# Will Canada pawn or polish the jewel in the crown of its social security system?

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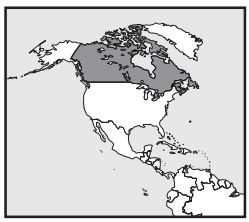

Canada's most treasured social programme is public health care. For almost forty years, access to doctors and hospitals has been based on need, not ability to pay.[1] Today the very purpose of public health care is in debate, from what is funded, to how it is delivered. How has a nation that has long viewed health care as a basic human right found itself here? Public uncertainty has emerged in the shadow of growing inequality and chronic public underfunding, and has been fed by the trade agenda of expanding commercialisation.

## The backdrop: growing inequality, greater vulnerability

After more than fifteen years of aggressively pursuing policies that provide less from the state and more from the market, the economy is growing more rapidly than that of all other G7 nations. That's the good news. The bad news is that economic growth has not led to economic security for most individuals, or for society as a whole.

Ironically, as real choices narrow for a growing number of people, those who *are* getting ahead are demanding greater choice. The affluent, by agitating for more personal choice, are breaking a historic consensus around health care, with profound implications for all society. Health care is the last public service to be dragged into the battle between the need for security and the desire for choice.

## The pressure: funding health care

Though Canadian citizens for the last seven years have consistently indicated a willingness to pay more in taxes to support public health care, politicians have not listened. Instead, they have cut taxes. Starting in some provinces in 1996, by 2000 all provinces and the federal government were cutting tax rates while characterising public health care as unaffordable and unsustainable. The total impact of these cuts is estimated at almost USD 26 billion in lost revenues in 2002 alone.[2]

As a result, public healthcare services have been starved for resources. The federal government reduced healthcare transfers to the provinces by USD 5.5 billion between 1995 and 2000,[3] while the provinces themselves cut over USD 1 billion in the mid 1990s.[4] Inadequate labour supply stems partly from global shortages of health professionals, and partly from explicit government choices. Policies over the past decade included: limiting enrolments to medical schools and deregulating tuition fees, which have skyrocketed; laying off thousands of nurses and other health professionals; and implementing early retirement packages.

Not all medically necessary services are publicly insured under the Canada Health Act. Access to prescription drugs and healthcare services provided outside a doctor's office or hospital – such as nursing home care or long-term care – are not guaranteed. The degree of public coverage depends on the province of residence and determines the amount spent on these services, publicly and privately.

Extending the Canada Health Act to comprehensively cover medically necessary care will cost billions of dollars. However, compared to the administrative savings, economies of scale and regulatory power of single payer systems, people pay even more when the same services are provided through increasingly privatised forms of funding. The question is not whether health care costs will increase; they inevitably do. The only real questions are: who gets access to health services, and on what basis – need or ability to pay?

Despite the funding cuts, between 1990 and 2000 a growing and ageing population drove public expenditures for health care up by 50%; private healthcare spending rose 73%. (Public spending accounts for 70% of all spending on health care.[5]) Without renewed federal support, most provinces will be unable to carry the costs alone. That means more cutbacks in public provision. Chronic underfunding of public health care has led to two forms of privatisation: covert and overt.

### *Covert privatisation*

The amount of time people spend in hospital has dropped, partly due to medical advances and partly due to cutbacks.[6] More patients are being released from hospital «quicker and sicker,» placing more demands on their immediate support network. It is estimated that 75% to 90% of home care is provided voluntarily by family and friends, mostly women.[7]

But fewer people are providing such care, due to falling birth rates, increased labour force participation by women, more single parents and geographically dispersed families. This has led to the increased use of paid home care services, which doubled during the 1990s.

Health care is the provinces' single largest and fastest growing budgetary expenditure. Provinces have contained costs by de-listing insured services. Some de-listed services, for example some intravenous transfusions, are so costly that even the non-poor face difficult financial choices. For the poor, elderly and disabled, the choice is often between rent and food.

### *Overt privatisation*

Corporations advertise to «consumers» (except where prohibited by law) or market to physicians to increase the demand for pharmaceuticals, medical technologies and diagnostic techniques. Public services become partially privatised through user fees and co-payment mechanisms. Delivery is privatised when an increased share of public funds flows to for-profit service providers. All three forms of overt privatisation are on the rise.

More provinces are responding to public demands for improved access to health care by asserting that for-profit businesses can provide it «faster, better, cheaper» than not-for-profit organizations. A growing number of public contracts

1 Access to acute healthcare services (doctors and hospitals) has been a right of citizenship since 1966, but today there is intense debate about the future of healthcare. Three provincial commissions have recently made recommendations regarding the funding and delivery of public healthcare. At the federal level a Senate Committee and an appointed Commission will recommend changes for the federal role in healthcare by the end of 2002.

2 Finance Canada, The Fiscal Balance: The Facts, October 2002, see http://www.fin.gc.ca/toce/2002/fbcfacts4_e.html

3 Calculated from Finance Canada, *Backgrounder on Federal Support for Health in Canada*, 29 March 2000.

4 Calculated from Canadian Institute for Health Information (CIHI), *National Health Expenditure Data, 1975 – 2001 (NHEX)*, Table D.3.1

5 CIHI, *NHEX*, Table A.2

6 CIHI, *Hospitalisation Statistics, Table 3: Hospital Days and Average Length of Stay for Canada, Provinces and Territories, 1994/95 to 1999/00*. Ottawa: September 2001.

7 Canadian Home Care Human Resources Study, *Phase I Final Report*, Ottawa: February 2002, p.4

for the provision of long-term care and home-care have been signed with for-profit suppliers in the past two years. Communities everywhere are challenging this approach and mounting public pressure has led to some hopeful developments.

