

Building on Values: The Future of Health Care in Canada

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In 2001 the Privy Council of Canada, at the direction of the Prime Minister, authorised a Royal Commission into Canada's Medicare system as there had been widespread concern about the direction health care in Canada was taking. This article examines the reasons for the Royal Commission, its findings, and their relevance to the Australian health care system.

Commercialisation of Health Care

Most Western countries, with the exception of the USA, have a system of general health care insurance covering all citizens, usually funded through taxes. The philosophy behind general health care insurance systems is that health care is a Samaritan service offered by the community to citizens in need regardless of their status or circumstances. It is a common good based on shared community values.

Economists and politicians across the globe have embraced and promoted competitive marketplace and global solutions to the world's health care problems. Investors in the business community have been enthusiastic about the opportunities for growth and the profit that can be taken from the public purse. In Canada, this has resulted in the decline of many large public institutions in the last 20 years. (Buske 1997)

Several Canadian provincial governments have adopted competitive market based prescriptions for health care in both public and private services. At the same time governments have courted multinational investment with taxpayer-funded enticements. Health care is not seen as any different. Policy-makers have promoted the use of profit oriented corporate service providers, and sought to encourage citizens into private care (Romanow 2002; Fuller 1998; Canadian Council for Public-Private Partnerships 2001). Canada has appointed health care corporatists to positions of power (Taft & Steward 2000; Canadian Health Coalition 2001) Ordinary Canadians feel threatened by the misconduct of nearby US multinationals who are potential providers of care (Fuller 1998; Globe & Mail 1996; Toulin 1996).

Until recently, Canada's hospitals have been run exclusively on a not-for-profit basis. For-profit corporations have not been eligible for Medicare funded services so that the penetration of large corporations into their core health system is some way behind Australia. Some provincial governments have attempted to circumvent this restriction and contract general health care insurance (Medicare) services to for-profit groups (Fuller 1998; Taft 1997; Armstrong 2000).

The Royal Commission

The Canadian Medicare system paid mainly for care in hospital and for physician care. Medical care had changed radically since the introduction of Medicare with shorter hospital stays and with major costs shifting to the home, the hostel and drugs (Coyte 2000). These were often paid to private providers out of pocket or by personal insurance. Insurers could exclude individuals with pre-existing conditions and base premiums on risk. Without equity many people were shut out of the market (Tully &

Saint-Pierre 1997; Romanow 2002; Fuller 1998). Medicare had not kept up with these expenses and was no longer working for citizens (Armstrong et al 2002).

In addition to this, Medicare funding had been steadily eroded. Provincial governments capitalised on the economies obtained and facilitated this shift from taxpayer funding to private care. During the 1990s many provinces closed public hospitals and there was a blow out in waiting lists. At the same time they started contracting services to for-profit businesses. Powerful business lobbies claimed that the market could provide care as well and more economically (Fuller 1998; Taft 1997; Evans et al 2000).

The Canadian Medicare system represented the victory of citizens over business interests in a bitter dispute in the 1960s. Over the years there had been regular federal and provincial reviews of the health system, but none of them had been acted on effectively. The public was confused and angry at the increasing out of pocket costs. It was distrustful of a move back to market medicine in an area that the public overwhelmingly considered a fundamental value-based social service. Under mounting pressure from a frustrated public, the federal government sought a totally independent evaluation of the situation (EKOS Research Associates 2000; National Post 2001).

The Hon Roy Romanow, an eminent Queen's Counsel and recent past premier of the Saskatchewan province, was appointed to head the Royal Commission. The Commissioner's brief was to conduct a thorough assessment of Canada's Medicare system, consult with the public, evaluate options for change and make recommendations within 18 months. This included determining what Canadians thought about health care.

The processes adopted for the Royal Commission insisted on evidence, and included canvassing the views of experts, commissioning expert reports, accepting submissions from stakeholders and the public, and examining the system in other countries. The issues and the facts were taken to the public through television and community seminars. Public meetings were held where people spoke of their concerns and surveys were conducted to determine the values and type of health system Canadians wanted. In all 38,000 Canadians contributed to the process.

