Alternative Federal Budget 2003

Canada Health Act? Or Canada Health Inaction?

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The federal government has both the legal and moral responsibility to act as the guardian of public health care. As the Romanow Commission demonstrated beyond a doubt, Canadians want and expect it to act quickly; otherwise medicare's future as a public system will be in jeopardy.

Introduction

Money is at the heart of the debate around the future of Medicare that continues to build on the eve of a federal cabinet retreat and next month's First Ministers' meeting on health care. Despite what some might think, however, the issue is not *how much* money should be spent on health care; rather, it is to what extent that money comes from public sources and is spent in a public health care system, as opposed to being spent on for-profit services.

If the public system does not have the resources necessary to meet demand, that demand will not disappear – instead, private, for-profit health care will move in to fill the gap, allowing wealthier people to buy access to services that others have to wait for or go without. This is already happening. Under huge spending pressures, provinces – especially but not only those with governments ideologically supportive of private health care – are already cutting public services, adding user fees, and welcoming private sector investors.

The evidence demonstrates that only a publicly-funded, non-profit health system is truly sustainable. Equally important to Canadians is that governments be required to be accountable for the expenditure of public funds on health care. After all, they foot the bill. New monies for health care should be used to buy change. This means targeting money with strings attached to establish standards of care.

If the federal government does not act quickly and decisively to shore up its contribution to health spending, it will, in effect, be undermining one of Canada's greatest social achievements: a truly public health care system.

In other words, it is time for the federal government to get back in the health care game with increased funding. Just as important, the federal government needs to start using its legal and moral authority to snuff out the growth of the private system. The February First Ministers meeting provides an opportunity for it to do just that, by making a commitment to public, non-profit health care, and expanding the range of services covered by the Canada Health Act.

The background

The current wave of debate over health care began in earnest with the National Forum on Health in 1995-96. The Forum laid out a number of valuable recommendations, almost

none of which were implemented. As a result, emerging problems in the system, such as waiting times for treatment and shortages of health care personnel, worsened.

In the years following the Forum's report, provincial and territorial governments continued to pressure the federal government to restore the 1995 federal cuts to health spending, emphasizing that health costs as a share of provincial spending were growing steadily. They argued that health care was crowding out resources for other areas and that the system was unsustainable without more federal money.

Provinces began to privatize parts of their health systems by removing specific health services from public health insurance plans, change eligibility criteria for home care and drug plan benefits and by contracting out services to private providers. They shut down hospital beds while reigning in spending on home care and long-term care institutions, and reduced the overall levels of health care providers, particularly nursing staff. It is largely the case today that hospitals are "no frill" institutions with some care, such as feeding, left in the main for families to provide.

In the 1997-1998 fiscal year, the federal government began posting budgetary surpluses, while provincial/territorial governments were not. By 1999-2000, the federal surplus was conspicuously large - $12.7 billion and clearly on the rise. In September 2000, the prime minister and the premiers struck an accord in which the federal government agreed to increase funding over five years by committing $21.1 billion in new funds for publicly insured health services.

While the infusion of funds was welcome and needed, it was not enough to address the growing imbalance between the federal and provincial share of funding public health care. More importantly, the accord was critically flawed, in that it failed to address the rapidly growing threat of privatization, and the fact that many health services had been shifted out from under the medicare umbrella.

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Enter Romanow

By the time the prime minister appointed Roy Romanow to chair a Royal Commission on the Future of Health Care in Canada, the flow of public money to for-profit health service providers had become a new form of threat to the long-term sustainability of public health care. This trend is hard to trace in public documents, but the available evidence suggests it appears to have been increasing steadily for several years.

In provinces such as Alberta, British Columbia, and Ontario, for-profit facilities were performing diagnostic tests and surgeries historically performed in public hospitals; some hospitals were operating in the form of public/private partnerships; and nutrition, cleaning, laundry and maintenance services were being contracted out to private companies.

Alberta has recently moved further, by giving the go-ahead for the delivery of publicly-

insured health services on a for-profit basis by passing legislation to allow for-profit facilities to perform surgeries requiring overnight stays.

Capital budgets in health care were held at below historic levels throughout most of the 1990s. The failure to maintain and invest in high-end diagnostic equipment such as MRIs and CT scanners led to long wait times for tests in the public system. This led in turn to the development of private, for-profit diagnostic clinics. Ontario, Alberta, Nova Scotia, Quebec, and British Columbia have all allowed these clinics to proliferate. These facilities, which provide a medically necessary health service under the Canada Health Act, set up the conditions under which people who can afford to do so can buy access to "just looking" tests, which, they reveal a serious condition, may lead to medically necessary procedures. This undermines the core principle anchoring Medicare: the principle of equal access to care based on need, not on ability to pay.

There is no doubt that part of the blame for this shift lies with the provinces' lack of resources. While Ottawa used to cover as much as 38% of provincial and territorial spending on health care, that figure has been falling, and now stands at about 16%. The problem of reduced federal funding has been compounded by provincial tax cuts. This year alone, the provinces gave away about $20 billion through tax cuts – money that could have been spent on health care. The provincial tax cuts will mean $23 billion in lost public revenue in 2003-04, rising to almost $30 billion by 2005-06.

