

Can we afford to sustain Medicare? A strong role for federal government



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LESS CARE + MORE COST!**



**Canadian Federation
of Nurses Unions**

THE NATIONAL VOICE FOR NURSES

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of Nurses Unions**
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Dear Premiers:

Like you, Canadian nurses are concerned about the sustainability of Canada's public health care system.

We agree that provincial and territorial health care costs are rising – growing faster than provincial/territorial economies. However this is a global phenomenon. In terms of managing public health care costs at a portion of our economy, Canada is practically un-rivaled among industrial nations over the last decade.

The word “crisis” is overused in the often over-heated rhetoric surrounding health care. But we know that some crises are real, and some come without warning, like dealing with SARS last year. The system was already overwhelmed but, out of sheer resolve, we made it work – because failure was not an option.

We must make a commitment to do better. There are serious problems in the public system that must be fixed now or they will become unmanageable. Drug costs are skyrocketing. Nurses, doctors and some technicians are in very short supply. Capital investments can no longer be put off.

It is our fervent hope that these can be addressed now by strong leadership from all federal/provincial/territorial governments. We believe a strong federal role is central to providing well-funded and high-quality Canadian health care. We hope that the provinces and territories would welcome this change. We believe that it's in the provinces'/territories' best interests to push for a fresh federal commitment.

Thirteen visions of health care may facilitate the weakening of the values and, ultimately, the bonds of this nation we call home. We believe that the vision of Douglas, Pearson and Diefenbaker is worth preserving – worth fighting for. The right to health care is Canadian.

We look forward to working with you towards re-building and improving the tangible proof of Canadians caring for each other.

Sincerely,
Linda Silas, RN, BScN
President, Canadian Federation of Nurses Unions

Can we afford to sustain Medicare? A strong role for federal government

A Message from Canadian Nurses

We are in a new era of possibility for public health care:

- a new federal parliament;
- a new team of provincial leaders;
- a new health accord in the making;
- an unparalleled consensus that change has to happen, now.

This is the opportunity for Canada's federal and provincial leaders to deliver what Canadians want: a sustainable high quality public health care system.

You have the power to make a difference.

We have the experience to help.

Canadian Federation of Nurses Unions

For sources and more information see our website:

www.cfnu.ca or call 1-800-321-9821 or 613-526-4661

Most countries are performing far worse than Canada when it comes to controlling the rising share of GDP that goes to spending on health care.

What do you mean by unsustainability?

Is health care spending growing too fast?

Unsustainability is more than a problem of rapidly rising costs. It is also about the ability to pay those costs. And Canada is better placed than most Organisation for Economic Cooperation and Development (OECD) nations to pay for its cherished public health care system.

As a share of Gross Domestic Product (GDP), Canada's total spending on health care has just recently returned to its previous peak levels, reached about a decade ago. But at about 9.6% of GDP it falls below 6 other OECD jurisdictions.

It is true that health care costs are growing more rapidly than government revenues, and more rapidly than economic growth in recent years. Trend lines since the mid-1990s show no sign that health care spending is plateauing, and indeed the longer view shows that, over time, health care is eating up a growing share of GDP.

The anxiety that this may not be sustainable is understandable, but we are not the only nation facing these trends. This is a global phenomenon.

As the recently released OECD 2004 health data base shows, between 1997 and 2002, 29 of 30 OECD nations saw an increased share of their GDP going to spending on health care. (Only the Slovak Republic, with its rapidly expanding industrial economy, showed a small decrease.) Fifteen nations saw health's share of GDP increase more quickly than Canada, including the U.S., the U.K., New Zealand, Norway, Sweden, the Netherlands, Italy, Ireland, Japan and Korea. (OECD 2004 Health Data)

And that's *total* health care spending, public and private.

When you look at **public** spending on health care, Canada's performance is even more impressive.

Compared to a decade ago, Canada's **public spending on health care as a share of GDP has fallen** (from 7.4% of GDP in 1992 to 6.7% of GDP in 2002), a dramatic decline that has only been matched by Finland. With few exceptions (namely Hungary, Italy, Poland and Spain) the trend all over the world is towards spending a greater share of GDP on public health care.

That's just plain smart. The data from Canada show that rates of growth in public health spending have been far below those of private health spending.

At well below 7% of the economy, even if public spending on health care continues to grow as a share of GDP, it is in no danger of crowding out other activities any time soon.

