

Profit is not the cure

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A Call to Citizens' Action to Save Medicare

There never has been or will ever be a more important thing in Canada than medicare.

– Stefania Morris—age 90

INTRODUCTION

CANADIANS TREASURE OUR UNIVERSAL HEALTH CARE SYSTEM. POLLS CONSISTENTLY CONFIRM THAT, no matter what turns the economy is taking or where the political winds are blowing, support for this core foundation of Canadian society never wavers. Yet we are currently experiencing the most sustained and deliberate assault on medicare in its thirty-six-year history. Unless ordinary Canadians from every part of the country rise up to defend it, our public health care system will not survive.

Two major commissions, one led by former Saskatchewan Premier Roy Romanow, and the other by Senator Michael Kirby, are currently examining “all possibilities” for the future of health care in Canada, including private options. Ontario, Alberta, and British Columbia are in a race to establish private hospital services, delist currently covered services, and establish two-tier health care for their citizens. Federal Health Minister Anne McLellan, who refers to Canadians as “consumers” of health care, has declared that she is open to amending the Canada Health Act to allow for private hospitals and has signalled a new era of “cooperation” with the pro-privatization provinces in upcoming negotiations over the future of health care.

In fact, the Chrétien Liberals, having embraced all of the values of economic globalization, including nation-state competitiveness, privatization, and drastic funding cuts, and backed by the powerful right-wing newspaper chains and well-financed think-tanks, have signalled that they see medicare as a relic of another time. By enthusiastically espousing free trade agreements such as NAFTA, the Free Trade Area of the Americas (FTAA), and the General Agreement on Trade in Services (GATS), the government has signalled the death of the Canada Health Act. The stakes are very high. These trade agreements radically redefine our health care as a commercial service. Once any part of a service is privatized by any province, there is no turning the clock back.

While governments plead that they can no longer afford to provide full coverage for Canadians, the truth is that money is not the issue—just the excuse. Before the deep funding cuts, Canada’s public system was delivering better overall health care, more equitably, and at a substantially lower cost than private systems, such as that in the United States. The real issue is one of values. Even after the cuts, our system is vastly superior.

Yet, right from medicare's inception, there have been forces intent on undermining it. At first, it was a powerful medical establishment and private insurance companies who teamed up with right-wing governments to limit medicare's scope and to wait for the right climate to destroy it altogether. Today, an international private service industry, anxious to get its hands on the estimated \$3.5 trillion (CAN) global health care sector, is seeking out and finding friendly governments—including the Chrétien Liberals in Ottawa—in order to profit from this lucrative sector.

The Canadian people must become mobilized in order to stop this assault on our most treasured social program before it is too late. Working with national groups such as the Canadian Health Coalition, the Council of Canadians, and the Canadian Union of Public Employees, as well as provincial and local public health coalitions, we must make our governments hear our clear message.

Profit is not the cure for medicare. Every Canadian has a right of citizenship to publicly funded, accessible, universally delivered health care. We can afford to maintain and even strengthen our health care system if we eliminate the current for-profit components that are causing some costs to spiral, such as patented drugs, fee-for-service, and overpaid administrators, and, instead, turn to a primary care, community-based, fully public model run more equitably and more efficiently. Further, the right of Canadians is the right of every human being on the planet; Canada must re-commit to its former position and work with other governments and the United Nations to see that universal, public health care is provided to the world.

The health care controversy in Canada is not a debate about money. It is a clash of values. The creation of medicare was the people's choice. It still is. It is not too late to save medicare. Its fate is in our hands.



PART ONE

A People's Legacy

MEDICARE WAS BORN OF A DREAM OF A PEOPLE. LIVING NEXT TO THE BIGGEST SUPERPOWER ON earth, Canadians knew that they had to create ribbons of interdependence across the country if they were to survive as a separate nation-state on the northern half of the North American continent. This people rejected the American narrative of "survival of the fittest" and embraced a Canadian vision of "sharing for survival." As a fundamental right of citizenship, all Canadians, they decided, no matter what their socio-economic or ethnic background or where they lived, had a right to comprehensive, accessible, portable, universal health care from cradle to grave.

The fight for medicare was hard. With the sole exception of Tommy Douglas's government in Saskatchewan, governments did not willingly give public health care to Canadians. Rather, citizens had to wrest it from reluctant politicians. The story of medicare is the story of a sustained struggle of a people. They fought for it with demonstrations, marches, and strikes. Churches demanded health care for the poor. Workers negotiated for it hard in collective bargaining. Women fought for its extension to families. It was earned as a right of citizenship by a people who had suffered greatly in its absence.

In the Beginning

At the turn of the twentieth century, there was no such thing as social security in Canada, and no recognition of social or health rights. Class structures were rigid. Child labour was common. Churches, private charities, and minimal municipal assistance provided the only relief for the poor. The destitute, the ill, the insane, the homeless, and criminals were all sheltered together in poorhouses. Most health care was delivered at home by family members or neighbourhood midwives. Hospitals and doctors were reserved for the wealthy.

Our current social system has its origins in two different ideologies. Upper Canada based welfare on the idea that the primary social and economic unit was the family, and responsibility for poverty was largely individual, not collective. Meanwhile, a more collective framework for social concern was developing in what is now Quebec, Atlantic Canada, and parts of the West. Almost everyone subscribed to the notion of a distinction between the "deserving poor" (the very young, very old, sick, or disabled) and the "undeserving poor" (the able-bodied unemployed). However, within the different views of society, different interpretations of these concepts were developing. The fusing of Loyalist sentiment, agrarian collective values, traditions of feudal hierarchy, and concern for the group (and later, social gospel teachings) produced a counterforce to free-enterprise individualism across the country. This would form the basis for universal social programs and anticipate future lines of contention.

Interrelationships were developing everywhere during this period, between private charities, churches, municipalities, and governments, as public monies were increasingly being sought by

those providing relief. Increases in the use of public money in turn led to increased government monitoring and regulation of relief programs.

World War I

A new Canada was beginning to emerge from the First World War. It was clear that unfettered, unregulated capitalism was not working for the majority. Anger at the old class structure in which a privileged few dominated government and the economic and social lives of millions exploded. The propertied classes had become richer from a war that had cost so many working families their sons. The elites used their power to suppress political dissent and resist workers' demands, fully expecting to return to their pre-war status.

But Canadians had changed. Women had fought for and won the vote. Western farm radicalism was growing. Grain growers were forming cooperatives and establishing collective, pre-paid hospital services. Trade union membership was growing exponentially, from 20,000 in 1890 to almost 400,000 by 1920. Medical protection for its members and their families was a top priority of the labour movement. The first medical insurance programs were won by mining and logging unions. During the war, increased pressure was placed on the federal government to provide health care and compensation in case of injury for the men on the front lines of the battlefield and the factory.

On the eve of the Great Depression, an ideology based on class analysis was fermenting in slums, in universities, on the factory floors, in mines and lumber camps, at rural revival meetings, in churches, and in kitchens. It would become the major influence on social policy development in the terrible years ahead, anticipating the concept of universal social and health rights. It would forever change the way Canadians live and work together. From the resulting convictions sprang courageous opposition to oppression in the form of labour marches, strikes, and other uprisings, most of which were brutally suppressed. This ideology would be further strengthened and defined in the twin crucibles of the Depression and the Second World War that lay ahead.

The Great Depression

Canadians were as hard hit by the Depression as any society in the world. At its height, two-thirds of prairie farmers and half the wage earners in the country were on relief. Employers terrorized their employees, paying wages as low as two cents an hour for work weeks as long as one hundred hours. There was no sick leave, no paid holidays, and no insurance for unemployment or hospital care. Over 100,000 homeless men wandered the country, sleeping in alleys, riding the rails, or growing restless in the hundreds of relief camps (in which there were no medical services).

Federal transfers to the provinces grew dramatically in these years. Spending on social welfare as a percentage of government expenditures grew from 2.5 percent in 1910 to almost 26 percent in the mid-1930s. This fact became crucial to the debate over universality since, in the absence of any coherent national plan or notion of social and health rights, this money was often wasted. Relief was administered by the provinces and municipalities, who were generally punitive in their approach to welfare and whose standards varied widely. Inspectors came unannounced into homes, and denied aid to any families in possession of undeclared food, new clothes, or liquor.

Those seeking medical assistance were even worse off. Most municipalities had a one-year residency requirement even for emergency health care. Health insurance was very expensive and, as policies were renewable annually, they were usually cancelled by the company if the insured patient developed any serious condition. There were no services for any kind of preventative medicine; only the very ill or injured could apply to municipal authorities for admittance to local hospitals, and free care was doled out sparingly.

More commonly, families of the ill were left to scrape together enough money for admittance to a hospital, which charged for every procedure from blood tests to surgery. Patients whose bills exceeded the admitting fee were kept in the hospital until a family member came by to pay, and many a patient was unable to finish treatment that took more than one hospital visit.

Conditions for the staff were terrible then, as well. A nurse who served at the Empress Hospital in Alberta remembers that she and one other nurse worked opposite twelve-hour shifts, 365 days a year, with no sick time or vacation.

Life without Medicare

In *Life Before Medicare*, the moving collection of stories published by the Ontario Coalition of Senior Citizens' Organizations, Canadian seniors share their memories of health care during these years. One remembers a young mother dying on the steps of a hospital in Grande Prairie while her husband was inside, begging them to admit her. Another senior described his mother's struggle with cancer of the larynx. His father borrowed money from family members and neighbours to take her by train from Saskatoon to Toronto where she had her larynx removed, but he was unable to find enough money for further treatment when the cancer returned. He took her home to Saskatoon to die.

Another young mother had to sell her two cows to pay the hospital bill for her dead baby before the hospital authorities would release the child's body.

A Manitoba senior recalls a neighbouring farm woman who was diagnosed with cancer. She knew that in order to get treatment in a hospital her family would have to sell the farm, so she decided to die at home. When her husband went out to work, she had him close all the windows so the neighbours wouldn't hear her screams of pain, and lock the doors from the outside to stop her from running to them for help. Her suffering lasted for two months, but she saved the family farm.

It is little wonder, then, that during the 1930s, fully half of all Canadians did not receive any health care whatsoever. Nor that, when war broke out in 1939, almost half the young men called up for active service had to be rejected because of poor health. As Colleen Fuller documents in her comprehensive 1998 book, *Caring For Profit*, Canada ranked seventeenth among industrialized countries in infant mortality at that time, with rates of between thirty-eight and eighty deaths for every thousand live births, depending on the part of the country being looked at. Because access to hospital care was limited, approximately three to five women died in childbirth for every thousand live births.

Over 9,800 Canadians died in 1940 alone from communicable diseases such as influenza, tuberculosis, diphtheria, measles, and whooping cough. Children and youth, reports Fuller, were

found to be in alarmingly poor health. In Manitoba, in 1941, for example, 70 percent of those between thirteen and thirty years of age required some kind of medical attention. In each year between 1931 and 1941, an average of fifteen thousand Canadian children under one year of age died from preventable or controllable illnesses.

World War II

Then came the war, and the same government that could not feed, house, clothe, employ, or provide medical care to the majority of Canadians, suddenly had all the money it needed to send them into battle. Unemployment dropped to 0.3 percent and trade union membership swelled to over 700,000 by war's end. The government's need to build a strong national war infrastructure coincided with its citizens' demands for a stable future. As the men of the relief camps, suddenly well paid and well fed, were sent to fight for their country, government was already being forced to plan for a post-war society, one that would include a modern social security system, the cornerstone of which would be universal health care.

Much of the pressure to build a welfare state came from the newly formed Co-operative Commonwealth Federation (CCF), a collection of farmers, academics, social reformers, urban socialists, labour unions, and social gospel adherents who had gathered in Regina in 1933 to launch a new social movement and political party that would have long-term ramifications for the country.

With its call to "conscript wealth as well as men," the CCF made rapid headway in several provinces, forming the government in Saskatchewan in 1944, and placing great pressure on the ruling Liberals under Mackenzie King, at the federal level. In the election of 1945, with the CCF nipping at his heels, King campaigned on a theme of "building a new social order," and promised a whole new social infrastructure for Canadians, including public health care.

New Foundations

Several major studies set the stage for the government's post-war plan. The *Rowell-Sirois Report on Dominion-Provincial Relations*, published in 1940, established the principles of the modern Canadian state: federal authority over the economy and national welfare, including unemployment insurance and relief; provincial subsidies, with national standards attached, for education and social services; and regional equality and equalization.

The 1943 Report on Social Security for Canada, written by Dr. Leonard Marsh, proposed pooling protection for maternity, sickness, unemployment, and old age into one universal, comprehensive social insurance plan. It called for a policy of full employment, comprehensive health insurance for all Canadians, fully funded federal assistance programs for the unemployed, and universal children's allowances.