In some cases, the "need" that the for-profit sector is moving in to fill has been artificially created by a provincial government eager to encourage the development of private health services. For example, in Ontario the government is prepared to purchase 20 new MRI and CT scanners. Public hospitals are actually prohibited from bidding for a contract to operate these machines. Whether the equipment is operated in hospitals or in stand-alone, private, for-profit facilities, the Ontario government will still pay for the equipment and for every test ordered by doctors. There will be no savings to be had by contracting this service to for-profit companies. In fact, evidence shows that the public system would provide this service at a lower cost.

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This case is worth exploring in more detail, as it is a clear demonstration of how an ideologically driven government can pare its own options down to one: more private, for-profit health care. The Ontario government argues that by prohibiting the hospitals from getting these new diagnostic services it is moving the services out into the community, and thus improving speed of access. Because hospitals are genuinely dealing with massive problems with resident patients, this argument may have some validity in theory. In reality, however, the Ontario government has rendered it nonsense by not funding community-based health care centers. As a result, the gov-

ernment has forced itself to turn to the private, for-profit sector as the only option by which it can provide homes for the new equipment "in the community." As well, given critical labour shortages, non-medically necessary services draw needed health-care workers away from medically necessary services.

As this example makes clear, in Ontario (as in other provinces), the government is frequently not motivated by cost pressures or quality of care, but by pure ideology.

Federal guardian

When a province such as Ontario deliberately acts to weaken the public health care system, the federal government has both the power and the responsibility under the Canada Health Act to intervene as the guardian of the national health system. Other than a bit of sabre-rattling when the government of Alberta passed legislation to allow for-profit surgical clinics (hospitals by any other name) to deliver publicly-insured services, the federal government has consistently abdicated its responsibility.

Under the Canada Health Act, the federal government has the legal obligation to enforce the Act's five principles and the two conditions prohibiting user fees and extra-billing charges being levied for medically necessary health services. These conditions hinder a proliferation of for-profit health care because the user charges would be a key source of profit in for-profit health systems.

Provincial governments so inclined could increase their physician and hospital payment schedules to account for the extra money needed for profit, but there are two key problems with this. First, it would set up a two-tier payment system: a lower one for health providers working in the public system and a higher one for providers and owners in the for-profit system. There would quite naturally be an automatic exodus of workers in the public system over to the for-profit system, which would seriously damage the public system and send waiting lines skyrocketing. Second, provincial governments know that it would be financially unsustainable for governments to be the source of profits for health care corporations.

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Auditor-General Sheila Fraser criticized the government for sitting on suspected violations of the Canada Health Act, noting that 25 suspected violations have not been dealt with. Fraser says the government is slow to act and relies on news articles as a source of information for potential violations. Under the Act, the government is required to monitor provincial compliance with the Act, apply penal-

ties when violations are confirmed, and report these to Parliament.

According to the Auditor-General, violations include charging user fees for drugs administered in hospitals and for medically necessary MRI and CT scans performed in private clinics; the private purchase of insured health services; user fees for abortions and not paying for abortions, a scheme that allows patients to buy their way in to see a specialist instead of waiting in line; and the sale of full-body CT scans in a hospital.[1] These are all serious violations of the Canada Health Act.

Romanow gets it (partly) right

A major strength of the Romanow Commission report was a recognition that the obvious principle of for-profit care – profit – is incompatible with the principles of equity, quality of care, and fairness in which Medicare is grounded. This conclusion is based on the evidence, as well as Canadian values, which hold health care as a public good.

During the Commission's work, Romanow amassed a significant body of research-based evidence which compared the for-profit delivery of health care services to public or non-profit delivery of care. Romanow repeatedly called for those who support the for-profit delivery of care to come forward with evidence to support their view that this direction would improve our health care system, provide better quality, or be more efficient and less costly. The report is clear that the call for proof went unanswered. "*The evidence has not been forthcoming.*"[2] Romanow examined the health systems of other countries and concluded that "*There is no evidence these solutions will deliver better or cheaper care, or improve access, (except, perhaps, for those who can afford to pay for care out of their own pockets).*"[3]

Certainly the evidence against for- profit care being cheaper, of better quality, less costly, and more efficient than publicly delivered care is compelling.

> "There is no evidence [for-profit] solutions will deliver better or cheaper care, or improve access, (except, perhaps, for those who can afford to pay for care out of their own pockets)." *Romanow Report*

Dr. Arnold S. Relman, professor emeritus of medicine and social medicine at Harvard Medical School, and former editor-in-chief of the prestigious *New England Journal of Medicine,* told the Kirby Senate Committee studying the health system that "No health care system in the industrialized world is as heavily commercialized as ours, and none is as expensive, inefficient and inequitable."[4] He also said the system is immensely unpopular among the American public and that the only sector of U.S. society that is happy with the system are the owners and investors "living off the system." Dr. Relman told the committee that there is much evidence that private businesses delivering health care have greatly increased the total cost of health care and damaged – not helped – the public system.