In fact, a recent report from the federal Department of Finance projected health care costs to 2040, when aging baby boomers are expected to most rely on health care but, as retirees, their contribution to the economy will be most limited. Its conclusion? Provincial-territorial health care spending will not even reach 10 per cent of Canada's GDP during the peak demand years.

Public spending on health care is not going to bankrupt everything else.

This is important in two ways:

- Public spending is growing less rapidly than private spending, pointing to important efficiencies available through:
 - the power of single payer administrations
 - governments' greater abilities to set prices and/or control expenditures through their buying power, and
 - lower costs of financing capital investments.

If a rising share of GDP going to health expenditures is deemed unsustainable, the best way to control the growth in that spending is to shift towards more public spending.

- Canadians have clearly indicated they want to spend more on health care through their governments and individually. There is nothing wrong with spending a greater proportion of the economy on health care. It's no less appropriate than spending more on information technology and telecommunications devices and has better macro-economic impacts than, for example, increased spending on cars. Health care is one of the economy's engines, offering well-paid, high-tech jobs in a sector with robust consumer demand. If we, as a society, choose to buy more health care than SUVs, what's the problem?

Whether government spending on health care is, or is not, "out of control" is in the eye of the beholder.

Using a different data base (CIHI, NHEX 2003) it is clear that annual rates of growth in provincial spending on health care have accelerated since 1998, though recent provincial budgets show that a renewed era of cost constraints may again taper off these trends. Still, the growth rates of the past few years are at a lower

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pace than that of the previous decade, 1980 to 1990, and even before. Then, too, rates of growth in health spending outstripped revenue growth or GDP growth, but they didn't trigger the use of the term "unsustainable".

Why are rising costs more of a problem today than a decade ago?

Canadians have clearly told their governments time and again that health care is their number one priority. This gives governments at all jurisdictions a mandate to invest wisely and accomplish what the individual taxpayer cannot do: manage the growing cost drivers within the system.

If taken seriously, the electorate's priorities will result in governments spending more on health care. If ignored, total health care spending will truly spiral "out of control", and in a way that creates clear benefits for some, and clear losses for others.

In either case, we'll be spending more. How much more is a matter of political choice.

Whether health care becomes the monster that ate everyone's budget is a more complicated matter. It is a function not just of rising health costs but also the budgetary capacity to spend on other programs, including the things that lead to a healthier population. Constraints in spending are, in turn, a function of the box that governments put themselves in. Today's tight budgetary circumstances are direct results of an aggressive tax cut agenda pursued by federal and provincial governments since 1996.

Is health care spending becoming an unmanageable share of government expenditures?

The sustainability of public health care is partly about governments' ability to pay, but it is also a reflection of governments' ability to manage.

In Canada, average provincial spending on health care increased from 33 to 38 per cent of all program spending between 1990 and 2003. Health care as a share of *all* provincial spending, including debt charges, grew from 29 to 33 percent over that period. (The years 1990 and 2003 were chosen for comparison because they are more alike macro-economically than 1993, a year which was near the bottom of the recession of 1991.)

As elsewhere in the world, health care is the fastest growing element of government expenditures in every part of Canada. But not all jurisdictions place the same degree of emphasis on health care, and there are stark differences between provinces in just how fast health's share of public spending is rising.

Today Ontario spends more of its budget on health care than any other jurisdiction (43% of program spending). Among the provinces, Quebec spends the least (31%).

Since 1990, P.E.I.'s share of spending on health care has grown the most rapidly (by 33%), closely followed by Alberta. Quebec's has grown the least (by 5%), keeping the share of government spending going to health almost stable throughout the period.

The very fact there are such important variations tells us there are lessons to be learned, not just in our ability to pay, but in our ability to manage costs, and in the balance achieved between health care and everything else governments do.

Although rising health expenditures are a fact of life, that's not the full story. Provincial governments are spending more, overall, but they are providing fewer services, having downloaded and offloaded to local levels of government or to the private sector. Health care is taking a bigger bite out of budgets because other government spending has either been constrained more tightly or cut.

In all but four of the 13 provincial and territorial jurisdictions (P.E.I., Manitoba, B.C. and the Yukon) public health care expenditures represent the same or a lower share of provincial GDP than they did a decade or more ago.

