

# MEDICAL REFORM

Newsletter of the Medical Reform Group

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## INVESTOR OWNED PRIVATE FOR PROFIT HEALTH CARE FACILITIES ARE TO DIE FOR

*PJ Devereaux*

Canadian health policy makers are considering an expansion of investor owned private for-profit health care delivery. Advocates of investor owned private for-profit health care delivery argue that for-profit providers can deliver high quality care more efficiently than not-for-profit providers. However, many fear for-profit facilities are more likely to respond to financial pressures by cutting quality of care to maintain shareholder returns. These viewpoints have resulted in a heated debate about whether the profit status of healthcare facilities influences patient death rates.

Health care can be separated into two essential and distinct components, funding (who pays for the health care) and delivery (who owns and administers the institutions or services that provide the care) (see Figure 1). Both funding and delivery can be public or private. Public funding means paid for by government (for example, through the use of tax dollars); public delivery means government ownership and administration of health care facilities. All public health care institutions are not-for-profit. Private funding and private delivery can both be for-profit or not-for-profit. On the funding side, insurance companies that channel premiums to pay for health care can be private for-profit or private not-for-profit. On the delivery side, hospitals and other health care delivery

institutions that are private for-profit corporations are owned by shareholders/investors. Private hospitals can also be not-for-profit institutions that are owned by religious organizations, communities, regional health authorities, or the hospital boards.

Public funding is the dominant method through which Canadian hospitals obtain revenue. However, 95 per cent of Canadian hospitals are private not-for-profit institutions. Because Canadians commonly use the term 'public hospitals' to refer to private not-for-profit hospitals, many are unaware of the private ownership and administration of our hospitals.

A group of us have recently published two studies that address issues of health care delivery, rather than health

care funding.<sup>1,2</sup> Accurate understanding of the impact of alternative health care delivery systems requires a systematic, comprehensive, and unbiased accumulation and summary of the available evidence. We therefore, undertook a systematic review and a meta-analysis to address the following questions: what is the relative impact of private for-profit versus private not-for-profit delivery of hospital care on patient mortality; and what is the relative impact of private for-profit versus private not-for-profit delivery of hemodialysis care on patient mortality?

We published the results of the first study evaluating risk adjusted death rates among patients admitted to investor owned private for-profit and private not-for-profit hospitals in the Canadian Medical Association Journal in May 2002.

We identified studies through an electronic search of 11 bibliographical databases, our own files, consultation with experts, reference lists, PubMed, and SciSearch. We masked (blacked out) study results prior to determining study eligibility to eliminate any bias in the selection process. Our eligibility criteria included observational studies or randomized controlled trials that compared private for-profit and private not-for-profit hospitals. We excluded studies that evaluated hospital mortality rates in hospitals that were under a particular profit status that subsequently

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## Medical Reform

*Medical Reform* is the newsletter of the Medical Reform Group of Ontario. Subscriptions are included with membership, or may be purchased separately at \$50 per year. Arrangements to purchase multiple copies of individual newsletters or of annual subscriptions at reduced rates can be made.

Articles and letters on health-related issues are welcomed. Submissions should be typed, or sent by e-mail to <mrg@web.ca>.

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**Editorial committee this issue:** Rosana Pellizzari, Janet Maher.

The Medical Reform Group is an organization of physicians, medical students, and others concerned with the health care system. The Medical Reform Group was founded in 1979 on the basis of the following principles:

### 1. Health Care is a Right.

The universal access of every person to high quality, appropriate health care must be guaranteed. The health care system must be administered in a manner which precludes any monetary or other deterrent to equal care.

### 2. Health is political and social in nature.

Health care workers, including physicians, should seek out and recognize the social, economic, occupational, and environmental causes of disease, and be directly involved in their eradication.

### 3. The institutions of the health system must be changed.

The health care system should be structured in a manner in which the equally valuable contribution of all health care workers is recognized. Both the public and health care workers should have a direct say in resource allocation and in determining the setting in which health care is provided.

# INVESTOR OWNED PRIVATE FOR PROFIT FACILITIES (continued)

converted to the other profit status. For each study, we calculated a relative risk of mortality with private for-profit hospitals relative to private not-for-profit hospitals, and pooled the studies of adult populations that included adjustment for potential confounders (e.g., teaching status, severity of illness) using a random effects model.

Fifteen observational studies, involving more than 38 million patients, fulfilled our eligibility criteria. In the studies of adult populations, with adjustment for potential confounders, private for-profit hospitals were associated with an increased risk of death (relative risk 1.020 [95 per cent CI 1.003 – 1.038];  $p = 0.02$ ). The one perinatal study with adjustment for potential confounders also showed an increased risk of death in private for-profit hospitals (relative risk 1.095 [95 per cent CI 1.050 – 1.141];  $p < 0.0001$ ).

How important is the relative risk increase of 2 per cent we demonstrated in the adult population studies? At a population level, the potential impact could be profound. Canadian statistics for 1999-2000 indicate 108,333 Canadians died in hospital (data provided by the Canadian Institute for Health Information). If we were to convert all our hospitals to private for-profit institutions, our results suggest that we would incur an additional 2167 deaths a year. This number of deaths is in the range of how many Canadians die each year from colorectal cancer, motor vehicle accidents, or suicide.

In our second study published in the *Journal of the American Medical Association (JAMA)* in November 2002 we provided evidence about death rates in the outpatient setting of investor owned private for-profit and private not-for-profit dialysis centres. We utilized explicit eligibility criteria; conducted a comprehensive search to identify all relevant studies; applied eligibility criteria

to potentially eligible studies in an unbiased manner; examined the quality of the eligible studies; and conducted a rigorous statistical analysis of the data from the studies that ultimately prove eligible.

Our search identified over 7,000 medical articles of which over 700 of these passed an initial eligibility screen. We then undertook an extremely important measure to eliminate any bias in the selection process of which studies to include in our systematic review. We trained research staff to read through all the articles and use a black marker to obscure the results of the studies. Two reviewers then independently examined these articles with the results blacked out and determined study eligibility. As a result of this process we could not select studies to reach a specific conclusion. Eight studies including data on over 500,000 patients met eligibility and quality criteria for our systematic review.

The results of these studies show that for-profit care resulted in an 8 per cent increase in death rates relative to private not-for-profit care. The findings were consistent across studies, and show that if American patients received care in private not-for-profit dialysis facilities instead of for-profit facilities, approximately 2,500 fewer patients would die each year. During 1999, 12,700 Canadians received hemodialysis, of whom 1,966 died. If we were to convert our private not-for-profit dialysis centres to private for-profit centres, we could expect approximately 150 additional deaths in Canada each year.

The results of both of our studies are plausible, because private for-profit facilities have to both generate profits to satisfy shareholders and pay taxes (typically these two expenditures

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# INVESTOR OWNED PRIVATE FOR PROFIT FACILITIES (continued)

are in the range of 10-15 per cent of expenses). Not-for-profit facilities can spend this money on patient care. The higher death rates result when for-profit companies cut corners to make sure they produce the required profit margin. The studies included in our systematic reviews suggested that private for-profit hospitals and dialysis centres were employing fewer and less highly skilled personnel to take care of the patients. Other examples of how for-profit dialysis facilities may be cutting corners include less time on dialysis and thus less thorough "cleaning" of the blood; and sub-optimal doses of expensive necessary medications, such as erythropoietin.

Although our results only include American patients the results are directly relevant to Canada. The results of our hospital meta-analysis are based on Medicare patients and end-stage kidney disease is the only medical condition for which the United States government funded treatment (i.e. Medicare) is

available regardless of age or socioeconomic background. American hospital and dialysis care is provided by both private for-profit and private not-for-profit facilities. Therefore, the American hospital data included in our systematic review and the American dialysis health care delivery provides ideal examples upon which to draw inferences for our Canadian inpatient and outpatient health care delivery systems that are publicly funded and dominantly provided by private not-for-profit facilities.

The results of our systematic reviews are consistent over time, despite changes in American health care. This suggests that the adverse impact of private for-profit health care delivery is manifest within a variety of health care contexts. Furthermore, whatever the context within which they function, for-profit care providers face the problem of holding down costs while delivering a profit. One would, therefore, expect the resulting problems in care delivery to emerge whatever the setting. Finally, if

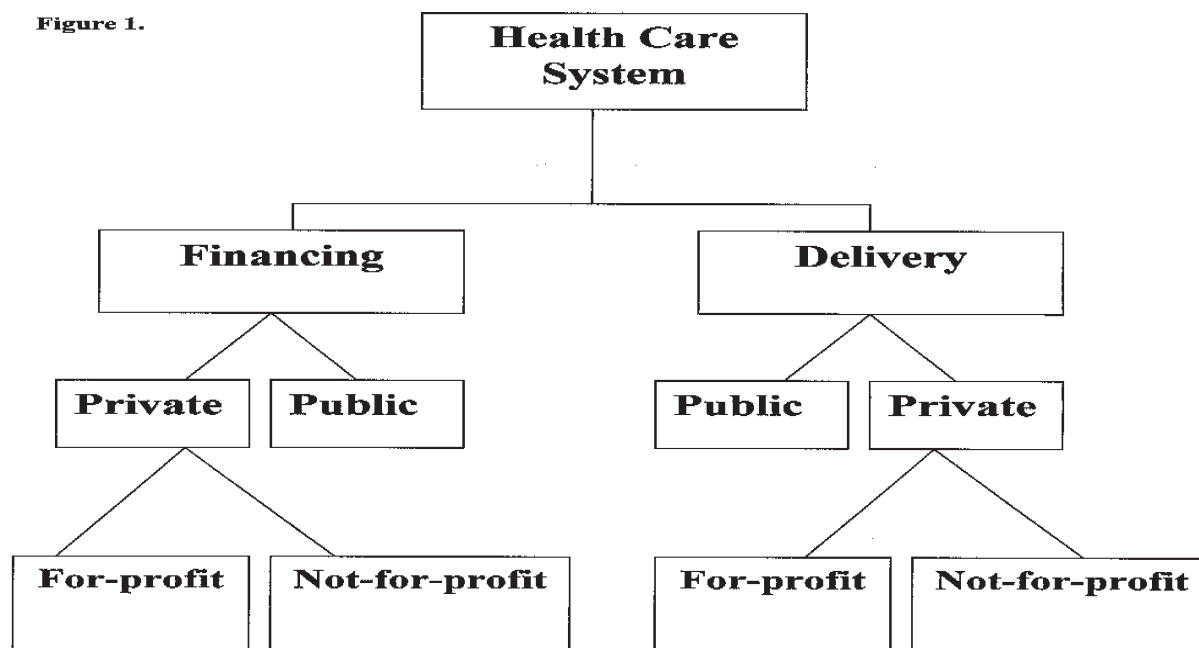
Canada moved to for-profit hospital or dialysis facilities, the same large American hospital and dialysis chains included in our systematic reviews would be purchasing Canadian hospitals and dialysis facilities.

Our systematic reviews show a major increase in death rates at private for-profit inpatient and outpatient facilities. Our research raises serious concerns about moves to investor owned private for-profit care, whether in hospitals or outpatient facilities. It is time to move arguments in the health care policy debate away from ideology and into the evidence based era. ♦

<sup>1</sup> Devereaux PJ, Choi PT-L, Lacchetti C, et al. A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals. *CMAJ*. 2002;166:1399-1406.

<sup>2</sup> Devereaux PJ, Schünemann HJ, Ravindran N, et al. Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: A systematic review and meta-analysis. *JAMA*. 2002; 288: 2449-2457.

Figure 1.



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# KIRBY WRONG TO DISMISS OUR FINDINGS

*Philip Devereaux and Gordon Guyatt*

**M**ichael Kirby's standing Senate committee, in its final report on the Canadian health-care system, sums up its view of private for-profit health care by stating, "The committee is neutral to the ownership question." Its members believe, therefore, that Canadian governments should take a permissive attitude toward for-profit hospitals.

Is the committee's decision evidence-based?

We are members of a research team that recently published a systematic review of 15 studies evaluating 38 million patients receiving care in either private, for-profit or private, not-for-profit American hospitals.

Overall, the studies show higher death rates in for-profit institutions, an excess mortality that, were we to switch to for-profit hospitals, would mean an additional 2,200 Canadian deaths each year. This is in the range of how many Canadians die each year from colorectal cancer, motor vehicle accidents, or suicide.

Kirby thought our findings important enough that he asked an economist associated with pro-market groups to prepare a critique. He used this critique to dismiss our findings, and justify his view that Canadians needn't be concerned about current moves toward for-profit health-care delivery.

There are serious problems with the senator's process and his conclusions.

Over several hundred years, the scientific community has developed processes to ensure that published research is of high quality. They include review by knowledgeable experts, under the scrutiny of journal editors. Other scientists have the opportunity to question findings in letters to the editor, and the authors have an opportunity to respond to these letters.

Our study underwent this rigorous peer-review process, and was published

in Canada's leading medical journal. Editorials by two leading scientists endorsed our findings.

Kirby did not question us about his concerns, or ask us to respond to the critique, which was not subject to peer review and remains unpublished. The critique, and the conclusions that Kirby draws from it, are deeply flawed.

The Senate committee's document states that "apart from psychiatric hospitals, provincial/territorial governments rarely own hospitals." Hence, the Senate committee appropriately corrects a common misconception that our Canadian hospitals are publicly (i.e. government) owned and administered. Canadian hospitals are private, not-for-profit institutions run by communities, religious organizations, and regional health authorities.

Having provided the basis for our comparison of private, for-profit and private, not-for-profit hospitals, Kirby nevertheless suggests that we should have compared for-profit hospitals to publicly owned and administered institutions. Referring to the critique, he contends that "including public hospitals in the Devereaux et al. meta-analysis could have led to very different results."

As it turns out, we also separately reported four studies that provided comparisons of mortality rates in for-profit hospitals with a mix of private, not-for-profit and public hospitals. All four showed higher death rates in for-profit hospitals, and two were "statistically significant" (meaning that they excluded chance as an explanation of their findings). Thus, we made the right comparison. Including public hospitals would, if anything, have strengthened our finding.

Kirby notes that the unpublished critique questioned our "methodology used ... on several grounds: criteria for the inclusion of pertinent literature;

selection of particular results for inclusion in the analysis." In fact, we took all possible safeguards to ensure an unbiased answer. These included explicit rules for deciding which studies to include, and restricting our sample to those of high quality.

