s. After 2000, spending on this aspect of health care expanded rapidly. It now accounts for about 6% of provincial and territorial expenditures, though again with great variation among the provinces. (On average, OECD nations spend about 3% of their health-care budgets on public health interventions.) The federal government itself introduced major new investments in public health measures in 2004, including a national immunization program to combat five communicable diseases of childhood and a new Public Health Agency of Canada.

Getting a bigger bang for the buck is a concern among policy-makers who need to balance health care against other needs within public spending, and primary care reforms have an important cost dimension

Health problems are much easier to deal with, and less costly, if you catch them early. So one goal of the primary care reform movement is to move more care "upstream." From a strictly budgetary point of view, it is cheaper to pasteurize milk than it is to bury hundreds of people who have died from typhoid. It is cheaper to prevent sexually transmitted infections through safe-sex education and condom distribution than to treat people with anti-retroviral drugs.

It is also cheaper to keep people out of hospitals, if at all possible. In Ontario, the average cost per in-patient hospital day was $1,471 in 2002. Across Canada, the default care system is the emergency department of a hospital — the only place where health care is guaranteed to be available 24 hours a day, seven days a week. But this is an extremely expensive option. More than half of the users of emergency rooms in Canada (57%) are non-urgent cases. Seeing a family doctor for a sore ear, eye, or throat can cost the health system $30. Going to emergency at midnight for the exact same care can cost 10 times that much: $300. Canadians are increasingly using emergency departments because they don't have access to a family doctor or a nurse to provide more simple forms of care in a timely fashion.

## Striving for equity

Even as we are trying to expand and improve our system to make care more equal across the country, we are also facing questions about how to limit the care we pay for out of the public purse. The system has also grown more expensive as medical science has advanced. We share a border with the United States, the world leader in research and development of health products and services. This means that cutting-edge technologies are available to Canadians who can afford them, just a short drive or air-flight away. This exerts constant pressure on our system to expand coverage to include highly advanced and often experimental treatments.

It is a fact of life that science advances faster than the public purse. It's also a fact that more money spent doesn't always mean better health outcomes, or even better access to care, at least as far as societies are concerned. We are struggling in Canada to strike a balance between those things.

Today there is rising insistence that the move towards an increasingly privatized approach to health care is inevitable. This argument has been rejected for more than a decade by the Canadian people. What comes through repeatedly are Canadians' values: the simple recognition that, no matter your income, gender, background, or any other factor, serious illness can afflict us all, and the belief that none of us deserves care more — or less — than anyone else.

Apart from this steadfast sense of a right to equal treatment, Canadians' history and experience have revealed important lessons about the interface between the health of individuals and the health of societies. We have learned that striving for equity sometimes means making sure everyone gets access to the same thing; and sometimes it means that interventions need to be targeted to at-risk and vulnerable populations.

Universal treatment and the reduction of disparities are complementary goals. Both are critical to achieving improvements in health — for individuals and for whole populations.

There is simply no better recipe for a healthy life than living in a healthy society.

---

*(Armine Yalnizyan is a CCPA researcher. This article was adapted from* ***Getting Better Health Care,*** *a report she recently produced for CIDA.)*

TOP 10 REASONS TO REJECT TWO-TIER MEDICINE:

# Health care and wealth care can't viably co-exist under Medicare

*By Colleen M. Flood, Terrence Sullivan, Noralou Roos, Steven Lewis and Tom Noseworthy*

The Alberta government is proposing to allow doctors to work in both the public and the private system. It is planning to create a two-tier system where people can pay doctors more to receive quicker treatment and can buy private insurance to cover these services.

Premier Ralph Klein is doing this, he says, because the Supreme Court's Chaoulli decision has opened up the possibilities for more private funding of the system.

Here are the Top Ten Reasons, based on the best research evidence, why Canadians should resist a two-tier system:

**10.** The Supreme Court decision in Chaoulli only looked at the Quebec law preventing the purchase of private health insurance. It did not strike down the law stopping doctors working in both the public and the private sectors, nor did it speak to any law in any other province. Many countries (e.g., Sweden) and nearly all provinces protect the public system by way of laws preventing doctors being paid both publicly and privately for essential services. The majority judgment in Chaoulli said that the law preventing doctors working in both the public and the private sectors is important to ensure the viability of the public system. Thus the Alberta government is wrong to say that the Chaoulli decision either requires or enables them to allow doctors to work both public and private.

**9.** More private funding will not improve the sustainability of our system. Countries in which private spending is high spend more in total on health care, not less. The U.S. already spends more public dollars per person than Canada does, but leaves 48 million Americans uninsured. They don't get much more for all this extra spending, but they do pay higher prices for what they get.

**8.** We have a shortage of doctors and nurses. Most developed countries do. Wealthier provinces are luring doctors from poorer provinces. This problem will be exacerbated if doctors are allowed to top up their public sector incomes by doing less difficult work for higher rates of private pay. If you were a doctor, wouldn't you? Doctors will spend more and more time in the private system. In New Zealand, where doctors are allowed to do this, specialists spend less than 49% of their time in public hospitals; the rest of the time they are working in their private clinics.

**7.** Countries that allow doctors to work in both the public and the private sectors at the same time have long wait lists, e.g., United Kingdom, New Zealand, Ireland, Spain. Why copy them? European countries like the Netherlands and Germany are different, as they require the wealthy to fully insure themselves by buying private insurance and, even so, there is a lot of regulation preventing inequities. For example, in the Netherlands there is a law that doctors are paid the same fee by private insurers as they are by public insurers—so they have no incentive to give better treatment to private patients.

**6.** In countries that have two-tier systems, only a relatively small percentage of the population holds private health insurance (for example, 11.4% of U.K. citizens); typically the wealthiest buy insurance. In other words, the vast majority of Canadians would not benefit from being able to buy private health insurance since either they will not qualify for it, or they won't be able to afford the premiums.

**5.** From the perspective of a private insurance company, if you are on a waiting list, you do not have an insurable risk. You don't have a risk of disease or illness, you *have* the disease or illness—current needs that must be met. If you can't pay cash, the public system is your only option. People currently on wait lists will not be helped by privatization unless they can pay cash.

**4.** Don't buy the baloney that Canadian Medicare is in league with communist states like Cuba and North Korea. We are third in the world in terms of the contribution of private health insurance to the funding of our system. Physicians are not employed by the state and hospitals are not owned by the state. We already have more private financing and private delivery than many other developed countries. The real question is whether privatizing insurance for essential hospital and physician services will make our system better or worse.

**3.** NAFTA requires that we must compensate U.S.-based private insurers for denying them access to Canadian "markets" if we subsequently change our mind about the benefits of two-tier insurance.

**2.** Governments and health-care providers can fix wait lists. Together they have been able to achieve extraordinary improvements: for example, in cardiac care treatments in Ontario and with respect to hip and knee services in Alberta. There is now little or no waiting for diagnosis and treatment; most of these gains have been achieved as a result of better coordination of existing resources and talent. We can and will do it in other areas. We don't need a "third way."

**1.** And the top reason why we shouldn't allow private health insurance for essential services? Access to essential care should be based on need, not on ability to pay. If resources are constricted, we should revisit what is essential but not allow a two-tier system for what are essential core services.

---

*(Colleen M. Flood is Canada Research Chair in Health Law and Policy at the University of Toronto. Terrence Sullivan is President of Cancer Care Ontario. Steven Lewis is President of Access Consulting Limited, Saskatoon. Noralou Roos is Canada Research Chair in Population Health Research at the University of Manitoba. Dr. Tom Noseworthy is Director of the Centre for Health and Policy Studies in Calgary.)*

OUR INADEQUATE NURSING HOME CARE:

# Canada's frail and elderly most vulnerable, most neglected

*By James Clancy*

There is a gaping hole in Canada's health care system. For tens of thousands of Canada's seniors today — and for many thousands more in the years ahead — the universality of our health care system ends at the doors of nursing homes.

Some of these facilities are excellent, but, sadly, they seem to be the exception. As a result of government cutbacks and corporate profit-taking, the needs of many seniors have been swept under the carpet, abandoned and ignored by health care commissions, politicians, and policy-makers alike. For far too many Canadian seniors, nursing home care is inaccessible or unaffordable. In some provinces, wait lists for nursing home beds are excruciatingly long — up to two years. Most beds become available only when residents die.

In addition to lengthening wait lists, affordable options have also been disappearing for many seniors. Private nursing home care can cost between $40,000 and $70,000 a year, depending on the community. This is clearly not a viable option for most seniors.

In the patchwork system that has evolved, it is apparent that public and non-profit nursing home care provides the most affordable solution. But even this option is becoming unaffordable for many seniors as these facilities struggle to fill the funding gap left by government funding cuts.

Cutbacks have also forced seniors and their families to pay a high price in unacceptable staff-resident ratios, diminishing quality and quantity of care, crumbling infrastructure, outdated equipment, poor dietary practices, and inadequate recreation.

As well, the ugly spectre of for-profit health care has cast a dark shadow across much of Canada's health care system in recent years. Nowhere is this shadow darker than in nursing home care, where seniors have already borne the brunt of the short-cuts that corporate profit-taking generates.

It is no coincidence that the decline in the quality of nursing home care in Canada is happening with the rise of privatization and for-profit care. The profit-taking nursing home industry, having established a dismal track record of lower standards in the U.S., is now exporting these same shortcomings to Canada.

The negative impact of diminished funding, corporate greed, lower standards, and weak regulation is also felt by the thousands of women and men who work in Canada's nursing home sector. They work heroically to fill the administrative and funding gaps they face, and to create a caring environment of respect and dignity. But they are undervalued, underpaid, and overstressed. They are injured at work more often than any other occupational sector. In far too many cases, the industry amasses lucrative returns for investors by denying fair wages for the back-breaking work performed by front-line workers.

**"The profit-taking nursing home industry, having set a dismal track record of lower standards in the U.S., is now exporting these same shortcomings to Canada."**

The annual turnover rate among direct care nursing home staff typically runs at 20% for nurses and 40% for health care aides. High turnover rates have a devastating effect on the working environment, staff morale, and quality of care. Nursing home workers know better than anyone the gap between the care they want to give and the care they are able to provide. Low funding levels, staff shortages, poor working conditions, pay inequity, and profit-taking have created a human resources crisis in the sector.

Governments are not only failing seniors today, but they are also woefully unprepared to meet the challenges of tomorrow — despite the demographic crisis now looming.

Three important trends are occurring:

- Canada has had a relatively low birth rate for the past 30 years, a trend that shows no sign of changing.
- The baby boom generation is nearing retirement age and the first shock will be felt around 2010. Five years from now, one Canadian resident will turn 65 every two minutes. Within 15 years, the rate will be one a minute.
- Canadians are living longer. Today, there are some 430,000 Canadians over 85 years old, twice as many as in 1981 and 20 times the number in 1921.

With this profound demographic shock just around the corner, and the increasingly unique and complex health care services required by seniors, the need for a cogent, national nursing home strategy is becoming even more pressing.