In Saskatchewan, the Prince Albert Regional Authority took over for-profit lab services and achieved significant savings. After a group of citizens exposed fraud and abuse at a large for-profit US homecare firm, the government of Manitoba imposed strict standards for care, forcing the company out. The government then purchased service provision from not-for-profit organisations, as it had before. Alberta has made major investments to modernise its public system's diagnostic capacity, reversing a decision to increase supply through private businesses.

These moves saved money, improved quality, or extended access by moving away from the use of for-profit service providers. They raise a serious question: why increase the use of for-profit care in the first place?

In the fall of 2002, the governments of British Columbia, Alberta and Ontario announced funding for investor-owned clinics and hospitals. While small in number, these provincial initiatives are testing the waters about the political legitimacy of «profitisation» in health care.

These proposals use private investors to provide the capital, and sometimes land, to build or expand public infrastructure. The government leases the facility at rates of minimum payment set for 25 to 30 years (but as long as 60 years). These payments exceed debt charges through public borrowing and provide a guaranteed rate of return to shareholders. The government incurs no debt but, in the end, like all renters, the public owns nothing. The contract may or may not stipulate that the owner/investor must offer the government first right of refusal to purchase at fair market value.

In Prince Edward Island, a government decision in 2001 to build a hospital using this sort of public-private financing scheme was reversed within months due to public pressure. The hospital is now being built exclusively with public funds, is owned by the government, and will operate as a not-for-profit enterprise. Communities across the country are organising similar campaigns of resistance.[8]

## The context: accelerating commercialisation, NAFTA and GATS [9]

Contrary to assurances made by government officials, Canada's healthcare system is not fully shielded from NAFTA and the General Agreement on Trade in Services. Though safeguards for public health care exist, health insurance is an explicit service category covered by these agreements. As provinces increase commercial involvement in public health care, they narrow the scope of existing safeguards, facilitating entry for foreign investors, and making it harder for future governments to reverse the trend towards private, for-profit health services.

The conflict between domestic health policy and international trade policy objectives is glaring. International trade treaties are designed to facilitate and expand commercialisation, limiting government's regulatory discretion so that services are provided according to market principles: demand driven by ability to pay, supply driven by the ability to make money. This conflicts with the purpose of Canadian Medicare – demand and supply driven by need (with «need» defined through the «single payer» system of government purchase, and the ability to meet need constrained by the ability to raise public revenues).

Viewed through the lens of trade, public health consumers represent untapped commercial opportunities, while public health systems represent unfair competition. In Canada, public healthcare spending has grown at an average annual rate of over 8% over the last 25 years. Private spending has almost doubled since 1990.[10] With over USD 63 billion, and growing, spent on health, the commercial potential in Canada is vast.

Dangers from trade agreements include:

- *Non-discrimination rules.* If foreign health insurers lose a part of their market share due to the expansion of publicly insured programmes- such as drug therapies or home-care – they could demand compensation under NAFTA expropriation provisions or the GATS monopolies provisions. If public policies favour local community-based health providers or not-for-profit providers, foreign corporations could use NAFTA and GATS rules against discrimination to demand compensation or right of entry into the market. Under Most-Favoured Nation rules, once any foreign provider operates in a market, all foreign providers are entitled to the same access.
- *Intellectual Property Rights.* WTO and NAFTA intellectual property rules require a minimum of 20 years of monopoly patent protection and forbid the stockpiling or export of generics. This is driving up drug costs and restricting the availability of affordable medicines to cope with health emergencies. A vivid example is the «Cipro» affair: in October 2001, Canada was almost blocked by a major pharmaceutical company when it tried to purchase enough antibiotic (patented or generic) to treat mass exposure to anthrax, a bio-terrorist threat of unknown proportions at the time.

## The response: what should the Canadian government do?

Trade and public health objectives have conflicting principles. They cannot both lead. Health care is a quintessential human right. Canada recognised this when it helped author the Universal Declaration of Human Rights in 1948 and signed onto the International Covenant on Economic, Social and Cultural Rights in 1976. The hallmark principle of the Canada Health Act is equity of access. The Canadian government must take decisive action now to halt the commercialisation of health care before the trade treaties make it too costly to reverse. This action should include:

- Explicitly recognising the primacy of international human rights law over trade and investment treaties.
- Pursuing universal exemptions for public health services with all negotiating partners (not just country-specific exemptions) at the WTO Doha Round and the FTAA negotiations.
- Withdrawing its support for investor vs. state dispute settlement procedures that allow investors to directly challenge public policy measures.
- Withdrawing its 1995 GATS commitment covering health insurance.
- Opening the government's trade policy position to full public scrutiny and participation, including full disclosure of all negotiation sessions and documents.
- Assuring high quality care by establishing and enforcing clear national performance standards in return for public funds.
- Expanding public provision of health care to include drugs and medically necessary treatments, and increasing federal financing to make this possible.

## The Canadian choice

Nations are characterised by the way they define and meet the basic needs of all their citizens. The provision of health care based on need, not ability to pay, means that every person has access to the solidarity of all when struck by illness. This evokes the meaning of Canadian citizenship more effectively than does a passport or an army, a currency or a diplomatic corps.

The choices made by the federal government in the next year will not only characterise what kind of nation we are; they will also signal what can be expected or hoped for among people elsewhere. Public health care is the jewel in the crown of our social programmes and social achievements. Whether our governments see it as a treasure or an asset to be liquidated remains to be seen. ■

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8 see http://www.healthcoalition.ca

9 The following draws from Matthew Sanger and Scott Sinclair, *Putting Health First: Canadian Healthcare Reform, Trade Treaties and Foreign Policy.* www.policyalternatives.ca.

10 CIHI, *NHEX 1975 – 2001.* Ottawa: 2002. Series C.