

**CLC Analysis of the Standing Senate Committee on
Social Affairs, Science and Technology Report**

**THE HEALTH OF CANADIANS — THE FEDERAL ROLE
Volume Six**

The Senate Committee Report on the federal role in health care should be placed in context. The Senate is composed of unelected representatives who are completely unaccountable to the people of Canada. The Committee showed no respect for the democratic process by not shutting down its examination of the health care system when the government of Canada established a Royal Commission on the Future of Health Care. With respect to this, not only did the Committee not shut down, but it also lengthened the timeline of its process to ensure that its Report was released as close as possible to the Romanow Commission Report. As well, the Chair of the Committee, Senator Michael Kirby, has a direct conflict of interest. The Senator sits on the Board of Directors of Extendicare, a for-profit company delivering nursing home care and long-term care. Should the Senate Report have credibility with the government, Extendicare would stand to benefit from the fact that the Report tacitly approves of the for-profit delivery of care.

So, the Report is really a “wolf in sheep’s clothing.” The glaring flaw is the Report’s failure to discuss, in any meaningful way, the implications of the for-profit delivery of health services versus the non-profit or public delivery. In fact, the Committee merely claims that the for-profit delivery of publicly insured services would not result in two-tier health care. Earlier volumes of the Committee Report strongly favoured expanding the role of for-profit health care, and even went as far as contemplating an end to our single-payer, public insurance program by allowing the purchase of private insurance to cover medically necessary health services.

It is a testament to all the progressive organizations and health advocates who appeared before the Kirby Committee that the final Report was forced to back off such explicit recommendations to allow the for-profit delivery of care. The Report fails to speak about the growing number of sites where healthcare is being provided on a for-profit basis in Canada,

and emphasizes again and again that the *Canada Health Act* does not apply to the delivery of health services.

It is not surprising that the Report does not directly call for the for-profit delivery of care. Virtually all of the peer-reviewed research evidence shows that the manner of delivering health services matters greatly. The research shows that the for-profit delivery of care greatly increases the total cost of health care. Studies focussing on quality of care indicate that the quality of care is higher in non-profit settings. In the for-profit home and long-term care setting in the US, conditions of patient care have led to numerous legal charges of abuse, not to mention fraud charges. Priorities in for-profit systems are inverted to priorities in public systems. In the public system, the patient is the top priority and the costs of the treatment at the bottom. In the for-profit system, investors and profit are the top priorities while the patient comes last.

Dr. Arnold Relman, Professor Emeritus of Medicine and Social Medicine at Harvard Medical School, appeared before the Senate Committee where he tabled evidence that private, for-profit health care markets and commercial competition in the US have made things far worse for the US health care system. He noted that health care services are fundamentally different than most other goods and services, and that markets are not designed to effectively deliver health care. This is primarily because health care is foremost a social function which needs to be in the public sector.

Outlined below are some of the key recommendations from the Senate Report. **Bolded text** indicates commentary on the recommendation. Some recommendations require further analysis.

1. Canadians strongly support national principles in health care.
2. More funding is critical to the reforms needed — must be raised primarily by the federal government. Federal transfers to provinces/territories are especially important. **The Report favours increasing government revenues to make Medicare sustainable rather than making some services available more quickly to**

those who can afford to pay privately. This is a huge shift in direction. Earlier reports argued for a parallel, private tier of services.

3. Health standards need to be country-wide.
4. The level of federal funding must be sufficient enough to allow for federal involvement in the restructuring of the system. The Committee concludes that an additional \$5 billion is needed annually to renew and reform the system. The Report is clear that this money will have to come from increased taxation.
5. Federal/provincial/territorial collaboration is important to Canadians.
6. Federal objectives should be:
 - a. to ensure timely access to medically necessary health services regardless of ability to pay; and
 - b. to ensure that no Canadian suffers undue financial hardship as a result of having to pay for health care bills.

The phrasing of the second goal is a shift in the fundamental values at the core of Medicare. It is not that Canadians should not have to suffer undue financial hardship that is the principle. Rather, the core principle is that all Canadians should have access to health care on the basis of need only, not on the ability to pay. The current principles of Medicare require Canadians have access to a system which is universal, accessible, comprehensive, portable, and administered on a non-profit basis. This means first-dollar coverage and no user fees or extra-billing.

7. The Report emphasizes that the CHA does not require the non-profit delivery of health services.
8. The Report states that it has been shown conclusively that the most cost-effective way of funding health care is single-payer and single-insurer model. This is a far cry from earlier reports where the Committee suggested an expansion of private insurance.

9. Enshrining a ‘national health care guarantee’ in legislation is a key recommendation of the Report to address the problem of waiting lines. If a service is not provided within a set reasonable timeline, the patient would have the right to access care elsewhere in the province, elsewhere in Canada, or in another country.