Canada's universal public health care system was designed to ensure that the health care needs of the most vulnerable would never be sacrificed for the benefit of the wealthy and powerful. Yet in nursing home care, that is exactly what is happening. Our most vulnerable citizens are suffering while governments tolerate, even foster, an inadequate system that favours the wealthy while allowing profits to be drained away by giant corporations.

It is time for bold and fundamental change. Canada has the resources to provide better nursing home care for the elderly, and Canadians want to see it happen. Creating a high-quality nursing home care system requires stable, sufficient public funding. It requires more staff. It requires legislated optimal standards of care. It requires more public scrutiny and better enforcement of standards. It requires adding nursing home care to the *Canada Health Act.*

Most of all, it requires political leadership. No longer can governments be allowed to ignore the inaccessibility, unaffordability, inferior care levels, and the deepening human resources crisis in our nursing-home sector. The care of our frail elderly, now so shamefully neglected, must becomes a top priority.

---

*(James Clancy is National President of the 340,000-member National Union of Public and General Employees www.nupge.ca)*

THE BOTTOM LINE:

# 7 myths about alleged benefits of private health insurance (They're easily refuted)

*By Diana Gibson and Colleen Fuller*

Canadians enjoy a health care system that yields some of the best outcomes in the world: we live longer and fewer infants die at birth than in most other industrialized countries. We have a health system that delivers emergency care immediately to those in need. Surveys show that Canadians who use our health care services rate the system highly.

That doesn't mean our health care system has no problems. It does. We have seen a rapid increase in the demand for certain procedures like hip and knee replacements and cataract surgery, a growth that may be linked to improvements in technology as well as supplier-induced demand. The system stumbled — waiting times for these procedures were way too high — but it didn't collapse. So let's not throw the baby out with the bathwater.

New initiatives have shown that waits can and are being brought down quickly within the public system through changes in how treatments and waiting times are managed. Introducing private insurance will only exacerbate the problems. The evidence is clear — and even confirmed by Fraser Institute economist Herb Emery — that private insurance will not reduce costs to the public system, but it *will* reduce access for the vast majority of Canadians.

The only thing private insurance would achieve is to ensure access for the wealthy few who can afford high-premium gold or platinum coverage. It is not about choice; it is about privilege and creating a society based on class differences.

Canadians should continue to reject any expansion of the role of private insurance in our health care system. The stakes are especially high because we will have a hard time changing our minds and re-imposing the ban on private insurance for services covered by the public system, if we were to make the mistake of lifting it.

Once we open that door to private insurance corporations, NAFTA would compel us to compensate U.S.-based private insurers for denying them access. The costs would be prohibitively steep.

## Myths and Realities

**1. Private insurance is a "new" model for health care.**

There is nothing new about it. Canada experimented with private health insurance before Medicare and it got a dismal failing grade. Significant numbers of Canadians couldn't afford coverage and it was costly for those who could. Little wonder, then, that public demand and support for a national public health care plan was as high as 80% as far back as the 1940s. There were four unsuccessful legislative attempts between 1935 and 1953 to introduce a public system, but the private insurers, the Canadian Medical Association, the Canadian Chambers of Commerce, and other right-wing interest groups wielded enough political influence to block them.

However, on April 10, 1957, the Hospital Insurance and Diagnostic Services Act finally passed unanimously in the House of Commons. This was followed by the introduction of the first public health care program in Saskatchewan in 1962, and its expansion to a national system — the Medical Care Insurance Act — six years later.

Undeterred, the private insurance industry and its political, corporate, and media supporters have continued their efforts to undermine public confidence in Medicare and convince Canadians of the "need" for more private insurers and care providers.

But nothing has really changed that would warrant reversing the decision Canadians made to reject private insurance in favour of a universal, publicly-funded system.

**2. Private insurance will increase access and choice for individuals.**

Private insurance will provide *less* access to health care for the majority, while only a privileged few will have better access. In countries that have two-tier systems, only a relatively small percentage of the population holds private health insurance (for example, 11.4% of UK citizens) and it is mostly the wealthy who do. Here in Canada, supplementary health insurance for those services not covered by the public system provides a good window into how private insurance would function on an expanded scale. Almost half of Canadians do not have supplementary health coverage today.

Aside from the obvious lack of health care for those who can't afford the premiums, access will be limited because many will not qualify. They will be denied coverage because of pre-existing conditions, or they will face higher premiums due to their medical history. Others will find their access limited even if they do have coverage because of high out-of-pocket costs — deductibles, co-payments, maximum lifetime payouts, and other hidden costs.

According to Colleen Flood, "Mr. Zeliotis, the patient at the heart of the Supreme Court's *Chaoulli* decision, exposes the fallacy in the idea that private health insurance will fix our waiting list problems. Mr. Zeliotis, 65 years old and with pre-existing heart and hip conditions, simply would not qualify for private health insurance, at least for those conditions."

**3. Private insurance will be cheaper for individuals.**

Private insurance is a direct downloading of costs onto employers, workers, and individuals. Premium costs are already growing out of control, rising by an incredible 20% a year in the 1990s. Employers will be hit with even higher health care costs while fewer and fewer employees will have access to benefits.

Bankruptcies due to health care costs, already a leading cause of bankruptcies in the U.S., will rise sharply in Canada, too. Individuals, already bearing the burden of increased out-of-pocket costs due to de-listing and de-insuring services from the public system, will face even higher costs as insurance companies download costs through deductibles, co-payments, and maximums.

It's significant that, while many Canadians view de-insuring

*(Continued on Page 19)*

# Medicare fine, but needs adequate funding, good management

(Continued from Page 18)

of this sort as a threat to the universality of Medicare, the insurance industry describes it as a "boon." The Canadian Life and Health Insurance Association gleefully welcomes "the potential for millions of dollars of new business."

**4. Expanding private insurance is part of a "Third Way"—a European model, not an American one.**
The reality is that Canada is heading toward a U.S.-style health care system, not a European one. Canada is already tied for third in the world in terms of the share of private health insurance in the funding of our system. Increasing the role of private for-profit health corporations will only move us closer to the American system—one that fails on all counts of access, affordability, and quality of care.

Instead of arguing semantics over some mythical "third way," governments and the public should simply be asking whether privatizing insurance for essential hospital and physician services will make our system better or worse.

We can learn from the countries that already have two-tier systems, such as Britain, New Zealand, and Ireland. They all have very long public waiting lists, with only the wealthy who can afford private coverage getting prompt treatment.

**5. The public system is unsustainable and costs are out of control.**
Canada's public system is strongly sustainable. The crisis of costs has been inflated by the misuse of statistics. The public is being deliberately and cynically misled.

The fact is that the amount we spend on hospital and physician services (i.e., Medicare) has remained stable since about 1970 at between 4% and 4.5% of GDP.

Overall health care costs have risen substantially, yes, but the main drivers are excessive expenditures on prescription drugs and private care, which are not covered by Medicare and not controlled by our governments.

**6. Private insurance will save the public system money.**
It is private for-profit care that is not sustainable. The areas where costs are growing fastest in health care are in fact precisely those with the most private involvement: pharmaceuticals and private health care premiums. That is where costs are growing in the double digits—at more than twice the rate of inflation.

The amount of our national income spent on drugs, most of which are neither insured nor regulated by governments, has doubled since 1980. If there is a real concern with costs, it is to those areas where private firms are most active that our governments should be turning their attention. Allowing more privatization would greatly increase the costs of health care, not reduce them.

**7. Public funding and universality are causing long wait times, so expanding private insurance will reduce waits.**
Allowing private insurers to compete with the public system will *increase* wait times for treatment, not lower them.

We already have fewer doctors and nurses than we need—a shortage that contributes to long waits for some services. Letting the private system draw already limited human resources out of the public system, and letting doctors bill on both sides of the fence, will only make this situation worse.

Again, we can learn from the countries that have made the mistake of setting up two-tier systems, where waiting lists are longer than they are in Canada.

Long waits are indeed a serious problem, but solutions can be found and implemented within the public system—as they already have been in some provinces. Examples are cited in several recent studies, including the one conducted earlier this year by Dr. Michael Rachlis for the CCPA.

❊ ❊ ❊

## How to improve Medicare

The public health care system continues to receive the support of a large majority of Canadians. We have mentioned improvements that have already been made in wait times within the public system. We have shown that, to address the issue of sustainability, measures need to be introduced to control the escalating costs of pharmaceuticals and privatized services.

Several excellent studies and reports over the past few years have rejected further privatization in favour of improving and strengthening the public system. These include the National Forum on Health Care and the Romanow Commission, as well as numerous publications of the CCPA.

What is needed is an agenda for reform that enhances and reinforces the public system—addressing wait times and soaring costs within the single-payer model. Such reforms would require the federal government to play a stronger role.

In the spirit of our conclusions on private insurance, we have developed seven recommendations for improving the public system. Though by no means comprehensive, these actions would fortify the core of the public system and put the architecture in place for solving health care problems within a universal, portable, comprehensive, publicly-administered system.

**1. Strengthen the Canada Health Act,** including provisions that physicians who bill for medically necessary services in the private sector must opt out entirely from Medicare. Enforce the Act.

**2. Expand the Canada Health Act** to include home care and long-term care as medically necessary services.

**3. Introduce a national Pharmacare program.** Such a program is needed to provide equity and to better manage access to drug therapies. Bulk purchasing by governments and price controls will reduce costs and promote generic substitutions of brand-name products. The 20-year drug patents should also be reduced.

**4. Restore and strengthen the public system.** Adequately fund multi-disciplinary primary health care within the public system. Reverse the de-listing and de-insuring which has reduced universal access to important care (e.g., vision care, physiotherapy, etc). Stop any further licensing of for-profit, investor-owned surgical and primary care clinics.

(Continued on Page 20)

## Here are seven proposals for improving, fortifying public health system

*(Continued from Page 19)*

**5. Reduce wait times through better management of the public system,** including human and financial resources. Make improvements from evidence-based best practices.

**6. Fund the public system adequately through a progressive tax system and corporate taxes.** Eliminate health care premiums. Canadian business firms gain a huge competitive edge from Medicare; they should pay a fair share of its costs.

**7. Keep Medicare a national Canadian program.** Restore the 50-50 federal-provincial funding for health care. Restore and strengthen provincial reporting and accountability for the funds transferred.

❊ ❊ ❊

These are just a few ideas that can be debated and discussed. We hope they spark a broader national debate on the issue of private health insurance. We hope to have offered a straightforward explanation of what is often depicted as an overly complex system. It is not.

We understand that people would be willing—if they could afford it—to pay for a family member who is in pain to get faster service. But we believe that faster service can and should be provided within a publicly-funded, publicly-delivered system that is better managed and adequately resourced. That—and not queue jumping for the privileged—is what should be sought.

Health care costs money, whether we pay for it collectively or individually. The issue is simply one of asking if we would rather pay together through a progressive tax system for universal health care, or whether we prefer to pay a higher individual out-of-pocket price for a class-based ad-hoc system driven by the pursuit of profit.

We hope our report helps readers make that choice more easily.

