SOCIAL WATCH

SOCIAL WATCH CANADA 2003 REPORT
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Social watch is a global civil society research and monitoring initiative involving non-governmental organisations from some 60 nations. It was formed in the wake of the 1995 United Nations Social Summit in Copenhagen to monitor how governments are meeting their commitments to eradicate poverty and reduce inequality.

This year's global report focuses on how governments are reshaping public institutions, national and globally, to advance private interests. It also advances strategies for promoting universal access to basic public services. The Social Watch Canada report singles out the threat to Canada's public health care system.

The Canadian Centre for Policy Alternatives has become the host of Social Watch Canada and works in partnership with the North South Institute. Bruce Campbell, Executive Director of the CCPA and co-author of this year's report, will be participating in the release of the global Social Watch Report at Porto Alegre. John Foster, senior researcher at the North South Institute and member of the Social Watch executive, will also be participating in the Porto Alegre release.

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Canada's health care choice:
Pawning or polishing the jewel in the crown of social programs

By Armine Yalnizyan and Bruce Campbell, Canadian Centre for Policy Alternatives

Canada's most treasured social program is public health care. For almost 40 years, citizen access to doctors and hospitals has been a right of citizenship, based on need, not ability to pay.[1]

Today we are in the midst of a profound debate about public health care: what is a medical necessity? how should we fund public provisions? how should they be delivered? Greater privatization – more specifically, "profitization" – is a possible response to each question, as we weigh the options of what choices to make for the future. For the first time since it was implemented, the universal approach to health care is in contest with a market approach.

How did a nation that enjoys such robust social consensus for health care as a basic human right find itself in this situation? It has emerged alongside growing inequality and chronic public underfunding, framed by the trade agenda of expanding commercialization.

The backdrop: Growing inequality, greater vulnerability

After more than 15 years of aggressively pursuing policies that provide less from the state and more from the market, the Canadian economy is growing more rapidly than all other G7 nations. That's the good news. The bad news is that the rise of economic strength has not translated into a return of affluence or economic security for most individuals, or for society as a whole.

In strictly material terms, the majority of Canadian families do not enjoy the same economic security and comfort that citizenship granted two decades ago, even though the economy is two-thirds larger than it was, in "real" (inflation-adjusted) terms.[2] Incomes have been rising for four straight years but, after taking inflation into account, average family incomes have barely regained the after-tax levels of 1980; median family incomes still aren't there; and the difference between average and median incomes is spreading.[3] All measures point to growing income inequality.

A falling median income means there are proportionately more poor families in society today than there were twenty or even ten years ago. This despite the promise that massive public and private sector belt-tightening since the 1980s would create greater affluence for everyone. To the extent that family incomes have kept pace, it is because of greater labour force participation by women, whose total paid hours of work almost doubled between 1976 and 2001.[4] There is a limit to that strategy.

The things that have led to Canada's strong economic growth — less state, more market — have led to the erosion of public goods and supports. Shrinking stocks of affordable housing, privatization of utilities, and deregulation of tuition fees mean the cost of living for individual

households is going up. Life is getting more precarious for the ever-growing number of families who are not "getting ahead." Ironically, as their real choices narrow, those who *are* getting ahead are demanding greater choice. Higher incomes and greater wealth permit some people to buy their way out of supply problems that are now endemic in the public system.

Their place in the income spectrum reflects the fact that these are the decision-makers of society. Their preferred option is to opt out of the constraints of public provisions, and secure the best that money can buy. Health care is the last public provision to have been dragged into the battle between the need for security and the desire for choice

The campaign: Raise doubts that public health care is sustainable

Though Canadian citizens have consistently indicated a willingness to pay more in taxes to support public health care provisions, politicians thus far have not listened. Instead, they have cut taxes, even as they have characterized public health care as unaffordable and unsustainable. The uncertainty of the current state of affairs stems from the following two main reasons.

The scope of guaranteed access to care is not comprehensive

Not all medically necessary services are publicly insured under the Canada Health Act. Prescription drugs and health care services provided outside a doctor's office or hospital — such as home-care or long-term care — are not included. Though these services are offered to varying degree in the provinces, there are no national standards, no guaranteed rights of access, and no cost-sharing by the federal government.

Increasing reliance on pharmatherapy and advances in diagnostic and therapeutic techniques are redefining the meaning of health care. More aspects of medically necessary care are falling outside the domain of the Canada Health Act. With the biggest cohort of post-war baby-boomers in the world, a key challenge for Canada over the coming years will be integrating low-tech preventive and chronic forms of care with the acute health care system. Without federal support, it is unlikely that most provinces and territories will be able to carry the costs on their own.