Similarly, members of our study team who decided which of a number of alternative analyses from the original studies were most appropriate to include were "blind," or unaware, of which approaches were more favourable to not-for-profit hospitals. Strategies such as these resulted in the positive peer-review, and endorsement by the two editorialists. Finally, despite Kirby's suggestion that American data cannot provide meaningful conclusions for Canada, the results of our systematic review are directly relevant to Canada.

First, the studies included patients receiving publicly financed care in private, not-for-profit and private, for-profit hospitals, a situation identical to what Canadian policymakers have been considering.

Second, the fact that the results are consistent over time despite changes in American health care suggests that the adverse impact of private, for-profit hospitals is manifest regardless of the context in which they operate.

Finally, should Canada open its doors to for-profit hospitals, we would find the same large corporations that own the hospitals included in our study trying to buy our hospitals. There is every reason to think their management strategies, and increased death rates, would cross the border.

Why did Kirby, if he was really interested in understanding the science behind our work, not ask us to respond to the criticisms? ♦

*First appeared as an op-ed in the Toronto Star, December 9, 2002*

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# KIRBY REPORT: THREE (OR MORE) STEPS FORWARD, ONE STEP BACK

**T**he Kirby Senate report on health care offers a number of positive directions for Canadian health care, with one major slip, the Medical Reform Group of Ontario said today.

“The report unequivocally endorses the five principles of the Canada Health Act, and rejects private payment of physician and hospital services,” said MRG spokesperson Dr. Gordon Guyatt. “Kirby has come down in favor of continued one-tier care for physician and hospital services. The report recommends a major reinvestment in health care by the federal government, including new national home care, pharmacare and palliative care programs. The report says the federal government should take a hands-on approach to directing Canadian health care.”

Earlier volumes of the report had led critics to conclude that Kirby, who has a conflict of interest in that he is a board member of a large private-for-profit nursing home chain, would recommend turning away from universally, publicly-insured health care. He has not.

Additional positive recommendations include a move to multi-disciplinary, integrated primary health care; direct federal contribution to hospital capital costs; increased funding for medical research; a health care guarantee for timely care; major federal investment in information technology infrastructure; major federal investment in training a greater number of health personnel, including nurses and doctors, to avoid the looming shortages.

“Kirby’s conflict of interest, and his personal involvement in for-profit

delivery of health care, shows through in only one set of recommendations,” said Dr. Guyatt. “The report suggests governments should be neutral about whether the provider of care is for-profit or not-for-profit. The report dismisses evidence that for-profit provision of hospital care increases death rates. To ensure shareholders’ return on investment, for-profit providers draw resources from patient care, and the consequences are disastrous.” In a directly related blind spot, the report ignores the free-trade agreements’ major threat to Canadian autonomy in maintaining the health care system that Canadians need and want.

“All in all, this is a report that Roy Romanow can build on,” Dr. Guyatt concluded. ♦

*Released October 26, 2002*

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# TRADE DEALS SPELL DANGER FOR CANADIAN HEALTH CARE

**A** just-released study for the Romanow Commission tells us that trade agreements may leave Canadian governments helpless to deal with health care problems, the Medical Reform Group said today.

“This latest analysis confirms previous expert reviews,” said MRG spokesperson Dr. Gordon Guyatt, one of the study’s co-authors. “We’ve already signed away Canada’s independence. The best hope now is to act fast, before NAFTA and the WTO agreements tie our hands completely.”

The report, prepared under the auspices of the Canadian Centre for Policy Alternatives, examines the key trade provisions that affect health care policy. The major finding is that Canadian initiatives, such as a national

pharmacare program, could open us to major penalties for taking away American insurance company’s business.

“Under NAFTA’s chapter 11, companies could charge us with expropriation,” Dr. Guyatt explained. “A non-elected body would tell us, as they’ve done before, that we have to pay huge penalties. Fortunately, the American insurance presence in Canadian drugs is still relatively small. If we act soon, the penalties might not be serious.”

Current initiatives to allow for-profit ownership of hospitals could result in the same penalties if we ever wanted our hospitals back as not-for-profit organizations. “We couldn’t have created Medicare under these trade agreements,” suggested Dr. Joel Lexchin, another co-author and MRG member, “and going

down the for-profit route may toss away our chances of keeping it.”

The recent auditor’s report has shown how lax the federal government has been in protecting Medicare. The MRG called on the federal Liberals to heed the report’s warnings. Aggressive action is needed to create a national pharmacare program, and stop provinces from sending us down a disastrous and irrevocable road by giving away our health care system to for-profit interests. ♦

*Released October 22, 2002.*

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# THE ROMANOW REPORT'S FUNDING PLANS

Gordon Guyatt

Roy Romanow's task included ascertaining how much additional money was needed to correct the fundamental problems in Canadian health care, ensure that future expenditures would keep pace with needs, and establish mechanisms for accountability of spending. He was clearly anxious to keep all his recommendations within what might be politically feasible in Canada today.

My conclusion regarding Romanow's funding proposals is that his recommendations represent an unequivocal step forward. Romanow, however, underestimates short-term health care costs, and backs away from desirable full funding of home care and pharmacare. Furthermore, his proposals fail to adequately address issues of provincial accountability. Finally, he does not specify from where the money should come, and indeed has implied that it should be drawn from anticipated federal surpluses. Romanow might well be aware of these limitations, and regret them, but argue that he has gone as far as current political exigencies permit. The remainder of this article provides specifics of Romanow's proposal, and expands on the criticisms.

## **Historical Background**

Understanding Romanow's proposals requires some context. In 1968, the federal government enticed the provinces into national Medicare by offering cash transfers that would pay half the costs of provincial programs that met federal requirements. All ten Canadian provinces bought in, and established publicly funded and administered programs that provided universal coverage of all medically necessary physician and hospital services.

Over the years, rules changed. Encouraged by provinces who wanted more flexibility in use of federal dollars, the federal government provided some of the money in the form of "tax

points" rather than cash transfers. This broke the link between money transferred for social programs, like health care, and what provinces do with that money. In 1996 the federal government drastically reduced their contribution, rolling together funding for health care, post secondary education and social assistance in the Canada Health and Social Transfer (CHST).

These changes make it difficult to sort out the federal contribution to health care funding. The provinces ignore the tax points and focus only on the cash transfers, which currently cover 16 per cent of the provinces health care costs. Even the federal government's calculations of its contribution shows a drop from 45 per cent in the mid 1970s to under 30 per cent today. The changes in funding structure have compromised accountability. The money goes in to a big pot, and the provinces can allocate the funds in whatever way they wish.

## **Federal transfers have facilitated provincial tax cuts**

Health economist Armine Yalnizyan has calculated that these cuts cost provincial governments \$20 billion in lost revenues for 2001-02 alone. While complaining they don't have the money for adequate health care funding, the provinces have tossed away the dollars they could have used to prevent growing waiting lists, nursing shortages, and emergency room delays.

The federal government has played the same game as the provinces, pleading inadequate funding for health care while instituting tax cuts that cost the federal government \$20 billion per year. Furthermore, the federal government's budgetary surpluses have allowed them to pay down more than \$47 billion on the national debt. Some of the money allocated to tax cuts and debt reduction could have helped the provinces maintain public health care. To put these dollar values in context, the entire government

expenditure on health in Ontario is in the range of \$28 billion.

## **Romanow's proposal for federal base funding**

Romanow now suggests that the government divide the CHST, and establish separate health and social services cash transfers. He suggests the current health portion of the CHST as \$8.14 billion - a disputable calculation. He recommends that the federal government should ultimately contribute 25 per cent of the money for provincial physician and hospital services, which by his calculations would constitute \$15.3 billion by the 2005/2006 fiscal year. This would represent an increase of \$6.5 billion to the cash base.

Romanow then suggests an escalator to ensure continued stable and adequate funding. The initial escalator would be tied to growth in the GDP, multiplied by 1.25. The 1.25 figure comes from the average greater growth in health expenditures over the GDP from 1960 to 2000. Ultimately, these funding proposals would provide dollars to the provinces without constraints as to how they spend the money, other than that it be spent on "health care". Over the next two years, however, Romanow suggests that the federal government use new money to buy change.

## **Short-term targeted expenditures**

While the legislation for the long-term transfer of funds is being prepared, the federal government would make some immediate targeted expenditures. These include, over a two-year period, \$1.5 billion to a rural and remote-access fund, \$1.5 billion for a diagnostic services fund, \$2.5 billion to promote primary health care reform, a \$2 billion transfer for a limited home care program and a \$1 billion catastrophic drug transfer. The total, 6.5 billion, would end up rolled in to the base for the cash transfer.

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## THE ROMANOW REPORT'S FUNDING PLANS (continued)

Provincial responsibility would include matching the primary health care transfer. The \$1.0 billion transfer for drugs would cover 50 per cent of provincial and territorial costs above a pre-set threshold.

### ***Strengths and Limitations of the Romanow funding proposals: Total dollar amount***

Clearly, a substantial boost in federal spending on health is a wise move. Targeting of funds for national home care and pharmacare programs is an unequivocal step forward, as are the other targeted programs. The dollar amounts should be seen in context. It could be easily argued that they are insufficient. Armine Yalnizyan has pointed out that even current contractual commitments to increases in salaries for nurses and doctors (at minimum \$2.5 billion over the next 2 to 3 years) will require substantial new expenditures in the next several years.

Romanow acknowledges the coverage of chronic home care, and full coverage of needed drugs are desirable. In particular, he notes that a full national pharmacare program will reduce total costs that Canadians pay for pharmaceutical products. He has, nevertheless, provided only very limited home care and particularly pharmacare proposals for pragmatic reasons.

The increased bill for the government - notwithstanding the total decreased bill for the taxpayer - would be, he believes, a political non-starter. Hospitals have noted that they have been left out of the Romanow report. The repeated crisis funding of hospitals over the last few years suggests their point is well-taken.

On the other hand, critics such as Noralou Roos, who holds the Canada Research Chair in population health, points out that despite decades of research documenting that some areas of the country have twice as many physicians per capita as other areas, (or MRIs or middle ear surgery), there is no

evidence showing that "having twice as much care" shows up in the health of the population. Furthermore, she highlights the social choices involved in the health care expenditure (alternative use of the funds might include, for instance, rent-gear-to-income housing units, subsidized day care spaces, or transitional shelter beds). Unfortunately, the most likely alternative use of the funds is to reduce taxes.

Counter-arguments to suggestions that Romanow did not suggest sufficient federal funds for health also include those of health policy analysts such as Michael Rachlis who suggest that we can achieve efficiencies in health care that would obviate the need for appreciable increase in funding.

### ***Where are the Dollars?***

The Kirby Senate report suggested a dedicated health care tax. Romanow has implied the federal government can find the dollars in their surplus. If the money does come from the surplus, will there be anything left for other social programs? That depends on the magnitude of the surplus. Economists such as Jim Stanford suggest the federal government is consistently, and substantially, underestimating the surplus.

Irrespective of arguments about the surplus, tax reductions in the last few years add up to \$20 billion yearly in foregone federal income, and another \$20 billion in provincial tax cuts. Social expenditures, as a proportion of GDP, have dropped by over one-third since the mid-1990s. Social expenditure as a proportion of GDP is at its lowest level since 1947. As Mr. Romanow has pointed out, there is plenty of money for health care, and other social expenditures, if they constitute a high priority for Canadians, and politicians listen to the citizens. Unfortunately, the media have failed to highlight the magnitude of the tax cuts, who benefits from those tax cuts, and the massive reduction in the proportion

of our national resources we are devoting to social programs. If they had, the political pressures might be different.

### ***Accountability***

The Romanow proposals still leave the option for provincial governments to effectively use federal health transfers to cut taxes. Let us assume that a province needs, at minimum, to spend an additional half billion dollars on a health in a given year. This amount happens to correspond to the increase in revenue that province can expect as a result of economic growth. Without increases in federal transfers, the dollars for health care would have to come from the provincial budget.

If increases in federal transfers cover the added health expenditures, the increased potential provincial income can be allocated elsewhere. This has, to an extent, been happening in provinces such as Ontario in response to recent federal increases in funding for health. Romanow's makes his recommendation for funds to contribute to provincial home care and drug benefit programs in anticipation that provinces won't reduce their contribution by commensurate amounts. However, the current funding structure provides no guarantees that they will not.

### ***Conclusion***

Romanow's funding proposals represent an unequivocal step forward. I suspect that they are limited by Mr. Romanow's sense of what is politically feasible. Indeed, pressures for new tax cuts, and provincial resistance to targeted federal program demanding provincial responsibility, may mean that even the relatively modest Romanow recommendations will receive only partial implementation. Forward movement is contingent on the federal government allocating the full \$3.5 billion Romanow recommends in the first year, and the

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## THE ROMANOW REPORT'S FUNDING PLANS (continued)

provinces accepting (or the federal government insisting) on Romanow's limited accountability provisions.

My sense is that, even if fully implemented, the limitations in Romanow's proposals will mean continued severe pressures on health excessive waits for surgical procedures,

heart catheterizations, and cancer care, and continued emergency room chaos.

Furthermore, they will fail to deal effectively with accountability issues, and in particular provinces that place a higher priority on tax cuts than programs (both health care and social) that are likely to improve public health.

Romanow clearly has the right idea. Can the world unfold so that his report constitutes only a first step forward? If the change in momentum that Romanow represents continues, perhaps that is possible. ♦

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## THE ROMANOW COMMISSION: CAUTIOUS STEPS IN THE RIGHT DIRECTION

**R**oy Romanow's report has been praised as a blueprint for medicare's salvation and vilified as an ideological defense of a faltering status quo. However, closer examination reveals it as simply a few cautious steps in the right direction.

Mr. Romanow claims that the house of medicare is still on firm foundations and, therefore, needs renovation not demolition. In fact, medicare has been very good to Canadians. Up until the 1950s, Canada and the U.S. had very similar health systems and similar health status. Over the next 50 years, while almost all other sectors of our societies became more similar, we created a uniquely Canadian institution.

The results are clearly in Canada's favour. All Canadians are covered for medical and hospital care and most provinces cover at least some of the costs of home care, pharmacare and long-term care. In the U.S., 42 million people have absolutely no insurance and tens of millions have such inadequate insurance that more than 500,000 Americans declare personal bankruptcy every year because of health-care bills.