---

*(Diana Gibson is the Research Director for the Parkland Institute. Colleen Fuller is president and co-founder of PharmaWatch, an independent consumer advocacy group for safe medicine, and a CCPA Research Associate. This article has been adapted from their recent co-authored NeWest Press/ Parkland Institute book* ***The Bottom Line: The Truth Behind Private Health Insurance in Canada.*** *Reprinted by permission of NeWest Publishers. To order copies of the book at $9.95 each go to www.ualberta.ca/parkland or www.newestpress.com)*

BEHIND THE CBC'S ATTACK ON MEDICARE:

## Biased film promotes two-tier care

*By Donald Gutstein*

Welcome to the CBC, the Corporate Broadcasting Company, disseminators of the propaganda video *Medicare Schmedicare.* This distorted and biased attack on our public health care system aired twice on the CBC, the second time in January in the middle of the federal election.

The thesis of the program was that one-tier Medicare is a myth. Well, everyone knows that Medicare doesn't cover everything and that the wealthy can pay for their own treatment. So the point of the video must have been to demean and disparage publicly-funded medicine.

The villain in the documentary by long-time filmmaker Robert Duncan was Tommy Douglas. Duncan claims "we've been swallowing the Medicare myth, saluting an emperor who has no clothes (over a picture of Tommy Douglas)...Big surprise, Tommy, a parallel private system already exists."

The attack on Douglas was ironic because, just before this program was broadcast, the CBC postponed for two months a mini-series on Tommy's life originally scheduled to air a week before the election.

The combination of these two decisions provoked a storm of protest. Complainants had a right to be annoyed. The video was financed largely by Canadian taxpayers through the Canadian Television Fund ($135,000), Knowledge Network (unknown amount), and the Canadian Film or Video Production Tax Credit and Film Incentive B.C. (substantial federal and provincial tax credits). The people who want and benefit from Medicare unwittingly financed this attack on it.

Eva Czigler, acting head of CBC network programming, wrote a boiler-plate response to the complaints. The Douglas program was pushed back until March, she claimed, because of the "appearance of partisanship" if it was aired during the election campaign. The Douglas program, she argued, emphasized Tommy Douglas's "profound commitment to socialism" and would surely be lambasted by the right.

But *Medicare, Schmedicare,* a film advocating a full-blown, two-tier system of health care, which is promoted by only one party, Stephen Harper's Conservatives—even though they pretended to support Medicare during the election—was considered by the CBC to be non-partisan!

What's going on at the CBC's headquarters in Toronto?

It's a small, insulated world at the CBC. Eva Czigler bears ultimate responsibility for airing the anti-Medicare program. Czigler is married to former broadcast executive Peter Herrndorf, who is a member of the CBC board of directors, so she is accountable to him. Herrndorf used to chair the Canada Television and Cable Production Fund, which has funded other work by *Medicare Schmedicare* producer Duncan. And Duncan has worked on many CBC productions.

With such a strong crony system in place, Duncan likely had carte blanche to produce the video he wanted.

Czigler claims that "the views of those who advocate 'two-tier' medicine are not the only views heard...throughout, the documentary returns to a staunch critic of the 'for-fee' system."

That would be Mike McBane of the Canadian Health Coalition. Duncan pulled every trick in the book to make McBane look bad. Duncan allows five private medicine practitioners, filmed in their professional contexts, to speak and set the frame for the documentary before he turns to McBane. Looking down on McBane is a large picture

*(Continued on Page 21)*

# CBC allows filmmaker to shamelessly promote privatization

*(Continued from Page 20)*

of Tommy Douglas, the guy Duncan had just slagged as the emperor with no clothes.

McBane was confined to a seat in a cramped office, with bad lighting and a solitary camera angle for the entire production, looking stilted in his owl glasses and crumpled shirt. In contrast, his 13 adversaries were out in the real world walking around, talking, joking, looking professional and in charge, and viewed from many camera angles.

Duncan used other tried-and-true propaganda tricks to disparage Medicare. The Institute for Propaganda Analysis can help us here. It was created in 1937 to educate Americans about the widespread nature of political propaganda. It is known for identifying basic devices, words and phrases that indicate a deceptive purpose to communication. *Medicare Schmedicare* is evidence the IPA's work is relevant today.

**Glitter words:** Glittering generalities are virtue words, like democracy or civilization, about which we have deep-set ideas. The IPA calls them "glitter words" because they mean different things to different people. Duncan's best glitter word is "choice." One private clinic operator says that "choice is a good thing, having choice in the delivery of health care." But if the choice is $25,000 for a new hip in a Bellingham, Washington hospital, how relevant is that word to most of us? Choice does not serve our best interests, but expensive privatized medicine is sold to us by giving it a name we usually like.

Another glitter word is "revolution." Duncan uses this word at the beginning and end of the documentary. "Brian Day is a leader in the middle-class revolution tired of the contradictions built into the system," Duncan says.

According to the Fontana Dictionary of Modern Thought, a revolution is sudden radical change in ruling classes and social institutions. But private medicine is what we *used* to have. The correct word is reaction: a move to turn back the clock and return to an earlier order of society when the wealthy and privileged possessed the rights and entitlements they believe society owes them, such as the right to obtain their own medical treatment. Day—also known as Dr. Profit—is leading the reaction against public health care and blocking progress towards a more just, equal, and enlightened society.

**Euphemism:** The purpose of this propaganda device is to pacify an audience in order to make an unpleasant reality more palatable. One classic example is that, during Word War II, the U.S. changed the name of the War Department to the Department of Defense. Duncan's best euphemism is calling private medicine a "parallel system." This is a cunning phrase because, as we all remember from Grade 6 geometry, parallel lines never meet. The private system does not intersect with the public system and, consequently, will have no impact on it. The reality, of course, is that, if the private system is allowed to grow unchecked, the public system will be destroyed.

**"Dr. Jacques Chaoulli, usually portrayed as a concerned physician, is also a senior fellow at the libertarian Montreal Economic Institute, which, like the Fraser Institute, is on a mission to destroy Medicare."**

**The Bandwagon:** This technique is used to convince us that everyone else is doing it, and so should we. Says Duncan, "There are now too many medical options and too many people using them to still believe there's only a one-tier system in Canadian health care." But, as the IPA points out, there's never quite as much of a rush to climb on the bandwagon as the propagandist tries to make us think there is. Duncan's video accounts for the health treatment of perhaps 30,000 Canadians, or 0.1% of the population. Some bandwagon!

❊ ❊ ❊

Why does the private system continue to expand when, in most cases, it contravenes the Canada Health Act? Duncan's glib answer is that Health Canada and provincial health authorities appear to be suffering from "temporary blindness or permanent amnesia."

For people familiar with the exercise of power, this answer is unsatisfactory. Duncan could have explained that the reason private clinics have been allowed to survive and expand is not because of government blindness or amnesia, but because of the industry's vaunted economic and political clout. The chief lobbyist for the Canadian Medical Association, for instance, worked for Health Canada for more than a decade before joining the doctors' organization.

It's not blindness and amnesia at work, but greed and undue influence.

Instead of the rhetoric, Duncan could have added to our understanding of the forces behind the "parallel" system. He could have explained that private medicine's hero, Dr. Jacques Chaoulli, usually portrayed as a concerned physician, is also a senior fellow at the libertarian Montreal Economic Institute. Like the Fraser Institute, the MEI is on a mission to destroy Medicare. Among MEI's prominent backers is the Desmarais family (net worth $3.94 billion), which owns Power Corporation. Helene Desmarais, wife of Paul Desmarais, Jr., is on the MEI board. Power Corp. owns three major Canadian life insurance companies, including Great West Life, the largest provider of supplementary health insurance in Canada and probably the single biggest beneficiary of the Supreme Court decision.

Now that deputy Conservative leader Peter Mackay is dating Sophie Desmarais (they met at Mila and Brian Mulroney's house), where does that put the Conservative Party?

And where does that put Canadian health care now that the Conservatives are running the federal government?

---

*(Donald Gutstein, a senior lecturer in the School of Communication at Simon Fraser University, writes a regular media column for The Tyee, where this commentary was first published.)*

WHILE COMPANIES BENEFIT FROM CANADA'S PUBLIC HEALTH CARE—

# U.S. firms hurt by high costs of privatized health care

*By Paul Webster*

Fifty years ago, Charlie Wilson, president of General Motors, told a panel of U.S. Senators that he had always thought "what was good for the country was good for General Motors, and vice versa." Wilson, who was asked by President Eisenhower to serve as Defense Secretary in 1953, is little remembered. But his words—redacted by newsmen as "what's good for General Motors is good for America"—have become a kind of unofficial constitutional amendment.

GM employs 325,000 worldwide and has been the world's largest carmaker for 70 years. Not surprisingly, GM presidents have long been accorded semioracular status. So, when GM's current president, Rick Wagoner, blamed the company's near-bankrupt status on the U.S. health-care system, people took note.

Speaking at an industry conference in Detroit during the run-up to last year's presidential election, Wagoner complained that the U.S. spends 15% of its total economic output on health care—far more than in any other wealthy nation, and 50% more than in Canada, America's closest economic competitor. GM, which is the largest private provider of health care in the U.S., will spend US$5·6 billion this year to provide health insurance coverage for about 75,0000 workers and retirees, as well as their spouses and family members. Ford Motors spent $3.2 billion on health care in 2003 for 56,000 U.S. employees, retirees, and their dependants.

**"GM will spend $5.6 billion this year to provide health insurance coverage for its American workers, retirees, spouses, and family members, and the health-care bill for Ford Motors in the U.S. in 2003 was $3.2 billion."**

In labour negotiations last year, executives at GM and Ford targeted their massive health-care liabilities (estimated at $20,000 per employee) by forcing union negotiators to reduce employees' and pensioners' access to ever-more costly U.S. health services.

"The worst part of all this is that these very high costs don't necessarily buy the best health care," Wagoner complained before noting the U.S. ranks 12th out of 13 industrialized nations in the 16 top indicators of health. "If our cars performed at the same quality levels as our medical system, nobody would buy our cars."

Unfortunately for Wagoner, fewer Americans are in fact buying GM cars and trucks. The company which once controlled 46% of the U.S. market in 1979 now has a 25% share. And, thanks in significant part to U.S. health-care costs, fewer and fewer of the 9·08 million vehicles GM annually produces worldwide are made in the U.S. A 1965 agreement guaranteeing free trade in automobiles and car parts across the Canada-U.S. border has strongly encouraged American car-makers to shift production to Canada, where the publicly-financed health care system allows automakers to shave a whopping $1,380 off each car's manufacturing cost.

"There's no doubt our public health-care system has been vital in attracting a lot more new investment into Canadian automobile production than in the U.S.," says Jim Stanford, chief economist for the 238,000-strong Canadian Autoworkers' Union. Stanford says executives with Ford, GM, Toyota, Daimler Chrysler, and International Trucks all cited Canada's public-health system while announcing $5·5-billion in new plant construction this year.

