EVENT REPORT

RESEARCH ROUNDTABLE

TALKING ACROSS SILOS IN CANADA'S HEALTH MOVEMENTS

BUILDING CONSENSUS FOR AN INCLUSIVE AND PRO-PUBLIC HEALTH MOVEMENT FOR ALL

NOVEMBER 30-DECEMBER 1, 2018
95 CLEGG ST., OTTAWA ON

Canadian Health Coalition / Coalition canadienne de la santé

RESEARCH CENTER IN SOCIAL INNOVATION AND TRANSFORMATION

Introduction

On November 30 and December 1, 2018, the Canadian Health Coalition and the Research Centre for Social Innovation and Transformation hosted a research roundtable entitled *Talking across silos in Canada's health movements: Building consensus for an inclusive and pro-public health movement for all*. The goal of this event was to build an integrated network supporting a national pro-public health care movement grounded in equity and human rights. The event created a space to discuss timely issues, make connections and plan ways of moving forward.

Over two days, fifty researchers from community and academic contexts came together to discuss challenges within Canada's health care systems. Panelists shared their research around three themes: the commodification of health and bodies, the commercialization of health care, and forgotten publics. The event closed with a collective strategy session focused on the future of public health care in Canada. While researchers presented on diverse issues, and came from different sectors and regions, common concerns emerged about the state of public health care and the movements defending it.

Among the many themes that surfaced were creeping privatization, barriers to accessing health care, and enforcement of existing policies.

Creeping Privatization

In recent years, we have witnessed corporatization of public management strategies. In the health care sector, this has manifested in the rise of private clinics and long-term care facilities, and in the greater influence of the private sector (i.e. drug and insurance companies) on doctors, patient groups, and government decision makers. Creeping privatization is increasing corporate profits at the cost of affordable, quality health care, as well as safe and innovative medicines. The drive to increase profits is also threatening equity and democracy in our health care systems.

Corporate management strategies emerged in the 1990s when private companies were used to perform non-core functions in hospitals such as cleaning, laundry, and food preparation. This led to staff reductions and poorer food and sanitary conditions. Privatization can also be seen in the rise of for-profit residences such as Revera Long-term Care, a large nursing home chain, and of private membership clinics in places such as Alberta. These clinics profit by getting people to pay more for things that are already available through the public system. For example, private clinics have been found to order unnecessary testing that is outsourced to public labs.

Big pharma has been exerting its influence by mobilizing business stakeholders including Innovative Medicines Canada, a pharmaceutical industry lobby group. It is also funding patient groups, which tend to support new medications. These groups are carrying corporate interests into public health discourse. Patients are being framed as consumers rather than citizens, and the pace and freedom of drug development is being framed as a consumer and public health issue. Patient groups are pushing to deregulate clinical trials and accelerate drug development and testing in the name of consumer choice. The result is an increased number of adverse drug reactions. A coalition of twenty-eight patient groups is currently attempting to stop Health Canada from trying to lower drug prices.

Business interests are also being advanced over public interests through disease mongering. Drug companies are increasing markets and profits by medicalizing common ailments for which

they are developing and selling drugs. These companies are ghost managing and writing research; they are hiring “authors” who haven’t viewed the relevant data to sign off on pre-written articles. Pharmaceutical companies are also deploying key opinion leaders to promote drugs through presentations. They are providing doctors with luxury travel and accommodations and paying them up to $2000 per lecture to speak to other doctors on their behalf.

Corporate influence results in Canadians paying for things they don’t need, such as drugs for ailments that don’t require drug therapy. It also results in Canadians paying more for things they *do* need, such as higher-priced brand name drugs for ailments that do require drug therapy.

In each of these examples, private interests are threatening the public’s access to affordable, high-quality services and therapies. This reinforces the need for public accountability, which can be achieved through public control of the services we pay for and use.

Barriers to Access

Inconsistent access to health resources results in certain populations falling through the cracks. This includes people with disabilities; LGBTQ+ folks; racialized communities; migrants, including those with temporary status or no status, new mothers, and newborns; the poor; and Indigenous peoples. Health care systems are often designed to actively exclude these groups. Indigenous people in particular often lack access to culturally safe and appropriate health care. People facing multiple forms of oppression (i.e. intersectional discrimination) often face even more barriers in accessing care. Furthermore, inadequate action on the social determinants of health leads to poorer access and health outcomes for certain populations.

Without universal pharmacare, many low-income people lack access to medication. Ten percent of Canadians can’t afford to take their prescribed medications. This can lead to unnecessary hospitalizations and even preventable deaths. Many new immigrants and temporary foreign workers who lack health insurance often delay seeking care. As a result, their conditions worsen, requiring them to wrack up large bills in emergency departments or to go without care all together. People with disabilities also experience physical, informational, attitudinal, and systemic barriers to accessing health care. They report having more unmet health needs than people without disabilities. Specific problems include barriers to finding a doctor, as well as entering and using facilities and services.