Canada now spends 9.4 per cent of GDP on health care while the U.S. spends 14 per cent. Half of this difference is the increased administrative expenses in an American system which is choking on private bureaucracy. The U.S. system spends \$1,150 U.S. per capita on

administration while Canada spends only \$325. While spending less, we actually get more. Canadians have more doctor visits, more days in hospital, more surgery, more days in long-term care and take more drugs than Americans. We have fewer MRIs but we get more bone-marrow transplants. Finally, U.S. infant mortality is now 34-per-cent higher than Canada's and American life expectancy is almost 2.5 years lower. Clearly Mr. Romanow is correct when he maintains that we took the right fork in the road 50 years ago.

Mr. Romanow notes that our health-care system is too focussed on hospitals and treatment and not enough on community care and prevention. There are too many patients in hospital beds who should be treated in the community. We tend to treat diabetes with heart surgery and kidney dialysis even though better ambulatory care could decrease these complications by up to 75 per cent. And the vast majority of cases of diabetes, heart disease and lung cancer could be prevented with better public-health programs.

These conclusions are consistent with 30 years of reports which have recommended improving primary health care as well as providing better coverage for home care and prescription drugs. However, reform has been slow. In September 2000, the federal government tried to target new spending to these

priorities but the provinces forced the feds to provide most of the money in untargeted grants. The result: the provinces immediately had their pockets picked by doctors, nurses and others who won large (albeit overdue) pay increases to do the same work as before.

Even the funds for high technology and primary health care weren't really targeted. Some provinces used the high-tech funds to buy lawn mowers. Initially the feds wanted five criteria for primary health-care pilot projects, but the provinces forced the feds to fund them if they met one. As result, the provinces were screaming for more money within months of the deal being signed.

Mr. Romanow warns the feds not make the same mistake again. He recommends targeted funds over two years where there would be strict accountability for expenditures. These include a \$1.5-billion rural and remote-access fund, a \$1.5-billion diagnostic services fund, a \$2.5-billion primary health-care transfer, a \$2-billion transfer for a limited home-care program and a \$1-billion catastrophic drug transfer. These funds total \$3.5 billion in 2003/04 and \$5 billion in 2004/05. He further recommends that the federal government raise the transfer to \$6.5 billion in 2005/06 and then grow it at a pace slightly greater than the GDP in a series of five-year plans. The federal

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## THE ROMANOW COMMISSION: CAUTIOUS STEPS IN THE RIGHT DIRECTION (continued)

funding would be sequestered to separate health-care funding from other transfers.

Mr. Romanow also recommends an electronic health record, better pharmaceutical and technology assessment, a national drug formulary and aboriginal health initiatives. Noting the lack of management of wait-lists, he recommends a centralization of such lists, which have reduced wait-times by up to 80 per cent in some jurisdictions. He further recommends the federal government move to protect Canada's health system in international trade agreements as well as reviewing the drug-patent legislation to prevent the brand-name companies from "evergreening" their patents through frivolous and vexatious litigation.

Some claimed that Mr. Romanow recommends elimination of for-profit providers. In fact, Mr. Romanow did not make such a recommendation, though he did expound at length on his concerns about for-profit care. Two major reports this year by Canadian researchers have confirmed previous studies that for-profit hospitals and dialysis clinics have higher death rates. Other literature indicates that for-profit hospitals have 12- to 25-per-cent higher costs than non-profits. As McMaster University cardiologist Dr. P.J. Devereaux explains, "Private for profit facilities have to generate 10 to 15 per cent profits to satisfy shareholders. Not for profit facilities can spend that money on patient care."

Mr. Romanow made two recommendations that would inhibit profit-making health-care businesses. First, he suggested that diagnostic services such as MRI and CAT scans be explicitly identified as medically necessary under the Canada Health Act. This would thwart the plans of some provinces to allow for-profit operators to sell some of their scans at market prices while having their base expenses covered by public patients. Second, Mr. Romanow

recommended that the federal government close a loophole in the Canada Health Act which allows workers' compensation boards to buy services outside of medicare. For-profit surgical clinics depend upon these contracts for the majority of their income.

Because of Mr. Romanow's criticisms of for-profit care and his recommendations for targeted federal money, he has been lambasted by the usual suspects. Quebec Premier Landry and Alberta Premier Klein have rattled their sabres, although their B.C. and Ontario colleagues have been more muted in their criticism. Right-wing ideologues have shrieked that Mr. Romanow is a Marxist Luddite who is standing in the road of progress.

However, the other six provinces have signalled their interest in striking a deal with the federal government. And the B.C. and Ontario governments will have difficulty explaining to their increasingly unhappy electorates why they would refuse money for such obvious good works as home care. Mr. Romanow's right-wing critics have never produced any evidence that for-profit care is more effective or less expensive. As a result, the eventual opposition will likely consist of Quebec separatists, Alberta, the Canadian Alliance, the Fraser Institute and other shrill conservative voices. On the other hand, if the federal government adopts Romanow's recommendations, they can count on the support of every health-care group, including the Canadian Medical Association, six provinces, the NDP, perhaps the Conservatives, and roughly 70 per cent of the electorate.

Finance Minister John Manley may be the biggest barrier to Romanow's report. He claims that the cupboard is bare. However, the federal government ran a surplus of \$8.9 billion in 2001/02. The \$8 billion which will accrue from economic growth this year will more than offset the planned new expenditures and

tax cuts. The federal government should have at least a \$10-billion surplus in 2002/03 and a \$17-billion surplus in 2003/04 — and still massively overshoot its target of \$100 billion in tax savings over five years.

There are some problems with Mr. Romanow's report. It recommends the creation of a National Health Council which would have an extensive mandate. However, bureaucrats would likely dominate this organization. This would decrease political accountability. The report recommends eliminating public insurance for out-of-country care. There is no mention of long-term care even though this sector represents 10 per cent of health costs, and there is limited mention of public health. The proposed home-care and pharmacare programs are considerably less comprehensive than those recommended by the National Forum on Health in 1997. Finally, there is no overall vision for the health-care system.

However, Mr. Romanow's small, pragmatic steps might be effective because they will be hard to resist. And because there is no overall blueprint, the report does not collapse completely if only some recommendations are implemented. Mr. Romanow claims that medicare belongs to Canadians. It is now up to the rest of us to ensure that his report is implemented as soon as possible and then used as a springboard for more reforms in the future.

Canadians waited 47 years after Mackenzie King promised medicare in the 1919 election before the Pearson government finally passed the legislation in 1966. We shouldn't have to wait until 2044 for the protection of what we have now and the implementation of the home-care and pharmacare promises, which were made in the 1997 campaign. ♦

*Michael Rachlis, December 1, 2002 in the Winnipeg Free Press*

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# ROMANOW ON PRIMARY CARE: THE SAME OL'?

Ted Haines

Romanow's report ventures into realms of health determinants and of prevention, but ends mainly in familiar 'care' territory.

Central to his mandate was to strike an 'appropriate balance between investments in prevention and health maintenance and those directed to care and treatment', in his recommendations.

And in fact he does show recognition of the impact of non-care determinants of health such as education, employment, income, housing, environment and nutrition. He says that primary health care organizations and providers need to pay more attention to such 'upstream' factors in order to reduce 'downstream' problems that have to be addressed by the health care system. He points out that 'a focus on the determinants of health at the community level can result in actions to strengthen social support mechanisms'.

He laudably advances the conceptualization of primary health care, in defining it as embracing services provided 'not only to individuals but also to communities as a whole, including

public health programs that deal with epidemics, improve water or air quality, or health promotion programs'. He recommends the integration of 'public health perspectives with front line medical care' for prevention and early detection.

On health care delivery itself, he valuably recommends a 'targeted fund for Primary Health Care Transfer', to support efforts to remove obstacles to reform, for example, in the scope and patterns of practice of health care providers. He contends that primary health care should have a 'common national platform ... based on four essential building blocks - continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives for health care providers to participate in primary health care approaches.'

In these ways, his analysis far supersedes the approach of more conventional primary care strategies such as the Ontario Family Health Networks (see the Winter 2002 issue of Medical Reform).

And yet, in spite of his comprehension of primary prevention matters, the 'balance' in his report is distinctly tipped toward 'care and treatment'. The bulk of the discussion is related to delivery of care, for example, with regard to home care, chronic diseases and drugs. Reference to specific prevention recommendations is limited to tobacco use, obesity, physical activity and immunization. There is no clear discussion of the role of public health providers or of socioeconomic intervention.

The overall tone remains one of 'experts' bringing health care advice, duly weighed, back to the people. The report is reticent about the role of patients, citizens and health care workers in participating in change.

It is understandable that, in his overall emphasis on care, Romanow has reflected Canadians' anxieties. But he has done so at the cost of ultimately 'medicalizing' the issues and limiting the scope of needed transformation ♦

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## WAS HOMECARE A HIT OR A MISS FOR ROMANOW?

Roy Romanow has been quick to point out that his 47 recommendations were strategic in nature: aimed at getting us to 2006 with a stronger, and more sustainable, health care system, he decided to target key areas either to stabilize or to initiate. Homecare has been identified as one of the targeted areas to receive part of a recommended \$3.5 billion in 2003-04, and \$5 billion in 2004-05.

Home Care: The Next Essential Service", or Chapter 8 of the Commission's report, outlines the three key areas where homecare must be

incorporated, under the umbrella of the Canada Health Act, as an essential service, rather than the piecemeal offering it has become.

Across Canada, eligibility for homecare varies, the range of services vary, and costs to patients vary, despite the fact that most provinces spend about 4 to 5 per cent of their total health care budgets on homecare services. In addition, costs have risen by an average of 14 per cent per year since 1980-01, compared to 6.1 per cent for hospitals. Obviously, the demand has been growing, as homecare has been used

more and more to shorten, or avoid, hospital admissions, or postpone institutional care for the chronically ill or frail elderly. The Commission refers to a study by Hollander and Chappell, in 2002, as evidence for the cost-effectiveness of providing care in the home.

In order to address disparities and improve access, the Commissioner has identified two urgent actions: including medically-necessary homecare in the Canada Health Act, and creating a Home Care Cash Transfer to support expansion

*(continued on page 11)*

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## WAS HOMECARE A HIT OR A MISS FOR ROMANOW? (continued)

by the provinces. This would be necessary for the first 2 years only, and would be used to introduce services in three priority areas, as a basic “floor” of services, which would be expanded with time.

In his November 28<sup>th</sup> speech, Mr. Romanow spoke passionately about the parts of the Homecare puzzle which require immediate priority: first on the list was support for home mental health care management. Long overlooked, the care of people with severe mental illness, in their homes, makes inherent sense. Among the most vulnerable in our society, people with mental illness are at risk of homelessness, abuse, incarceration, and death. Their care presents challenges that many families are unable to meet. The health care system has failed to provide the flexibility, resources, and capacity for response that mental illness demands. Mr. Romanow has recommended that case-management and mental health treatment be brought into the Canada Health Act as an explicitly defined service in need of funding and provision.

Secondly, the provision of “post-acute” homecare services, including medications and rehabilitation, for a period of 14 days (treatment) to 28 days (rehabilitation), has also been targeted as an immediate priority for funding. This would address both the trend for day surgery and shorter hospital stays, and

the current gap in funding for services or medications usually provided in hospital. Again, Mr. Romanow proposed using the Canada Health Act as the vehicle for ensuring that all provinces and territories participate in the provision of this national programme.

The third priority for Homecare in the first two years is the provision of palliative care to patients in their last 6 months of life. Access to home hospice care is currently only available to about 5 per cent of Canadians. A 1997 Angus Reid poll found that 80 per cent of Canadians would prefer to die at home. Mr. Romanow believes it should be the right of every Canadian to die at home.

The cost for these services is estimated to be \$1 billion. But the true costs of homecare must take into consideration the fact that about 80 to 90 per cent of this care is delivered by unpaid family and friends, most often women. When the time of informal caregivers and unpaid volunteers is factored into the costs of homecare, the true costs are probably between \$20 and \$30 billion per year.

For this reason, the Commission has recommended that informal caregivers should be allowed to take time away from paid employment, without penalty, to care for loved ones, and that the Employment Insurance fund be used to provide benefits for persons providing home care to a patient. Finally, a

responsible and just way to use that surplus! That alone would be worth the price of the Commission’s report.

Part of the fine print in the chapter on Homecare includes recommendations to address issues in human resource planning and in integration and coordination, so that care in the home occurs as part of the continuum of care, rather than a fragmented add-on. This will require more resources both in the hospital and in the community, improved linkages and the improved use of information technology.

This, then, is the Commissioner’s prescription for what to do and how to do it quickly, over the next 2 years, so that all Canadians have access to priority homecare services: Canadians with severe mental illness, Canadians who are dying, and Canadians who require hospital services in the home. In addition, the Commissioner has identified Employment Insurance funds to compensate Canadians who are providing care to infirm or frail loved ones. Finally, the Commissioner has recommended using the legislative powers of the Canada Health Act to ensure that all this is accomplished in every province and territory. It is a minimum. It is still not enough. But it is a way forward and it is possible. Now it’s up to the federal Liberals to do it. ♦

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## THE PHARMACARE PROMISE

**C**atastrophic drugs – We wanted Pharmacare, as proposed by the National Forum and promised by the federal Liberals, and Mr. Romanow has disappointed us in his lack of support for a comprehensive national program which guaranteed prescription therapy to all Canadians requiring medical treatment. Instead, he has recommended a

catastrophic drug plan, despite his own acknowledgment that “the current and potential benefits of prescription drugs are undeniable. But the benefits will only be fully realized if prescription drugs are integrated into the system in a way that ensures they are appropriately prescribed and utilized and that the costs can be managed.”

One of the first casualties of Mr. Romanow’s decision to rely on surpluses rather than recommend more stable and robust funding, is his own unwillingness to recommend the establishment of a Canadian Pharmacare plan. Warning that including prescription drugs in the Canada Health Act would come at too

*(continued on page 12)*

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# THE PHARMACARE PROMISE (continued)

high a cost, Mr. Romanow has proposed the following as incremental steps towards a future Pharmacare:

- The expansion of provincial drug formularies through a cash transfer, the Catastrophic Drug Transfer, so that high cost treatments would be covered for all Canadians in need;
- A new National Drug Agency, to review, monitor and evaluate pharmaceuticals on behalf of all provinces and territories;
- The development of a national drug formulary, by the National Drug Agency;
- The integration of medication management into any primary care reform; and
- The review and revision of patent laws to enable fast and affordable access to generic drugs in Canada.