But in virtually every jurisdiction, the share of GDP spent on all other programs has consistently dropped since 1993, in most cases quite dramatically. Two jurisdictions (Quebec and B.C.) show softer trends to 2003, though they move in the same direction.

So while growing health care costs are one reason why the health care share of budgets is rising, another reason is that governments are actually spending less on other things.

From the mid-1990s to 2003, two provinces stood out as cutting government services most deeply: Ontario and Alberta. Statistics Canada's Financial Management Systems database shows Ontario's deepest funding reductions between 1995-6 and 2003-4 were for social services (particularly social assistance), housing and transfers to municipalities. During the same period, Alberta's deepest cuts were to transfers to municipalities and the ministry of the environment, but cuts starting in 1993 significantly reduced social assistance and housing budgets. The same pattern held in smaller provinces that showed strong contraction in program spending outside health care. In Newfoundland, the biggest budget cuts were in social assistance, transfers to municipalities, and resource conservation/ industrial development.

In virtually every jurisdiction, spending on programs other than health care dropped since the mid 1990s. That's a big reason why health care appears to be taking a bigger bite out of government budgets.

Tax cuts are, by far, the most costly single initiative undertaken by provincial and federal governments in recent years.

Canadian taxpayers have never seen tax cuts of this magnitude, even in the immediate aftermath of World War II.

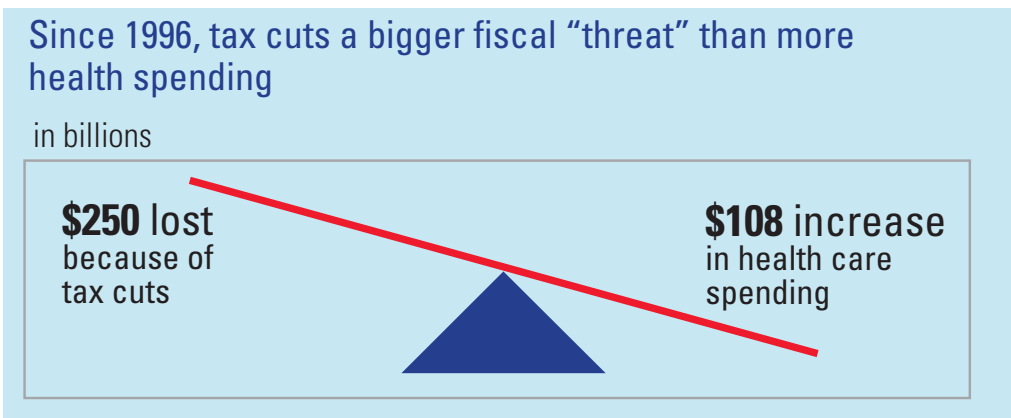
Ironically, dropping investments in these areas may make health care costs more difficult to manage in the future. These areas of public spending are especially key to addressing the determinants of ill-health: poverty, inadequate housing, air and water quality, limited public health programs and reduced access to programs that increase participation – both physical and social – in our parks, schools and community centres.

Budgetary constraints have been the reason given for over a decade of spending cutbacks. First triggered by recessionary conditions a decade ago that cut deeply into federal and provincial revenues, these constraints were compounded by retrenchment of federal transfers to the provinces, for housing, health care and other major programs.

But by the mid-1990s, with faltering economic growth still the reality, governments had also started to implement significant corporate and personal income tax cuts. Tax cuts became the universal policy initiative of choice in Canada by the end of the decade, constraining the growth of revenues and governments' ability to pay for all the services they used to provide.

The federal Department of Finance estimates foregone revenues at the provincial level, compared to 1996 personal and corporate income tax rates, totaled almost \$119 billion between 1997-8 and 2004-5. The federal Budget Plan 2003 shows that, over the same period, the federal government gave up \$130 billion in tax revenues.

That means tax cuts cost public coffers a cumulated total of almost \$250 billion in foregone revenues since the late 1990s. At the same time cumulative increases in public spending on health care, about \$108 billion, have been increasingly portrayed as a fiscal threat. Yet tax cuts are, by far, the most costly single initiative undertaken by provincial and federal governments in recent years. In fact, Canadian taxpayers have never seen tax cuts of this magnitude, even in the immediate aftermath of World War II.



