



Strengthening our publicly funded,
not-for-profit health-care system

RNAO Vision backgrounder

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RNAO's vision for the future of nursing can only be realized if our publicly funded and not-for-profit health-care system is strengthened. Nurses want to see renewed emphasis on the principles laid out in the *Canada Health Act*: public administration, comprehensiveness, universality, portability and accessibility.¹

Expanding Medicare

We know that the health-care system has to adapt to meet changing needs. That's why it should be expanded to include a pharmacare program and home care services.

The *Canada Health Act* (CHA) is a valued tool to deliver health care to all Canadians in an equitable way. It guarantees universal access to hospital and medical care via first-dollar coverage. Unfortunately, omitted are key health-care services, including home care, pharmacare, long-term care, physiotherapy, and dental care. The omissions lead to very uneven access to the uncovered services across the country. They also result in inefficient overuse of covered services and underuse of uncovered services. The time to expand medicare through parallel legislation to the CHA is long past. Tommy Douglas' vision of Medicare was to cover drugs, dentistry, vision, home care and most other health services.² In 1997, the National Forum on Health called for protection of the single-payer model and "expanding publicly funded services to include all medically necessary services and, in the first instance, home care and drugs".³ In 2002, the Romanow Commission recommended expansion of home health care for mental health, post-acute care and palliative care.⁴ It also recommended coverage for catastrophic drug expenses.⁵ The Kirby Report called for a national post-acute home care program, catastrophic drug coverage and a national drug formulary.⁶ RNAO has long called for expansion of medicare "to all uncovered areas, including home care, pharmacare, long-term care, rehabilitation services, public health and truly comprehensive primary health care."⁷ It shares the National Forum's belief that we could start with pharmacare and home care.

Pharmacare. Canadians are covered by a patchwork of partial pharmacare coverage.⁸ A commentary written for the conservative C.D. Howe Institute neatly summarizes the case for pharmacare in Canada:⁹ ¹⁰ it would deliver equitable access to medicines; it would better financially protect the ill; and it would result in a net saving of money. The savings come from reduced administrative, marketing and regulatory costs (due to being a single-payer system), from integration of decisions on pharmaceutical care into overall health care (e.g., health-care providers have more incentive to rationally optimize between medical and pharmaceutical care), from pooling of risk over larger populations, from value-for-money testing, and from use of purchasing power to reduce drug prices. A 2010 study quantified the potential savings of a comprehensive first-dollar pharmacare programs for Canadians at up to \$10.7 billion annually (or 42.8 per cent of total spending on pharmaceuticals).¹¹ RNAO,¹² Canadian Federation of Nurses Unions^{13 14}; Canadian Medical Association,¹⁵ Standing Senate Committee on Social Affairs, Science and Technology,¹⁶ Canadian Health Coalition,¹⁷ Canadian Association of Retired Persons,^{18 19} and Canadian Doctors for Medicare²⁰ have called for a national pharmacare program. The public is on side: a

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May 22, 2013 poll by EKOS found 78 per cent of Canadian respondents supported a universal public drug plan for all necessary prescription drugs.²¹ The poll also found strong support (82 per cent) for bulk purchasing of drugs and strong negotiations to lower drug prices.

It would be better if pharmacare were implemented nation-wide, but as the C.D. Howe article points out, in the current policy environment, one or more provinces must lead the way. Ontario would serve its citizens and all Canadians well if it were to play that role. Currently, the Ontario Drug Benefit Program covers senior citizens and those receiving social assistance, while the Trillium Drug Program subsidizes those whose costs are high relative to their income.^{22 23} The Ontario government has indicated an interest in a full provincial pharmacare program, but it requires a push.²⁴ RNAO will continue to mobilize for a national pharmacare program.

