Profit Is Not the Cure 2010: Is the Canadian economy sustainable without medicare?

By Robert Chernomas
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In November 2002 the most comprehensive review of health care ever produced in Canada was published. The Romanow report, “Building on Values: The Future of Health Care in Canada,” (1) took advice from Canadian and international experts while engaging in a conversation with citizens across the country. The report concluded that our medicare system is efficient, effective and accessible. No evidence could be found to justify introducing for-profit, private two-tier health care or user fees into the system. Needed improvements required innovation in and an expansion of the public system. And yet the war of what works and what is fair versus that which is driven by profits and self-interest continues.

On September 12, 2002 (2) General Motors, Ford and Daimler-Chrysler and the Canadian Auto Workers’ union, in an effort to influence the Romanow Commission, signed a joint public letter in support of Canadian medicare based on its affordability, its universal access, the fact that it contributed to a healthier and more productive work force and its labour cost advantages. The letter noted that there should be a prohibition on user fees and that medicare should be expanded to cover drugs and home care.

In the same year (3) Maude Barlow, National Chairperson of the Council of Canadians, wrote Profit Is Not The Cure: A Call to Action on the Future of Health Care in Canada, an in-depth look into Canada’s public health care system that provided an historical and political context for the health care debate that continues to this day. Barlow identified how Conservative and Liberal federal governments have used tax cuts, free trade agreements, the media and deregulation to undermine medicare. As the book jacket describes: “Canadians overwhelmingly support medicare. Many, however, have been persuaded that it is a luxury we can no longer afford. Barlow argues that this proposition is wrong. An earlier generation fought a bitter battle to bring medicare into existence. Another battle must be fought now to save it. But we owe it to the founders of the system, as well as to future generations, to take up the cause again. This important book shows the way.”

This battle continues. This paper is another weapon in defence of a health care system that is not a luxury, but a necessity.
Is the Canadian health care system unsustainable?

“Repetition does not transform a lie into a truth.”
- Franklin D. Roosevelt

“Opponents of Medicare claim that public health care is ‘fiscally unsustainable’ and that the only viable solution is a shift to more private coverage. Bluntly, this is a lie.” (4)
- Robert G. Evans, Ph.D., Professor of Economics, University of British Columbia, internationally renowned health economist.

On March 28, 2010 the Toronto Star reported that David Dodge, former governor of the Bank of Canada and former deputy finance minister, joined a list of economists and other pundits who predict that public health care will be financially unsustainable in coming years as Canada faces an aging population and escalating costs for scientific advances in care and treatment. (4)

Citing a report by a founder of Quebec health care, a Winnipeg Free Press editorial of February 28, 2008 argued that user fees and private health care should remain part of the public debate lest health care become unsustainable.

The Free Press editorial reported that according to Claude Castonguay, the “father of Quebec medicare,” the health care system was going to chew up 50 per cent of the Quebec provincial expenditure by 2014. User fees were a way to relieve pressure on the treasury, while European health systems’ blend of private and public care should be considered as a way to deliver cheaper and superior health care. The editors then chastised Quebec Health Minister Philippe Couillard for a “tepid” response because he argued that user fees won’t reduce demand, nor allow doctors to operate in both the private and public systems. (5)

These are only a few examples of many that repeat the lies referred to by Robert Evans. The sustainability issue, more than any other, provides the ideological cover for any number of schemes to undermine political support for medicare.

What do they mean by unsustainable?

There are a number of identifiable meanings of unsustainable either in isolation or in combination.

1. It can mean there isn’t enough money (resources) to provide equitable health care that addresses the full range of health needs independent of the ability to pay in a timely way using technologically appropriate standards.

2. It can mean that to pay for medicare we will diminish our ability to pay for other things such as education and/or tax cuts.

3. It can mean that if we pay more for publicly funded medicare than our competitors the resulting taxes will make our products too expensive.

4. It can result in the need to introduce two-tier private for-profit health care and user fees in order to make the system sustainable.
Are Canadian health care costs growing?

It is true that total health care spending in Canada has risen in recent years, taking larger shares of both government revenues and budget allocations. The question remains: what happened to create this situation?