Tax cuts: The biggest priority of governments in recent years

In millions	PROVINCIAL Personal and Corporate Income Tax Measures	FEDERAL Personal and Corporate Income Tax Measures plus EI Premium Cuts	TOTAL TAX CUTS
1997-1998	\$ 2,550	\$ 235	\$ 2,785
1998-1999	\$ 4,890	\$ 2,030	\$ 6,920
1999-2000	\$ 8,509	\$ 5,550	\$ 14,059
2000-2001	\$ 12,469	\$ 12,253	\$ 24,722
2001-2002	\$ 20,173	\$ 20,782	\$ 40,955
2002-2003	\$ 19,969	\$ 23,924	\$ 43,893
2003-2004	\$ 23,180	\$ 29,513	\$ 52,693
2004-2005	\$ 27,090	\$ 35,893	\$ 62,983
CUMULATIVE TOTAL	\$ 118,831	\$ 130,180	\$ 249,011

SOURCES: Provincial calculations from unpublished tables, Department of Finance; Federal amounts from Budget Plan 2003 Table A1.9 p.238 (amounts do not include the Canada Child Tax Benefit or Canadian Opportunities Strategy)

In 2004-5 alone, the combined effects of federal and provincial tax changes cost public coffers \$63 billion. If just a fraction of the tax cut agenda had been diverted to support public health care, there would be no fiscal “crisis” in funding health care.

To resolve this problem today would only require reversing a small portion of these cuts. For example, simply reclaiming part of the federal income tax cuts (both personal and corporate) equivalent to 1 percentage point across the board would yield well over \$6 billion a year – far exceeding the amount needed to “close the Romanow gap”. But the federal government does not need to do this, as its annual budgetary surpluses have exceeded \$6 billion for the past four years. This year the surplus is expected to be at least as large: in late March 2004 the federal budget foresaw \$20 billion in fiscal surplus over the next five years, based on contingency and prudence lines in the budget plan. But by early June

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There are no free lunches. Politicians now have to decide whether they will maintain tax levels and cut services or raise taxes to maintain service levels.

the cost of the federal Liberals' election platform added up to between \$39 and \$41 billion over the next five years, all funded by the apparently revised Finance Department forecasts for surplus.

Provinces who feel the pinch the most may not face the luxury of surplus budgets, but they have the same revenue levers at hand. In Ontario, as at the federal level, simply restoring one percentage point to each personal income tax bracket – which is but a fraction of the reductions since the mid 1990s – would yield about \$2.5 billion in new revenues. This is exactly the amount raised by the new Ontario health premium, with the difference that lower income earners would pay relatively less than they do now under the premium, and higher income earners would pay more.

Historically we relied on the progressivity of the income tax system so that people would pay in direct proportion to their means. What the new generation of public finance mechanisms has in common is that health premiums, sales taxes or user fees are all more regressive ways of raising revenue, since the effective bite of these new taxes falls as income rise.

The point is there are many ways to raise revenues, some more fair than others; but we don't need to raise a lot more. We are not facing an unmanageable financial problem. What started out as macro-economically induced pressure turned into a budgetary nightmare created by politicians themselves, essentially a fiscal crisis of their own making.

Given the priority placed on scaling down revenues and expenditures, governments' capacity to reinvest in health care *plus* a wider range of programs has been explicitly and deliberately limited.

That has nothing to do with the sustainability of increases in health care. It has to do with the sustainability of a major tax cut agenda, a fact that is coming home to roost in the frequently invoked phrase that the status quo is no longer an option.

Elected officials of all political stripes are now facing an unappetizing choice – maintain tax levels and cut services; or maintain services and increase taxes. There are no free lunches. Both options make for poor campaign platforms. But that is where we are at – hanging on to what we've got is going to cost us more, publicly or privately, and nowhere is that more true than in the area of health care.

Governments elected to govern and protect services will find it unsustainable to maintain their commitment to freeze taxation rates let alone further tax cuts.

The choice is unpalatable but it is real – protecting public health care requires more revenues, and many of our governments are recognizing that. Ontario has introduced health premiums again, Alberta has raised its premiums and is talking about user fees, Nova Scotia and other jurisdictions have increased deductibles on some aspects of public health insurance (for drugs). What is becoming increasingly obvious is that the commitment to freezing public revenues is unsustainable if you are going to continue to protect health care.

But instead of increasing funds through the fairest form of generating revenue – income taxes, both corporate and personal, which are specifically designed to address issues of ability-to-pay – there is a not-so-subtle shift towards user-pay systems, all of which place a greater burden on those with the least income: increased health premiums, higher deductibles, or delisting services entirely from coverage through public insurance.