Home care. Expansion of medicare to include home care would yield similar types of benefits to those related to a national pharmacare program. A 2002 study called for funding for all home care services. It concluded that home care would be less costly than residential care under most circumstances: it is considerably cheaper for stable clients (half or less); it was only more expensive for clients who die, due to their use of hospitals. The advantage was all the more remarkable because it included an imputed value to informal caregiver time in the home. The study found more mixed results when it came to home care vs. acute care; results were sensitive to the condition of the client and the availability of home care services that could meet those needs; if the needs could not be met in the community, the client would end up back in emergency and costs could be higher than in acute care. The study made the more general point that cost efficiency would be best enhanced with full integration of client care across the spectrum. In any case, system navigators must decide the most cost effective way to achieve good health outcomes.²⁵

Ultimately, expanding home care improves health system efficiency and saves society money, but it will require more government expenditure, at least at start-up. There are ways of making initial outlays manageable. Economist Dr. Peter Coyte estimated the cost in 2002 of a national post-acute home care program at between \$1.0211 billion and \$1.5118 billion.²⁶ Health policy analyst Michael Decker put the five-year net cost of starting a national home care program at \$1 billion.²⁷

There is broad support for a national home care program. As noted above, the National Health Forum, the Romanow Report and the Kirby Report called for various forms of national home care programs. Then-federal Health Minister Allan Rock made a spirited case for a federal home care system.²⁸ Home care expansion was one of the mandates of the 2004 Health Accord, which committed provinces to cover two weeks of home care for the acute, mental health and palliative areas.²⁹ In his submission to the Kirby Committee, RNAO, the Canadian College of Family Physicians,³⁰ the Canadian Healthcare Association,³¹ and the Ecumenical Health Care Network^{32 33} have all called for a national home care program. The Canadian Medical Association offer qualified support: “Governments should adopt a policy framework and design principles for access to publicly funded medically necessary services in the home

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and community setting that can become the basis of a “Canada Extended Health Services Act.”³⁴ The Sinha report called for an expansion of home care, albeit income-geared.³⁵ A much broader and more equitable access to home care services; reduction in the need for more costly long-term care and acute care; better outcomes; and greater client satisfaction.

Making Medicare More Efficient

Creating true universality in medicare is only half of the battle. We must also make medicare financially and politically sustainable by ensuring that it is delivered in an efficient way.

Expanding medicare by creating a national pharmacare and homecare programs would improve health outcomes and make better use of resources, instead of overusing covered services and underusing uncovered services. That would help make medicare more efficient. But that is not enough.

Transparency and accountability are important in all public activities, including health care, to ensure that services are efficiently and effectively delivered. The loss of the Health Council of Canada weakens transparency and accountability at the national level. Health Quality Ontario³⁶ and the provincial Auditor General³⁷ do provide accountability for health at the provincial level for Ontario, and the same accountability is required nationally.

Privatization in Health Care

Private Payment. Private payment restricts access to health-care services, based on income, meaning that lower income people without insurance get delayed, reduced or no access to health care.^{38 39 40 41}

Private payment results in higher costs due to limited buying power, higher administrative costs, and skewed usage to insured vs. uninsured services.^{42 43 44 45} The American health-care system is a signal example. As of 2012, 15.4 per cent of Americans had neither public nor private health insurance.⁴⁶ In part due to its multi-payer nature, US health expenditures exceed those of the rest of the OECD, but health outcomes are comparatively poor.⁴⁷

An area of growing concern for RNAO is medical tourism: the sale of health care at a profit to well-healed people who travel abroad to access health services more quickly or more cheaply. RNAO is aware of at least three Toronto hospitals that have provided non-urgent health services to paying patients from abroad.⁴⁸ Given the existence of waiting lists, this queue-jumping can only lengthen the delay facing others patiently waiting their turn.

