

Reclaiming Medicare

A Response to the
Mazankowski Misdiagnosis



A Report Prepared for Parkland Institute, the University of Alberta • May 2002

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Contents

Preface	8
Introduction	10
PART ONE	
Medicare, Then and Now - Gillian Steward	11
What Is Medicare?	11
Why Was Canada's Medicare System Created?	11
What Was Life Like Before Medicare?	11
What Has Been The Alberta Government's Attitude To Medicare Over the Years?	12
How Do The Federal And Provincial Governments And The Regional Health Authorities Work Together To Operate Alberta's Health System?	13
PART TWO	
Public Health Care and the Sustainability Myth - Trevor Harrison	15
Reading Mazankowski	15
• What do we know?	16
• How much do we spend on health care in Alberta?	16
• How does Alberta's spending on health care compare with other provinces?	20
• How does Canada's spending compare with other countries?	20
• What are the risks to sustainability?	20
The Functions of Crisis And The Real Risks To Sustainability	22
What Must Be Done?	23
PART THREE	
Private Follies: Why Profits Do Not Belong in Public Health Care - Tammy Horne	24
What Does "Private" Mean?	24
What Does "Two-Tier" Mean?	26
Can Health Care Be Treated As A Market Commodity?	27
Does Competition From Private Facilities Not Make Public Facilities More Efficient?	28
Won't Contracting Out To The Private Sector Save Money Because Businesses Are More Efficient Than Government?	28
Wouldn't The Private Sector Provide Better Care Because It Has More Incentive Than Government To Focus on Customer Service?	29

How Does A For-Profit Clinic Differ From A Doctor In Private Practice?	30
If My Regional Health Authority Contracts With A Private, For-Profit Clinic To Provide Some Surgeries Or Other Procedures, Won't Waiting Lists In The Public System Get Shorter?	31
If We Have More Private Providers In The System, Doesn't That Give Me More Choice?	32
If I Experience Complications After Surgery In A Private, For-Profit Clinic, Who Is Responsible For Whatever Treatment I Need?	33
Why Not Bring More Private Insurance Options Into The System? Aren't The Health Care Premiums I Pay A Type Of Insurance?	33
Haven't User Fees Been Shown To Cut Down Abuse Of The System?	34
Would Giving People Their Own Personal Health Accounts, And Letting Them Keep What They Don't Spend, Encourage Them To Stay Healthy?	34
• Medical savings accounts	34
• Variable health premiums	36
What Values Underlie Individual Health Accounts?	36
Wouldn't Providing Everyone With Information On The Costs Of Their Individual Health Care Costs Teach Them To Use The Health System More Responsibly?	37
How Will Higher Health Premiums And More Private Insurance Involvement Affect The "Alberta Advantage"?	37

PART FOUR

Building on Success: Promising Directions for Health Reform - *Tammy Horne*

Pharmacare	40
• What Is Pharmacare?	40
• Drugs Are One Of The Fastest Rising Health Care Costs. How Could A Pharmacare Program That Covers Everyone Be Affordable?	40
• What Can Be Done On A National Level To Keep Drug Costs Down?	41
• What Does The Mazankowski Report Say About Pharmacare?	42
Home Care In Context	42
• What Does Home Care Do?	42
• Who Pays For Home Care?	42
• When Is Home Care Appropriate And When Is It Not?	45
• How Can We Provide A Range Of Accessible, High Quality Services For People Who Need Continuing Care?	46
Primary Health Care	48
• What Is Primary Health Care?	48
• Why Are Governments So Interested In Primary Health Care Reform?	48
• What Are Some Examples Of Primary Health Care Models Where Health Care Providers Work In Teams?	48
• Should We Pay Doctors Differently?	49
• What Kinds Of Primary Health Care Organizations Do The Mazankowski Report's Recommendations Suggest?	50
Focus On Health Promotion	52
• What Makes Us Healthy?	52
• What Are The Limits Of The "Lifestyle" Approach To Health Promotion?	54
• What About Incentives To Stay Healthy?	55

Better Accountability	56
• How Can The Health System Be Better Managed Day-To-Day?	56
• How Should Decision-Makers Use Evidence To Plan Health Services And Policies?	57
Conclusion - <i>Gillian Steward</i>	60
References	62
Authors' Biographies	69

Preface

Gillian Steward

Medicare is as Canadian as hockey and McIntosh apples. All across the country people of all political persuasions treasure the right to necessary medical care whether the patient has the money to pay for it, or not. This is the way it has been in Canada for almost 40 years. No need to buy expensive private insurance to ensure medical bills will be paid. No need to figure out which treatment you can afford if your child is diagnosed with cancer. No need to sell the house in order to pay thousands of dollars worth of expenses if you are hospitalized by a serious car accident. Instead of loading medical expenses onto individuals and their families we chose to pay for it collectively through our tax system so anyone who needs medical care can have it. This is the Canadian way. If you are a patient in an intensive care unit you get the nursing, medications, and surgery you require regardless of whether you are a single mother on social assistance or a corporate lawyer. In fact, in a Canadian intensive care unit there is no way of telling who is wealthy and who is poor.

Perhaps we have become so accustomed to Medicare, and so frustrated with its shortcomings, we have forgotten how privileged we are in Canada to have this sort of health care available to everyone. Perhaps we have forgotten that Medicare came out of Saskatchewan, a province where tough, but often poor people, living in a harsh environment recognized that they had a better chance of living well, and seeing their children live well, if they pooled their resources and created a health care system that would be available to everyone, not just a privileged few.

Perhaps we have forgotten because there is such a determined effort on the part of insurance companies, for-profit health care corporations and some politicians to make us forget. To make us believe that public health care isn't working and we can't afford it anyway. To make us believe that the private sector can provide health care better than the public sector even though Canada already has one of the best public health care systems in the world. So instead of talking about the best way to make good health care available to anyone who needs it we find ourselves talking about health care as though it were a business or an industry. Words such as sustainability, competition, choice, rationing and monopoly now frame the debate about Medicare. These words turn up again and again in the report prepared for the Klein government by a task force headed by Don Mazankowski, former federal minister of privatization and a paid board member and shareholder of private insurance companies. Senator Michael Kirby, also a director of Extendicare, one of the largest for-profit providers of long term care in North America, heads up a Senate Committee that is also looking at health care. Reports from this committee are also seeded with business terms. Premier Ralph Klein talks publicly about patients as customers or consumers.

If we are going to maintain, and reform, a publicly funded, universal health care system we must reclaim the language of Medicare. And the first step is to expose the fuzzy phrases and jargon being used by the enemies of Medicare to lull us into believing that publicly funded, universal health care is a second rate idea that costs too much. So far the enemies of Medicare are winning the war of words. Just listen to TV newscasts or read a newspaper and see how often the language of business pops up in stories about health care. If we fight on their terms we will lose. We will be embarrassed into believing that public health care couldn't possibly be as efficient, up-to-date and well-funded as a privatized, or business model.

We have to turn their arguments upside down. We have to insist that Medicare is not a business, it is health care provided to people in need. The providers receive money for their services, but unlike profit-oriented businesses this is not what motivates them. With Medicare physicians don't need to create patients like businesses need to create customers. We can easily understand that little harm is done if MacDonal'ds convinces thousands of people to eat more hamburgers than they really need. But can we say the same for clinics who need to create lots of patients and provide them with medical treatments that guarantee investors at least a 15 per cent return, every year? if they are to make money. We need to insist that patients are not consumers who can look around for the best deal. They are sick people who need help and cannot simply get out of bed to "go shopping." We have to insist that it's not good enough to simply say Medicare is "unsustainable" therefore we have to abandon it and start loading costs onto individuals and their families as recommended in the Mazankowski Report. If we want Medicare, and most Canadians do, then we have to find ways to keep it. That has to be the first premise.

That's why the Parkland Institute is publishing this primer. And as you read through it you will rediscover the language of Medicare. The fuzzy phrases and jargon used by the enemies of Medicare are replaced by clear ideas and words. Complex bafflegab is exposed for it really is - double speak intended to confuse people and then sell them something they don't want - or need - in the first place. A simple question and answer format is used so readers can get to the point quickly and move through the material easily. Take this booklet with you next time you go for coffee with a friend. Use it to make a point during your next conversation about Medicare. When you hear a politician or a for-profit health care lobbyist use the language of business ask them what they mean. Ask them to explain the words they use. Ask them why they insist on talking about Medicare as a business.

Let's take back the language of Medicare.

Introduction

Parkland Institute conducts non-partisan research into issues affecting Albertans. In the fall of 2001, the Alberta government was about to release its long-awaited Mazankowski Report on health care in Alberta. In this context, Parkland Institute drew together a number of public policy advisors and health care researchers to discuss the state of the health care system and the Alberta government's intent to take it in a direction contrary to all the evidence of both quality and cost-effectiveness. The initial intention of the group was to produce a primer analyzing the Mazankowski Report. Over the next weeks and months, the primer metamorphosed into the enlarged critique of that report you see here and a substantive series of suggestions. Parkland Institute is very proud of the result.

Gillian Steward provides in part one a concise, easy to read account of what Medicare is and how it came about. She also shows how the Alberta government's opposition to public health care is not a new phenomenon but, indeed, one with deep, historical roots.

Trevor Harrison in part two deconstructs - or perhaps just "deconstructs" - the Mazankowski Report's central argument that Canada's public health care system, as it now operates, is "unsustainable." He uses the report's own data to show that, far from becoming more costly, Alberta's and Canada's health care system has become increasingly cost-efficient in recent years. Finally, he raises the question of who benefits from current efforts to create a climate of crisis and fear around health care?

Similarly, **Tammy Horne** in part three decodes the various meanings of "privatization," showing the many ways this is occurring, and answers such questions as "What does two-tier mean?" But she also shows why health care cannot be treated as any other "market commodity" and why many of the solutions proffered in the Mazankowski Report - user fees, medical savings plans, variable health premiums, and contracting out to the private for-profit sector - will not do what the Alberta government suggests. In fact, the evidence is clear that these solutions will cost both Albertans and their government more, while actually diminishing the quality of care.

Finally, in part four Tammy Horne lays out a series of common sense avenues for health care reform, based on a sound body of evidence, that might prove far more advantageous to Alberta's and Canada's health care system. These avenues include a universal pharmacare program, home care in a context of the need for a continuum of care, improved primary health care, and a renewed focus on health promotion that takes into account not only behavioural but also social influences. Tammy also emphasizes a need for greater accountability in the health care system and decisions based on evidence, not ideology or private interests.

We hope you will take time to read this report. It will inform you. Some of it may also enrage you. In the end, we believe the report will also make you very proud of Canada's already world-class health system - a system worth fighting to preserve.

PART ONE

Medicare Then and Now

Gillian Steward

What Is Medicare?

Medicare was originally designed to ensure that all Canadians, regardless of income or ability to pay, receive the medically necessary care they need from hospitals and doctors. It has also provided coverage or partial coverage for other services such as home care or long term care. The federal and provincial governments fund Medicare with revenues garnered from taxpayers. A publicly funded, single-payer health insurance program, Medicare was made available throughout Canada in 1968 when the federal government passed the *National Medicare Insurance Act* adding coverage of physician services to an already established national hospital insurance program. The *National Medicare Insurance Act* was later replaced in 1984 by the *Canada Health Act* (Rachlis and Kushner, 1989; Fuller, 1998).

Why Was Canada's Medicare System Created?

Medicare's roots were first established in Saskatchewan after the depression of the 1930s left many people so poor they often died or were permanently disabled because they could not afford to pay to go to hospital or consult a doctor. In 1947 the CCF government, backed by a broad coalition of unions, churches, farmers and other grass roots organizations, established a public insurance program for hospital care. Ten years later the federal government followed suit and passed the Hospital Insurance and Diagnostics Services Act which offered federal funds to any province that established a hospital insurance program. In 1962, the Saskatchewan government once again led the way by expanding coverage to include physicians' services thereby establishing the first tax-supported universal insurance program for medical care in North America. Medicare had so much popular appeal other provincial governments soon followed in Saskatchewan's footsteps. In 1968 Parliament passed the National Medicare Insurance Act and agreed to provide half the funding if provincial Medicare programs were comprehensive, accessible, universal and portable. However, by 1977, the federal government had abolished 50-50 cost sharing in favour of "block funding" (Rachlis and Kushner, 1989). This meant that federal funding was no longer tied to the actual costs of the provincial programs.

What Was Life Like Before Medicare?

Before Medicare Canadians who were ill or injured were often denied treatment if they couldn't afford to pay for it. Or they had to pay big bills before they could be discharged from hospital. Sometimes they were discharged too early because they couldn't afford to stay. Doctors who worried about the patient's health first and payment later often found they were working for eggs and vegetables, or perhaps nothing. Patient's able to afford it (and who were eligible) could take advantage of private insurance, but many could not afford the high premiums.

Here are just three such stories taken from *Life Before Medicare: Canadian Experiences* a book written by Helen Heeneey (1995) and published by the Ontario Coalition of Senior Citizens' Organizations:

"...a three year old boy in Newfoundland lost his hearing after red measles. The parents were told by a surgeon in Montreal who could and would operate, that he could restore the child's hearing. But the cost was \$2000, in the thirties, and the family did not have the money. The child grew up deaf. He was educated at a school for the deaf in Nova Scotia, so he was deprived of his family, and his hearing."

Grace Rosamond - Toronto.

"My ninety-three-year-old father tells a story of the very hungry thirties when he had been out of steady work due to a broken leg suffered in an accident in the woods. My young brother was admitted to the Banff Mineral Hospital for a tonsillectomy. My parents received a phone call to say my brother would not be released from the hospital until they paid \$100. I can remember my mother crying, wondering what they were going to do. A loan was arranged at a time when \$100 was a fortune, to obtain his release."

Nellie Wright - Duncan, British Columbia.

"While life was hard for the rank and file of people, doctors found it even more so. To start with they needed to travel a great deal. On top of that, a good half of their patients failed to pay the bill. There was little they could do to collect because the patient had little or no assets."

Arthur W. Fletcher - Hythe, Alberta.

What Has Been The Alberta Government's Attitude To Medicare Over The Years?

Successive Alberta governments have been less than enthusiastic about Medicare and have tried to limit coverage, impose user fees, or introduce private, for-profit health care. This is not surprising in the light of the fact Alberta, under then Premier Ernest Manning, was the only province in the 1960s to oppose a Canada-wide Medicare program. At the federal provincial conference of first ministers in July 1965, Mr. Manning stated the individual should have the right to decide how he received medical care. Mr. Manning also said the commercial and private medical insurance plans in place at the time were satisfactory to their policy holders and that it would be unwise to eliminate them since this would mean a further interjection of government into private business. He then undertook a national campaign to defeat Medicare (Finkel, 1989).

In the 1970s when Peter Lougheed was Premier, extra billing by doctors was permitted. Ontario also allowed extra billing and the practice became so prevalent the federal government called on Justice Emmett Hall to review the situation. He found that extra-billing would lead to a two-tier health care system and recommended that it be banned. In 1984, the federal government passed The Canada Health Act giving it the power to penalize provinces that permitted user fees or extra-billing by doctors (Rachlis, 2000).

In 1987 the government of Premier Don Getty announced that Medicare would no longer cover doctors' counselling for family planning, tubal ligations, vasectomies or periodic eye examinations (Rachlis and Kushner, 1989). Public pressure forced it to back down, but since then several services and procedures have been de-listed in Alberta.

The government of Premier Ralph Klein has undertaken a number of initiatives to weaken Medicare. In the mid-1990s it supported private for-profit eye surgery clinics which were charging patients “facility fees,” a form of extra billing. The Alberta government paid \$3.6 million in fines imposed by the federal government for contravening the Canada Health Act rather than forbid the owners of the clinics to stop charging the extra fees. Rather than continue paying the fines the Klein government then decided to pay for the facility fees - costs over and above the doctor’s fee for service - through Medicare. The federal government conceded that such subsidies would not contravene the CHA as long as the patient did not have to pay (Taft, and Steward, 2000).

Subsequently, the Klein government introduced Bill 37 that would have given the health minister power to approve private, for-profit hospitals. It was eventually withdrawn due to public opposition (Taft and Steward, 2000). But in 2000 the Klein government introduced and passed Bill 11, legislation which permitted over-night stays in for-profit clinics, thereby opening the door for private, for-profit hospitals (Rachlis, 2000). The Alberta government has also supported the expansion of for-profit diagnostic clinics where patients can pay out of their own pocket for MRIs and other detailed electronic body scans. This enables patients to jump the queue for surgery or other treatments.

In 2002 a Framework for Reform, also known as the Mazankowski Report (PACH, 2001a), became the Alberta government’s manifesto on Medicare. It contained several recommendations that undermine the original foundations of Medicare. These include: private funding for Medicare such as user fees and private insurance; medical savings accounts which would limit medical coverage; de-listing of necessary medical services now covered by Medicare; opening the door even wider to for-profit health care providers.

How Do The Federal And Provincial Governments And The Regional Health Authorities Work Together To Operate Alberta’s Health System?

Through the Canada Health Act and its tax revenues the federal government can exercise a good deal of control over Medicare. But for the most part, the federal government is not responsible for the delivery or maintenance of health care services provided under Medicare, nor is it responsible for most of the funding. Hospitals, physician services, specialty services such as cancer clinics, and mental health facilities fall under provincial jurisdiction and are the responsibility of individual provincial governments. In Alberta, the provincial government is responsible for setting standards and developing strategies to ensure that the population is as healthy as possible. The Alberta government is also the main funder of Medicare in the province. But it has delegated responsibility for purchasing and ensuring the delivery of all health care services to 17 Regional Health Authorities. Each RHA is allocated certain funds each year and is accountable to the provincial government for the services they provide with those funds.

PART TWO

Public Health Care and the Sustainability Myth

Trevor W. Harrison

Alberta's recently released Report of the Premier's Advisory Council on Health (a.k.a., the Mazankowski Report) early on makes the following claim:

Many have suggested - and the Council agrees - that without fundamental changes in how we pay for health services, the current health system is not sustainable. Spending on health care is crowding out other important areas like education, infrastructure, social services or security. If health spending trends don't change, by 2008 we could be spending half of the province's program budget on health (PACH, 2001a: 4).