With two colleagues at McGill University in Montreal, Marsh had conducted a major analysis of class and health during the Depression. Based on their findings, he concluded that "if medical care is a contingency left to each individual to secure as best he can, it becomes a function of the distribution of wealth."

The Heagerty Report of the Advisory Committee on Health Insurance, also released in 1943, held that the provision of adequate medical care for all Canadians was essential to the maintenance and security of a democratic state. It called for a national, compulsory system of health insurance and a comprehensive system of public health. The whole population was to be eligible for medical, dental, pharmaceutical, hospital, and nursing services.

These reports did not spring up in a political void. They reflected the will of the Canadian people. As early as 1941, *Saturday Night* would declare: "Almost everyone agrees that health and unemployment insurance schemes, regulation of business, and a sharp limitation of profits are necessary to provide Canadians with real security." Canada must become a country fit for returning heroes, it added, and asked why anyone would want to go to war to preserve the kind of society that had existed before 1939.

The first real universal social program was a family allowance for everyone with children under age seventeen, introduced in 1945. This was the first program without a means test and the first indication that government was assuming some responsibility for the well-being of all Canadian families. The principle of universality, said Leonard Marsh, "enlists the direct support of the classes most likely to benefit at the same time as it avoids the evil of pauperization and undemocratic influence of state philanthropy." The income support afforded by the program was not merely symbolic. Family Allowance in 1945 represented a substantial amount of family income: 20 percent of the average income for a family with three children.

The second major universal social program, an old-age pension for those seventy years of age and older, was initiated in 1952. Many Canadian seniors were reluctant to apply for it; for them, pensions bore the stigma of means-testing. It was only after Prime Minister Louis St. Laurent was photographed applying for his own benefits that many seniors gave in and accepted their pensions.

Powerful Foes

But on the health care front, powerful forces were aligned against the popular will. The British Columbia Manufacturers' Association, the B.C. Board of Trade, and the B.C. Chamber of Commerce had joined forces with the Canadian Life Insurance Officers' Association and the Canadian Medical Association (CMA) to defeat a popular public health insurance plan in British Columbia in 1936.

This coalition went on to work tirelessly inside the provinces to slow progress towards the acceptance of an agreement for universal health insurance drafted at the August 6, 1945, Dominion-Provincial Conference on the post-war reconstruction of Canada. While the four western provinces supported the federal government's strategy of steadily increasing federal grants for comprehensive provincial health insurance in exchange for provincial tax monies and the achievement of minimum standards, the remaining provinces, led by Ontario, balked. The talks broke down ten months later in a stalemate.

Meanwhile, as Colleen Fuller documents, an alliance was forming to unite the two types of insurance plans that had formed in Canada during the War years, although these had at first appeared to be at odds with one another. Physician-sponsored insurance was run on a non-

profit basis, and was aimed at a different sector of society than was generally covered by the commercial insurance industry. Non-profit hospitals run by physicians did, in fact, enable many Canadians to obtain minimal health care for the first time. Commercial insurers, on the other hand, concentrated on the healthy employed, whose coverage was paid for by their employers. Their coverage, therefore, did not extend to families, the ill, or the elderly.

But, in spite of their differences, both types of plans were initiated to prevent governments from implementing what opponents called “socialized medicine.” So worried was the CMA about popular support for a national compulsory plan, it brought all the provincially based, doctor-run plans under one national umbrella called the Trans-Canada Medical Plan. This new consortium joined the commercial insurers, now also under one banner, the Canadian Health Insurance Association, and the Canadian Hospital Association, also newly formed, to “prove” that Canadians were sufficiently insured and didn’t need the government to introduce public medicare.

A People United

It is true that, by the mid 1950s, over half of Canadians had some form of health insurance. But it was by no means equitably distributed. As Fuller documents, people with high incomes obtained the lion’s share of health care services, even though the poor experienced ill health more often and for longer periods. Ironically, of course, this is in part because they could not access preventative medical treatment. And the Canadian people were adamant that they were going to get their promised national program. By war’s end, fully 80 percent of the Canadian population supported a national health plan and this support only increased in the coming years.

Saskatchewan and British Columbia introduced universal hospital insurance in 1947 and 1949 respectively, and in 1957, in spite of fierce opposition from the insurance industry and the business community, the federal government passed the Hospital Insurance and Diagnostic Services Act, allocating funds to provinces that set up a universal hospital insurance program in accordance with national standards. By 1961, all ten provinces were eligible for the funds.

Meanwhile, Tommy Douglas’s CCF government in Saskatchewan had entered into one of the most ferocious political fights in Canadian history. Saskatchewan had experimented with universal health care schemes for many years. The roots of this struggle lay deep in the prairie soil. In town halls and farm kitchens, the people of that province fought for a public health care system. There had been trials with salaried doctors in some communities as early as 1919, and some doctors went on relief during the Depression, unable and unwilling to charge their destitute patients.

Tommy Douglas was actually elected in 1944 on the promise of universal health coverage, “available to all without counting the ability of the individual to pay.” Treatment for cancer, tuberculosis, and polio was provided free to all who needed it. A free air ambulance service was set up to fly patients from remote settlements to hospitals. And geriatric centres were built to provide care for the chronically ill, free of charge. As early as 1945, Douglas was prepared for a full public system, and was bitterly disappointed that the federal government was unable or unwilling to deliver. (A federal health plan had been a Liberal promise since 1919.)

During the 1950s, the battle in Saskatchewan heated up. Douglas fought the Saskatchewan College of Physicians and Surgeons, who went on strike; the Canadian Medical Association, who helped fund the opposition in Saskatchewan and who were working with the American Medical Association, also waging a no-holds-barred campaign against President John Kennedy's efforts to introduce a prepaid scheme for the elderly in the U.S. in 1961; the Dental Association; the Chambers of Commerce; private drug companies; and the right wing newspapers owned by the Sifton family. But Douglas stood by his people. Said *The Vancouver Sun*, "This man Douglas is—well, a good deed in a naughty world. He's a breath of clean prairie air in a stifling climate of payola and chicanery and double-talk and pretence, global and local."

On July 1, 1962, the Government of Saskatchewan passed legislation that brought universal health coverage to every citizen of the province, regardless of income, ethnicity, or state of health. The people of Saskatchewan had spoken; now, a national plan was within sight.

The Hall Commission

In 1960, Prime Minister John Diefenbaker appointed Justice Emmett Hall to head up the Royal Commission on Health Services; four years and over 400 submissions later, on June 19, 1964, the report was tabled. The Commission had attracted an amazing amount of intense interest and debate. On one side was the vast majority of the public, the newly formed Canadian Labour Congress, churches, consumer groups, social workers, and others concerned with the common good; on the other was the same powerful alliance of business, insurance companies, and doctors who had been fighting the process for two decades.

Essentially, the former argued that health care should be a public service to which every Canadian, by right of citizenship, is entitled. Most were also seeking a publicly run system, like education, in which all medical personnel would be on government salary. The latter, on the other hand, advocated for public subsidies for the poor and the hard-to-insure so that they could buy into private plans for medical services.

As Colleen Fuller explains, in the great Canadian tradition, the Royal Commission opted for a compromise. It rejected a full public program and opted instead for a tax-supported public insurance model as the mechanism through which a self-regulated, privately administered health system would be financed, supplemented by federal grants where needed but "free of government control or domination." In other words, a public insurance system that pays for health services supplied mainly by the private sector.

Yet, in spite of the compromise position taken, the Royal Commission's report was a milestone in Canadian history in its explicit recognition of Canadian social values. In the introduction to the report, the commissioners said that the popular support for public health care came from Canadians' own history of community-based measures to counter epidemics in the earlier part of the century, and it praised the humanitarian concern of Canadians for their fellow citizens and the common understanding in Canadian society that "the well-being and happiness of society is simply the sum total of the well-being and happiness of its individual members."

The commissioners called for a universal and comprehensive health insurance system with uniform standards across the country, and laid out in no uncertain terms the responsibility of the

federal government for the health and well-being of Canadians. They also said that dental and optical services for children, expectant mothers, and welfare recipients should be included in the plan as well as prescription drugs and home care.

Medicare at Last

On July 12, 1966, the Medical Care Insurance Act was passed in the House of Commons with only two dissenting votes. Federal-provincial wrangling as well as divisions within the ruling Liberal Party would delay the implementation of the long-promised legislation for another two years. Although the act bowed to the medical establishment by allowing doctors to opt out of the program and extra-bill, and did not cover dental and optical services or drugs, it did finally establish a comprehensive, universal health care system for every Canadian.

Conditions for federal grants to the provinces for health care were clear: the provinces had to deliver non-profit, comprehensive, universal, accessible health care to their residents and ensure portability of benefits from one province to another. For the first time, a social minimum in health care for all Canadians was clearly defined and the federal government agreed to pay 50 percent of all provincial health costs.

Most important was the notion that the major goal of medicare was the achievement of greater equity in health and access to health care. The government recognized, as expressed by the Hall Commission, "the fundamental principle that health is not a privilege but rather a basic right which should be open to all." Now every Canadian, regardless of ethnic origin, socio-economic status, age, sex, or region, had a right to quality health care.

There was a second goal. It was hoped that by creating equality of access to health care, medicare would reduce the poverty gap in the country and narrow class differences. No longer denied preventative care, it was argued, poorer Canadians would become healthier Canadians, and would be able to compete in the job market on an equal footing with their wealthier neighbours.

It had been a long struggle, for which many had paid a high price. We will never know the whole story of the thousands of ordinary people who fought to bring our country its greatest social program. Nor will we ever have a full tally of the suffering in the decades that preceded it. What we do know is that the vast majority of Canadians held steadfastly to a vision of a universal health care system, one to which every person was entitled access. With the passage of the 1966 Medical Care Insurance Act, Canadians finally had their cherished medicare.

PART TWO

Life with Medicare

MANY CANADIANS HAVE NEVER KNOWN LIFE WITHOUT MEDICARE. WE EXPECT TO BE ABLE TO see a doctor or go to a hospital whenever we need to. It is hard to imagine a society that would turn people in need of medical help away because they are unable to pay. But we need to understand that there are very different values in government and business today than there were when medicare was created. In Canada and around the world in the 1960s and '70s, humanity was drawn by the possibility of eradicating world poverty and hunger. The United Nations had serious plans for bringing universal education and health care to the whole world. There was a vision of "peace in our time." It was in this climate that a generation crafted a new Canada: a nation of universal social rights and an international peacemaker.

The Leap Forward

Health care is not the only area that saw significant social reform. The main fabric of Canada's social safety net was completed in the rebellious times of the 1960s and early 1970s. The Vietnam War, the sexual revolution, the women's movement, the civil rights movement, the peace movement, the youth movement, and the war on poverty all formed the backdrop for far-reaching social reform. Advocacy groups—for tenants, the poor, seniors, consumers, aboriginal peoples, farmers, racial minorities—sprang up everywhere. The notion that equal treatment of all, in spite of differences of region, ethnicity, income, age or gender, should be fundamental to social policy was taking deep root.

The Medical Care Act of 1966 was wrapped together with federal funding for hospitalization and post-secondary education into the Established Programs Financing Act, which guaranteed stable funding for these services, and demanded accountability ensuring that funds earmarked for health care went to health care. The Canada Assistance Plan (CAP) consolidated all federal-provincial assistance programs into one comprehensive package and enshrined the right to social assistance for all Canadians in need. In order to be eligible for federal funds, the provinces would have to meet national standards by developing programs to help people in need achieve and retain independence; by meeting financial needs regardless of their cause; by improving standards of public welfare; and by granting certain benefits to the working poor. Provinces could not deny benefits on the basis of non-residency, and could not force recipients to work for social assistance benefits.

Similarly, the new Canada Pension Plan enshrined several key new rights: it lowered the qualifying age to sixty-five; it added a wage-related pension as a supplement to the universal pension; and it declared that Canadian seniors and the disabled should receive a government pension adequate to maintaining a socially acceptable standard of living, rather than bare subsistence. For the first time, those who were widowed or had long-term disabilities were fully provided for.

The National Housing Act of 1964 provided loans to provincial housing corporations for public housing at reduced interest rates. A youth allowance extended family benefits to children up to the age of eighteen, and, in 1973, a new Family Allowance Act significantly increased funding to the existing program. The Department of Regional and Economic Expansion addressed underdevelopment in poorer provinces, and the new Unemployment Insurance Act of 1971 expanded benefits and access under the program, making it one of the most comprehensive in the world.