While equity and efficiency support a single-payer system, there is money to be made through private payment for health care, and that creates powerful interests to lobby against the common good. The scope of private services available is broad, as can be seen from www.findprivateservices.ca. Private providers sell CHA-insured services to Canadians, as Dr. Brian Day has been doing very publicly with his two for-profit clinics. Privatization of health services creates a two-tier system, with higher-income

Canadian able to buy their way to the front of the queue. Dr. Day's clinics have already been ordered to cease extra-billing for services covered under British Columbia's Medicare system.⁴⁹ Dr. Day is also challenging the single-payer Medicare system in BC in the Supreme Court of British Columbia (opposed by interveners like the Council of Canadians). The case went to court in January 2014.^{50 51} This follows on the heels of the 2005 Chaoulli Supreme Court decision that invalidated Quebec's ban on private insurance to cover publicly-insured procedures.⁵² The Day case could go all the way to the Supreme Court of Canada, potentially undermining the CHA and Medicare's universality.

Private Delivery. Delivery of services is another area of privatization. Services are generally delivered privately, either by not-for-profit or by for-profit agencies. For example, in Ontario, most hospitals are private, not-for-profit bodies. In the home care and long-term care sectors, services are delivered by a combination of for-profit and not-for-profit bodies. The profit incentive turns out to be perverse in health care, because it harnesses human ingenuity in ways that inflate costs and deliver worse outcomes. Health care is particularly vulnerable because it is very difficult to assess and monitor quality of care; the incentive to cut corners is very powerful, and the penalty for not cheating may be loss of market share. A review of four decades of experience with privatization in the United States with a combination of public funding and private health care management and delivery found that "for-profit health institutions provide inferior care at inflated prices."⁵³ For-profit provision leads to cherry-picking of profitable services and clients, leaving the public sector to deal with high-cost clients.^{54 55} An abundance of literature points to poorer outcomes from for-profit health care^{56 57 58 59 60 61 62 63 64} and at higher cost.⁶⁵

Public-Private Partnerships (also known as P3s or Alternative Financing and Procurement⁶⁶) are a variation on for-profit provision, in the case of infrastructure. They generally involve the private sector organizing the financing, design, and construction of infrastructure. Controversially, they tend to be very complicated and long-term contracts that also include private operation and maintenance of the facility after it has been built. P3s tend to be more expensive because private borrowing costs are higher than public borrowing costs, because of the high negotiation costs of these complex deals, and because the representatives of the public sector are ill-equipped to negotiate such complex contracts. The public ends up absorbing higher costs and lower quality of services as a result.^{67 68 69 70 71 72 73 74 75}

The Health Accord

The historic 2004 Health Accord is at risk of being lost.

In an alarming development, the federal government has walked away from renegotiating the 2004 ten-year Health Accord. This was federal-provincial-territorial agreement aimed at strengthening Canadian health care under which the federal government funded health care via the Health Transfer, in return for provincial/territorial performance undertakings.⁷⁶ The federal government also terminated the Health Council of Canada with the stated reason that it is no longer needed now that the Health Accord

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has expired; creation of a Health Council of Canada was Recommendation 1 of the Romanow Commission.⁷⁷ RNAO was quick to respond. “We are extremely disappointed with Prime Minister Stephen Harper’s decision to end support for the Health Council of Canada. This decision is a failure of the federal government to recognize strong, credible, evidence-based health organizations who work to strengthen Canada. Everyone in this country should be deeply concerned because the federal government is distancing itself from the health and health care of Canadians.”⁷⁸ The Canadian Medical Association also registered its dismay: “The recent decision by the Government of Canada to cut funding to the Council is a failure of its responsibility to protect and strengthen Canada’s health-care system. Further, cutting the Health Council also means the loss of an important tool to monitor the performance of the health care system.”⁷⁹ The provinces say that in lieu of negotiation, the federal government unilaterally slashed \$36 billion in transfers to the provinces and territories for the period after the expiry of the Health Accord.^{80 81} This further reduces provincial/territorial health care resources and gives the federal government even less leverage to enforce the *Canada Health Act* (a paper written for the Canadian Institute of Actuaries estimates that the federal transfer share of provincial/territorial health expenditures would drop from its current 21 per cent to 14.3 per cent under the new formula by 2037, down from an initial 50 per cent).⁸² The federal government could withhold transfers to provinces that allow billing for services covered under the CHA, but it has chosen not to act, which encourages further violations.⁸³ Furthermore, the federal government has switched to transferring health funds on a per capita basis, which will leave poorer provinces worse off. Former Saskatchewan premier Roy Romanow described the Prime Minister’s plan for health-care transfers as a deliberate strategy to abandon health care to the provinces and foster the development of more private, for-profit medical enterprises.⁸⁴