Ensuring that the Canada Health Act covers a comprehensive range of medically necessary care will cost billions of dollars. But providing the same range of services through private financing costs more, compared to the administrative savings, economies or scale, and regulatory clout of single payer systems. We will pay more regardless, collectively and individually. The only real question in health care reforms is who gets access, and on what basis: need or ability to pay?

Chronic shortages of public money and care-providers compromised the system

The public system of acute care has been starved for cash for the past decade. Efforts to reduce public spending and shrink the role of government are hardest to accomplish in the sphere of health care, but even here the cuts have numbered in the billions. The federal government reduced cash transfers to the provinces for the purposes of health care by $7.5 billion between 1996 and 2000,[5] and the provinces themselves cut over $1.5 billion in the mid-1990s.[6]

Shortages in health professionals stem partly from global shortages, and partly from explicit government choices. Policies over the past decade included: limiting enrolments to medical schools and deregulating tuition fees, which

have skyrocketed; laying off nurses and other health professionals in the thousands to save cash; and implementing enriched early retirement packages as part of the cutback process, encouraging health workers to voluntarily leave the profession.

Chronic underfunding of public health care provisions have led to two forms of privatization: covert and overt.

Covert privatization is due to less time cared for in hospital and de-listed insured services.

The amount of time people spend in hospital has dropped, partly due to new techniques and medicines, partly due to service cutbacks.[7] Despite improvements for some, more patients are being released from hospital "quicker and sicker." Without adequate supports in the community, more demands have been placed on patients' immediate support network.

It is estimated that 75 to 90 per cent of home care is provided voluntarily by family and friends, mostly women.[8]

The problem is that there are fewer people around to provide such care, due to falling birth rates, increased labour force participation by women, increased divorce rates, more single parent families, and more geographically dispersed families. Increasing medical complications and decreasing availability of informal care have led to the increased use of paid home care services.[9]

Paid work in both home care and institutional care has intensified over the decade. Nurses, mostly women, have one of the highest rates of workplace injury and time lost due to illness.[10] The supply shortage is taking a toll on both the care providers and those who need care.

If expansion of federal cost-sharing for public health care does not occur, more provinces will use the excuse of inadequate fiscal room to continue to de-list services. Health care is the largest single public expenditure, and in recent years has grown most rapidly of all public spending areas. It already accounts for more than a third of most provincial budgets. It has risen to 43 per cent of program spending in the biggest province, Ontario, partly due to cuts in other public goods.[11] The argument that health costs are squeezing out other public priorities remains an issue.

As total public health spending continues to rise, the scaling back of provisions towards a more restricted core means more people will pay directly for aspects of medically necessary care that used to be provided publicly, or do without. Some de-listed services, such as certain IV transfusions, are so costly that even the non-poor find themselves facing impossible choices. But those most affected are those who are already the most vulnerable and sick : the poor, the frail elderly, the severely disabled, patients without advocates. For the poor, the choice is often between rent and food. New costs for medication or services simply mean more episodes or severity of illness.

Overt privatization is occurring on both the funding and delivery sides of health care.

The basic need for health care does not follow market rules, but the perception of need does. Corporations advertise to "consumers" (except where prohibited by law) or market to physicians to increase the demand for pharmaceuticals, medical technologies, and diagnostic techniques.

Public funding is privatized through increased reliance on user fees and co-payment mechanisms. Delivery is privatized when public funds shift from not-for-profit to for-profit service providers.

All three are now occurring in Canada, but changes at the margin regarding how health care is delivered present serious long-term implications in the context of international trade laws.

Long-term care and home care – delivered by a mix of private for-profit and not-for-profit service providers – has seen a shift in the use of public money, with more funds flowing to for-profit care providers in the past two years. In just the past few months there has been a rash of policy decisions to use public dollars to create investor-owned facilities in British Columbia, Alberta, Ontario, and Nova Scotia.[12] These decisions will double the number of private for-profit diagnostic clinics, and introduce plans for for-profit hospitals in three provinces.

But mounting public pressure has also led to several more hopeful developments in the past year. Alberta made major investments to modernize its public system's diagnostic capacity, thereby taking away the market for for-profit provision of such equipment and services. After a group of citizens exposed the fraud and abuse of a large for-profit North American home-care firm, the government of Manitoba imposed strict regulations and standards of care, forcing the company to abandon its home-care operations in the province. In Saskatchewan, the Prince Albert Regional Authority took over for-profit lab services and achieved significant savings.