In adopting these far-reaching social programs, Canada had joined a number of progressive countries that believed in a collective response to social problems, such as Sweden, Norway, France, and Germany, and distinguished itself from the individualistic track that had been chosen by the U.S. The overall goal of these programs, declared the Government of Canada, was “the elimination of poverty among our people.” While many would fall short of the original dreams of their creators because of constant funding constraints and federal-provincial squabbles, these programs were seen by Canadians as synonymous with the progress of a modern nation-state. And they established important principles that have been key to our culture and our national identity.

Principles of the Progressive Society

Social Equality: Social programs should be universal. Limiting them to the poor transforms them from a right to a charity. Social security is not simply a means to relieve the conditions of the most unfortunate, nor even to establish a minimum standard of living below which no Canadian should have to fall. Social security is a right of citizenship, based on the fundamental notion that Canadians have equal social rights. One major goal of social programs is to narrow the gap between rich and poor.

National Standards: Effective social programs should be based on national standards, generating a sense of shared responsibility and community. National standards guarantee every Canadian in every part of the country access to social services as a right of citizenship. Universal standards give a sense of continuity and security to social funding, allowing people to plan ahead for their future. And they are a key tool of nation-building as they provide a national sense of purpose and of community.

Public Delivery: National social programs require a strong public service. Private social, education, and health care service providers operating on a for-profit basis must find ways to cut costs in order to provide the required services and still show a profit. This is generally done by downgrading employees’ pay and working conditions, and finding ways of recovering costs such as imposing user fees or reducing services. In the area of health care, it is not profitable, for example, to put resources into prevention; rather, the profits come from expensive surgeries, treatments, and medicines. A private social security system results in widening inequality, fewer choices, and less skilled and accessible care, and will always be more interested in expanding markets than in delivering quality care.

Canada’s social and universal health care programs came into being only because generations of Canadians fought and, in some cases, died for them. We gained our rights through collective action and the formation of citizen and public advocacy groups. Governments

reluctantly gave way to public demand in creating social security, and have often sought to undermine public will by whittling away at program funding. Canadians should not be grateful for medicare and other social programs; we secured them and they are our birthright.

The Canada Health Act

By 1971, every province in Canada was a full participant in the national public health care program. To qualify for federal funds, provinces had agreed to administer a public, non-profit insurance program covering hospital and physician services. Every Canadian was now covered for basic hospital and medical care.

But many doctors, in spite of steadily rising incomes, were still unhappy. They claimed that American doctors, free to bill patients under a private system, were making more money. They started extra-billing to increase their incomes above the levels possible through the public insurance system. At the same time, some provinces started charging user fees for hospital services. An unsympathetic Canadian public supported the Trudeau government's enactment of a law that would allow it to withhold funds from provinces that permit hospitals to charge user fees or physicians to extra-bill.

The 1984 Canada Health Act, described by the president of the Canadian Medical Association as "constitutional rape," was passed unanimously by the House of Commons. It outlawed extra-billing. During the first nine months after the passage of the new law some \$86 million in federal sanctions were invoked against provinces continuing to permit the collection of additional charges by physicians.

The new act also strengthened Ottawa's role in enforcing national standards. It set out five conditions that the provinces must meet in order to receive transfer payments; the "principles" of medicare became the "conditions" of the Canada Health Act. According to the Canada Health Act: "The primary objective of the Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers."

Principles of Medicare

The five conditions of the Canada Health Act are:

Universality: The health care insurance plan of a province must entitle all of the insured persons of the province to the health services provided for by the plan.

Accessibility: The health care insurance plan of a province must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly, whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons. Equally important, those providing the services must receive "reasonable compensation."

Public Administration: The health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province.

Comprehensiveness: The health care insurance plan of a province must insure all medically necessary health services provided by hospitals, medical practitioners or dentists, and, where the law of the province so permits, similar or additional services rendered by other health care practitioners.

Portability: The health care insurance plan of a province must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for and entitled to insured health services. And it must provide for the payment of the cost of insured health services provided to insured persons while temporarily absent from the province.

The Canada Health Act was an important building block of Canada's health care system and gave the federal government stronger tools with which to enforce national standards across the country. It also fortified the legal framework within which the most cherished social program in Canada was delivered, and recognized the clear wishes of the Canadian people to maintain a universal, public, accessible, portable, and equitable health care system.

The System Delivers

Medicare works for Canadians. Health policy analyst and practitioner Dr. Michael Rachlis says that medicare has worked very well in terms of providing access, economic efficiency, a compassionate system, and high quality care. In fact, as soon as public hospital and health insurance programs were introduced, Canadians felt their effect. Within 15 years of the institution of medicare in 1966, for example, the average life expectancy in Canada had risen four years.

Louise James worked at a large medical ward at Saint Michael's Hospital in Toronto in the early 1960s. She remembers turning away patients who could not afford admittance. "In those years, the elderly were not as healthy, nor did they live as long or as comfortably, in health, as they do today. After medicare, you could slowly see the rise in the number and lifespan of older people with a better health status." Second World War veteran M.A. Boyce adds, "If I had to have paid for all my medical care in these last years, I would not own my own house now, and I do not want to burden a nursing home as I get older."

Senior Mildred Cleverley Holst of Delta, B.C., explains what medicare meant to her.

The major change, as I see it, is that medicare has made it possible for enormous advances in diagnosis and treatment. People no longer crave simple coverage for acute care, but expect a continuum of care: preventative, acute, specialized, rehabilitative and long-term maintenance care, as well as chronic and home care. We expect inoculations to prevent illness, laboratory and ancillary services to diagnose, and appropriate medications and medical aids. The increased life-expectancy of those with extremely severe disabilities and chronic illnesses, and the prolonging of life of the seriously and terminally ill, have been heroically achieved.

In the early 1990s, respected researchers Robin F. Badgley and Samuel Wolfe conducted a comprehensive survey of the literature on the impact of medicare during the first twenty-five years of its life. While they found that intransigent class differences in Canada have undermined one of medicare's goals, that of reducing class and income differences, our universal public plan has nevertheless succeeded in its other goal: universal access to health care services.

Badgley and Wolfe found that medicare substantially “levelled out” long-standing regional disparities in the distribution of physicians and hospital beds as well as in the availability of front-line services. It also greatly reduced regional variation in infant mortality and longevity. And medicare, they reported, has closed the class differences in access to medical services.

Health care experts Terrence Sullivan and Patricia Baranek argue, in their 2002 book, *First Do No Harm*, that, in particular, three fundamental aspects of medicare have proven beneficial to Canadians. Medicare is an effective subsidy and transfer program; it is a simple program; and it creates a strong single purchaser.

First, through taxation, the public portion of health care is funded by a progressive transfer of money from the wealthier levels of our society to provide health services for all on the basis of need. This point is supported by a 2001 study published in *The Social Economics of Healthcare*, in which Terrence Sullivan and Cam Mustard looked at how the progressive pattern of taxation and health care benefits affected Manitobans in ten different income brackets. They found that those in the highest income brackets, on average, pay the most taxes and consume the fewest health care dollars (owing to their superior health). On the other hand, those in the poorest bracket, where there is the greatest disease burden, derive the greatest benefit in terms of the cash equivalent of health care services consumed. Say the authors:

This transfer of benefits based on health need is a distinguishing feature of the Canadian health care system...Our health care system is one very important way in which Canada redistributes the burden of financing health care and health benefits to its citizens. [And, in fact, there is very compelling recent research suggesting that the way we pool taxes to subsidize health services to poorer Canadians results in higher overall levels of health in Canada as compared to the United States.

Second, the single public-payment mechanism keeps administrative and transaction costs to a minimum, eliminates overheads for sales and competition, and provides a national standard of public coverage for most medically necessary services.

Third, argue Sullivan and Baranek, medicare controls costs well because the bargaining power of a single payer determines how much care we will buy and what kind of deals we can make. A strong single payer can cut better deals with workers, suppliers, and professionals.

As a result of these three fundamentals, Canadians receive better, more equitably distributed care for less money.

A Different Model

One way to highlight the strengths of Canada’s health care system is to compare it to the health care system in the United States, which is largely private. Although the U.S. did institute the Medicare program for the elderly and the disabled and the Medicaid program for the poor in the 1960s, universal health care has never been attempted in that country. Indeed, massive and steady cuts to public health care in the U.S. since the sixties have left increasing millions of Americans with no access to quality health care at all. The majority of Americans are dependent on their employers to provide prepaid health insurance through health maintenance organizations (HMOs).

While originally based on a non-profit model through which HMOs provided quality care for millions of employed Americans, in the 1990s, HMOs came increasingly under the control of large insurance corporations who now run them on a for-profit basis. Colleen Fuller calls this takeover of non-profit health care organizations by for-profit companies the largest transfer of charitable assets in U.S. history.

The evolution of the system has been driven by vertical and horizontal corporate mergers resulting in the formation of huge transnational health care corporations that dominate the Fortune 500. Large drug companies merged with the health insurance industry to swallow up hospitals, free-standing clinics, doctors' practices, nursing homes, outpatient clinics, and pharmacies. In 1993 alone, at the height of the mergers, the top ten HMOs saw profit increases ranging from 14 percent to 270 percent over the course of the year; and third quarter profits in 1994 rose 732 percent over the same quarter in 1993. The annual profit of the corporate health care market in the U.S. now stands at almost one trillion dollars (US). Meanwhile, front-line nurses cover their arms and hands with sticky bar codes and slap them on patients' "bill" charts to record each drug, treatment, or supply administered.

Because they operate on a for-profit basis, HMOs "cherry pick" by providing medical care to those with good health and a full-time job. Doctors are actually given bonuses for denying expensive care to patients, although this practice has come under fierce criticism. "Gag" rules preventing doctors from discussing the full range of medical options with their patients are set by the HMO, as are doctors' salaries. The HMO effectively redistributes income from individual physicians to corporate executives and shareholders.

It is no surprise, then, that physicians' incomes have steadily decreased over the last decade in the U.S., while the average HMO executive's earnings now exceed \$10 million (US) a year. Or that, during the 1990s, the ranks of administrators swelled while the number of doctors did not, and the number of registered nurses plummeted. And that, as a consequence, while health care spending was frozen, administrative costs soared.

Furthermore, fraud is rampant in the U.S. system. The General Accounting Office estimates that almost 10 percent of all health care money spent in the U.S. is defrauded through over billing and other abuses. Health care fraud costs Americans \$100 billion (US) annually. According to many inspectors with the FBI's Health Care Fraud Unit, health care fraud is the number one white collar crime in America. The largest certified home care agency in Florida was recently caught in a huge fraud in which \$120 million (US) in Medicare funds went to the company for non-existent patients or unneeded services. In another case, Fresenius Medical Care North America Inc., the world's largest provider of kidney dialysis products and services, agreed to pay the U.S. government \$486 million (US) for conspiracy and fraud, the largest civil fraud recovery in history.

Says Dr. Marcia Angell in the June, 2000, edition of the *New England Journal of Medicine*:

The private managed-care market has been a miserable failure at delivering health care. It has creamed off even larger percentages of health care premiums in bloated administrative and marketing costs and profits; it has rewarded health plans that cherry-pick the healthy and avoid the sick; and it has resisted at every turn providing adequate services to those unfortunate enough to need them.

Private Insurance

The results of relying on private health care insurance have frequently been devastating for ordinary Americans. People who change jobs find their chronic illnesses are no longer covered. And people who have recovered from a serious illness often find that they cannot get insurance because of their previous health record. Forty-four million Americans are completely uninsured for health care, up one million in the last year alone. Another thirty to fifty million have sub-standard care and over 200 million do not have comprehensive coverage, i.e., coverage for items such as long-term care. The American Institute for Health and Socio-Economic Policy reports that, on average, 264 Americans die every day because they have no health insurance.

In a June, 2001, report prepared for the Kaiser Family Foundation (as reported by the Canadian Federation of Nurses' Unions), Georgetown University's Institute for Health Care Research and Policy describes its findings that private health insurance is very hard to come by for people without a good health record. The authors sent out applications for insurance on behalf of seven hypothetical families and individuals to sixty insurance companies. The policies that they sought, in an effort to remain in the "affordable" range, had a \$500 (US) deductible and a \$20 (US) co-payment per physician visit.

The least expensive quote came in for "Alice," who was described as 24 years old and suffering from hay fever. Her insurance quotes averaged \$1,656 (US) per year with the a high of \$4,596 (US). Despite her age, she was rejected by 8 percent of the insurance companies. The "Crane family" was offered coverage by all sixty insurance companies, but nine of the offers excluded their son "Colin" because of his asthma condition. "Denise," described as a seven-year breast cancer survivor, was denied any coverage at all 43 percent of the time. A number of the companies that did offer her a policy, excluded coverage for cancer of any type.