The Commissioner's Findings

Faced with ongoing market and political rhetoric urging the increased privatisation of the Canadian Medicare system and a greater role for for-profit private health care the Commissioner said:

“Early in my mandate, I challenged those advocating radical solutions for reforming health care – user fees, medical savings accounts, de-listing services, greater privatisation, a parallel private system – to come forward with evidence that these approaches would improve and strengthen our health care system. The evidence has not been forthcoming. I have also carefully explored the experience of other jurisdictions with copayment models and with public-private partnerships, and have found these lacking. There is no evidence that these solutions will deliver better or cheaper care, or improve access (except, perhaps for those who can afford to pay for care out of their own pockets). More to the point, the principles on which these solutions rest cannot be reconciled with the values at the heart of Medicare or with the

tenets of the Canada Health Act that Canadians overwhelmingly support. It would be irresponsible of me to jeopardise what has been, and can remain, a world-class health care system and a proud national symbol by accepting anecdote as fact or on the dubious basis of making a ‘leap of faith’”.

Romanow described Medicare as a national achievement that defined citizenship and expressed social cohesion. He considered it financially sustainable. Health care was a "partnership of individuals, health care providers and governments... a vital part of society". He called for a restoration of trust and a new social contract.

The Canadian public saw Medicare as a fundamental social service and a defining right of citizenship. They were prepared to pay more taxes if it gave them the sort of health system they wanted.

“It has been suggested to me by some that if there is a growing tension between the principles of our health care system and what is happening on the ground, the answer is obvious. Dilute or ditch the principles. Scrap any notion of national standards and values. Forget about equal access. Let people buy their way openly to the front of the line. Make health care a business. Stop treating it as a public service, available equally to all. But the consensus view of Canadians on this is clear. No! Not now, not ever. Canadians view Medicare as a moral enterprise, not a business venture”.

The report is not a plea for the status quo but a reaffirmation and invigoration of the principles on which the Canadian health system is based. The report focuses on a collaborative integrated system which embraces the community and seeks to serve them. While not excluding for-profit corporations, it seeks to marginalise them.

The report makes 47 specific recommendations that set the directions for reforming the health system including:

- establishing a new Canadian Health Covenant that would clearly define the roles of all participants;
- expanding Medicare’s scope to embrace several new areas including pharmacy products, home care, palliative care and workers compensation;
- revamping Medicare to meet the needs of the times, for example, recognising the move to take health care out of the hospital and into the community, and the increasing importance of preventive medicine;
- making Medicare more accountable to the people through open reporting;
- expanding not-for-profit radiology and pathology services to prevent the wealthy using private services then jumping the queue back into the Medicare system;
- increasing health care assistance to developing countries and stopping the poaching of skilled staff from countries in greater needs;
- expanding primary health care in the community with an emphasis on prevention and adequate remuneration;
- increasing support and funding for remote regions and Aboriginal care, and
- developing technology, electronic medical records and telemedicine.

The Commissioner condemned the acrimony and distrust that characterises Canada's dual provincial/federal funding system:

"The Corrosive and divisive debates must end. If the status quo continues, the result will be the eventual unravelling of Canada's health care system into a disparate set of systems with differing services, differing benefits and differing ways of paying for health care across the country. This is not what Canadians want or expect for their health care system or for their country".

The report calls for "new funding arrangements which are adequate, stable and predictable over the longer term and de-politicise day-to-day health care issues" and proposes a central Health Council of Canada to buffer the disputes, oversee the disbursement of funds, and the setting of standards and accountability. The Canadian federal government has steadily reduced its financial contribution to health care over the years. The Commissioner insists that it increases its contribution, restoring the previous balance between federal and provincial funding.

Romanow responds to the deficiencies and uncertainties in international law and trade agreements, such as those at the World Trade Organisation (WTO), realising that the position of health care in international agreements is uncertain and has never been tested in law. International companies may demand equal treatment (a level playing field) or else demand compensation. The report recommends:

"Take clear and immediate steps to protect Canada's health care system from possible challenges under international law and trade agreements and build alliances within the international community... within the WTO Canada should take a clear and unambiguous position that access to affordable, quality health care should not be compromised for short-term economic gain. Every country should retain the right to design and organise its health care system in the interests of its own citizens... all countries should have the freedom to provide access on terms that are acceptable to their citizens".

Response to the Romanow Report

The Commission's report was released in November 2002 and there has been a predictable backlash from the corporate community and from the governments of Alberta and Ontario. Both these provinces have drastically cut their public systems and been active in supporting corporatised medicine. The knives are already out, with these provincial premiers rejecting the report. They are refusing to accept Romanow's integrating health care council stating that it impinges on provincial jurisdictions.

