RNAO

Registered Nurses Association of Ontario

L'Association des infirmières et infirmiers autorisés de l'Ontario

Ontario Registered Nurses Speak Out for Medicare:

Protect, Preserve and Strengthen

Submission to the Commission on the Future of Health Care in Canada

by

The Registered Nurses Association of Ontario

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Introduction

The Registered Nurses Association of Ontario (RNAO) is the professional voice of registered nurses in Ontario with a mandate to speak out for health and for nursing. RNAO has a proud tradition of speaking out on provincial and national issues as they impact on healthy public policy. In fact, during the early 1980s the Association joined with other nurses in Canada in advocating for the Canada Health Act (CHA). We now join with nurses and others to defend the principles of the CHA and to see them extended to those areas of essential health care that are as yet uncovered by the CHA.

Our analysis demonstrates that there is no necessary contradiction between a healthy public policy and a healthy economy. Indeed, if we proceed prudently, each supports the other. In our response we will show that strengthening our publicly funded system and not-for-profit delivery makes sense in health, economic and moral terms.

There is need for a comprehensive, clear-headed dialogue on health care in Canada. It is time, once and for all, to chart a path to a Canadian solution to the many challenges we now face and those that will come our way.

We want to thank the Commission on the Future of Health Care in Canada for the opportunity to present our views today. RNAO also commends the Commission for identifying many of the key issues that need to be addressed as we move to strengthen this cornerstone of our Canadian identity.

Executive Summary

The Romanow Commission has embarked on a daunting and very important task – to evaluate a wide range of issues related to understanding and strengthening Canada's health system and health care system. The Commission has challenged Canadians to engage in a dialogue on the future of this defining institution. The timing is critical, as we now are at a crossroads. Resource constraints are forcing us to face three options (not necessarily mutually exclusive): finding more money; considering greater rationing on the basis of medical necessity; or rationing more on the basis of ability to pay (relying on market mechanisms).

The RNAO submission is organized around the four themes identified by the Commission. Section A addresses the starting point – **Canadian values**. Universal access and the enduring principles of the 1984 Canada Health Act are now at the core of Canada's soul. Although medicare is relatively new, the principles flow from a strong Canadian tradition of collective action for the common good. Canadians quickly embraced medicare, and it has achieved iconic status. Section A traces the development of the health care system, which remains incomplete, but still a monumental achievement. In recent years, a gradual erosion of access via privatization represents a challenge to the system. We call on all levels of government to reaffirm their commitment to all of the principles of the Canada Health Act: universality, accessibility, comprehensiveness, portability and public administration.

Section B discusses growing **challenges to sustainability**. An examination of health care spending reveals that spending is not out of control. Rather, the problem is that government spending is sharply shrinking as a share of Gross Domestic Product (GDP). This jeopardizes the sustainability of all social programs, including health care. We call on government to take appropriate **macro steps** to protect health and health care:

- Recognizing the importance of employment to population health, government should make full employment a high priority.
- Recognizing that providing health care and other essential public services costs money, governments should be fiscally prudent, and not engage in tax cuts before alternative revenue sources are found. These alternatives could include health-promoting options such as green taxes.
- Recognizing that health care has failed to keep pace with economic growth, government should consider heeding the call to devote a stable share of GDP to health care expenditures

Government must respond to a number of **urgent issues concerning health care**:

- Long waiting times for certain procedures are a major public concern. Better management of waiting lists and – in some instances, more resources – are required.
- Far too many health care providers face unsustainable workloads and intolerable work circumstances. This is particularly true for the nursing profession. Urgent attention and collaboration is required at the federal and provincial levels.
- Drug expenditures are running out of control. A comprehensive response is needed, including support to best-practice prescribing, co-ordination of purchasing, a national drug formulary, and an aggressive response to monopoly drug pricing.

- Credible commitments to health care must be made at both levels of government. This will require leadership by all concerned.
- Government must explicitly exclude health care and other essential social services from free trade agreements. These services are already dangerously exposed to challenges under existing agreements, and must be protected.

Evidence from Canada, the US and elsewhere is very strong: **public payment** for health care services not only yields better access and improved health outcomes, it is also cheaper. The evidence also leads us to conclude that **not-for-profit provision** is superior in terms of efficiency, cost and quality. Given the evidence, we make the following recommendations:

- There should be a moratorium on privatization of health care funding, and on transfer of provision to for-profit institutions.
- User fees should be banned for any essential health care services. These user fees constitute a barrier to access for poor people, and do not save the system money in the long run, because they do not discriminate between appropriate and inappropriate use of the system.
- Canada must find a way to extend coverage of the Canada Health Act to all uncovered areas, including home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care. The path will take time, cannot be done all at once, and must be responsive to fiscal realities.
- The federal government must raise its cash contribution to 25% of provincial health care spending, and tie this contribution to the above expansion of coverage of the CHA.

In addition to the above recommendations, there are a number of other ways to enhance sustainability by improving delivery. Section C includes recommendations on efficiency and effectiveness, and recommendations on accountability and governance.

Efficiency and Effectiveness:

- There is broad agreement among health care experts on the need to commit fully to primary health care reform, with 24/7 service being delivered by interdisciplinary teams. This would enhance the scope and quality of services delivered, and reduce the costly and unnecessary use of the hospital system.
- Government must commit more resources on a permanent basis to the integration of prevention and population health concepts into policy. We as a society must address all of the determinants of health: income, income distribution, employment, stress, environment and social support. There is a role for all sectors of government, and not just the health care sector.
- Government must introduce more appropriate incentives for users, providers and providing institutions. For example, the fee-for-service mechanism rewards assembly-line medicine and punishes more conscientious treatment.
- Government should strengthen its support for the systematic identification and implementation of more effective and responsive health care interventions. We know that many physicians could improve their practice by implementing existing best practice guidelines.

Accountability and Governance:

- The public wants greater participation in the governance of our health care system, along with greater accountability and transparency. Accountability and transparency offer mechanisms for promoting more effective and efficient delivery of care and system utilization.
- Government must continue to devote resources to improving co-ordination and integration of health care. The creation of regional health authorities has been one approach widely used, and is a step in the right direction.
- A national health care advisory council formed by the two levels of government could perform a number of important functions:
  - consultation on health policy
  - provision of a forum for collaboration in defining the scope of medicare programs
  - monitoring of programs facilitation of co-operation in improving the efficiency and effectiveness of health care programs (including setting up an information system that could allow cost-benefit analyses of health treatments)
  - performing an accountability service

Section D addresses the challenges of implementing our vision:

- Canadians' confidence in government commitment to medicare has been shaken, and can only be regained by consistent and substantial steps by governments determined to show leadership
- The lack of co-operation and co-ordination between provinces and the federal government is a serious hindrance.
- Many domestic and foreign interests would gain from the Americanization of the Canadian health care system, at the expense of the health of Canadians.
- There are powerful and well-placed interests promoting unhelpful forms of deregulation, globalization and withering of the state. Arrayed against them are many citizens' groups. In spite of this opposition, Canada has already endured considerable harmful restructuring, such as the weakening of the social safety net.
- Proponents of the traditional methods of organizing health care (curative, physician-centred, fee-for-service, etc.) are still predominant.

The good news is that the public is not ready to let go of Medicare – a system that for the most part has served them well. Indeed, in our public forums we have become keenly aware that the public is looking for leadership to sustain and strengthen Medicare. The public wants universal access to essential health care services and does not mind paying taxes for it. However, they want assurances that the system will be there for them when needed.

Section E speaks to federal-provincial relations. It calls on both sides to put aside disagreements and find ways to fully realize universal access to essential health care services in Canada. In particular, it invites the federal government to be inventive in finding ways within its power to extend coverage of medicare over uncovered areas. Experts suggest that national home-care and pharmacare programmes would be ideal starting points.

Universal access to essential health care services is a simple and compelling idea. It fits squarely with Canadian values, and it makes good health and economic sense. Fully realized, it would be

the completion of a visionary dream, and a tool for a positive national unity. We must do more than merely save our health care system – we must make it the envy of the world. It will be a major undertaking, but anything of enduring value takes real commitment, vision and work. We owe that much to the people whose struggles have brought us this far.

Summary of Recommendations

Canadian Values

1. Reaffirm Commitment to Canada Health Act We urge the Commission to identify universal access to health care as being a core Canadian value, and a right to all who make their homes in Canada. We further urge the Commission to reaffirm its commitment to the principles of the Canada Health Act (universality, accessibility, comprehensiveness, portability and public administration) as an essential basis for health care provision. These principles should be extended to all areas of essential health care.

Sustainability: Macro Steps

2. Target Full Employment to Improve Population Health We recommend that the Commission identify maintenance of full employment as an important target for the Canadian government, as this helps to avoid the significant health costs associated with unemployment. It also creates the financial resources to sustain the health care system.

3. No Tax Cuts at the Expense of Health Care We recommend that the Commission advise the Canadian government to manage its fiscal and monetary policy in such a fashion that it will have sufficient revenue to pay for the essential social services that Canadians want, such as health care. This would include a halt to further cuts in tax rates before alternative sources of revenue are found. Alternatives could include green taxes and taxes on speculative flows of financial capital. Essential services are not sustainable in the current environment of a rapidly shrinking government sector.

4. A Fixed Share of GDP for Health Care We ask the Commission to support those who have called for a commitment of a fixed share of GDP to health care. This would serve two purposes: to avoid the quiet erosion of government support that we have witnessed in the past decade, and to focus attention on the affordability of our health care system. Any formula would have to adjust for fluctuations of GDP over the business cycle.

Sustainability: Responding to Urgent Pressures

5. Rationalization of Waiting Lists We urge the Commission to recommend that waiting lists for procedures be rigorously maintained on a province-wide basis, and that placements should be done solely on the basis of relative need. A possible model would be Ontario's Cardiac Care Network. This would help to resolve some but not all of the problems associated with long waiting times for certain procedures.