This recommendation is problematic for two reasons. First, for provinces ideologically committed to for-profit health care, it is too simple to make sure that services can’t be provided within a ‘reasonable timeline.’ Limiting the public funding available for certain services can manufacture waiting times, thus providing a private, for-profit market for those services. If all our health services were provided on a public or non-profit basis as they are in Sweden, such a proposal may have some merit, but this is not the case. Secondly, there are other measures to deal with waiting lines, including more funding, better management, and better information. Pilot projects have demonstrated success.

10. The Report calls for establishing a permanent, independent, national, federally funded Health Care Commissioner mechanism which would report to Canadians annually on the state of the health care system, on the status of the health of Canadians, and other reports on improvements in health outcomes.

The major drawback of the Senate Committee’s proposal is that the proposed structure would see a new federal/provincial/territorial body created which would appoint a Health Care Commissioner and members of a National Health Care Council. Thus all the reports would be written by government representatives. Such a structure would leave no room for democratic participation or accountability.

11. The Report call for a prescription drug plan in which the first \$5,000 in drug costs would be paid for by a combination of provincial public plans, private insurance, and individual contributions. Individual, out-of-pocket costs for drugs would be capped at three per cent of family income. Drug costs would be deemed to be catastrophic if they exceeded \$5,000 in any given year, at which point the federal government would pay ninety per cent of those costs with the remaining ten per cent to be paid for by a

supplementary insurance plan through provincial governments or a private plan. A national drug formulary would be established.

This plan doesn't address the root cause of soaring drug costs — excessive patent protection. It will do nothing to contain the growing burden on the public system as a result of the cost of drugs. The three per cent cap is problematic for low income families and individuals.

12. The Report takes a limited approach to expanding Medicare to cover the cost of home care. It calls for Medicare to cover home care costs in situations where people leave the hospital, but require medical services which are a direct extension of hospital care.

This recommendation falls far short of the need for a true home care program under Medicare which has the goal of keeping people in their homes, and keeping people healthier so that the need for expensive, acute care is avoided or delayed. This is really a proposal for sub-acute care to transfer care from the more expensive hospital setting to the less expensive home setting. On its own, this is not necessarily a bad approach, but it does not address the pressing need for real home care services. This type of care is now provided by Para-Med Inc., a subsidiary of Extendicare!!

13. The Report recommends establishing a national palliative home care program to be cost-shared with the provinces/territories.

This is a good recommendation, but the setting for palliative care should not be limited to the home. A national palliative care program should fund various care settings. Such a program must be delivered on a non-profit basis.

14. The federal government should increase funding (\$2 billion) for developing an electronic health information system.

The Report is silent on the need to address a key problem in the field of health information systems and health records — the private, for-profit ownership of health information.

15. The federal government should invest \$2.5 billion over five years to aid hospitals in the purchase and assessment of health technology, but with accountability mechanisms.

16. The federal government should play a role in addressing the shortages in health care human resources; specifically, measures to increase enrollment in medical schools and nursing schools.
17. The Report recommends that the federal government should contribute more to health research by investing one per cent of health spending annually in health research.

The Report does not address the issue of private sponsorship of basic science in universities which has led to unhealthy outcomes, such as gag orders on scientists when research results do not align with private company goals.

18. The federal government has a role to play in: health and wellness promotion; chronic disease prevention; illness and injury prevention; public health protection; and, population health strategies.

The Report did not address the deregulation of the standards for health protection, which is at the root cause of the increased risks to the public health.

19. In terms of funding, the Report recommends a separate funding stream for health outside of the CHST, and that this stream be ear-marked for health outside of the Consolidated Revenue Fund. This is a dedicated revenue source. The \$5 billion which would be required to fund the Report's recommendations would be raised through a Variable National Health Care Insurance Premium, collected through the income tax system, and based on individual income. Such a premium would cost people in the lowest tax bracket \$182 a year. The highest tax bracket would pay a yearly premium of \$1,460. Middle income taxpayers would pay \$365 a year.

A second recommendation is to use the GST to fund federal transfers to the provinces for health care. Ear-marking fifty per cent of the GST for health funding would result in an additional \$1.5 billion in the money transferred to the provinces for health care.

These are interesting proposals which require fuller examination. The GST, as a regressive tax, is not the best vehicle for federal transfers to the provinces. However, it is the case that additional revenues are required to fund Medicare.

20. The Report recommends the establishment of a Committee on Public Health Care Insurance Coverage, made up of citizens, health providers, scientists, etc., which would determine the basket of health services which should be covered by public health insurance.

This approach is not advocated by almost all progressive health care advocates and experts for many reasons. The key reason is that such a process can be used to create a market for private, for-profit health services.

21. The Report recommends changing global hospital budgets with a payment for service approach and devolving responsibility to regional health authorities for purchasing physician services, and to choose between providers.

These two proposals fit with a market approach to health care. The regionalization part comes from the Mazankowski Report in Alberta. The hospital funding recommendation means that the insurer (government) would be neutral with respect to the ownership of the hospital. The Report says that there is no reason why a private, for-profit provision of publicly funded health services would result in two-tier care.

I rest my case.

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