That shift, at the hands of our elected representatives, ultimately redistributes resources away from those who already have the least. And, notwithstanding politicians' commitment to the Canada Health Act, these policy choices compromise two key principles underlying public health care – accessibility and universality.

It has been repeatedly shown that people on limited incomes (whether seniors, those relying on social assistance, or working people) who can't afford to pay for drugs or eye exams often opt to not "consume" such goods or services – even if it's for their own good health.

The current range of provincial options to pay for health care, offloads costs onto people who can't afford it in the same way that the federal government offloaded costs onto the provinces.

If governments feel that, collectively, society can't afford public health care, what makes them think Canadian society can better afford private health care if we paid for it individually?

The costs are rising for health care. How we pay for those rising costs is a political, not an economic, choice. It's more about managing cost increases than cutting costs.

Not only are health care costs manageable, they are more affordable as a share of GDP in most parts of the country than they were a decade ago. But it would be foolish to rest on that argument. We can and must do more. Rising costs can be managed much more wisely, and our public dollars stretched much further.

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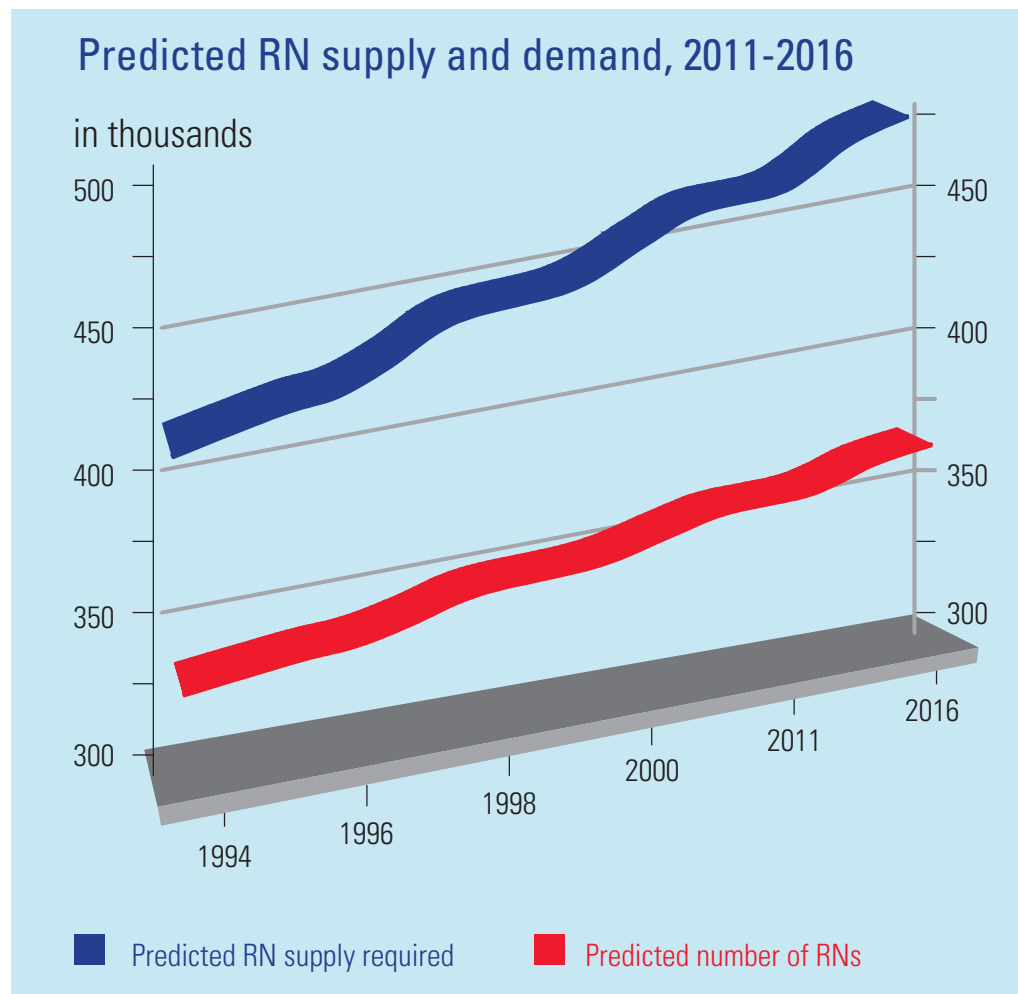
The four biggest threats to the sustainability of public health care are: labour shortages; soaring drug costs; long waiting times; and increased public funding for for-profit care.