"Frank" was described as sixty-two, overweight, and a smoker with high blood pressure. He was rejected 55 percent of the time, and the average price quoted by companies that were willing to insure him was almost \$10,000 (US) per year. "Greg" was described as HIV positive. None of the sixty insurance companies would cover him.

Left Behind

In 1998, more than 2,300 Massachusetts physicians signed a despairing memo printed in the *Journal of the American Medical Association*, in which they said:

The time we are allowed to spend with the sick shrinks under the pressure to increase throughput, as though we were dealing with industrial commodities rather than afflicted human beings...Physicians and nurses are being prodded by threats and bribes to abdicate allegiance to patients and to shun the sickest, who may be unprofitable. Some of us risk being fired or 'delisted' for giving, or even discussing, expensive services, and many are offered bonuses for minimizing care.

Their position is backed up by a 1999 article in the same journal in which Harvard physicians Woolhandler and Himmelstein estimated that there would be an extra 5,925 breast cancer deaths annually in the U.S. if the remaining 25 percent of HMOs that still operate on a non-profit basis were to become for-profit.

Not surprisingly, services in the impoverished public system in the U.S. have deteriorated in the last decade as well. Thousands of registered nurses have been laid off, replaced by unqualified health care “aides,” and millions of beds have been closed. To deliver cheaper care, administrators are cutting nurse-to-patient ratios, substituting qualified professionals with untrained workers (called “generic workers”), and shifting to a part-time workforce. Nurses are doubling up on their work load. Sheets go unchanged, tests are less frequent, and housekeeping standards are falling.

Horror stories abound. A generic worker at a Rhode Island hospital mistakenly filled a syringe with potassium chloride instead of saline and used it to clean out an intravenous line. The mistake killed an 11-month-old girl. A generic aide was left alone at a major Boston hospital to feed a plate of food to an elderly burn patient in the intensive care unit. A nurse was called when the patient started to choke from the food stuffed into her mouth. The aide had fed the patient as instructed, but had failed to notice that she wasn’t swallowing. The patient died. At a hospital in Allegheny, an unlicensed aide fed an 81-year-old patient food through a tracheotomy tube, flooding his lungs with the liquid.

A 2001 *Chicago Tribune* investigation found that poorly trained or overwhelmed nurses are responsible for thousands of deaths and injuries each year in U.S. hospitals. Since 1995, at least 1,720 hospital patients have died and 9,548 others have been injured because of mistakes made across the country. The report followed an earlier study by the Institute of Medicine that estimated medical mistakes kill anywhere from 44,000 to 98,000 patients every year. In fact, medical errors now constitute the third leading cause of death in the U.S., after deaths from heart disease and cancer.

The *Tribune’s* investigation also found that many hospitals have increasingly turned to part-time and generic personnel from temp agencies, and that many of the patients who died were under the care of unlicensed, unregulated nurses’ aides. Under cost-saving programs in at least two Chicago hospitals, housekeeping staff assigned to clean rooms were pressed into duty as aides to dispense medicine. Mandatory overtime and sixteen-hour shifts were also cited as major problems. Said one nurse quoted in the study: “Every day I pray, God protect me. Let me make it out of there with my patients alive.”

A Tale of Two Systems

A comparison of the two systems shows that Canada’s more egalitarian model saves lives. Canada ranks second in the world in terms of life expectancy; the U.S. ranks twenty-fifth. Canada’s infant mortality rate is 5.6 per thousand live births; in the U.S., the rate is 7.8. Maternal mortality in Canada stands at 7 out of 100,000; in the U.S., that number is 14.

The World Health Organization (WHO) has an index that measures how efficiently health systems translate expenditures into health taking into account a population’s general health including factors such as patient choice and the equity of health care distribution. Canada ranks thirty-fifth on this index; the U.S. ranks seventy-second. On another WHO index, measuring the effectiveness of health care services, including confidentiality and the quality of basic amenities, Canada ranks seventh and the U.S. ranks fifteenth.

The irony of the U.S. health care system is that, in spite of extraordinary measures to cut costs (in order to increase profits), the U.S. spends more per person on health care than any other country in the world. The U.S. spends \$4,637 (US) (approximately \$7,000 (CAN)) a year per person on health care, and millions go without care, while Canada spends \$3,298 (CAN) and insures every citizen. Canada's administrative costs are about ten cents on the dollar; administrative costs in the U.S. are more than double that, close to twenty-four cents on the dollar. This difference can be attributed to the administrative efficiencies of a publicly funded system. In 1971, Canadian health care costs were 7.4 percent of the GDP, compared to 7.6 percent in the U.S. Since then, Americans' health care expenditures have almost doubled, to over 14 percent, while Canadians' have remained relatively stable, rising to just over 9 percent.

The costs borne by employers also differ greatly between the two countries. Health insurance premiums paid by Canadian employers amount to only 1 percent of gross pay compared with 8.2 percent in the U.S. This gives Canadian business a huge advantage. In fact, the World Competitiveness Report has identified Canada's universal health care system as a major competitive advantage. Canada's health care system has been shown to save the auto industry, for example, between \$1,200 and \$1,500 for every car assembled here.

Says Theodore Marmor of the Yale School of Management: "For all the criticism of Canada's Medicare program, I for one, would be delighted to have its manageable problems in place of those in the United States."

Firmly Committed

Small wonder, then, that Canadians continue to be deeply committed to their universal public health insurance system. Ekos Research tracks Canadian opinions on health care. In a series of polls taken in 1999 and 2000, Ekos found that 95 percent of Canadians are committed to strong national standards and 93 percent believe that the federal government should make the maintenance of our health care system its highest priority. A *Globe and Mail/EnviroNics* poll done in November, 2000, found that the five principles of the Canada Health Act have virtually universal support among Canadians. As well, in spite of concerns about the declining quality of care in Canada, 93 percent of women and 83 percent of men who were patients in the last year described themselves as very or somewhat satisfied with their care.

In a November, 2001, *National Post* special called *The State of Health Care*, polling company COMPAS Inc. reported not only that Canadians remain firmly committed to free, universal medicare, but that they reject private-sector solutions to the system's problems. Further, says Conrad Winn, COMPAS president, Canadian support for user fees, corporations running hospitals, and cost-cutting by closing hospital beds and reducing services is "plummeting." In fact, when asked whether they would support the introduction of a "Patient's Bill of Rights" that would guarantee all Canadians a certain level of medical and hospital services, 74 percent of respondents said "yes."

PART THREE

The Internal Assault

IN SPITE OF THE ONGOING POPULARITY OF OUR PUBLIC HEALTH SYSTEM WITH THE CANADIAN PEOPLE, forces opposed to medicare continued to seek ways to undermine it. This was made difficult by the anti-big-business sentiment sweeping society in the heady days of the 1960s and the 1970s.

The Pearson Liberals were pushed sharply left during the 1960s as a consequence of forming several minority governments with a new and aggressive NDP holding the balance of power, and of a politically active populous. They unleashed not only the social programs described above, but also a whole host of laws and initiatives that would come to define the Canadian state: bilingualism, a new labour code, the doubling of external aid, collective bargaining for the public service, the Royal Commission on the Status of Women, and the “war on poverty.” In fact, the social assistance reforms created in those years were so broad that, by 1965, federal welfare expenditures exceeded the nation’s defence bill for the first time.

David Lewis and his “corporate welfare bums” campaign kept the pressure up on the minority government of the Trudeau Liberals in the early 1970s. By the mid-1970s, high employment, decent wages, and social security had given working Canadians substantially increased economic and political clout. They saw their social programs as rights and were empowered, freed from any sense of shame, in claiming services.

At this time, Canadians overwhelmingly believed that Canada was not sufficiently independent of American foreign policy and were deeply worried about economic survival. Driven by strong concerns among the public about the increased amount of foreign control over Canadian industry and natural resources, the government created the Foreign Investment Review Agency, the National Energy Policy, the Canada Development Corporation, and Petro-Canada. As a result, foreign ownership declined from 35 percent of the Canadian economy in the mid 1960s to about 20 percent in the early 1990s, when it started to rocket upwards again. (Canadians now control a smaller portion of our productive wealth than any other industrialized country on earth.)

Counterforce

All this sat very badly with Canadian big business, much of it foreign-owned anyway. The Canadian welfare state was created in the first place with only the reluctant support of the private sector. During the 1930s, capitalism had been on trial, its failures there for everyone to see. Communism and socialism were on the rise around the world; real modifications were going to have to be made if capitalism was to survive. Thus, business leaders of the day reluctantly helped Mackenzie King create the foundations of the welfare state and committed themselves to accept unions and rising wages.

Now, in the early 1970s, the same progressive forces were dominating the public discourse again. Further, as Tony Clarke documents in his 1997 book, *Silent Coup*, opinion polls in North America showed support for business at an all-time low as a result of the behaviour of the giant oil companies during the 1973 energy crisis. As millions of Americans and Canadians braced themselves for a quadrupling of oil prices by the OPEC countries, and North America slipped into recession, the big companies continued to post record profits. The unpopularity of the oil companies spread to big business in general.

Business in other sectors was also facing a faltering economy and a squeeze on profits during this time, which it attributed to ongoing demands for wage increases and social protections, and an insufficiently cooperative government. The public sector had become too intrusive, big business decided, both as a regulator of economic activity (to ensure that the economy operated for the public good), and as a producer encroaching on their turf. There was, they believed, an "excess of democracy," characterized by the growing political influence of groups that challenged corporate interests.

This time, the big business community decided to fight back. To counter the erosion of its power, business leaders set in motion a multifaceted effort to make their agenda the agenda of government, and to influence the political culture of society. The anti-medicare forces hitch-hiked a ride on this bandwagon and never looked back.

National Citizens' Coalition

In 1967, the business community supported Colin Brown, a millionaire insurance agent with a deep antipathy to unions and medicare, when he formed the National Citizens' Coalition (NCC) to wage a "ceaseless war" against government. The NCC spends hundreds of thousands of dollars on negative advertising at every election targeting candidates who support social welfare, and it has consistently fought legislation designed to curb corporate influence on the political process. The NCC once predicted that Canadians would die as a result of the adoption of medicare, and it has consistently called for the privatization of medical insurance and hospitals. It is an advocate for the position that corporations and charities ought to take over the social functions now performed by government, and for the view that government's role ought to be limited to national defence, protection of private property, and law enforcement.

NCC bylaws forbid policy meetings of its general membership; instead, its political decisions are made by the real "coalition," a small cadre of directors and corporate and foundation backers that runs the organization like a private lobbying firm. (A recent CEO of the NCC was Steven Harper, now a leading candidate for the Alliance Party leadership.) The group's advisory board, past and present, reads like a who's who of the Canadian establishment. Through the NCC, wealthy individuals and corporations can promote their political goals with total anonymity; even investors are not allowed to know whether companies they invest in contribute to the NCC, and businesses are allowed to claim donations as business expenses.

The Fraser Institute

In 1975, the Vancouver-based Fraser Institute was created. The brainchild of MacMillan Bloedel, handsomely funded by large Canadian banks and resource corporations, this institute has become a powerful presence in Canada, even regularly providing “statistics” and “studies” to the mainstream media and to university and college professors as federal government cutbacks have dried up government sources of information. It has been maintaining a presence on Canadian university campuses for over twenty years.

The Fraser Institute considers Canada’s social security system both immoral and an inefficient use of taxpayers’ money. It advocates a mix of private and public charity for the “deserving poor,” i.e. the unfortunate, not the irresponsible. And it argues that the extent of poverty in Canada has been exaggerated by “special interests” in order to justify public “overspending.” In a 1992 publication, it stated that poverty is not a major problem in Canada and recommended a new definition of poverty to apply only to those families who lack the “cost of basic necessities for absolute physical survival.” President Michael Walker adds, “In some cases, poverty is simply a reflection of the fact that the sufferers were dealt an unlucky physical or intellectual allocation from the roulette wheel of genetic inheritance.”

The Fraser Institute has also worked tirelessly against medicare since its creation, advocating a system in which public medical insurance would cover only catastrophic illness.

The CCCE

In 1976, Canada’s business elite formed the influential Business Council on National Issues (BCNI), which recently changed its name to the Canadian Council of Chief Executives (CCCE). It is made up of the 160 biggest corporations in Canada and was first led by former Trudeau advisor Thomas d’Aquino, who remains its CEO today. Modelled on the powerful right-wing American corporate lobby group, the Business Roundtable, the BCNI/CCCE set out to create a more hospitable public climate for big-business concerns. Government’s role had to change; instead of acting as a protector of society against the excesses of the market, government would become the protector of a favourable climate for business. The values of community and cooperation would be replaced with the values of individualism and competitiveness. In other words, the values long-associated with Canada would be replaced by U.S. style values.