In this paper, I will use the Mazankowski Report's own data, augmented with data from other sources, to prove false its claims that Alberta's and Canada's health care system is unsustainable. That is to say, the data itself is not incorrect; what is incorrect is the interpretation of this data. I argue there is no fundamental financial problem with Canada's existing public health care system. The current problems plaguing the system are political and - being political - are greatly exaggerated. All can be redressed easily by people of good will. Nonetheless, should policy makers adopt many the assumptions and recommendations of the Mazankowski Report, I believe that Canada's Medicare system might well be fatally injured.

Reading Mazankowski

Many people will read the Mazankowski Report. Fewer will likely read the Context Papers included in the Report's Appendices. This is unfortunate, because read critically they contain some very useful information. Here, I will concentrate on reading the Context Paper entitled, "Is Alberta's health system sustainable" (PACH, 2001b). The indented headings, questions, and quotations that follow are taken from that Context Paper.

What's the issue?

This is the first heading in the Context Paper on sustainability. Under it are two paragraphs (PACH, 2001b: 1):

Escalating costs, new services and treatments, a growing and aging population all add up to increased spending on health care. While government spending on health was reduced in the mid-1990s, since then, spending has increased considerably. Spending on health is taking up an increasing share of the provincial budget. And some argue that we're not getting significantly better access to health care services or better health as a result.

Politicians, policy makers and pundits have all raised concerns about whether our current rate of increased spending on health is sustainable. That raises important questions like: How much is enough money to spend on health? What happens if health care takes up more and more of the province's total spending, leaving little left for other priorities like education or children's services, police, roads and highways? Is more money the answer - does it result in better health care? Are we headed for a crisis?

There is an axiom in politics that one should only raise questions to which one already has the answers. The purpose of the opening section of the Context Paper is to frame the question the government wants answered. In order to get to "the question," the Context Paper must first construct a series of underlying assumptions. Thus, the first paragraph presents a series of assumptions couched as fact - that health care spending has been increasing and taking up a larger share of the budget - and raises the suggestion that Albertans are not getting sufficient "bang for the buck." The second paragraph builds on these assumptions to finally raise the spectre (technically a question, but actually a statement) of health care being in crisis.

The Context Paper continues with the following headings and general statements (PACH, 2001b: 1):

What do we know?

How much do we spend on health care in Alberta?

There's no doubt that Alberta spends a lot of money on health. In 2001-02, the provincial government will spend over \$6.4 billion on health. If you add in capital costs, the total is over \$7 billion. Provincial spending on health makes up close to a third of its total spending on programs. We spend about \$20 million every day on health care. Ten years ago, Alberta spent \$4.1 billion on health, about 27% of its total spending on programs.

Here are some things we know about spending on health in Alberta.

In the ten years from 1982-83 to 1992-93, spending on health increased fairly consistently. For three years, 1993-94 to 1995-96, spending on health decreased. Since then, increases in spending have been on the upswing, and recent trends show considerably higher spending on health.

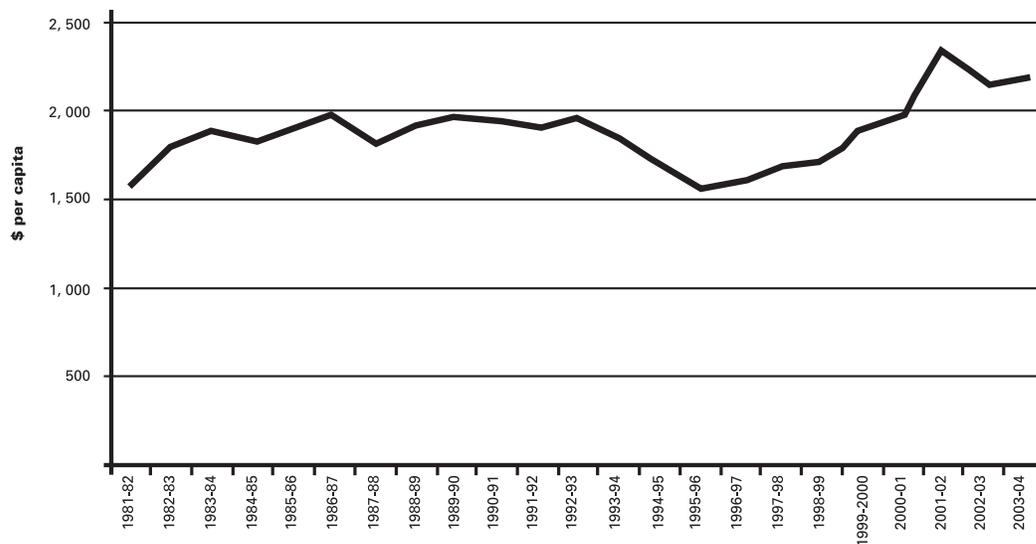
These statements contain the gist of the Alberta government's claim that health care spending in the province is unsustainable. Three forms of evidence are used to assert this claim, and are repeated throughout the Mazankowski Report (PACH, 2000a) as a whole. The first form of evidence uses comparisons of nominal spending over a selected period of time. The second form of evidence relies upon proportions or percentages. The third form of evidence relies upon past trends and future projections. There is nothing inherently wrong with these statistical forms of evidence. Used selectively, however, they can be misleading.

Take the first form of evidence, based on nominal spending. Yes, Alberta's health care spending has risen from \$4.1 billion to \$6.4 billion, but these sums are meaningless unless they take into account inflation and population growth. Regarding the former, the compounded inflation rate for the period 1991-2001 is 19.2 percent.¹ Regarding the latter, recently released figures from Statistics Canada show, for example, that Alberta's population between 1991 and 2001 rose from 2,545,553 to 2,974,807 (Edmonton Journal, 2002) - an increase of 429,254 people or nearly 17 percent. Curiously, some of the producers of the graphs in the Context Paper seem to have understood the need to allow for inflation and population growth, even if those who interpreted the evidence and wrote the text did not.

¹ University of Alberta economist Dr. Melville McMillan notes as follows: "Using CPI, all items, 1996 classification, for June 91 to June 01 the CPI increased from 98.9 to 117.5 so $117.5/98.9 = 119.2$ or a 19.2 percent increase in consumer prices." Dr. McMillan adds, "just out of interest, prices fell by Dec. 2001 to 115.9."

Take, for example, the figure reproduced below from the Context Paper (PACH, 2001b: 3). It shows that real health care spending per capita did not increase “fairly consistently” as claimed, but was in fact relatively stable, especially during the period 1986-87 to 1992-93. The Canadian Institute for Health Information (2001a) - the body that collects and presents health system data from all the provinces - confirms this finding. So also does Statistics Canada data independently analyzed by political economist Greg Flanagan of St. Mary’s College for a recent Parkland Institute study of Alberta’s 2002 budget (Parkland Institute, 2002). Thereafter, the government implemented a series of deep cuts, returning only in 1999-2000 to the level of expenditure in 1992-93 before the cuts began (Canadian Institute for Health Information, 2001a: Table C.9.3). At the same time, it should also be noted that the government’s figure is misleading insofar as its title purports to show “real” spending. In what sense, one might ask, can “real” spending be pre-determined for the period 2001-02 to 2003-04 - the period on the graph showing the steepest curve - when we know neither the rate of inflation nor the rate of population growth for this period?

Real Provincial Health Expenditure Per Capita - Alberta



Source: Alberta Finance, September 2001

The Mazankowski Report’s repeated use of proportional evidence (e.g., health care spending used to make up 27 percent of program spending but today makes up one-third) to argue that health care is “unsustainable” is equally misleading. As a thought experiment, consider the following. I will use Alberta government figures from the most recent budget (Alberta Finance, 2002). For the coming year, the government has projected total program spending of \$19.2 billion and spending on the Department of Health and Wellness at \$6.8 billion, or 35.4 percent. Without increasing health care spending, but by cutting spending entirely for other programs, the government could make health care spending take up 100 percent of public spending. The suggestion is absurd, of course. Albertans would rightly complain, which seems precisely the government’s intent in the main body of the Mazankowski Report (PACH, 2000a: 4) when it suggests health care is threatening to crowd out spending on “education, infrastructure, social services or security.”

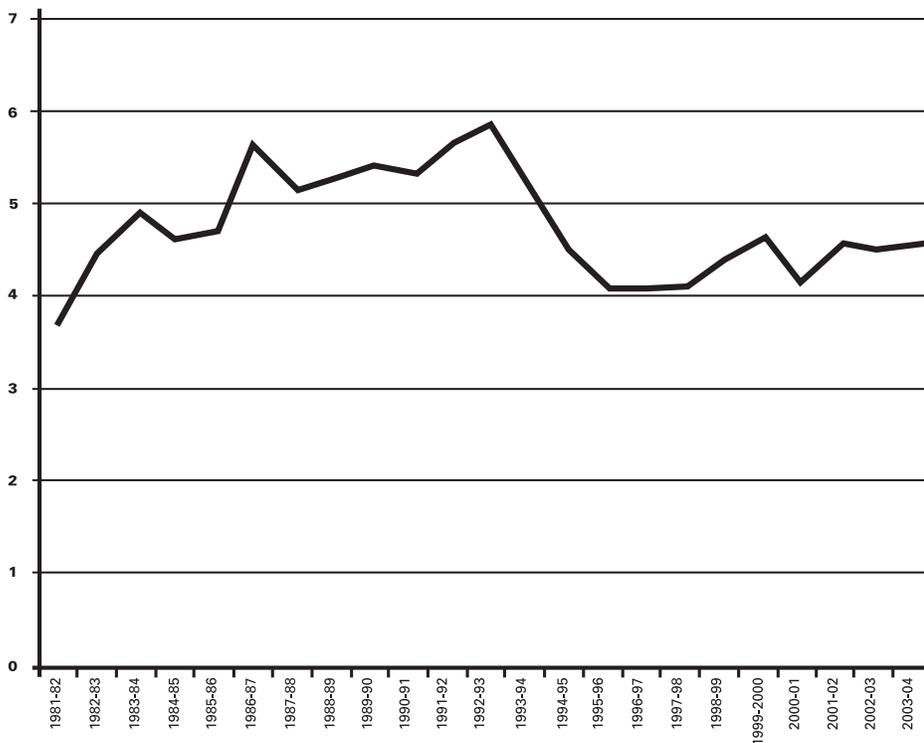
Alternatively, however, were the government to spend an additional \$6 billion on other programs (bringing total spending to \$25.2 billion) it could return health care spending to the seemingly magical level of 27 percent. The government and many of supporters will say such an idea is as absurd as the previous scenario. They will say this based on the question, "Where would Alberta get \$6 billion to spend on other programs?" Fortunately, the Context Paper on sustainability once more provides the answer (PACH, 2000b: 4) in the form of a statement and a graph, both reproduced here.

The statement reads:

Another way to look at spending compares what we spend on health to a measure of the size of Alberta's economy - our gross domestic product (GDP). This comparison shows health spending actually dropping as a percentage of Alberta's GDP since the early 1990s. That's because Alberta's economy grew at a dramatic rate, especially in the late 1990s. The rate of growth in the economy outpaced increased spending on health, even though spending increased considerably during that time.

The graph is as follows:

Provincial Health Spending as % of Nominal GDP - Alberta



Source: Alberta Finance, September 2001

The Context Paper on sustainability accompanying the Mazankowski Report (PACH, 2001a) thus provides clear evidence refuting the conclusions drawn by the authors of the same Report. The Context Paper instead is suggestive of two very different conclusions. First, arguments based on the proportion of total government expenditures spent on health (or any other program) tell us very little in and of themselves. Second, far from being impoverished, Alberta has more than adequate fiscal room to sustain health care and other spending. **The problem is not financial. The problem is one of political will.**

The third form of evidence presented by the government involves the use of past trends and future projections. I have already shown the Context Paper on sustainability suggests real health care spending per capita has been relatively stable over time. But what should be the time frame? When does a trend start and when does it end? These are valid questions. Unfortunately, the authors of the Mazankowski Report seem to have chosen start dates meant not to inform debate but to give a false depiction. Take, for example, the statement contained in the Mazankowski Report's (PACH, 2001a: 26) summary that, "Health spending in Alberta has increased from \$3.9 billion in 1995/96 to over \$6.4 billion in 2001/02 - a 64% increase." Why begin the spending sequence at the very bottom when (some would suggest) health care spending in the province had been gutted to unacceptable levels?

The choice of end dates is even more problematic. Clearly, we are always on firmer ground in reporting on what has already occurred. While we all like to "see into the future," and projections are sometimes helpful, as a rule the further we try to see the less accurate is our vision. I have already drawn attention to the mislabelled graph (opposing page) which purports to show "real" spending to 2003-04. This same error is repeated in another graph in the Context Paper (PACH, 2000b: 7) showing comparisons with other selected provinces. (As a professor specializing in public policy, were I handed these graphs as an assignment, I would gently have sent the student back to redo them.)

But the makers of these graphs have nothing on the Nostradamian prescience shown by those who constructed the graph titled "Projected health and non-health program spending" (PACH, 2000b: 9). This particular graph projects health care spending into 2012-13 based on an assumed 10 percent growth in health care spending and overall program spending and revenue growth of 4 percent. Question: out of what hat did these "researchers" pull these figures? Answer: they picked 10 percent based on spending since the deepest point of the cuts and then suggest the percentage of money spent in recent years on catching up will continue ad infinitum. I cannot be more blunt in my criticism when I say this isn't research; it isn't even particularly clever statistical gimmickry to anyone who cares to really read it. **It is a blatant attempt to mislead the public.**

Consider the following alternative (and more realistic) scenarios. Data calculated from the Canadian Institute for Health Information (2001a: Table C.9.3) show that real per capita government spending on health care in Alberta increased by 22.8 percent between 1990-91 and 2000-01.² Divided by ten, one might project based on these figures a 2.3 percent annual growth in health care spending into the future. Using the CPI figure calculated by Dr. Melville McMillan (previously discussed) of 19.2 percent for the period 1991-2001, again divided by ten, one could similarly project 2 percent growth in health care spending until some future date. Whichever one chooses, either of these figures is more statistically grounded and more defensible than the Context Paper's (PACH, 2000b) projections.

In summary, the Alberta government's repeated assertions that health care spending is "out of control" and that the current system is "unsustainable" are unsupported by the vast bulk of data presented in the Context Paper on sustainability accompanying the Mazankowski Report (PACH, 2000a). One is left with the strong impression that either the Report's authors did not read or understand the data presented, or intentionally misinterpreted the data.

² It should be noted that spending only rose by 6 percent from 1990-91 through 1998-99. The bulk of the increase occurred only in the last two years.

How does Alberta's spending on health compare with other provinces?

The Alberta government wishes to use percentages as a basis for arguing that the current health care system is unsustainable. I have shown some of the problems based solely on percentages. Still, if the government insists on making such arguments, it might reflect awhile on the statistical comparisons of Alberta with other provinces contained in the Context Paper on sustainability. The table on the top of page 5 (PACH, 2000b) shows that Alberta's total health expenditures as a proportion of provincial GDP in 2000 were the lowest in Canada. That year, they were 7.8 percent of GDP, compared to the Ontario (the next lowest) at 8.7 percent of GDP and 9.3 percent for Canada as a whole. Moreover, total provincial government expenditures on health in Alberta in 2000 were 5.3 percent of GDP - again the lowest in Canada - compared to Ontario (5.9 percent) and Canada (6.6 percent).

How does Canada's spending compare with other countries?

The Context Paper tells a similar story in its comparisons of health care spending with other countries. The figure presented on p. 8 of the Context Paper (PACH, 2000b) on sustainability shows Canadian expenditures on health as a percent of GDP to be well below that of the United States (an outlier in any comparison) and about on par with most other western European countries. The same figure shows health care spending as a proportion of GDP in Canada has actually dropped since 1992.

The Context Paper's table (PACH, 2000b: 11) specifically shows Alberta's spending as a percent of GDP in 2000 to be well below that of these same countries (in 1997): 7.8 percent vs. USA (13.6), France (9.6) Australia (8.3), Sweden (8.5), Germany (10.5), Norway (8.1), and the Netherlands (8.6).

The same table also contains data on health care outcomes. Examining this table, one is left with the inescapable conclusion that Alberta and Canada have a highly effective health care system operating at reasonable expense compared to other jurisdictions. Yet, this fact seems to have escaped the authors of the Mazankowski Report (PACH, 2000a) in drawing their conclusions. Likewise, the authors of the accompanying Context Paper (PACH, 2000b) seem adamant at times in ignoring their own evidence. Note, for example, that the latter employs a heading on page 9 that assumes a proven risk to sustainability, despite the evidence presented thus far in the paper to the contrary. The heading reads:

What are the risks to sustainability?

The first words under this heading state:

A look at current spending on health shows that Alberta's spending:

- Has increased considerably in the past few years - by an average of 10% per year since 1996
- Is taking up an increasing percentage of total government spending
- Compares favourably with other provinces and countries

Based on this misreading of its own data, the Context Paper then boldly states:

So do we have a problem of sustainability?

*The answer clearly is **yes**, for these reasons.*

There is, of course, nothing at all clear about this answer; indeed, the Context Paper's own evidence to this point contradicts the conclusion. It is perhaps the fragility of the claim that has caused the authors to write the word "yes" in bold type. The Context Paper then identifies (PACH, 2000a: 9-10) what are presumably meant to be four chief risks to health care sustainability.

The first:

We can only afford to spend more if Alberta's economy keeps growing faster than spending.

This is a wonderful way of saying nothing. Nonetheless, return once more to the figure above showing that Alberta's GDP since the early 1990s has been growing faster than spending on health care. The real problem in Alberta is not health care or any other spending. The real problem is a government wedded to a low tax regime and incapable of managing an export-dependent economy subject to recurrent booms and busts. In any case, I also ask: **What is the risk to sustainability?**

The second:

Health spending could soon take up half of all government program spending.