6. A Coordinating Body to Deal with Health Human Resource Issues We urge the Commission to recommend the creation of a permanent national coordinating body to deal with health human resource (HHR) issues, such as working conditions, and recruitment and retention. The body would be comprised: of health care workers; federal, provincial and territorial governments; and health care providing institutions. A national collaboration is essential to ensure that all Canadians have equal access to health care providers, and to deal with the problem of interprovincial poaching of health care providers

(A full set of HHR recommendations appears in Appendix B)

7. A Minimum of 70% Full-Time Positions for Nurses We urge the Commission, in addition to its call for healthy, safe workplaces to specifically call for a guaranteed minimum of 70% full-time positions in nursing, and to call for adequate and stable funding to ensure improved working conditions (including safer workloads), for the nursing profession. Of RNs employed in nursing in 2000, 43% alone were part-time.[1] Many others are employed on a casual basis.

8. Develop a Strategy to Control Drug Costs We urge the government to develop strategies to control the rapid growth in pharmaceutical expenditure, without compromising the quality of health care. When drugs rise from 8.5% to 15.5% of Canadian health expenditures, urgent action is necessary. These strategies should include:

- Developing comprehensive support for effective and cost-efficient prescribing,
- Coordination of national drug purchasing and a national drug formulary, and
- Devising methods of countering the monopoly pricing that the excessively powerful patent laws allow. This could entail negotiating a return of compulsory licensing for pharmaceuticals.

9. Make Credible Commitments to Health Care We call upon the Commission to urge both levels of government to make credible commitments to health care, in order to restore Canadians' confidence in their health care system. This confidence has been shaken badly in recent years, and this is confidence is essential to the survival of the health care system.

10. Explicitly Exempt Health Care from Free Trade Agreements We urge the Commission to call upon the government to explicitly exempt health care and other essential social services from all trade agreements. Without such exemptions, foreign interests are sure to challenge these services, and could easily dismantle them using the very intrusive tools available in the free trade agreements.

Sustainability: Funding

11. Moratorium on Privatization of Health Care Funding We urge the Commission to recommend that all levels of government place a moratorium on privatization in health care funding. Allowing private payment has been shown to reduce access, reduce efficiency, and raise costs.

12. Ban User Fees for Essential Health Care Services We recommend that Canada maintain its strict ban on user fees for services covered under the Canada Health Act. We further recommend that governments develop strategies for eliminating user fees on other essential health care services. User fees are a proven barrier to access for the poor, and they do not lead to

more appropriate use of health care services. On the contrary, they indiscriminately discourage both appropriate and inappropriate use, with predictable costly consequences for health and hospital budgets.

13. Extend CHA to Cover All Essential Health Care Services We recommend developing a commitment and strategy for a phased extension of the CHA principles to essential services in home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care. This would make access to health care in Canada truly universal. It would also make the system more rational and efficient. The phasing would be timed to meet fiscal realities.

14. Democratic Definition of Medical Necessity We recommend the development of a democratic and transparent process for defining medical necessity. We can do more with existing resources, and we can apply more resources, but these resources are finite. Rationing is inevitable, but it must be on the basis of need, not on the basis of ability to pay.

15. Raise Federal Cash Contribution to Health Care We recommend that both levels of government make substantial and credible commitments to funding health care in a comprehensive framework. For the federal government, this means raising the cash contribution to provincial health care, ultimately to a minimum 25% of provincial spending. This increased cash contribution must have attached with it an expansion of the CHA to cover those as-yet uncovered essential health care services.

Sustainability: Not-For-Profit Provision

16. Moratorium on For-Profit Provision We urge the Commission to recommend that all levels of government place a moratorium on transfer of health care activities to the for-profit sector, because of risks under free trade agreements and because of serious concerns about cost and quality of care.

Sustainability: Other Ways of Improving Delivery

17. Implement Interdisciplinary Primary Health Care Reform We urge the Commission to recommend the implementation of true primary health care reform, with 24/7 care being delivered by interdisciplinary teams of health care professionals. Primary health care reform offers the possibility of providing better care, making better use of all health care providers, and alleviating the load on some overworked providers.

18. Prevention and Population Health We request the Commission to recommend devoting more resources to the integration of prevention and population health concepts into our system. It would be a wise investment that both improved health and reduced the greater expenses for treatment of unnecessary illness and injury.

19. Develop Appropriate Incentives We must reward good practices in health care. We ask the Commission to chart a staged path to more appropriate incentives, including alternative payment mechanisms for health care professionals and alternative funding mechanisms for health care institutions. In contrast, the current fee-for-service mechanism for doctors is recognized for its

perverse incentive effects. Another example of perverse incentives is the failure in Ontario to compensate hospitals for lab expenses; the hospitals then direct lab work to private labs where it costs the hospitals nothing, but it costs the governments a great deal.

20. Best Practices We recommend much stronger government support for systematic identification and implementation of more effective and responsive interventions. There is considerable work being done in this area, and there is much evidence that the implementation of what is currently known about best practices would markedly improve outcomes and costs.

21. Governance We request the Commission to chart a process towards greater public participation in the governance of our health care system along with greater transparency and accountability of government. This is an expectation of the public, and has the added benefit that it could make the system more responsive to need.

22. System Co-ordination and Integration We request the Commission recommend devoting resources to improving the co-ordination and integration of the system. The guiding principles ought to be

- Democratic control. This should include community participation in governance.
- Maintaining universality of access

Many jurisdictions have taken major steps in this direction, such as the formation of regional health authorities. This brings cost savings through such things as avoiding duplication of services; it also delivers generally more prompt and better care.

23. A National Health Advisory Counsel We recommend the formation of a national health advisory council. It should be created jointly by the two senior levels of government, and charged with the following tasks:

- consultation on health policy
- provision of a forum for collaboration in defining the scope of medicare programs
- monitoring of programs
- facilitation of cooperation in improving the efficiency and effectiveness of health care programs (including setting up an information system that could allow cost-benefit analyses of health treatments)
- performing an accountability service

Managing Change

24. Measurement and Accountability We recommend that the proposed national health advisory council (or some other appropriate body) facilitate measurement and accountability functions. Whether done by this body or some existing body, the accountability component must be arm's length from funders and providers. Again, accountability and access to information is increasingly the expectation of the public.

Cooperative Relations

25. Focus on Health Care, Not Turf We recommend that both levels of government set aside squabbles over health care funding, in the interest of benefiting all Canadians. There is little more debilitating of public participation and confidence than the kind of quarrelling that has been on offer of late. Canadians expect and deserve better.

26. Leadership from the Federal Government We urge the federal government to explore all ways that it might be able to implement extension of public insurance to cover uncovered essential health care services. To the extent possible, the federal government should creatively explore ways to make health care equally accessible across the country.

A. Canadian Values

(i) Belonging to the Canadian Community

What does it mean to be Canadian? It is impossible to walk across the border from Detroit to Windsor without realizing that we are in a very different country. Canada is truly the product of a national project, and has grown up around its national institutions. It is a country that has chosen not to exalt individualism at the price of exclusion. Instead, Canadians grew up with a strong sense of community and of responsibility for all in that community. Our universally accessible health care system is a clear expression of that sense of community – an institution that is embraced by Canadians of all political stripes. Our health care system has become an integral part of our Canadian identity, and contributes to the social cohesion that is so crucial to the health and well-being of our society.

Charles Baillie, Chair and CEO of the Toronto Dominion Bank, expresses the moral content of the national consensus that emerged on the health care system.

> *"Well, I happen to be someone who believes that a great country is not just an address, some sort of geographic convenience. It is a **community**. It is not simply a construct of economic **value**. It should also be about social **worth**. We Canadians made a decision a generation ago that gave content to that proposition: that every person in this large community – young and old, rich and poor – has a **right**, by virtue of our common citizenship and our common humanity, to equal access to equal health care. That mutual commitment has been a force for national unity – a concrete expression of our common Canadian cause. Stated simply, I believe our national spirit would be diminished were we to let our health care system go."* [2]

(ii) The Canadian Health Care System: Knowing where we've been

There was a time when many Canadians suffered greatly and even died for want of money to pay for health care. Others bankrupted themselves when illness occasioned ruinous health expenditures. This remains a reality for too many people around the world, including millions living in the US. It is this pre-medicare memory that convinces us we have too much to lose if we fail to protect our health-care system. People like Tommy Douglas were driven by a vision of a world where people's access to health care would not depend upon their incomes or wealth. By dint of a long political struggle, Douglas helped realize part of that dream

The first step towards what we now know as medicare was the introduction of province-wide hospital insurance in Saskatchewan in 1947. Provincial medical insurance, also first introduced in Saskatchewan, in 1962 was next. This step was fought vigorously by a well-funded alliance and included a doctor's strike that failed in the face of a system that continued to function. Ironically, many medicare opponents became its biggest backers. Finally in 1971, medicare was adopted across Canada.

The five principles of medicare – accessibility, universality, comprehensiveness, public administration and portability – were enshrined in the Canada Health Act (CHA) and passed unanimously by Parliament in 1984. Canadian nurses, led by the Canadian Nurses Association, were proud to play a strong role in promoting this key legislation. Although publicly-funded medicare is a tremendous achievement, it is only the first step in developing a Canadian health care system. Even the founders of medicare – people like Tommy Douglas and Justice Emmett Hall believed that medicare should cover all essential health care services. Indeed, most Canadians are surprised to learn that the Canada Health Act only covers medically necessary hospital and physician services.

(iii) The Canadian Health Care System: New Realities

While the architects of medicare always planned to include these other services, they were already struggling with entrenched interests simply to get hospitals and doctors covered. In the 1960s, this covered the bulk of health care needed. For reasons to be discussed later, this is no longer the case. As the health care system evolved, more and more services started moving away from hospitals and away from the protection of the CHA.

In part, this is a phenomenon of creeping privatization. It deeply concerns experts in health care and it is happening without adequate public debate. The share of total health expenditure paid for privately has risen from 23% in 1976 to 29% in 2000.[3] This is very high by the standards of developed economies. Of the 29 OECD countries, Canada had the 8th most privatized health care system in 1997. [4] This growth in private payment means that access is increasingly restricted to those with supplementary health insurance or those able to pay out of pocket. The reality is that our publicly funded, universally accessible health-care system is being quietly but steadily undermined. This is important not only for access, but also for affordability and effectiveness, both of which are better under public funding.

Recommendation 1 We urge the Commission to identify universal access to health care as being a core Canadian value, and a right to all who make their homes in Canada. We further urge the Commission to reaffirm its commitment to the principles of the Canada Health Act as an essential basis for health care provision. These principles should be extended to all essential health care services.