These five steps are what Mr. Romanow has prescribed, in the interim, to set the stage for Pharmacare.

The reliance on prescription drugs in Canada is astounding: over 300 million prescriptions are filled each year, costing the average Canadian family an average of \$1,210. Increasingly, drugs are used as a substitution for alternative therapies, such as surgery. And yet, despite the benefits, estimates using data from the U.S. suggests that drug errors are the sixth leading cause of death. The Canadian Pharmacists Association estimates that the misuse, underuse, and overuse of drugs in Canada costs us from \$2 to \$9 billion each year.

Access to drugs for the poor and elderly varies considerable across the country, with Maritime provinces providing the least amount of coverage. In addition, drug benefits are not portable, so that Canadians moving to new provinces generally face a three-month period without access to medications. In 1999, Canadians paid 22 per cent of total drug costs, or \$2.3 billion, out of pocket. Provinces insurance plans covered 44 per cent of the costs,

and private insurance picked up 34 per cent of the tab for prescription drugs.

According to Romanow, the relative private to public share of spending of 56 per cent/44 per cent on drugs has not changed significantly since 1985. What has changed dramatically has been the amount spent on drugs: from 5 per cent of the total health care budget in 1980, to 12 per cent, or \$12.3 billion in 2001. It is this increasing cost, rather than the proportion of private funding, which is driving the prescription drug agenda and robbing governments of any desire to assume more costs. That is why the brakes are on when it comes to Pharmacare, despite efforts of groups like the MRG who continue to lobby for universal coverage.

What we don't want, and Mr. Romanow agrees, is extending universality as a trade-off to higher deductibles and co-payments, or limited formularies. Experience from Quebec has taught us that the cost in human suffering is too dear a price to pay. So, instead, the Commission has made its five recommendations. The recommended Catastrophic Drug Transfer would reimburse 50 per cent of a province or territory's total drug costs over a threshold of \$1,500 per person per year. Using Manitoba data to calculate costs, Mr. Romanow has recommended \$1 billion annually for transfer. The Catastrophic Drug Transfer does not appear to have an expiry date.

The new National Drug Agency being proposed would undertake and address Canada's flawed new drug approval process as one of its mandates. Negotiating and reviewing prices for both brand name and generic drugs, currently partially done by the Patented Medicines Prices Review Board, would also fall under the purview of the new agency, as would the bulk-buying of drugs for provincial and territorial formularies.

Post-marketing surveillance, monitoring and evaluation, developing and disseminating evidence-based guidelines, and monitoring patent legislation have all been described as important roles for the new agency. In addition, the new National Immunization Strategy has been given to the drug agency to implement.

Much of the chapter in the report dealing with drugs is devoted to describing the potential work of the new National Drug Agency. Clearly, the Commission sees the establishment of the agency as providing the necessary infrastructure for any future progress in addressing issues in the use and procurement of prescription drugs.

The fifth and final recommendation dealing with drugs addresses the problem with prolonged patent protection as an obstacle for manufacturing lower cost generics. Specifically, the Commission calls for an end to "evergreening", which is the practice, by patent-holders, of prolonging patent protection by making small modifications to the product. Problems with existing patent laws, which lead to costly delays in the introduction of generics, must be addressed, according to Mr. Romanow. And finally, existing gaps in patent protection for genes and DNA are highlighted in the report as requiring urgent attention.

In the past 18 months, Commissioner Romanow has often used the analogy of house building and home renovations to describe the work of securing a future for Medicare. When it comes to Pharmacare, it is obvious that he has been spending his time in the basement, pouring the concrete for the foundations. We can't wait another 40 years to complete construction. ♦



**CENTRAL TORONTO**

Community Health Centres

**QUEEN WEST**

Community Health Centre



**CENTRAL TORONTO COMMUNITY HEALTH CENTRES  
PHYSICIANS: Full time, Contract and Locum Positions Available**

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- Participates in a collaborative model of care with nurse practitioners, other staff and local organizations
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**Qualifications:**

- CPSO registration, CCFP, certificate preferred
- Experience in community medicine and multi-disciplinary team model
- Desire to work with people who are marginalised
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**Salary: \$91,001 - \$123,119**

The successful candidate will demonstrate a willingness to participate in CTCHC's commitment to becoming a discrimination-free health centre and an ability to work interdependently and respectfully in a multi-disciplinary team. Languages other than English are an asset.

Excellent benefit package including same-sex spousal benefits.

To better represent the communities we serve, applications from members of racial or cultural minority groups, First Nations, lesbians and gay men are encouraged.

**Applications are encouraged before January 26, 2003 to:**

**Hiring Committee, Job Number QW27,**

**Central Toronto Community Health Centres, 168 Bathurst St., Toronto, ON. M5V 2R4**

**Fax: 416-703-7832 E-mail: [hiring@ctchc.com](mailto:hiring@ctchc.com)**

*Expressions of interest are welcomed at any time.*

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# ROMANOW GETS AN A

The Medical Reform Group is giving Roy Romanow near-top grades for the central recommendations in his landmark report. “On the key issues of who funds health care, and who delivers it, Romanow has got it right,” said MRG spokesperson Dr. Ahmed Bayoumi. “Romanow not only endorses continued public funding of physician and hospital services, but the expansion of Medicare coverage to home care and pharmacare. On the delivery side, he correctly concludes that not-for-profit delivery gives the best assurance of high quality health care.”

Romanow’s report points out that public funding meets two key policy goals. First, it ensures equitable access to high quality care. Second, because a single

payer system results in far lower administrative costs than private funding, public funding has proven more efficient. “If Canadians understand Romanow’s central points, they will quickly buy in to his funding argument,” said another MRG spokesperson, Dr. Gordon Guyatt.

“While publicly funded pharmacare and home care may result in higher taxes, lower insurance costs and decreased out-of-pocket expenses will more than make up. In the end, publicly funded health care will result in greater disposable income for Canadians.” On the delivery side, Romanow’s recommendation are completely consistent with the evidence. The Commissioner challenged advocates of investor-owned, for-profit provision

to provide data to support their claims. They were unable to meet the challenge.

“In contrast,” said Guyatt, “systematic summaries of studies comparing private for-profit versus private not-for-profit care have shown increased death rates in both for-profit hospitals and for-profit dialysis units. For-profit care is a deadly prescription for Canadians. Romanow has heard the message loud and clear, and has acted accordingly.”

The reason that Romanow missed an A+ grade is that he has backed away from new tax revenue to fund health care,” Dr. Bayoumi concluded. “High quality health care is too important to trust to hit-or-miss budget surpluses.”

*Released November 28, 2002*

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## 2002 FALL MEMBERS MEETING

The Fall Members Meeting took place December 5<sup>th</sup> at the St. Michael’s Hospital Auditorium, when Dr. Robert McMurtry, Special Assistant to the Hon. Roy Romanow, gave a short presentation and review of the Commission and its report, released November 28<sup>th</sup>. Following McMurtry’s presentation, moderator Roana Pellizzari introduced the reaction panel of three—Toronto Star columnist Tom Walkom, health policy analyst Michael Rachlis and Steering Committee member Gordon Guyatt. A lively exchange of opinion ensured between audience and panelists.

Robert McMurtry, until recently Special Assistant to Romanow, led off by speaking about the experience of working on the Commission, which had inserted itself in the lives of Canadians more significantly than any recent public inquiry, for two reasons. Consistent with his own political orientation Romanow framed the work as an expression of Canadian values. Although he put some energy into making recommendations

with some reasonable chance of implementation, he explicitly did not make recommendations on where the money should come from as his approach was that Canadians can afford Medicare, including an enhanced Medicare, if we want to.

Commission by the numbers: over and above briefs and correspondence sent to the Commission, there were 21 days of public hearings, 9 sectoral consultations or round-tables; 12 citizen sessions of approximately 40 persons each organized by the Canadian Policy Review Network, and over 30,000 completed the on-line workbook. In an unprecedented mobilization. The research effort associated with the commission included 40 invited papers and 3 consortia.

His own observations of the “successes”—Romanow can take credit for the demise of private funding as an option, thought there is still some way to go on private delivery. They could have been a little more prescriptive on

definitions, but McMurtry thinks they went further than any previous attempt. He is not clear there is a right answer on re-opening the Canada Health Act, in particular if it adds risks of diluting some pretty effective legislation. He thinks the CHA has by now achieved iconic status, and as such, it is important to make a statement now that we are focusing on modernization on expanding the act beyond doctors and hospitals. (His extended family of lawyers and judges thinks the contention of Health Canada and Senator Kirby that the Act is permissive on the issue of private delivery needs to be tested, and is unlikely to be sustained.) If it is opened, there needs to be a focus on public administration.

The other item on which McMurtry believes Romanow made an advance was on a very specific recognition of the risks of privatizing social programs including health programs.

*(continued on page 15)*

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## 2002 FALL MEMBERS MEETING (continued)

Where the report could have devoted more energy in McMurtry's view:

- **Person-Centred Care:** the commission got a great deal of input from Canadians on how well care was delivered and continuing access issues.
- **Population Health and Public Health:** mentioned but only in passing, and again a lot of input from Canadians on healthy policy, health promotion and the role of the full range of social and environmental determinants of health.
- **On Academic Health Science Centres:** he thinks there is something to the Kirby recommendations, but still need to think seriously about community accountability.
- **Vision:** although the commission exercise was well grounded in Canadian values, and a number of recommendations were quite specific, there was less attention to looking ahead 20 years and considering a blueprint about how to get there.

While he thinks Romanow made some important statements and recommendations, the work only begins now. First ministers meetings and the political agendas of outgoing and incoming PM could derail things very easily

### **THE REACTION PANEL**

**Tom Walkom** addressed mainly the issue of where the report can and should go politically in the next year or so. He is concerned that without a way to maintain popular momentum, not much will happen. He summarized the critical response to the commission report in the following terms:

#### ***Criticisms that are not that important***

- silence of the report on where the money will come from. This is not usually part of the mandate of a public inquiry. Although he is criticized

by Kirby and others on this issue, it's probably easier not to complicate.

- silence on specific recommendations about how to curb private delivery—this may be a strength in that it will prevent sandbagging by premiers.
- silence on teaching hospitals and staff shortages in health human resources. \$6.5 billion will address a lot of staff issues, and he has made a number of more specific recommendations around primary care, home care and pharmacare that set some of the goal posts.

#### ***What is important about the recommendations***

- The addition to Canada Health Act of home care and possibly pharmacare. At this point historically, it is important to have people and governments appreciate Medicare as more than doctors and hospitals.
- Take on the drug companies; although he dodges and weaves and throws a few bones, but does take serious aim at the patent laws and international trade agreements.
- The funding formula. This exercise IS about money and the return to an automatic escalator and dealing with health as a dedicated transfer will do a lot to restore public confidence about accountability. On the other hand he thinks the Canada Health Council is a snoozer.

**Michael Rachlis** referred the audience to his website at michaelrachlis.com. In his view, there are two recommendations that reduce the for-profit market—including diagnostic tests as medically necessary and bringing WCB clients within the Canada Health Act.

He thinks that it is now safe to open the CHA as there is a weight of popular support for it, which did not exist before, and that an expansion of the CHA covenant with Canadians to cover more

than doctors and hospitals will be an important component of the modernization. Rachlis has some concerns that there is no mention of long term care, and that home care is recommended only for limited situations. He also has little use for the proposed Canada Health Council and the prospect of a more extensive CIHI. He would rather see something like a Chief Medical Officer for Canada.

As far as Rachlis is concerned, one of the best features of the Romanow report is that it will be very difficult to cherry-pick the recommendations—each can be implemented on its own and advance Medicare. His evaluation is that the report represents cautious steps in the right direction and that we need to work diligently to make all Canadians equally literate in economics, referring specifically to Jim Stanford's assessment in a recent Canadian Centre for Policy Alternatives bulletin of a minimum surplus in 2002 of \$16 billion without any tax changes.

**Gord Guyatt** began his reaction by noting the importance of the report in that, for the first time in 15 years, it puts social justice advocates on the offensive. More than any other recent exercise, he believes that Romanow started from a position of genuine uncertainty about the right direction, and concluded from evidence that publicly funded health care, and not-for-profit delivery, is more efficient and effective.

To take advantage of the initiative Guyatt advises that, since we are going to spend the money on health one way or another (wasteful private spending or more efficient public spending) we should characterize the \$15 billion not as what health care will cost, but as a way of saving.

On delivery, Guyatt recommends we follow the lead on language of PJ Devereaux who advises that the distinction is between investor-owned for profit and not for profit, not public and private... ♦

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# GETTING PRIMED FOR THE 2003 FEDERAL BUDGET

*The best laid plans of Medicare supporters need to include an aggressive approach on the federal budget which will be delivered early in the new year. We have witnessed a great deal of sparring in the final days of 2002, between federal and provincial protagonists, between supporters and critics of the Romanow recommendations. Economist Armine Yalnizyan, recently awarded the first Atkinson Foundation Fellowship in Economic Justice, shared with us some of the analysis she is preparing for broader dissemination.*

*The first item is an op-ed first published in the Toronto Star on December 21, 2002. The two fact sheets which follow are also posted on the website of the Canadian Centre for Policy Alternatives. Reproduce and share them with friends and neighbours and encourage them to seek assurances from federal and provincial legislators to summon up the political will required to meet the promise of the Romanow report.*

## MESSAGE TO MANLEY: THE CUPBOARD ISN'T BARE

Armine Yalnizyan

For the last 18 years I've fought alongside countless Canadians to protect the least advantaged members of society from losing the little they have.

In the mid 1980s, after the most profound recession since the Great Depression, we fought for full-employment policies, and lost.

In the late 1980s we fought to improve training opportunities for the unemployed, and lost.

In the early 1990s we fought to prevent cuts to unemployment insurance benefits and welfare, and lost.

In the mid 1990s we fought to preserve social housing programs, and lost.

In the late 1990s we fought for sufficient investment in core infrastructure to assure clean water and affordable electricity, access to community centres and libraries, and lost.

We lost every time because the counter-argument was "the cupboard is bare".