Based on the twin gospels of deregulation and privatization, the BCNI/CCCE set out its wish list: a freeze on social spending and a return to targeted, not universal, social assistance; restrictions on government borrowing; reduced unemployment premiums; lower corporate taxes; the deregulation of energy; a war on the deficit; privatization of public services; and the removal of foreign investment reviews. It focused on key issues through task forces that paralleled government departments, becoming a virtual shadow cabinet.

The BCNI/CCCE knew that it needed to enlist the support of powerful media and recruit its own economists. BCNI/CCCE members put themselves on the editorial boards of newspapers they increasingly control, as well as on the boards of governors of the major universities, where they promote the corporate control of research; private-sector funding of courses, programs, “chairs,” and capital costs; and the raising of tuition fees.

The BCNI/CCCE was the original and major catalyst for free trade and a big backer of Conservative leader Brian Mulroney. Mulroney became prime minister in 1984 and, shortly thereafter, started free trade negotiations with the U.S. In his 1998 book, *Wrestling With the Elephant: The Inside Story of the Canada-U.S. Trade Wars*, Gordon Ritchie, who was the deputy chief negotiator to the Canada-U.S. Free Trade Agreement, boasted openly about the fact that BCNI/CCCE members (who spent millions in public advertising to sell free trade during the 1988 election) acted as co-negotiators with the government to secure the deal.

"In a radical departure from past practice," writes Ritchie, "I assigned two [Trade Negotiations Office] staffers to each of [the Sectoral Advisory Groups on International Trade]...Over the opposition of traditionalists, I shared our intelligence with these [business] advisors, who were naturally sworn to confidentiality...Their contribution was absolutely indispensable and changed forever the way the government managed trade policy." Once established, this relationship between the trade bureaucracy in Ottawa and the country's business elite has never been broken. If anything, in the January, 2002, cabinet shuffle, which named right-winger John Manley as deputy prime minister and put him in charge of North American integration, the relationship was strengthened.

The BCNI/CCCE was also instrumental in promoting the GST and the "war" on the deficit, and has been crucial to the fight to dismantle Canada's social programs and medicare. Its official position on social policy is "to do more with less, target those in need and create incentives that encourage individual self-reliance." In other words, reject universality.

CCCE members are the power behind the hundreds of corporate lobby groups who pay middlemen to act on their behalf to lobby governments in their interests. Through deepening informal ties with politicians, and the huge financial contributions they make to politicians they favour, corporations of the CCCE have come to wield enormous power in Ottawa and the provinces. They are the most important sector in Canadian society in the eyes of government, and have become the driving force behind all public policy decisions today.

Hearts and Minds

But it is never enough to become influential with those in power. To really have lasting influence, it is necessary to change the hearts and minds of ordinary people and to shape the political culture of a society. As Michael Walker of the Fraser Institute says, "If you really want to change the world, you have to change the ideology of the world."

To accomplish this a powerful set of myths was introduced into Canadian society—toxic myths about the failure of the public systems of education and health, the laziness of the poor, and the suffocating drain of a "bloated" public service. These toxic myths, repeated continually in the corporate-dominated mainstream media, are part of a campaign to reduce Canadians' expectations for their own well-being and that of their families, at work and in retirement.

In this ideology, government is, by definition, the problem, as is any notion of entitlement. Families must take responsibility for themselves and stop relying on government. Children are the sole responsibility of their parents; so, too, is child poverty. Public services are merely products that the private sector could deliver better. Citizens are consumers who should have the "choice" to buy the best health care and education "products" they can afford. Families, not

governments or communities, are the defining unit of society. (Margaret Thatcher famously said that there is no such thing as society, only individuals and families looking out for themselves.) The role of educators is to help sort winners from losers in order to help stream young people into the appropriate slots in the new class structure of the global economy.

Social programs have failed, we are told. They have robbed Canadians of our initiative and created a crippling legacy of debt. This particularly pernicious myth persists despite a groundbreaking Statistics Canada study by government economists Mimoto and Cross that found that government spending, and specifically social spending, held steady between 1975 and 1991, the years in which the Canadian debt spiralled. In fact, the authors found that the growth of the debt was due entirely to the compounding of interest on the original debt: by 1991, interest payments on the debt were costing Canadian taxpayers more than the combined spending on transfers for education, health, welfare, and unemployment insurance together. Said Mimoto and Cross, "social program spending has not increased relative to Gross Domestic Product (GDP) over the last 16 years."

Perhaps no one has verbalized the toxic myths of Canadian "inferiority" better than Conrad Black, who recently abandoned his powerful Canadian newspaper chain (which he used effectively to promote his views) in 2001 to take his place in the British House of Lords. Black said that, because of its welfare state, Canada is "uncompetitive, slothful, self-righteous, spiteful, an envious nanny-state, hovering on the verge of dissolution and bankruptcy." Its people, a "society of over-compensated self pitiers," suffer from the "great Canadian sloth, the spirit of smug entitlement."

Black took special aim at universality, which he called plundering and bribery. "Canada extended the safety net to encompass not simply the genuinely unfortunate," he wrote, "but rather anyone who is second-rate. We would rather take care of the second-rate people than reward the first-rate for their initiative." While his views are more extreme than most, an increasingly corporate-dominated print media in Canada has voiced largely the same editorial position for a number of years.

CanWest Global Communications Corp., owned by Winnipeg's Asper family (who are prominent Liberals), now owns *The National Post*, 14 major metropolitan newspapers, 126 smaller papers, and Global Television. In most markets in which the company operates it is the only game in town. In national editorials, the company has backed privatized health care. "Profit needn't be a dirty word," wrote Murdoch Davis, vice-president, editorial and editor-in-chief of CanWest's Southam News. A number of CanWest's local papers, such as *The Ottawa Citizen*, have taken an aggressive pro-privatization position in their editorial pages as well. And *The Globe and Mail* has joined the privatization chorus. In spite of polls that indicate the opposite, the Globe felt able to declare that, "People do not care who owns the hospital or clinic that treats them, as long as they receive timely, high-quality care" in a January 22, 2002, editorial.

Retreat

The trouble with these toxic myths, of course, is that they work. While most wealthy Canadians have long been willing to support government withdrawal from universal social programs in

return for tax breaks, only in the last decade have many middle-class Canadians reluctantly joined the call for tax cuts. The trick is to allow public services to become so underfunded and rundown that they no longer serve their constituency; citizens then demand their tax money back in order to “buy” services no longer provided by the state. As governments began to withdraw funding from Canada’s social programs, Canadians began to doubt the viability of their universal social security system, even though they still support it in principle.

From the mid 1980s to the early 1990s, the Conservative government of Brian Mulroney savaged Canadian social programs, eliminating universal child benefits, “clawing back” family allowance and old-age pension payments, and restructuring the unemployment insurance program so that it was entirely funded by employer and employee contributions. The Chrétien Liberals followed suit. Finance Minister Paul Martin’s 1995 budget cut an unprecedented 40 percent out of federal cash transfer payments to the provinces for health care, social assistance, and post-secondary education.

Most important, the 1995 budget killed the Canada Assistance Plan (CAP) that had provided a universal standard for Canadians in need, and had funded social services and post-secondary education. By losing the shared cost aspect of welfare, citizens of provinces that reduced their debts on the backs of the poor lost their safety net of last resort. The repeal of the CAP also negatively affected a wide range of services that directly or indirectly affect the health of the Canadian people: community assistance for people with disabilities; homemaker and meals-on-wheels services for the elderly; home care services for people newly discharged from hospitals, and many other assistance programs. With the death of the CAP, the distinction between “deserving” and “undeserving” poor was fully reintroduced to Canadian society. Freed from national standards for social assistance, provinces were able to slash welfare budgets and impose stringent conditions on welfare recipients.

The results of all these changes have been devastating for many Canadians. Funding for social programs is at its lowest level since 1950. Billions have been taken from public pensions. Cuts of about \$7 billion a year to the unemployed have left only one-third of unemployed workers eligible for Employment Insurance benefits, compared to 85 percent in 1989. The cuts to social programs and to the unemployed have been so deep that Standard and Poors, the New York-based ratings institute, says the myth of a “kinder Canada” must be put to rest. In 1999, for the first time, it says, Canada spent less on its elderly and unemployed than the United States did. Further cuts by most provincial governments have left many citizens without a social safety net.

Not surprisingly, while corporate profits and CEO earnings soared during the 1990s, Statistics Canada says that the real incomes of most Canadians eroded to less than they were in 1980. During the 1990s, the number of millionaires tripled and corporate salaries grew at a rate of about 15 percent a year, while workers’ wages rose just 2 percent—less than the rate of inflation.

Tragically, child poverty exploded during this decade as well. Since 1989 (the year Parliament unanimously voted to eradicate child poverty by the year 2000), the number of poor children has grown by 60 percent; the number of children in families with incomes of less than \$20,000 has grown by 65 percent; the number of children in families needing social assistance has grown by 51 percent; and the number of children living in rental housing for which the rent takes an unsustainably large proportion of family income has grown by 91 percent.

Next Target – Medicare

It can come as little surprise, then, that in this environment, medicare has become the next social program to be targeted for destruction. Because of medicare's enduring popularity with Canadians, however, few people with political ambitions will openly tell Canadians the truth about what is happening to our universal health care system. In fact, with the exception of Alberta's Ralph Klein, no politician who has dared to run on a campaign to privatize health care has been elected. Even Klein has had to sell his privatization schemes as just a way of improving medicare by shortening the waiting lists for medical services for ordinary working Albertans.

Yet the undermining of medicare began almost as soon as it became the law and has escalated in recent years. In 1977, the Trudeau government, worried about the lack of upper limits to increases in health care costs, passed the Established Financing Act (EPF). The new arrangement ended the fixed 50-50 cost-sharing formula to fund health care and made it clear that the federal government would not share costs with the provinces in new areas of spending such as home care and drug benefits. It also gave notice that the federal government would not continue to cost-share hospital expenses after 1980.

The EPF replaced the 50-50 formula with a block funding arrangement that included a complicated system of transfer payments, grants, and tax points. In exchange for dollars, the federal government allowed the provinces to raise more taxes. Over time, the provinces wanted more and more tax point credits because these tax revenues did not have to be spent on health care. As a result, the federal government lost a fair amount of power over provincial health care spending. The block funding arrangement also allowed a steady reduction in federal cash transfers that started out modestly, but became huge over time, intensified by successive, massive cuts to health care spending.

By the time Brian Mulroney's Conservatives took power in 1984, the federal share of health care spending was down to 33 percent, from 42 percent in the mid-1970s. When the Chrétien Liberals took power in 1993, the proportion had been further reduced to 23.5 percent. By 1998-99, it hit an appalling low of 10.2 percent. This can come as no surprise, since between them, the Mulroney and Chrétien governments had cut \$36 billion from federal transfer payments for health care. The new formula, together with the huge cuts to health care funding, weakened the ability of the federal government to enforce national standards in health policy.

While one-time increases in health spending in the 1999 and 2000 budgets moved the federal share modestly up to 13.8 percent of health funding in 2001, the reality is that, in spite of repeated public promises to protect medicare, successive federal governments have all but abandoned it. Not coincidentally, these cuts and the changes to the 50-50 formula began around the same time that the big business community launched the BCNI and its assault on social security. And the assault intensified as the influence of corporate Canada became more prominent in the halls of power in Ottawa.

As University of Regina political scientist John Conway explains, the business lobby sees a strong central government as a real threat to the expanding political hegemony business now enjoys. The devolution of social programs and the curbs on the federal government's ability to enforce national standards, as a result of the reduction of its financial participation in social programs, are key to a number of long-term corporate objectives.

“The business lobby,” Conway says, “wants to continue downsizing social programs and the public sector, remove government as a central actor in the social and economic life of Canadians and open up the social spending basket, especially the huge baskets in education and health, to the private sector. National standards and enforcement make this difficult.” The provinces are more amenable to two-tiered health care systems, he adds, a second tier funded publicly and characterized by underfunding and low quality, and a first tier funded jointly by governments and consumers.

The CHST

The EPF was just the first of several key structural changes that undermined Ottawa’s role in enforcing the provisions of the Canada Health Act. In his 1995 budget, Finance Minister Paul Martin introduced the Canada Health and Social Transfer (CHST), which combined transfers to the provinces for health, education, and social assistance into a single, smaller block grant and chopped the funds by a whopping 40 percent over the next two years. Not only would there be less money for these services, but the provinces were given the right to determine where the money would be used; it was no longer tied directly to particular programs.