These moves saved money, improved the quality of care and/or sped up access to service by shifting money from for-profit to not-for-profit service providers. They raise a serious question: why shift money out of the public, or not-for-profit realm, in the first place?

Fighting the use of public funds to establish investor-owned facilities has also seen success and failure. In New Brunswick, a business consortium financed the building of a new psychiatric hospital. The government leased back the facility, providing the investors guaranteed payment for 25 years, but at the end of 25 years the government owns nothing. More recently, in nearby Prince Edward Island, a government decision to build a hospital using public-private partnerships was reversed within months, due to public pressure. The new hospital is being built exclusively with public funds, is owned by the government, and will operate as a not-for-profit incorporation.

More provinces are responding to public demands for improved access to health care by asserting that for-profit businesses can provide it "faster, better, cheaper." Communities everywhere are challenging this approach. While small in number, these provincial initiatives are testing the waters for a political signal about the legitimacy of "profitization." The federal Minister of Health's silence is signal enough, an eloquent reflection of the same ambiguities that exist in our international trade stance. Domestically and internationally, the clash of cultures between commercialization and public policy is most acute in the area of health care.

The context: NAFTA, GATS, and health care in Canada[13]

Contrary to assurances made by government officials, Canada's health care system is not fully shielded from NAFTA and GATS. Though safeguards for public health care exist, health insurance is an explicit category of service covered by these agreements. As provinces increase commercial involvement in the financing or delivery of public health care, the scope of the existing safeguards is narrowed. As the protective effect of the safeguards weakens, entry for foreign investors becomes easier. Once established, the ability of future governments to reverse the trend towards greater private for-profit health services becomes more difficult and costly.

The lack of coherence between domestic and international health policy objectives is glaring. International trade treaties are designed to facilitate and expand commercialization, con-

straining and redirecting the regulatory ability of government so that services are provided according to market principles: demand driven by ability to pay; supply driven by the profit imperative. This conflicts with the purpose of Canadian Medicare: demand driven by need; supply driven by need (with necessity defined through the "single payer" system of government purchase, and resources constrained by the ability to raise public revenues).

Viewed through the lens of trade, public health services are, at best, untapped commercial opportunities; at worst, unfair competition. The resources spent on health care worldwide are enormous, estimated at $US 3 trillion annually. In industrialized countries – all with aging populations – growth seems guaranteed. In Canada, the public health care system has grown at an average annual rate of over 8 per cent over the last 25 years. Private health spending almost doubled in the 1990s.[14] With over $100 billion in spending on health, and growing, the commercial potential in Canada is vast.

The challenges: Naming the dangers from trade

Investor-state provisions and the expansion of Medicare

If foreign health insurers lose a part of their market share due to the expansion of publicly insured programs — such as moving toward a national pharmacare or national home-care program — they could demand compensation under the NAFTA expropriation provisions and under the GATS monopolies provisions. Investor-state provisions are on the table in the FTAA negotiations and are likely to be on the table at the WTO investment negotiations scheduled to begin after September 2003.

National treatment and Most Favoured Nation (MFN) provisions and trying to reverse the trend to commercialization

If public policies favour local community-based health providers or not-for-profit providers, foreign corporations could use NAFTA and GATS rules against "discrimination" to demand compensation or right of entry into the market. Under MFN, once any foreign provider operates in a market, all foreign providers are entitled to the same access.

Intellectual Property Rights and Drug Costs

WTO and NAFTA intellectual property rules (TRIPS) require a minimum of 20 years of monopoly patent protection and forbid the stockpiling or export of generics. This is driving up drug costs and restricting the availability of affordable medicines to cope with health emergencies, for example the HIV-AIDS pandemic.

The response: What should the Canadian government do?

The Canadian government must take decisive action now to halt the commercialization of health care before the trade treaties make it too costly to reverse.

Trade and public interest frameworks have conflicting guiding principles. They cannot both lead. The tension between the state's role as trader and its role as guardian mirrors the larger tension in the pursuit of global development: the tension between economic growth and human rights.

Health care is quintessentially a human right. We recognized health as a human right when we helped author the Universal Declaration of Human Rights in 1948 and signed onto the International Covenant on Economic, Social and Cultural Rights in 1976. The hallmark princi-

ple of the Canada Health Act is equity of access.