To my dismay, the fight has now turned to securing the future of public health care, the social program most treasured by Canadians. And the reason that we are struggling to assure everyone's access to this most quintessential human right – timely, quality health care – is again because "the cupboard is bare".

That line is not as credible as it once was. Not when you have \$20 billion in

tax cuts this year from the federal level and another \$20 billion at the provincial level. Not when unanticipated and planned surpluses in the federal budget since 1997 have devoted almost \$47 billion to one purpose only – paying down the debt. Not when the inflation-adjusted size of the economy is two-thirds bigger than it was in the early 1980s.

The fiscal basics are there to protect health care. But it will take a critical combination to ensure we win this fight: more money; targets for common/national objectives for improvement; public ways to monitor progress; and the political champions who will push this agenda forward.

The meeting of Canada's Finance Ministers in mid-December certainly was not a promising start. The feds are low-balling the amount of money needed to relieve the pressures on the system. The provinces are refusing to accept money tied to conditions of any kind.

That federal Finance Minister Manley maintains the cupboard is bare is no surprise. The November 2000 election was called primarily to determine what should be done with the emerging surplus. Former Finance Minister Paul Martin laid out the path: the books would be balanced by a major commitment to tax cuts and debt reduction. The point was to make the cupboard bare.

That line of thinking was first scripted in the 1995 budget, when Martin set out to "redesign the very role and

structure of government itself". The stated objective was to make the federal government as small as it was in 1951. Today, it is smaller than it was in 1949.

Back then, we didn't have Medicare. In 2003, we won't be able to afford Medicare if the goal of our elected representatives remains small government at any cost, including the loss of quality public health care. This is a matter of political choice, not fiscal capacity.

We need at least \$3.5 billion next year, and rising with every subsequent year, to prevent rapid erosion of public health care. The \$3.5 billion is Romanow's price tag, and it is likely too modest, given the pressures on the system. We also need better systems of public accountability about how the money gets used. Here's why.

In September 2000 the federal government agreed to hand over more than \$21 billion over five years to the provinces in new cash for health care, with virtually no strings attached. Two years later, nobody can identify how these re-investments are making the system work better. People are still talking crisis. So clearly more money, alone, is not the answer.

We need clear targets for improvement, with commonly accepted objectives, and an ability to publicly monitor progress. Otherwise

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## MESSAGE TO MANLEY: THE CUPBOARD ISN'T BARE (continued)

public health care will simply be seen as the monster that ate everybody else's lunch – be that investment in housing, education, clean water, or [insert your favourite cause here].

More importantly, if the feds insist that the cupboard is bare, the provinces will be left to deal with the pressures as best they see fit. This has inspired some provinces to turn to private investors to provide the money to for expanded capacity in buildings and equipment.

Evidence cautions us that such policy drift may risk the quality and access to medically necessary services; or make the public system too expensive to keep running at the present scale of service. In either case, you can kiss the principles of Medicare good-bye.

Let's be clear: the feds are signaling they may be prepared to let Medicare slide to meet a fiscal agenda based on tax cuts and debt reduction.

So why did the federal government even bother to put Romanow on the road?

First of all the cupboard is not bare. Secondly, the public has clearly and repeatedly said they are willing to pay more taxes to invest more in health care if they get their money's worth. With or without a big surplus – which could and should be used to address other critical issues – the public has said they want the necessary investments made to protect and secure the future of public health care.

Minister Manley and the Prime Minister are thus far missing the mark. Canadians are looking for federal leadership to implement the modest, do-able plan Romanow laid out for health care. The last thing taxpayers want is more federal-provincial infighting, and lack of meaningful action.

Medicare stands as a crucial test of our elected representatives' willingness to work towards common cause, as a nation, rather than go in thirteen different directions. It's time both sides grow up – or witness, at their hands, the slow death of public health care.

Universal access to health care is good for everyone. Strengthening Medicare is key to the Canada we want. This is a fight that we must win. ♦

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## BEYOND ROMANOW: WHY \$3.5 BILLION IS NOT ENOUGH

**M**uch has been made of Alberta and Quebec's rejection of the Romanow report's recommendations as an intrusion into provincial sovereignty. But the Premier of Ontario, Ernie Eves, named the real challenge: the success of these recommendations depends on whether enough cash will be provided to implement them.

Given the political consensus that more money is needed, the most critical issue will be how quickly Ottawa ramps up to renewed levels of federal commitment, and how willing the provinces are to work with the feds to make this a reality. Provinces are moving now to deal with the immense pressures on public health care and the public purse by turning to private sector investors and by de-listing publicly insured services and drugs. This isn't an academic exercise. The provinces are moving now. It's time for the feds to act. The speed and scale of an increased federal role matters.

For years Ottawa's share for health care has been dropping. From a high in the early 1970s of about 38 per cent, the federal government's cash contributions to provincial spending for public health care fell to 10 per cent by 1998. Today it is estimated to stand at about 16 per cent—less than half of what it used to be. But the provinces have compounded the problem: this year alone they gave up \$20 billion in revenues due to tax cuts, money desperately needed to sustain public services such as health care.

Romanow's recommendations are widely viewed as the pragmatic and critical first steps in securing public health care and guarding against rapid erosion towards a direct-pay commercialized system. He wants the feds to unilaterally increase funds for health care by \$3.5 billion next year, rising to \$6.5 billion a year by 2005-6.

Clearly, this represents a substantial increase in health care spending. It will buy some breathing room for public

health care. But it is not enough to tackle today's pressing demands on the system, let alone leverage real change in how we do things.

Taken together the provinces and territories are forecast to spend about \$74 billion on public health care this year, an increase of \$4 billion over the previous year, which is the smallest increase since 1998. An extra \$3.5 billion in federal contributions won't stretch very far. In fact, a lot of pressing needs will remain unanswered.

Both the Senate Committee report and a backgrounder for the Romanow Commission recently suggested that the protection of public health care required a much higher infusion of cash immediately from federal coffers. Like Romanow, Senator Kirby's report calls for an extra \$6.5 billion in federal cash transfers to the provinces in order to secure the future of public health care (\$5 billion in new initiatives paid by new

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# BEYOND ROMANOW: WHY \$3.5 BILLION IS NOT ENOUGH (continued)

taxes, \$1.5 billion from reallocating existing revenues to doctors and hospitals). The difference is, Kirby says the \$6.5 billion is needed right away, while Romanow recommends starting slowly and building to \$6.5 billion in three years.

Romanow is clearly playing it safe by starting at \$3.5 billion and hoping for political consensus. Remarkably, even that modest figure hasn't been embraced by the Finance Minister or the Prime Minister. Any increase is a move in the right direction, but this amount is not nearly a big enough deposit to secure the future of public health care. Here's why.

## ***Not enough to relieve the pressure: Supply issues come with a big price***

Provinces are facing built-up pressure to expand the supply of health services. Whether it's buying more MRI and CT scanners or creating more acute or long term care beds, they are reluctant to take on large scale investments through the public purse. In an effort to keep a lid on public spending, governments are increasingly turning to private investors to supply the capital. But this approach comes with a price: it can lead to more commercialized health care (meaning access to services may depend on cash, not need) or it can simply drive up the costs of delivering these services publicly.

Romanow responded to these pressures by proposing a Diagnostic Services Fund, a two-year \$1.5 billion program. That gives the provinces \$750 million to split between them next year for equipment and people to run the equipment.

At over \$26 billion, the government of Ontario's spending on health care is up \$8 billion compared to 1995, and Premier Eves states that it now takes up 47 per cent of the provincial budget.

In its latest round of expansion (2 new hospitals, 20 more MRI and 5 more CT scanners) Ontario is turning to investors, financiers who expect to see a return on their investments. That return

comes in two forms - leasing arrangements and using the equipment after 35-40 hours of medically necessary services per week to charge for "uninsured" (not medically necessary) services.

Is the \$750 million enough to relieve the pressures the provinces face? Is Romanow's prescription enough to prevent further deterioration of public services and commercialization of public resources?

## ***The Price of Progress***

- One MRI costs \$1.5-2.5 million.
- A CT scanner costs between \$1-1.8 million
- A PET/CT scanner (the latest, most efficient merger of imaging technology) costs \$3-4 million.
- Building the lead-lined room that houses the radiation-emitting CT scanner costs \$300,000.
- The specialized construction materials that are used to accommodate the highly sensitive magnets in an MRI raise the building costs to \$500,000 per machine.

MRI and CT scanners account for less than 10 per cent of diagnostic exams. The Canadian Association of Radiologists points out that about half of all radiology equipment is outdated across the country.

## ***Case in Point: Ontario***

The Ontario Association of Radiologists (OAR) recommends the purchase of 35 CT and 51 MRI scanners to deal with the waiting list problem. It estimates capital costs would be \$225 million, and a further \$75 million to staff the machines. A study by the OAR found that 24,000 pieces of radiology equipment were outdated. The replacement cost? \$760 million. It's safe to assume old technology will not be replaced by old technology. Rather, MRIs, PET/CT scans and emerging technologies will be used to replace and

expand diagnostic services more efficiently. But moving towards greater efficiency relies on investments made today. The money needs to come up front.

## ***Not enough to buy change now: How quickly \$3.5 billion gets absorbed***

For six of the provinces' and territories' health budgets, capital spending was the fastest-growing category last year. It reflects the provinces' move to expand the supply of facilities and equipment in the system. But expanding the system relies on having enough people to do the job.

Labour shortages—in part the result of almost a decade of policy reversals in the system—are driving up the costs of keeping the doctors and nurses who are currently working in public health care. Many provinces are still adding staff after drastic cost cutting that wound up costing taxpayers more than they saved. Other elements of the system relentlessly drive costs too. The growing use of drugs to treat, manage and prevent conditions is a long-term trend in health care. Aging of the population, and reductions in hospital stays, are increasing the use of paid services and facilities in the community.

Viewed by itself, the initial \$3.5 billion appears to be a massive new increase in spending. Viewed in the context of the sheer scale of the system, its cost-drivers, and public demand to expand the supply of services, it's not nearly enough. Provinces are starting to commercialize now, claiming inadequate public funds for needed expansions. This seriously jeopardizes the future accessibility of Canada's public health care system.

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## BEYOND ROMANOW: WHY \$3.5 BILLION IS NOT ENOUGH (continued)

### *Follow the money: Where did it go?*

Collective agreements signed across this country contractually bind taxpayers to increase payments to health professionals by at least \$800 million a year for the next two or three years. This problem will not go away in the next five years. Provinces face tremendous competition to find ways of staffing up, or lose quality staff to other jurisdictions. These increases are a way of hanging on to quality and experienced staff, without whom public health care suffers.

Spending through provincial drug programs rose by \$400 million last year, and that was the lowest rate of growth in many years. Drugs represent one of the biggest cost drivers in the system. Many provinces are seeing the growing use of institutions other than hospitals, such as residential long term care facilities. Those costs grew by \$560 million last year alone. With an aging population, the need for more long term care is sure to increase in the years to come, whether

through home care or facilities based care.

### *Passive-aggressive privatization*

Money, whether public or private, is the key to accessing health care. Public health care makes access a right of citizenship, at least where doctors and hospitals are concerned, by adequately funding these services through our tax dollars. Romanow validated this position in his report, accurately reflecting the concerns of most Canadians. As Romanow says, it's double solidarity: between the rich and poor, and between the sick and the well.

Commercialization of health care services erodes the principles of universal access in two ways. It siphons off labour that is already in very short supply from the public system, making the public waiting lists longer. And, by aggravating the shortages, it creates more pressure for those with more money to demand the ability to jump the queue—moving

ahead of people with greater medical need—simply by virtue of their ability to pay.

If the federal government balks at providing quick and significant expansion of federal transfers, the fix is in: public health care will keep shrinking under the force of passive-aggressive privatization. Universal access to medically necessary services will turn into a guarantee to wait if you have no money.

It's time for decisive federal action. Without hesitation, the federal government has found \$100 billion for tax cuts, \$46.7 billion for debt reduction and \$7.7 billion for security measures in the last few years. Though the provinces need to take responsibility for health care too, if clear federal commitment, backed by real hard cash, doesn't kick in soon, a fast-eroding medicare system will be the ultimate security issue for Canadians. ♦

*Armine Yalnizyan is the author of the forthcoming book *Paying for keeps: Securing the future of public health care in Canada*, to be published by the CCPA.*

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## ACCOUNTABILITY: WHY STRINGS NEED TO BE ATTACHED TO HEALTH CARE DOLLARS

**N**ow that there is emerging consensus that Canada's public health care system needs a serious cash injection, it's time to talk about the next cure for what ails us: accountability.

If the provinces had their way, the federal government would wire them more cash without a single string attached — and that's a problem.

The recent debacle of the Medical Equipment Fund serves as the ultimate case in point. Half of the \$1 billion Medical Equipment Fund that came out of the landmark September 2000 federal-provincial agreement remained untouched. Most of the money sat in

trust funds. Some of that money could not be accounted for — nobody knew where it went.

Even when the provinces used and accounted for the money, the records show they did not necessarily use the fund for its intended purpose.

In New Brunswick, the fund was used to purchase lawn tractors, icemakers and floor scrubbers in hospitals, equipment that was not geared to either diagnoses or treatment.

In Ontario, large for-profit chain operators of long-term care facilities have received grants for the purchase of inventory such as specialized beds and bathing equipment. Public money has

provided grants to investor-owned firms to purchase diagnostic equipment that could be used "after hours" to generate a profit.

On December 12th, CBC TV revealed that Ontario granted about \$9 million to Diagnosticare, a company that was going to shut down operations when their 15 per cent profit margin did not match their corporate goal of 23 per cent rate of return.

Flush with the new publicly-paid investments, the company's assets were subsequently purchased by another for-profit chain, Canadian Medical Laboratories. Diagnosticare shareholders

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# ACCOUNTABILITY: WHY STRINGS NEED TO BE ATTACHED TO HEALTH CARE DOLLARS (continued)

saw the value of their stocks rise from 12 to 13 cents a share before the public grant, to 35 cents after the grant. The purchase was at 60 cents a share.

What happened in Ontario and New Brunswick serve as two prime examples of why accountability needs to be structured into any new funding agreements for health care.

## ***Accountability — the real meaning of fiscal responsibility***

The sting of the Enron and Worldcom cases and, closer to home, the Canadian blood scandal has been chastening. People now expect greater transparency from large organizations, public or private. Governments top that list. Taxpayers are paying the bills for health care. They want to know — and in a democratic system they deserve to know — how that money is being spent.

