

Brief presented to the Commission on the Future of Health Care in Canada

May 31, 2002 – Toronto

MEDICAL REFORM GROUP

Mr. Romanow, the Medical Reform Group, an organization of about 200 doctors, believes you bear an enormous responsibility, and have an enormous opportunity.

The Mazankowski and Kirby reports have followed a line taken by most government leaders and political commentators, characterizing Canada's health care spending as out of control, and in crisis. Mr. Romanow, you know better. Health spending as a proportion of our gross domestic product has dropped in the last decade from 10 per cent to 9.4 per cent and public spending from 6.8 per cent to 6.3 per cent. Canada as a nation has fallen from second in health care spending as a proportion of GDP to fifth.

Between 1996 and 2001, the federal government ran surpluses that they used to pay down the national debt by \$35.8 billion. In the last fiscal year, the federal government reduced the debt by a record 17.1 billion. These surpluses have occurred in the face of tax reductions which by 2001 amount to a total of \$20 billion provincially and \$20 billion federally each year.

Huge tax cuts, huge federal surpluses, and a falling share of the GDP spent on health care: the image of a health spending crisis could not be further from the truth. Mr. Romanow, you must use all your resources to fight the misrepresentation of a health funding crisis that the enemies of public medical care are perpetrating, and your recommendations must reflect the reality.

While they cut taxes and run surpluses, the federal and provincial governments squabble about responsibility for underfunding public health care.

On July 9th the Canadian Medical Association Journal is scheduled to publish an article by two Medical Reform Group members and Canadian

Centre for Policy Alternatives economist Armine Yalnizyan on this very issue. It shows how the current structure of federal and provincial spending allows the federal government to make unilateral cuts in health care, allows the provinces to use federal transfers to fund tax cuts, and all the while obscures what federal and provincial governments are actually contributing to health funding.

The Mazankowski and Kirby reports have ignored this problem. Mr. Romanow, you must not do the same. The way to ensure sustainability is a revised funding formula that binds both levels of government to adequate funding, while making their contributions transparent. A move back to previous funding formulas that tied federal transfers to the GDP, and ensured increases in federal funding in proportion to provincial health care expenditures, is required to remedy the problem.

Mr. Romanow, you must not be nihilistic about the ability of federal and provincial governments to act in concert in the best interests of Canadians. Rather, you must be courageous in abandoning pious statements about the need to cooperate, and instead sound the one national voice calling on governments to take action to institute the real changes that will reverse the squabbling that has so alienated the Canadian public.

Mr. Romanow, you are well aware of the changes in the distribution of Canadian health care expenditures away from physician and hospital services and toward prescription drug and home care. You know that the data indicate the great benefits of single payer funding:

- administrative efficiency,
- equity, and
- an ability to control costs.

You must resist the voices that would compromise the Canada Health Act and its commitment to full public funding of physician and hospital services. You must show us not only how to preserve public physician and hospital insurance, but how to extend that successful model to national home care and pharmacare funding.

The Canadian Health Forum of 1997 saw the wisdom of these national programs, while more recently the Kirby commission has floated a

number of options in their regard, without necessarily committing to the great benefits that would come from extension of Canada Health Act principles as part of national public programs of home care and pharmacare. Mr. Romanow, without your clear indication of how the federal government can lead the establishment of national home care and pharmacare programs, they will remain an unfulfilled dream.

Mr. Romanow, we believe the Medical Reform Group has special insights both because we are practising physicians, and because a number of our leading members are academic physicians involved in issues of applied research and health policy. The MRG has a high respect for research evidence, and believes that it is critical that health policies reflect the lessons of that evidence. A number of MRG members have participated in a systematic review of the evidence regarding the impact of for-profit versus not-for-profit status on hospital mortality.

You are familiar with the findings, published a few days ago in the Canadian Medical Association Journal. Our results provide strong evidence that patients cared for in for-profit hospitals have a higher risk of dying. One likely mechanism of the effect is that for-profit hospitals, constrained by the necessity for generating profits, cut personnel costs by employing fewer skilled health workers, including nurses and pharmacists.

The same team is currently extending their systematic review to look at issues of cost and quality in hospitals, and other health care delivery organizations, and mortality in dialysis centres. The team is determined to complete these reviews in time to inform your recommendations, and you will receive a report of the results. However, the team's preliminary research already suggests that, like hospitals, for-profit dialysis centres demonstrate higher death rates than do not-for-profit dialysis centres. Given these results, it is not surprising that studies of quality of care appear, on the basis of evidence identified to date, suggest that for-profit institutions deliver poorer care than not-for-profit institutions. Finally, for-profit institutions do not generate cost savings. Indeed, research identified to date suggests an increase in costs.

Given these results, unless they are indifferent to quality of care, death rates, and costs of health care, governments should not take a permissive attitude to issues of health care provision. The current federal health

minister seems to be ignoring the evidence, and the lessons that the evidence offers. Mr. Romanow, you must provide a strong, urgent warning against current trends toward expanding for-profit delivery in the Canadian health care system. Nothing less will provide the impetus necessary to stem these destructive trends.

