RNAO

Registered Nurses Association of Ontario

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

Submission to the Senate Committee on Social Affairs, Science and Technology

by

The Registered Nurses Association of Ontario

October 30, 2001

438 University Avenue, Suite 1600, Toronto, Ontario, M5G 2K8
phone: 416-599-1925 toll free: 1-800-268-7199 fax: 416-599-1926
www.rnao.org

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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 fighting 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 both health and economic 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 Standing Senate Committee on Social Affairs, Science and Technology for the opportunity to present our views today. RNAO also commends the Committee for identifying many of the key issues that need to be addressed as we move to strengthen this cornerstone of our Canadian identity.

Summary of Recommendations

Recommendation 1. We urge the Standing Committee 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 Standing Committee to reaffirm its commitment to the principles of the Canada Health Act as an essential basis for health care provision.

Recommendation 2. We urge the Standing Committee 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.

Recommendation 3. We urge the Standing Committee to recommend the creation of a permanent national coordinating body, comprised of health care workers, government and health care providing institutions, in order to deal with health human resource (HHR) issues, such as working conditions, and recruitment and retention.

Recommendation 4. We urge the government to develop strategies to control the rapid growth in pharmaceutical expenditure, without compromising the quality of health care. These strategies would 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.

Recommendation 5. We call upon the Standing Committee to urge both levels of government to make credible commitments to health care, in order to restore Canadians' confidence in their health care system.

Recommendation 6. We urge the Standing Committee to call upon the government to explicitly exempt health care and other essential social services from trade agreements.

Recommendation 7. We urge the Standing Committee to recommend that all levels of government place a moratorium on privatization in health care funding.

Recommendation 8. 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.

Recommendation 9. 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.

Recommendation 10. We recommend the development of a democratic and transparent process for defining medical necessity.

Recommendation 11. 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.

Recommendation 12. We urge the Standing Committee to recommend that all levels of government place a moratorium on transfer of health care activities to the for-profit sector.

Recommendation 13. We urge the Standing Committee, in addition to their call for healthy, safe workplaces to specifically call for a reduction of casual employment to 30% of total and to call for adequate and stable funding in order to ensure improved working conditions for the nursing profession.

Recommendation 14. We urge the Standing Committee to recommend the implementation of true primary health care reform, with 24/7 care being delivered by interdisciplinary teams of health care professionals.

Recommendation 15. We request the Standing Committee to recommend devoting more resources to the integration of prevention and population health concepts into our system.

Recommendation 16. We must reward good practices in health care. We ask the Standing Committee to chart a staged path to more appropriate incentives, including alternative payment mechanisms.

Recommendation 17. We recommend much stronger government support for systematic identification and implementation of more effective and responsive interventions.

Recommendation 18. We request the Standing Committee to chart a process towards greater public participation in the governance of our health care system along with greater transparency and accountability of government.

Recommendation 19. We request the Standing Committee 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.

Recommendation 20. 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

A. A Question of 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."*[1]

(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 in1971, 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: Knowing Where We're Going

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. As the health care system evolved, more and more services started moving away from hospitals and away from the protection of the CHA.

This phenomenon of creeping privatization is one that deeply concerns experts in health care and it is one that 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.[2] 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.[3] 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.

Recommendation 1. We urge the Standing Committee 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 Standing Committee to reaffirm its commitment to the principles of the Canada Health Act as an essential basis for health care provision.

B. Sustainability: The Key

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

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 as a share of 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%. After that, tight restraints on government health spending drove the share below 9%. The share has subsequently recovered to a stable 9.3% over the last three years. There is now no significant upward trend.

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 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.[4] [5] OECD figures show that, by 1979, health expenditures amounted to 7.2% of GDP in Canada and 9.1% of GDP in the US.[6] 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.

(ii)Threats to Sustainability

(a) Misguided Policy Directions

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 2. We urge the Standing Committee 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.**

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.

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.

> **Recommendation 3. We urge the Standing Committee to recommend the creation of a permanent national coordinating body, comprised of health care workers, government and health care providing institutions, in order to deal with health human resource (HHR) issues, such as working conditions, and recruitment and retention.**
> *(A full set of HHR recommendations appears in Appendix B).*

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.

Curative/Medical Model Focus

As discussed, the health-care system was set up to fund hospital and medical care. 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. In addition, the science of health promotion and illness prevention has also grown.

Now, the health care system 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. In the long run, greater costs may be avoided as earlier intervention can prevent more acute and costly illnesses.

The curative model also relies more on costly technology, some of which is becoming increasingly expensive. While some new technologies are cost-saving (e.g., those that allow less invasive techniques and shorter hospital stays), others offer new services at higher costs.

The physician-centered, medical model tends to make inadequate use of other health care professionals. Overall, this arrangement contributes to neglect of health promotion and illness prevention, which can have significant cost implications.

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.[7] 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 4. We urge the government to develop strategies to control the rapid growth in pharmaceutical expenditure, without compromising the quality of health care. These strategies would 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.

(b) Lack of Transparency/Accountability

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.[8]
  - 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.[9]
  - 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.[10] [11] [12]

- 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.