As the Romanow Commission validated, the public is indeed willing to spend more for health care, but they want to make sure more money buys real improvement. Increased political cynicism and heightened public scrutiny means, now more than ever, that public spending is subject to the “value-for-money” test.

Accountability matters, now more than ever; yet the provinces have been rejecting efforts to build accountability into the health care funding mechanism. They have aggressively lobbied for “flexibility” in their use of cash transfers from the federal government, such as block funds or targeted funds.

Claims of fiscal responsibility from both levels of senior government will ring hollow if they are not accompanied by a quick readiness to be responsible and accountable to those who pay the bills, the taxpayers.

## ***Targeted funds...or targeted objectives?***

Accountability is not the only sticking point in the federal-provincial discussions

on how to secure the future of public health care. The provinces are also rejecting targeted funds, money dedicated to priority areas for improvement of public health care.

New Brunswick’s criticisms of targeted funding are hard to dismiss. That province is at the head of the pack with respect to the per capita availability of advanced diagnostic equipment. New Brunswick does not need more equipment, but there are many other areas of health care that can be improved in that province. If New Brunswick didn’t take up targeted funds for diagnostic services because they had already made appropriate investments, would it be frozen out of access to an equivalent amount of cash? Just because it is ahead in one area, it would be indefensible if New Brunswick lost out on scarce resources for other priorities, such as primary care reforms or training for health care workers. Clearly, some flexibility is needed.

But generally, the argument — provinces need more flexibility to address their priorities than funds “with strings attached” will permit — only passes muster if it meets three tests:

- 1) Minimum standards or targets for priority areas have already been met;
- 2) Incremental funds only go to health care; and
- 3) There is documentation to show the first two conditions have been met.

Is the issue targeted funds or targeted objectives? Those who have described health care as a sink hole are simply observing how easy it is for huge quantities of money to be absorbed by the sheer scale of this system, showing little improvement in quality or timeliness of service. More money alone is not enough to assure improvement.

## ***Comparable standards***

The Canadian public has a right to expect a set of common standards since it is supplying a common level of

resources across the country. Federal taxes are the resources in question. If consistency of service throughout Canada is a goal, public health care needs to be funded centrally. That means nationally raised cash, for national purposes.

The clash between the sovereignty and equalization cultures needs to be resolved. The alternative is to give provinces the tax points and let the system devolve into thirteen definitions of public health care, based on public and private ability to pay. That is what Canada has been moving towards, and that is clearly what the Canadian public has rejected.

Comparable standards are at the very heart of what this debate is about. Without them, there is no rationale for any federal funding. Indeed, the unanimously supported principles in the Canada Health Act require funding from the centre to achieve common — or at least comparable — standards of quality service and access for all citizens. That is what Canadians are paying for, that is what they expect, that is what they want.

## ***Value For Money — Why we need cooperation and coordination***

The best way to assure greater value for money and control costs is through a single payer system. Key to achieving the improvements possible through a single payer system is better coordination and planning — difficult, but not impossible, to achieve among 13 jurisdictions.

It may be assumed that there is no political will for such cooperation, given the fractious nature of federal-provincial talks over funding. But there is already plenty of evidence that the feds and the provinces are able to negotiate successful deals when they both come to the table ready to make it work.

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# ACCOUNTABILITY: WHY STRINGS NEED TO BE ATTACHED TO HEALTH CARE DOLLARS (continued)

In 2003, the Common Drug Review will be initiated — a hallmark of federal-provincial coordination, cooperation and trust announced in September 2002.

The review promises to streamline the process of clinical evaluation of the effectiveness of new drugs and examine their cost-effectiveness, necessary but costly steps for every province, all of which are pressured to add drugs on the formularies of their provincial drug plans. This is an important step towards ensuring the most efficient formulary possible, from both cost and health outcome perspectives. It also moves us a step closer to the greater efficiencies of a national formulary, with the potential for reduced costs through bulk buying.

Another process underway, again coordinated by the federal government, focuses on a review of human resources issues in public health care. It attempts to accurately assess needs for doctors and nurses both in terms of numbers and distribution. This is key to ensuring thoughtful and appropriate investments in such areas as: expanding education and training opportunities, increasing opportunities for skills upgrading, and improving the accreditation system for existing health workers who reside in Canada.

While individual provinces are also moving on these issues, a coordinated approach will pay off in two ways: 1) it will help identify systems and strategies for dealing with regional bottlenecks that are caused by inadequate allocation of health human resources; and 2) within five to 10 years, a reduction in the sharp rates of increase in pay that health professionals can command during periods of labour shortage — both the current global one, and regionally specific pressures.

## ***Achieving priorities — does the end justify the means?***

But coordination and cooperation, key as they are to a more effective system,

will not suffice. Targeted funds identify priority areas where improvement must occur — the same priority areas that have consistently been identified by Romanow, Kirby, and the provinces themselves.

Targeted federal funds simply provide an infusion of resources to achieve commonly held goals for improvement.

Without strings attached to public resources, access to public health care will remain in jeopardy — not abstractly, not in some distant future, but now, in homes, waiting rooms and emergency departments across this country.

Chronic supply shortages of doctors, nurses, technicians, equipment and beds in the public system have led to waiting lists — sometimes with devastating consequences. One critical dimension of these shortages is poor geographic distribution of resources, especially in non-urban areas.

Instead of dealing with these shortages and expanding public or not-for-profit service provision, some are agitating for more rapid access through expansion of services provided by investor-owned facilities. These facilities provide a return to the investor by accommodating a tier of paid access for services that are not “medically necessary” or by leasing arrangements in return for capital expansion.

Three provinces (Ontario, Alberta and B.C.) are moving rapidly in this direction, while others are more circumspect. All provinces and territories are dealing with huge pressures on tight public treasuries and growing demand.

The first backgrounder in this series argued why the Romanow recommendation for \$3.5 billion in increased federal cash for 2003/04 was not enough to secure the future of public health care. It must be said that it is not clear how much money would be enough given current pressures. The point is that more money alone is not enough.

## ***Money alone is not enough***

Pharmatherapy continues to be the fastest growing area of health costs, due to rising utilization and increasingly expensive prescriptions, but new issues are emerging too. Diagnostic tools are used for pro-active and defensive reasons as well as medically necessary treatment. The medical profession is also agitating for richer compensation, though the impact of that compensation on increasing supply is not clear.

An expanded public purse provides undeniable opportunities for some suppliers of health-related goods and services to make big money. It is very easy to spend a great deal more on new technology, drugs, infrastructure or salaries. It is far more difficult to prove whether that is the best buy for improving peoples' health in specific and Canada's public health care system in general.

As the misuse of the Medical Equipment Fund amply illustrated, more money, even when directed through targeted funds, may or may not yield improvements. If the objective is to buy improvements and greater efficiencies, Canadians deserve to be shown what their money bought.

If it is deemed more fruitful to let provinces specify how they will use their share of the “improvement” transfer over the next two years, two issues need to be addressed: What if individual provinces do not move to improve access or timely service in key areas, such as rural and remote service or primary care reform? How would we know if they did?

## ***Following the money***

The point is that some form of accountability is required. That means that strings must be attached to money that is transferred to the provinces. The strings should ensure minimum standards are met and improvements are made to

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## ACCOUNTABILITY: WHY STRINGS NEED TO BE ATTACHED TO HEALTH CARE DOLLARS (continued)

the system. Provinces must be required to document how money was used to achieve commonly held goals and objectives, including an assessment of the improvements the incremental funds bought.

The provinces have already agreed to file annual reports based on common criteria. The first ones came out in September 2002, but are only available on a province by province basis and do not highlight the incremental changes that were achieved with the incremental funding.

That such documentation should be filed in a national repository, like CIHI, is not an affront to provincial sovereignty. It allows cross-jurisdictional comparisons, an instrumental aspect of assuring greater value for money to citizens in every province and territory. Following the money helps avoid another round of claims that billions of dollars

achieved nothing, as some commentators have suggested in the aftermath of the September 2000 agreement.

The provinces understand: Without conditions and limits there is no way to contain costs. Without some techniques of accountability, the single-payer system is reduced to a grossly inefficient funding mechanism, feeding bottomless corporate, institutional and professional appetites without necessarily assuring accessible quality health care.

Without more money it is impossible to make the investments needed today for more efficient and well functioning public health care tomorrow. More money is critical at this stage; but more money, by itself, is not enough.

Health care costs will be rising on the private and the public sides of the ledger for the foreseeable future. Only the public side has the capacity to account for rising costs in a clear and comparable

manner. Only accountability — true strings attached to federal funding — can assure Canadians that when it comes to more health care spending, they are getting their money's worth.

Accountability means national standards and objectives are tied to national cash...and vice versa. Accountability means both levels of government are accountable to citizens, to assure quality service and value for money.

Accountability is the cure for what is ailing public health care, and the way to ensure a strong, secure system is there when we need it. ♦

*Armine Yalnizyan is the author of the forthcoming book *Paying for keeps: Securing the future of public health care in Canada*, to be published by the CCPA.*

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## AUDITOR'S REPORT WAKE-UP CALL FOR LAX LIBERALS

**T**he Medical Reform Group called today on the federal government to finally address violations of the Canada Health Act. "The Auditor-General's report is very clear," said MRG spokesperson Dr. Rosana Pellizzari. "She was able to identify 21 reports of violations that remain unresolved. It is likely there are more violations that remain unreported. If the federal government is serious about maintaining the principle of equal access, they have to finally take some action."

The Canada Health Act gives the federal government the power to withhold funds from the provinces if they allow direct charges to patients for necessary health services. The federal

government has seldom exercised this power.

"The Auditor-General's report notes reported violations in every province," said another MRG spokesperson, Dr. Ahmed Bayoumi. "The most serious violations of which we are aware are occurring in British Columbia and Alberta where patients are paying to jump the queue for MRI scans."

In June, 2002, the MRG wrote a letter to federal health minister Anne McLellan, asking for clarification of federal policy. A report in the Toronto Star suggested the federal government had made a deal with the provinces in which they would not define prompt access as necessary care, thus allowing for

the MRI queue-jumping. The Minister has not yet responded.

"Continued stone-walling is not acceptable," said Dr. Pellizzari. "Roy Romanow has found that Canadians continue to value equitable access to health care. The federal government presents itself as the champion of Medicare, but continues to violate the public trust. The Liberals hypocrisy is blatant. If the federal Liberals want to reputation as defenders of Canadian public health care, they have to earn it with prompt and decisive action." ♦

*Released October 9, 2002*

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# TORIES IGNORE LOCAL INPUT ON PRIMARY-CARE REFORM

**T**ony Clement, Ontario's Minister of Health, has called for an "open and honest" debate about health care. At the same time, Mr. Clement withheld an important report that could improve health care in Ontario. Why this contradictory behaviour? Primary care reform is a major health care issue that has been simmering on the back burner for twenty years. By primary care, we mean the first health care provider people consult when they have a health problem. For most of us, that's our family doctor. Depending on the problem, though, the visit could potentially be with a nurse practitioner, social worker, or dietician.

That description of primary care highlights its first big issue. Who should be in the front line seeing the patients? Traditionally, the family doctor, operating as a solo practitioner or part of a small group, may have a nurse to help run the office, screen patients, take blood pressures, and draw blood samples. Otherwise, the doctor runs the show. But that's not the only way to organize primary care. In an alternative model, the doctor is part of a team that includes a nurse practitioner, a social worker, and other health workers such as a dietician or occupational therapist. Nurse practitioners, a key player in the model, can deal with many of the problems that, in traditional practice, the doctor handles. These include management of chronic problems such as diabetes and high blood pressure, care of the healthy newborn, and patient education around issues such as stopping smoking.

A second key aspect of primary care reform is monitoring quality of care. For instance, the primary care team can keep track of whether patients have received needed preventative services (such as flu shots, or cervical cancer screening). A related issue is attention to broader influences on health including, for instance, housing, social isolation, and

language and employment skills. These issues are particularly important in communities that are poorer, native, or largely newly immigrant. Payment mechanisms represent a third important issue in primary care reform. Most primary care physicians in Canada are paid on a fee-for-service basis every time they see a patient.

Primary care reform plans suggest physicians be paid through capitation, in which they receive a set amount for each patient, no matter how many times they see the patient in the course of a year. Another option is to pay doctors a yearly salary. Ontario has 55 community health centres (CHCs), including two English-language CHCs and a French language CHC in Hamilton. CHCs capture three major elements of primary care reform: multi-disciplinary care, commitment to a broad definition of health services, and salaried payment of employees. Typically situated in poorer communities and run by community boards, the CHCs employ salaried physicians as part of a multi-disciplinary team.

Over 100 Ontario communities have expressed interest in sponsoring a CHC. But since the Conservatives took over in 1995, the government has approved only two new centres. Not only that, but CHC workers have not had a raise since 1992. As a result, even existing CHCs are in danger. In May of 2001, the Ontario Ministry of Health received the final report of a strategic review of CHCs. The review, which the Ministry had commissioned, was extremely positive about the accomplishments of the CHCs, and their service to Ontario communities. The report recommended major expansion of CHCs, with new resources to bring salaries to competitive levels.

What was the Ministry's response? First, they buried the report for 14 months. When they did release the report, it was on the Friday before the July 1st

weekend when most Ontarians, including opposition MPPs who had been asking for the report for a year, were heading off for the long weekend. There was no press release, and the Ministry didn't even inform the authors of the report, or the centres themselves, that the document was finally public. Since its release, there is still no hint of action in response to the report's recommendations.

Why are the Tories so opposed to the CHCs? The CHCs are a model of community involvement in health care, with the community boards playing a major role. The CHCs explicitly recognize that health care is only one determinant of how healthy we are, and that poverty, unemployment, poor nutrition, and inadequate housing are major causes of ill health. As a result, CHCs include programs addressing these issues. But community involvement has given this government nothing but headaches. Last year, the public boards of the Community Care Access Centres that run home care in Ontario banded together to let the public know that the budget constraints planned by the government would mean major cuts in home care. Their predictions have come true. The Tories responded by eliminating the elected boards and replacing them with their own appointees.