B. Sustainability: Challenges

There is much talk in influential circles about the sustainability of Canada's health care, as it is presently constituted. The question asked is: **Can we afford to maintain universal access?** Our answer is: **Yes!** We must maintain the strengths of our system - not out of a misguided commitment to the past – rather – because it is efficient and effective and critical for the well being of all Canadians. At the same time, there are some things that we must do differently. A truly comprehensive approach to sustainability would address all of its dimensions: political, fiscal, economic and social. We first address fiscal and economic sustainability; without sound fiscal and economic fundamentals, we risk losing the best features of our health care system.

(i) Fiscal and Economic Sustainability – the Macro Dimension

It is critical to start our sustainability discussion with a comprehensive picture of spending. A review of the pattern of health care spending in Canada is instructive. Overall health care spending (public plus private) as a share of Gross Domestic Product (GDP) tells us about **economic sustainability**.

From 1975 to 1980, health care spending was about 7% of GDP. It then jumped sharply to over 8%, coinciding with a deep recession in Canada, which sharply reduced the denominator of the equation. As the economy recovered, the health care share of GDP stopped its sharp climb [For a graph of the relationship, see Appendix A].

With the onset of the deep recession of the early 1990s, health care share of GDP again leaped up, this time to over 10%. Two key factors served to reduce the health care share to below 9%:

- an economic recovery; and
- severe government cutbacks.

The share has subsequently recovered to a stable 9.3% for 1998-2000 (the year 2000 is the latest for which we have health spending estimates). As of 2000, there was no significant upward trend in health share.

Government health care spending has followed exactly the same pattern. There is no current upward trend in this spending as a share of GDP. That is, **there is no issue of fiscal sustainability due to government health care spending.** However, there is a serious fiscal squeeze. Health care is occupying a rising share of government spending. This is due to one factor – the **collapse of government spending**:

- Federal program spending (program spending equals overall government spending minus interest and debt reduction payments) has dropped from 16.6% of GDP in 1993-94 to 12% in 2000-01.
- Provincial spending is also down. For example, Ontario's program spending dropped from 15.6% of GDP in 1994-95 to a budgeted 12.2% in 2001-02.

This unparalleled decline in government spending could jeopardize most social programs. Indeed, this is where the sustainability crisis lies.

A comparison with the US provides further clarity. In 1971, both systems consumed about the same share of GDP – 7.4% for the US and 7.3% for Canada. However, the two systems quickly diverged after that, with Canada going the public route, while the US stayed with its privately funded system. Costs climbed much more quickly in the US.[5] [6] OECD figures show that, by 1979, health expenditures amounted to 7.2% of GDP in Canada and 9.1% of GDP in the US.[7] For 1997, the figures were 9.1% for Canada and 13.9% for the US.

There are thus several important conclusions to be made about affordability of health care:

- Much of the **affordability pressure** is associated with periods of **poor economic performance**.
- Health care spending is occupying a much smaller share of GDP than it did in the early 1990s, suggesting that **there is no affordability crisis due to health care spending now**, and no alarming trend in health care spending.
- It is the **dramatic decline in government spending that is putting sustainability pressure on all spending, including health care**.
- The much **more privatized American health care system is far costlier than our less privatized system**. To adopt American solutions would be highly counterproductive.

Troublesome Macroeconomic Policy Directions

Much of what has driven restructuring and cutbacks in health care and elsewhere in the economy is an unfortunate trend in economic policy. This has included:

- **a weak commitment to maintaining full employment**. Over the past two decades, a periodically excessive focus on fighting inflation has occasioned two severe recessions, in the early 1980s and early 1990s. These recessions have significant effects on the health care system. First of all, they contribute to health problems, which adds to the burden on the health care system. They do this through raising unemployment, raising poverty, and widening income disparities. Second, these recessions have also severely strained government budgets, and hence their capacities to deliver essential social services such as health care. We have already shown the correlation between recessions and affordability of health care.
- **a diminished role for the state**. As we have pointed out, government program spending is declining precipitously as a share of GDP. The reason given is budgetary constraints, but this is impossible to separate from the deliberate choice to cut government sources of revenue. Tax rates are being cut at the federal and provincial levels, with no compensating rise in revenues from other sources. If one wants a vibrant, effective role for the public sector, as is essential in health care, one must find ways of paying for it. The current trends are very worrisome, as government spending programs are the major way to alleviate the disparities created in the market. Of course, the weak commitment to full employment contributes to the shrinking of the state.

Recommendation 2. We recommend that the Commission identify maintenance of full employment as an important target for the Canadian government, as this helps to avoid the significant health costs associated with unemployment.

Such a step would also relieve general budgetary pressures on government, which will reduce constraints on delivering the essential health and social services that Canadians want.

Recommendation 3. **We recommend that the Commission advise the Canadian government to manage its fiscal and monetary policy in such a fashion that it will have sufficient revenue to pay for the essential social services that Canadians want, such as health care. This would include a halt to further cuts in tax rates before alternative sources of revenue are found.**

Such new sources might include green taxes and taxes on speculative capital flows. Finance Minister Martin has expressed support for the latter.

Recommendation 4. **We ask the Commission to support those who have called for a commitment of a fixed share of GDP to health care. This would serve two purposes: to avoid the quiet erosion of government support that we have witnessed in the past decade, and to focus attention on the affordability of our health care system.**

A formula would have to be based on some multi-year average in order to provide reasonable stability and predictability in funding.

(ii)Sustainability: Health System Issues

In addition to sustainability at the macro level, there are many system-level issues for health care, including: changing domestic environments, stability of funding, health human resources, incentives, allocation of health care resources, and drug costs.

(a) Ongoing Changes in the Environment

The health care system faces a number of challenges from changing circumstances:

- **Demographics** present challenges on the demand and supply side
  - On the demand side, Canada's population is aging, and older people use a disproportionate share of health care services. If we can keep people healthier and if we can deal with their needs in a more efficient and effective way, we can keep costs under control. We are optimistic that that the changes we propose will do just that.
  - On the supply side, the health care provider population is aging, and Canada will face accelerating retirements of this sector. Retention and particularly recruitment issues are important here. The good news is that many people want to be health care providers, so long as the work can once again be made secure and rewarding.

- **Technical change** creates both opportunities and challenges for sustainability:
  - Some technical changes are cost saving, such as new, less-invasive medical procedures that reduce reliance on costly hospital services.
  - Some technical changes offer tradeoffs between improved quality and increased costs. In this case, society makes a choice between spending on these services and on other services. For example, many new drugs only offer marginal gains in effectiveness, but often at great cost.

- **General trends in income, income distribution and the provision of public services** have a huge impact on population health, and hence on costs and on the types of services needed. Our hospital system was built to meet needs of the day, which were predominately infectious disease and traumatic injury. Today, our health care system deals more with chronic illness

and the infirmities of age. Our economy and public system have largely solved the earlier health problems.

(b) Unstable Funding and Imposed Restructuring

Governments moved to rein in health-care spending via the introduction of spending controls. They have also imposed major restructuring, sometimes closing some services before substitutes were in place. Notwithstanding the upheaval and the stop-go funding, our system continues to deliver quality service on a generally timely basis. However, the signs of stress are showing in reduced access to some care and in unreasonable workloads for health care providers.

As far as access to care is concerned**, waiting lists** for some procedures are unacceptably long. Even here, careful research shows that the situation is not nearly as bad as some (such as the Fraser Institute) have claimed. Waits have shortened for some procedures, but not for others. Some areas are clearly under-resourced, such as access to care in the community, and this must be addressed. Furthermore, not all waiting lists are coordinated and managed to ensure efficient and fair usage of scarce resources.

Recommendation 5. We urge the Commission to recommend that waiting lists for procedures be rigorously maintained on a province-wide basis, and that placements should be done solely on the basis of relative need. This would solve some but not all of the problems associated with long waits for certain procedures.

(c) Health Human Resources

Paralleling health care spending cuts has been a deterioration of work circumstances in the health care sector. Unreasonable workloads are a fact of life for too many health care providers. Many are dangerously over-worked, with the expected consequences. For example, nurses lose more time to illness and injury than any other profession in Canada. Many are deeply dissatisfied with a lack of support and with caseloads that do not allow adequate time to meet patient needs.

The nursing profession, critical to the health and well being of Canadians, is under threat and in need of immediate policy interventions. In a recent brief to the Minister of Finance and the House of Commons Standing Committee on Finance, the Canadian Nurses Association outlined our national recruitment problem. "There has been a reduction over 50% - from 10,000 to 5,000 – in the annual number of graduates from schools of nursing over the last ten years. Of those who do graduate, three of ten nurses depart the profession and the country within five years of graduation" [8] We are also in the throes of a retention crisis due in large part to increased workload and other work setting problems, inability to find full-time positions and ongoing wage and benefit inequity between sectors. [9]

"The average age in 2000 of a working nurse in Canada was 43.3 years, and 28% of them are 50 or over. All of this adds up to a projected shortage of up to 113,000 nurses in ten years. Study after study reveals the importance of the link between high quality nursing care and positive health outcomes. If a nursing shortage of this magnitude is allowed to develop, the adverse consequences for Canadians' health are incalculable."[10]

These health care providers have borne the brunt of spending constraints, and have kept the system functioning remarkably well, all things considered. However, many providers have left

the system because of the stress and too many of those remaining are rapidly approaching burnout. Inevitably, quality of care begins to suffer. This is not sustainable, even in the short run. Some steps have been taken in some jurisdictions to address this problem. For example, Ontario has started to reverse the negative trend in nursing. It needs to aggressively continue these positive steps. All jurisdictions must address health human resource issues as a top priority.

Recommendation 6. We urge the Commission to recommend the creation of a permanent national coordinating body to deal with health human resource (HHR) issues, such as working conditions, and recruitment and retention. The body would be comprised: of health care workers; federal, provincial and territorial governments; and health care providing institutions. A national collaboration is essential to ensure that all Canadians have equal access to health care providers, and to deal with the problem of interprovincial poaching of health care providers.
(A full set of HHR recommendations appears in Appendix B).