What's driving the rising costs of health care?

The last few years have focused on the need for more money, and who should get stuck with paying the bill. Short of offloading or delisting publicly insured health services, there has been far less emphasis placed on how to control rising costs.

If we are concerned about rapid growth in health expenditures, we should be looking at what elements of health spending are growing most rapidly, and what is driving that growth, to see what we can learn to manage or do better.

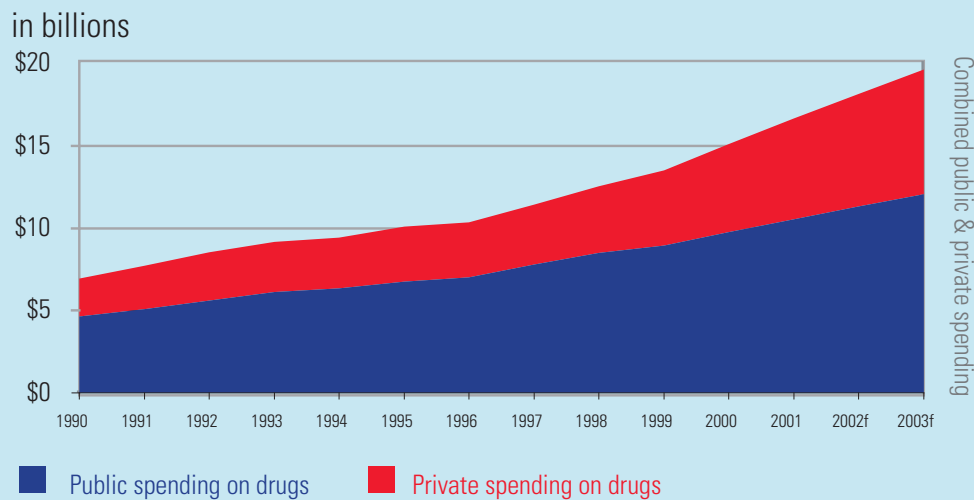
- **Labour** accounts for about 75% of all costs in health care. A labour shortage that only promises to get worse is driving costs of compensation, in order to retain or relocate scarce supplies of health professionals.



Health Canada Office of Nursing Policy Ryten 2002 CNAC Report

- **Drugs** are the fastest cost driver within provincial/territorial health programs, with more drugs being used for a broader range of treatments over time, and with newer, more expensive drugs being constantly developed.

Since 1990 public spending on drugs has tripled, to \$7.6 billion, and private spending has reached \$12 billion



- **New possibilities in technology** and pharmaceuticals are emerging faster than our ability to assess what should be publicly funded on the basis of clinical and cost effectiveness.
- **Non-acute services**, especially home care and long-term care, are growing at a rapid rate. But demand is rising faster than supply and there is little coordination and integration of information and service across the full spectrum of care, resulting in unnecessary costs.
- The growing demand for **accessible health care services in rural and remote areas, particularly for Aboriginal peoples**, is also driving cost factors. Increased rationing of the system, tightening supply of health human resources and escalating health status challenges are causing spending to soar simply from the costs of moving patients to where the care is.
- Finally, after more than a decade of deferred maintenance and repair of existing infrastructure, and inadequate expansion of the system to meet population growth, **we are in the midst of a period of capital investment in the system.**

With the exception of technological breakthroughs, the rest of the cost drivers can be managed far more than is currently the case.

Most cost drivers could be managed much more effectively if governments were willing to flex their considerable muscle. They can do what individuals cannot do – buy in huge scale and bargain hard for the best value for money.

The federal commitment to public health care should not be judged only by how it offsets provincial spending costs. It has a unique role to play in supporting and even delivering health care.

The answer to our health care problems is not just more money. More money is required to get through the next stage of needed investments in people and equipment. But this rate of growth in costs will decline if today's reinfusion of cash yields a plan: a plan to be more effective purchasers of pharmaceuticals, to address labour shortages, to integrate and streamline the provision of care, and to expand and maintain physical capacity. And that plan has to work in every part of the country.

Fiscal imbalance = a renewed and distinct role for federal support

There is more federal money coming through, in the billions of dollars, though some claim it is too little too late.