By withdrawing its direct financial commitment, the federal government surrendered its capacity to maintain national standards in all three areas. This was most obvious in the area of social assistance. By killing the Canada Assistance Plan (CAP), the federal government left the welfare field altogether. Although there never were legislated standards in the area of post-secondary education, federal transfers that were directly tied to this sector had given a role to the federal government. Now, this was gone. In the area of health care, of course, the Canada Health Act was still technically the law. But the Act was always and only enforced by the shared-cost funding formula; now, with dwindling enforcement capacity, the federal government was suddenly much less able to defend medicare.

“Bluntly put,” said the National Council of Welfare, “the Canada Health and Social Transfer is the worst social policy initiative undertaken by the federal government in more than a generation.”

Social Union

Not surprisingly, over the next several years, the provinces and territories grew increasingly impatient with this situation. Here were the Chrétien Liberals talking about their love of universal health and boasting about (and running elections on) their defence of medicare, all the while hollowing out the federal role in this area to pre-1950 levels. They were challenging the provinces’ proposals of user fees and privatization schemes as if they were still delivering 50 percent of the funding for medicare, when they were providing only 10 percent. Several provinces were clamouring to take over full responsibility for health care and determine for themselves the level of privatization their citizens wanted. And all were looking for ways to accommodate Quebec’s desire for more autonomy in the delivery of its social and health services while riding on its decentralization coattails. So in February, 1999, the federal government and the provincial premiers signed a framework agreement for an accord that will renegotiate the balance of powers between the federal and provincial governments in the delivery of social security.

This so-called Social Union (to be reviewed in 2002) established several key principles: 1) the right of provinces to opt out of federal social programs with full financial compensation as long as the province pursues a program with "similar objectives;" 2) an end to the enforcement of national standards for social programs by Ottawa, to be replaced by a vague provincial consensus on standards with no meaningful enforcement mechanism; 3) strict limits on Ottawa's use of federal spending power for the creation of future social programs such as home care and daycare, requiring provincial consultation and consent for any new social programs; and 4) the transfer of almost the entire administration of social programs, including those heavily funded by Ottawa, to the provinces. The only concession Ottawa could claim was that the provinces agreed in principle to the five pillars of the Canada Health Act. In exchange, the provinces were promised all of the above, plus the partial restoration of funding, particularly in the area of health care.

At first blush, these funds, which were announced in the 1999 and 2000 budgets, appeared to be substantial: total federal cash transfers through the CHST will increase from \$12.5 billion in 1998 to \$21 billion by 2005-06, and the health care portion of that total will go from \$5.3 billion to over \$13 billion. However, an analysis of these figures done by the Economics Division of the Library of Parliament shows that cash transfers in 2005-06, even with the infusion of this new money, will not reach even the levels they were a decade ago. This is because the increase does not take inflation or population growth into account. As well, some of the increase is a one-time supplement, and none of it is cumulative; rather, it is added to the newly set base of \$15.5 billion (up modestly from the former base of \$12.5 billion). As the Canadian Labour Congress explains, this is akin to giving workers yearly bonuses instead of wage increases on the wage grid. When this deal is up, a future government can go back to the base amount, leaving the provinces worse off than ever.

Furthermore, provincial public health costs will grow faster than the federal contributions, even with the infusion of new money. The additional cash transfers for health care will raise the federal share of health care spending from its current level of 13.8 percent to 19.2 percent in 2002-03. But the federal share will start to fall again the next year; by the fiscal year 2007-08, the share will be down to 16 percent of health care spending. With the institution of the Social Union, and the continued decline of the federal government's financial participation, the role of the federal government in medicare will continue to erode.

The most dangerous aspect of the Social Union is that the provinces will be allowed to decide whether money earmarked for health care will be put into public or private services. This was the quid pro quo for their agreement to maintain the principles of the Canada Health Act. As long as they continue to guarantee their citizens access to hospitals and doctors, the provinces are now free to use federal transfer payments to contract out to private service deliverers.

Between them, the CHST and the Social Union did far more than transfer responsibilities for health care from one level of government to another; rather, they opened the way to a fundamental realignment of power from governments to markets and from the public sector to the private sector.

PART FOUR

Health Care Restructured

THE DOWNLOADING OF HEALTH CARE AND SOCIAL SECURITY TO THE PROVINCES REPRESENTS A NEW stage in Confederation. Years of wrangling over jurisdiction between the provinces and the federal government have not served Canadian citizens well. Right-wing provincial governments have whipped up anti-Ottawa sentiment to cover their own severe social spending cuts and hide their privatization intentions. In turn, federal governments have blamed the provinces for not delivering social and health services at the same time as federal funding was being cut.

Neither level of government has dealt well or fairly with Quebec's demand for more autonomous decision-making powers. Neither the Mulroney Tories nor the Chrétien Liberals had the foresight to see that, while the other provinces want more power inside Canada, Quebec wants more autonomy; neither therefore, could fashion a unique relationship with Quebec. Several provinces, meanwhile, have used Quebec's demands for more autonomy to shield their own plans for a two-tier health care system. Alberta's Ralph Klein has shamelessly befriended successive Quebec leaders in his quest to grab power over health care from Ottawa. But most Quebecers do not seek a private system. They want to have more control over protecting their fading public system.

The downloading of health care and social security to the provinces has also pleased the corporate community, which wants the responsibility for social welfare to reside with lower levels of government. At the time the CHST was created, André Bérard, CEO of the National Bank of Canada, noted that lower levels of government do not have Ottawa's ability to set monetary policy, and thus, they have far less budget flexibility. "It is only by decentralizing the state even more that we can obtain more efficient public services and a permanent reduction in deficits. We should give the power to spend to those who have little power to borrow." In this way, decentralization facilitates the privatization of health care services.

Privatizing Medicare

As successive federal governments have cut transfer payments to the provinces for health care, provincial governments have responded by chopping their own funding to hospitals, laying off registered nurses, and closing beds. Analyses of health care funding show that, while the federal government's contribution to the total health care budget has steadily diminished over the last two decades, so has that of the provinces and the territories.

By 1998, the combined public provincial and federal share of total health care spending was only 70 percent, down from over 75 percent a quarter century before. Meanwhile, the private sector had been steadily expanding its presence in the system and by 1998 represented almost 30 percent of the total national health care budget. In fact, the private sector now accounts for a bigger slice of the health care pie than the federal government does. Although a

December, 2001, study by the Canadian Institute of Health Information showed that the private sector share as a percentage of the whole was falling slightly (due to the 1999-2000 federal infusion of public dollars into health care), and likely stands at 27.4 in 2002, the private sector is continuing to grow in Canada. Private spending on health care increased dramatically in the decade between 1988 and 1998; overall, in those years, private health care spending increased from \$12.7 billion in 1988 to \$25 billion in 1998—an increase of 96 percent.

The private sector operates in a variety of ways in Canada's health care system. As fewer services are listed on public plans, costs are shifted to employer-sponsored plans where premiums have been rising by 18 to 20 percent per year. Individuals and families, particularly those employed by small and medium-sized businesses, are being forced to shoulder more and more of the cost of medical care.

In addition, public funding cuts are leading hospitals to narrow the scope of their "core business;" outpatient services are being privatized and hospitals are contracting with the corporate sector to provide a broad range of "non-core" services such as lab work, MRI and CT testing, dietary services, and housekeeping. "The private market is more than flourishing," says Normand Laberge, CEO of the Canadian Association of Radiologists,

In spite of the completely open nature of many provincial privatization schemes taking place, including user fees and extra-billing, the federal government refuses to act. Perhaps this is because, as the Auditor General has strongly pointed out in its last three annual reports, the Chrétien government is keeping no record of where privatization is taking place or whether any of these practices are in violation of the Canada Health Act. It may also be because, when the Canada Health Act was passed in 1984, clear criteria for "medically necessary services" were never established. Provinces are now taking advantage of this grey area to privatize.

The public has paid for these changes with long waiting lists for surgery, clogged emergency rooms and growing fear and alarm. Ideologically driven governments such as those in Ontario, British Columbia, and Alberta have used this "crisis" to prove that the public system doesn't work, and that the "more efficient" private sector can do the job better. One contract at a time, most provinces have steadily introduced the private delivery of at least some health care services, and some are now openly courting a full private, for-profit hospital system.

Quebec

In Quebec, for-profit corporations are setting themselves up in competition with public institutions, especially in areas where the public system can no longer meet the demand. Privatization is growing in long-term residential facilities, home care, convalescence and rehabilitation centres, private physiotherapy and radiology clinics, and medical clinics providing diagnostic services.

As economists Pat and Hugh Armstrong document in a 2001 report for the Canadian Health Coalition, for-profit firms specializing in home care and home-support products and services, such as remote diagnostic and monitoring equipment, technical aids, and nursing services, are rapidly expanding in Quebec as well. And, they report, Quebec hospitals are embracing management practices developed in the private sector, even those evolved among manufacturers

of consumer goods. The transfer of the operation of health and social services to the private sector in Quebec is not simply a change in service-delivery methods; it reflects a more general shift in attitude to where a concern for economic efficiencies is gaining ascendancy over concern for care, access, or quality.

As a result, Quebec has dramatically cut spending for health and social services. Public spending per person in Quebec is the lowest of all the provinces, and Quebec has gone from the province with the highest percentage of public funding in health care (81.5 percent in 1980) to one of two provinces with the lowest percentage (69.1 percent in 1998).

Ontario

Ontario is pursuing privatization more aggressively than any other province except Alberta, and is the province with the greatest private contribution to health care funding—33 percent of expenditures. Former Finance Minister (and a candidate in the 2002 Ontario leadership race) Ernie Eves has said his government welcomes any “reasonable” proposal from for-profit firms wishing to provide services currently provided by government. “Everything is on the table,” he said.

As the Armstrongs describe, in addition to cutting hospital budgets by a massive \$800 million in the late 1990s, the Harris government amended several provincial laws giving the minister of health new, sweeping powers to: “restructure” the hospitals; order hospital shutdowns or amalgamation; allow private medical facilities, such as laboratories, to be established without tendering; impose user fees under the Ontario Drug Benefit Plan; and force thousands of hospital patients waiting for beds in nursing homes to pay a daily charge for room and board.

Despite public pronouncements to the contrary, Paul Leduc Browne and Bill Murnighan of the Canadian Centre for Policy Alternatives found that the Ontario government has in fact reduced spending on health care in real per capita terms over the second half of the 1990s. As a result, Ontario has laid off nearly 25,000 hospital and long-term care workers and had a deficit in health care services estimated at \$4.1 billion in 2001.

The Ontario government has also vested itself with the power to override the decisions of local authorities and boards, while downloading responsibility for services to them without their consent. Ontario residents have been obliged to pay more out-of-pocket charges and user fees for health care, and hospitals have moved further down the road to commercialization, contracting out work to the private sector and entering into public-private partnerships.

Ontario is the first province to ask the private sector to build, own, and maintain a hospital. Up until now, the provinces have put up the lion’s share of the operating costs for new facilities; under the plan for the \$350 million Osler Centre in Brampton, however, a private company will build the facility and rent it back to the government. It’s a great deal for the private company. It will receive loans and other funding to build the hospital, rental fees in perpetuity on a for-profit basis from the Ontario government, and subsidies from both levels of government to operate it.

Ontario under Mike Harris allowed the rise of Toronto’s King’s Medical Centre, which became the largest and most opulent private facility in the country, with “regal rich colours, statues,

artwork, plush chairs and warm wood furniture” according to *The Medical Post*. Opened in 1996 by financier Ron Koval, King’s catered to wealthy Canadians and Americans, and was hailed as the future of Canadian medicine by the business community. The business supplied the doctors with everything, including the expensive surroundings, and in turn, took 40 percent of their gross earnings.

Koval paid himself and his wife, Loren, an annual salary of \$1 million, and they drove around in a fleet of vintage cars. They owned a home in Waterdown, Ontario, and a mansion in Hamilton, but lived most of the time at the Toronto Hilton, where they racked up bills of up to \$8,000 a month. But the whole empire was built on deceit. In March, 2001, the couple was sentenced to seven years in prison by an Ontario Superior Court judge for massive fraud totalling at least \$95 million. Said Koval at his trial: “We had a dream to become the standard for private health care providers in this province.”

Ontario is also the site of the first hospital to hire a CEO (for \$500,000 a year) whose role is to lure private business from the United States. Responsibilities for the new head of the University Health Network, consisting of the hospitals Toronto General, Toronto Western, and Princess Margaret, include “development, identification, and introduction of new electronic technologies to facilitate the delivery of health care services ...particularly in the large, resource-rich U.S. market.”