Recommendation 7. We urge the Commission, in addition to its call for healthy, safe workplaces to specifically call for a guaranteed minimum of 70% full-time positions in nursing, and to call for adequate and stable funding to ensure improved working conditions for the nursing profession.

(d) Maintaining Perverse (and Costly) Incentives

One perverse incentive in the current system lies in the fee-for-service payment structure for the majority of doctors. It is a structure that punishes conscientious doctors and rewards assembly-line care and costly over-treatment.

The limited coverage of the Canada Health Act generates other perverse incentives; hospitals and doctors get overused because they are free, relative to other professionals and institutions not covered by the Act (such as home care, long-term care, and rehabilitation therapy). While it is perfectly efficient and appropriate to use hospitals and doctors for certain interventions, other services can be provided more efficiently out of hospitals or by non-physicians. We are currently witnessing people staying in costly hospital beds because there is no access to less expensive home care.

(e) Curative/Medical Model Focus

As discussed, the health-care system was set up to fund hospital and medical care -- a reflection of the traditional, curative focus of our health care system. In the 1950s and 1960s, hospitals provided a much greater share of care than they do now. Technological change and new therapies have now made it possible to reduce reliance on relatively expensive hospital service. For example, less invasive procedures can be done on an outpatient basis. Furthermore, we now know better how to prevent people from getting sick in the first place.

As a result of health policy successes, the health care system of today is confronted more with chronic illnesses associated with an aging population (such as cancer and heart disease) that are often better taken care of in the community or in different settings. However, investment has not followed this trend to more community care. Patients are being moved out

of hospitals, often finding themselves either with inadequate or inappropriate care, or with no care at all. Too often the more expensive hospital is the only alternative for access to care that is covered. This tends to be care that is physician-centred and makes inadequate use of other health-care providers. Overall, it is an arrangement that contributes to neglect of health promotion and illness prevention; a neglect that will lead to more acute and costly illnesses.

(f) Inadequate regulation of pharmaceutical sector

Pharmaceutical expenditures have been rising quickly, a result of both increased use and rising prices. In Canada spending on pharmaceuticals has risen from 8.5% of total health expenditures in 1976 to 15.5% (projected) for the year 2000.[11] This is a result of monopoly pricing and aggressive marketing. The strengthening of general patent rights has particularly benefited this industry, at the expense of consumers. In Canada, the abandonment of compulsory licensing has greatly reduced access to cheaper generic alternatives to increasingly costly name brand drugs. As a result of the strong patent protection, the pharmaceutical industry is consistently the most profitable of the manufacturing industries.

Recommendation 8. We urge the government to develop strategies to control the rapid growth in pharmaceutical expenditure, without compromising the quality of health care. When drugs rise from 8.5% to 15.5% of health expenditures, urgent action is necessary. These strategies should include
- developing comprehensive support for effective and cost-efficient prescribing,
- coordination of national drug purchasing and a national drug formulary, and
- devising methods of countering the monopoly pricing that the excessively powerful patent laws allow. This could include negotiating a return of compulsory licensing for pharmaceuticals.

(iii) Issues in Accountability, Transparency and Sovereignty

There has been a lot of talk about a "crisis" in Canadian health care. Compounding this has been a great deal of finger pointing between the federal government and the provinces. Canadians deserve better. Surveys show that Canadians still have generally good experiences with the health care system, but they are **very concerned about its future**. This concern comes from a variety of sources:

- People can see the signs of **stress** already cited, but they are unsure of the cause.
- They are aware that **governments are backing away from responsibilities** that they formerly shouldered. For example, they have come to expect cutbacks – a revolution in lowered expectations.
- The public is also **skeptical about government's commitment and credibility in supporting health care**.
  - For example, the Canadian government has claimed that health care services are protected from trade challenges under WTO's GATS (General Agreement on Trade in Services). However, as has been shown, health insurance has already been left unprotected.[12]

- The federal Liberals promised during the election to spend half of any surplus on social programs. They have only spent a small fraction of the surplus on social programs.

- People are concerned that **globalization is limiting the ability of society to fund and deliver social programs** that they value. This concern comes from several sources:
  - **Free trade agreements** are intruding increasingly into domestic policy and regulation. These agreements are very wide reaching, and give enormous power to non-elected panels to order governments to change policy in response to complaints from exporters. These panels convene behind closed doors, and almost invariably find on behalf of commercial interests over social interests.[13]
  - It should be noted that **creating a toehold for the for-profit providers** (as happened in Alberta with Bill 11, legalizing for-profit hospitals) **may leave the entire country open to demands that similar market access be provided for foreign providers**. One legal opinion is that Bill 11 could open the door to allow private hospitals in all provinces, as the North American Free Trade Agreement (NAFTA) may require similar privileges to be granted across the country, once they are granted in any jurisdiction.[14] [15] [16]
  - There is an **aggressive public campaign to convince the public that there is no alternative to the withering of the public sector.** Talk of flight capital and brain drains accompanies the argument that this would all be fixed by tax cuts. This campaign seeks to convince people that uncompetitive tax rates are driving away business and driving away skilled people. In essence, it claims that we cannot afford to pay for social programs, because we cannot afford to levy the taxes. In the next section, we conclude quite the opposite – that we cannot afford the continuing erosion of the public sector.

Recommendation 9. We call upon the Commission to urge both levels of government to make credible commitments to health care, in order to restore Canadians' confidence that their health care system will be there when they need it in the future. This confidence has been shaken badly in recent years, and this is confidence is essential to the survival of the health care system.

Recommendation 10. We urge the Commission to call upon the government to explicitly exempt health care and other essential social services from trade agreements. Without such exemptions, foreign interests are sure to challenge these services, and could easily dismantle them using the very intrusive tools available in the free trade agreements.

C. Sustainability: Solutions

(i) Rely on Public Funding – It Works!

People are drawn to medicare because of its fundamental ethical appeal: access should be based on need, not ability to pay. However, medicare turns out to be a win-win choice. Public funding is cheaper. This is one of the most well established results in health care. To quote Charles Baillie again,

> *"To set aside our single-payer, publicly funded universal health care system would not simply be a **moral** error. It would be a grave **economic** error as well.*
> *The fact is, the free market, efficient and desirable as it is, cannot work in the context of universal health care.*
> *While health care could be purchased like any other form of insurance, the real point is that the risk and resource equation will always be such that, in some cases, demand will not be matched by supply. In other words, some people will always be left out.*
> *The fact is, provided we can make it more efficient and effective, our kind of system is **inherently** superior to the alternative. The reasons are clear.*
> *The system covers everyone. Therefore, economies of scale are maximized.*
> *There is no rating or discrimination. Therefore, large administrative savings occur.*
> *The system is financed through general revenues. Therefore, there is no costly stand alone collection system.*
> *And payments are provided directly to physicians. Therefore, expensive multi-stage billing is avoided.*
> *In other words, not only is our system more **fair** than the alternative. It is also more **affordable.** That is not argument. That is fact*."

Generally, countries with a higher share of publicly funded health care have less costly health-care systems.[17] Public funding is cheaper for a number of reasons:

- It is **more efficient**, as Baillie notes.
- It affords greater opportunities for achieving **stability**.
- It affords the opportunity to **control input prices** through the use of buying power.
- It **avoids paying for insurance profits**.
- It can **correct for market failures**. For example, the market will not supply essential public health services, which are not profitable to produce.

(For an elaboration of these points, see Appendix C.)

Key Cost/Funding Realities

- **A Matter of Political Choice**: We know that the economy as a whole can afford publicly funded health care, because it is cheaper than a privately funded system. The issue is **willingness of the public to pay via taxes for this system.** Polls show that Canadians do value their health-care system, and are willing to pay for it. A problem arises because they are being told that we can no longer afford the system, as it is becoming too expensive; a message that conflicts with reality. They are also being told any attempt to pay for it by raising taxes is doomed to failure, because taxes are currently too high, and a further tax hike will only drive away business and result in a recession.

- **Health Care will Cost, No Matter Who Pays**: No amount of reorganizing and cost saving will obviate the fact that health-care delivery contains a very labour-intensive component. Care will cost money, perhaps even more than we currently spend. There is room for rethinking how to promote health in a more rational and economic fashion; this is part of saving the system. We offer solutions later in this paper. However, any health-care system is costly, and a public system can do it much more economically than a private system. "Cost savings" associated with privatization of funding generally turn out instead to be expensive shifting of costs to families and individuals.

- **Ultimately the Public Pays**: When public funding is reduced, costs are shifted directly or indirectly to the public (making a tax break somewhat useless). For instance, when services are delisted, their prices usually rise. The public not only has to pay directly for these services, but it must pay more than the government paid before. Other times, it is health workers who bear the costs, as wages are squeezed (e.g., in home care as a result of increased competition). Ultimately, the public bears these costs, as the service deteriorates. This deterioration is inevitable, since health-care providers are struggling with fewer resources and declining morale in the face of a growing gap in wages and employment conditions relative to other sectors.

- **Cost Shifting May Not Save Government Money**: Even when the government divests itself of its responsibilities, it is not clear that it will result in money saved. For example, according to the OECD, the US government pays more per capita for health care than Canadian government does (US $1,901 per capita in 1997 vs. US $1,274 for Canada), even though the public share is much smaller in the US (46.4% for the US, vs. 69.8% for Canada).[18] This arises as a result of **private skimming** of profitable services, with government picking up the tab for the high-cost services and high-cost patients; and **a greater reliance on more costly for-profit providers.** It is also worth noting that the above US figures omit substantial hidden government costs, such as the **cost of health insurance deductibility from taxes**. For example, the Clinton administration estimated that the health insurance deductibility would cost the federal government alone US $76 billion.[19] The total cost to government of this deductibility has been placed at $125 billion for 1998.[20] Thus, public funding is an even better deal than the above 1997 figures suggest.

<u>Recommendation 11.</u> We urge the Commission to recommend that all levels of government place a moratorium on privatization in health care funding.

Such activities risk setting precedents that could jeopardize our health care system via international trade agreements. Any future privatization or movement to for-profit provision of health care services must only proceed if there is demonstrable cost saving with no loss in quality. The burden of proof must rest with those who would privatize. Privatization that has taken place to date has been done in the absence of convincing proof of its merit; indeed, it has taken place in the face of proof to the contrary.