See again my comments on the falsity of proportions as an argument and how easy it is to alter them. **What is the risk to sustainability?**

The third:

Costs in health care are growing dramatically.

Again, taking into account inflation and population growth, this is not the case. The Alberta government's own data shows no "dramatic" rise in health care costs. Therefore, and again, what is the risk to sustainability?

But I would add two caveats. First, health care costs are rising in one area: the area Canadians pay for privately. As pointed out by the Canadian Institute for Health Information, between 1990 and 2000, private health costs in Alberta - borne by individuals and insurance companies - increased by 31.1 percent (CIHI, 2001b: Table 6). By contrast, costs to the Alberta government rose by only 22.4 percent (Table 10).

Second, some specific elements of public health care spending need to be addressed. As recently reported by the Canadian Institute for Health Information (2002), pharmaceutical costs have been spiralling (see part four of this report regarding a remedy). Likewise, there is evidence the contracting out of services in Alberta has raised public health care costs (see Armstrong, 2000, regarding the contracting out of cataract surgeries). In the former case of drugs, current patent protection laws seem to be at fault. In the case of the latter, the government has not shown due regard for monitoring and evaluation, and contracts have become practically impossible to void (see Auditor General of Alberta, 2001; Taft and Steward, 2000).

The fourth:

Albertans expectations for health care are growing.

Albertans and Canadians support the public health care system and are willing to pay more for a good health care system. They don't like waste, but they do want more money put into the system. What is the risk to sustainability?

The functions of crisis and the real risks to Sustainability

A critical reading of the Mazankowski Report shows there is no evidence that Canada's public health care system is unsustainable, even less that it is in crisis. But several of the Report's statements and recommendations, based upon a market model of health care provision, would cause serious harm to the system.

Take, for example, the implicit and often explicit call for increased private involvement in the health care system. Arguably, the system could use more personnel - doctors, nurses, and health professionals - and equipment. Increased private involvement will not increase access or deliver more services, however; it will merely shift existing resources. Worse, increased private involvement will over time increase health care costs, first because of the need of such companies to generate profits, second because as private firms and health care entrepreneurs become a larger part of the system they will exert growing pressure on the direction of health care.³

We must abandon certain myths. The first myth regards markets. Markets work well for some goods and services. Health care is not one of them, however, in part because consumers lack perfect knowledge of the service or good they are buying (and are often not in shape to make "rational" choice), in part because good health care is a necessity and not a choice (see Taft and Steward, 2000). The second myth regards competition. Health care is what is termed a "natural monopoly." It would be wasteful to have "real" competition in health care. But the situation as it would evolve with private firms would in fact be much worse: private monopolies paid for by public funds, yet largely unaccountable due to their size, current security laws surrounding private companies, and existing regulatory mechanisms. Does anyone wish that Enron had operated Canada's health care system?

No system is perfect, of course. Humans are fallible. Waiting lists could be shorter, for example, and should be, but the Mazankowski Report's (PACH, 2000a) recommendations in this regard and others would do nothing to attract new personnel into the system.⁴ Ultimately, the Mazankowski Report greatly exaggerates the problems facing Canada's public health care system, ignoring its own best evidence that - on the whole - the system works very well. This raises an important question: Why do the framers of the Mazankowski Report insist that Canada's Medicare system require extensive renovation? Why do they wish to create a climate of crisis and fear?

The explanation can be found in the adage, "Follow the money." What is to be gained, and by whom, if the Canadian public and policy makers can be made to believe that Canada's health care system is in irredeemable trouble? Several possible beneficiaries of the "crisis" can be identified.

First, the various provincial premiers may be using the perceived crisis as a means of prying more money from the federal government. I neither support nor refute these demands, but would note that one sub-heading in the Context Paper on sustainability (PACH, 2001b) is titled, "How much does the federal government contribute?"

Second, health care provides fertile ground for profit making. Private insurance companies were in the forefront of initial efforts to prevent the development of Medicare in the 1960s (Finkel, 1989). Private health care corporations and insurance firms are major moneymakers in the United States, and shares in them in recent years have been among the strongest performers on North American stock exchanges. Humana Inc., for example, recently announced its first quarter profits for 2002 surged by 75 percent, up to US\$ 46.8

³ An analogy can be made to the criminal justice system in the United States where private companies specializing in running prisons are able to lobby for laws that influence the practice of criminal law, including sentencing.

⁴ One could increase supply by increasing salaries, thereby inducing more people to enter the profession or otherwise attracting professionals from elsewhere. Both public and private systems could do this already, but current debates on improving health care are driven largely by concerns over cost containment, and doing so would of course raise costs.

million. Total revenues for the period were US\$ 2.73 billion (Dow Jones, 2002). Ideas of contracting out, privatizing hospitals and clinics, and de-listing services, along with such terms as “diversifying revenue streams” all point to opening up market niches for profit seekers.

Third, shifting the costs of health care onto individuals saves governments money. Sometimes this is being done for ideological reasons, for example, a belief in smaller government for its own sake. Sometimes these cost savings in the health area are being pursued to “free up” money for use on other things, or to cut corporate and other taxes; in effect, privatizing health care costs becomes a matter of redistributing the costs. Finally, privatizing health care costs once more opens up opportunities for profit by private health care providers who can step into the breach.

It is the move towards private health care provision, with its greater administrative overhead and need to incorporate profit margins that ultimately threatens the sustainability of Canada’s health care system. Those recommendations of the Mazankowski Report - or any other offering to the Commission - that endorse this direction for health care should thus be rejected out of hand.

What must be done?

In conclusion, I want to suggest some of the reasons why Canada’s public health care system must be maintained. First, public health care is the most cost affective means of ensuring the general health of all citizens. Second, public health care is an instrument for achieving social solidarity. Third, public health care provides a “Canadian advantage” in lowering the costs of exports to other countries, most especially the United States. Fourth, public health care is a fundamental element of Canadian national identity. In its travels across Canada, the Romanow Commission will receive many submissions. I have attempted here to show the general falsity of, and danger inherent in, the recent submission made by the Alberta government based as it seems to have been upon the Mazankowski Report (PACH, 2000a).

The Mazankowski Report’s recommendations for more proactive and preventive programs in health are to be lauded (though it largely ignores the social correlates of health). But much of the Report is based upon the false assumption that Canada’s health care system is unsustainable. Given this initial falsehood, most of its conclusions are also false. That something is false does not mean it will be rejected, however. Indeed, this is my chief concern in writing this paper. Repeated endlessly by self-interested private sector providers, assorted ideologues, and earnest but uninformed politicians and policy makers, **THE BIG LIE** that Canada’s public health care system is unsustainable will likely find fertile ground in some quarters.

Look around you. Go to any store, walk the streets of Edmonton and Calgary, visit the suburbs. This is a very wealthy province in a wealthy country. The question facing Albertans and Canadians is not whether they can afford public health care. The question is whether they can afford not to have public health care. As citizens, we have a choice to make. Which will it be: SUVs, video games, and the other trappings of consumer society, or quality health care?

I know what my choice is. My choice is to defend the system bequeathed by my parents to me to make sure it is there for me and my children - and their children - in future. Far from retreating into Medicare’s past successes, the public side of health care in Canada should be growing. The federal government and provinces should expand Canada’s public health care system into new areas and (still public) forms of health care delivery. In doing so, these new areas and forms would expand Canada’s health care advantage over the United States in both the economy and society. In time, Canada might even provide a useful service in bringing that country’s health care system up to a standard commensurate with its political power and financial resources.

PART THREE

Private Follies: Why Profits Do Not Belong in Public Health Care

Tammy Horne

Much of the recently released Mazankowski Report focuses on ways to expanding both private payment and private delivery - especially private for-profit delivery. The report's assumption is that privatization will make the health care system more sustainable and accessible to Albertans. The report is heavy on market language - saying the health system is a "monopoly," arguing that more "competition" is needed, and that "customers" (rather than patients) should be given "choices." Following this model, the report argues the private provision of services can take pressure off the public system. The report further argues it makes no difference whether services are delivered publicly or privately as long as Alberta Health pays the costs, and that patients will use the health care system more "responsibly" if they have to pay for some portion of their health services directly. In this chapter, I show that the research evidence in fact runs counter to these claims. First, however, I dissect the language of privatization used in the Mazankowski Report.

What does "private" mean?

The term "private" has several meanings. The Women and Health Reform Working Group has developed one of the most comprehensive definitions of privatization.¹ Though this group was mainly concerned with the impacts on privatization on women, their recent book (Armstrong et al., 2002) *Exposing privatization: Women and health reform in Canada* tackles a range of issues that affect both women and men, as citizens and health care providers. The book defines the privatization of health services as including (p. 9):

- privatizing the costs of health care by shifting the burden of payment to individuals;
- privatizing the delivery of health services by expanding opportunities for private, for-profit health service providers;
- privatizing the delivery of health care services by shifting care from public institutions to community-based organizations and private households;
- privatizing care work from public sector health workers to unpaid caregivers;
- privatizing management practices within the health system by adopting management strategies of private sector businesses, by applying market rules to health service delivery and by treating health care as a market commodity.

¹ This group is comprised of representatives from the Centres of Excellence for Women's Health, funded by Health Canada since 1996.

In this section, we will focus on private financing and delivery. Many of the reforms proposed in the Mazankowski Report ask individuals to pay more for their health care. Some examples are medical savings accounts, variable premiums, and the de-listing of some services from Medicare coverage. Other Mazankowski proposals would further expand the involvement of for-profit health care delivery. For instance, the report encourages regional health authorities to look for more opportunities to contract out services, and suggests that doctors set up “care groups” based on a business model.

When we speak of paying privately, this most often means paying out-of-pocket for health care services not covered by Medicare (such as some types of physiotherapy) or products (such as prescription drugs). For people with private health insurance, it means paying for premiums, deductibles, and co-payments.

“Private” can also mean **private delivery**. Raisa Deber (2000), health policy researcher at the University of Toronto, has identified several different types of private delivery - including not-for-profit organizations, for-profit corporations, and small businesspeople (like self-employed doctors).

Private not-for-profit hospitals are common in Ontario (where health care has not been regionalized), but there are few in Alberta. With the creation of regional health authorities (RHAs) in Alberta, most independent hospital boards were abolished. Over 200 community hospitals that used to be owned by municipal district boards are now owned by the RHAs. Thirty-five private not-for-profit healthcare facilities owned and managed by charities kept their own boards (Armstrong, 2000). However, they are effectively controlled by the RHAs through ongoing contractual arrangements and funding. Deber (2000) points out that although not-for-profit hospitals fall within a definition of “private,” they act in the public interest and are referred to by some as the “third sector.”

Another type of “private” delivery involves free standing diagnostic, surgical, or other types of treatment clinics in the community - most of which are for-profit companies. Edmonton-based consumer health researcher Wendy Armstrong has outlined the development of private for-profit surgical clinics since the mid-1970s. These small surgical suites were originally owned by one or two doctors or dental surgeons, and were considered an expansion of an individual doctor’s surgical practice. However, when the first such day surgery clinic opened, Alberta’s Minister of Health refused to add the cost of running the facility into the surgeon’s professional fee, leaving doctors to bill patients directly an unregulated amount to cover these costs.² In 1988, the first multi-purpose clinic was opened, and over time, the number of surgical facilities expanded in size and scope with many different surgeons working out of one facility, some merged, and eventually third party investors were brought in. The number of free-standing surgical clinics has climbed from two in 1975 to 52 in 1999 (see Armstrong [2000] for an in-depth discussion of this issue).

The problem is that when surgeries or other medical procedures are provided through private clinics there are no limits on how many can open. These private businesses are decentralized. Consolidating health care services under one roof is less expensive overall than paying the overhead costs for many facilities. A government that claims health care spending is “out of control” needs to take a critical look at these inefficiencies. Furthermore, private businesses must make a profit for investors. The profit-motive can encourage cutting corners and selling unnecessary “extras.” Unnecessary tests and treatments can prove risky, depending on the person and his or her condition. As well, because private for-profit clinics spend money on advertising and other business-related costs, their costs are typically higher per procedure than those in the public system.³

² This practice was ended in 1995 under pressure from the federal government, which ruled that the facility fees were a user charge and thus violated the accessibility principle of the Canada Health Act. However, surgical clinics are allowed to market uninsured services alongside those paid for by Medicare. As well, part of the federal provincial agreement to end the facility fees reiterated the right of doctors to practice both within and outside of Medicare.

³ See Taft and Steward (2000) and Armstrong (2000) for a fuller discussion of these issues.

Private administration is another meaning of the word “private.” The public administration principle of the Canada Health Act makes the provincial government responsible for administering and managing the public health plan, and ensuring the availability of hospitals and doctors to provide services covered by Medicare. If the government did not do this, there would be no co-ordination of the health system and no public accountability. In the United States, where private insurance companies administer health plans, administrative costs are substantially higher than in Canada. For example, doctors and hospitals need to hire staff just to deal with billing and collection from patients and insurance plans (Armstrong et al., 1998). Furthermore, without public administration, it would be harder to evaluate the health system. Evaluators would have to rely on many private insurers to provide data, without knowing if the companies fully disclosed all data necessary for proper evaluation.

With public administration, governments can reform the health system so it can keep meeting the needs of Canadians. These advantages would be lost with private administration. Private insurance companies have to guarantee return on investment. So they must look for business opportunities, as opposed to meeting all the health care needs of the population, so in most cases they only insure “healthy” people without any problems. Private insurance is also unaffordable for many people, as we will see in the next section.

What does “two-tier” mean?

“Two-tier” is a common term used to distinguish the American health care system from the Canadian system. In Canada, all people have equal rights to hospital care and medical care. Thus our system is considered to be a single tier system for these types of care. By contrast, the American system is often said to be a two-tier system, as people either have access to doctor and hospital care or they do not. In the U.S., this usually depends on whether their employer provides health insurance coverage for employees and their families. One third of working-age Americans do not have health care coverage because their workplace does not provide this for them (Committee on the Consequences of Uninsurance, 2001). Employees of small businesses are most often affected. A recent survey found that only 41 percent of small businesses provided health care coverage (Goldman et al., 2000). Overall, about 39 million Americans have no health insurance (Coalition for Covering the Uninsured, 2002).

Yet, it is not entirely accurate to say the U.S. has a two-tier health care system. It has a multi-tier system, with many levels of health care accessibility. The uninsured can get charity care provided for free by doctors or hospitals, though this care is often the bare minimum. Other people have ample health care insurance and so can access a wide range of health care services. However, private insurance plans have premiums, deductibles, co-payments, and limits on the types of conditions that are covered. So millions of Americans who do have insurance have inadequate coverage because of limits on what they can afford or what their plan will cover. In short, there is an incredible range of access to health care for Americans (see Fuller [1998] and the web site www.coveringtheuninsured.org for more in-depth information on private insurance coverage).

Canadians can easily slip into a two-tier model whenever patients are allowed to pay to access faster treatment. For example, many Albertans have paid extra fees for faster access to cataract surgery at private for-profit clinics owned by the surgeons (Armstrong, 2000). As well, some Albertans used to be able to pay privately for Magnetic Resonance Imaging (MRIs) to get a diagnosis sooner and thus get quicker access to treatment. Of course, this option was only available to those who could afford to pay. The less well-off had to wait for public MRIs. Friends of Medicare brought this to the attention of former federal Minister of Health Alan Rock, who then pressured the Alberta government to rectify the problem. By October 2001, Alberta had reimbursed 1,400 people who had been forced to pay for “urgently needed” MRIs in order to access timely treatment, at a cost over more than \$1 million (Ohler, 2001).

If we look beyond doctors and hospital services (where Medicare applies), we actually see a multi-tier system in Canada. For instance, some families purchase private care from home care agencies if they view the care provided by the public system as inadequate or unreliable or if they have to wait for public care. Many products and services that are free when care is provided in hospitals must be purchased at home. Examples include intravenous supplies and drugs. As more of the basket of services required to recover from illness or injury are provided outside hospitals, the difference in tiers in Canada relates to whether or not someone has an affordable employer sponsored group benefit plan that covers the extra costs (Armstrong, 1996; 2000; Coyte, 2000).

So in many ways the term “two-tier” is an over-simplification - both in Canada and the U.S. The number of tiers we see depends on how we define health care - whether we think only of doctors and hospitals, or consider a broader range of services that are only partially covered or not covered at all by Medicare. For services not publicly covered, one’s access to private coverage determines the tier one is on.

Can health care be treated as a market commodity?

Health care is largely treated as a market commodity in the United States, with health care coverage, tests and procedures bought by consumers (and employers) and sold by investor driven corporations traded on the stock exchange. When health care is treated as a commodity, then it must be paid for privately, and when there is no pay, there is no care or minimal care. By contrast, in Canada health care is considered a public service for the common good.

Since 1993, the Klein government has steadily introduced business language into Alberta’s health system. They call health care an “industry,” require “business plans” from regional health authorities, and refer to patients as “customers.” This language has set the stage for ongoing policy and planning decisions designed to continually expand the for-profit role in health care. (For a review of key government bills and health planning documents - including Bill 11 — see Scott et al., 2002).

Taft and Steward (2000) discuss a number of reasons why health care is not a commodity like food, shoes, books or other retail items. Patients do not have the extensive medical knowledge to judge the quality of the “products.” People who are sick are vulnerable and are in no position to “shop” for services. It is inappropriate for doctors to market unnecessary, expensive and potentially harmful procedures to patients for the purpose of making a profit. Health care procedures cannot be returned if the patient is harmed by or dissatisfied with them.

As well, a sudden bankruptcy of a private company could seriously disrupt access to health care. For example, the Australian insurance company HIH collapsed last year, racking up losses of \$4 billion dollars - the largest corporate failure in Australian history (Dodson, 2001). Canadian hospitals and provincial health care insurance plans do not go bankrupt. Canadians are much more assured that health care will continue to be available in public hospitals than in private for-profit clinics. Canadians also do not have to be concerned that they are having unnecessary or harmful tests or treatments because a facility needs to turn a profit. Perhaps the greatest danger of for-profit involvement in health care delivery, to patients and the public, is that commercial values often drive the inappropriate use of tests and treatments that can cause harm (Mintzes, 1998).