When you hear that a province is going to spend 50 per cent of its expenditure on health care at some time in the future (as referenced in the Free Press Castonguay article), such a number should always be treated with suspicion. It often reflects the fact that the province has made relatively severe cuts to other social programs so that health care expenditures look proportionally larger, even if they haven’t changed at all. It could also mean that tax rates have been cut so much that the expenditure becomes proportionally larger than the diminishing taxes. Conservative Federal Finance Minister Jim Flaherty boasted that his third budget reduced tax levels to what they were 50 years ago in the Diefenbaker era, a time when Canadians paid privately for services such as health care and post-secondary education. Cutting taxes enough will make any public program unsustainable regardless of how much more efficiently it is run compared to a private program. (5)

Non-health programs without as much public support such as housing, social assistance, environmental programs and transfers to municipalities have suffered large funding cuts. Between 1997 and 2004, tax cuts removed an estimated $170.8 billion from public sector revenues. (4) Huge tax cuts and reduced spending on other social programs inevitably create a picture of an economy cannibalized by medicare.

In 1992 during Canada’s last serious recession health care spending spiked to 10 per cent of the Canadian economy. Once the economy began to grow, that percentage declined. If you spend $10 of a $100 economy on health care one year, and $10 again the next year but the economy has shrunk to $90, the $10 health care budget is going to appear much larger. In 2009, a recession year, health care took 11.9 percent of our Gross Domestic Product (GDP). Once the economy expands, that percentage will shrink again. Whether that will cause a corresponding decline in the demands for medicare to be financed and delivered privately remains to be seen.

What isn’t driving Canadian health costs?

Although ideologically driven headlines misrepresent the facts, over time the Canadian health care system has taken a larger share of our economy. From 1971, the first year of the full implementation of Canadian universal health care, to the present that number has grown from approximately 7 per cent to around 10 per cent.

The Canadian health system is mandated by the Canada Health Act (CHA) to control three sub-sectors: hospitals, physicians and administration and not other sub-sectors such as dental care, pharmaceuticals, long-term care, medical devices and so forth. The former is hereafter referred to as CHA services and the latter as non-CHA services. (6)

It is important to identify which parts of our health care system are driving expenditures and which parts are not if we are to be prudent about our policy options. Our health care system is already, of course, part public and part private. Organizationallly, hospitals and doctors are privately run, but publicly funded, regulated and not-for-profit. Since 1971 until 2009, expenditures on hospitals, administration and doctors have remained stable at between four and five per cent of GDP. From 1975 to 2009, hospital expenditures under the publicly funded system have dropped from 44.7 per cent of the health budget to 27.8 per cent, while spending on doctors has dropped from 15.1 per cent to 14 per cent (7). With the share of hospital and physician costs of the overall economy being stable, and the share of overall health care costs rising, these “public” subsectors have come to absorb a declining share of the total spending on health care. The publicly financed and regulated parts of the system are clearly a source of sustainability.
In Robert Evan’s words, “The central fact is that, recession years apart, medicare spending – hospitals and physicians’ services – has fluctuated between 4 per cent and 5 per cent of Gross Domestic Product since 1975. After the introduction of medicare in the late 1960s these costs stabilized because universal, comprehensive coverage consolidated expenditures in the hands of a single payer. The cost of health services not covered by medicare has risen from 3 per cent of GDP in 1975 to 7 per cent in 2009.” (4)

These are fundamentally important facts in the so-called sustainability debate. The source of increased health care expenditures is the private for-profit sector largely and unnecessarily outside the scope of the public system.

**What is driving Canadian health care costs?**

While there is no indication that spending on CHA services is getting out of control, the cost of the non-CHA services (e.g. prescription drugs, dental and home care) borne by provincial and territorial governments as well as by individuals is the source of growing expenditures.

As Dr. Michael Rachlis wrote in an article in the Toronto Star (8) on April 4, 2010, “Not coincidently, these sectors mirror the U.S. multi-payer health system. Government covers a minority of costs. There are high administrative expenses. Prices are inevitably higher without a single payer. And many Canadians suffer grievously because they can’t afford needed care.”

