Ten Vital Measures for Health Care Reform

By Seth Klein
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Canadians are hearing mixed messages. They know the health care system is under stress. The provinces say the feds must pay more. The federal government says the provinces need to discuss health care reform. Who's right? They all are. We need more funding and substantial reform. The following recommendations for saving public health care emerge from various CCPA publications, and from a recent CCPA workshop on progressive health care reform:

1) Increase health care funding. Perhaps stating the obvious. This is required from both federal and provincial governments. While it is true that more money alone will not fix our health care system, lack of funding guarantees a deepening crisis. The federal government needs to fully restore and enhance health funding transfers to the provinces. This should take the form of a specific and targeted health transfer (separate from other social and educational transfers), so that the provinces cannot redirect these funds for other purposes. BC is in a better situation than most other provinces. It is the only province that continued to increase spending through the 1990s. However, these increases have not kept pace with the combination of population growth and inflation (hence the increased stress on the system). BC needs more nurses in particular (we have fewer nurses per capita than all provinces but Ontario). As the health care system is deprived of funds across the country, care is increasingly falling to family and friends (particularly women), and people are paying more out-of-pocket.

2) Keep the health care system public. Stop the slow growth in private delivery. There is now clear and indisputable evidence, from Canada and internationally, that public health care delivery is more efficient as well as more equitable than private delivery. Private delivery of publicly-funded health care means vital health dollars are lost to the profits investors demand (as much as 15%), higher executive salaries, higher marketing/advertising costs, and lost economies of scale. That means fewer public dollars going into direct services, and thus longer waiting lists. Alberta's move towards private over-night hospitals must be stopped. If it is allowed to proceed, the terms of the North American Free Trade Agreement may make it impossible to ever bring these services back into the public sector. We need public institutions accountable to citizens, not shareholders, capable of integrating and coordinating our health care needs.

3) Bring in a Community and Home Care Act (CHCA). As health care delivery moves increasingly into the community and people's homes (which is, by and large, a good thing), it is escaping the Canada Health Act, and that means privatization trouble (see point 2). The Canada Health Act only applies within the walls of our hospitals and doctors offices. BC should lead the way in bringing forward a CHCA, which would bring the principles of the Canada Health Act into force in community and home care, and ensure continued public delivery and universal accessibility.

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4) Build new public long-term care facilities. There is a clear shortage, and that shortage is increasing quickly (about 7,000 seniors are currently waiting for one of BC's 24,707 publicly funded long-term care beds). Without adequate investment in new facilities, long-term care patients will increasingly take up acute care hospital beds and our emergency rooms, in turn, will remain clogged with acute care patients. These facilities should be built directly by provincial governments, not contracted to the private sector. Private long-term care facilities hamper regional and provincial coordination. Private facilities have higher administration costs, poorer pay and training, lower standards, and higher borrowing costs (public building means access to lower financing costs).

5) Move away from paying doctors primarily on a fee-for-service basis. This is critical for controlling costs, as doctors working on a fee-for-service basis have an incentive to see too many patients for an inadequate period of time, too frequently, and to order unnecessary procedures. (This is particularly true in BC, which spends a larger share of its health care budget on doctors than any other province.) Doctors on salary can take the time needed for each patient, and do not face the same incentive to "over-doctor". Every major federal and provincial inquiry into our health care system and its financing has identified fee-for-service as a major barrier to improving medicare's efficiency. This is not to say there is no place for fee-for-service. It may make sense for some services (births, for example) to be remunerated on a fee basis (we need to compensate people for getting out of bed in the middle of the night). The point here is to get the right mix. And contrary to popular perception, many doctors would prefer being on salary (better income security and enhanced personal lives).

6) Move towards multidisciplinary, community-based, primary health care centres. Our health care system needs teams of professionals working together (on salary) serving their local communities (Vancouver's Reach Community Health Centre on Commercial Drive is a good model). Such centres can provide total care to a given population, and the centre's team can focus on the task of providing ongoing care, without worrying about their personal incomes. Many health care problems do not require the ongoing services of a doctor; they can be looked after by other (less highly-paid) professionals (nurses, physiotherapists, psychologists, counselors, nutritionists, etc.). We need to encourage everyone to establish long-term relationships with a family doctor/general practitioner, ideally based out of community centres (such as Quebec's CLSCs). We need people's first line of contact to be local health centres or GPs, not expensive emergency rooms or "doc-in-a-box" clinics that do not provide ongoing primary/family care. There is strong research showing that jurisdictions with multidisciplinary primary health care teams have healthier populations and lower costs. Professionals working with teams can also spell each other off and live more reasonable personal lives.

7) Bring in a public National Drug Plan and control drug costs. Drug costs are escalating more than any other component of the health care system, increasing health costs borne by individuals, employers, and the public system. This requires repealing federal drug patent legislation (even if it means fighting off a WTO/NAFTA challenge). BC's referenced-based pricing is a good model. If

prescription drugs (clearly a medical necessity) are bought under public health care for everyone (not just seniors), governments will find the will to lower drug costs.

8) Provide adequate resources for the Provincial Mental Health Plan. De-institutionalization has left too many mental health patients out in the cold. These patients still need adequate housing, incomes and support, and the on-going care of mental health practitioners. The Provincial Mental Health Plan talks about integrating acute and community mental health services, to create a continuum of care. That takes money.

9) Give health care workers and patients a greater say within the health care system. Working in the health care system is stressful, and too often encountering it as a patient is even worse. Less hierarchical workplaces would be a good start. There is a growing literature indicating front-line workers with more autonomy and support functioning in more democratic workplaces experience decreased injury rates, take less sick-leave, and deliver better patient care. We need reform, and both workers and the public will be more willing to go along for the ride if they are included in the policy-making and governance process.

10) Last, but certainly not least: Tackle the determinants of health and adopt a comprehensive anti-poverty strategy. The research on the determinants of health is clear. The empirical evidence connecting poverty and inequality with poorer population health and increased health costs is unequivocal. That means rethinking tax cuts for those who need it least, and budget cuts for the programs low-income people depend on. If our governments declare war on poverty, child poverty, homelessness, and unemployment, health care costs will come down. More supportive non-profit housing for poor seniors and people with physical and mental disabilities is the most pressing need. Tied to this recommendation, we need to put more money into prevention and wellness, not just illness. That means tackling the causes of cancer and heart disease, not just the acute emergencies. It means dealing with environmental and food safety issues. It means better working conditions, and fostering healthier lifestyles.

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