Cutbacks in federal transfers since 1986, and especially between 1996 and 2000, downloaded more costs onto the provinces. By 1998 only 10% of all provincial/territorial health expenditures were covered by federal cash transfers for health.

The February 2003 Health Accord brings the federal cash share back up to about 20% by 2005-6. If provincial spending continues to rise by an average 7% a year, mostly driven by elements of the system that are not cost-shared with the federal government, it will drop back down to 18.6% by 2007-08. But at least four provinces – Quebec, Ontario, Alberta and B.C. – have signaled they are going to slow down the rate of growth in health care spending, so the federal share might stay close to 20% or more.

Recent electoral promises by Paul Martin and the Liberal party for another \$9 billion over the next five years will further raise the federal share of provincial costs for health care. Depending on how the roll-out of these funds is timed, and how fast provincial/territorial spending increases, the federal share could reach the marker that has become the de-facto proof of appropriate cost-sharing: 25% of the cash costs of provincial/territorial health care. More cash, not tax points, is the key to making sure there is uniformity of improvement across the land.

The 25% rule of thumb is more than just a dollar amount. It is a sign that the federal government is, once again, an equal partner in supporting Canadians' most cherished public program. More than money, it is used as a potent symbol of right relations between orders of government.

That assistance to the provinces is inarguably important, and federal support for public health spending will undoubtedly continue to increase. But the federal commitment to public health care should not be judged only by how it offsets provincial/territorial spending costs.

There are other things that the federal government can do on its own to help shoulder the costs of health care and introduce greater efficiencies into the system, and these initiatives could signal a much deeper commitment to ensuring the viability and sustainability of public health care for the next generation.

The following is a proposal for new unilateral shouldering of the costs, which should be a welcome change from over a decade of unilaterally pulling funds for cost-sharing. Some of the proposal comes in the form of one-time multi-year infusions of investment capital; some is more permanent in nature.

The case for a stronger, more distinctive Federal role

After a decade of downloading, the federal government should upload some health costs and delivery, and it should start with public drug programs. Such streamlining would introduce better clinical evidence and cost discipline in how new drugs are added to formularies, improve uniformity of access to pharmacotherapy across the country, and use single purchaser power to get better bulk buy prices. Over time this shift could relieve the provinces and territories of more than \$7.6 billion in public expenditures (and rising), create a wider range of policy levers to manage costs in the future, and introduce a mechanism for expanding pharmacare in order to manage more effectively the cost escalation in drug purchases overall.

The federal government should also get more involved in the capital costs of maintaining and enhancing the health infrastructure it helped build a generation ago. Historically the federal government has played a crucial role as financier of the stock of public goods and assets. In 1948 the federal government cut a deal to fund about a third of capital costs for building hospitals across the country. This was a period remarkably similar to the current situation – for six years the federal government ran back-to-back budgetary surpluses while the provinces were in deficit positions. With the war over and in the spirit of “reconstruction”, the nation threw itself behind the project of building a country. Both levels of government acknowledged the job could not be put off. They put their shoulders to the wheel, and infrastructure sprang up across the country, in the form of needed schools, hospitals, roads and much more.

Today, too, the job cannot be put off any longer. In Ontario alone it is estimated that the capital costs required to expand and upgrade hospital infrastructure over the next few years will be between \$7 and \$9 billion. At 38% of the population, Ontario’s situation suggests that the current capital needs of the country’s health care sector could easily surpass \$20 billion. Like the immediate post-war period,

The Federal government should:

- upload provincial drug programs to the federal level.
- play the crucial role of public financier for this wave of necessary capital investments.
- coordinate and shoulder most of the costs of training this cohort of health professional graduates.

The most cost-efficient way to maximize access to health care services is through public funding of not-for-profit providers.

most provinces face budgetary deficits, while the federal government can count on budgetary surpluses for years to come. The federal government can also borrow money at the cheapest rates in the country. Cash-strapped provincial governments are turning to the private sector to help build needed infrastructure, but private-sector financing is the most expensive way to build. This is a period where federal capital reinvestments could play a critical role in the future sustainability of the public health care system, ensuring Canadians in every part of the country have public infrastructure they can rely on, while ensuring the lowest possible costs.