Most significantly, drug expenditures have increased from 8.8 per cent of the health care budget in 1975 to 16.4 percent in 2009. It is interesting to note that expenditures on over-the-counter drugs (the ones we choose) has remained stable at 2.5 per cent of health care expenditures from 1975 to 2009 while prescription drug expenditures have more than doubled (6.3 per cent to 13.9 per cent). (7) We now spend more on drugs than we do physicians!

The increase in the cost of prescription drugs has largely been driven by the introduction and use of the more expensive patented drugs. It is often argued that higher drug costs pay for themselves by saving on hospital costs at least for those health conditions for which surgery and management with pharmaceuticals are competing therapies. However, aside from anecdotal evidence on a few new drugs there is little known about the cost saving of the new drugs or their relative therapeutic efficacy over the existing drugs. According to a study of 1,035 new drug applications that received approval by the Food and Drug Administration in the United States for the 12-year period from 1989 to 2000, in 85 per cent of the cases the new drugs do not provide significant improvement over currently marketed therapies. According to the National Institute for Health Care Management (NIHCM), brand manufacturers have flooded the market with product line extensions (known as “evergreening” in the industry) in response to perverse incentives related to changes in patent laws and advertising regulations. Moreover, the claim that increasing drug costs have lowered hospital costs runs afoul of the timing of the so-called effects. The alleged beneficial effects of many new and expensive drugs on the health – and thus health care use – is problematic because the fall in in-patient use in Canada is both prior, and contemporaneous with the rapid escalation of expenditures on drugs. (6)

In the same Toronto Star article, Michael Rachlis warns us of the economic and safety consequences of relying on the multinational drug companies’ increasing share and control of our health system. “More important, there are many choices available besides additional spending or less service. In 2003, the Ontario Drug Benefit Plan spent $65 million for Vioxx, an anti-arthritic drug. The next year, Vioxx was withdrawn from the market because it was linked to heart attacks. Not only was Vioxx more dangerous than alternatives like ibuprofen, it was 50 times more expensive. While we were telling seniors there was no money for home care, we poured $60 million down the drain and hundreds of Ontarians died premature deaths.”
The “history of Vioxx” is an instructive one if we are to make meaningful reforms to our health care system.

Dr. David Graham is a senior official in the U.S. Food and Drug Administration’s Office of Drug Safety — the office responsible for monitoring drugs once they’ve been approved for sale. (9)

Graham, who received medical, epidemiological and biostatistics training at the Johns Hopkins University School of Medicine, Yale and the University of Pennsylvania, blew the whistle on Vioxx after finishing a study that showed the drug had injured and killed tens of thousands of people.

According to Graham, the FDA “reacted violently” when he announced he was going to submit his research for peer review. “FDA saw no problem with 100,000 people having heart attacks.”

Senior people in the FDA told him they didn’t want him studying Vioxx and heart attacks. His supervisors called his work “scientific rumour,” and his centre director told reporters that Graham’s study “constitutes junk science.”

The day after his remark, Graham’s study was the lead article in the *Journal of the American Medical Association*. The article was accompanied by an editorial calling for a complete restructuring of the FDA.

Agency officials contacted at least one Senate staffer accusing Graham of being a “liar, cheat, bully, a demagogue and untrustworthy.” At the same time, they contacted a lawyer he obtained through a whistleblower protection group called the Government Accountability Project with the same line of character assassination. His director contacted an Editor at *The Lancet*, another leading medical journal, accusing Graham of scientific misconduct.

Dr. Graham says the FDA is willing to give a free pass on safety in exchange for its “user fees,” which the pharmaceutical industry pays under the Prescription Drug User Fee Act to reduce the approval time for new drug applications. He says the effect of which is that “our parents and grandparents, our children — all of us — get to be the guinea pigs in that grand experiment while drug companies continue to make profits.” In 2002 the FDA collected fees of $143.3 million of the $209.8 total operating costs for reviewing drugs from the pharmaceutical industry.

Graham charges that the FDA approach to product safety is to “virtually disregard it,” believing there is no risk that cannot be managed “in the post-marketing setting.” FDA’s concept of risk management enables the marketing of unsafe drugs.

His policy prescription is that industry can’t be the client – health care must be funded by the publicly and administered publicly.