- Canada should explicitly recognize the primacy of international human rights law over other areas of international law, including trade and investment treaties. This articulation of foreign policy would shape our priorities and participation in international trade negotiations.

- Canada should pursue fully effective, generally-agreed-upon exemptions for public health with all negotiating partners, not country-specific exemptions, at the WTO Doha Round and the FTAA negotiations. It should withdraw its support for investor-state dispute settlement procedures that allow investors to directly challenge public policy measures, and withdraw its 1995 GATS commitment covering health insurance.

- Canada's international trade policy position should be open to full public scrutiny and participation from health professionals, advocates, and the general public. The federal government should propose adoption of the United Nations treaty-making process in which negotiating sessions are open and all documents public. Inclusion and transparency have become watchwords about how governments formulate policy and laws. Yet the very opposite is the norm when these same governments negotiate trade agreements that have profound effects on their citizens.

- Canada can and should expand public provisions of health care. It can assure that a comprehensive range of medically necessary care is available for all citizens by publicly insuring access to pharmacare and continuing care provisions. It can better integrate service delivery to facilitate timely access to appropriate forms of care. It can assure high quality care by establishing and enforcing clear national standards of performance and accountability in return for public funds. None of this is possible without increased federal financing and federal coordination of policy developments. Without a renewed and invigorated federal role, universal access to basic health care will only be a charming anomaly in Canada's history.

The Canadian choice

Nations are characterized by the way they define and meet the basic needs of all their citizens. The provision of health care based on need, not ability to pay, means every person has access to the solidarity of all when struck by illness. This evokes the meaning of Canadian citizenship more effectively than does a passport or an army, a currency or a diplomatic corps.

The choices made by the federal government in the next year will not only characterize what kind of nation we are; they will also signal what can be expected or hoped for among people elsewhere. Public health care is the jewel in the crown of our social programs and social achievements. Whether our governments see it as a treasure or an asset to be liquidated remains to be seen.

Endnotes

1 Access to acute health care services (doctors and hospitals) has been a legal entitlement since 1966. In the past year 3 provincial commissions have made recommendations regarding the future of public health care. At the federal level a Senate Committee process and an appointed Commission, will make recommendations by the end of 2002.

2 Statistics Canada, Gross domestic product, expenditure-based, *CANSIM 100126*

[3] Statistics Canada, *Income Trends in Canada 1980 – 1999*, Catalogue Number 13F0022XCB, Ottawa: 2001; and Statistics Canada, *Family Income*, The Daily, July 18, 2002. Average income is total income generated by a population divided by the population. Median income is the half-way point, where half the population makes more, half makes less.

[4] Statistics Canada, *Labour Force Historical Review*, Catalogue Number 71F0004XCB, Table 9.

[5] Calculated from Government of Canada, *Backgrounder on Federal Support for Health in Canada*, March 29, 2000, p.7, using 1995-96 allocations for health care as the base year.

[6] Based on calculations from CIHI, *NHEX 1975 – 2000*, D.3.1 Series of provincial/territorial expenditure tables.

[7] CIHI, *Hospitalization Statistics*, *Table 3: Hospital Days and Average Length of Stay for Canada, Provinces and Territories, 1994/95 to 1999/00*. Ottawa: September 2001.

[8] Canadian Home Care Human Resources Study, *Phase I Final Report*, Ottawa: February 2002, p.4

[9] Health Canada estimates of public spending on home care services show it doubled in the 1990s to about $2 billion, though it is dwarfed by spending on hospitals ($26 billion) and long term care ($7.5 billion). Health Policy and Communications Branch, Health Canada, *Health Expenditures in Canada by Age and Sex, 1980-81 to 2000-01*, Statistical Annex, Ottawa: August 2001

[10] Advisory Committee on Health Human Resources, *Our Health Our Future: Final Report of the Canadian Nursing Advisory Committee*, Ottawa: Health Canada, 2002, p. 14.

[11] Based on calculations from the Canadian Institute for Health Information (CIHI), *National Health Expenditure Data, 1975 – 2000 (NHEX)* Appendices.

[12] See http://www.healthcoalition.ca

[13] This section and the next draws from Matthew Sanger and Scott Sinclair, "*Putting Health First: Canadian Health Care Reform, Trade Treaties and Foreign Policy*." Final report prepared by the CCPA consortium on globalization and health for the Commission on the Future of Health Care in Canada, October, 2002 (available at http://www.policyalternatives.ca).

[14] Canadian Institute for Health Information, *National Health Expenditures 1975 – 2001*. Ottawa: 2002. Series C.

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