Dr. Alan Hudson, president of the hospital group, explains that this is the future for Canadian hospitals that want to stay afloat. “What you’re looking at in the public sector is the death spiral. The only way to sustain the Canadian health-care system is for private money to go into the public system.” Adds Ontario Health Minister Tony Clement, “If the private sector can deliver better, cheaper, faster, safer health care, then I would look at it from that pragmatic perspective.”

Manitoba and Saskatchewan

Because NDP governments are more committed to maintaining a public health care system, the provinces of Manitoba and Saskatchewan have not allowed anywhere near the amount of privatization as have Ontario and Alberta, although some private incursions have taken root. Both provinces have shifted much of their treatment out of institutions and into the community. This, in turn, has opened the door to for-profit providers to offer care and support services, such as home care, physiotherapy, and occupational therapy.

Manitoba, under the former Conservative government, had launched a number of privatization experiments, some of which, such as the private Pan-Am clinic, are now being rolled back by the new government. By 1997, 130 private clinics were operating in Manitoba, offering minor surgical procedures. And Manitoba was the site of the first fee-for-service home care experiment. We Care set up shop in Brandon in 1984, and competed with the public system by paying registered nurses substantially less than the province did. The company eventually set up sixty-five franchises across the country before being swallowed by Aetna Health Management, a subsidiary of Boston-based John Hancock Mutual Life Insurance Co, in 1998.

Manitoba also conducted the first experiment in contracting out some home care services to a private U.S.-based corporation, Olsten Health Services, in 1997. But the contract was not

renewed the next year, after it came to light that the company was being investigated by the FBI for improper Medicare billing in the U.S.

Alberta

Alberta, of course, has been Canada's Petri dish of privatization. Premier Ralph Klein was the first elected politician to openly promote private health care services. Since 1993, the Klein government has supported massive privatization schemes in "non-core" hospital services. In a major January, 2002, report, the Premier's Advisory Council on Health, headed by former Deputy Prime Minister Don Mazankowski, called for an overhaul of the province's health services, including user fees and delisting of formerly covered services. To sell these controversial recommendations, the Klein government is spending \$1 million on a public campaign, including a comic book and radio and TV ads.

In a preliminary report published a year earlier, the Premier's Advisory Council called the Canada Health Act an "unregulated monopoly" antithetical to competition and recommended "opening up" the system to an "innovative blend of public and private health services." Referring to the citizens of Alberta as health care "customers," the Premier's Advisory Council advised the government not to let "fear of private medicine" get in the way of making the necessary changes to the delivery of health care.

The Advisory Council needn't fear. For, as health economists and researchers Kevin Taft and Gillian Steward have documented, the government of Ralph Klein is determined to bring in a for-profit system of health care in Alberta, regardless of the wishes of the people and the clear evidence that a for-profit system costs more and serves fewer people.

When he came to power in 1993, Ralph Klein immediately slashed the health care budget by 18 percent and the welfare budget by 40 percent, and laid off 6,000 public service workers. Many hospitals and almost half of the province's hospital beds were closed. Over 3,000 registered nurses were fired and thousands more were shifted from full to part-time, casual status. The remaining front-line health care providers were forced to accept wage freezes and roll-backs. Psychiatric hospital and mental health clinic budgets were slashed as well; thousands of patients were sent into the community with no services to help them adjust. And seniors in public care facilities were being cared for by unsupervised and unqualified staff.

In the wake of the cuts were horror stories of people dying after having been turned away from closed or crowded emergency wards. The United Nurses of Alberta said that Albertans had gone from being patients, to customers, to consumers, and then to victims of health care, all in the space of a few years.

It is not surprising, then, that this was the first province to dare to introduce an explicitly two-tier health care system. The people were at their wits' end and open to any innovation that might ease the trauma. Bill 11, dishonestly named the Health Care Protection Act, which became law in 2000, allows for-profit hospitals to provide surgical services covered under the provincial health plan, a first in Canada. Physicians will now be allowed to practice in both the public and for-profit private systems, and several designated hospitals will be converted from non-profit to for-profit status.

Under Bill 11, commercial institutions will now have their fees paid partially by provincial health insurance, i.e., will receive subsidies from the public purse. People who can top up this public money with their own will go to the front of the line; this totally undermines the principles of universality and accessibility that are the foundation of the Canada Health Act.

Distressingly, the federal government, although bound under the Act to uphold universality, gave its blessing to this development. In 1996, the Chrétien government signed a "Working Understanding" with the Government of Alberta to end a dispute over the province's practice of allowing private eye clinics to charge patients.

Among the "Twelve Provincial Principles" included in the "Understanding" endorsed by the federal government were: a strong role for the private sector in health care, both "within and outside" the publicly funded system; the right of consumers to purchase health services outside assessed need; options for private clinics to become completely private or to enter into any of a variety of funding arrangements with the public sector to cover the full costs of insured services; and, the right of physicians to practice in both the private and public systems.

A senior Alberta government official stated in a memo that was obtained under the Access to Information Act, "Without Health Canada's agreement on the principle that it is acceptable for physicians to work in both the public and private sectors, the existing policy [Bill 11] would have been impossible to implement."

British Columbia

Until recently, privatization in British Columbia's health care sector has been minimal. As in the Prairie provinces, the relocation of health services to the community had meant the delisting of some services from the province's Medical Services Plan. User fees for physiotherapy and other supplementary services delivered in private clinics have risen. As well, for-profit firms offering health care services had gotten a toehold in the province. But now, under the new government of Gordon Campbell, British Columbia has adopted an aggressive stance in favour of privatization.

In January, 2002, not to be bested by Ralph Klein's blueprint for Alberta, Campbell's Liberals announced the deepest public service cuts in Canadian history. Almost 12,000 jobs will be eliminated over the next three years and government services will be cut by an average of 25 percent. While the health budget won't be cut immediately, it has been frozen, which means that, in real terms, it will drop over the next few years as a result of population growth and inflation.

Eight hundred and fifty-four Health Ministry employees, including thirty-seven paramedics, will be eliminated. The fifty-two regional health authorities have been reduced to six. British Columbians will now have to pay for routine eye exams, and seniors will be subjected to a means test to determine how much they will have to pay for prescription drugs. All this is taking place under the guise of "spiralling health care costs" and "out-of-control health care spending" even as the Campbell Liberals are implementing huge tax cuts, thereby reducing the funds available for health care.

British Columbia is racing with Ontario to become the first province in Canada to open a private hospital, in Abbotsford. The plan mirrors a British hospital initiative which has been strongly criticized for providing substandard care while rewarding shareholders with huge profits. Perhaps Valerie Roddick, chair of the B.C. Select Standing Committee on Health, summed up the new government's position best when she declared, "The age of entitlement ended on September 11. We can no longer demand [health care] services as our due. We have to accept responsibility along with our rights."

Home Care

The fastest growing sector in the health care field is home care. Funding cuts have left the provinces scrambling to save costs. Discharging people early from hospital, shifting services from institutions to community clinics, and caring for people in their homes instead of expensive hospitals, are all ways to save money, especially in the care of the elderly, who make up nearly two-thirds of home care users. Demand for home care increased in Ontario, for example, by 30 percent in just one year (1996/97 to 1997/8).

Home and community care also fit into a more humane vision of the future, one in which families, communities, and governments work together to provide more personal care than institutions are capable of giving. Home care could also be an important component of a more holistic approach to health care, one that stresses lifestyle changes, prevention, and general wellness.

There are two big problems with home care however. First, if home care is not accompanied by adequate community resources (and almost always, it is not), the burden falls on family members—usually women. Over 80 percent of home care is delivered by unpaid family members. If there are no family members or friends who can take up the role of caregiver, patients may have to undergo humiliating means tests to qualify for publicly funded care. Also, changes in hospital policies have resulted in home care programs and services being channelled away from the traditional users into care for people discharged from hospital earlier than they would have been formerly, or those whose condition used to lead to hospital admittance but no longer does, leaving those in chronic need to depend even more on family members for care.

Second, home care does not come under the Canada Health Act since it falls outside the legal definition of insured doctors and hospitals. This is because home care was originally seen as a supplementary service for those who did not require chronic or acute care and, therefore, did not need to be in a hospital or other institution. More and more provinces, however, are sending chronically ill and acute-care patients home without the proper services.

While some provinces and municipalities provide home care on a non-profit basis, more and more are allowing it to become privatized, thereby giving the private sector access to the area of health care with the most potential for growth, especially as the "baby boomers" approach retirement. Since home care is not covered by medicare, individual patients and their families often have to fork out large amounts of money to pay for basic care. The money-making potential in home care is huge, and the private sector has taken sharp note.

Another consequence of not being bound by the Canada Health Act is that, unlike hospitals, which are not allowed to turn away patients, home care agencies can pick and choose their

clients. Not being bound by the Canada Health Act means that home care is being delivered in a patchwork manner across the country.

Home Care Blues

As Colleen Fuller found in a May, 2001, study on home care for the Canadian Federation of Nurses' Unions, the lack of national standards and funding for health care delivered outside of the hospital sector is undermining Canadians' access rights across the country. User charges also vary dramatically; residents in Ontario outside the Community Care Access Centres (CCAC) system (set up to implement a competitive home care model for the province) pay an average of \$825 a year while those next door in Manitoba pay no user fees at all.

Home care has traditionally been provided by non-profit agencies such as the Victorian Order of Nurses (VON), or by religious or other charitable organizations. However, some provinces have undertaken a tendering process, introducing market forces into what should be a public service, and allowing private companies to dip into public health care funds. In doing so, Fuller points out, Canada is adopting the concept of "managed competition" which lies at the heart of the American HMO system. In a situation of "managed competition," the provision of a service is put out to tender, and a contract is awarded to a private provider which then has a monopoly over the service for the length of the contract.

In the U.S., the National Health Service was transformed from being a system of government-financed and provided services to one based on competitive tendering and contracting. A central aspect of the "reforms" was the movement of patients out from under the Health Service where they were provided with free services and where there were higher standards for health care workers, to the care of underfunded local authorities who had the right to administer means-testing, and to contract care out to private sector providers.

Patients felt the difference right away. One U.S. study found that for-profit home care companies offered an average of 18 visits a year for each client, compared with 46 for public and non-profit providers. It is through home care that the model of "managed competition" is gaining a foothold in Canada.

Atlantic Canada

Because of small populations and the high cost of institutional care, the Atlantic provinces have embraced home care with a passion. There, much of it is delivered by private, for-profit companies. Comcare, of London, Ontario, is the largest home care corporation in Canada and operates extensively in Atlantic Canada. When it set up shop in Newfoundland in 1992, where it was to deliver home care to means-tested seniors, it immediately cut the hourly wages of care providers from \$7.00 an hour to \$5.25. Fierce public opposition forced the company to pull out of that province four years later.

Comcare also operates in New Brunswick, which Colleen Fuller calls the perfect example of what is wrong with health care in Canada today. "New Brunswick's shift to community care underscores the problems being confronted in a part of the health system bereft of federal funding and national standards, and increasingly dominated by for-profit operators such as Comcare."

In a clear violation of the Canada Health Act and to save money, home care recipients in need of chronic care (and who are therefore eligible for insured services and would have been hospitalized in a former time) are subjected to a means test to determine how much they will have to pay for services and prescription medicine. New Brunswick's home care support workers are the lowest paid in the country, bringing home wages that put them well below the poverty line. Often, they are caring for seniors who also live below the poverty line.

Nova Scotia, where Comcare and other private, for-profit providers also operate, has moved many acute care patients out of institutions and sent them home to fend for themselves. As a result, overall demand for home care in the province, which has an unusually high rate of disability as well as a higher-than-average number of seniors, is skyrocketing. Patients have to buy expensive hospital services themselves or be subjected to user fees and means tests, all of which are banned by the Canada Health Act.

In addition, Nova Scotia will only provide home care to those with "unmet needs" due to lack of family caregivers. Competition has resulted in low wages for home care workers, minimum care for the patients and a terrible toll on families, who end up having to administer medical care, such as IV therapy and injections, to bedridden loved ones.

The Harris Revolution

Ontario, with the largest unregulated home care workforce and the highest per capita rate of home care clients in Canada, is the province that has taken the most aggressive stance on home care privatization. Mike Harris's Conservative government openly set out in 1996 to fully privatize the system within three years. Discharging thousands of patients from closing hospitals, the province all but eliminated direct public funding of a non-profit, community-based health care system, and diverted health care dollars to the private sector through competitive tendering, in a system similar to that used in the U.S.

Then the Harris government introduced a series of new regulations and practices that limit services to its citizens. Eligibility criteria for access to limited public funds became more stringent; prescription drug costs were deregulated, and user fees imposed on seniors and people on social assistance; and the minimum number of hours of care in long-term facilities was cut back.