“Companies are selling their products to the public and essentially doing a study on the American people to determine the safety of their products,” he says. “Doing a proper study on drugs like Vioxx takes longer and needs to be much larger than those that serve industry interests. If a drug maker is ringing up $3 billion a year in sales, every day of clinical trials is another day it’s not making $10 million.”

In 2002, two-thirds of FDA scientists surveyed said they weren’t confident that products approved by the FDA were safe, while 18 per cent said they were pressured to change their conclusions on reviews of new drugs.

In Canada in 1997, the Canadian Health Care Coalition reported that the entire Bureau of Drug Research was quietly dismantled and facilities for independent lab investigations of pharmaceutical products destroyed. These scientists were recognized internationally for independent research on drug quality, toxicity, bioequivalence, and clinical application of drugs. It was at this juncture that Dr. Michelle Brill-Edwards resigned as the head of the pediatrics branch of the Bureau of Drug Research because she could no longer assure the Canadian public of the efficacy of new drugs now that pharmaceutical companies were doing their own safety studies.
For Drs. Brill-Edwards and Graham an independent public-only review system is the only means to ensure drug efficacy and safety.

According to the Canadian Health Care Coalition, in February 1997 Health Protection Branch drug reviewers were instructed that their client is not the general public, but rather the drug companies they were supposed to be overseeing. “By adopting a client focus and service orientation, regulatory organizations can help those seeking approval to comply with regulations as easily as possible, promote voluntary compliance, earn goodwill from the regulated community... and improve the working atmosphere.” The bulletin also says: “there is no conflict of interest between delivering a service to a client and functioning in a regulatory environment.”

**How are we doing compared to our competitors?**

Facts and history make using the United States’ mostly private health care system as a model for change no longer tenable as an alternative to our medicare system, even by the most ideological of advocates of the market. (For international comparisons 2007 is the latest data available) (10). The Americans spent over 15 per cent of their GDP on health care, while 15 per cent of their citizens have no health insurance and another 20 per cent are underinsured. So, instead of the U.S. system, Europe is invoked. How much cheaper is that magical European elixir of private and public health care? The most recent figures from the Canadian Health Services Research Foundation inform us that France and Germany, with their parallel public and private systems, spend 11.1 per cent and 10.7 per cent respectively of their GDP on health care, while Canada spent 9.8 per cent. (10)

Advocates of two-tier, for profit, privately funded health care are always looking for a new model to use propel their arguments against medicare. Of late France is often used for this purpose. As for the idea that the French have shorter waiting lists because of a very small private for-profit sub-sector, this is another example of faith in ideology over facts. The fact that the French have 50 per cent more doctors who are paid 60 per cent of what our doctors are paid goes a lot farther in explaining how they shorten waiting lists without spending U.S. levels of GDP on health care.

One of the complaints about our medicare system is a supposed shortage of technology. In 2007 the vaunted French system had fewer MRI units and CAT Scanners per million population than Canada. (10)

**Aging population and future sustainability: the apocalypse?**

While there is no indication that Canada’s health care system is financially unsustainable today, there is the question as to whether it will remain sustainable in the future in light of an aging population, introduction of new and expensive interventions, and changing public expectations. More specifically, it is argued that continuing increases in life expectancies, combined with low birth rates will lead to steady increases in the average age of the population and an increasing concentration in older age groups whose health needs and health care costs grow faster than the rate for the younger population.

In contrast to the pure age factor, the observed changes in patterns of practices as reflected in the intensity of services offered to the elderly are dramatic. Have these observed changes in the pattern of practice in the past reflected, as assumed under the “apocalyptic” projections, changes in needs arising from greater illness over time or higher capacity to benefit from a wider range of expensive and effective interventions made possible by technological change? Or, alternatively, have there simply been changes in age-related patterns of medical practice in response to a complex array of pressures, economic and professional, which are not closely linked to patients’
needs and conditions? As health economists Morris Barer and colleagues suggested in their examination of health care utilization in British Columbia and other jurisdictions over three decades, from 1960-1980: “Over the period of this expansion, the rapidly increasing supply of providers has created a potential ‘patient shortage’ which has been avoided through more intensive servicing. At the same time, the rapid diffusion of new technological and clinical capabilities (particularly in the diagnostic, scoping, some surgical, e.g., hip and eye, and pharmaceutical areas) has meant that, on average, providers were able to do more to and for the average age patient. Since the conditions of aging are often non-specific, and chronic, this ‘grey’ segment of the population affords never-ending opportunities for intervention to improve patient health status (or at least quality of life), or defer possible risks. There is always something more that could be tried, or something that should be checked – just in case – and new interventions become available every year.” (6)