The calculation behind their logic is simple enough: in the U.S., automakers pay about $1,500 in insurance premiums to private health insurance companies for every vehicle they build. Canadian health-care costs—largely in the form of corporate taxes—amount to about US$120 a unit, according to Stanford, who notes that Canada now produces almost 1.5 million vehicles for export to the U.S. annually, about the same number as is produced for Canada's domestic market. Although many might argue the automobile industry produces products harmful to public health, health care has undeniably been good to the Canadian automobile industry.

With billions in new investment flowing north of the border in search of taxpayer-financed health care, big businesses beyond the auto sector increasingly view Canada's taxpayer-funded system as a major competitive advantage.

Richard Nesbitt, president of the Toronto Stock Exchange, which ranks as the world's seventh largest capital pool, took that message to Wall Street last year. In a speech to the Harvard Club, a venerable Manhattan investment forum, Nesbitt strongly urged U.S. investors to pump their money into an economy where health care serves, rather than shackles, manufacturers. The logic behind that message is easy, says Nesbitt's speechwriter David Ablett: "Americans are headed to spend almost $2 trillion, or 16% of their gross domestic product, on health care this year. These costs are a huge burden on companies, on the federal and state governments, on retirees, on the whole economy. It's just not clear what the advantages are in maintaining a system where about 20% of costs represent profits for private managers."

Ablett's passion for public health is somewhat surprising. The company he works for, Toronto Stock Exchange Group, is the private corporation that manages Toronto's stock market. It makes sizeable profits from the fees paid by businesses listed on the exchange, and the commissions paid on every stock transaction. There's been a steady increase in the number of private medical companies listing on the Toronto exchange in recent years, and stock exchange officials might be expected to see private health care as a lucrative new area for expansion. But Ablett says stock exchange officials strongly support public health care.

The over-arching reason for this, he says, is simple: "It's in the Exchange's best interest to have it clearly understood that there are advantages to investing in Canada—and public health is one of the strongest economic advantages we have over the U.S."

*(Continued on Page 23)*

# Canada's Medicare saves automakers $1,380 on every car

*(Continued from Page 22)*

The policy appears to be well-grounded. Shares in the Toronto Stock Exchange Group have risen rapidly this year. The exchange as a whole has also delivered stellar performance, in keeping with Canada's overall economic performance despite corporate and personal income taxes slightly higher than in the U.S. The Canadian government has delivered eight annual budget surpluses in a row.

Although auto executives like GM's Rick Wagoner and Ford Motor Vice-Chairman Alan Gilmour denounce the heavy costs U.S. health insurers impose on employers, there is little consensus on how to reform the system among U.S. business leaders. Larry Denton, head of the largest U.S. auto parts makers' association and chief executive of parts-maker Dura Automotive, which employs 17,000, has called for a government-run "socialised" system similar to those in Canada and most other industrialized nations.

Americans have heard this before. More than a decade ago, Lee Iacocca, a former Chrysler Motors president, strongly supported President Bill Clinton's aborted effort to move the U.S. toward Canadian-style health care, an effort successfully opposed at the time by the health insurance and pharmaceutical industries.

Gerald Anderson, a health-care finance specialist at John Hopkins University in Baltimore, says the crisis in U.S. health-care costs stems directly from high prices for pharmaceuticals, physician care, and hospital care. "The solution is clear: we have to reduce prices to international standards. But the political will to force that to happen doesn't exist," says Anderson, who notes that U.S. business leaders and politicians have attempted in recent years mostly to reduce access to health care and service consumption rather than prices.

**"The Canadian Stock Exchange strongly supports public health care because it is one of the strongest economic advantages Canada has over the U.S., and it is very much in the interest of the Exchange to encourage investment in Canada."**

"Our system doesn't deliver a whole lot," Anderson quips, "but we charge an awful lot for it."

Bob Evans, a health care economist at the University of British Columbia, agrees that rising U.S. health-care costs are already far out of line with those of most other industrialized nations. It's an economic wound that is only going to deepen as baby-boomers begin retiring and more and more Americans require long-term care at an average annual cost of $70,000 to private patients, Evans thinks.

"GM isn't the only company permanently saddled with the cost of insuring these people," Evans argues, while noting that U.S. health insurers have begun strategically pushing the most expensive types of patients toward publicly-funded Medicare and Medicaid programs, which now account for almost half of U.S. health-care budgets.

Evans points to evidence that some U.S. employers, including Wal-Mart, the world's largest private employer with 1.4 million employees, may have begun systematically rejecting unhealthy employees and job applicants in order to trim their health-insurance costs.

"The U.S. health-care system represents a competitive disadvantage for all sorts of U.S. companies," Evans says, before warning that Canadian-style reforms are unlikely to gain popularity among U.S. executives and the Bush administration, which has introduced numerous reforms aimed at entrenching private insurers, despite data indicating "administrative waste" among private insurers consumes 17% of U.S. health-care spending.

"On the one hand, U.S. executives can see that public health care represents a competitive advantage for foreign companies," Evans says. "On the other hand, they fear higher taxes."

---

*(Paul Webster writes on health and medical issues for* ***The Lancet,*** *where this report was first published.)*

## Health Canada should be compelled to report violations of Health Act to Parliament

The Canada Health Act puts conditions on the transfer of federal funds to the provinces and territories for health care and obliges the federal government to ensure that these conditions are met before payments are made.

But Auditor-General Sheila Fraser has found that Health Canada does not have the information it needs to identify non-compliance.

"The Department is therefore unable to tell Parliament the extent to which health care delivery in each province and territory complies with the criteria and conditions of the Act," she declared.

"Parliamentarians are expected to make decisions on billions of dollars transferred to the provinces and territories for health care," said Fraser, "but they still don't have enough information to know the extent to which the Canada Health Act is being respected."

Following this report by the Auditor-General, the Canadian Health Coalition (CHC) demanded that the Minister of Health take immediate steps to plug this critical information gap.

"Health Canada has the duty to tell MPs how the criteria and conditions of the Act are being complied with," said CHC chair Kathleen Connors. "Canadian taxpayers also expect to know how and where their health care money is being spent. But if key information, such as data on for-profit delivery, is withheld—as it is in some provinces, including Alberta and Quebec—then federal transfers for health care should also be withheld until this vital information is provided."

Health Canada's annual report on the CHA consistently fails to identify, let alone assess, the privatization initiatives under way in some of the larger, wealthier provinces which threaten the integrity and viability of Medicare.

HUMAN RESOURCES:

# Health care system plagued by shortage of professionals

*By Armine Yalnizyan*

At the heart of any health-care system are the people who provide the care. Without enough doctors, nurses, and other health-care providers, even the most advanced system will fail. An investment in health-care reform — introducing an immunization program, for example, or expanding a clinic — will never be effective if there are not enough people on the ground to deliver the service.

These people on the ground are known in general as "health human resources." And all health systems struggle with four seemingly constant problems related to these valuable human resources:

- assessing how many *different* kinds of health workers the system needs;
- training and recruiting the right number of people;
- deploying the most effective mix of people; and
- making sure these people get, or have received, the best training possible.

## Supply and demand

When it comes to health care today, countries around the world face one thing in common: a shortage of health-care "professionals" — doctors, nurses, pharmacists, diagnostic technologists, and others — the people who have to receive years of expensive training in the field of medicine before they can do their jobs.

Too often there are simply not enough qualified people around to provide the necessary care in the appropriate location. The number of professionals available to do the work becomes a very real limiting factor on how much care can be provided.

Still, not all roads to improved health require long (often interminable) stops at a doctor's office or a hospital, or visits to a pharmacist or diagnostic technologist. A central goal of health systems is to get the right person to do the right job at the right time. The right person could be one of the many "non-professionals" who work in the field of health care: a community worker, for instance, or a health aide, or even a clerical worker trained to take on a routine administrative or educational aspect of care.

Having a "non-professional" in place can free up doctors or nurses to focus their time on the things that only they can do. In essence, this is what is called a multidisciplinary or team approach.

As obvious as that approach might seem, it frequently meets with resistance — from different groups of professionals, especially — and can lead to conflict between professionals and trained health workers over issues of scope of practice, decision-making authority, and legal responsibilities. These problems can make the shortage of help much worse than it needs to be.

## Demographic pressures

Canada, like many other Northern nations, is facing growing demographic pressures. The demand for health services is increasing with the aging of the baby boom, the unusually large cohort of people born immediately after World War II. This same age cohort also accounts for a disproportionately large segment of the people providing health services. Not enough young health professionals are available to replace the growing wave of retirements, let alone meet increased levels of demand.

Canada is also grappling with the problem of how to meet the health-care needs of its chronically underserviced rural and remote areas. Canada has an increasing concentration of people living in big cities. Although 30% of the population lives in rural, remote or northern locations, only 17% of family doctors practise there. Almost 30% of the people in the Northwest Territories have no access to a family doctor. Remote areas are where health needs and labour shortages tend to be most acute, and where necessity can become the mother of invention.

These kinds of pressures will undoubtedly force big changes in how people in Canada come into contact with health care. But an enduring lesson of recent decades is that, once you have adopted a particular focus, major change becomes difficult to achieve. Our focus for the past half-century has been on primary care: on treating an individual's complaints with medical care and cure delivered by doctors, often in hospitals and increasingly using drugs.

Repeated efforts have been made since the 1970s to shift the emphasis of spending in health-care budgets "upstream," moving it from doctors and acute care in hospitals to community-based care, programs of health promotion, and more active prevention of disease, such as immunization or smoking-cessation programs.

But even existing levels of care are frequently seen as being inadequate — and critics are concerned that we will be unable even to sustain those levels. As a result, like the shift towards more multidisciplinary approaches to care, the attempt to recalibrate the health system by placing a greater emphasis on improving wellness and population health — through preventive measures and health promotion — is slow and frequently resisted.

The resistance is not just because different groups of care providers hold different ideas about how best to improve health. It is also about shifting power dynamics, triggered by the reallocation of scarce public dollars.

## Train or import?

In the next five years, about one-fifth of Canada's physicians and a third of its nurses are poised to retire. Only one nurse in ten is under the age of 30. There are simply not enough younger professionals to take the place of those who are leaving.

Although enrolments at medical and nursing schools have risen in every region of Canada over the past decade, the anticipated number of graduates will also not be enough to

*(Continued on Page 25)*

# More training or more imports? Both options have problems

*(Continued from Page 24)*

offset the decline in capacity to serve.

Policy-makers have been aware of these trends for years, yet Canada still has no national training strategy in place for either doctors or nurses. In part this is because of jurisdictional realities: training and education are provincial responsibilities, and provinces have no mandate to address these problems at the national level.

Faced by mounting staffing pressures, some health-care institutions have stepped up recruitment strategies, at least so far as their budgets permit. The institutions use financial incentives to entice existing staff to leave one place for another or stay put—often using relocation bonuses, retention bonuses, or simply higher pay. That makes it more expensive to keep the staff they have and hire new staff. This micro-level solution does nothing to increase the total supply of health professionals, and only ends up making the shortage worse in other areas. It also drives costs up.