[wpd%2FCMAPolicy%2FPublicB.htm&TN=PubPol&SN=AUTO13436&SE=1952&RN=12&MR=20&TR=0&TX=1000&ES=0&CS=1&XP=&RF=Public%3E+TableDE&EF=&DF=Display%3E+English&RL=0&EL=0&DL=1&NP=3&ID=&MF=wpengmsgcmapolicypublicB.ini&MQ=&TI=0&DT=&ST=0&IR=1770&NR=0&NB=0&SV=0&SS=0&BG=&FG=000000&QS=Staff&OEX=ISO-8859-1&OEH=ISO-8859-1.](http://www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf)

¹⁶ Standing Senate Committee on Social Affairs, Science and Technology. (2012). *Time for Transformative Change: A Review of the 2004 Health Accord*. Retrieved December 16, 2013 at <http://www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf>. “Recommendation 28: That the federal government work with the provinces and territories to develop a national pharmacare program based on the principles of universal and equitable access for all Canadians; improved safety and appropriate use; cost controls to ensure value for money and sustainability; including a national catastrophic drug-coverage program and a national formulary.”

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²¹ EKOS. (2013). *Canadian Views on Prescription Drug Coverage*. May 22. Retrieved January 2, 2014 at http://www.ekospolitics.com/wp-content/uploads/press_release_may_22_2013.pdf.

²² Ontario Ministry of Health and Long-Term Care. (2012). *Ontario Public Drug Programs*. Retrieved January 2, 2014 at <http://www.health.gov.on.ca/en/public/programs/drugs/default.aspx>.

²³ Advocating for a Poverty Free Ontario. (2013) *Pharmacare: What is Publicly Funded in Ontario*. August 13. Retrieved January 2, 2014 at <http://povertyfreeontario.blogspot.ca/2013/08/pharmacare-what-is-publicly-funded-in.html>.

²⁴ Ontario Minister of Health Deb Matthews indicated the government would make prescription drug coverage a priority if it had sufficient money. See: Morgan, S. (2013). *Why Ontario should pioneer the expansion of prescription drug coverage in Canada*. Retrieved January 2, 2014 at <http://umanitoba.ca/outreach/evidencenetwork/archives/12588>.

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⁴⁶ United States Census Bureau. (2013). *Income, Poverty and Health Insurance Coverage in the United States: 2012*. Retrieved December 20, 2013 at http://www.census.gov/newsroom/releases/archives/income_wealth/cb13-165.html.

⁴⁷ OECD. (2013). *OECD Health Data 2013 – Frequently Requested Data*. Retrieved December 16, 2013 at <http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequentlyrequesteddata.htm>. In 2011, US health expenditures consumed 17.7 percent of GDP; the next highest was 11.9 percent for the Netherlands, while the OECD average was 9.3 percent. In spite of the elevated costs, American health outcomes lag the OECD: US infant mortality is 6.1 per thousand vs. 4.1 average for the OECD and 0.9 for Iceland. Life expectancy is lower in the US at 78.7 years vs. 80.1 years average for the OECD. Correspondingly, the US performs poorly on potential years of life lost per 100,000: 5,814 vs. 4,633 OECD average for males and 3,447 vs. 2,415 OECD average for females).

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