(ii) Just Say "No" to User Fees

Opponents of full public funding argue that patients abuse the free system and cause waste. Health care is not a typical market commodity, like widgets. People will over-consume market-type goods, if they are free. On the other hand, health care is not a commodity that is consumed for its own sake. It is consumed for its health effects, and is costly in terms of time and trouble to consume (it can also be uncomfortable or painful). Hence, estimates of the costs due to abuse of the system by patients are quite low – in the range of 2%.[21] When the health care system is misused, it is largely because of other factors:

- **misinformation** (e.g., going to hospitals for ailments that could be treated by their family doctor, or seeking treatment for ailments for which there is no benefit from medical treatment);
- the **absence of better alternatives** (e.g., many people go to emergency rooms because they fall ill when their family doctor's office is closed);
- **inappropriate incentives** to doctors, such as the fee-for-service system, which strongly encourages doctors to practice assembly line service and can encourage unnecessary services.

User fees have been employed to save costs, but there is little evidence of significant saving. There is simply a switch of services from lower income to upper income people, as physicians make up the shortage of demand from poor people by encouraging higher income people to consume more services.[22] [23]

There is also little evidence that user fees deter misuse of the system. Studies show that people are just as likely to forego essential as nonessential health care in the face of user fees.[24] [25] Even small user fees deter use of essential health care services. The cost in consequent readmissions can be high.[26] Even if we were to save costs by deterring use of essential services, would we want to do so, as a society?

Recommendation 12. We recommend that Canada maintain its strict ban on user fees for services covered under the Canada Health Act. We further recommend that governments develop strategies for eliminating user fees on other essential health care services.

The federal government has been reasonably effective in controlling extra-billing for essential hospital and medical services. This principle should be extended to all essential health care services.

(iii) Extending Public Funding to Other Essential Health Care Services

As it is much cheaper to rely on public funding for health care services, so too is this the case for essential services not fully covered, such as pharmaceuticals or home care. It is much less expensive to have the services paid through taxes, than individuals having to pay directly or through private insurance. This "efficiency bonus" will also solve the current system irrationality that encourages inefficient overuse of hospital and medical services. People naturally go for help first where they do not have to pay. Physicians are aware of people's

financial constraints, and will often accommodate them with less than appropriate, costly services, when they know that many lower income people will simply forego services that they cannot afford.

It is clear that Canadians want necessary health care to be available to all residents. This requires an expansion of health care coverage in order to cover such essential services as pharmacare, home care, long-term care, physiotherapy and public health. A staged expansion with due regard for affordability and political support is necessary and would depend upon cost, urgency, and ease of transition.

Recommendation 13. We recommend developing a commitment and strategy for a phased extension of the CHA principles to essential services in home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care.

Such an expansion must heed budgetary and political constraints. The expansion would save the economy money as we have noted. Nevertheless, government health care spending would likely rise for two reasons:

- *Increased access is likely to raise consumption of services, at least at the start.*
- *Government would be paying for services that are currently paid for privately. Thus, fiscal prudence is in order, but we must not let the discussion be hijacked by a tax-cutting agenda.*

Recommendation 14. We recommend the development of a democratic and transparent process for defining medical necessity.

Transparency and democratic participation in the definition of medical necessity is important for two reasons. First, when expanding coverage of the CHA, we must be clearly and accountably determine what we will and will not cover. Second, when considering existing coverage, we also require transparency in what we insure or deinsure. Unfortunately, today, services are deinsured without public consultation. This is not a way to give Canadians ownership of their health care system.

Recommendation 15. We recommend that both levels of government make substantial and credible commitments to funding health care in a comprehensive framework. For the federal government, this means raising the cash contribution to provincial health care, ultimately to a minimum 25% of provincial spending. This increased cash contribution must have attached with it an expansion of the CHA to cover those as-yet uncovered essential health care services.

We need a sufficient carrot to ensure national standards and the CHA are secure. The increased contribution must be accompanied by an obligation for provinces and territories to deliver the services implied by the expanded CHA.

(iv) The Costs of For-Profit Health Care Provision

The delivery of Canadian health care is overwhelmingly private. The issue is whether the providers are for-profit or not-for-profit. The evidence against for-profit provision of health care is very strong. Studies in top journals show that the **quality of care in for-profit institutions is lower**. [27] [28]

In short, for-profit providers have a stronger incentive to cut corners in areas where monitoring is difficult or costly.[29] There is also evidence that **for-profit provision of health care directly costs more:**

- For-profit provision of health care is **less efficient and more costly:**
  - More **costly activities** arise: marketing; investor relations; takeover strategies; and defences against takeovers.
  - Competitive pressure drives **over-investment in very costly high tech equipment**.
  - A major study reported in the New England Journal of Medicine[30] found that administration consumed more resources in for-profit hospitals than in not-for-profit hospitals, while the least resources were consumed in public hospitals (thus not as efficient).[31]
  - The government must pay for **profits** that are a drain on the public system. Investors press for returns of 15-20% per year and annual growth of 15% per year.[32] When funders are concerned about rising health care expenditures, they should worry about introducing entities whose entire raison d'être is to raise revenues rapidly.
  - The possibility of **increased fraud.** Medicare fraud is reported to be widespread in the US, where there is a heavy reliance on for-profit provision. In 1997, an audit by the Medicare inspector-general's office found 12% of payments "erroneous"[33], while random audits of different states' Medicare billings have shown much higher rates of bogus claims (e.g., 26% in Florida[34]).
- The potential for **conflict of interest** is greater when providers are allowed to provide both insured and uninsured services in the same clinics, as is the case in Alberta. Here, many patients bought "enhanced" soft lenses at $400-700 each (the cost of purchase is said to be much less) in order to get placed into much shorter queues. The effect has been to lengthen the queue for those who rely exclusively on public funding for their procedures.

With for-profit provision, taxpayers will either face higher taxes, or patients will face a lower level of services. In either case, the political support for the public sector will erode, thus threatening public universal health care.

<u>Recommendation 16.</u> We urge the Commission to recommend that all levels of government place a moratorium on transfer of health care activities to the for-profit sector, because of risks under free trade agreements and because of concerns about cost and quality of care.

(v) Towards Improved Delivery of Health Care

Tommy Douglas identified the challenges of delivering care at the time when medicare was brought in to Saskatchewan. We inherited a physician and hospital -centred system that focused on treatments rather than prevention. Health care experts generally agree on a range of changes that would improve care while either saving money or costing no more:[35] We briefly restate these here, under two categories: improving effectiveness and efficiency; and accountability and governance.

(a) Improving Effectiveness and Efficiency

There is broad agreement among health policy analysts on a range of reforms that would make health care delivery more effective and efficient: true primary health care reform; the implementation of prevention and population health concepts; the development of more appropriate incentives for providers and institutions; and the identification and implementation of more effective interventions. Our subsequent recommendations on accountability and governance would also address effectiveness and efficiency.

Recommendation 17. We urge the Commission to recommend the implementation of true primary health care reform, with 24/7 care being delivered by interdisciplinary teams of health care professionals.

We are in agreement with our colleagues from the Saskatchewan Registered Nurses' Association, in their October 16th submission to this Senate Committee that states "a strong, comprehensive primary health care system (is) the cornerstone of an overall health strategy…."[36] *There is far too much inappropriate use of emergency rooms and physicians that could be avoided if people could access the right health care service when they need it. ("the right service, delivered by the right health care professional, in the right place, at the right time"). For example more extensive use of registered nurses, including nurse practitioners would reduce the burden on family physicians. The improved access and improved quality of service will reduce unnecessary illness and thus save on future hospital admissions.*

Recommendation 18. We request the Commission to recommend devoting more resources to the integration of prevention and population health concepts into our system. All of the determinants of health must be addressed: income, income distribution, employment, stress, environment and social support. There is a role for all sectors of government, and not just for the health care sector.

These areas frequently suffer from neglect, which is unfortunate, as they offer the possibility of highly cost-effective interventions.
One promising initiative is the recent creation of an Advisory Committee on Population Health for the Federal/Provincial/Territorial Conference of Deputy Ministers of Health.

<u>Recommendation 19.</u> We must reward good practices in health care. We ask the Commission to chart a staged path to more appropriate incentives, including alternative payment mechanisms for health care professionals and alternative funding mechanisms for health care institutions.

For example, the fee-for-service system rewards assembly-line medicine, and penalizes physicians who take more time to fully address patient needs. This mechanism should be replaced with more appropriate incentives. Fortunately, most doctors do not favour fee-for-service, so opposition to its replacement should not be strong. The staged process would start with those physicians who are most eager for more appropriate payment mechanisms, such as salaries. Another example of inappropriate incentives is the funding formula for hospitals in Ontario. There is no additional compensation for use of hospital laboratories, so work is sent to much more costly private labs, where the bill is paid for by the Ministry of Health, and not out of the hospital budget.

<u>Recommendation 20.</u> We recommend much stronger government support for systematic identification and implementation of more effective and responsive interventions.

We already know of some better and cheaper ways of delivering care (e.g., through better management of prescribing practices). Best practice guidelines are being developed in many areas of health care, and this is a positive step, although far from a cure-all. Many of these guidelines will be cost-saving.

<u>(b) Improving Accountability and Governance</u>

We have noted room for improvement in accountability and governance. We offer a series of recommendations here: on public participation; and on coordination and integration. Measuring system performance is another essential element of accountability. In section D (iv), we offer a recommendation on performance measurement.

<u>Recommendation 21.</u> We request the Commission to chart a process towards greater public participation in the governance of our health care system along with greater transparency and accountability of government.

These are universal goals that would apply equally to other areas of public service. This is a common expectation of the public at present, and offers the possibility of greater responsiveness to community need. The Commission's own consultation process is a step in the right direction.

Decisions will be required, even if we manage everything well. We must still make choices between competing resource uses. RNAO is not content with the current arrangement, whereby choices are made behind closed doors in consultations between doctors and health funding agencies. There must be a more open and democratic process. This process should evolve out of an open and democratic consultation. The current Commission could form part of that consultation.