This dilemma has led to two main policy responses: train more doctors, nurses, diagnostic technologists, and pharmacists; or import them from another jurisdiction, whether from another part of Canada or from another country. Both options present problems.

The track record of universities and colleges when it comes to training in the field of health and medicine is marked by a checkered history of over- or under-shooting the "right" number of spots. That's partly due to the difficulties of planning for the future, and partly the political reality of competing institutions making competing claims for public resources.

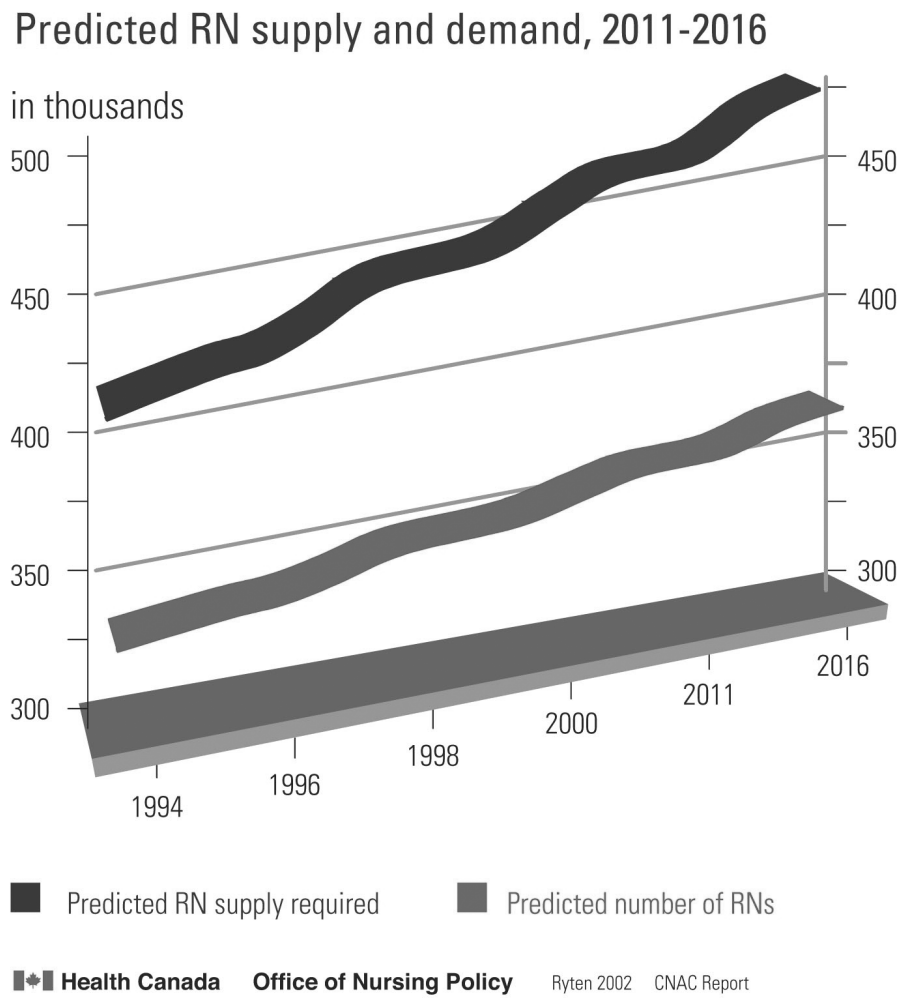
A more appropriate kind of planning for the future would ideally link health personnel requirements to basic facts about the population in the area to be served. This necessary information includes demographic, health, social, and environmental factors particular to the group or area, plus consideration of the health issues that are likely to emerge over the next decade given these known factors. But sometimes this kind of planning is eclipsed by budgetary constraints. Strangely, for example, a number of regions in Canada are struggling with both nursing shortages and mass layoffs of nurses.

Variations in budgets are not the only wild card. Getting the "right" number of new doctors and nurses depends on the other investments that are being undertaken to promote health. The demand for acute health-care services can be offset by education campaigns to reduce smoking, better access to information about reproductive health, immunization programs, or projects for water purification or safe housing. Then too, introducing more of a team approach in providing care could offset the requirements for some types of health workers, while increasing the need for others.

Education and training are a costly public policy option, particularly when it comes to health professionals. They call for a serious investment of time and money for the individual, too. In Canada, it takes four years to get a nursing degree, with tuition ranging from $3,000 to $5,000 a year. It takes at least six years of post-secondary education to become a medical doctor, plus two to three additional years of training to become a family physician. Tuition fees have been steadily climbing in Canada: medical-school tuition now costs, on average, $10,000 per year. At the leading medical schools, tuition is even higher, at more than $16,000 a year, triple the amount in 1997.

Tuition fees also do not cover the full costs of post-secondary education. Each physician and nurse receives significant public support and investment in his or her training. In the province of Ontario, tuition fees contributed only 44% of the costs of a university education in 2002.

*(Continued on Page 26)*



# Saskatchewan stands alone in doubling its training of nurses

*(Continued from Page 25)*

They represent a much lower share of the costs in other provinces.

Clearly, determining how many spaces should be made available in universities and through residencies is not a decision to make without planning. Yet planning is fraught with difficulties. The short-term answer at the macro level has been the same one used at the micro level: buy your way out of the problem.

In Canada, this answer has meant importing the solution. For instance, if Canada is to implement its planned reforms to primary care, we will need many more nurses than we now have. Yet neither existing trends in enrolment nor planned expansion of training spots makes this a likely reality, at least over the next decade. The only remaining solution is an influx of foreign-trained nurses.

his solution has huge implications for the developing world as countries struggle to retain their existing cadre of health professionals and realize returns on their own public investments, made with government revenues that are so much harder to come by.

In the past, Canada has relied heavily on foreign-trained physicians to meet short-term physician needs. In the late 1960s, Canada imported more physicians on a yearly basis than it educated. From the mid-1970s to the early 1980s, 30% of our employed physicians were trained abroad. Today, 23% of our physicians are foreign-trained.

Since it takes about a decade to train a doctor, and since the wave of retirements will probably begin within the coming 10 years, our reliance on other nations' investments in doctors is about to increase again.

Canada's inadequate investment in training and its growing reliance on importing the necessary supply of health professionals reflect a profound inconsistency in our foreign aid and development policies, immigration policies, and domestic health policies. The approach also creates friction between jurisdictions. Some provinces put more resources into training, while others focus on recruiting and relocating health professionals.

## "Return Service"

Virtually every jurisdiction in Canada today offers some way of reducing the costs of tuition if graduates — particularly graduates of medical and nursing schools — in return provide a certain period of service. The arrangements for what is called "return service" are generally focused on underserved communities, especially in rural and remote northern locations.

At the federal level, for example, Health Canada offers to reimburse the tuition of nurse practitioner students in exchange for a year of service in British Columbia's Pacific region for the First Nations and Inuit Health Branch.

Saskatchewan stands apart as a jurisdiction that has more than doubled its training of nurses since 1999. In large measure it has done this through expansion of its bursary program, which now offers over 600 bursaries a year. The amounts range from $2,000 to $10,000 for up to two years of training, and they are tied to a "return service" requirement.

Return service programs sponsor medical undergraduates, residents, and trainees through loans, bursaries, and grants. Nursing students in later years of study can be eligible for different forms of financial support, too. Return of service agreements provide financial assistance to the student — from $4,000 to $15,000, depending on the program — that may be partially or fully waived on condition that the graduate commits to practise in the sponsoring jurisdiction within a few months of professional registration. Typically, the period of service is one year, though some jurisdictions require a two-year commitment.

Sometimes this type of financial assistance is limited to residents of the area, particularly in smaller provinces and territories, in an attempt to stem the out-migration of young people. These programs have also been used to increase the interest of certain groups to consider medical and nursing professions, as a form of affirmative action and capacity-building within communities. For example, British Columbia has a unique program that aims at increasing the supply of Aboriginal health professionals. It focuses on Aboriginal nursing recruitment strategies and mentorship programs, including partial loan forgiveness for graduates who work in designated underserved areas.

Some Canadian jurisdictions are using return service arrangements as a way of integrating foreign-trained physicians. In return for an assessment of skills and the provision of training to meet local qualifications, the province of Ontario demands a five-year return of service agreement. Upon completion of the program, selected applicants must spend five years of practice in one of the province's 140 underserved communities. Ontario offers additional financial incentives for doctors who opt to serve in small remote communities in designated northern areas.

## Primary Care Reform: A few alternatives

Both studies and practice have shown that a wide range of trained personnel with a variety of skill levels can provide ready access to basic health services, not only in areas with plenty of service options, but also in areas where care is hard to come by. Instead, the prevailing tendency is to entrust health-related tasks to a narrow range of people, especially doctors and specialists, who are considered to have the greatest amount of expertise.

Medical schools today are producing more specialists than family doctors or general practitioners. The proposals of nurses' unions and associations to widen their scope of practice, using their existing training to the fullest extent in the workplace, have met with resistance from the medical profession. Registered nurses, in turn, have expressed concern about the expanded use of licensed practical nurses and other trained non-professionals in their traditional areas of practice. Unions of health-care workers continue to advocate for improved training opportunities for non-professionals. They see this as a way of alleviating shortages by expanding the range of tasks that these workers can

*(Continued on Page 27)*

# Team approach, more nurse practitioners among alternatives

*(Continued from Page 26)*

routinely take on. But such proposals are more often dismissed than taken up.

The tendency to specialization is also now facing a counter-current, particularly among the youngest generation of health professionals. The curriculum of today's course-work and residencies increasingly includes an emphasis on team work. Attitudes about scope of practice, while still complex, seem to be changing.

Such change is long overdue. Despite decades of attempts to reform the delivery of primary care, about one-third of Canada's primary care physicians still work alone, in private practice. In 2002, only an estimated 10% of doctors worked in multidisciplinary practices.

Figure 1: International Medical Graduates (IMGs) as a Percentage of Active Canadian Physicians, 1969 to 1999


*Source: Dr. Mamoru Watanabe, Canadian Physician Workforce: The Role of IMGs, International Medical Graduates National Symposium Proceedings, 2002. Data from Southam Medical Database, Canadian Institute for Health Information.*

## The one-stop shopping approach

The multidisciplinary approach is not by any means a new concept—nor did it originate as a policy response to labour shortages among professionals. It emerged from a different approach to attaining and maintaining health.

Since the 1970s, community health centres in English-speaking Canada, and *centres locaux de services communautaires* (CSLCs) in Quebec, have been providing a "one-stop shopping" approach to meeting health needs, and not just when people are sick. It emphasizes the connection between individual and population health, integrates the provision of care with involvement in the community, and stresses pro-active interventions (medical and otherwise) to attain and improve wellness. *(See Page 28.)*

In addition to providing medical care through teams of doctors, nurse practitioners and nurses, this type of primary care approach also tends to offer access to a range of other health-related professionals such as dieticians, physiotherapists, occupational therapists, dentists, and podiatrists.