Recommendation 5. We call upon the Standing Committee to urge both levels of government to make credible commitments to health care, in order to restore Canadians' confidence in their health care system.

Recommendation 6. We urge the Standing Committee to call upon the government to explicitly exempt health care and other essential social services from trade agreements.

C. Sustainability Solutions

(i) Rely on Public Funding – It Works!

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.[13] 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 Avoid Costs**: 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).[14] 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.[15] The total cost to government of this deductibility has been placed at $125 billion for 1998.[16] Thus, public funding is an even better deal than the above 1997 figures suggest.

Recommendation 7. We urge the Standing Committee 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%.[17] 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.[18] [19]

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.[20] [21] Even small user fees deter use of essential health care services. The cost in consequent readmissions can be high.[22] Even if we were to save costs by deterring use of essential services, would we want to do so, as a society?

Recommendation 8. 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 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 9. 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 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.*
- *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 10. 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 11. 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**. [23] [24]

In short, for-profit providers have a stronger incentive to cut corners in areas where monitoring is difficult or costly.[25] 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[26] 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).[27]
  - 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.[28] 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"[29], while random audits of different states' Medicare billings have shown much higher rates of bogus claims (e.g., 26% in Florida[30]).
- 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.

Recommendation 12. We urge the Standing Committee to recommend that all levels of government place a moratorium on transfer of health care activities to the for-profit sector.

(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:[31] We briefly restate these here, under three categories: revitalizing the nursing workforce, improving effectiveness and efficiency, and accountability and governance.

Revitalizing the Nursing Workforce

The nursing profession, critical to the health and well being of Canadians, is under threat and in need of immediate policy interventions. Last week, in a 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" [32] 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. [33]

"In 2000, the average age of a working nurse in Canada was 43.3 years, and 28% … are 50 or over… All of this adds up to a projected shortage of 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 shortage of this is allowed to develop, the adverse consequences for Canadians' health are incalculable." [34]

Recommendation 13. We urge the Standing Committee, in addition to their call for healthy, safe workplaces to specifically call for a reduction of casual employment to 30% of total and to call for adequate and stable funding in order to ensure improved working conditions for the nursing profession.

(Additional HHR recommendations in Appendix B)

Improving Effectiveness and Efficiency

Recommendation 14. We urge the Standing Committee 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…."[35] *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.*

<u>Recommendation 15.</u> We request the Standing Committee to recommend devoting more resources to the integration of prevention and population health concepts into our system.

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 16.</u> We must reward good practices in health care. We ask the Standing Committee to chart a staged path to more appropriate incentives, including alternative payment mechanisms.

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 17.</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.

Improving Accountability and Governance

Recommendation 18. We request the Standing Committee 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.

Decisions will be required, even if we manage everything well. 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 Standing Committee could form part of that consultation.

Recommendation 19. We request the Standing Committee 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 20. 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. Ultimate Goal: Social Cohesion & Sustainability

What are the measures that must be pursued in order to build social and human capital, and build social cohesion? Major decision-makers[36] are belatedly recognizing the importance of social capital in productivity. Furthermore, the epidemiological literature on the social determinants of health makes it very clear that health is heavily dependent upon a series of key social factors: income, income distribution, employment, stress, social isolation, etc.

Canadians need policy changes that rebuild the sense of community that has been fraying as governments have retrenched over the past decade. These changes must build on positive trends in our system and 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