Mr. Romanow, you will face arguments from for-profit providers, and their apologists, suggesting that perhaps things will be different in Canada, and for-profit providers should have the opportunity to show what they can do in the Canadian context. Two prominent Medical Reform Group members are part of the Canadian Center for Policy Alternatives research team that will be advising you on issues related to trade agreements and health care policy. This group will tell you that there are grave dangers in a permissive policy with regard to experimentation with private for-profit health care provision.

In recommending a national pharmacare program, you will face the issue of a likely challenge from foreign health care insurers, charging expropriation. Under NAFTA, it is quite likely that these companies will win their case, and increase the cost of moving to a system of prescription drug provision that meets Canadian's needs.

Fortunately, foreign ownership of companies providing prescription drug insurance remains limited. This situation argues not only for acting promptly to institute a national pharmacare program, but highlights the dangers of opening the door to private for-profit provision of other health services, in particular hospitals. American mega-companies are eager to enter the so-far unexploited Canadian market, and given the opportunity they will act quickly to do so. Once foreign ownership of Canadian health care facilities is appreciable, trade agreements will limit future options for our national health care policies.

Mr. Romanow, as practising physicians, Medical Reform Group members have been proud of their ability to deliver their services without regard for the patient's ability to pay. We have felt great comfort in being able to recommend the necessary investigations, and the hospital care, equally for all those we treat. At the same time, we have become increasingly worried as we have seen the consequences of constrained health care expenditures.

We have seen patients suffer likely adverse health consequences, including death, because of the unavailability of prompt access to needed tests, procedures, and skilled professional care. We have become distressed by evidence that health workers are accepting these constraints as part of the system, and reconciling themselves to the delivery of suboptimal care. We regularly see patients who suffer because they cannot afford the home care they need. We see illness go untreated because patients cannot afford the medication we prescribe. These inadequacies in care, and these inequities, violate our sense of fairness. It is these experiences that bring me here today, appealing to you to act as the champion for Canadian values of compassion, justice, and social solidarity.

Like you, Mr. Romanow, we are well aware that health care is only one factor that promotes good health. We know your focus is, appropriately, on health care delivery, and not on other determinants of health. We believe, however, that we must all be cognizant of the environment in which you will deliver your recommendations. The corporate agenda is increasingly dominating government policies. The result has been an increase in income disparities between wealthy and poor Canadians, a crisis in low income housing, an increase in homelessness, an increase in child poverty, and an increase in the number of Canadians relying on food banks for their nutrition. All of these factors threaten the health of Canadians.

Mr. Romanow, you are one of the very few who are well-positioned to strike back at these destructive social trends. To Canadians who are reluctant to pay increased taxes to maintain high quality public health care for all, you can point out that what is required is not increased taxes, but foregoing tax reductions.

You can let middle-class Canadians know that the alternative to maintaining universal public care through taxes is paying a greater portion of their income for health care, some through taxes, and some through insurance, deductibles, and co-payments. You can sound a clarion call to reverse the process of diminishing social solidarity, and the marginalization of the poor, elderly, and infirm.

Establishing a federal-provincial funding structure that not only ensures the sustainability of universal physician and hospital care, but extends

national health insurance to home care and prescription drugs, would be a huge step forward. We appeal to you to provide the strong, effective, courageous leadership that will inspire both federal and provincial politicians to act in the interests of all Canadians.

Presenters:

Gordon Guyatt is a Professor in the Departments of Clinical Epidemiology and Biostatistics and Medicine at McMaster University. He has made important contributions to clinical and health care research, recognized by over 350 publications in peer-reviewed journals. His educational work includes seven years as Director of the Internal Medicine Residency Program. His work in dissemination of evidence-based decision-making was recognized by a McMaster University President's Award for Excellence in Resource Design in 1996. Dr. Guyatt was instrumental in founding the Medical Reform Group in 1979 and has been a spokesperson for the group for much of the time since then. He has contributed to the development of MRG policy, and in recent years has taken a major role in packaging and dissemination of MRG approaches to health issues.

Alexandra Heber is an Assistant Professor of Psychiatry at the University of Toronto, and the psychiatrist on an Assertive Community Treatment Team in downtown Toronto. She works with a multi-disciplinary team to provide intensive community care to people with severe and chronic mental illness. Prior to her present position, Dr. Heber worked at Mount Sinai Hospital in the Clinic for HIV-Related Concerns. In 1999, she coordinated the psychiatric response to the Kosovo refugees on three Canadian Forces bases in Ontario. Originally from Winnipeg, Dr. Heber graduated from nursing in 1976, and worked as a registered nurse for nine years, before entering medical school. She graduated with an M.D. and a B.Sc. Med. from the University of Manitoba in 1989, and then completed five years of residency training at McGill University and the University of Toronto, obtaining her fellowship in Psychiatry in 1994.

Armine Yalnizyan is an economist who has written extensively about the trends in the labour market and in government social and budgetary policies, the economic fundamentals that shape people's daily lives. For the last 16 years she has worked closely with community groups, including 10 years as program director with the Social Planning Council of

Metropolitan Toronto. She has served on government advisory groups at the provincial and federal levels on issues such as training, welfare reform and working time. In 1998, Armine authored a ground-breaking report on income inequality in Canada, entitled *The Growing Gap*, published by the Centre for Social Justice. She teaches economics at York University and is a research fellow with the Canadian Centre for Policy Alternatives.

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