What sets them apart from the growing numbers of more typical multidisciplinary medical clinics is that, particularly in the larger towns and cities, these centres also focus on addressing social needs *before* they become health problems. Their initiatives include:

- outreach to high-risk populations, such as homeless people, the elderly, sex-trade workers, people at risk of developing HIV-AIDS, or low-income households;
- engagement with immigrant communities, which experience language barriers to health and social services;
- expanded prenatal and neo-natal care, with a particular focus on nutrition and breastfeeding; and
- early childhood development initiatives.

This approach to care doesn't depend on the existence of a large team of service providers.

## Nurses as the hub of care

Canada offers financial incentives to encourage doctors and nurses to practise in the North and other remote, under-serviced areas, but this policy tends to attract mainly new and less experienced health professionals. Turnover of personnel is high, and these regions remain chronically underserved.

Since the early 20th century, Northern nursing stations have permitted communities to have most of their primary care needs—including access to emergency care—addressed by trained but not overspecialized personnel. The hub of such operations has usually been the local nurse. Today, nurse practitioners are becoming a highly valued substitute for a family doctor, especially in rural and remote locations.

Nurse practitioners are registered nurses with additional education that enables them to provide a broader range of basic acute health care: from assessing, diagnosing, and treating non-complex injuries and disease to delivering babies, ordering tests, referring patients, and prescribing drugs. Just as importantly, they focus their practice on health education and preventive care, often providing many of the same health promotion services that are found in community health centres.

The use of nurse practitioners is expanding rapidly in Canada—by 20% between 2003 and 2004 alone. Even so, only eight of the 13 provinces and territories license nurse practitioners. There are 878 nurse practitioners currently employed in the country, compared to 60,600 doctors and 247,000 registered nurses.

---

*(Armine Yalnizyan is a CCPA research associate. This article was adapted from* ***Getting Better Health Care,*** *a study she recently completed for CIDA.)*

# Community health care needs: A multidisciplinary approach

*By Armine Yalnizyan*

The past 30 years of research show that the type of care delivered in community health centres can save the health-care system somewhere between 17% and 30% per patient treated as compared to traditional fee-for-service, and the care can also lead to sustained improvements in health outcomes. These results occur in both rich and poor communities, in urban and rural locations.

The good results come from a greater emphasis on preventative forms of care, in individual and group sessions; more auxiliary services through multidisciplinary teams; longer hours of access to health-care professionals; more routine follow-up, by phone as well as in person; and more patient training to improve self-care and wellness habits.

Quebec is the only jurisdiction in which this approach to primary care is sufficiently extensive to be an option for all residents. Beginning in 1972, a network of geographically defined centres locaux de services communautaires (CLSCs) was created to provide coverage for the entire Quebec population. CLSCs are open evenings and weekends. They offer mental health, public health, and home-care services, and are the sites of the province's health telephone advice line, Info-Santé. They liaise with community organizations, municipal officials, and police to assess and address the determinants of health.

Together Quebec's 146 CLSCs employ 1,500 salaried physicians and have a ratio of five nurses to every one doctor. This ratio stands in strong contrast to the ratios in private practice, where typically there is only one nurse for two or three doctors.

Despite the extent of their reach, the CLSCs still operate—and are seen as—an alternative or complement to private practice. Only about 20% of family physicians and general practitioners work in CSLCs, either full-time or part-time. Recent reforms in Quebec have placed the province's traditional commitment to this approach to health in question.

Other provinces have much further to go. In Ontario, the first community health centres (CHCs) opened in the mid-1970s, but expansion has been slow. The number of CHCs increased from 29 to 56 between 1991 and 1995, when no more applications were accepted by the province. The existing CHCs provide service to only 2% of the population, and the province has focused its primary care reforms on hospitals and doctors in private practice. In late 2005, the province changed its approach to the role CHCs could play, announcing an expansion of 22 new CHCs and 17 satellite sites.

The CHCs in Ontario offer a range of health services that can include community outreach and support, health promotion and education, mental health services, and programs to reduce preventable illness and injury. Unlike the Quebec model, they cannot act as brokers for other health services in the community, such as home-care providers; and their hours tend to be more restricted than are those of their counterparts in Quebec.

# Private health care providers have one overriding motive: profits

*By Shirley Douglas*

*"Of all the forms of injustice, inequality in health care is the most shocking and inhumane."*
***—Martin Luther King, Jr.***

The mid-January federal election has resulted in considerable debate about the future of universal health care. And that debate should be welcomed.

There is a lot of money to be made in breaking Medicare. I believe this is the reason Dr. Brian Day is promoting private, for-profit clinics. He is bringing the U.S. model of investor-owned health care to Canada, and convincing people that this is the only way to remedy waiting times or other problems in our health care system. He knows this is not true.

Remember: every doctor who leaves the public system to work at Day's for-profit clinic in Vancouver makes waiting times longer. Expert research evidence shows this seriously compromises access to care in the public systems by taking badly needed surgeons, nurses, and technicians out of the public hospitals.

Canadians are proud of and must fight to defend the core principle of Medicare: Every man, woman and child should receive care based on need, not on their ability to pay. To ration health care based on ability to pay, rather than need, is a perversion of Canadian values.

I would invite Dr. Day to set up a not-for-profit clinic so that he could become part of the solution—not the problem.

It's true that private, for-profit clinics exist in Canada. The question is not whether clinics like Day's will be allowed to operate, but whether our tax dollars will subsidize their profits.

Prime Minister Stephen Harper and the Conservatives say "yes," unequivocally. They claim that paying private corporations to perform medically necessary procedures will somehow improve the delivery of public health care.

The Liberals, now they are in Opposition, say "no." But their record of neglect and broken health care promises while in power speaks for itself. The New Democratic Party, on the other hand, has been the most outspoken and effective political defender of Canada's universal health care. Which is why Dr.Day is resorting to spurious attacks on the NDP to legitimize his weak arguments. The simple fact remains that he stands to reap tremendous profits—paid by the taxpayers of Canada.

Don't be fooled when they say it doesn't matter if it's public or private as long as it's covered by your health card. Remember who's paying the bill for your health care: you are.

---

*(Actor and activist Shirley Douglas is the daughter of former NDP leader Tommy Douglas, now recognized as the father and founder of Medicare in Canada.)*

# Ontario doctors urge gov't to keep hospitals public

*By Robert Benzie*

Dozens of doctors across Ontario, in an open letter sent in March to Premier Dalton McGuinty, urged him to "stop the privatization of Ontario's hospitals. We call on the government to act in the public interest and to use citizens' dollars responsibly."

The letter opposed the building of hospitals by private-public partnerships, or the so-called P3 hospitals.

"Hospital construction and services must be publicly funded and hospitals must remain fully publicly managed and serviced," says the letter, written on behalf of the Ontario Health Coalition. It was signed by 73 doctors, including University of Toronto researcher Nancy Olivieri and health consultant Michael Rachlis.

"The solution is for hospital redevelopment to be funded publicly. Governments can obtain much more favourable borrowing terms than can the private sector. The public will pay for our hospitals either way. But with public funding, we avoid the higher costs of P3s and keep hospital management, property and services in public hands," the letter says. "And we stop the growth of a for-profit health industry that has an interest in two-tier health care from which they can take profit, further increasing the cost of health care."

When the previous Progressive Conservative government first broached P3 hospitals several years ago, the Liberals promised to curb the trend.

One week before the Oct. 2, 2003 election, McGuinty attacked then-premier Ernie Eves for proceeding with P3 hospitals in Brampton and Ottawa.

"I'm calling on Mr. Eves to halt any contract signing when it comes to P3s in the province of Ontario. I stand against the Americanization of our hospitals," McGuinty said at the time.

Since winning the election, however, McGuinty has triggered 22 new private-public hospital projects. The Liberals, who forbid the public use of the term "P3" by government officials, refer to their P3s as "Alternative Funding and Procurement," or AFP, and claim their model is tantamount to paying a mortgage on a new hospital while the Tories' plan was like paying a lease.

But the doctors say in their letter that "AFP is a version of a...P3, in which for-profit consortia take over financing, construction, facility management, maintenance and some hospital services for long-term deals stretching up to 40 years."

AFP projects "often seek additional revenue through commercial land deals on the public hospital lands, and service charges or user fees for patients and their visitors," the doctors add.

Opponents fear P3s will edge toward a more privatized health-care system.

---

*(Robert Benzie is a reporter with the* ***Toronto Star,*** *in which this story was first published.)*

# Health Care Decoder

## THE HIDDEN AGENDA BEHIND THE PRIVATIZERS' WORDS

### *(Beware! They speak in code)*

*The Canadian Health Coalition*

*"To reassure us, they lie to us, and then treat us as idiots by insisting on things we all know are untrue. Not only does this prevent a reasonable debate from taking place, but it also creates a very unhealthy relationship between citizens and their elected representatives."*
***—John Ralston Saul***

**"INNOVATION":** The commercialization of health care services in a cutthroat market. ***Problem:*** *Some things—health care, human life, blood, etc.—don't belong in the market.*

**"EUROPEAN MODEL":** U.S.-style two-tier, for-profit health care disguised as a "Third Way." ***Problem:*** *Canada is integrating with the U.S., not Sweden or any other European country—and it is the U.S. health industry that is seeking access to Canada.*

**"FLEXIBILITY":** Operating outside the parameters of the Canada Health Act. ***Problem:*** *The duty of the Minister of Health is to ensure that people with lots of money don't buy their way to the front of the line.*

**"MODERNIZATION":** Returning to the old days of life without Medicare. ***Problem:*** *Private health insurance for the wealthy, and freedom for doctors to charge whatever they want.*

**"CHOICE":** Health care services to be treated like any other commodity. ***Problem:*** *Health care is a human right, and access should be based on need, not ability to pay. In the U.S., over 40 million citizens have no health insurance, no health care—and no choice.*

**"PARTNERSHIP":** Private-public partnership (P3) is a parasite that drains our tax dollars. The public pays and the private investors profit. That's not a partnership! ***Problem:*** *Costs go up, quality goes down, and there's no accountability.*

**"EXPERIMENTATION":** This is no experiment! Commercialization of health services would expose Medicare to the wide-open privatizing effects of NAFTA and WTO trade agreements. ***Problem:*** *Once foreign insurers get inside the walls of the Canadian health care system, international trade treaties will give them the legal right to offer private medical care to people who can afford it. The gates will be opened to change our public system into the same kind of two-tier model that prevails in the U.S.*

---

*(This Health Care Decoder is provided by the Canadian Health Coalition. For more on this and other Health Coalition publications, go to* ***www.medicare.ca)***

SWEDEN'S U-TURN ON PRIVATE CARE:

# Voters in Sweden reject market medicine and privatization

*By Tom Sandborn*

B.C. Premier Gordon Campbell, in a recent speech promoting private health care, asked rhetorically, "Does it really matter to patients where or how they obtain their surgical treatment if it is paid for with public funds? Why are we so afraid to look at mixed health care delivery models, when other states in Europe and around the world have used them to produce better results for patients at a lower cost to taxpayers? Why are we so quick to condemn any consideration of other systems as a slippery slope to an American-style system that none of us wants?"