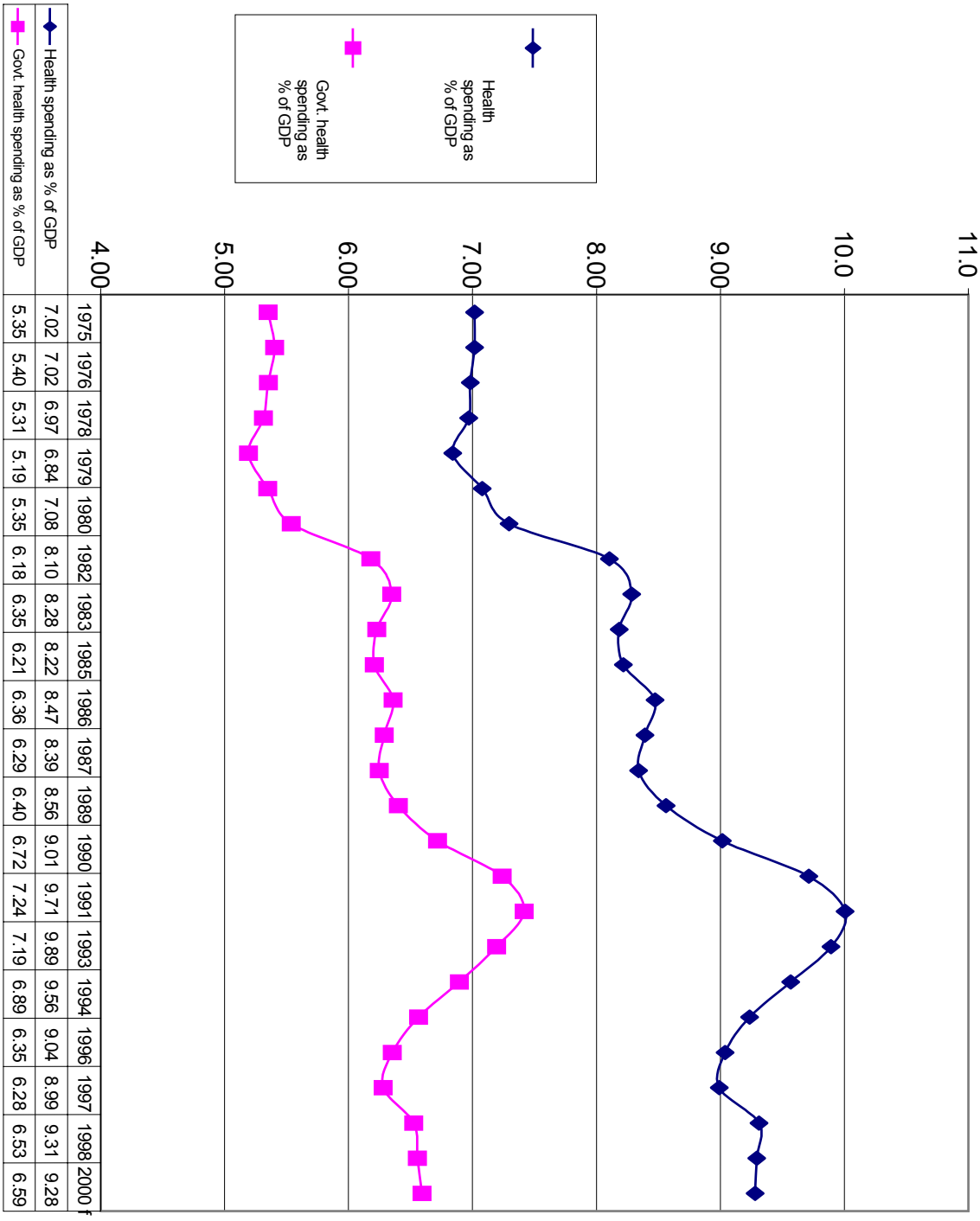
Obstacles exist to achieving these positive trends within our health care system. There are many interests who want or promote a limited and reduced health care system. In some cases, it is simple ideology. In other cases, it is the pursuit of private interests against the interest of all. While the health care system benefits all, there is a lot of money to be made from dismantling it. The obstacles would include:

- Those who are actively seeking to shrink the size of government, not based on any demonstrated proof/evidence that this will improve the quality or effectiveness of health-care provision.
- Those who actively promote trade agreements that give primacy to commercial rights over environmental, social, and labour rights.
- Those in support of more deregulation and strong patent rights for pharmaceuticals and for other products.
- Those who support the continuation of curative-focused, doctor-centred care
- Those who continue to champion the fee-for-service payment system.
- For-profit sellers of health care insurance and of health care services.

However, the list of those committed to strengthening our publicly funded health care system is large and growing. Virtually every health care expert agrees on what should be done. Similarly, public consultations such as the National Forum on Health reaffirm that the public is behind this approach. We simply need the political will to act on what the experts and the Canadian public know must be done.

We call upon the Standing Committee 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 important dimension of their lives.

Appendix A: Health Spending as a Share of GDP in Canada



	1975	1976	1978	1979	1980	1982	1983	1985	1986	1987	1989	1990	1991	1993	1994	1996	1997	1998	2000
Health spending as % of GDP	7.02	7.02	6.97	6.84	7.08	8.10	8.28	8.22	8.47	8.39	8.56	9.01	9.71	9.89	9.56	9.04	8.99	9.31	9.28
Govt. health spending as % of GDP	5.35	5.40	5.31	5.19	5.35	6.18	6.35	6.21	6.36	6.29	6.40	6.72	7.24	7.19	6.89	6.35	6.28	6.53	6.59

Data Source: Canadian Institute for Health Information (2000), *National Health Expenditure Trends 1975-2000*

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 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 on a percentage basis in the US for a number of years.[38]

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 spiraling 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] 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.

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

[3] 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.

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

[5] 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.*

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

[7] CIHI. *The National Health Spending Trends* 1975-2000. P. 93.

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

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

[10] 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.

[11] 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.

[12] 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.

[13] 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.

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

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

[16] 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.

[17] 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: Suser fees would stop waste and ensure better use of the healthcare system*.

[18] 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.

[19] 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.

[20] 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.

[21] 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.

[22] 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.

[23] 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.

[24] 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.].

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

[26] 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.

[27] 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.

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

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

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

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

[32] 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.

[33] 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*. For a fuller discussion of these issues.

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

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

[36] E.g., see story of Toronto symposium on human capital sponsored by the Organization for Economic Co-operation and Development and Human Resources Development Canada in Crane, David (2000), "Economists finally discover social capital," *Toronto Star*, March 25, p. E2.

[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 much cheaper drugs available 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.