Similarly, in their study of utilization of physician services by Manitoba seniors, changes in patterns of servicing the elderly played a major role in explaining increased utilization between 1971 and 1983. (6) The service intensity accounted for as much as two-thirds of the observed increase in use of consultative visits, of which a substantial proportion was directed to individuals who appeared to be in good health.

A recent study of “end-of-life” expenditure across regions in the U.S. concludes that the nearly twofold differences in Medicare spending observed across U.S. regions are largely due to greater frequency of physician visits, more frequent tests and minor procedures, and greater use of the hospital and intensive care unit in high-spending regions (6). The residents of high-spending regions received 60 per cent more care but did not have lower mortality rates, better functional status, or higher satisfaction. A careful reduction in spending in the high spending regions to those of the lowest-spending regions could lead to an annual saving of up to 30 per cent of the Medicare expenditure for the United States as a whole (6).

The relationship between the increase in the share of elderly in total population and per capita health care expenditures for 20 Organization for Economic Co-operation and Development (OECD) countries over the period between 1966 to 1988 was also unable to discern any effect of aging on health expenditure. (6) Aging was also found to be an insignificant force in driving the per capita health expenditures in Switzerland. (6)

Even if the apocalyptic projections were to be realized and aging does exert upward pressure on public health care financing, it is not clear why the public health care system would become less sustainable. Since financing health care from private sources is typically more expensive and less equitable than public financing, the reasons why the latter should, as noted by Evans (6) become “unsustainable” in the face of escalating costs have always been somewhat obscure. Moreover, with a growing proportion of elderly in total population there would be a contemporaneous decline in the need for public spending on education and other public services that are generally directed at the young. (6) Finally, since aging is a global phenomenon, it imposes similar pressure on the public health care of Canada’s main trading nations.
Is the Canadian economy sustainable without medicare?

It is “not so much the rich are getting richer; it's the very, very rich.” (11)

“Statistics Canada reported the earned income of the “average” Canadian – the so-called median income – was the same in 2004 as in 1982. It turns out that median income, before taxes, did not rise at all over 22 (Conservative and Liberal) years. Yet during that same time the Canadian economy grew, in real per capita terms, by more than half. But only the very well-paid – those above the 90th percentile of the income distribution – saw any significant increase in earned income; and the higher up the earnings ladder, the greater the growth.” (11)

Canadians are working harder and smarter, and are contributing to a growing economy, but their paycheques have been stagnant for the past 30 years, says a new study by the Canadian Centre for Policy Alternatives (CCPA). The study, *Rising Profit Shares, Falling Wage Shares*, finds that Canada’s economy grew steadily and workers’ productivity improved by 51 per cent in the past 30 years, but workers’ average real wages have been stuck in a holding pattern all this time.

“Canadians are constantly being told they need to improve their productivity and grow the economy – which is exactly what they’ve done, but their paycheques aren’t growing to reflect their work effort,” says study co-author Ellen Russell, CCPA senior economist.

The study finds that Canadian workers’ wage share of national income is the lowest it’s been in 40 years. If workers’ real wages had increased to reflect improved productivity and economic growth, they could be earning an average of $10,000 more each year on their paycheques (in 2005 dollars).

Instead, corporations – not workers – have been banking the lion’s share of the benefits of economic growth and improved productivity. “Corporate profit shares are the highest they’ve been in 40 years, and we’re not talking peanuts here,” said Russell. “In 2005, corporations banked $130 billion more in gross profits than they would have if the profit share had remained at 1991 levels. Sharing those earnings with workers could have gone a long way to reducing Canada’s growing income gap.”