For all of the above reasons, most health economists have concluded that health care is a case of “market failure.”⁴ Markets fail to control prices, ensure adequate access to all who need it, or ensure a service is available in all geographic regions. If it were left to private markets, even fewer hospitals and other health services would be available in rural areas.

⁴ Taft and Steward (2000) provide a more detailed discussion of these issues.

Does competition from private facilities not make public facilities more efficient?

Some researchers suggest competition is a positive force that brings down costs. For instance, one review of hospital ownership points out that costs for for-profit, not-for-profit and public hospitals in the U.S. increase more slowly in areas where there is more competition among them (Baker et al., 2000). The authors say this is because all hospitals in a competitive market - regardless of type of ownership - operate more like businesses as they vie for government and patient dollars. However, cost containment by itself is problematic if it comes at the expense of quality of care. Some medical researchers have questioned what is being sacrificed in return for cost efficiencies, and how much of the savings are passed on to patients and governments (Altman and Shactman, 1997).

Competition in health care can actually create inefficiencies, such as overbuilt capacity. Taft and Steward (2000) give an example of U.S. for-profit hospitals buying more MRIs while machines at other facilities are not fully booked. Also, competition in theory does not occur in practice when there are monopoly providers. This happens when major diagnostic or laboratory companies have long-term contracts with government and there are no other providers, especially in rural areas, able to provide the service. Stability of services is necessary for public confidence in the system. The next chapter explains how competitive bidding for contracts in the home care sector, particularly in Ontario, has undermined quality of care as providers cut corners to win bids. For all these reasons, it makes the most sense to provide stable, long-term services in the public system.

Won't contracting out to the private sector save money because businesses are more efficient than government?

Most large studies comparing for-profit and not-for-profit facilities has been done with hospitals in the U.S. This research has found that for-profit hospitals actually have higher costs than not-for-profit hospitals (public hospitals are operated on a not-for-profit basis).

The U.S. research most relevant to the Canadian context is that which compares costs of treating American patients covered by the U.S. Medicare program for seniors. That is because Medicare payments to the hospitals are made by government (as in Canada) rather than by private insurance companies. Three recent studies found that the costs to Medicare were higher in for-profit hospitals than in not-for-profit hospitals (Silverman et al., 1999; Sloan et al., 2001; Woolhandler and Himmelstein, 1997). In addition, Silverman et al. (1999) found the highest per-patient cost increases among hospitals that converted from not-for-profit to for-profit during the years of their study, and that administrative costs were especially high in for-profit facilities.

These studies have been published in a number of prestigious and credible journals — *New England Journal of Medicine*, *Journal of the American Medical Association* and *Journal of Health Economics*. The findings are not surprising when we consider that investors in for-profit facilities need to keep costs low in order to maximize profits. In situations where the total patient costs are similar between for-profit and not-for-profit hospitals, the similarity is achieved by having shorter lengths of stay to offset higher daily costs in for-profit facilities (Ettner and Herman, 2001). Furthermore, for-profit facilities are less likely to be involved in professional education, research, or provision of services for which they are not reimbursed - such as treating uninsured persons and providing community education (Baker et al., 2000).

A study of cataract surgery by Edmonton researcher Wendy Armstrong for the Consumers Association of Alberta found that private surgical contractors were more costly to the provincial health insurance plan than public hospitals were (Armstrong, 2000). For instance, the “soft” or “foldable” lens option was more expensive in Calgary (\$250-\$750 per eye), where the regional health authority contracted out all publicly insured cataract surgeries to private clinics, than in Edmonton (\$250-\$425 per eye) where only 20 percent of surgeries were contracted out. In Lethbridge, where all cataract surgeries were done in the public system, the enhanced lens was provided at no charge (and cost the health region less than \$100 per eye).

Some concerns have been raised in the U.S. about stand-alone surgery clinics taking procedures - particularly orthopedic surgeries — away from community hospitals that get much of their funding from those procedures. There is also a rising trend for doctors who own surgery centres to expand them into specialty hospitals. This allows them to both gain more control over their services and to keep profits up as procedures formerly done in surgery centres move to offices (Becker and Biala, 2000). The implication for Alberta is that public money spent contracting out services to the for-profit sector is lost to the public system. And as for-profit clinics look for more opportunities to make money for investors, they will increase the pressure on governments to open up more of the public system to for-profit providers. Wendy Armstrong suggests the rapid increase in the number of surgical clinics in the late 1980s and early 1990s, coupled with a shrinking market of people able to pay privately, pressured the government to close hospitals and contract out more publicly-funded services to these private for-profit clinics (Armstrong, 2000).

Wouldn't the private sector provide better care because it has more incentive than government to focus on customer service?

There is no conclusive evidence that for-profit hospitals or clinics provide better quality care. Arnold Relman, a retired Harvard medical professor and former editor of the *New England Journal of Medicine*, has studied this issue for many years. Relman has recognized the challenge of doing quality comparisons across different types of hospitals and procedures. For example, it is hard to compare complex medical procedures and patients may have other complicating factors when they seek treatment, like other diseases, when they seek treatment. However, he told a recent hearing of the Standing Senate Committee on Social Affairs, Science and Technology (chaired by Senator Michael Kirby) that when services are standardized and prices are fixed - for example, with kidney dialysis - comparisons are relatively easy. In these cases, for-profit care is of poorer quality than not-for-profit care (Relman, 2002).

A study published in the *New England Journal of Medicine* followed more than 3,500 U.S. kidney dialysis patients for 3-6 years. This research found that for-profit ownership of dialysis facilities was associated with more deaths and fewer patients on the waiting list for a kidney transplant, compared to not-for-profit facilities. The researchers suggested that a decline in Medicare payments for dialysis may have compromised the quality of care in the for-profit facilities, and that they may have been reluctant to refer patients for transplantation for fear of losing payments for dialysis if patients received transplants (Garg et al., 1999).

One of the most extensive studies comparing quality of care in for-profit and not-for-profit facilities looked at national quality of care data for 56 percent of the total health maintenance organization (HMO) enrolment in the U.S. This study, published in the *Journal of the American Medical Association*, found that not-for-profit HMOs scored higher than for-profit HMOs on 14 quality-of-care measures. The largest differences were observed for measures that dealt with more serious medical conditions. For example, for-profits did fewer mammograms. The researchers estimated that if all women ages 50-69 were enrolled in for-profit HMOs in 1996, almost 6,000 more breast cancer deaths would be expected (Himmelstein et al., 1999).

One area where for-profit hospitals usually do worse is adverse affects. A recent study of hospitals in Utah and Colorado found that patients in for-profit hospitals were more likely to suffer preventable adverse effects - especially for operations and delayed or incorrect diagnosis and treatment (Thomas et al., 2000). Adverse effects are also more likely when nursing staffing levels are low (Baker et al., 2000). Adverse affects are a more sensitive indicator of quality of care than death rates (mortality). Mortality is influenced by patient characteristics, whereas adverse effects following surgery are related to hospital characteristics (Baker et al., 2000).

However, one large national U.S. study of Medicare heart disease patients (age 65 and over) that did adjust for patient factors influencing mortality (such as presence of other diseases), found that both for-profit and government hospitals had lower mortality rates than not-for-profit hospitals and teaching hospitals.⁵ Between 1985 and 1994, mortality differences between for-profit and not-for-profit hospitals actually increased (McClellan and Staiger, 2000).

Quality of care is closely tied to staffing ratios and qualifications. Though they have a higher percentage of registered nurses, for-profit facilities in the U.S. are more likely than non-profit facilities to have fewer total employees per occupied bed. In most cases, the for-profit hospitals also offer lower salaries (Baker et al., 2000). This suggests a heavier load on health professionals in for-profit hospitals and a risk of burnout - conditions hardly conducive to attracting and retaining qualified staff for the long term.

The overall trend in quality of care research points to not-for-profit care being of higher quality in most cases. Given the very clear evidence on the higher costs of for-profit care, why would governments pay more to have for-profit facilities provide care that will be no better, and will often be worse, than the care already provided on a not-for-profit basis in our public system?

How does a for-profit clinic differ from a doctor in private practice?

People who want to advance a for-profit health care business or an American-style health care system in Canada often say that most health care is already provided privately here anyway. What they are often referring to is the fact that most medical doctors are self-employed with their own private office or clinic in which they see patients. Self-employed doctors are for the most part paid by government and are not allowed to extra bill for services. Also, as Taft and Steward (2000) point out, self-employed doctors are only accountable to patients and professional standards, not to investors.

By contrast, when doctors work in a private for-profit clinic, they are expected to contribute to the main aim of that clinic - making a profit. Therefore, doctors who work in investor-owned clinics are in a position where accountability to patients and professional standards can conflict with pressure to create profits for shareholders, or to bring in money to pay for expensive equipment. These issues become especially problematic when doctors are themselves investors as well as practitioners. The need to ensure sufficient sales in order to maintain an expensive facility and avoid financial losses can influence the professional advice upon which patients depend. The greater the investment and the more to lose, the greater the potential for conflicts between business objectives and professional values.

⁵ Government or public hospitals in the US provide last-resort treatment to people who have inadequate or no private insurance. By contrast, public hospitals in Alberta more closely resemble not-for-profit hospitals in the US. This is not surprising, as most of our hospitals started out as community owned not-for-profit organizations. Teaching hospitals are involved in the training of health professionals - the Canadian counterpart would be university-based public hospitals.

The Mazankowski Report does not distinguish between self-employed doctors and doctors in investor-owned clinics. It recommends more group practices (including both doctors and other health professionals), in part to reduce office costs. This could be positive in public or not-for-profit settings such as community health centres. On the other hand, the report further suggests that these “care groups” of doctors operate on a “business model” (PACH, 2001a). This model appears to go beyond the current situation where some self-employed doctors work in a group practice to share space and resources - and suggests a greater private for-profit role in primary health care. This issue will be further discussed in the next chapter.

If my regional health authority contracts with a private, for-profit clinic to provide some surgeries or other procedures, won't waiting lists in the public system get shorter?

It is tempting to think that opening up new operating theatres and diagnostic clinics will shorten the waiting times for treatment in the public system. Unfortunately, countries that allowed the private for-profit sector in do not show much benefit from this change.

The Centre for Health Services and Policy Research at the University of British Columbia conducted a review of private for-profit health care. The review pointed out that in Britain, where there are both public and private for-profit hospitals, doctors work in both systems and can choose how to allocate their time between them. Contractual obligations to the public system are not well enforced, and these obligations cover time only, not productivity. The review suggested that the British system actually acts as an incentive for doctors to allow public waiting lists to grow, so they can then serve patients in the private system where they can earn more money (Evans et al., 2000). The British experience should be a lesson to Canada. When doctors are allowed to practice “on both sides of the Medicare fence” - such as in a public hospital and a private surgical clinic, as they are allowed to do in Canada — contracting out procedures to for-profit facilities will not shorten wait times.

The Alberta cataract surgery study found that waiting times were related to how much cataract surgery was contracted out to for-profit clinics (Armstrong, 2000). In Calgary - where 100 percent of cataract surgeries were performed in private clinics - patients waited an average of 16 to 24 weeks for treatment. In Edmonton, where 80 percent of cataract surgeries were done in public hospitals, waiting lists were five to seven weeks long. In Lethbridge, where 100 percent of cataract operations were performed in the public system, patients waited an average of only four to seven weeks. Furthermore, some patients of the for-profit clinics were being enticed to shorten their waiting time for surgery by purchasing a more expensive type of lens implant. So private for-profit health care does not necessarily shorten waiting lists. Providing public contracts to private clinics often also subsidizes the start-up costs of other business at the clinic that eventually draws physicians away from Medicare work to more lucrative activities such as laser eye surgery. With fewer doctors in the public system, waiting lists will grow longer.

Our public health system has worked reasonably well and efficiently to date because doctors must decide if a person's need for health care is urgent (need care now or later today), emergent (need it within 2 weeks), or elective (can wait for it without undue harm). This means people who most need care get it more quickly, which contributes to a more efficient use of health care resources.

However, waiting lists could be better managed. Doctors decide who goes on a waiting list and when. There are no clear, consistent criteria (beyond the degree of urgency mentioned above). And there is presently little co-ordination of lists among doctors or across specialty care areas (National Leadership Roundtable on Health Reform, 2000). Health policy researcher Michael Rachlis presents evidence that 20-50 percent of patients on waiting lists either do not want surgery, have already had it, have died, or are on more than one list (Rachlis, 2000b). There are a number of initiatives in Canada to develop better waiting list management. For example, the Western Canada Waiting List Project has been testing ways to help doctors assign priority to where on a waiting list patients should be placed — on the basis of both need and potential to benefit from a treatment (Western Canada Waiting List Project, 2001).

Under the overall recommendation to “put ‘customers’ first,” the Mazankowski Report (PACH, 2001a: 43-44) presents several recommendations concerning wait times — including guaranteed wait times of 90 days or less, centralized booking, and posting wait times on a web site. The last recommendation includes the option of choosing another facility to get faster service. This flies in the face of better system-wide co-ordination and monitoring of waiting lists, and is also inconsistent with the recommendation for centralized booking. The 90-day guarantee is presented as an incentive to manage and shorten waiting lists. The potential effectiveness of this is hard to determine without knowing the acceptable wait times for specific procedures, how people are put on lists, and the criteria used to prioritize cases. But of most concern is the report’s suggestion that if waits exceeded 90 days, patients could go to other public or private providers. This perpetuates the myth that private facilities can be used to alleviate wait times, when the evidence is that the opposite occurs.

If we have more private providers in the system, doesn’t that give me more choice?

Currently, Canadians can choose which doctor to see, and which emergency department or hospital to go to when they are sick, without having to check with their insurance company first or pay up front and then try to get reimbursed. And they are not asked for evidence of a line of credit before being treated in an Emergency Department. If we allow the choice to pay out-of-pocket or through private insurance for additional health care beyond what the public system provides, we create a situation where the wealthy have these choices but the majority of us do not.

In Canada, we can choose a family doctor or hospital - our choice being limited only by their availability and location. Because of Medicare, our choice is not dependent on their fees. If there were more private for-profit providers, our choices would not necessarily increase. There are a limited number of health professionals in the province. If we further fragment the supply of providers to cover new for-profit facilities, it will be at the expense of the public system. If our public health system deteriorates because public funds are spread between public and private systems, then we may have little choice but to accept a lower quality of care and longer waiting times in public hospitals.

Also, when care is provided in private for-profit clinics, there is nothing to prevent these business operations from marketing “enhanced” (but unnecessary) uninsured services alongside the services covered by Medicare, in order to increase profits. Most patients do not have the medical background to know the difference between medically necessary and unnecessary procedures. Though the provincial regulations developed for the Health Care Protection Act (Bill 11) say that doctors must discuss these issues with their patients (Alberta Health and Wellness, 2000), most patients will defer to the recommendations of the doctor. This puts doctors who answer to investors (or are investors themselves) in a conflict of interest between their own and their patients’ best interests.

If I experience complications after surgery in a private, for-profit clinic, who is responsible for whatever treatment I need?

For surgery in a private clinic, the clinic is paid by the Alberta Health Care Insurance Plan (for example, cataract surgery) or by the individual (for example, laser eye surgery for vision correction that the government has deemed not medically necessary). Private clinics are only equipped to treat the easy, uncomplicated cases. When complications arise, the patient ends up in the public system. The reasons for this are many. Private clinics are not usually open 24 hours a day, seven days a week, so complications are dealt with in the emergency department or a doctor's office that has extended hours. Stand-alone private clinics also do not have emergency equipment, or critical care expertise. This care is only available in a full service public hospital.

Private for-profit clinics in some cases contribute to surgical complications through the marketing of new and often experimental procedures. Or they may encourage a procedure such as surgery for individuals who are not appropriate candidates from a safety perspective. When complications occur, these patients often end up back in the public system (Consumers' Association of Canada, 2002).

Why not bring more private insurance options into the system? Aren't the health care premiums I pay a type of insurance?

Our health, education and other public services are funded through federal and provincial revenues such as income taxes and the federal GST. Albertans also pay health care premiums, which have recently gone up by 30 percent. Alberta and British Columbia are the only provinces that require citizens to pay what amounts to an additional flat tax for health care. Premiums have recently covered about 11 percent of total health care costs, and the government wants them to cover 20% of costs, as noted in the Mazankowski Report (PACH, 2001a).

Premiums are regressive in that people just above the low income exemption pay the same amount as the wealthy. But government health care premiums, as regressive as they are, are not the same as private insurance premiums. Insurance premiums are higher if we have pre-existing health problems like a previous heart attack. Insurance plans provide different levels of service according to whatever premium rates we can afford. The present government premiums are the same for all, regardless of the state of our health or the services we require. The advantage of pooling our resources for health care within a public health insurance plan is that a collective pool of funds is available for people who need health care, so that their care does not depend on their individual ability to pay.

The Mazankowski Report talks about a larger role for private insurance companies to cover diagnosis and treatment not covered by Alberta Health Care, or to cover home care and long-term care services (PACH, 2001a: 55). Increasing the role of private insurance shifts costs from governments to individuals. This will create inequities in access to health care as those with higher incomes can afford to buy more private insurance than can those living on middle and lower incomes.

Haven't user fees been shown to cut down abuse of the system?

What does the government mean by "abuse"? The word implies intent to cause harm. Most people are not health professionals. They do not know if their symptoms are serious or not. Delaying a doctor visit because of cost means that diseases will not be detected and treated until they become serious. This will cost the system more in the long run - and create more stress for patients and their families. How is being vigilant about one's health and seeking early treatment "abuse"?

Years of research from various countries have shown the only impact of user fees is in keeping the poor, the sick, the elderly and the disabled from making a timely visit to a doctor (Deber, 2000). User fees are also likely to affect women more than men, as women are over-represented in the above groups (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999). Are these results we want?

Furthermore, user fees are unlikely to save health care costs because of (1) the higher costs of delayed treatment, (2) costs of administering the fees, and (3) the fact that most patient visits beyond the first one are requested by doctors, not patients (Deber, 2000).