While these may be rhetorical questions, they deserve answers. So we went looking for experts and activists who would speak with us about some of the implications of health care delivery and reforms in Sweden.

**"New legislation enacted by Sweden's government earlier this year closed the door against any further privatization of public hospitals and sharply limited the room for private enterprise in delivering health care across the country."**

Does it matter "where or how" we get our health care services? And are there lessons to be learned in Scandinavia that apply to our situation in Canada? Well, yes, it turns out, it does matter quite a bit how health care delivery is structured, and at least some of the northern lessons suggested by the folks we consulted are highly unlikely to be part of Premier Campbell's final recommendations.

First of all, let's deal with the myth of Swedish repentance. It is a favourite narrative of those promoting more free-market delivery of health care in Canada. Sweden, the story goes, after a long, misguided experiment with socialism, has seen the light and is rapidly turning its "inefficient" socialized Medicare system over to the private sector, reaping great benefits for all. Privately owned hospitals. For-profit clinics. Cost reductions and the efficiencies only the market can deliver. A new light was breaking in the European north and Canada should hurry to emulate the Swedish example.

Johan Hertqvist, writing for the right-wing Stockholm think-tank Timbro, wrote a typical such article published in 2002, titled "The Health Care Revolution in Stockholm." After describing the privatization of a Stockholm hospital and the creation of more room for profit-making in the health care delivery system in one Swedish county, Hertqvist rounded off his essay with the claim that there was now, for Swedish health care, "no way back."

It turns out, however, that there was a way back, and Swedish voters decisively chose it. The right-wing county government that brought in the celebrated turn toward the market in Stockholm County (one of 21 in Sweden) was defeated in the next election, and in January 2006, new national legislation closed the door against any further privatization of public hospitals and sharply limited the room for private enterprise in delivering health care across the country.

The four private hospitals currently up and running in Sweden will be allowed to continue operating, at least until 2011, and some limited room was left for a few private sector operations entirely outside the public system, but the experiment with grafting for-profit mechanisms onto the taxpayer-supported system was decisively rejected by Swedish voters.

The Ministry of Health and Social Affairs announcement of the new legislation makes no bones about it. "The government's point of reference is that Swedish health and medical services should continue to be democratically controlled, financed on the basis of solidarity, provided on equal terms and according to need. Otherwise there is a risk that a conflict of interest may arise between the players in the market and the people in need of care."

This comes as no surprise to Kathleen Connors, national chairperson of the Canadian Health Coalition. Connors, a retired RN and lifelong campaigner for Medicare, has spent a lot of time in conversation with health care professionals from Scandinavia, and she sees the Swedish rejection of sweeping market reforms as consistent with what she learned from those conversations.

"The value given to collective responsibility in Sweden and Norway is high. None of the people I talked with complained about high taxes. They see that they derive big benefits from the investment in collective well-being. Any reforms and modifications they make will be within their basic system, without lurching off track. They experimented with privatization, and it didn't work."

Connors believes there are important lessons for Canada to learn from countries like Sweden. "If we look at what the Scandinavian countries spend on the social determinants of health—the environment, women's rights, clean water, secure employment, wellness and peace—where spending far outreaches what Canada now invests, there are lessons for us."

One feature of the Swedish health care system that might be instructive for Canada is the way Sweden handles pharmaceuticals. Rather than leave marketing of prescription drugs to private industry, Sweden has established a state monopoly, Apoteket, which conducts all retail sales of drugs across Sweden.

❊ ❊ ❊

There are lessons closer to home, as well, that might help Premier Campbell assess the value of adding for-profit layers to B.C. health care. Dr. Margaret McGregor, who divides her time between clinical work and a research position at the Department of Family Practice at UBC, has looked closely at the implications of allowing for-profit operators into a publicly-funded health care sector—something that already occurs in B.C. in long-term care homes, where 30% of facilities are for-profit.

The results of Dr. McGregor's research are no more

*(Continued on Page 31)*

# Extensive research finds for-profit health care unsafe and costly

*(Continued from Page 30)*

encouraging about such experiments than the failed Swedish experiment. She and her co-researchers, writing last year in the *Canadian Medical Association Journal,* determined that "not-for-profit facility ownership is associated with higher staffing levels. This finding suggests that public money used to provide care to frail, elderly people purchases significantly fewer direct-care and support staff hours per resident-day in for-profit long-term care facilities than in not-for-profit facilities."

Dr. McGregor's research compared for-profit and not-for-profit long-term care facilities in B.C. that received similar levels of funding from the public purse. The for-profit homes—not surprisingly, given their need to generate a cash flow for shareholders—delivered diminished service to their residents for the same investment of public money. (Dr. McGregor's paper cites earlier research that links higher staffing levels to better service for patients and better medical outcomes.)

Dr. McGregor cited more recent research that extends this comparison. This new work, still being prepared for publication, found that patients in for-profit, long-term care facilities were more likely than their peers in not-for-profit homes to be hospitalized for three of six diagnostic conditions viewed as indicators of quality of care.

"The publicly-funded for-profit homes have fewer nurses and fewer support staff," she pointed out. "The data from B.C. comparing delivery models suggests the for-profit sector doesn't deliver better service. As a clinician, having read the research on for-profit models, I'd say the proponents of privatization are not considering the evidence to date, including this B.C. experience."

Premier Campbell, however, remains enthused about adopting a mixed public-private system model for delivery of health care in B.C., despite all the research in the U.S. and Europe that support the B.C. findings cited by Dr. McGregor. The data suggest that Swedish voters knew what they were doing when they rejected privatized hospitals and an expansion of the for-profit sector in their health care system.

In 2002, researchers at McMaster University in Hamilton did a meta-analysis of studies across the United States capturing the experience of over 38 million American patients. Their finding: *being treated in a for-profit hospital significantly increased mortality when compared to treatment in a not-for-profit facility.* In 2004, the same research team determined that the cost of care was 19% higher in for-profit hospitals than in not-for-profit institutions in the U.S.

"Our previous study showed that the profit motive results in increased death rates, and this one shows it also costs public payers more," said Dr. P.J. Devereaux, the study's lead author. "With for-profit care, you end up paying with your money *and* your life."

Meanwhile, in Europe, the World Health Organization's Health Evidence Network issued a major study in July 2004, asking some related questions in its cumbersomely titled "What are the equity, efficiency, cost containment and choice implications of private health-care funding in Western Europe?" This densely researched 35-page report, reviewing research from across Europe, would be a logical addition to any primer on the experiences in Sweden and elsewhere in Europe.

The report concludes: "Evidence shows that private sources of health care funding are often regressive and present financial barriers to access. They contribute little to efforts to contain costs and may actually encourage cost inflation."

---

*(Tom Sandborn is a Vancouver journalist and a regular contributor to The Tyee [TheTyee.ca], where this report was first published.)*

# Overmedication turning seniors into zombies, says specialist

*By Joel Kom*

Doctors may be overmedicating their elderly patients in the mistaken belief they are suffering from depression, says a University of Toronto geriatric psychiatrist.

Dr. David Streiner, who treats seniors at the Baycrest Centre for Geriatric Care in Toronto, said family doctors across Canada may be confusing clinical depression with just a simple feeling of sadness, but the latter doesn't require prescription drugs.

If doctors are overdiagnosing depression, Streiner said, it could mean too many seniors are being given unnecessary drugs.

"It means we're got a bunch of zombies out there," he said from his Hamilton home.

Streiner's concerns came in the wake of his study, available in the latest edition of the *Canadian Journal of Psychiatry*, that suggests the prevalence of depression and anxiety disorders in elderly Canadians decreases with age. Moreover, the study claims, seniors suffer less from those disorders than their younger adult counterparts.

His findings put him on one side of a well-documented depression controversy within the world of geriatric psychiatry.

Some studies have claimed to find older patients suffer more from depression; other studies, such as Streiner's, have claimed the opposite.

Dr. Streiner, also a professor of psychiatry at the University of Toronto, said he's well-aware of the controversy, but he believed his results were a good indication seniors are not only in good mental health, but also do better than their juniors.

One of the main reasons for the confusion with clinical depression may be doctors making false assumptions. Many of the symptoms of old age—sleeping problems, decreased appetite and sex drive—are also depression symptoms, he pointed out.

"Don't go with the automatic assumption that the elderly are more depressed because of the losses they've incurred," said Streiner. "They're a resilient bunch."

---

*(Joel Kom writers for* ***The Ottawa Citizen,*** *where this article was first published.)*

LOST IN TRANSLATION:

# France's public-private health care system differs from ours

*By Dominique Polton*

Many Canadians, from Alberta Premier Ralph Klein to columnists across the country, cite France's medical system, ranked No. 1 by the World Health Organization, as a potential model for Canada. What is France's particular mix of public and private delivery? Should it be exported?

Most of the time, when French patients visit a general practitioner or specialist, they see an independent professional in a private practice. But this is also true in Canada. What has drawn other countries' attention is that a patient in France needing hospitalization may choose a public, a private non-profit, or a private for-profit hospital.

The for-profit hospital sector (one that is nevertheless covered by the public insurance system) provides about 20% of all in-patient beds. Such hospitals specialize in delivering babies, cataract removals, and other standard surgical procedures. But, while these clinics are private, they are subject to the same planning procedures and price regulation as the public sector. The rules for reimbursement by public health insurance are also the same. So it makes no difference whether a patient chooses a public or a private hospital.

It should be noted, however, that in France, a proportion of private physicians are allowed to bill fees above the official tariffs. In such cases, the patient pays the difference.

**"France has 3.3 physicians for every 1,000 people compared with Canada's 2.1, and 4 hospital beds per 1,000 compared with Canada's 3.2. This suggests that the shorter wait times in France are not because of its system's private sector involvement, but simply because France has more health-care providers."**

The second element of France's public-private mix is financial. In most countries, GP visits are free. In the French system, co-payments by patients have been the rule from the very beginning. For example, a patient pays €6 ($9.61 Canadian) out of the total €20 ($32 Canadian) cost for a GP visit. Patients with serious illnesses or low income are exempted, though, and they account for almost 70% of expenditures.

Does this public and private mix of supply and financing enhance the health-care system's performance? It depends on what is meant by "performance." The WHO's No. 1 ranking remains controversial—but most observers agree that the French system, which provides universal access to good-quality care, is probably one of the world's best systems.

But different health-care systems achieve a specific balance among conflicting goals: high health outcomes, public-expenditure control, quality and accessibility of care, and equity. France's system favours freedom of choice, easy access, and responsiveness over cost control. As well, the French system [like Canada's] emphasizes cure over prevention. This is reflected in health outcomes: French women have the longest life expectancy after Japan, and life expectancy after age 65 is high for both women and men. But France performs poorly on mortality before age 65, as related to individual behaviours. For example, 29% of French adults smoke, compared with only 18% of Canadian adults. And, while infant mortality is lower in France (4.5 deaths per 1,000, versus 5.2 in Canada), perinatal mortality is higher (6.9 compared to 6.3).