Paul Krugman, a Nobel Laureate in economics and New York Times’ columnist, after reflecting on the even worse income distribution conditions in the U.S. over the same period, suggests a means of partially compensating American workers for their increased exploitation. “Fears that low-wage competition is driving down U.S. wages have a real basis in both theory and fact. When we import labor-intensive manufactured goods from the Third World instead of making them here, the result is reduced demand for less-educated American workers, which leads in turn to lower wages for these workers. And no, cheap consumer goods at Wal-Mart aren’t adequate compensation” while domestic pro-labor policies like “universal health care, paid for by taxing the economy’s winners, would be a good place to start.” (12)

Earlier Krugman argued that there are economic as well as political benefits for the U.S. to implement a Canadian style health care system. He asserts that Canada’s national health insurance system saves auto manufacturers large sums in benefit payments compared with their costs in the U.S., making the companies more competitive. (13) Estimates are that a car produced in the U.S. has more than three times (approximately $1,400) as much medical costs built into it compared to a car built in Canada (which has approximately $400).

“Funny, isn’t it? Pundits tell us that the welfare state is doomed by globalization, that programs like national health insurance have become unsustainable. But Canada’s universal health insurance system is handling international competition just fine. It’s our own system, which penalizes companies that treat their workers well, that’s in trouble.
For now, let me just point out that treating people decently is sometimes a competitive advantage. In America, basic health insurance is a privilege; in Canada, it’s a right.” (13)

Implicit in the sustainability argument is the assumption that what matters to a nation’s capacity to maintain its health care spending – everything else being equal – is not who pays, but rather how much is spent. However, everything else is not equal if a single-payer public system can raise financing, administer claims, and spread risks over the population more efficiently than a multi-payer private system (6). A tax financed single-payer system “combines in one authority both the incentive and capacity to contain costs, to a greater degree that is possible in any of the other financing mechanism.” (6) Moreover, there are no “marketing expenses, no cost of estimating risk status in order to set differential premiums or decide whom to cover, and no allocations for shareholder profits.” (6) A comparative analysis of the health care costs in the OECD countries suggests that total health care expenditures are lower on average in systems predominantly funded through general taxation. Indeed, the larger the private share of health care financing, the more difficult it is to control health care expenditures. The overhead cost of administrating a multi-payer system, for both reimbursing agencies and providers, is generally much larger than a single-payer public system. In 1999, the estimated cost of prepayment and administration accounted for 13.6 per cent of total payments to private insurers in Canada versus only one per cent in the public sector. (6) The administrative cost differentials between Canada and the United States are also found to be large, accounting for nearly half of the difference between the share of resources allocated to the health sector in the two countries. (6)

**How can we make the Canadian economy and medicare more sustainable?**

In a new report by the Canadian Centre for Policy Alternatives entitled, *The Case For Universal Pharmacare* (2010), Canada, the report tells us, deliberately sets drug prices high to encourage research and development on Canadian soil. The policy is a complete failure, since it leads Canadians to spend $1.53 Billion more than the average price of brand-name drugs in OECD countries to generate $537 million in research and development spending. Raising drug prices is not the way to create innovation in the industry. (p.10)

By eliminating these perverse incentives, extra administrative costs of private drug insurance plans, the tax subsidies these plans receive, and setting prices in line with other OECD countries, it is estimated the net cost of drugs in Canada can be reduced by up to an extraordinary $10.7 billion or 42.8% of total costs! (p.10)

The products used by our public health care system are purchased from for-profit drug manufacturers, diagnostic equipment and hospital suppliers, etc. at very high prices. Our hospitals are profit conduits for a medical-industrial-complex located mainly in the U.S. An alternative would be to consider a Crown corporation that would, for instance, produce generic drugs and possibly look to invent new drugs. Such an operation would be a not-for-profit publicly regulated alternative to the multinational drug companies we now depend on. The public sector would need to greatly bolster its assessment of which drugs are effective and safe. The same review is necessary for the diagnostic technology that we are always charged with not having enough of. In order to invent new drugs, more public money would have to be invested in research and development if we chose to compete with the multinationals.