Now, at least three elected boards of education in Ontario have refused to toe the Tory line on education cutbacks. Again, community governance has proved a problem for the government. On top of that, government policies of cuts in welfare payments and a freeze on public housing have just compounded the health problems related to poverty, homelessness and inadequate housing, have to wait for a change in government ♦

*(First appeared September 20, 2002 as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

# HARPER OR ROMANOW, WHO'S THE REAL DINOSAUR?

If that is where his report is going to go, it should be filed as an exhibit in Jurassic Park.” That’s what Alliance leader Stephen Harper said about Roy Romanow’s speech of October 16. Romanow’s talk gave a clear indication of the recommendations that his report, due at the end of November, will include.

Given that Romanow is the Commissioner charged with setting directions for Canada’s health care system, the speech was big news. What did Romanow say that led Harper to call him a dinosaur? The key issues in the health care debate boil down to how we should pay for health care, and who should deliver that care. Romanow’s speech indicates that he believes that public funding of physician and hospital services has been a success. Such a success, in fact, that he will recommend extension of federal funding to drugs and home care.

One reason Romanow considers public funding a success is because it achieves a goal that Canadians value highly. According to Romanow, we believe “that people should have equal access to care, and that medical need should be the only criterion governing who should be tended to first.” Mr. Harper doesn’t think so.

The Alliance is attracted by a private pay model that already allows queue-jumping for MRI scans in a number of Canadian provinces. Those who can pay get the scan first. Afterwards, they get the surgical or medical treatment indicated by that scan, while those who can’t pay are still waiting in line. Mr. Harper believes that Canadians are ready for a change, that the values Romanow represents are a thing of the past.

Perhaps he is right.

Canadians used to believe in sharing, in a society that made sure that the basic needs of all our citizens were met. Maybe

those values belong to a different age. The last 10 years have seen cuts in unemployment insurance, welfare benefits, and a shut-down of public housing programs. In Ontario, cuts to education have damaged the public system so badly that the number of children in private schools has more than doubled since 1995.

Canadians have seen increased user fees for everything from public swimming pools to prescription drugs. These policies have resulted in rises in homelessness, the number of children relying on food banks, and increased differences in wealth between rich and poor Canadians. Looking at these patterns, one might forgive Mr. Harper for concluding that the universal health care that Mr. Romanow advocates will share the fate of the brontosaurus.

There is another part of his speech, however, in which Romanow undoubtedly leads, and Harper lags. From the beginning of his work, Romanow committed himself to recommendations based on evidence rather than ideology. The Commission has released dozens of reports summarizing what we know about health care funding and delivery.

While Harper pushes his case for private health care through rhetoric about out-of-control health spending, Romanow’s speech included the facts. Publicly administered health care has not only ensured equitable care for Canadians, it has also been responsible for limiting spending. In 1992, we were spending 10 per cent of our gross domestic product (GDP) on health care. The figure is now 9.4 per cent. Health care is more, not less affordable, than it was a decade ago.

Why is it so clear that single-payer public funding is responsible for cost control? First, in the areas of single payer, hospital and physician services, we are

spending no more per citizen than we were a decade ago. Drug costs per person have, on the other hand, doubled. Most of the funding for drugs is private, and payers include insurance companies, employee drug plans, and individuals.

Even more compelling is comparison with United States, which has mixed private-public funding in all areas of health care delivery, and spends 14 per cent of its GDP on health care. Comparison with the US tells us that in terms of avoiding administrative waste, the Canadian single payer system is spectacularly efficient. Canadians pay an average of \$325 on health care administration each year, Americans \$1,150.

Romanow’s speech explains the difference. “Private insurance systems spend a lot of money on the extensive infrastructure required to deal with multiple insurance companies, assess risk, set premiums, design benefit packages, review claims and reimburse beneficiaries.” He could have added the profits that insurance companies take out of the system.

Single payer systems are free of all these costs. If Romanow recommends extending single payer to prescription drugs and home care, it will be on the basis of evidence of efficiency and equity.

If evidence-based health policy is the way of the future, Harper is also behind the times in advocating for an increasing role of for-profit health care delivery. A systematic review of American studies from our research group at McMaster showed higher death rates in for-profit than not-for-profit hospitals. American studies also demonstrate that for-profit hospitals are no cheaper, and may be more expensive.

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## HARPER OR ROMANOW, WHO'S THE REAL DINOSAUR? (continued)

So, whose policies really belong in Jurassic park? Polls consistently show that Canadians prefer high quality health care to tax cuts. Furthermore, Mr. Romanow's public consultations suggest

that Canadians still value high quality care for all of us. Finally, even the conservative-leaning Kirby Senate report has recommended expansion of public funding. ♦

*(First appeared October 31, 2002 as one of Dr. Guyatt's twice monthly columns in the Hamilton Spectator.)*

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## PUBLIC HEALTH CARE IS THE CHOICE OF BIG BUSINESS

**F**red Krawczyk has been in business for over 30 years. The 59 year-old Torontonian has held positions from President of the North American operation of an international Finnish construction materials and support corporation to vice-president of the Globe and Mail. Mr. Krawczyk believes in publicly-funded health care - and not just because of the protection it provides for him, and for his family.

"Canadian business reaps major benefits from publicly funded physician and hospital services", Mr. Krawczyk maintains. "It gives Canadian companies, particularly large ones, a huge competitive advantage. It also allows employees job mobility without having to worry about losing health care coverage, a big problem in the U.S."

Mr. Krawczyk is not alone in his view. In June of 2002, I was part of a doctors' group presenting at Roy Romanow's public hearings on Canadian health care. The group presenting immediately before us, the Employer Committee on Health Care - Ontario (ECHCO), represents over 30 of Ontario's largest employers. ECHO members include Stelco, Dofasco, and the Bank of Nova Scotia.

ECHCO surprised me with its worries about private health care funding. "As a result of passive privatization of services, in addition to rising costs of medical services, in particular prescription drugs, the affordability of

employer sponsored plans are at risk." In her presentation, the ECHCO spokesperson said that business would be happy to pay higher taxes for a national pharmacare plan that would reduce the burden of drug costs in employee benefit packages. Wise industrial leaders like ECHCO know that in health care, their self-interest and the interests of their workers overlap.

Health care is one area where even auto industry management and unions see eye to eye. In September 2002 the Canadian Union of Auto Workers, along with General Motors of Canada, Ford, and DaimlerChrysler signed an unprecedented joint letter.

"The success of (the auto) industry has been crucial to Canada's economic progress over the past decade," the letter states. "Canada's health care system has been an important ingredient in the auto industry's performance."

Why the surprising agreement among private sector companies? First, Canada's health care system is far more efficient than that of the United States. While the US spends more than 14 per cent of its gross domestic product (GDP) on health care, Canada has limited health spending to 9.4 per cent of our GDP. The administrative efficiency of single-payer health care, and the ability of governments to hold the line on hospital and physician expenditures, are responsible for our success in controlling costs.

Second, individual Americans must, one way or another, pay the very large costs of their own health care. Just as in Canada, health care coverage is part of standard American employee benefit packages. Public funding of physician and hospital services in Canada means that Canadian companies pay far less. Canada's auto industry illustrates how this competitive advantage plays out. Employers' health costs in the U.S. amount to \$900 per automobile. As the joint letter from the auto makers and their union tells us, the situation differs in Canada.

"The public health care system significantly reduces total labour costs for automobile manufacturing firms, compared to the cost of equivalent private insurance services purchased by U.S.-based auto makers."

The health insurance savings amount to four dollars for every hour of labour worked. Those dollars eventually generate profit for the companies, making Canada an attractive place to set up shop. The story is the same for other large industries. In the U.S. steel industry, health insurance costs are 18 per cent of total employment costs compared to between 4 and 6 per cent in Canada. This advantage has helped Stelco and Dofasco survive the contraction of the steel industry. Wise Canadian industrial leaders are aware that threats to high-quality publicly funded health care mean threats

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## PUBLIC HEALTH CARE IS THE CHOICE OF BIG BUSINESS (continued)

to their privileged position. The automakers' letter summarizes the situation with compelling clarity.

"The erosion of publicly funded health care — through measures such as the delisting of currently covered services (and) the imposition of user fees...will impose significant costs on automotive employers and undermine the attractiveness of Canada as a site for new automotive investment." In the areas where Canadian health care is not publicly funded, including home care and prescriptions drugs, we have not succeeded in controlling costs. The result is a rapidly increasing burden on

large companies to cover drug benefit packages.

The automakers, and ECHCO, want more than the preservation of public health care. They know that a national government-funded pharmacare plan will reduce drug costs both through administrative efficiencies and the enormous bargaining power of a single buyer. While the government may levy additional taxes to fund a national drug program, employers know that their overall costs will decrease.

That is the reason ECHCO called on Roy Romanow for national leadership in ensuring affordable drug access for

Canadians. It is why the automakers identified the need for "updated range of services (including prescription drugs and home-care services) that reflects both the evolving nature of medical science and the emerging needs of our population."

The message is clear. Maintaining, and indeed expanding, publicly funded health care will be good not only for the health of individual Canadians, but for the health of the Canadian economy. ♦

*(First appeared December 3, 2002 as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

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## LOTS OF REASONS TO THINK TWICE ABOUT CANCER SCREENING

**S**andra (not her real name), a colleague of mine at McMaster, noticed a lump in her left breast. A trip to her doctor resulted in a mammogram. The lump Sandra had noticed proved to be a benign cyst, but the mammogram showed an abnormality in the other breast. A biopsy under local anaesthetic revealed suspicious cells, and Sandra had to undergo a lumpectomy under general anaesthesia.

The lumpectomy showed no cancer. The mammogram had proved to be a false positive, meaning that the positive result was a mistake, there was no cancer at all. A few days after surgery, Sandra noticed a painful swelling in her breast. Her family doctor prescribed antibiotics for an infection. Sandra had a frightening allergic reaction to the antibiotics bad enough that she had difficulty breathing.

When Sandra went to the emergency room to deal with the allergic reaction, the doctor found an abscess that eventually required painful packing of the breast with gauze to help clear the infection. Sandra had to attend a clinic for the packing every day for two months, felt terrible for much of that time, and was only able to work 3 hours per day. The point of the story? Screening, particularly screening for cancer, is not problem-free.

Sandra's story illustrates the most important limitation. No screening test is perfect, and there is a high risk of false positive results. A 50-year old woman who follows recommendations for yearly mammograms has a risk of over 40 per cent of, like Sandra, having a false positive result during the next 10 years. More than 9 out of 10 positive results will turn out, on further investigation, to be false positives. Fortunately, few of those with false positive results will have the disastrous consequences that Sandra

experienced. Still, that is a lot of breast biopsies, and a lot of worry and fear. In one study, over 40 per cent of women with false positive mammograms were still feeling frightened of breast cancer three months later. In 17 per cent the fear was still having bad affects on their daily function.

Are the benefits of screening worth all the additional tests and their complications, and the anxiety that results? Many people overestimate the benefits of screening. If 1,000 50-year old women undergo breast cancer screening for a decade, screening will prevent 4 breast cancer deaths. That means we have to screen over 250 women for 10 years to prevent one premature death from breast cancer. The price we pay will be 100 false positive results in those 250 women. Another way to put it is that if a 50 year-old woman chooses to pass on screening, her likelihood of dying of breast cancer in

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## LOTS OF REASONS TO THINK TWICE ABOUT CANCER SCREENING (continued)

the next ten years is 13 in 1,000. If she is screened, the likelihood of dying of breast cancer drops to about 9 in 1,000. If she complies with yearly screening, her risk of a false positive is 400 in 1,000.

It's the same story with other cancer screening. Say that, at age 50, 1,000 people start screening for cancer of the bowel by using a test that detects blood in their bowel movements. They continue to test each year for the rest of their lives. The life time screening would cut the number of bowel cancer deaths by 13. The price will include over 2,000 false positive tests. Each person who chooses to screen can expect to have 2 false positive tests. Each time a test is positive, the patient has to have a colonoscopy.

Colonoscopy means an examination of the entire lower bowel with a long tube with a light on the end. Not most peoples' idea of a good time. Those

2,000 colonoscopies will result in 10 major complications.

My point is not that we should give up on screening. But I would say that people tend to overestimate the benefits, and underestimate the risks. Screening may not be for everyone. What all these sobering numbers certainly tell us is that we should avoid screening for cancer until we know for sure that screening will postpone at least a small number of deaths. Sometimes, screening doesn't work at all. The high quality studies of lung cancer screening have, for instance, shown no reduction in lung cancer deaths.

I've been thinking for a while of writing this article pointing out the limitations of screening for cancer. The Ontario government's plan to set up for-profit magnetic resonance imaging (MRI) and computer tomography (CT) scanning told me this is the right time to get the message out. The government plans to

encourage for-profit providers to charge patients for screening MRI and CT scans, so-called yuppie scans, looking for cancer. In this case, there is no evidence that anyone will live any longer as a result of the yuppie scans. Will there be lots of false positive results? For sure. Will doctors need to investigate with invasive tests to check out those false positive results? Of course. Will there be complications such as those Sandra experienced? Naturally. We have a shortage of radiologists and MRI technicians. The government plans to have the scarce supply of radiologists and technicians spending their time on tests with certain harm, and uncertain benefit. Is this a crazy idea? I'd say so. ♦

*(First appeared October 4, 2002 as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

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## NEW MAY NOT BE BETTER WHEN IT COMES TO DRUGS

**O**n March 18, 2000, 15-year-old Vanessa Young collapsed in her Oakville home and was rushed to the hospital. The following day, she died of complications related to her heart. A medication that Vanessa was taking to relieve vomiting and a bloated feeling was responsible for her death. About 18 months before Vanessa died, American consumers received warnings about cisapride's dangerous effects on patients' hearts. In August, 2000, several months after Vanessa's death, the drug was pulled from Canadian shelves.

Cisapride was not a new drug. Health Canada approved the drug in 1990, and it was one of the pharmaceutical industry's big sellers. That proved

to be plenty of time to do a lot of damage. Across North America, cisapride was responsible for the death of 24 infants who received the drug for harmless spitting up.

Unfortunately, the cisapride story is not unusual. Seven drugs approved since 1993 and later withdrawn from the market contributed to over 1000 deaths across North America. Equally frightening are the number of people exposed to potential serious drug reactions. Nearly 20 million Americans took 1 or more of the 5 drugs withdrawn from the market between September 1997 and September 1998. That's more than 5 per cent of the U.S. population exposed to drugs that had to be withdrawn.