Without doubt, the French are generally satisfied with their system's access to care, its responsiveness, and promptness of services. Other countries, keen to reduce waiting times, muse about whether that private-sector presence is a reason. In fact, the public/private factor may be less important than France's sheer quantity of health-care providers. According to OECD figures, France has 3.3 physicians per 1,000 people, compared to Canada's 2.1; it has four acute hospital beds per 1,000 compared to Canada's 3.2. Such comparative data suggest that France's lower wait times are simply because France has more health-care providers.

Why? Both countries devote the same proportion of their resources to health care (around 9.7% of GDP). But there's a big wage difference. A typical full-time French GP works an average of 55 hours per week for an annual income of €65,000 ($104,000 Canadian) before taxes.

When considering the private sector's role in France's health-care system, it's important not to confuse the status of health-care providers with the sources of financing. Relying on public or private hospitals or clinics is one issue; how the care they provide is financed is a different question. The confusion arises because, in some countries, private providers are only available through private financing, outside the national health service. In France, all providers are under contract with the national system, and patients are reimbursed on the same basis.

In fact, public financing accounts for 76% of total health expenditure in France—a higher proportion than Canada's 70%. In that sense, Canada's system is more "private" than France's. A greater proportion of physician services are covered in Canada (98% versus 74%), while drug costs are less covered (38% versus 67%).

Now let's look at the relationship between public and private insurance. Is that the key? Unlike other countries, where private insurance covers separate populations (as in Germany), or buys quicker access to private producers (U.K., Spain) or better quality of care (Ireland), in France, public and private voluntary insurance jointly finance the same services, delivered by the same providers, for virtually the entire population.

In France, it's generally believed that this mingling isn't a big factor when it comes to efficiency or cost control. But, compared to other models of mixing public and private health-care financing, it may have one advantage: maintaining a sense of social solidarity.

---

*(Dominique Polton originally wrote this article for the Globe and Mail. She is director of the French Institute for Research and Information on Health Economics [IRDES] and is vice-president of the Haut conseil pour l'Avenir de l'Assurance maladie.)*

KLEIN'S REFORMS UNDERMINE MEDICARE:

# Alberta headed for U.S.-style, not European-style health care

*By Diana Gibson*

Ralph Klein wasted no time after the January federal election challenging the election promises of Stephen Harper's Conservative minority government.

Alberta Health Minister Iris Evans promptly presented the first phase of Alberta's health-care reform plans to the provincial cabinet — reforms she freely admitted potentially violate the Canada Health Act.

Harper solemnly pledged to uphold the Act, which requires, among other things, universality, comprehensiveness, and public administration. Yet Klein is rolling out an agenda to dramatically expand private health insurance and delivery. Carefully crafted rhetoric like "third way," "increasing access," "Medicare plus," "increasing choice," and "European model" are used to shroud the fact that he is talking about privatization, and taking Alberta toward a U.S.- style, corporate health system.

There is no "third way" or "European model." As the Supreme Court's Justice Marie Deschamps pointed out in the Chaoulli decision, "There is no single model; the approach in Europe is no more uniform than in Canada." There is, rather, a spectrum of health-care models ranging from purely public to purely private.

Canada already has significant private-sector involvement on both the funding side (insurance) and the delivery side (private surgeries, labs and diagnostics). In fact, Canada is already farther down the path to private insurance than most European countries.

In most European countries, private insurance covers less than 10% of health-care costs, whereas Canada is already at approximately 14%.

In fact, Canada is already fourth among OECD countries for private health insurance spending.

European health care is more comprehensive. Among members of the EU, health insurance tends to be more universal and more comprehensive than Canada's, covering a wider range of benefits such as pharmaceuticals, dental care and long-term care.

If there is a trend in OECD countries, it is towards *less*, not more private funding. Between 1994 and 2004, the private share of health spending was either constant or decreased in more than half of OECD countries.

European countries protect their publicly-funded system. Health-care practitioners can't be in two places at the same time. So creating a parallel for-profit system simply takes doctors, nurses, and radiologists away from the public sector, where there is already a shortage.

For this reason, many European countries have regulations that protect the public sector from such erosion. Examples include requirements that doctors and even patients must opt in or out of the public system; and limits on what practitioners can charge and insurance companies can pay in the private system. For example, in Austria, private insurance can only pay 80% of the cost billed by professionals practising in the public sector.

**"If there is a trend in Europe, it is towards less, not more private funding. In most European countries, private insurance covers less than 10% of health-care costs, whereas Canada is already at 14%."**

Alberta currently has a provision that doctors must opt out of the publicly-funded system if they want to offer services covered by the public system on a for- profit basis. As the bulk of the work is in the publicly-funded system, this presents a disincentive to doctors practising outside it: they can't do both.

Such protections are precisely what Ralph Klein is proposing to remove. He has already said that the requirement for doctors to opt in or out will be eliminated.

There have also been hints that the protections for the public system introduced in Bill 11 will be reversed — for example, the provision that private, for-profit surgeries could operate but not private, for-profit hospitals.

These changes take us down an American path, not a European one.

There are other reasons to believe that Klein is taking the U.S. path and not the European path.

First, Canada is integrating our economy with the U.S., not with Germany, Sweden or France — and Canada has clearly become part of a North American health-care market.

Second, it is U.S. health-care corporations, not European ones, who are pushing for access to the Canadian health-care system. Not surprisingly, the U.S. has the world's largest health insurance industry.

The influence wielded by U.S. health insurance corporations is reason enough to carefully scrutinize Klein's choices.

Witness the Alberta government's decision to hire U.S.-owned AON Corporation to design health care options for Alberta. This choice speaks volumes; AON will be intimately familiar with the U.S. model. And yes, this is the same AON whose American parent recently paid out $190 million following a probe into allegations of fraud and anti-competitive practices.

Once the door is opened to further privatization in Canada's health-care system, it will be difficult to turn back to the principle of universality

We are embarking on a critical debate about the future of our health-care system, a system that represents the fundamental values of equity and justice at the core of Canadian society.

Harper promised during the election that he would "stand up for Canada?" But he can't do that if he fails to stand up to Klein.

---

*(Diana Gibson is research director of the Parkland Institute, a public policy network based at the University of Alberta. She and Colleen Fuller co-authored a book,* ***The Bottom Line: The Truth Behind Private Health Insurance in Canada,*** *which was recently published by NeWest Press and the Parkland Institute. An excerpt from the book may be found elsewhere in this* ***Monitor*** *supplement.)*

SHORTENING THE HEALTH-CARE QUEUES:

# Better public than private solutions to Medicare wait problem

*By Michael Rachlis, MD*

Waits for care are the biggest political issue facing Canadian health care—a priority reflected in the accord reached a few months ago by the federal and provincial health ministers. They agreed to set limits on wait times for major surgeries and treatments, but conceded that these limits would be targets rather than guarantees. This is welcome news for Canadians already on long wait lists—but overlooked in the ministers' program was a plan to reduce wait times by making more efficient use of existing resources and facilities.

In the absence of such administrative improvements of the public health care system, the operators of private clinics and their supporters—buoyed by the Supreme Court's ruling against a Quebec ban on private insurance for Medicare-covered treatments—are aggressively selling services to anyone who has enough cash to jump the public waiting queues.

Before going down this road, however, Canadians would do well to consider public sector solutions to the wait-times problem. Two such reforms are readily available:

• Establish more specialized short-stay surgical clinics within the public sector to provide the efficiencies that private clinics have capitalized on—but without diverting millions of public dollars to private owners.

• Adopt lessons learned from queue-management practices in other sectors. We have only to look at how line-ups have been streamlined at banks, for example, to see how a better coordination and flow of queues can dramatically reduce wait times.

First, the public system should shift as many minor procedures and low-risk elective surgeries as possible (e.g., hip and knee replacements) to short-stay, public, specialized clinics. It has been widely—and wrongly—assumed that the only such clinics are for-profit businesses. In fact, Toronto's Queensway Surgicentre, a division of the Trillium Health Centre (a public hospital), is the largest not-for-admission surgical centre in North America. And in Manitoba, in 2001, the government bought the Pan-Am Clinic from its private sector owners. It now operates as a unit of the Winnipeg Regional Health Authority.

Evidence from both Queensway and Pan-Am suggests that public sector delivery is superior. These clinics achieve the benefits of specialization and innovation normally ascribed exclusively to the private sector, while reducing overall administrative costs and providing broader societal benefits.

The second new public sector approach to health-care waits is the use of applications of queuing theory to manage waits and delays. Queuing theory applications are used to maximize flow in such diverse areas as air traffic control and manufacturing. Rather than thinking of every wait list as a capacity or resource problem, we need to look at delays through the "lens of flow."

**"We tend to assume that, if there is a wait for health care, there isn't enough of it. But most waiting is not due to lack of resources."**

Canadians tend to assume that, if there is a wait for health care, there isn't enough of it. But most waiting is not due to lack of resources. For example, many breast patients have to wait for a mammogram, then wait for an ultrasound, and then wait again for a biopsy. The Sault Ste. Marie breast health centre reduced the wait-time from mammogram to breast-cancer diagnosis by 75% by consolidating the previously separate investigations. If a woman has a positive mammogram, she often has the ultrasound, and sometimes the biopsy as well, on the same day.

We could also eliminate waits for doctors' appointments. Family doctors often have delays of up to four weeks for appointments. The wait is typically shorter just before vacation and longer thereafter, but overall it is fairly stable. A doctor's capacity may be close to meeting demand, but he or she is servicing last month's demand today while postponing today's work until next month. If doctors cleared their backlogs—and they could by analyzing and consolidating the different steps in the diagnosis and treatment process, measuring demand and capacity for each, and eliminating bottlenecks—then they could realistically clear the path to same-day servicing. Patients want one-stop shopping.

The Saskatoon Community Clinic serves over 20,000 patients. In 2004, patients faced a four-to-six-week wait for appointments. The centre temporarily increased resources to clear its backlog, re-designed some of the care pathways, and now provides same-day service.

We could also dramatically reduce delays for specialist care. The Hamilton HSO Mental Health Program integrated 90 family physicians with 23 counsellors and two psychiatrists. The result: the number of mental health patients treated went up by 900%, while the family doctors made 70% fewer referrals to the psychiatric specialty clinic.

The enemies of Medicare have used the legitimate public concern about delays in the system to peddle ill-advised policies such as for-profit delivery and private finance. But private clinics are aggravating personnel shortages, and siphoning off more public dollars to shareholders and insurance companies.

The public solutions I propose—specialty clinics in the public sector and application of queueing theory to health care wait lists—are but two of many alternatives to private finance and for-profit delivery. Others include increasing surgical capacity in public hospitals and putting greater emphasis on prevention. There is no shortage of such public system solutions *if the political will is present.*

---

*(Michael Rachlis, MD, MSc, FRCPC is a health policy analyst and the author of three national best-selling books about Canada's health care system. This article was adapted from his recent CCPA paper,* ***Public Solutions to Health Care Wait Lists,*** *the full text of which may be found on our website.)*