Recommendation 22. **We request the Commission recommend devoting resources to improving the coordination and integration of the system. The guiding principles ought to be**

- **Democratic control. This should include community participation in governance.**
- **Maintaining universality of access**
- **Delivery of the best service possible given resources available.**

Health care experts have identified many failures in coordination and integration, leading to inefficiency and untimely care. Some jurisdictions have addressed this issue more thoroughly than others, but there are sufficient gains to be had that it still will pay to devote resources to solving this challenge. Most provinces have formed regional health authorities in part as a response to this challenge. The geographic areas chosen ought to be selected using the best evidence available on optimal size for regional health authority.

Recommendation 23. **We recommend the formation of a national health advisory council. It should be created jointly by the two senior levels of government, and charged with the following tasks:**

- **consultation on health policy**
- **provision of a forum for collaboration in defining the scope of medicare programs**
- **monitoring of programs**
- **facilitation of cooperation in improving the efficiency and effectiveness of health care programs (including setting up an information system that could allow cost-benefit analyses of health treatments)**
- **performing an accountability service**

D. Managing Change: Yes, We Can Get There From Here

(i) Obstacles

There is a moral imperative to ensure universal access to all essential health care services, wherever they are delivered. We have proceeded a significant distance down this path, in our patchwork Canadian fashion. RNAO has proposed a vision for this, and we believe that this is a vision shared by the vast majority of Canadians. Nevertheless, there are obstacles to achieving this goal:

- Some Canadians wonder whether government can and will deliver quality and value for money. Their confidence has been shaken, and often with reason, as they watch service cuts and squabbles between different levels of government. We believe that by following a judicious, fiscally responsible, sequential path with abundant public consultation, we can win back that confidence.
- Provinces and governments have not found a way to work together to build the health care system that Canadians want and deserve. A process of public consultation and transparency should provide the incentive that governments need to find the will to work together.

- There are very powerful forces promoting unhelpful forms of globalization and deregulation. Canadians recognize that they cannot shut themselves off from the world, but they reject the unnecessary intrusions on the rights of countries to regulate and run programs to promote the health and welfare of their countries. They will put more pressure on the government to protect them from these threats when they realize how intrusive current trade deals are. We are entering a crucial period now.
- Proponents of more traditional methods of organizing health care (curative, physician-centred, fee-for-service, etc.) still hold considerable power. Other organizations and movements (physician and non-physician) will have to confront these ideas and show that a better way exists.
- There are inevitably domestic and foreign interests that gain from dismantling of the health care system, no matter how good it is for Canadian society.

(ii) Facilitators

Most health care experts agree on the broad outlines of what must be done: public funding, not-for-profit provision, a comprehensive approach to health human resource issues, more appropriate incentives, primary health care reform, a range of measures on effectiveness and efficiency, greater accountability, and improved governance. Unfortunately, this expertise is often ignored, as was the fate of the National Forum on Health. It is to be hoped that Commission's initiative will help provide the impetus for a dialogue that will start to realize Tommy Douglas's dream.

(iii) Public Support for Change

We believe that the public is ready for the kind of change we propose. People clearly want essential health services to be covered by public health insurance, although some are not confident about affordability. Government commitment and appropriate pacing of change are crucial. The public will not support a process littered with failures.

True government commitment must include stable funding at a level consistent with delivering the range of services currently covered, as well as those services that may be on offer in the future.

One threat to public support for the health-care system is confusion over real choices. Health care experts know that a publicly funded, not-for-profit health care system is cost effective, but the public is being told otherwise. Rather, they are too often told that social programs and comprehensive health care are beyond the means of the country. The findings of health experts must receive greater coverage.

(iv) Performance Measurement

The federal and provincial governments have started to put some money back into health care science, including the area of performance measurement. The CHSRF funds a number of projects that are refining measurement, with a goal to improving practices.

In Ontario, there are a number of interesting and ambitious initiatives for measuring and benchmarking. For example, the Ontario Hospital Association has recently refined and extended its hospital report cards. Currently, they cover most types of services in most hospitals (in-patient, emergency, and complex continuing care) and are expanding to include studies on nursing, rehabilitation therapy, mental health and population health. The process of using measurement in an on-going way improves the quality of the data and assists hospitals to address weaknesses in their systems.

An Ontario Municipal Benchmarking Initiative is also underway to measure many of the services that municipalities deliver, including long-term care.

These initiatives are promising. They offer both a start at developing accountability measures and a mechanism for continuous quality improvement. These initiatives include a range of stakeholders on their advisory panels, and this makes the process broader and more democratic. RNAO is pleased to represent the nursing community in both panels, and can report that the process does incorporate the insights of the many sectors represented.

Measurement can raise accountability, lead to quality improvement, and can also be used to guide financial incentives. Of course, there is a cost to collecting and processing data. This implies a limit to the quantity of data that can and ought to be collected.

Another limitation is that some things are very difficult to measure. Finding feasible measures that can be used to guide change is very challenging. This is particularly true if the measures are used to determine funding. Naturally, the measured agencies will seek to influence the measure in such a fashion that they enhance their funding ("gaming"). We will not be able to rely exclusively on measurement to guide improvement and funding.

Recommendation 24. We recommend that the proposed national health advisory council (or some other appropriate body) facilitate measurement and accountability functions. The accountability component must be arm's length from funders and providers.

(v) *Harmonizing Formal Changes with Trends in the System and Culture*

Canada needs policy changes that rebuild the sense of community that has been fraying as governments have retrenched over the past decade. We believe that our proposals can build on positive trends in our system and in our culture. These include preferences for:

- More democratic, community control
- Greater transparency in public and private institutions
- Building community
- Greater attention to all the dimensions of sustainability:
  - Building physical, human, social and environmental capital
  - Greater attention to population health and well-being
  - Attention to government fiscal sustainability, in the context of delivering the kinds of services we propose
  - Finding appropriate sources of revenue. For example, green taxes and taxes on flows of financial capital across borders are major untapped sources of revenue that also offer the

advantage of correcting for market failures. These taxes would discourage harmful activity. These taxes could help to replace other less popular taxes, thus enhancing public support for the funded activities.

(vi) Creating a Culture of Continuous Improvement

This can only be done in an environment in which there is a long-term commitment to funding and support. Health care institutions must become communities in their own right. In these communities, a continuous improvement is achieved by focusing on the improvement and not on blaming. This must be supported by adequate systems of performance measurement.

E Cooperative Relations

Federal-provincial-territorial relations are fraught with tensions over turf, credit and responsibility. We believe that our proposals offer opportunities to build on a national project that transcends these tensions. It is a worthy goal to aim at achieving truly universal access to essential health care services and true primary health care reform. This is something that could capture the imagination of Canadians, and help to recover what it means to be Canadians.

(I) FPT Arrangements and National Agendas

We remain concerned that the public wish to have public insurance cover all essential health care services is foundering on jurisdictional issues between the two upper levels of government. To maximize the effectiveness/support for health care by the 2 levels of government, we advise the following:

Recommendation 25. We recommend that both levels of government set aside squabbles over health care funding, in the interest of benefiting all Canadians.

This means showing leadership and commitment to healthy public policy.

Recommendation 26. We urge the federal government to explore all ways that it might be able to implement extension of public insurance to cover uncovered essential health care services.

We have already outlined essential health care services that are not insured. Some analysts have suggested that there is latitude for the federal government to take its own initiative in expanding coverage to essential drugs.

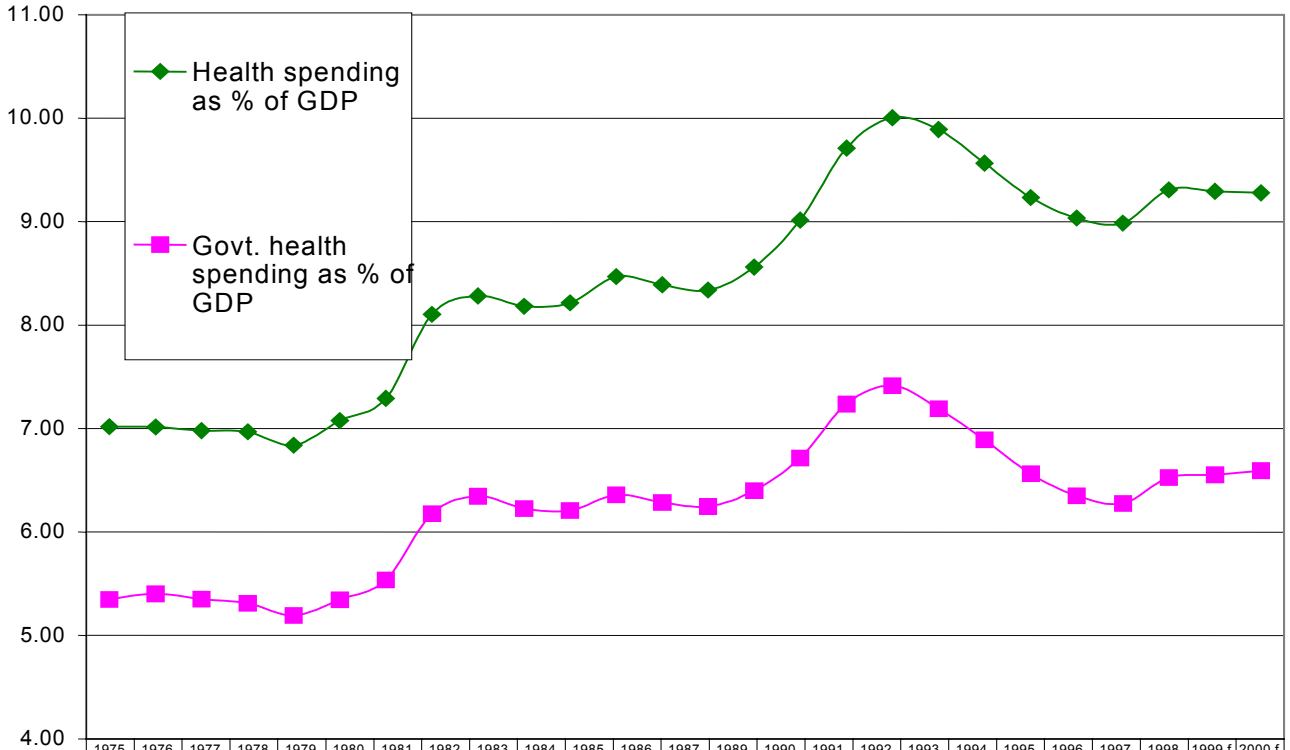
(ii) Development of a Unifying Vision

We offer what we believe to be a widely held vision of health and health care. We feel that it fits with the Canadian experience. We call upon the Commission to develop the kind of process that will realize this vision. This will not be a short process, but it can be a process that reinvigorates the country, and one that can help Canadians to take back control of an important dimension of their lives.