It is important to note a few facts here:

**A.** Contrary to the claims in drug companies’ advertisements, 75 per cent of the new drugs that provide real clinical medical benefits have been invented by, and paid for by, the public sector in the U.S. and handed to the multinationals for production and sale for profit. (9)

**B.** Public funding in Canada for the evaluation of drugs and technology would be best accomplished as part of an...
international effort. In this case doing the job locally, provincially, regionally or even nationally is inefficient. Why repeat the same analysis in Canada, the U.S., Japan, and the EU on the same drug?

The same must be said of investment in research and development for drugs and diagnostic technology. Redundancy becomes necessary because either no government is willing to challenge the medical-industrial-complex and/or there is no mechanism to coordinate these research efforts internationally.

Policy options: What doesn’t work?

For-profit health care

If what the Winnipeg Free Press or Claude Castonguay have in mind with respect to private health care is for-profit health care then they will need evidence to counter the overwhelming findings of the New England Journal of Medicine, the Journal of the American Medical Association, the Canadian Medical Association Journal and the Harvard School of Public Health that for-profit health care is more costly, of lower quality, provides lower patient satisfaction and has a higher mortality rate than not-for profit health care. Why spend $1.10 for something you can get for $1 of higher quality, whether it is paid from taxes or out of your pocket? Privatization will not control health costs, but it will shift the burden of increased expenditures driven by the profit motive from the tax system to individuals.

User fees

As for user fees, when experimented with in Saskatchewan they didn’t reduce health expenditures but did deter the poor and the elderly from using the system as much. Doctors called in their more well-to-do patients more often so that expenditures remained the same while the poor got less care – which evidence suggests they need more of.

Of course you could always devise a scheme where user fees on a sliding scale are so prohibitive as to discourage use by almost anyone regardless of income. The Rand Corporation did such an experiment some years ago and discovered that foregone medical care was not of the frivolous kind, but just as likely to be important. People don’t know when the system can help them or not. Creating financial barriers leads to greater acuity – you get sicker than if you treated the problem earlier – making health care more expensive. User fees accomplish one thing: they redistribute health care resources from the poor to the rich and the more needy to the less needy. (14)

The two-tier systems option to reduce waiting lists

Two-tier health care systems don’t work. England and New Zealand have parallel private health care systems and longer waiting times in the public system than countries with a single-payer system such as Canada. In Manitoba researchers found that surgeons performing cataract surgery waited 10 weeks for surgeons who worker exclusively in the public sector and 26 weeks for surgeons who worked in both the public and private systems.

Recognition of this tendency has led the Netherlands to separate their private and public hospitals so that the rich who use the private system cannot use the public ones. Sweden, Greece and Italy also prohibit practice in both
systems. Other countries use different ways to achieve the same results. France prohibits doctors in private practice to charge more than they would get in the public system. Allowing parallel private systems doesn’t increase the existing resources, e.g. doctor and nurses, just shifts them from the public system to the private, lowering the waiting list in one place while raising it in the other. (15)

Canada does have a problem with waiting lists. If the answer isn’t for-profit medicine, a two-tier system or user fees, what can be done? From the description of Michael Rachlis’ recent book *Prescription for Excellence*:

“The Right shrieks, “Privatization will save our health care system!” The Left pleads, “Medicare is underfunded!” And all Canadians wonder —will the health care system be there when I need it?”

The answer, maintains Canada’s leading health care reformer, is staring us in the face. We don’t need privatization and we don’t need a lot more money. The solution, Dr. Michael Rachlis says, lies in championing the innovative programs we already have and rolling them out on a national basis. *Prescription for Excellence* offers these timely success stories, or “best practices,” as proof that medicare is far from dead. But we must unshackle innovation if we want medicare to thrive.

Looking across the country, Rachlis describes forward-thinking and practical solutions to many of medicare’s most entrenched problems. He shows how we can decongest ERs and hospitals, improve access to physicians, and make prescription drugs more affordable. We can even dramatically trim waiting lists, simply with better management.”