Critics have described the report as expressing 1960s ideology and have called the proposed expansions of primary and preventive care "boutique medicine" (Edmonton Journal 2002) The Minister of Health in Alberta stated that the 392-page report could have been "written on the back of a postage stamp", disregarding the evidence amassed or the clear way this information is laid out for people to see on the Commission's website (McMaster 2002).

Other critics of the report have made more incisive analyses of the modest funding increases requested, raising doubts that the increases will be sufficient. Funding will be taken from the federal surplus rather than by increasing tax and this is not a sustainable long-term solution (Yalnizyan 2002).

Baring an unexpected technological revolution health costs will continue to rise. If this is the case, then this will require increased taxation and ultimately the rationing of taxpayer funded care must follow. Romanow carefully skirts this political hot potato. The not-for-profit system suggested in the report may ultimately have to allow citizens the right to pay or insure for care under the system when the public purse fails them.

Romanow has already met some of this criticism (C.B.C. TV National, 2002). When questioned about paying for care, he said:

“They say this is the future. I can take you to the future! I can take you to the future 50 years ago when that's all we had was private-for-profit, and people lost their houses!”

Not everyone has rejected the report. Some provinces have come out in strong support and the medical profession has endorsed the plan (Lowson 2002).

Relevance to Australia

This major government appointed review is relevant to Australia and the type of health system Australians need and want but are not getting. The report should be a watershed for Australia as well as Canada and its conclusions should be heard above ideological rhetoric.

There are many similarities between the Canadian and Australian systems. Both countries have followed similar competitive market-based prescriptions for health care reform, favoured large market listed corporate groups, appointed health care corporatists to positions of power, and attempted to contract Medicare services to for-profit groups. The areas of concern, the financial targeting, and the proposed solutions would be familiar to those involved in the health care debate in Australia. The problems identified by the Commission in Canada are the same problems being wrestled with in Australia.

In Australia, the main advocates of ‘market reform’ in health care have included the former federal Minister for Health, Michael Wooldridge (Wooldridge 1996) and Graeme Samuel, a health care theorist and chairman of Australia’s National Competition Council (Samuel 2000). Private health and aged care have been turned into a competitive marketplace dominated by shareholder interest and adjudicated by the Australian Competition and Consumer Commission (ACCC). The federal government’s commitment to this path is revealed by their decision to put Samuel forward as their preferred replacement for Professor Alan Fels as chairman of the ACCC.

Government has sought to globalise the Australian health system by welcoming large multinationals like Tenet Healthcare, Columbia/HCA and Sun Healthcare. These three multinational megacorps have between them paid around A\$4 billion to settle allegations of health care fraud in their home country (Mealy's Litigation Report 1994; Julien 1999; Medical Newswire 2002). Issues relating to the quality of care, values and morality are ongoing (US House of Representatives 1992; Tampa Tribune 1998; Morey 2002). Similar issues and problems are emerging in the increasingly corporatised Australian system (Brown & Dickie 2003). The Romanow report seeks to protect the Canadian health system from the threat posed by market place globalisation and produce a health care system very different to that proposed by market theorists in Australia.

In Australia, the moral issues and conflicting value systems surrounding health care have not been debated, nor have the views of the public been adequately canvassed. Most people still believe that those organising their health system are motivated by an ethic of compassion and service rather than shareholder interests.

Conclusion

The Romanow report has established that the encroachment of the competitive corporate market system brings conflicting and inappropriate values into the health system. These are disruptive. The for-profit health care market does not live up to its claims to economy, efficiency or to providing equity. It has little to commend it.

Clearly, if rationing becomes necessary, community involvement in the public/not-for-profit system provides an acceptable avenue for this. Rationing care to preserve shareholder profit is a macabre affront to the Hippocratic tradition and is morally untenable.

The Romanow report recommends moving away from aggressively competitive market solutions towards a sensible vision of integrated care based on values. While addressing similar problems, the report challenges the utility and the morality of the competitive market-based road that Australia is following.

It remains to be seen whether the power of political ideology and the corporate community in Canada will triumph over the will of the people and their values, as is so clearly reflected in Romanow's report. What is clear is that the current Medicare battle is likely to be as fierce, as bitter, and as acrimonious as that of 40 years ago.

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The full Romanow report (392 page) and a summary (12 page) can be downloaded from the Commission's website at www.healthcarecommission.ca

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