Sweden is sometimes given as an example of a user fee success story. But Swedish researchers - like those elsewhere — have found that lower income groups delay treatment from doctors and end up in hospital more often as a result of fees (Gerdtham and Sundberg, 1998). Because user fees are not allowed under the Canada Health Act, there are no recent Canadian studies of doctor or hospital-based fees. However, earlier research found that when Saskatchewan brought in user fees for doctor visits from 1968-75, the poor and the elderly saw their doctors less often, and the better off saw their doctors more often (Beck and Horne, 1980). More recent research in Quebec shows how increases in prescription drug fees are related to lower use of essential drugs and poor health outcomes. (This will be discussed in part four under Pharmacare.)

Would giving people their own personal health accounts, and letting them keep what they don't spend, encourage them to stay healthy?

The short answer is no. Let's take a look at the two schemes proposed in the Mazankowski Report - medical savings accounts and variable premiums coupled with an "Alberta health care account" (PACH, 2001a: 57-59).

Medical savings accounts

With the type of medical savings accounts (MSAs) proposed in the Mazankowski Report:

- the government would deposit a set amount per year into a personal account for each Albertan - perhaps the amount of the premium we already pay, or the premium plus some additional amount;
- these amounts would be somehow adjusted for factors like age and sex;
- people would draw down this account to pay for the health services they use;
- people could accumulate unspent MSA money tax-free to cover future health costs as they age.

The assumption behind MSAs is that they will encourage people to take personal responsibility for their health. When people use up their MSA amount for the year, there would most likely be a "corridor" (or gap) where some amount of health care would not be covered. At some point after that, Medicare coverage would kick back in to protect people from serious illness. Although the report presents a second option where the government would pick up the total cost after the MSA is spent, this would work against the

report's focus on "incentives to stay healthy" and "diversifying the revenue stream." It also would increase administrative costs to oversee all those individuals accounts, with no resultant savings. So the "corridor" approach is more likely. MSAs in other countries all have gaps or "corridors" where people have to pay some of their own costs.

The people most likely to need health care may not find enough money in their MSAs to cover all their costs. Given that the average Albertan's doctor bill is \$350 per year (Alberta Health and Wellness, 2001a), many Albertans in poor health could not expect to bank much of their health care premium - which is \$530 a year for an individual after the recent 30% hike — for future years. In fact, many would likely use up their accounts before the year is up. This would create a captive market for private insurance companies offering "gap insurance" to cover the "corridor" between when the MSA is spent and Medicare kicks in to cover serious illness.

There is no evidence from any other jurisdiction that MSAs reduce costs or improve health status. One Canadian health policy analyst has pointed out that MSAs will have similar effects to user fees because people will try to accumulate surpluses in their accounts by delaying visits to doctors (Deber, 2000). It is also possible that people could use MSAs to purchase anything they want - including seductively marketed but medically unnecessary, ineffective or even harmful procedures not presently covered by Medicare.

It is not yet clear how the government would design MSAs in Alberta. In Singapore, MSAs have existed since 1984, and a public insurance plan to cover catastrophic illness has been in place since 1990. Yet health costs continue to rise and to shift from governments to individuals. Singapore's public catastrophic insurance plan uses the risk selection practices of private insurance. For instance, the plan does not cover people with a pre-existing condition, and excludes some conditions such as mental illness and HIV/AIDS. Patients also pay high deductibles when they use the health system (Barr, 2001; Hsiao, 2001).⁶

Even if the Alberta government fully covers serious illnesses and hospital costs under Medicare (as they suggest in the report that they will do), people may find that their health status prevents them from getting private insurance to cover services they need while in the "corridor." And because private insurance companies can insist on pre-authorizing care, they could deny payment for care, even if a doctor recommended it. So some Albertans could end up paying "corridor" costs out of their own pockets. Given that more illness is associated with lower incomes, the MSA scheme will hit hardest Albertans who fall just above low income premium exemptions.

The Mazankowski Report does acknowledge some of these problems with MSAs - including the possibility that the "corridor" payments could contravene the Canada Health Act because they are direct charges to patients. That begs the question of why MSAs have received so much attention in the report.

⁶ The different MSA models in other jurisdictions are discussed in a recent Parkland Post article by Donna Wilson, Professor of Nursing at the University of Alberta (Wilson, 2002) and in a report on health reform from the Queen's University Centre for Health Services and Policy Research (Shortt, 2001).

Variable health premiums

According to the Mazankowski Report (PACH, 2001a: 58-59) variable health premiums and the associated Alberta health care account would work as follows:

- the government would deposit the base health care premium into individual accounts;
- a base premium would be deposited to individual accounts (similar to MSAs);
- premiums would rise over time at a similar rate as health care costs;
- individual accounts would be debited for the first 20% of the cost of each health service provided to the individual (co-payment);
- a premium supplement, or top-up, would be charged if 'debits' exceed the amount in the base account - to be charged after the health services are provided;
- people could save surplus amounts to be used for health services in future years - though with less flexibility than for MSAs, in that the amount could only be applied to services covered under Medicare;
- the maximum total of premiums and premium supplements would not to exceed a set percentage of taxable income (3 percent proposed), with the lowest income earners exempt.

Variable premiums have many of the same problems as MSAs. If people have to pay premium supplements up to a set amount of their income, there is again an uninsured "corridor" or gap. People will either have to dig into their pockets or buy private insurance to cover the extra costs. Charging patients for services - even if it is after the fact - raises the same concerns regarding the Canada Health Act as MSAs do. Specifically, the Act's principle of accessibility — no barriers, including financial ones, to getting services — would be violated.

What values underlie individual health accounts?

The notion of financial incentives to stay healthy is misguided. Despite our best efforts to look after ourselves, any of us could be struck down by weak genes, bad environments, or the reckless behaviour of others. For example, eating well and exercising cannot prevent degenerative diseases like Alzheimer's, Parkinson's or multiple sclerosis. Looking before we cross the street may not save us from drunk or speeding drivers. People who live close to intensive livestock operations (feedlots) or gas flaring can do little to protect themselves from pollutants in their air and water. How do we tell victims of violence in the home or on the street that they should have been more careful? And finally, income - and income disparities within a population - is the strongest influence on our health, as discussed in the next chapter.

Right now, Medicare funding is a pool of money from which all of us draw when we get sick, according to our needs. Individual accounts - whether MSAs or personal accounts linked to variable premiums - encourage us to look out for ourselves rather than each other. They undermine the principle of caring for each other as part of the common good. The sick use up their accounts and pay extra out of pocket. The healthy hoard their account surpluses from year to year, even though those funds could benefit the sick. This is somewhat like the TV show *Survivor*, except we each would keep others off our own islands. What does it do to the fabric of society when our government encourages us to see ourselves as a collection of self-interested individuals, rather than part of a community where we share resources to look after each other?

Wouldn't providing everyone with information on the costs of their individual health care costs teach them to use the health system more responsibly?

Some people think there is abuse of the Canadian health care system because health care is "free." Yet there are few people who look forward to chemotherapy, barium enemas and other uncomfortable diagnostic tests, surgery or other treatments. When this reality is considered, we can see that concerns about health system "abuse" are greatly exaggerated and are not backed up by the evidence. In fact, most medical visits happen at the request of the doctor, not the patient (Deber, 2000).

While more visibility of the average costs of products and services might help everyone appreciate the value of having a public health insurance plan, this information may be disconcerting (and even guilt-inducing) for those who are less healthy. Do we really want to send the sick the message that they might be abusing the system? Would this not discourage early treatment of conditions that turn into more serious problems if people delay treatment?

It would take a great deal of effort to cost out every procedure and every treatment in Alberta, and then create a U.S.-style bill itemizing our health care. For example, the number and type of procedures done in a facility in any given month, as well as the bulk price of each item used for those procedures, will affect the per procedure price.

How will higher health premiums and more private insurance involvement affect the "Alberta Advantage"?

Both business and labour groups in Alberta have raised alarms about higher health premiums. For instance:

- The President of the Edmonton Chamber of Commerce stated that higher premiums would force businesses to decide whether to continue to pay all or part of workers' premiums. The Alberta Director of the Canadian Federation for Independent Business called premiums a payroll tax and said any increase would be a financial burden to business (Finlayson, 2002);
- The Alberta Federation of Labour has pointed out that it is not only premium hikes that will increase business costs, but also supplementary private insurance benefits that workers will need if some health services are de-listed (McGowan, 2002).

Similar issues have been raised at the national level. A recent article (Galt, 2002) in the *Globe and Mail's* business section presents some health care concerns of labour and business leaders:

- The President of the Communication, Energy and Paperworkers union emphasized that if universal health care is eroded and unions go after employers for private coverage, labour costs could rise - "it will become the bargaining issue of the decade."
- The Conference Board of Canada noted that public health care "has been a real source of competitive advantage, particularly over the United States... any policy debate on the future of the health care system in Canada should recognize not only Medicare's symbolic value to individual Canadians, but also its economic contribution to the competitiveness of Canadian businesses vis-a-vis the United States."

The Galt (2002) article also reported that a KPMG survey found that Canada is the least costly place to do business out of nine countries, and has a 14.5 percent cost advantage over the U.S. - based on a comparison on wage and benefit costs, taxes, transportation and utility costs. The study also found that universal health care is a significant factor in keeping down private benefit costs in Canada.

Given these concerns raised by both labour and business, why would the Alberta government move toward a system where employers will have to purchase additional health benefits for their employees if they want to attract and retain skilled workers and avoid labour unrest?

PART FOUR

Building on Success: Promising Directions for Health Reform

Tammy Horne

Our report has so far been critical of some of the assumptions and proposals put forth by the Mazankowski Report. This final chapter offers some constructive solutions for strengthening Canada's public health system. The Alberta government would do well to revisit the recommendations of the National Forum on Health from 1997 that called for universal pharmacare, expanded home care, and a stronger focus on primary health care (the first point of contact with the system when we are ill). In this chapter I suggest how these solutions could work in the Alberta context - in a strong public system. Alberta already has done some good work in all these areas, and I include some examples of this. But there is much room for improvement.

I caution against simplistic solutions, however. For example, home care is not appropriate for all patients, and should not be done as a way to save the government money by shifting costs onto patients and their families. Likewise, changing the way doctors are paid without considering how they can best work with other health care providers is simplistic. I provide examples of both established and new models of health care teamwork that include different ways of paying doctors, but more importantly, offer more comprehensive care to patients than the usual medical model. The Mazankowski Report recognizes some of these issues, but over-emphasizes the issue of physician payment and promotes a business model of teamwork among doctors that downplays the contributions of other providers and opens up in-roads to for-profit health care.

This chapter also goes beyond a focus on illness care to include health promotion. As a middle-class health promotion researcher and educator, my own thinking used to be firmly grounded in the assumption that by promoting healthy lifestyles - lots of physical activity, good eating habits, no smoking - we could help people stay healthy. Over the last 10-15 years I have been involved with organizations and individuals that better understand the realities of living with poverty and other stressful life circumstances. I have learned from them - as well as from a growing body of research on social factors that influence health - that we cannot simply promote health behaviours in isolation from the context of people's lives. The Mazankowski Report also recognizes both behavioural and social influences on health. Its call for more emphasis on health promotion is welcome. But it still focuses mostly on behaviour. The section on health promotion in this chapter highlights the need to deal with social issues while still recognizing the contribution of "lifestyle" behaviour to health.

Finally, no discussion about solutions would be complete without calling for more accountability. The Auditor General of Alberta has raised some alarms about poor planning and accounting regarding how public money is spent. We saw in part three that many of the Mazankowski proposals contradict the available evidence. Albertans will have confidence in the public system only if they believe they are getting good value for the taxes they pay, and that decisions about their health care are based on evidence of what works. They will not have confidence in any system based on political ideology or the personal interests of the few that stand to benefit from its dismantling.

Pharmacare

What is Pharmacare?

In 1997, a national panel of health care experts recommended a pharmacare program for all Canadians. They argued that prescription drugs are as medically necessary as doctor and hospital services, and pointed out that drugs covered in hospital are not covered when the patient goes home. This group recommended “first dollar coverage” - with no deductibles or co-payments.¹ They suggested this could be done by expanding provincial budgets for doctors payments to include prescription drugs (National Forum on Health, 1997c).

Pharmacare would most benefit people with lower incomes, who spend a greater proportion of their incomes on drugs than people with higher incomes. Those on lower incomes are also less likely to have private insurance and more likely to get sick (Lexchin, 2001a).

All provinces have some type of public drug plan, but with restrictions. Alberta limits coverage to seniors and others not eligible for workplace or individual private drug plans. Seniors do not presently pay drug premiums. Premium subsidies for people under 65 are limited to those on low incomes. Others under 65 can buy non-group coverage at full premiums (Alberta Blue Cross, 1999; Alberta Health and Wellness, 2001b).

Only five provinces - British Columbia, Saskatchewan, Manitoba, Ontario, and Quebec — have some type of universal plan that covers everyone under age 65. However, even those plans have deductibles and co-payments, and in some cases premiums, though the costs are geared to income in most provinces (see BC Ministry of Health Services, 2001a, regarding a comparison of provincial drug plans).² Though these plans do not reflect the “first dollar coverage” recommended by the National Forum on Health, they go further than Alberta’s plan in their public coverage of people under 65.

Drugs are one of the fastest rising health care costs.

How could a pharmacare program that covers everyone be affordable?

Prescription drug costs have more than doubled in ten years. The Alberta government spent about \$74 per person for drugs in 1991-92. Inflation-adjusted costs to the provincial government for 2001-02 are projected at \$149 per Albertan. Drug costs today account for 6.6 percent of Alberta’s health budget, compared to 4.6 percent ten years ago (Canadian Institute for Health Information, 2001a).

So how can pharmacare be affordable? British Columbia has gone the furthest to control prescription drug costs. Their overall cost (public and private combined) was the lowest of any province in Canada in 1999, at \$362 per person. Alberta’s overall prescription drug costs for that year were \$385 per person. However, B.C. has been paying a higher public share of those drug costs than other provinces - 48 percent in 1999. By contrast, the provincial government share in Alberta was only 37 percent (Canadian Institute for Health Information, 2002).³

How has B.C. controlled its public drug costs? One method is B.C.’s Reference Drug Program (RDP), which enables the government to comparison shop for the most effective drug at the lowest price. That means that if several drugs in a category work equally well in treating a disease or condition, only the cheapest one (the “reference” drug) is fully covered by the drug plan. There is room for exceptions based on clinical judgement. For example, if a person has an adverse reaction to the reference drug, a doctor can prescribe a more expensive drug that the person can tolerate (BC Ministry of Health Services, 2001b).

¹ With deductibles, coverage kicks in after patients have paid some initial costs (e.g., the first \$100). With co-payments, patients pay a percentage toward each prescription.

² This information is subject to change over time, and relies on the self-reporting of the provinces.

³ This most recent report from CIHI uses 1999 figures as those are the latest ones that have been confirmed.

The RDP presently applies to five categories of drugs. In its first year of operation, the program saved B.C. \$6.7 million on the cost of drugs to treat high blood pressure (Schneeweiss et al., 2002). A study headed by Malcolm Maclure of the B.C. Ministry of Health found that the program has saved B.C. \$44 million a year overall since 1995, in comparison to what costs would have been without the program (Maclure et al., 2001). Alan Cassels, an independent drug policy researcher in Victoria, notes that several independent evaluations of the reference drug program have shown no negative impacts in terms of deaths, hospitalization rates, or higher costs elsewhere in the health system (Cassels, 2002). The Alberta public drug plan has a cost control system to some degree through its "least cost alternatives" program (Alberta Blue Cross, 1999), and Alberta could look to the B.C. model to further enhance this system. By reducing the costs they pay out to drug companies, the Alberta government could afford to cover more Albertans under the public drug plan.

In addition to the RDP, B.C. has a central, secure computer database through which all pharmacies and emergency departments can check a person's prescription history. This system helps pharmacists identify and avoid duplication and assess possible interactions with other drugs (B.C. Ministry of Health Services, 2001b). However, such databases need to be implemented with safeguards to protect privacy. In Alberta, the Mazankowski Report (PACH, 2001a) calls for a system where all of a person's health information would be on a "smart card" that could be read by a computerized system. Sharing prescription history among pharmacists and hospitals has merit for both cost control and patient safety. But giving pharmacists and hospitals "carte blanche" access to a person's entire health record is unnecessary and an invasion of privacy. Health information should only be shared as needed to benefit the patient.

Should the Alberta government expand public prescription drug coverage to its residents, it must not happen at the expense of groups presently covered. Quebec offers a cautionary tale. When they made drug coverage universal in 1996, Quebec financed the expansion in part by bringing in fees for welfare recipients and low income seniors, who had until then been exempt from paying for drugs. As well, the minimal fees that other seniors already paid were raised. After these changes, both welfare recipients and seniors used fewer essential drugs, made more visits to emergency, had more hospital and nursing home admissions, and had more deaths (Tamblyn et al., 2001).

What can be done on a national level to keep drug costs down?

Even with the RDP, drug costs in B.C. more than doubled from 1990-99 (BC Ministry of Health Services, 2001a), though this increase is less than it would have been without the RDP (Maclure et al., 2001). So more needs to be done to control drug costs.

A national purchasing plan - or at least more co-operation among provinces — would allow bulk buying and more consistent drug coverage across provinces. Ministers of health across Canada have discussed a national drug-buying program. As a province concerned about fiscal responsibility, Alberta could take the lead on this issue. Another way to reduce drug costs on a national level would be to severely curtail the current 20 year patent protection for brand name drugs that was instituted in the early 1990s through Bill C-91 - which delays the availability of cheaper generic drugs on the market (Lexchin, 2001b).

Continuing education for health professionals, especially doctors and pharmacists, is also critical. Credible resources would allow professionals to be more critical of information they get from drug company sales representatives. In addition, doctors could work more closely with pharmacists to better understand when a new treatment is required and when an older, cheaper treatment is equally effective (Rachlis et al., 2001).

What does the Mazankowski Report say about pharmacare?