Keep in mind that the drugs pulled off the market are the worst of the worst. If a drug has major benefits, and kills only a few people through toxic effects, it stays on the shelves. For instance, I was recently looking after a man dying of liver failure caused by a drug in common use. The benefits of the drug, amiodarone, in prolonging life in the patients with heart-beat abnormalities are worth the risks. But that is little consolation to the patient who develops major drug-related problems. A research study published earlier this year in the prestigious *Journal of American Medical Association* took a careful look at

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## NEW MAY NOT BE BETTER WHEN IT COMES TO DRUGS (continued)

major problems with drugs that develop after marketing and distribution.

The authors examined the Physicians' Desk Reference (PDR), the source of drug information American physicians use most commonly. When a new serious drug reaction is reported, the Food and Drug Administration demands the addition of a warning highlighted by a black box - so-called "black box warnings". These warnings also appear in the PDR.

The researchers looked at 548 new drugs approved between 1975 and 1999, and examined the PDR up to the 2000 edition. Of these 548 drugs, 16, or 3 per cent, were eventually withdrawn from the market because of serious bad reactions. Another 45, over 8 per cent, had new black box warnings after they were marketed.

Because drugs introduced more recently had shorter follow-up, these figures underestimate the long-term risk of new serious reactions coming to light. For instance, a drug introduced in 1998 had only two years for doctors to discover major problems.

The researchers calculated that each of the 548 drugs they studied had a 20 per cent, or one in five, likelihood of withdrawal or new black box warnings over 25 years. Of these, half would oc-

cur more than seven years after being introduced.

What does this study tell us? First, unexpected serious reactions often turn up after a drug appears on the market. Second, it can take years of use before doctors discover serious drug toxicity. Why does it take so long to uncover these serious, and sometimes fatal, reactions? Companies developing new drugs set out to prove their benefits. The studies they need to show that a drug works require only a few thousand, or at most tens of thousands, of patients. That is too small a sample to detect rare but serious adverse reactions.

In addition, once the drug gets on the market, physicians do a bad job of reporting adverse reactions. There are no rules requiring doctors to report the problems they see, and research suggests that more than 90 per cent of the adverse drug reactions go unreported.

Put those facts together, and you see why it often takes a long time for the evidence to add up.

What is the bottom line of this story? New is not necessarily better. Doctors know the bad things that can happen with drugs that have been around for a long time, say over 20 years. The newer a drug, the more risk that we will find out in the near, or not so near future about some

awful adverse reaction that drug has been causing. Does that mean we should stay away from new drugs? That depends on how much they have to offer. If the new drug does provide a major advance over all existing drugs, holding back because of worries about long-term effects would be a mistake. Most new drugs, however, provide only minor, if any, improvements over older ones. Each year, only a handful of drugs represent an important step forward.

For instance, when the cholesterol-lowering cerivastatin appeared on the market, there were already three similar drugs with a long history that could lower cholesterol and reduce heart attacks. After about six years on the market, cerivastatin was withdrawn when it caused 52 deaths from severe muscle damage.

Would doctors have been wise to stick with the older drugs? You bet.

If all this makes you slightly nervous about the medication you, or a loved one, are taking, you've got the message right. The lesson for doctors and patients is that if there is a tried-and-true drug that does the job, it is usually the one to use. ♦

*(First appeared October 18, 2002 as one of Dr. Guyatt's twice monthly columns in the Hamilton Spectator.)*

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## DRUG FIRMS' POWER A CHALLENGE FOR CANADIAN PHARMACARE

**W**hen I finally met David Henry, an internationally recognized Professor of pharmacology, I was impressed. Henry, an Australian originally from Scotland, proved intelligent, thoughtful, astute and courageous. But why would an academic physician, an expert in assessing effects

and costs of drugs, need to be courageous? For ten years, Dr. Henry served as a key member of the Australian Pharmaceutical Benefits Advisory Committee (PBAC). Australia has a national program that pays for a large proportion of essential prescription drugs, and the PBAC is responsible for

deciding which drugs the program covers, and recommending how much the government should pay.

The PBAC uses a scientific, evidence-based approach to assessing applications from the pharmaceutical

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## DRUG FIRMS' POWER A CHALLENGE FOR CANADIAN PHARMACARE (continued)

industry. Beginning in the early 1990s, the committee applied what was then a revolutionary approach. They required the industry to demonstrate not only that their drugs were safe and effective, but also that they were cost-effective at the suggested selling price. In other words, given what the drug would add to those already on the market, were the costs worth it? With drug costs exploding all over the world, and governments chopping public expenditures, the Australian PBAC had a difficult job. The power and influence of the multinational pharmaceutical industry made things worse. The industry exerted influence by encouraging physicians and patient groups to pressure the PBAC to accept their new drugs.

The result was intense public pressure, and periodic outrage when the PBAC rejected a drug. "Being accused of killing children is always unpleasant," Henry has recalled, thinking of the worst pressure tactics he suffered. On one occasion, when less extreme tactics didn't work, the industry tried using the courts to cripple the PBAC. Pfizer, makers of Viagra, challenged the PBAC's right to consider total cost to the community, and the way the drug was likely to be used, in making their decisions. When Pfizer lost, it meant individuals, rather than the general public, would be paying for improving their sex lives. It also meant the loss of an estimated \$50 million in income for Pfizer.

As Chair of the Economic Subcommittee of the PBAC, Dr. Henry was not popular with the industry. His approval rating dropped further when he co-authored an influential scientific article in a high-profile and prestigious medical journal. The paper demonstrated the deep flaws in most of the industry's submissions to his PBAC Economic Subcommittee. Dr. Henry's courage in taking a hard line for what he believed was about to undergo a further

test. Frustrated by their failure to rein in the PBAC with two independent reviews and a lawsuit, the pharmaceutical industry turned to putting pressure on the government.

This tactic proved more successful. Industry influence led the Australian government to a decision to remove Dr. Henry, and other PBAC members they considered a problem, from the committee. Unfortunately for the government, they required new legislation to change the make-up of the committee. The proposed legislation generated resistance, and not only from the PBAC itself. The opposition parties questioned the legislation, as did the Australian Medical Association and leaders in the academic community. Perhaps most important, the David-and-Goliath nature of the struggle - the government and the multinational drug industry against a small group of dedicated academic physicians - appealed to the media. The result: a national scandal. Dr. Henry became a leading public spokesperson for the committee.

This also meant he became the number one target of increasingly personal attacks by the frustrated government. The attacks reached their peak when the Australian Health Minister insulted Dr. Henry in parliament, comparing him to a baby spitting out a pacifier.

Eventually, the government passed their legislation, and appointed new members to the committee. But the public scrutiny generated by the scandal meant that the government and industry have had to keep their hands off. The PBAC has continued to do a good job. Why am I telling this story now, almost two years after Dr. Henry was tossed off the PBAC? While Canada has done a good job of controlling physician and hospital costs, drug costs have risen at an alarming rate. Proposals for Canadian health care reform include a national drug

program that would include an Australian-style PBAC with real decision-making power. A national pharmacare plan like Australia's could both help control drug costs and make drugs available to the 15 per cent or so of Canadians without drug coverage who currently have difficulty affording their medications.

The lesson from Dr. Henry's story is that we can expect intense opposition from the pharmaceutical industry to any plan that would lead to evidence-based decisions and effective cost control. Furthermore, as it did in Australia, that opposition is likely to have a major influence on our own politicians.

Pfizer, the Viagra company that launched the infamous Australian law-suit against the PBAC has recently bought out another drug company, Pharmacia, for \$50 billion. The new company will be the largest in an industry that has a yearly revenue about the same as Spain's GDP. Such pharmaceutical giants have enormous resources for advertising, and for influencing the political process. They are also big enough to blackmail governments by threatening to pull drugs, or investment, out of the country.

The Australian experience shows us a way to deal with out-of-control drug costs, and increasing problems with threatened access. It also tells us that, to succeed, our political leaders may require the sort of clear-sighted courage that David Henry demonstrated. ♦

*(First appeared November 15, 2002 as one of Dr. Guyatt's twice monthly columns in the **Hamilton Spectator**.)*

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# THE DOHA DECLARATION AND ACCESS TO DRUGS

**A**s the year runs out USTR and DG-Trade are putting immense pressure on developing countries to accept an extremely weak solution to paragraph 6 of the Doha Declaration on TRIPS — one that not only has few benefits to developing countries but is skillfully designed to undermine and narrow the broad benefits of the original declaration, and which would create a system of special supervision for patent exceptions in developing countries. It is possible that there will be a push to end the negotiations in the next few days, or the negotiations may drag on for a while. Things are quite unpredictable. Apparently nearly every developing country delegation views the USTR/DG-Trade/Japan/Canada/Swiss proposals as worse than no deal, but some delegations are afraid the US and Europe will blame developing countries if the negotiations fail, and they are also under a great deal of bilateral pressure (particularly from US) to sign off on a bad deal. This bilateral pressure is most problematic in capitals, where Ministers of Trade are relatively uniformed of the technical details. The Geneva delegates tend to be better informed, but have to convince the home officials that it is worth offending the US government.

There are many things that would help, and one is to document that the weight of world opinion is against the USTR/DG-Trade/Japan/Canada/Swiss proposals, and evidence that developing countries would be supported at home and abroad if they reject a bad deal. Specifically, it is helpful if firms, NGOs, academics, experts and others can organize various statements that oppose a bad deal on paragraph 6. The issue is of course quite complex, so not every group will find it easy to address some of the more obscure issues, but there are some very obvious flaws in the

proposals that are easy for most people to understand. In particular, the United States and Japan are now focused on PhRMA's demands that the Doha Declaration be redefined to only apply to a very limited number of infectious epidemics. Put another way, the PhRMA/USTR/Japan position is that diseases from Cancer, Asthma, Diabetes, heart disease, and thousands of other diseases should be excluded. This would be a huge setback, because the Doha Declaration now says that the TRIPS "Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all." (Paragraph 4), and if a "solution" to paragraph is framed only to apply to HIV, TB, Malaria and similar infectious epidemics we will have accepted a (PhRMA's) very limited definition of public health problems. There is also the issue of what technologies will be included, now that the Japan/USTR/DG-Trade efforts have produced a draft that excludes vaccines, an astonishingly bad decision from a public health point of view.

These letters or statements can be fairly short, and can focus on only a few issues. Actually, shorter letters are often more likely to be read. A single paragraph is sufficient, with signature or signatures. Then have someone send a copy of the letter to [ip-health@lists.essential.org](mailto:ip-health@lists.essential.org) or [mpalmedo@cptech.org](mailto:mpalmedo@cptech.org), so it can be shared with the list and the delegates, and linked to our web page on this, which is at <http://www.cptech.org/ip/wto/p6>

Here are a few talking points:

1. There should be no compromise on the scope of diseases. Paragraph 4 of the Doha Declaration says: "the [TRIPS] Agreement can and should be interpreted and

implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all." It is ridiculous to limit the definition of public health problems to a handful of diseases.

2. The solution should not exclude vaccines or important medicine devices.

3. The solution should not be limited in terms of countries that can import or export products for public health problems, recognizing that the use of compulsory licensing has been limited.

4. The solution should not be protectionist (prohibiting developing countries from supplying medicines to rich countries in cases where the rich countries issue a compulsory licensing, and should allow every country to have the same opportunities to address abuses of patent rights, regardless of how large or small its domestic market is.

*For more details contact: Joel Lexchin at [joel.lexchin@utoronto.ca](mailto:joel.lexchin@utoronto.ca) or James Love, Consumer Project on Technology, Website: <http://www.cptech.org>, Email: [love@cptech.org](mailto:love@cptech.org) Voice: 1-202-387-8030; mobile 1-202-361-3040.*

*SEE ALSO THE MEDICAL REFORM GROUP LETTER ON THIS ISSUE ON PAGE 32.*

# SOME WEB LINKS TO ASSIST YOU IN KEEPING UP-TO-DATE

Canadian Health Coalition:  
[www.healthcoalition.ca](http://www.healthcoalition.ca)

The Registered Nurses Association of Ontario:  
[www.rnao.org](http://www.rnao.org)

To contact a federal Member of Parliament:  
[www.parl.gc.ca/common/senmemb/house/members](http://www.parl.gc.ca/common/senmemb/house/members)

The Ontario Medical Association:  
[www.oma.org](http://www.oma.org)

The Canadian Centre for Policy Alternatives:  
[www.policyalternatives.ca](http://www.policyalternatives.ca)

The Canadian Medical Association:  
[www.cma.ca](http://www.cma.ca)

The Council of Canadians:  
[www.canadians.org](http://www.canadians.org)

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# THE DOHA DECLARATION AND ACCESS TO DRUGS (continued)

The Medical Reform Group sent the following letter on December 16<sup>th</sup>, 2002 to the Hon. Bill Graham with copies to the Hon. Anne McLellan, Minister of Health, and Ross Duncan at the International Affairs Directorate of Health Canada:

The Hon. Bill Graham, Minister  
Foreign Affairs and International Trade  
125 Sussex Drive  
Ottawa, Ontario K1A 0G2

Dear Minister:

We as doctors strongly object to efforts by the United States and other countries to limit the scope of diseases covered under the Doha Declaration of November 2001. The Ministerial agreement that came out of Doha was meant to ensure that the agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS agreement) would not prevent countries from accessing medicines necessary to protect the public health in their jurisdictions.

Now a group of developed countries including Canada is trying to reinterpret Doha to mean that only drugs necessary to treat infectious diseases are covered. This reinterpretation means that developing countries may not be able to access drugs that treat important causes of diseases. According to an article in the November 2, 2002 edition of *The Lancet*, the leading causes of disease in high-mortality developing regions include high blood pressure and high cholesterol. In lower-mortality developing regions cancer and chronic respiratory diseases are also major causes of morbidity and mortality. None of these problems would be covered under the proposed agreement that is now circulating.

As health professionals we believe that it is unacceptable to leave major causes of disease untreated especially in light of the recent Romanow Report which states that "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 organize its health care system in the interests of its own citizens. International trade agreements should not penalize countries, especially those in the developing world, for protecting and promoting their own domestic approaches to delivering health care services". ♦

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**RPO Marlee**  
**Toronto, Ontario**  
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*Please visit and comment on our web-site  
at <http://www.hwcn.org/link/mrg>  
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