The federal government can also shoulder a bigger part of the costs of health education, helping offset the costs of training the wave of new health professional graduates this country needs today and even more so in the coming decade. Within five years, there will be an unprecedented increase in retirements in the health professions due to the demographic profile of these workers. If you think the labour shortage is bad today, just wait a few years. It takes time to train nurses, doctors and technicians. But there is no integrated plan to meet this challenge in a way that avoids one jurisdiction poaching off another's investments.

A combination of scholarship and granting mechanisms that flow directly to individuals could be made available to students training as health professionals in a range of occupations. Free tuition could be offered as a quid pro quo for successful graduates who agree to serve in rural, remote and under-served areas for a fixed duration. Called "return service", variations on these arrangements are already being used today in various jurisdictions. **It's time for a national plan.**

The private sector doesn't have the answers for public health care's problems

Health care costs will continue to grow over the coming years, regardless of who pays for them. The most cost efficient way to maximize access to health care is through public funding. Public health care is sustainable. It just needs clear vision about what is driving health care costs and political will to manage those costs.

There are four main threats to the sustainability of Canada's public health care system: rising labour costs, rising drug costs, long wait times, and growing use of public funds for private, for-profit delivery of services.

These all have cost dimensions, but one of these things is not like the rest: the growth in public financing of investor-owned health facilities.

Labour costs, drug costs, even wait times, can go up and down over time. Policies or funding changes can make these things better or worse. But the

increase of publicly-funded investor-owned, commercialized health care is not easily reversed by policy, given contractual obligations stretching out 20, 30 even 60 years. Given the backdrop of international agreements that views services as the new frontier for the expansion of trade opportunities, it is both difficult and costly to change our minds about going down the path of more public funding for for-profit delivery of health care.

Governments that turn to the private sector to help shift the costs of investing in health care infrastructure and service provision are implementing short-term fixes that hurt public health care in the long run. Why? Because it costs more to go private.

Repair and expansion of infrastructure of all sorts have been delayed for over a decade, while the population has grown by over 10% overall, more rapidly in some parts of the country. The reluctance of governments to increase public debt has driven some to turn to private sector financing mechanisms. The extra costs of private financing are considered attractive when it appears that capital charges can be shifted off the public books, or when it is assumed that governments have transferred the risks of building to schedule and to budget.

Bond rating agencies around the world are assessing the risk transference in these deals as limited or nil. Taxpayers don't save any money unless there is full risk transfer. Even if investors absorb unanticipated cost increases, when cost overruns go up too much companies fold, and the taxpaying public is left holding the bag. No government would dare close a hospital because the company behind it went bust. These "innovative" financing alternatives are simply disguised government borrowing. If governments can't fool the bond rating agencies with these deals, they shouldn't be trying to fool their taxpayers.

There simply is no cheaper form of financing arrangement than public borrowing. The lower the risk, the lower the cost of borrowing money. Businesses are higher borrowing risks than governments. Lower levels of government (and hospitals) have higher risks than higher levels of government. The player with the lowest risk – and consequently lowest borrowing costs – in the capital market is the federal government.

Evidence from Australia, the U.K., and even some provincial jurisdictions shows that Offices of the Auditor General are questioning the value of public-private partnerships.

Business provision of capital does not save borrowing costs. Business provision of services is unlikely to save money while holding levels and quality of service intact. Either workers get paid less, leading to lower quality, or services are

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It's cheaper to go public. Governments have enormous purchasing power. Why aren't we using it better?

restricted to provide room for returns on the business' investments. If costs are not scaled back in one of those ways, operations must cost more, because the bottom line in a business is turning a profit.

There is another reason why it's cheaper to go public: governments have enormous purchasing power. And when they choose to consolidate procurement practices, there is an enormous "bulk buying" pay-off in volume discounts.

Whether buying drugs, supplies, labour, capital or insurance, we get huge savings when deals are brokered on our behalf through thoughtful, vigilant public purchase. Why pay retail when you've got that kind of purchasing power behind you?

Public financing of health care offers unique potentials for huge economies of scale, economies which are simply not available when the system becomes increasingly fragmented with individual purchasing decisions.

It's time governments stopped experimenting with "alternative" funding or delivery arrangements, and started focusing that creative energy on ways to harness the power of public finance to give us better value for money.

A Message from Canadian Nurses

Prepared by Armine Yalnizyan,

Research Associate, Canadian Centre for Policy Alternatives.

First Recipient, Atkinson Foundation Award for Economic Justice

Cette publication est disponible en français.

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