LGBTQ+ populations also face many barriers in accessing health services. Trans people are under-represented in data collection and institutional contexts as they are excluded from forms and documents, infrastructure, policies, practices, and curricula. Many trans persons do not have a family doctor, and many avoid doctors because of past negative experiences. Access to gender-affirming surgeries and hormones is also an ongoing challenge, particularly in rural communities.

Although people may be legally entitled to health care, services may not be available to them due to regional disparities, inadequate funding, discrimination and other structural barriers. Researchers differentiated between three aspects of access to health care: the right to health care protected by the law, the actual availability of health care on the ground, and the ways in which individuals experience their access to health care. All three of these aspects must be taken into account when working to improve the current system.

Enforcement

Many researchers pointed out that laws and regulations are not consistently being enforced. For example, although it is illegal to pay for surrogacy, sperm or eggs in Canada, fertility agencies are finding ways of bypassing the law. The lack of enforcement of the law is allowing bodies to be commodified. Private membership health clinics in Alberta are also finding ways of exploiting legislative loopholes to continue questionable billing practices. This is paving the way for a two-tiered health care system.

Another example of the lack of enforcement is the denial of health coverage for newborns of uninsured parents. Although newborns are legally entitled to health coverage, hospital staff and advocates are not always aware of the law. As a result, practices vary within and across hospitals, ultimately impeding patients' rights. The lack of training, oversight, and enforcement of existing regulations is creating barriers in accessing health care.

Conclusion: Moving Forward

Feedback from participants

All attendees indicated that they saw value in organizing more events like this in the future. Participants highlighted that the event was important for bringing people together to share and discuss research and strategies, and to build connections. Attendees stated they were able to learn about a range of issues, research, initiatives and perspectives from academic and community contexts. The roundtable was a useful opportunity for knowledge exchange and building future collaborations. Participants widely felt that more opportunities are needed for researchers, advocates, and policymakers to come together to share information, build consensus, and strategize. These opportunities are integral to advancing the common goals of protecting public health care and making it truly universal.

Research and collective strategies

Moving forward will require creative strategies and research. Leaders of the pro-public health care movement must build broad coalitions across diverse groups, including patients. This means engaging and linking groups who might disagree on certain issues, but with whom we can build consensus around an inclusive pro-public movement. The movement also needs to build a narrative that captures and communicates stories and lived experiences. This narrative must incorporate the diversity of patient and community perspectives. For example, when advocating for universal pharmacare, it will be important to show how it will benefit not just the worst-off, but also those in the broader population who are inadequately insured. Numbers and stats will not be enough; we should also include personal stories of individuals.

A pro-public vision must be innovative and critical. This means shifting our perspective from one of defending to one of demanding and re-imaging what our health system could be. We can start by identifying innovative, successful and efficient examples of public services elsewhere (e.g. Barcelona Energia, Eau de Paris and Antel, Uruguay's government-owned telecommunications company). Researchers highlighted that the pro-public movement has been put on the defensive by proponents of privatization, and that to move forward, we must stop defending the status quo. This means being critical of the current state of public services and putting the private sector on

the defensive. To this end, new research could ask: “What are the public’s concerns and anxieties about private services?”, and “What are the current problems with private service provision in Canada and elsewhere?”. Finally, it is important to balance short-term goals (managing problems) with long-term goals (prevention and sustainability). This means focusing less on knowledge translation, and more on policy and politics. This will require locating windows of political opportunity, such as elections.

Health system management

Moving forward, we must focus on improving user experiences, especially with wait times. Instead of always relying on physicians, we can deliver high-quality services while working within fiscal constraints by drawing on the skills of other specialized professionals such as social workers, and psychologists. Participants advocated for reforming the basis of remuneration for physicians by eliminating the fee-for-service model. This model gives an incentive for physicians to provide more treatments because payment is dependent on the quantity rather than the quality of care.

Furthermore, we can help sustain the quality and efficiency of care by halting the trend of de-listing services (i.e. removing coverage of certain health services). We should also update policies and legislation to include new technologies such as online physician consultations. It is important to explore these options as ways of increasing the efficiency of delivering high-demand services.

Democratizing health care

Researchers commented on the need for more democratic control over health care. This entails increasing transparency and accountability. It means facilitating public inclusion in decision making and ensuring public access to information. It also means creating public forums that bring the public face-to-face with drug companies, doctors, and decision makers. Traditionally marginalized communities must be included in these discussions and their perspectives must be valued. Leaders must critically examine their own and others’ understandings and assumptions of who is included in the “public” when we talk about public health care.

To build an inclusive and democratic public health care movement, we must be willing to challenge the status quo. Researchers and community advocates must reflect on the inadequacies of the current health system, and people’s legitimate anxieties about it. Participants noted that the power of medical associations needs to be challenged since they currently wield a significant amount of power over government.

Additional training is required on how to consistently and fairly apply existing laws and policies so that no one’s right to care is compromised because of their unique needs. In addition to informing organizations and practitioners about how to apply and conform to the law, we must monitor and enforce compliance to ensure that no one is left out of the system that ought to be inclusive for all.