This is very fitting work for the Commission – fitting because Commissioner Romanow comes from the province that brought medicare to Canada. The vision of Tommy Douglas is a very good place to start. The only work remains in fitting it to the somewhat changed circumstances of today. As we have shown, this is not a major stretch.

Universal access to essential health care services is a simple and compelling idea. It fits squarely with Canadian values, and it makes good health and economic sense. Fully realized, it would be the completion of a visionary dream, and a tool for a positive national unity. We must do more than merely save our health care system – we must make it the envy of the world. It will be a major undertaking, but anything of enduring value takes real commitment, vision and work. We owe that much to the people whose struggles have brought us this far.

Appendix A: Is Health Spending Out of Control in Canada?



	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999 f	2000 f
Health spending as % of GDP	7.02	7.02	6.98	6.97	6.84	7.08	7.29	8.10	8.28	8.18	8.22	8.47	8.39	8.56	9.01	9.71	10.01	9.89	9.56	9.23	9.04	8.99	9.31	9.29	9.28
Govt. health spending as % of GDP	5.35	5.40	5.35	5.31	5.19	5.35	5.54	6.18	6.35	6.23	6.21	6.36	6.29	6.40	6.72	7.24	7.42	7.19	6.89	6.56	6.35	6.28	6.53	6.55	6.59

Appendix B: Health Human Resource Recommendations

- Integration of health professional input into public policy development and into decision-making at all levels of health care organizations.
- Promotion of primary health care reform, as a way to improve care, make better use of resources and to make employment more meaningful, challenging and fulfilling.
- Establishment of greater accountability in health human resources (HHR). One essential component is collection, processing and publication of key HHR data on a timely basis, including employee satisfaction surveys. Another component is whistle-blower protection, in order to protect employees who raise serious concerns around work or health care. An independent body of providers and government should handle both. HHR accountability would be a major component of an overall accountability mechanism for health care.
- Support for a national HHR research agenda to be dealt with by the professional organizations representing health care professionals.
- Positioning nursing as an entry point to health care.
- Specialized support for health care professionals working in underserviced areas.
- Fostering a positive image of nursing and other health care professions.
- Sufficient support for education. This will vary from province to province. For example, on the education side, our estimates conclude that Ontario will have to significantly raise the number of seats in its nursing schools to meet need in the near future. Strategies must be developed to ensure adequate clinical education opportunities for students and adequate mentoring and orientation opportunities for new graduates.
- Revamping the health professional education system to incorporate training for a reformed primary health care system.
- Promotion of life-long learning and improved access to educational programs.
- Recognition of the full continuum of health care practice.
- Facilitation of matches between employers and prospective employees. There must be coordination between the federal government and the provinces and territories.

Appendix C: Efficiency of Public Funding

Competitive market pressure by itself may work to lower costs for some industries (although this may be at high cost to employees and to society as a whole). Evidence does not show any efficiency gains from private health insurance. We consider a range of evidence and advantages of public funding.

Canada/US Comparison of Expenditure Trends
Recall that in 1970, Canada and the US were spending roughly equal shares of GDP on health care. After that time, the systems diverged, with the US staying heavily privatized. Health expenditures in the US rose at a much higher rate. The high expenditures are driving US insurers to restrict coverage and restrict doctors' practices. Note also that slower Canadian economic growth has inflated the share occupied by health care, relative to the US. Thus, this comparison is very conservative evidence for the superiority of the Canadian system in controlling costs.

Single-Payer Systems – Administrative Efficiency
One advantage of a single-payer system (such as our publicly funded health care system) is the huge savings in administrative costs. There are significant savings to payers, providers and consumers.

Savings for Payers
Consider the payers. Relative to a private insurer, the single funder saves on client assessment, setting rate premiums, record-keeping, complex contracts, marketing, commissions, revenue collection (done here through an existing tax system), and by avoiding the costly problem of adverse selection.[37] There is huge duplication of bureaucracy in the multiple-payer system.

Savings for Providers
Administrative savings also accrue to providers in a single-payer system. Providers have much lower compliance costs and billing costs. They know what they will receive, whereas in the U.S., doctors often do not know how much, if any, of a bill will be paid by an insurer (unless the doctor checks in advance, which is often required by health maintenance organizations).

In the U.S., doctors need to employ many times the person power in billing and collection that Canadian doctors do. Many U.S. doctors are now netting less than their Canadian counterparts, because of very high administrative costs, problems with collecting bills, malpractice insurance costs, etc.

Savings for Consumers
Consumers also save in a number of ways. They don't have to choose from various confusing insurance plans. They know that essential health care by hospitals and doctors is covered, and that they are not at risk of becoming de-insured. They don't face copayments for covered services. They know in advance that a bill will be paid by the government, and do not have to

front money that may not be reimbursed, if their private insurer determines that coverage does not apply. And of course, it is much cheaper.

A Comparison with the US Administrative Costs

Let us return to our comparison with the US. In 1997, Canada spent 0.2% of its GNP on health care administration, as opposed to 0.6% for the US. Administration has cost three to four times as much as a share of GDP in the US, for a number of years.[38] This measure is conservative, as per capita GDP is much higher in the US.

Stability and Planning Advantages of a Single-Payer System

Unless the funder starts behaving erratically, the public, single-payer system offers the possibility of greater stability and predictability, which is more likely to lead to more rational decision-making and better co-ordination of activities. Of course, we are all too aware of stop-go funding by governments of late. Governments must be pressured into more stable commitments of funding for health care, or Canada will forego the stability advantage.

The public, single-payer approach can also help to reduce wasteful spreading of costly but profitable procedures across too many institutions, and thus offer more specialization. In the US, competitive forces have resulted in over-investment in expensive medical capital, as each providing institution seeks to grab its share of high-return procedures by duplicating their competitors' machinery. This machinery sits idle much of the time.

Single-Buyer Advantages

The single-payer system achieves further cost savings by avoiding some unnecessary transfers to the private sector. A single-payer's buying power[39] keeps input prices down, which in turn helps to control spiralling health-care expenditures.[40] A significant portion of Canada's success (relative to the US) in controlling health-care expenditures is due to this fact. For instance, physicians' fees appear to have been easier to restrain in the Canadian public system than in the American private system (physician fee levels in the US are about double those in Canada[41]).

The saving comes not only in smaller price hikes, but also with weaker incentives to push more costly private services, which happens in the US, as doctors and institutions are encouraged to promote pricier options.[42] Furthermore, the single-buyer bargaining power helps to level the playing field against powerful sellers. Excess profit is reduced, and more money stays within the health care system.

A Missed Opportunity with Pharmaceuticals

While Canadian governments have used their buying power to help control some prices, they are letting slip significant opportunities to control other prices. For example, pharmaceutical expenses have been skyrocketing, in part due to rising drug prices. These price increases have been largely due to a strengthening of patent protection, and due to the abolition of compulsory licensing.[43]

Ironically, the one feature of the more privatized Australian health care system that outshines its Canadian counterpart is Australian pharmacare, which has better controlled

pharmaceutical prices.[44] In Canada, pharmaceutical expenditures have grown rapidly – much more rapidly than all other categories of health care expenditures: from 8.4% of total health care spending in 1978 to 15.5% in 2000.[45]

Net Gains stay Within the System if it is Publicly Funded

Not only are prices better controlled, but we also avoid paying excess profits to private health-care insurers (according to one source, American plans insist on 20% profits/year[46]). In short, the money that is removed as profit is lost to the care delivery system. Note further that, in the case of foreign-owned insurers, the profits not only leave the health care system, but they leave the country.

Public Funding Can Help Correct For Other Market Inefficiencies

There are also other significant advantages in not relying on the market to fund health care. The market does a poor job in allocating resources to health care, inherently under-supplying key elements of health care because of the positive externalities associated with that health care.[47] For example, the market generally will not supply health promotion and illness prevention, because there is no profit to be had by their provision.[48]

There are other important externalities such as universal access that has the virtue of increasing use by those with the greatest need for health care – people with low income. This raises overall productivity, and reduces prevalence of communicable diseases, which in turn benefits all Canadians.

Of course, governments must take appropriate action to correct for these market inefficiencies. In recent years, governments have been going in the wrong direction – cutting spending on public health and beneficial social programs.

Conclusion: Public Funding =Enhanced Affordability

Endnotes

[1] Canadian Institute for Health Information (2001), *Supply and Distribution of Registered Nurses in Canada, 2000,* p. 73, based on 95.7% response rate.

[2] Baillie, A. Charles, Chairperson and CEO of the Toronto Dominion Bank (1999), *Health Care in Canada: Preserving a Competitive Advantage*, remarks delivered to Vancouver Board of Trade, April 15, 1999.

[3] Canadian Institute for Health Information (2000), *National Health Expenditure Trends, 1975-2000*, Ottawa, p. 97.

[4] OECD Health Data 99. By privatization of funding, we mean that the insurer or payer is not public. The consumer either pays out of pocket or has private insurance.

[5] Evans, Robert (1984), *Strained Mercy: The Economics of Canadian Health Care,* Toronto: Butterworths, p. 10.

[6] Evans, Robert (1986), "The Political Economy of Health Care," in Clarke, J.N., L. Devers, M. Kelly, D. McCready, and B. Noble, *Health Care in Canada: Looking Ahead.*

[7] OECD (1999), *Health Data 99: Comparative Analysis of 29 Countries,* for the data.

[8] The Canadian Nurses Association. (October, 2001) *Revitalizing the Nursing Workforce and Strengthening Medicare.* A Submission to the House of Commons Standing Committee of Finance and the Minister of Finance, p.1-2.

[9] For a fuller discussion of these issues, see Registered Nurses Association of Ontario (2000) *Ensuring the Care will be There* and Registered Nurses Association of Ontario (2001) *Earning Their Return: Why Ontario RNs left Canada and What Will Bring them Back*.