**What are the real motives behind the claims of medicare’s unsustainability?**

First and foremost the fact that health care in Canada, in large part, like education and hydro, is beyond the grasp of the for-profit system is maddening for those who might profit from it. The medicare part of health care in Canada is part of “the Commons” – resources shared by all – and not a commodity to be sold in a market place for profit. For those who are driven to make profits it does not matter that health care is delivered more efficiently, effectively and is more accessible under the public sector. By definition it is in need of privatizing. A close corollary to this is that in Evan’s (4) words, “Canada’s universal tax-financed medicare, higher-income people contribute proportionately more to supporting the health care system, without receiving preferred access or a higher standard of care. Any shift to more private financing would reduce the relative burden on those with higher incomes and offer (real or perceived) better or more timely care for those willing and able to pay.” Of course, ironically, the profits to be made by a for-profit medical sector would make other sectors – especially those such as autos, buses, aircraft, agriculture and resources that depend on trade – lose a competitive advantage.

**The “Sustainability” Issue: Part of a much bigger lie?**

In Barlow’s *Profit is Not the Cure* book, (pg. 73) she refers to Conrad Black on the topic of medicare and beyond: “Black said that, because of its welfare state, Canada is ‘uncompetitive, slothful, self-righteous, spiteful, an envious nanny-state, hovering on the verge of dissolution and bankruptcy.’ Its people, a ‘society of over-compensated self-pitiers,’ suffer from the ‘great Canadian sloth, the spirit of smug entitlement.’”
Black took special aim at universality, which he called “plundering and bribery.” “Canada extended the safety net to encompass not simply the genuinely unfortunate,” he wrote, “but rather anyone who is second-rate. We would rather take care of the second-rate people than reward the first-rate for their initiative.” While his views are more extreme than most, an increasingly corporate-dominated print media in Canada has voiced largely the same editorial position for a number of years,” observed Barlow. Eight years later these observations remain valid.

The World Economic Forum (WEF) is a Geneva-based foundation whose Annual Meeting of chief executives and political leaders, held in Davos, Switzerland, is a gathering of the truly rich and powerful. The WEF is a think tank funded by 1,000 corporations. Member companies must have annual revenues of more than $1 billion. Every year the WEF produces its Global Competitiveness Report, which ranks the competitiveness of the world’s economies. Unlike the ideologues like Black and those who dominate the Conservative-Liberal austerity policy perspective at the Canadian Council of Chief Executives, National Post, Globe and Mail, many in the mainstream think tanks and the economics’ profession, the WEF wants to know what really works in the capitalist context. (9)

The top 10 countries of World Economic Forum Growth Competitiveness Index Rankings for 2005 in rank order from top down were; Finland, U.S., Sweden, Denmark, Taiwan, Singapore, Iceland, Switzerland, Norway, Australia, Netherlands, Japan, UK, Canada and Germany (Lopez-Carlos et al, 2006). What is most interesting about this list is how few of these countries follow a conservative economic strategy.

The countries that dominate the top 10 list are the so-called Nordic countries, better known for being labelled disparagingly by Conservatives for their “welfare states.” It seems the quality of their public institutions, budget surpluses, low levels of corruption and high degree of technological innovation trump their high taxes and strict regulatory framework so that they are characterized as having “excellent macroeconomic management overall”, according to Augusto Lopez-Claros, chief economist at the WEF.

“Integrity and efficiency in the use of public resources means there is money for investing in education, in public health, in state-of-the-art infrastructure, all of which contributes to boost productivity. Highly trained labor forces, in turn, adopt new technologies with enthusiasm or, as happens often in the Nordics, are themselves in the forefront of technological innovations. In many ways the Nordics have entered virtuous circles where various factors reinforce each other to make them among the most competitive economies in the world, with world class institutions and some of the highest levels of per capita income in the world.” (9, p. 37)

**Conclusion**

The introduction to this report referred to the joint letter between the Canadian Auto Workers’ union and General Motors, Chrysler and Ford and their support for Canadian medicare based on its affordability, its universal access, the fact that it contributed to a healthier and more productive work force and its labour cost advantages. Nothing in the past eight years since that letter was written has transpired to challenge the wisdom of those recommendations. The current Conservative policy environment that is at the forefront of the attack on medicare has made our society less healthy, more dangerous, less stable, more unequal, less fair, and more inefficient. Instead of taking apart medicare we should be applying its principles to other sectors of our economy.
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