Statistics bear this out. The per person expenditure on health care in the U.S. is $4,631 USD, the highest in the industrialized world. By comparison, expressed in U.S. dollars, Canada spends just $2,748 per person on

health care.[5] As well, health spending as a share of GDP in the United States consumes a whopping 13% of GDP compared to Canada's 9.5%.[6] Yet, public taxes in the U.S. contribute 47.6% of all spending on health services.[7] Hardly value for money, especially considering health outcomes are poorer in the U.S. Canadians are healthier, have a longer life expectancy and lower infant mortality rates than the American population. The chief difference is that, while almost half of health spending in the U.S. is publicly funded, it is delivered on a for-profit basis, and a significant share of health care is privately insured.

Dealing With For-Profit Care

While Romanow recognized that the for-profit delivery of care represents a threat to the sustainability of Medicare and its values, he did not say that the federal government should directly ban the use of public dollars for the for-profit delivery of care.

While the federal government could pass legislation prohibiting the use of federal funds for private, for-profit care, provincial governments favouring for-profit delivery could get around this by simply saying that federal dollars were going into the public system and provincially raised taxes were supporting "alternative" modes of care delivery. If the federal government were to pass legislation to dictate how provincial governments were allowed to spend their own revenues, it would face a serious constitutional challenge from the provinces.

This is why Romanow chose a route intended have the effect of drying up the revenue stream for private, for-profit companies. Services under the expanded public health insurance umbrella that he proposes should be provided on a public or non-profit basis. The effect would be to severely curtail the market for commercial health services.

In his report, Romanow made several other specific recommendations to curb the growth of commercial health care. These include: 1) confirming the five principles in the Canada Health Act; 2) establishing a new principle of accountability; 3) explicitly including medically necessary diagnostic services such as MRI and CT scans under the terms of the CHA so as to prevent user fees or extra billing for these services; 4) withholding federal Medicare contributions to provinces where user charges are allowed for such diagnostic tests; and 5) closing the loophole that allows Workers' Compensation Board systems to get preferential treatment in accessing medical services and allows the Boards to contract medically necessary services out to for-profit facilities.

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As well, the report dismisses other forms of privatization in health care, such as user fees and co-payments, medical savings accounts, and an income tax on health service utilization.

Unfortunately, the report creates a split between direct medical services and ancillary

services such as laundry, cleaning, nutrition, food preparation, and maintenance. The report fails to view these services in hospital and other medical institutional settings as real health services, and allows their provision by the private, for-profit sector.

While these services are often called "hotel" services, in a hospital or long-term care setting, they are anything but. In a health care setting, a germ-free environment, including properly sterilized laundry and high-level food safety precautions, are essential to the health of patients and staff alike. A sizeable body of evidence shows that, when public services are transferred to the private sector, the quality of the service suffers, and the lower wages that almost always accompany privatization lead to high staff turnover and the hiring of less well-trained personnel. In addition, the cost of privatized services does not decrease even though the rationale for privatization almost always includes lower costs.

Political Will Hunting

Overall, the Romanow Commission report sets out a framework for curbing the growth of privatization in health services. Required now is the political will, commitment and leadership to move ahead.

This plan has one major potential flaw: in order to be successful, it requires sufficient funding for public health care. And here Romanow appears to fall into his own trap. He wants the federal government to increase its contribution to health care by $8.5 billion over the next two year and a third installment of $6.5 billion in 2005-6. While this much money is a good start, it will quickly be absorbed, and is not sufficient to choke off the demand for private health services.

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Provincial reaction to Romanow's recommendations has been mixed.

In Quebec, the government and opposition parties all attacked Romanow's report for recommending that conditions be attached to federal funding, going as far as taking a unanimous vote in the National Assembly against the recommendation. However, a December Leger Marketing poll revealed that Quebeckers are willing to sacrifice some of their province's jurisdictional power in exchange for federal money to shore up the health care system. About 62% said that the Quebec government should accept conditions on the transfer of federal money, even if the Quebec government thought they were unacceptable.

The federal government has not yet demonstrated a sense of ownership over the Romanow Commission's report. However, there have been some encouraging signs. Prime Minister Chrétien appears to recognize that the Romanow report is the voice of the Canadian people and that action must be

taken, and has said that his government will not tolerate jurisdictional squabbles getting in the way of securing Medicare.

This is an ideal moment for the federal government to take a strong leadership role against health care privatization. If it does so, it will have wide public support, and enough money to back it up.

The worst possible outcome is one in which the federal government hands over health care money to the provinces with no conditions attached, and no mention of growing privatization. This would be a blow that Medicare may be unable to withstand.

Endnotes

1. Globe and Mail, December 13, 2002
2. Romanow, Roy, J., *Building on Values: The Future of Health Care in Canada,* Final Report, November, 2002, p.xx
3. Ibid;
4. Relman, Arnold, S., M.D., *For-Profit Health Care: Expensive, Inefficient and Inequitable*, Presentation to the Standing Senate Committee on Social Affairs, Science and Technology, February 22, 2002
5. Canadian Institute for Health Information, *National Health Expenditure Trends*, 1975-2000, p. 45
6. Ibid, p.43
7. Ibid, p.49

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