Nothing. The Premier's Council notes that the provinces and territories are working together to explore ideas for joint purchasing or developing a national formulary (the list of drugs covered by government). The Council suggests that solutions must be national, rather than specific to a province (PACH, 2001a). As mentioned earlier, national co-ordination of purchasing would give governments more bargaining power with the drug industry. A single formulary could benefit Canadians with consistent coverage - as long as coverage is not based on some lowest common denominator. Regardless of what happens nationally, Alberta could move on its own to make public drug coverage universal as five other provinces have done, and to further enhance its cost containment programs by looking to models like the reference drug program in B.C. The Mazankowski Report is silent on these possibilities.

Home Care In Context

Five years ago a group of leading health policy experts recommended a national home care program (National Forum on Health, 1997a). This section will argue that home care is a good start, but it needs to be further enhanced and better integrated with other types of continuing care options such as day programs, respite for caregivers, long-term care homes, and supportive housing options for seniors and people with disabilities. Furthermore, the home may not always be the best setting for providing health care.

What does home care do?

Peter Coyte, Co-Director of the Home Care Evaluation and Research Centre at the University of Toronto, explains that there is no consistent definition of home care across Canada. Services can include nursing, social work, physiotherapy, speech language pathology, audiology, occupational therapy, meals on wheels and home making (Coyte, 2000). For example, Alberta provides professional services (such as nursing, physiotherapy, occupational therapy, social work) and personal care services (such as bathing, dressing and grooming) free of charge based on "assessed need" and the availability of services. Professional care is provided through the public health care system. Personal care is contracted out to a mix of not-for-profit and for-profit providers (Health Canada, 1999b). Home care can have one of three functions - substitution for hospital care, substitution for residential care (such as in long-term care homes) or prevention/maintenance to keep people healthy for as long as possible in their own home (Health Canada, 1999b).

Who pays for home care?

Home care programs across Canada are poorly funded (Coyte, 2000; Flood, 1999; Fuller, 2001). Donna Wilson of the University of Alberta's Department of Nursing found that despite a commitment to increase support for home care and community health, their proportion of health system funding remained relatively constant and low - 4.7 percent in 1996-97, 4.9 percent in 1997-98, and 5.1 percent in 1998-99 (Wilson, 2000). Similar trends are evident nationally. Even though home care spending increased four times as fast as other health spending (9 percent vs. 2.2 percent a year) from 1992-97, its overall share of the budget is small — between 4-5 percent (Coyte, 2000).

Comparisons by the Canadian Institute for Health Information (CIHI) of provincial government home care spending for all provinces and territories showed Alberta seventh - at \$65 per Albertan in 1999, compared to the national average of \$90. So Alberta appears to be around the middle of the pack in home care spending. The CIHI researchers note that because Alberta reports its home care data combined with other forms of community care, it is hard to isolate the cost of home care specifically, and impossible to separate home health care from home support spending (Ballinger et al., 2001). Other inter-provincial comparisons by Health Canada for 1998 show that Alberta spent 3.6 percent of its health budget on home care specifically, compared to a national average of 4.5 percent (Health Canada, 1999a).

Approximately 80 percent of total home care costs in Canada are paid publicly through various forms of provincial taxation, and 20 percent privately through out-of-pocket payments or individual or group insurance plans (Coyte, 2000). By contrast, about 90 percent of home care was publicly funded in the mid-1990s (Fuller, 2001). Thus the private share of home care spending is growing.⁴

The private share includes co-payments in some provinces toward some of the publicly covered home care services. For instance, Alberta has a \$5/hour co-payment fee for homemaking services up to maximum of \$300/month, though fees are waived for people on low incomes (Alberta Health and Wellness, 2001d). However, consumer health researcher Wendy Armstrong has observed that patients in Alberta may also be wholly or partly responsible for costs of supplies (e.g. dressing supplies) in some regions, and bear additional costs for care at home such as co-payments for drugs and equipment (such as intravenous supplies). Over the years many former services provided by home care such as foot care for seniors have disappeared from coverage in some regions. The availability, scope of services and quality of home care varies across the province and the country (Armstrong, 2002, personal communication).

People also must pay out-of-pocket or through private insurance if they want more services than the public home care program provides. Most provinces have a limit on the amount of care a patient can access. In Alberta, the limit for professional and/or personal care combined is \$3000 worth per month, with exceptions for those in palliative care or waiting for long-term residential care (Alberta Health and Wellness, 2001d; Health Canada, 1999b).

These various private payments add up. A recent national survey found that 25 percent of Canadians paid an average \$407 a month on home care and \$138 on prescription drugs, and that patients recently discharged from hospital spent about \$200 a week on home care services (PriceWaterhouseCoopers Health Care Group, 1999; cited in Coyte 2000). Similarly, a national qualitative study by a team from the Canadian Research Institute for the Advancement of Women found that patients and their caregivers picked up costs (such as meals, drugs, medical devices) that would be covered if the patient was in hospital (Morris et al., 1999). The main users of home care are the elderly and women - many of whom are living on low or modest incomes (Coyte, 2000; Flood, 2001; Fuller, 2001)

Coyte (2000) points out that since the Canada Health Act was passed in 1984, the share of overall health costs covered under its principles has fallen from 57 percent of total health spending to 45.5 percent. The growth of home care has contributed to expansion of private finance in health care. Coyte estimates that about half the growth in private health care financing overall is due to cost shifting from government to individuals (passive privatization) and half to expanding markets for health services (active privatization).⁵ An example of the latter in home care specifically would be people buying private services - such as extra nursing hours - to supplement what they get from their public home care system.

4 Given the wide variations in how home care services are defined across Canada, exact percentages are hard to derive. The Canadian Institute for Health Information has a project underway to develop consistent methods for tracking and reporting home care expenditures, but so far this includes only public costs, so public versus private breakdowns are not available (Ballinger et al., 2001).

5 Coyte did not provide figures specific to home care.

Private payment for home care is not just about money. It is also about the demands on one's private time. Home care programs operate on the assumption that their services will only be provided when family and community members are unable to provide the care "free." In fact, about 80 percent of home care is provided by family members (Fuller, 2001). Colleen Flood of Dalhousie University's Health Law Institute is critical of these expectations of families:

It is one thing to facilitate and encourage those family members who want to provide home care services. It is another thing again to demand and expect a patient's family or community to provide care and only to supply publicly-funded care when the family and community are incapable of doing so or are stretched to the breaking point (Flood, 1999: 10).

Flood notes - as have many others- that family caregiving falls more often to women.⁶ She cautions that home care eligibility assessment processes should not play into gender stereotypes about women's and men's abilities to care for themselves or others, and that the assessment process consider caregivers' other work obligations both inside and outside the home. Other researchers have gone further - stating home care eligibility should be based strictly on a person's health needs and not on whether or not family members are available (Morris et al., 1999).

Closer to home, annual surveys conducted by the University of Alberta Population Research Laboratory for Alberta Health and Wellness show a substantial percentage of Albertans providing home/personal health support to a family member. There was a large jump in the percentage of Albertans providing such care between 1998 (31 percent) and 1999 (43 percent), despite ongoing "reinvestments" in the health system. The figure was 46 percent by 2001. Though the home/personal health support statistics are not presented separately for men and women, figures on health care support more broadly tell us that 45 percent of females and 38 percent of males provided such support in 2001. Of those providing care, women were more likely than men to say that providing support was a major disruption - 16 percent versus 11 percent.⁷ (Northcott, 1998; Northcott and Northcott, 1999, Northcott and Northcott, 2000; Northcott, 2001).

Some policy analysts have suggested tax-based subsidies to caregivers would compensate them for their time as well as reduce demands for formal care (Coyte, 2000; Flood, 1999). Tax incentives already exist to some extent through the federal caregiver tax credit. However, tax credits only allow people to claim back a portion of their costs. And even if people could deduct their full expenses, their jobs or other obligations may make it difficult for them to provide the level or quality of care required. Though tax incentives have a place in recognizing care work, they are not a substitute for more public investment in community-based care.

University of Alberta researchers Janet Fast and Norah Keating note the need to examine how various types of social policies affect caregivers - particularly policies on income security (such as pension, welfare rules), and employment (such as family leave, flexible hours). They also emphasize the need for flexibility in health policies. For example, restricting support services to one primary caregiver may disadvantage other caregivers in a person's social network and reduce the capacity of the network to share the caregiving. Fast and Keating further note that the independence of care recipients will be affected by housing and transportation policies. And there may be differences in care needs and preferences in different cultures (Fast and Keating, 2000).

⁶ Interested readers can refer to the reference by Armstrong et al. (2002) for an in-depth discussion of this issue.

⁷ This support includes emotional support, home/personal care, help with household chores, transportation, financial assistance and child care related to caring for someone who is ill.

When is home care appropriate and when is it not?

Home care analyst Peter Coyte (2000) points out that the push for more home care is based on three assumptions that are accepted as conventional wisdom but have yet to be verified:

- Canadians want to assume greater responsibility for health care at home;
- housing and employment circumstances permit the shift of safe and effective care to the home;
- safe and effective care at a lower cost will result by shifting care to the home.

Coyte questions these assumptions. For example, he says that homes are not designed for long-term health care and may in fact be hazardous to both clients and care providers. For people in unsafe or overcrowded housing, who cannot afford food, or who are being abused - the home is not conducive to health (Flood, 1999; Morris et al., 1999).

The evidence for home care as a cost-effective substitute for residential long-term care depends on the patient's condition. A British Columbia study (Hollander, 2001) found that, on average, health care costs to government for home care clients were half to three quarters of costs for clients in residential care. But costs were lowest for clients who were stable in their level and type of care. For clients who died during the study, costs were higher for home care clients than for residential clients. Half of all home care costs were associated with hospital use and were incurred when there was a change in the level and type of care needed.

Studies of the effectiveness of preventive home care for maintaining or improving peoples' independence and good health have also shown mixed results. British Columbia in 1994 cut funding for the homemaking support aspect of home care for patients classified as having low level needs. Some health units continued to provide this service, while others made severe cuts. This variation created a natural experiment to study the impact of the cuts. The study showed no differences after two years. After three years, however, almost 22 percent of people whose services had been cut had died, compared to about 15 percent of those who kept the services. Furthermore, people whose housekeeping had been cut were more likely to end up in residential long-term care - at 17 percent, compared to only 7 percent of those who retained the service. Annual cost to the system was almost \$12,000 per person for the group that experienced cuts, compared to about \$8000 for the group that continued to receive services (Hollander and Tessaro, 2001).

However, a Saskatchewan study found that seniors who received preventive home care were 50 percent more likely to lose their independence or die than those not receiving any services. By contrast, residents of seniors housing were 63 percent less likely to lose their independence and 40 percent less likely to die than other seniors in the province (HSURC, 2000). In reviewing these two conflicting studies and several others on preventive home care, the Health Services Utilization and Research Commission (HSURC, 2002) stated that there is no conclusive evidence for the general effectiveness of preventive home care.

These types of studies have a number of limitations. They each researched different types of home care and/or residential programs or different populations (which makes cross-study comparisons difficult). They also failed to control for other factors that could affect results, and had different lengths of follow-up (Coyte, 2000; HSURC, 2002). As well, most studies comparing home care to other types of care only examine costs to the health system, not to family members and other caregivers in the community. We do not know if and for whom home care would be cost-effective if these other costs were factored in.⁸ Furthermore, not enough is known about health and quality of life outcomes, cost-effectiveness, social support, or how much the burden of care has shifted to patients, families and community agencies (Coyte, 2000; HSURC, 2002). Coyte concludes that decisions about home care are made in an "informational vacuum."

⁸ Some work on costing informal elder care in the home has been done by University of Alberta researchers Janet Fast, Deanna Williamson and Norah Keating (1999).

In summary, the conflicting results from the different studies strongly suggest that there is no one best type of care. It depends on the patient's health and the types of services needed. So a range of well-integrated services must be available. More evaluation is needed to determine which home care services are most effective and for whom.

How can we provide a range of accessible, high quality services for people who need continuing Care?

In a recent book on community and continuing care in Canada, the Canadian Centre for Policy Alternatives (2000) outlines several types of programs. One model is "integrated programs" - such as the Comprehensive Home Option of Integrated Care (CHOICE) operated by Capital Health in Edmonton. This program serves frail elderly people who live at home and attend a day health centre 3-4 times a week. Clients get meals, physical activity and social contact, and health care from teams of providers. Family caregivers get a break. A similar program in New York showed a 34 percent decrease in hospital costs and a 70 percent drop in nursing home costs for those in the program, as well as a 5 percent decrease in overall health costs. CHOICE has been touted as an innovation within the public sector (Rachlis et al., 2001).

For those no longer able to live at home, but still able to maintain some degree of independence, the book describes supportive housing or assisted living ("congregate care") for seniors and people with disabilities. People have their own living space, 24-hour monitoring and emergency response services, and access to meals and housecleaning if they wish. Consumer health researcher Wendy Armstrong observes that there has been an explosion of such settings in the high end private market here in Alberta over the past decade, but few are affordable for those with less income. There are a few supportive housing options to replace traditional nursing home care as well, but the type of care and services vary. While a welcome change from traditional nursing home care, they are only suitable for certain individuals and are often more expensive for the patient and family. To date, these settings are largely unregulated and there is no consistent definition of assisted living or supportive housing (Armstrong, 2002, personal communication).

The research reviewed earlier suggests that home care is an important component of a *continuum* of care. Home care is a good option for people who wish to stay in their homes and are able to live independently. It must be better funded to reduce the load on family members, and there need to be closer links between home care and day programs that provide a break for the family and a change for the patient.

People also need different levels of supervised living options - including assisted living and long-term care facilities — should they no longer be able to live at home due to changes in their health condition or in the home environment. Appropriately trained and qualified personnel must adequately staff and supervise these settings. Understaffing (in numbers or in qualifications) is incompatible with the monitoring needed to prevent or quickly respond to adverse events before they create serious health conditions. Sufficient numbers of professional, unharried staff are also essential to developing rapport with patients - which is helpful for activities like feeding and bathing. If patients are uncomfortable with staff, family caregivers end up with more of that work.

Public or community-owned not-for-profit delivery is preferable to for-profit delivery so that funds go to qualified care professionals and corners are not cut to enhance profits. Colleen Fuller, a B.C. health policy researcher, along with researchers from Queen's University in Ontario, raise a number of concerns about contracting out - especially to the for-profit sector. These concerns include restrictions on the type and level of services that agencies can provide (funding only covers what is in the contract) and staffing issues (such as retaining qualified staff in low wage settings, raising the spectre of a loss of continuity of care). Other concerns include downward pressure on quality as the competitive bidding process forces cost cutting (for instance, fewer and shorter patient visits) and disruption of patient-provider relationships when one agency

loses a contract and another one takes over (Anderson and Parent, 2000; Fuller, 2001). Fuller (2001) documents increasing interest by for-profit providers and insurance companies in both home care and long-term care, and of Industry Canada's and the Department of Foreign Affairs and International Trade's promotion of private investments in Canada's health sector.

We need to also take a hard look at co-payments charged by public programs, as well as service limits that force people to either buy extra private care or rely more on family and friends. Out-of-pocket payment is a form of privatization, and is hardest on people who fall just above low income exemptions. At the very least, it makes sense that services and supplies covered under the Canada Health Act when a person is in hospital would be fully covered in home care and other continuing care settings. Coyte calls for the federal government to play a strong role in setting national standards for home care, and for an extension of the Canada Health Act principles to cover care provided in the community. There is less agreement on where to draw the line between public and personal responsibility for services that are less obviously "health care" - such as housekeeping (see Flood, 1999). Still, the B.C. study suggests that these services can be beneficial for at least some types of patients.

Manitoba's home care program has no co-payments for any services, and no individual limits on coverage - though the overall program budget restricts the total amount of service provided, and the program recognizes limits on what can safely be done at home (Health Canada, 1999b). Manitoba has invested more in home care than Alberta - \$117 per person compared to our \$65 as of 1999 (Ballinger et al., 2001). What is especially interesting about Manitoba is that the government tried to privatize home care in the mid-1990s, but ended up bringing it back into the public system. Reasons included lack of cost savings from privatization, evidence that one contractor had a history of fraud in the US, and public and provider opposition (Fuller, 2001; Willson and Howard, 2002).

The issue of accommodation charges for supervised housing options is more complicated. One could argue that people pay to live in their own homes, so should pay to live elsewhere. However, policy makers must understand that if people live in long-term care facilities or new substitute supportive housing options because they cannot live on their own, they have few choices to move if they cannot afford the daily or monthly accommodation fees. So leaving such "rents" to market forces will cause hardship or limit accessibility. For this reason, it works best to keep supervised housing in the public or community-based not-for-profit sector, and to have strict limits on charges. The for-profit housing sector must depend on market rents to stay in business, so their interests are in conflict with the needs of the sick for stable housing. We could learn valuable lessons from organizations that have been involved in social housing, as well as those who speak for the aged and people with disabilities, about what is both fair and feasible.

Most of the health reform debate is focused on acute care. The Mazankowski Report makes little mention of home care or long-term care - other than to point out that many such services are contracted out to private (for-profit) or not-for-profit agencies (p.50). Many Albertans are passionate about wanting to keep Medicare public, as we saw with the large rallies against Bill 11, designed to allow overnight stay surgeries in for-profit facilities. Meanwhile, the private for-profit role in home care and long-term care is growing without much public vigilance.

Primary Health Care

What is Primary Health Care?

Primary health care is the first point of contact we have with the health system, encompassing health promotion, disease prevention, treatment and rehabilitation. It involves teams of health professionals who encourage our participation in decisions about our care, and who recognize the many individual, social and environmental factors that affect our health (Alberta Health and Wellness, not dated; World Health Organization, 1978)⁹

Most health care we get is primary health care, usually from our family doctor. Primary health care reform would encourage doctors to focus on prevention as well as treatment, and would expand the role of other professionals in our care - such as nurses, nurse practitioners, pharmacists, physical and occupational therapists and social workers. The National Forum on Health (1997a) called for such reforms. Their report led to a federal Health Transition Fund that has supported 27 primary health care projects in Alberta over the last few years (Health Canada, 2001). But primary health care is not a new idea. For instance, community health centres with teams of health providers have been around for the last 30 years, as will be discussed shortly.