[10] Canadian Nurses Association (October, 2001) *Revitalizing the Nursing Workforce* (op cit.) p. 2.

[11] Canadian Institute for Health Information (2000), *The National Health Spending Trends* 1975-2000. P. 93.

[12] Sanger, Matthew (2001), *Reckless Abandon: Canada, the GATS and the Future of Health Care*, Canadian Centre for Policy Alternatives.

[13] Canada has the dubious rare distinction of losing a challenge – against a European Community ban on the use of chrysotile asbestos.

[14] Shrybman, Steven (2000), *A Legal Opinion Concerning NAFTA Investment and Services Disciplines and Bill 11: Proposals by Alberta to Privatize the Delivery of Certain Insured Health Care Services*. "Canada failed to insist upon a broad exclusion for health care, relying instead upon the more limited protection of certain 'reservations'…the US has argued that, notwithstanding these reservations, 'services supplied by a private firm, on a profit or not-for-profit basis' are entirely subject to NAFTA investment and services disciplines." Pp. 1-2.

[15] For further analysis on NAFTA and health care, read Appleton, Barry (1999), "International agreements and National Health Plans: NAFTA", in Drache, Daniel and Terry Sullivan (1999), *Health Reform: Public Success, Private Failure*, Routledge, London, pp. 87-104.

[16] Under the North American Free Trade Agreement (NAFTA), an **investor-state mechanism** allows corporations to directly challenge any government policy or regulation. Any kind of programs, regulations or policies offer the opportunity for opportunistic claims by any firm that sees the possibility of winning "damages". Already, an

individual has set up a phantom water-importing company in the US, in order to file for damages against the British Columbia government, because BC banned bulk exports of water.

[17] For instance, see Pfaff, Martin (1990), "Differences in Health Care Spending Across Countries: Statistical Evidence," *Journal of Health Politics, Policy and Law*, Vol. 15 (1), 1-67.

[18] OECD Health Data 99. . Canadian expenditures are converted at current exchange rates to US dollars.

[19] Kuttner, Robert (1999), "The American Health Care System – Health Insurance Coverage," *The New England Journal of Medicine*, Vol. 340(2).

[20] Evans, Robert G. (2000) "Two Systems in Restraint: Contrasting Experiences with Cost Control in the 1990s" in D.M. Thomas, ed. Canada and the United States: Differences that Count, Peterborough, Ont.: Broadview, pp. 21-51.

[21] Stoddart, GL et al. (1993), *Why Not User Charges? The Real Issues*, Centre for Health Services and Policy Research, UBC, HPRU, 93:12D, referenced in Canadian Health Services Research Foundation (2001), *Myth: User fees would stop waste and ensure better use of the healthcare system*.

[22] Beck, R.G., and Horne, J.M., (1979), "Study of user charges in Saskatchewan 1968-1971," in *User Charges for Health Services: A Report of the Ontario Council of Health*, Toronto: Ontario Council of Health, 133-162.

[23] Fahs, M.C., (1992), "Physician response to the United Mine Workers' cost-sharing program: The other side of the coin," *Health Services Research,* Vol. 27(1), 25-45.

[24] Siu, AL et al. (1986), "Inappropriate use of hospitals in a randomized trial of health insurance plans," *New England Journal of Medicine,* Vol. 315, pp. 1259-66.

[25] Foxman, B. et al. (1987), "The effect of cost sharing on the use of antibiotics in ambulatory care: results from a population-based randomized controlled trial," *Journal of Chronic Disease*, Vol. 40, pp. 429-437.

[26] Tamblyn, R. et al. (2001), "Adverse events associated with prescription drug cost-sharing among poor and elderly persons", *Journal of the American Medical Association*, Vol. 285, No. 4, pp. 421-429.

[27] American studies in prestigious medical journals confirm the health risk of relying on for-profit providers. A very large study published in *The Journal of the American Medical Association* [Himmelstein, David U., MD, Steffie Woolhandler, MD, MPH, Ida Hellander, MD, and Sidney Wolfe, MD (1999), "Quality of Care in Investor-Owned vs. Not-for-Profit HMOs," July 14, 1999, vol. 282, No. 2, pp. 159-163.]. The study used 1996 quality-of-care data from the National Committee for Quality Assurance's Quality Compass 1997. The 329 HMOs covered 56% of all HMO enrolment in the US reported that for-profit health maintenance organizations (HMOs) scored lower than not-for-profit HMOs on quality of care for all 14 indicators examined.

[28] In a major study of renal dialysis facilities, the *New England Journal of Medicine* found that for-profit ownership was associated with higher mortality and lower levels of placement on transplant lists. [Garg, Pushkal P., MD, Kevin D. Frick, PhD, Marie Diener-West, PhD, and Neil R. Powe, MD, MPH, MBA (1999), "Effect of the Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation," Nov. 25, 1999, Vol. 341, No. 2, pp. 1653-60. The study used data from the US Renal Data System. It selected a nationally representative group of patients with end-stage renal disease, and followed them for 3 to 6 years. Of 3,681eligible patients, 3,569 were followed for mortality and 3,441 for placement on waiting lists.].

[29] In the language of economists, you cannot write a complete contract to cover all contingencies.

[30] Woolhandler, Steffie, MD, MPH, and David U. Himmelstein, MD (1997), "Costs of Care and Administration at For-Profit Hospitals in the United States," *New England Journal of Medicine,* March 13, 1997, Vol. 336, No. 11, pp.

769-774. The data covers 6,225 hospitals that submitted sufficient data on cost categories to the Health Care Financing Administration in 1990 and 1994. These data are submitted in order to receive Medicare payments.

[31] Silverman, Elaine M., MD, MPH, Jonathan S. Skinner, PhD, and Elliott S. Fisher, MD, MPH (1999), "The Association Between For-Profit Hospital Ownership and Increased Medicare Spending," *New England Journal of Medicine,* Aug. 5, 1999, Vol. 341, No. 6, pp. 420-426. The study categorized American hospital service areas according to whether they were for-profit, not-for-profit or mixed, using American Hospital Association data. It then looked at per capita Medicare spending, controlling for age, gender, race, region, urban share of population, Medicare mortality rate, number of hospitals, physicians/capita, share of hospital beds affiliated with medical schools, share of hospital beds belonging to chains, and share of Medicare recipients enrolled in HMOs. As noted, Medicare expenses in for-profit areas exceeded those in not-for-profit areas.

[32] See Rachlis (1998) op. cit, Miller (1997), op. cit, and Herbert, (1997), op. cit.

[33] Anders, George (1997), "Improper Medicare Spending is Frequent," *Wall Street Journal*, June 11, 1997.

[34] Eisler, Peter (1996), "Fraud on the Rise: Those Who Get Caught Say It's Just Too Easy," *USA Today*, Nov. 12, 1996.

[35] See for example the recommendations of the Fyke Commission and the National Forum on Health.

[36] Saskatchewan Registered Nurses' Association (2001), *Presentation to the Standing Senate Committee on Social Affairs, Science and Technology.* p. 8.

[37] Adverse selection in insurance is the problem that poor risks are attracted to insurance. This causes insurance premia to rise, which causes better risks to drop out, which raises average risk, which raises premia, and so forth. Thus, insurance premia end up being very high and many people do not get served by the market. To reduce this risk, insurance companies engage in expensive screening of potential clients (sometimes called risk selection). This is costly to the client, to the insurance company, and to the government that has to pick up many of those rejected by private insurers.

[38] OECD (1999), *Health Data 99: Comparative Analysis of 29 Countries*.

[39] In the parlance of an economist, this is monopsonistic power.

[40]For instance, our single-payer system "lends itself to effective supply management and cost-control" in the opinion of *National Health Expenditures in Canada, 1992-1993*, Health Canada (1994), p.11. Quoted in Armstrong, Pat and Hugh Armstrong (1996), *Wasting Away: The Undermining of Canadian Health Care.* Oxford University Press, p. 187.

[41] Evans, Robert G. (2000), "Two Systems in Restraint: Contrasting Experiences with Cost Control in the 1990s," in D.M. Thomas, ed. *Canada and the United States: Differences that Count*, Broadview, Peterborough, Ontario, pp. 21-51.

[42] Bear in mind that Canadian doctors don't need as high fees because the costs of operating in Canada are much lower than they are in the US, due to the greater administrative efficiency of our system. Canadian doctors have an additional advantage in that they do not face the huge malpractice insurance premia that their American colleagues face.

[43] Under compulsory licensing, generic companies were able to produce generic equivalents of name brand pharmaceuticals. In return, the generic companies paid a small license fee of 4-5% of revenue associated with the sale of the generic equivalent. This made drugs much cheaper in Canada.

[44] "Ironically, the real success story in the Australian health system – both financially and medically – has not been private medicine. It has been pharmacare, a universal, publicly-funded drug benefit program." Thomas Walkom, "Condition critical: Where two-tier hospitals are failing," *Toronto Star*, March 18, 2000.

[45] Canadian Institute for Health Information (2000), *National Health Expenditure Trend, 1975-2000*. While critics are sceptical about the successes of the Canada's Patented Medicine Prices Review Board in controlling pharmaceutical prices, things in Canada could be worse. Cross-border tours by Americans seeking relatively cheaper Canadian drugs show that drug prices are even more weakly controlled in the US. One could conjecture that the comparative success would be a combination of monopsonistic buying by provinces and controls over prices.

[46] Rachlis, M., (1998), *The Future of Canada's Health Care System*, mimeo, Jan. 11, 1998.

[47] Externalities, also called "third party effects" are effects on people who are not parties to transactions. For example, if someone engages in preventive health care, she will protect others who will thus avoid the given illness. This would be an example of a positive externality. Pollution would be an example of a negative externality. Private markets underproduce goods associated with positive externalities, and overproduce goods with negative externalities. Thus, markets deliver too much pollution, and not enough public health. Some external agent, like a government, has to intervene, so as to correct these problems.

[48] Note that, although all provincial governments provide some public health services, this area is not in the CHA, but it should be. Governments often see the wisdom of correcting for market failures, even if not forced to do so. However, public health is in our opinion a neglected area.