Why are governments so interested in primary health care reform?

As provincial governments strive to reduce people's use of hospital-based services, they need to promote alternatives. So expanding primary health care options is part of their solution to crowded emergency rooms and hospital down-sizing.

Governments also see primary health care reform as a way to lure doctors away from the fee-for-service payment system. Under this system, doctors who do many procedures are rewarded financially. Doctors who do fewer procedures but spend more time with their patients earn less money. So fee-for-service does not reward doctors for a comprehensive approach to primary health care. For example, there is little or no reimbursement for helping patients quit smoking or for other types of health education (Alberta Health and Wellness, 2001e; Canadian Medical Association, 2001). Furthermore, doctors cannot bill for the services of other health providers (such as nurses or dieticians) or for consultations with other health professionals when the patient is not present (Alberta Health and Wellness, 2001e; PACH, 2001a). The fee-for-service system promotes primary medical care rather than primary health care.

What are some examples of primary health care models where health care providers work in teams?

Primary health care innovations began shortly after Medicare became a national program. Almost 30 years ago, Quebec set up centres locaux de services communautaires (CLSCs). There are now 146 CLSCs serving specific geographic populations. The CLSCs employ 20 percent of Quebec's family doctors in about 1500 full or part-time salaried positions, as well as having 5000 full-time equivalent nursing positions. These centres are open nights and weekends. They integrate primary health care with mental health, home care, and public health, and employ a provincial telephone health advice line. Some CLSCs, especially in rural areas, are also closely integrated with hospital and long-term care facilities. In addition, CLSCs work closely with other services such as police and municipal governments to address social issues that affect health. (Hutchison et al., 2001; Rachlis et al., 2001).

⁹ Alberta Health and Wellness based their description of primary health care on the commonly-used definition of primary health care from the Declaration of Alma-Ata. This Declaration was developed at the International Conference on Primary Health Care the World Health sponsored by the World Health Organization and held in Alma-Ata in the former Soviet Union. The complete Declaration and the Alberta definition of primary health care can be found on the web sites noted in the two references cited.

Ontario's 66 community health centres (CHCs) are independent not-for-profit agencies governed by elected community boards. They contract with the government to deliver services to specific communities. Like CLSCs in Quebec, Ontario's CHCs use teams of providers, do health education and promotion, and make links with other community services to address social issues. Ontario's Minister of Health recently pointed to community health centres as an integral part of health reform. The Ontario Association of Health Centres (AOHC) is presently talking with the government about expanding the number of CHCs across the province (AOHC, 1997, 2000).

Though the CHC presence looms largest in Ontario, most Canadian provinces have some (Rachlis and Kushner, 1997). In Alberta, Edmonton's Boyle McCauley Health Centre has served the downtown community for more than 20 years. Calgary has two community health centres - Alexandra and the Calgary Urban Project Society (CUPS).

More recently, 27 new primary health care projects were evaluated in Alberta. Some of these focused on health centre models recently developed by regional health authorities (RHAs) - such as the Northeast Community Health Centre in Edmonton, the 8th and 8th Health Centre in Calgary, and the Elnora Primary Health Care Project in central Alberta. These RHA-governed centres are structured differently than the not-for-profit neighbourhood CHCs mentioned earlier. But they have adopted many similar approaches to care, such as using teams of health care providers and adopting a broader focus than a strictly medical model (Alberta Health and Wellness, 2001c; Howard Research, 2000). These 27 Alberta "pilot" projects, as well as the three long-established CHCs, demonstrate that innovations in primary health care can take place within the public sector or in closely linked community-based not-for-profit agencies.

Should we pay doctors differently?

In his response to the Mazankowski Report, the Minister of Health and Wellness said he wants 50 percent of Alberta doctors paid by methods other than fee-for-service by 2005 (Alberta Health and Wellness, 2002). Is this a good idea? There is no conclusive research evidence for one best way to pay doctors. The Mazankowski Report has recognized this and presents the pros and cons of various payment alternatives (PACH, 2001a; p. 64-67).

However, some primary care models that include payment methods other than fee-for-service have shown benefits in cost savings and quality of care. For instance, an evaluation in Saskatchewan showed that community health centre (CHC) patients - whose doctors worked on salary — used fewer hospital services and drugs than fee-for-service patients in the same communities. Hospital use was also lower among CHC patients compared to fee-for-service patients in Ottawa. And there is some evidence that CLSCs in Quebec have provided better quality of care for some interventions than doctors in fee-for-service practice. As well, a northern Ontario study found overall health costs per person lower for patients in a health service organization (HSO), compared to fee-for-service patients. HSO doctors are paid a set amount of money for each patient in their care - an approach called "capitation" (for details of these studies, see Angus and Manga, 1990; Church, 1995).

These evaluations were small and had some limitations. Most important, we cannot conclude that it was the payment method by itself that made the difference in cost savings or quality of care. In fact, the success story of the northern Ontario HSO in Sault Ste. Marie was not repeated with other HSOs.¹⁰ There have been no overall differences in hospitalization rates between patients of Ontario HSOs where doctors are on capitation compared to fee-for-service practice (Hutchison et al., 1996). In a paper on primary health care re-

¹⁰ Sixty-three health service organizations in Ontario were set up under this method between the late 1970s and the early 1990s.

form prepared for the federal government, health policy analysts Michael Rachlis and Carol Kushner pointed out that the Sault Ste. Marie clinic operated very much like a community health centre. By contrast, the other HSOs operated like medical group practices and did not emphasize prevention or hire other professionals like nurses (Rachlis and Kushner, 1997).

So simply changing how doctors are paid will not save money or improve care. The similarity in findings between CHCs (where doctors are salaried) and the Northern Ontario HSO (where doctors were paid a set amount for each patient on a roster) suggests the common element of success was not the payment method *per se*. Rather, it was the use of provider teams and a comprehensive primary health care approach. Furthermore, savings may not show up in doctor costs. The Saskatchewan evaluation mentioned above found that in the short term, the in-clinic physician costs were higher in the CHCs. The savings were in the longer term when patients needed less drug or hospital treatment - which suggests better health outcomes as well.

This all suggests that simply getting doctors to work in groups under alternate payment schemes is not likely to be effective. Focusing on the payment issue alone can actually cause problems. For instance, there have been a number of concerns raised about paying doctors a fixed amount (capitation) for each patient on a roster. First, this approach could lead to under-servicing patients, taking only the easiest cases (sometimes called "cream skimming"), or referring more patients to specialists (Alberta Medical Association, 2001a, 2002; Hutchison et al, 2001). Second, "rostering" could take away patient choice if doctors or patients are penalized if the patient goes elsewhere for service. Though "doctor shopping" should be discouraged, we do need to respect that in some situations patients may wish to discuss a sensitive issue with a health provider who does not know them or their families (Armstrong and Armstrong, 2001). Examples might be birth control, abuse, or mental health concerns. Third, most clinics paid on a per-patient basis tend to be very doctor-centred (rather than team-centred), in that doctors have the primary say over what other types of health providers are able to do (Armstrong and Armstrong, 2001; Rachlis and Kushner, 1997). Fourth, this payment method is similar to that of U.S.-based health maintenance organizations (HMOs). That could make it easy for these for-profit U.S. firms to take over such practices, if these companies move into Alberta. World trade agreements open up health care to foreign firms unless it is explicitly protected as a service in the public interest - which it is not once the for-profit sector is involved (Barlow, 2002). The Mazankowski Report actually encourages private sector involvement in primary health care, as will be discussed later.

Rachlis and Kushner (1997) point out that salaried doctors have more time to spend with patients. The salary method also lends itself well to organizational structures and decision-making processes that are more egalitarian between doctors and other professionals. Salaries appear to have fewer drawbacks than payments on a per-patient basis (capitation). However, there is a risk that salaried doctors would see fewer patients because there are no incentives to see more. Though this allows more time with each patient, it could also lead to longer waiting times unless other health providers such as nurse practitioners are available for hire and are used to their fullest capacity.

Some Alberta doctors are already trying out other payment methods (Alberta Medical Association, 2001a; 2001b). And a recent Canadian Medical Association survey found that while 35 percent of doctors preferred fee-for-service, 24 percent preferred salary and 27 percent preferred some blended method. The health system needs to work with those doctors who are willing to try out other methods of payment and models of practice, and evaluate the results in both health benefits and cost savings. Most important, the above evidence suggests that payment methods should not be changed without also facilitating better teamwork among professionals and a more comprehensive approach to patient care that includes health promotion as well as treatment.

Finally, changes to how any providers - including doctors — are paid, or to the scope of their practice, needs to involve the professional associations and/or unions that represent those providers. Those groups should not be seen as “barriers,” as they are in the Mazankowski Report (p.33-34), but as full partners in decision-making. Decisions about what providers can do should be based on the skills that each profession can offer to both patients and colleagues. The government should not substitute one provider for another simply to save money.

What kinds of primary health care organizations do the Mazankowski Report’s recommendations suggest?

The Mazankowski Report (PACH, 2001a) echoes the national trend toward primary health care reform. This could be positive if it is focused within regional health authorities and not-for-profit community health centres. But the Mazankowski recommendations do not limit primary health care reform to the public and not-for-profit sectors. In fact, a number of statements in the report encourage more private for-profit involvement.

For instance, Recommendation 5 says “reconfigure the health system and encourage more choice, more competition, and more accountability” (PACH, 2001a: 48). Further to that, regional health authorities would be responsible for “establishing service agreements with physicians, labs, private surgical facilities, clinics, groups of health care providers, and private and not-for-profit organizations and agencies to provide health services, including primary health care (emphasis added)” (p. 49). An expanded role of for-profit businesses in primary health care is clearly pointed to by this statement.

There is a further sub-recommendation to “implement new models of care including comprehensive primary health care, disease management and other comprehensive care approaches” (p.50). This section goes on to say that people would be able to choose clinics or providers that take a comprehensive approach if new funding mechanisms are implemented to give people more control and choice. Given that similar points about control, choice and funding options appear in Recommendation 6 on diversifying the revenue stream, this statement could suggest more private insurance or direct user payments in primary health care. The next sub-recommendation under Recommendation 5 is to “encourage an innovative blend of public, private and not-for profit organizations and facilities to deliver health care services” (p. 51).

But of greatest concern is the sub-recommendation to “encourage groups of health care providers to establish ‘care groups’ and offer a range of services to individuals and health authorities” (p.52). To elaborate further, “with new models of care and diversified sources of revenues, groups of health care providers could set up health care organizations *on a business model and market their services both to individual Albertans and regional health authorities and provide insured as well as uninsured services* (emphasis added)” (p.52).

Recommendation 7 on health providers again addresses these “care groups.” After a brief nod to some of the innovative primary health care projects being tried out in the public system, this section then notes that:

“...different health providers should be able to form ‘care groups’ and offer a range of health services to individuals and to health authorities. These organizations could be established on a corporate model and allow providers the option of providing a range of insured and uninsured services. This option would provide more flexibility for different providers to work together, provide comprehensive care and meet people’s needs” (p. 67)

This approach appears to go well beyond the existing group practice model where self-employed fee-for-service doctors share common space and resources. The reference to a business or corporate model telegraphs an expanded role for investor owned for-profit clinics - already prevalent in day surgery and diagnostics — in primary health care.

In summary, the Mazankowski Report clearly fits primary health care within a business model and opens it up to include for-profit providers. With its talk about “diversified sources of revenue” and “a range of insured and uninsured services,” the report also inserts user pay options into primary health care. This is all consistent with earlier statements that refer to users of the system as “customers” (p.43). **This use of market language reflects an ideological belief in health care as a market good for individuals, rather than a public service for the common good.**

A move toward care groups operating as businesses, combined with more “integration” and “comprehensive care” as outlined in the report, creates the risk that large parts of our health system could ultimately resemble for-profit models similar to health maintenance organizations (HMOs) in the U.S. The Mazankowski Report does not explicitly state this as the intent, but it could happen if we allow the continuing expansion of the for-profit sector throughout the health system - from primary health care to diagnosis to surgery, not to mention home care and long-term care which already include for-profit delivery of some types of services.

In the 1970s and early 1980s, most U.S. HMOs were community-based, not-for-profit organizations. They offered a wide range of primary health care services and many encouraged community input into their operations. By the late 1990s, most had been taken over by for-profit insurance companies who now dictate how doctors and other providers practice and what services are available to patients. Patients now pay more for fewer services and have less choice over their doctors than they did when most HMOs were not-for-profit (Fuller, 1998).

The problems that arose when U.S. HMOs were taken over by for-profit firms should serve as a cautionary tale of what is likely to happen when the profit motive is brought into primary health reform and other comprehensive approaches to health care. There are many innovative models in the public and not-for-profit sectors that can serve us better.

Focus On Health Promotion

What Makes Us Healthy?

The first recommendation in the Mazankowski Report is “the first reform is to stay healthy” (PACH, 2001a: 41). The report recognizes both behavioural and social factors that influence health. It is also appropriately critical of the paltry amount that regional health authorities spend on health promotion (3 percent) compared to hospitals (25 percent) and diagnosis and therapy (19 percent). So far, so good. Health promotion professionals might be heartened to think the government is getting serious about health promotion.

The “options and alternatives” on pages 16-17, and the corresponding recommendations (p.41-43) include a mix of health education, lifestyle change programs (particularly tobacco reduction and healthy eating), and attention to educational attainment and financial support for children in poverty. However, by far the most emphasis is on health education and lifestyles, and on individual responsibility to adopt healthy behaviours. Unfortunately, the government’s response to the Mazankowski Report has stripped out any reference to the social influences on health mentioned in the report - choosing instead to focus entirely on health education and lifestyle behaviour (Alberta Health and Wellness, 2002).

An approach that focuses only on lifestyles ignores the evidence that behaviour change alone does not make people healthy. A well-known British expert on health inequalities, Richard Wilkinson, estimates from previous research that only about 25 percent of heart attack deaths are likely explainable by risk factors that can be at least partially controlled through behaviour change - such as diet, smoking and exercise (Wilkinson, 1996).

In Canada, the Federal, Provincial and Territorial Committee on Population Health has identified 12 key determinants of the health of Canadians (Health Canada, 1996):

- income and social status;
- social support networks;
- education;
- employment and working conditions;
- social and physical environments;
- biology and genetic endowment;
- personal health practices and coping skills;
- healthy child development;
- health services;
- gender;
- culture.

These determinants interact with each other. For example, income and social status not only have a direct impact on health, but they also affect health by influencing child development, the environments in which we live and work, and our personal health behaviours such as smoking, diet and physical activity. And education level, gender and culture influence our income prospects and social status, as well as our health behaviours and day-to-day environments. (e.g., Evans et al., 1994; Horne et al., 1999; Wilkinson, 1996).

Let's take a closer look at income. Wilkinson points out that among "developed" countries, unequal per capita incomes between countries do not translate into differences in the health of their people. However, income disparity within countries is strongly related to health differences. He brings together evidence from around the world that the healthiest societies are those where income disparities among its people are small and social cohesion is high. He further notes that societies with more economic inequality show more signs of "disintegration," such as crime and violence. More egalitarian societies are more socially cohesive, in that people have strong support networks and participate in the life of the community (Wilkinson, 1996).

In Canada, the most recent comprehensive national study of population health concluded that low-income Canadians are more likely to die earlier and to suffer more illnesses than those with high incomes. For instance, Canadians in the lowest income group were four times more likely than those in the highest income group to report their health as only fair or poor, and twice as likely to have a long-term activity limitation. The report also estimated that if the premature death rates of the highest income earners applied to all Canadians, more than 20 percent of all years of life lost before age 65 could be prevented. Groups at greatest risk for poverty are Aboriginal people, single mothers, and unattached female seniors (Federal, Provincial and Territorial Advisory Committee on Population Health, 1999).

The report also found that health status improves with each step up the economic ladder. High-income Canadians are healthier than middle-income Canadians, who are in turn healthier than low-income Canadians. Wilkinson's (1996) research presents similar examples from other countries of this health "gradient" across income levels. He presents evidence that psychosocial stresses — such as consciousness of social status, social exclusion, or low degree of control over one's work or other life circumstances — may explain more of these differences in health status across the whole income range than the absolute material deprivation associated with very low incomes.

In Alberta, as in the rest of Canada, the gap between rich and poor has been growing. Researcher Patricia Lawrence used Statistics Canada data to show that the richest 10 percent of Alberta families had market incomes 22 times higher than the poorest 10 percent in 1997, compared to 14.2 times higher in 1981. While the 1997 market income gap is the smallest of any province, Alberta's gap in 1997 after-tax incomes was the third highest in Canada. The richest 10 percent of families had after-tax incomes of 6.96 times those of the

poorest 10 percent. (Lawrence, 2001). What all this means is that although Alberta had less income disparity before taxes than other provinces - possibly due to a strong economy and low unemployment in the late 1990s - our government does much less than other provinces to even out the disparities that do exist. The new "flat tax," though reducing taxes for the lowest income Albertans (those earning \$12,900 a year or less now pay no provincial tax), will actually increase after-tax income disparities between wealthy Albertans and those on middle incomes (Flanagan, 2000). A government that is serious about health promotion would be taking actions to reduce inequalities in income, not to further exacerbate them.

What are the limits of the "lifestyle" approach to health promotion?

Promoting healthy behaviour is positive, and as a health promotion researcher and educator I applaud its inclusion in the Mazankowski Report (PACH, 2001a). However, there is a growing consensus among health promotion experts in Alberta and Canada that a variety of strategies, focusing on the multiple determinants of health discussed earlier, are needed to improve the health of the population (Hamilton and Bhatti, 1996; Hyndman, 1998; Thurston and Wilson, 1998). For instance, these researchers recommend a combination of strategies first outlined in the Ottawa Charter for Health Promotion in 1986: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services.¹¹

The Alberta government does recognize multiple strategies to some degree. For instance, Alberta Health and Wellness worked with university researchers to develop a Health Promotion Effectiveness Framework to determine if programs are using the five Ottawa Charter strategies and addressing the 12 determinants of health (Thurston and Wilson, 1998). Unfortunately, this framework does not appear to be in widespread use.

Let's take a closer look at one of the more detailed Mazankowski Report's (PACH, 2001a) wellness recommendations, the provincial tobacco reduction plan that was first drafted more than 18 months before the Mazankowski Report was released (AADAC, 2001).¹² It does appear to include all the Ottawa Charter strategies, though they are not named as such. But the primary focus of the plan is still behaviour change. For example, a key policy emphasis is on higher tobacco taxes for the purpose of discouraging smoking behaviour, but there is no discussion of what other policies might be needed to address the social conditions associated with high tobacco use, such as poverty.

The tobacco reduction plan adopts "best practices" from the U.S. Centres for Disease Control that underlie successful campaigns to reduce smoking in several states. A key component of these campaigns is higher tobacco taxes, based on some research that shows making tobacco more expensive often does reduce its use, especially among teens, young adults and people with lower incomes (U.S. Department of Health and Human Services, 2000).

However, some researchers have questioned the link between tax hikes and quitting. Lorraine Greaves, Director of the B.C. Centre of Excellence in Women's Health, has been studying tobacco use from a broad sociological perspective for close to 20 years. In her report *Filtered Policy: Women and Tobacco in Canada*, she reviews research in Canada and the U.K. showing that low-income smokers reduce their spending on basics such as food, clothing, shelter and health care as cigarettes become more expensive (Greaves, 2000). She also points out that tobacco tax hikes should be accompanied by free support to help smokers quit.

¹¹ The Ottawa Charter is a document produced jointly by the World Health Organization, Health and Welfare Canada and the Canadian Public Health Association (1986).

¹² This discussion focuses on the tobacco plan at the provincial level in its present stage. Many dedicated health promotion professionals in regional health authorities and other provincial and community organizations already provide the supports they can, with limited resources, to help smokers quit and to discourage youth from starting to smoke. The problem is that local resources have been limited and inconsistent across regions.

Unfortunately, the Alberta government has raised tobacco taxes before putting in place such supports.¹³ Albertans should be forgiven if they see this backward approach as a sign that smokers are just another way to “diversify the revenue stream,” rather than as people who need diverse avenues of support to deal with an addiction.

A truly comprehensive tobacco reduction initiative would address not only behaviour, but also the social conditions associated with smoking that make it hard for people to quit. For example, Greaves (2000) presents some research with low income single mothers who have described cigarettes as one small luxury in their lives - as a relaxation break or a time out from child care or housework. She also notes that people need a sense of optimism when trying to quit smoking - which is difficult for people whose focus is on day-to-day survival.

Actions to address the broader social determinants of health such as poverty and social environments are outside the direct mandate of Alberta Health and Wellness. However, the health department could show leadership in encouraging and assisting other departments to look at the potential impacts of their policies on health-related behaviour and health status.

In conclusion, our lifestyles do contribute to our health and healthy behaviours should be encouraged. But we need to focus on a wider range of factors that influence our health, not just one. Otherwise, an over-emphasis on lifestyle behaviour can become a way to blame people for getting sick.

What about incentives to stay healthy?

One of the points under the overall recommendation on staying healthy is to “provide better incentives for people to stay healthy” (PACH, 2001a: 42). After recognizing that social as well as behavioural factors determine our health, it is logically inconsistent for the report to then suggest that medical savings accounts, variable premiums, tax credits or partial premium refunds will motivate people to stay healthy. Such schemes are likely to punish those who are prone to illness, who are usually less well-off financially. Given that these approaches are showcased in recommendation 6, to “diversify the revenue stream” (p.52), it is obvious that their main purpose is to get people to pay more for their health care, rather than to motivate them to stay healthy. These schemes also encourage us to focus not on the common good but on our individual needs - which flies in the face of the social cohesion that British researcher Richard Wilkinson says is important for a healthy society.

The most sound health promotion strategies encourage not only personal change, but also social change through building strong communities and healthy public policies - not only within the health sector, but in other sectors as well. Let’s take the example of social assistance. How do Alberta’s social assistance policies provide “incentives” for single parents (usually mothers) to provide a home environment conducive to healthy child development? The Edmonton Social Planning Council (ESPC) has repeatedly raised concerns about parents turning their children over to Child Welfare because they were unable to provide the basic needs of food, clothing and shelter. One ESPC study found that Alberta’s child welfare caseload climbed by 37 percent between 1993, when welfare rates were cut, and early 1997. In all other provinces and territories combined, the number of children in care rose by an average of only 7.9 percent during that time (ESPC, 1998). More recent figures presented by the ESPC in 2000 showed that by the end of fiscal year 1998-99, there were 55 percent more children in care compared to 1992-93 (ESPC, 2000).¹⁴

¹³ The Alberta plan includes a focus on helping smokers quit, but the details on what will be offered — beyond self-help materials and a hot-line - are not yet clear. The Wellness Fund proposed by the Minister of Health and Wellness, which would have funded health promotion programs including help to quit smoking, was not approved in the recent provincial budget.

¹⁴ Inter-provincial comparisons were not presented for that time period.

In another study, the ESPC counted up the costs of child welfare investigations, assessments and various types of placements, and concluded that an average monthly increase of \$290 in social assistance rates would save \$1542 a month in child protection costs. They concluded that the government could save up to \$27 million a year by increasing welfare payments to parents — rather than taking their children into the child welfare system (Eoin, 1998). The ESPC has also noted that from 1986-98, the welfare rate for a single parent dropped by over 25 percent in real dollars after inflation was considered (ESPC, 2000). How do the government's social policies for low income parents and their children motivate them to "stay healthy"?

We could also question other government policies such as electricity de-regulation and cuts to the extended health benefits program for seniors. How do these policies affect the living standards seniors living on fixed incomes but who have too much money to qualify for low income programs? If they must pay more for electricity, glasses and dental work (or go without or with less), how does that help them "stay healthy"?

Better Accountability

How can the health system be better managed day-to-day?

If the health care system is to be accountable to the public, the government needs to know where the money is going and how it is being spent. They also need to be able to tell us if the money spent is making a difference in people's health. And there need to be clear rules to prevent individuals who work in the health system from influencing decisions in ways that benefit them personally. Such prevention of conflicts of interest does not happen when doctors who own shares in private clinics are also regional health authority managers in a position to decide which private clinics get contracts with their region.¹⁵

The Auditor General of Alberta raised several of these issues in his last report (Auditor General of Alberta, 2001). Overall, he called for improved planning and control of the health care system. Here are some of his concerns about planning and evaluation:

- regional health authority business plans are not in place at the start of each year - plans for 2000-2001 were not approved until that fiscal year was half over;
- one-time funding has become more the norm than the exception - and has been used for predictable expenses like population growth;
- one-time funding - especially the portion that goes to general revenues rather than specific uses - sends mixed messages to the regions about whether they need to plan equipment and service needs coherently and manage their budgets;
- both the provincial department and the regions need better ways to understand and accurately forecast health needs and costs;
- there is inadequate measurement and reporting of results and costs, and planned results are seldom compared with actual results - prompting the Auditor General to state, "More money is spent - but to what end?" (p. 114)

The Auditor General also raised a number of red flags about contracting out health care delivery. He noted there is no consistent process for contracting, and that relying on contracts to provide health services poses several risks. These include higher costs, inability to sustain the skills of public sector employees, and questions about the capability to use competitive bidding when reliance on contractors is long term.

¹⁵ See Steward (2001) for an extensive discussion of this and other conflict of interest issues.

He also made several observations specific to contracts with for-profit clinics. Province-wide performance expectations have not been developed for contracts with surgical facilities. For instance, there are no standards for death rates, complication rates, wait times, or number of patients served.

The Auditor General recommended that the Calgary and Capital Health Authorities enhance their conflict of interest policies. First, he stated that these health authorities should extend their private interest disclosure requirements so that they apply to senior managers who are in a position to influence contract decisions — such as doctors who are managers of health authority departments that contract with private clinics. He also called for an independent third party review body - such as the Ethics Commissioner - to deal with potential conflicts of interest when public employees operate private practices or clinics that contract with their employers. Although the Auditor General singled out the large urban health authorities, he noted that these recommendations should apply to other health authorities too. He also called for consistent standards to determine whether services should be provided directly by health authorities or contracted out, and for performance measures to compare the costs and outcomes of private and public facilities (Auditor General of Alberta, 2001).

In other words, decisions about contracting out should be based on evidence rather than political preferences or pressures. As we saw in the last chapter, the evidence for contracting out to the for-profit sector is that costs are higher. And outcomes are no better, and are in some cases worse, than when services are delivered by the public or not-for-profit sectors.

How should decision-makers use evidence to plan health services and policies?

The National Forum on Health (1997b) made “evidence-based decision making” a central feature in their recommendations for health reform. In Recommendation 8 on quality and accountability, the Mazankowski Report (PACH, 2001a) says “Alberta’s health system should focus on using the best research and information available to improve health outcomes” (p. 68) — including health research and an arms-length “Outcomes Commission” to evaluate the effectiveness of health services. More attention to research and evaluation is positive - though one could question how a government-appointed commission is arms-length. Remember that the Provincial Health Council of Alberta was axed when it consistently provided evaluative information that the government did not like - and was replaced with the Premier’s Advisory Council on Health which produced the Mazankowski Report.

Evidence-based decision making calls on providers, managers and policy makers to take the best available information into account when making decisions — evidence about treatment effects, costs of procedures, and factors outside the health system that influence health (such as income and employment). Up-to-date evidence needs to be pulled together and shared in a timely way in easily understandable formats. Current evidence should be shared with patients so they can make informed decisions about treatment options. The infrastructure needed for all this includes public investment in health research as well as health information systems that balance research and clinical needs with patient privacy (National Forum on Health, 1997b).¹⁶

More attention to evidence is welcome. Knowing what interventions are most effective, how much they cost, and how waiting lists can best be managed is important for the planning and delivery of health care. It is also important to measure the total costs of care to everyone, not just to the public plan. If the Alberta government was really committed to evidence-based decision making, they would not be looking to for-profit clinics to reduce waiting lists or save money - as the evidence is clear that the opposite occurs.

¹⁶ For a more in-depth discussion of these issues, see National Forum on Health (1997b), chapter “Creating a culture of evidence-based decision making.”

However, there are limits to evidence-based decision making as it is often practised. First, there is a danger of evidence being used as dogma. For instance, University of Toronto health policy analyst Raisa Deber and her colleagues have argued that having fixed lists of medically necessary services is too rigid. They suggest lists of recommended services that would suit the majority of cases, while leaving room for clinical judgements. Doctors would then be able to make decisions based on the appropriateness of a treatment for an individual patient and (to some extent) the patient's preference (Deber et al., 1997). The "de-listing" of services proposed in the Mazankowski Report (PACH, 2001a) - based on an "expert panel" review of effectiveness - could limit the tailoring of treatments to individual circumstances. This is indeed ironic coming from a government that professes to be committed to choice and quality.

A second limitation of the dominant approach to evidence-based decision making is an over-emphasis on system-oriented statistics. Women's health policy expert Pat Armstrong of York University in Toronto is critical of reducing nursing work to countable tasks:

A bath is reduced to a quick application of water to skin, and the way nurses use the bath to comfort, support, educate and assess disappear, as do the varied skills involved in getting the patients to co-operate and in lifting them without injury. Any time not spent directly on tasks is defined as wasted, not productive... (Armstrong, 2001: 136).

She also points out that rigid formulae for length of hospital stay and maximum home care hours per day leave no room for professional judgement, a patient's condition, or the preferences of paid or unpaid caregivers. Colleen Flood of Dalhousie University's Health Law Institute in Halifax provides other examples of important quality of care indicators that are overlooked with a narrow administrative focus; for example, how long a patient is left in distress or in pain without help, how quickly a diagnosis or treatment is given to relieve anxiety, and whether providers respect the wishes of patients (Flood, 1999).

Here is an example of how the conventional approach to evidence-based decision making can miss issues relevant to patients and caregivers. Over the last few years, the Manitoba Centre for Health Policy and Evaluation has studied whether bed closures in Winnipeg - and a corresponding shift from inpatient to outpatient care for all but the sickest patients - have impacted quality of care or population health (Brownell et al., 1999). To measure quality of care, the researchers looked at how many people, within 30 days of being sent home, were either readmitted to hospital, visited a doctor or emergency ward, or died. For a population health measure, they tracked how many Winnipeg residents died before age 75. Seeing little change in any of these statistics after bed closures compared to before, the researchers concluded that bed closures had no adverse effects on quality of care or health status.

However, University of Manitoba sociology professor Karen Grant has questioned why this type of research does not look at the impacts - especially on women - of shifting care from hospitals to communities and homes (Grant, 2002). She points out the likely effects on family caregivers, in terms of extra responsibilities beyond existing family and work obligations. Grant also notes impacts on nurses and other health professionals whose work becomes more intense as they deal with sicker patients in hospitals - potentially leading to more injuries and burnout.

Grant's critique prompts us to ask why bed closures have not shown adverse effects as measured by health statistics? What invisible caring work is being done in the home and community so patients do not come back into the health system? Are discharged patients using public home care services, or must they rely on family caregivers and/or pay for private care? Research questions like these are more complex than counting numbers of people who go in and out of hospitals. A more complete approach to evidence-based decision making in this case would include the hours spent on caregiving by various family members, the out-of-pocket costs involved for patients and their families, and the impacts of all this on the other parts of their

lives. Answering these additional questions would require a mix of both additional statistics and qualitative data such as the personal stories of patients and family caregivers.

A third limitation of evidence-based decision making is that it usually focuses on clinical or behavioural interventions at the expense of social factors that determine our health. Researchers in both medicine and health promotion have been critical of this (Davey Smith et al., 2001; Raphael, 2000). An example of a broader approach can be seen in the recommendations for health promotion evaluation from the World Health Organization (1998). These recommendations include: the meaningful participation of those with a direct interest in a program or policy, a focus on process as well as results (so we learn not only what has worked or not, but also why a particular approach does or does not work), and the use of a wide range of both quantitative (statistical) and qualitative (narrative and experiential) methods that go beyond conventional experimental approaches.

Despite the limitations of relying only on statistics, they will remain an important source of evidence. This raises privacy concerns. Pat Armstrong (2001) has cautioned against health records getting into the hands of private interests and used in ways that harm patients (for example, denial of insurance coverage). The Mazankowski Report (PACH, 2001a) recommends extensive health information systems tied to electronic health records ("smart cards"). Information systems are needed for research and evaluation. But data should only be shared - and under strict conditions — if benefits for treatment or research can be clearly demonstrated. For example, a cancer specialist does not need a woman's reproductive health history unless it is relevant to treatment. For research studies, the typical guidelines used by university research ethics committees should be applied - such as confidentiality, anonymity, voluntary participation, and informed consent.

Finally, when using evidence to make decisions, it is important to look at how a program or policy affects different groups of people. For example, any out-of-pocket costs for health care are likely to burden women more than men. Women are more likely to be poor, use more health services, live longer and have more disabilities (especially later in life) than men (Horne et al., 1999). Similarly, one could examine how user charges impact people living on fixed incomes, such as seniors and people on social assistance.

Conclusion

Gillian Steward

For forty years successive Alberta governments have tried to derail Medicare. There's never been any evidence Albertans don't want public, universal health care but our provincial governments have opposed it anyway.

Premier Ernest Manning undertook a national campaign to defeat Medicare when it was first introduced in Saskatchewan then spread to other provinces. He said Medicare wasn't necessary because private insurance was available and Albertans preferred to choose how they received medical care rather than have a government program imposed on them. He even suggested it would be preferable to have the government subsidize private insurance rather than adopt Medicare. Despite Mr. Manning's objections federal legislation established Medicare throughout Canada, including Alberta, and it is now Canadians' most treasured social program.

But once again we see government in Alberta using Mr. Manning's pro-business, anti- Medicare argument to convince Albertans that they would be better off if they let the private sector provide more health care. Like the Manning government, the government of Premier Ralph Klein, with the help of the Mazankowski Report, is trying to convince Albertans that it all boils down to choice: with more private sector, for-profit funders and providers Albertans will have more choice and therefore better health care.

It wasn't true in Mr. Manning's day and it's not true now.

What is true and has been proven over and over again, is that private insurance costs more than public insurance and is therefore out of reach for many people. Private insurance also means that the insurance company decides on treatment, not the doctor and the patient. It's also been proven over and over again that for-profit providers of health care cost more than public health care.

Mr. Manning's echo can be heard in other arguments against Medicare made by the Klein government. It says Medicare is simply "unsustainable," that it is too expensive a burden on the public purse. But, as we have shown here (part two), the financial numbers can be - have been - manipulated to make this look the case. The real truth? Medicare is not only sustainable, it is an enormous social and economic benefit to Alberta and Canada. Indeed, it is not too much to say that Medicare is the real Alberta and Canadian "Advantage."

Rather than stand up for Medicare, the Alberta government prefers to create a crisis of confidence. Albertans are led to believe that there is "no choice" when it comes to scaling back Medicare and asking the private sector or individuals to pick up the pieces (part three). This has already happened to a great extent with home care, long term care and diagnostic services. What the Alberta government doesn't tell Albertans is that there are plenty of successful reforms to Medicare that don't involve the private, for-profit sector. Rather than scale back Medicare, sound arguments can be made (part four) for expanding it to cover drug costs, home care, and long term care.

Those wanting to derail Medicare for their own interests have long seen Alberta as a beachhead. During the past few years they have convinced the Alberta government to turn over more and more of our public health care system to private funders and for-profit providers. There is no evidence this will benefit Albertans; indeed, there is much evidence suggesting of harm. Yet the government persists. And as the private sector moves in on Medicare in Alberta, it uses its gains as proof that this is what other provinces need to do as well. The defense of Canadian Medicare begins in Alberta. The future of public health care in Canada will be decided in the newspapers and radio talk shows of Alberta; in public forums and on the streets; in the legislature and on the hustings; in small towns and in the cities; in doctor's offices and hospitals. It is a fight Albertans and Canadians dare not lose.

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