The Ontario government set up Community Care Access Centres (CCACs) to act as brokers in forty-three regions around the province, awarding home care agencies contracts for one to three years for visiting nurses, therapists and homemakers. The centres oversaw the transition to an open market in home care. Non-profit agencies such as the VON had to compete with other agencies for a proportion of their caseloads, starting with 10 percent in 1996, and increasing to 100 percent by 1999. The CCACs also have the power to determine "eligibility" for their services, and, when they run out of money, are able to cut off services to people in need.

Ontario has proven to be a bonanza for the private health care sector, particularly the American private health care sector. Since the government amended the Independent Health Facilities Act in 1996, removing the preference for Canadian-owned, non-profit groups in funding and licensing arrangements, American firms can openly compete in Ontario. According to the U.S. State Department, "current and foreseeable market conditions in Canada," such as those that exist in

Ontario, "offer expansion and/or export business opportunities for many U.S. home care product and service companies."

The Ontario Home Health Care Providers' Association is made up of thirty-six for-profit companies, including American transnationals such as Olsten Health Services (the largest private home care corporation in North America), We Care, and Comcare. These companies can underbid the non-profit providers because they pay lower wages and offer no benefits or overtime. Until 1997, the VON, a century-old household name, had 90 percent of the visiting nurses "market" in Ontario. Now, it is struggling to survive, its nurses taking wage cuts in order to compete with low-wage, underqualified, non-unionized workers hired by the for-profit sector.

Unless Canadians are able to stop these developments, home care as it is delivered in Ontario and several other provinces represents the future of health care in Canada.

PART FIVE

The External Assault

THE ASSAULT ON CANADA'S HEALTH CARE SYSTEM IS A DOMESTIC MANIFESTATION OF A GLOBAL phenomenon. In a global economy, no country or society is immune to what is happening at the international level. While Canada has been struggling with competing forces and ideologies, so too has the rest of the world. Huge financial and trade institutions have grown up in the last several decades that are shaping the social and economic policies of every society in the world.

In many ways, the global economy now has a greater impact on the lives of peoples around the world than the actions and decisions of their own governments. Or, put another way, these global institutions and financial forces dictate governments' policies by punishing those who dare to disagree with them. To understand what is truly happening to Canada's public health care system, we must look to the global forces that are undermining universal health care everywhere.

The Washington Consensus

Economic globalization—the creation of a single global economy with universal rules set by the private sector—is the dominant economic and social movement in the world today. Originally conceived by American business interests, the so-called “Washington Consensus” is a model of development rooted in the belief that liberal market economics constitute the one and only economic choice for the whole world. The term “Washington Consensus” was coined in the early 1990s by John Williamson of the Institute for International Economics, a conservative Washington-based think-tank. This free-market doctrine has forced successive governments around the world to give up controls on foreign investment, liberalize trade, deregulate their internal economies, privatize state services, and enter into head-to-head competition with one another. The Washington Consensus forms the major philosophical foundation for government downsizing around the world and is behind the privatization of public services in many countries. It is also the foundational ideology of all major global financial institutions, including the World Bank, the Asia Development Bank, and the International Monetary Fund, who in turn use their clout to force it on Third World governments. The Washington Consensus is also at the heart of international trade rules.

Economist Paul Krugman explains that the Washington Consensus now defines “not only the U.S. government, but all those institutions and networks of opinion leaders centred in the world's de facto capital—think-tanks, politically sophisticated investment bankers, and world finance ministers—all those who meet in Washington and collectively define the conventional wisdom of the moment.” Of course, he fails to note that the Washington Consensus exists to protect the powerful—powerful countries, powerful currencies, powerful corporations—against the weak. And he fails to note that true competition is not possible in our world because of the access to capital of the Washington Consensus countries and the entrenched power imbalance between the North and South.

In the new global economy, everything is for sale, even in those areas once considered sacred, such as air and water, health and education, heritage and culture, and life itself, in the form of genetic code. This process could be called “the privatization of everything.” Increasingly, all services and resources are controlled by a handful of transnational corporations operating outside of any national or international law. Of the one hundred largest economies in the world, fifty-three are now transnational corporations. The top two hundred global corporations are now so big that their combined sales surpass the combined economies of 182 countries and they have almost twice the economic clout of the poorest four-fifths of humanity.

Under their influence, massive privatization of the world’s resources and services is taking place. Every year, more government services in the areas of education, social security, and health care are being turned over to the private sector by governments faced with massive debt-servicing costs and reductions in tax revenues as a result of wealthy individuals and powerful corporations refusing to pay their share of taxes. Especially vulnerable is health, because it is so intertwined with other issues such as poverty, hunger, and access to clean water.

Universal Health Care Targeted

The privatization of social and health services was not always an international objective. The United Nations Universal Declaration of Human Rights, ratified in 1948, guaranteed a standard of living adequate for the health and well-being of the whole family, and the right to security in the event of sickness, disability, or old age. In several attending covenants, the Declaration bound signatory states to accept the legal and moral obligation to protect and promote the rights enshrined in the Declaration.

In 1979, virtually all governments adopted the World Health Organization’s (WHO) Health for All by the Year 2000 Declaration. This treaty said that all peoples are entitled to basic health rights, and that societies and governments have the responsibility to ensure that the people’s health needs are met, regardless of gender, race, class, and relative ability or disability. The Declaration’s centrepiece was “primary health care,” a comprehensive strategy based on an equitable approach to the delivery of health services. The Declaration called for health ministries and health workers to be accountable to the common people, and included social guarantees to ensure that the basic needs of all people were met by the state.

Unhappily, these commitments were never met. Even as many agencies and some parts of governments tried to move this universal agenda forward, other forces were at work to undermine and sabotage the great dream of health for all. As in Canada, elsewhere powerful ideological myths about the failure of governments were being promoted by those with a great deal to gain if health care was privatized. The health sectors in most countries were targeted to become subject to the laws of the marketplace and the theory of “managed competition.” Rich and poor countries alike were told that the discipline of the market would act to contain costs through competition while more efficiently delivering services according to consumer demands.

Health trends were also following global economic and social trends. International institutions and governments eventually gave up on the goal of universality, and opted for a tiered system instead. The shape of society in almost every country in the world now resembles a pyramid: the few in the top third are getting richer and increasing their power; the middle class is striv-

ing to hold on, although it is being squeezed downward by market policies; and the bottom third has become an entrenched underclass. Goals and policy designs for health care in a world that accepts this economic model are different from goals and policy designs for a world seeking equality.

Governments are restructuring health care in order to ensure that those at the top of the pyramid have access to the very best health care—social Darwinism in action. Access to the best is restricted to those who can afford it. A second-tier, public system, obviously funded a little better in rich countries than in poor, is now operating in most parts of the world.

The World Bank and the IMF

This process was promoted by a regime enforced on Third World countries by the World Bank and the International Monetary Fund (IMF). These two powerful financial institutions lend money to developing countries, supposedly for “development” (usually consisting of mega-projects such as dams) and to stabilize currency crises. However, they have come under fierce criticism in recent years for a legacy of deep social turmoil and poverty in the South and for primarily serving the interests of the big corporations and powerful governments of the North.

The Washington-based Institute for Policy Studies has calculated that nine out of ten energy-related projects financed by the World Bank benefit at least one corporation headquartered in the United States or one of the other six main industrial powers. A top U.S. Treasury Department official bragged to Congress, in 1995, that for every dollar the United States contributes to the World Bank, U.S. corporations receive \$1.30 in procurement contracts.

During the 1960s and 1970s, transnational banks lent hundreds of billions of dollars to poorer nations at very low interest rates. When interest rates soared in the 1980s, the countries found themselves unable to pay off their debts. The IMF and the World Bank (which has famously described public services as a barrier to the abolition of world poverty) made them an offer they couldn't refuse: agree to implement a set of Structural Adjustment Programs (SAPs) and the terms of their loans would be renegotiated. In addition, many countries were given new loans by these institutions, which added to their debt.

Structural Adjustment

About eighty countries were forced to weaken their tools of national sovereignty and adopt the “Washington Consensus” package, including cuts to social subsidies, public education, and health care. The results were deep cuts to health care budgets, user fees, cost-recovery practices, increased malnutrition, and the resurgence of cholera, tuberculosis, malaria, and plague. The World Bank's health policy openly includes support for “diversity and competition” in health services. Public hospitals and health centres were sold to the private sector, resulting in the pricing of their services out of reach of the poor. Privatization of health services became a condition of further loans in many countries.

The results have been disastrous. Costa Rica, the first Central American nation to implement a SAP, experienced a 35 percent cut in health programs which led to a dramatic increase in infec-

tious disease rates and infant mortality. Under the dictator Pinochet, Chile followed a SAP agenda that destroyed its universal health care system, leaving millions without protection. Much as in Canada, the federal government of Chile dropped its shared-cost contribution for health care from 61 percent in 1974 to 17 percent of total costs in 1989, and downloaded its health care responsibilities to levels of government unable to fund them. A two-tier system replaced the universal model and private companies flowed into the country.

In the 1990s, Argentina slashed government subsidies to all non-governmental public health care service providers, as well as funding for government-provided services. The country adopted U.S. style HMOs which paid incentives to doctors who ordered less costly treatment. Millions of Argentinians, who had traditionally received quality health care from their union-related cooperatives, were thrown out of work by IMF and World Bank restructuring and lost their health care altogether. In a decade, the national medicare system of Argentina went bankrupt.

In the first five years of restructuring, all the progress that had been made in reducing the infant mortality rate in many African countries was totally undone by Structural Adjustment Programs. Between 1980 and 1985, the infant mortality rate rose by 54 percent in seven African countries, including Ethiopia, Somalia and Uganda. Yellow fever staged a comeback in Ghana. A ten-country UNICEF study found that SAPs had caused the decline in the nutritional status of African children that took place between 1975 and 1990. Hospital deaths due to malnutrition soared in Zambia. In Kenya, the introduction of user fees at a centre for sexually transmitted diseases caused a sharp decline in attendance and an increase in these diseases in the population.

In fact, as hospitals were privatized all over the Third World, outpatient visits dropped. In Vietnam, the introduction of user fees meant that poor families had to sell their livestock or borrow money to receive even the most basic care. As a result, there was a 50 percent reduction in the number of public health care consultations in the first seven years following IMF imposed liberalization in 1986.

The massive restructuring of health care in the Third World has caused untold suffering. Jubilee 2000, the international ecumenical movement working for the cancellation of Third World debt, conservatively estimates that nineteen thousand children die every day as a result of the restructuring proposed and imposed by the World Bank and the IMF. And, of course, when HIV/AIDS hit Asia, Latin America, and, particularly, Africa, the public health infrastructure had already been decimated and the affected countries were unable to cope with this terrible crisis.

The saddest irony is that all this suffering hasn't produced the promised financial security. Third World debt has grown by over 400 percent since 1980; countries of the South now send more money to the North in debt repayment than they receive in foreign aid and export earnings combined. Foreign aid has been slashed in most developed countries: Canada's aid package has dropped to its lowest level in decades. The World Bank gave less than 4 percent of its total development finance to basic health, education, water, and sanitation in 2000, representing just 0.1 percent of total World Bank financing. The global shortfall in annual public spending on basic services has more than doubled to \$90 billion (US) in the last five years.

Private Sector Winners

There have been winners, however. When governments in the Third World abandoned the health care field, they left a huge vacuum. For just as the First World now has an entrenched underclass, the developing world now has its own elite. A health care market was created by the wealthy and new business classes of poorer countries that is being filled by private, for-profit health corporations, many of whom are transnationals unconstrained by the domestic laws of any one country.

Latin American countries, for example, are experiencing an invasion of U.S. health care corporations and insurance companies, like Aetna International and American International, who report a 20 percent growth in the region per year and over five million clients. A Singapore-based health corporation, Parkway, owns and operates most of the hospitals and dental clinics in Southeast Asia. South Africa's Afrox Healthcare is operating for-profit clinics in a number of other African countries.

But it is not just the poorer countries who have abandoned universal health care. Great Britain and Australia are two examples of industrialized countries that have set up a two-tier health care system in which private corporations deliver an increasing proportion of health services to those who can pay.

There is a great deal of money to be made when governments vacate the field of health care, or at least leave the more lucrative areas to the private sector. The service sector is the fastest growing sector in international trade. According to the European Commission, the service sector accounts for two-thirds of Europe's economy and jobs, almost a quarter of Europe's total exports and half of all foreign investment flowing from Europe to other parts of the world. In the U.S., more than a third of economic growth over the past five years has been because of service exports.

Service Sector Winners

Of all services, health care has the potential to be the most lucrative of all. Global expenditures on health care exceed \$3.5 trillion (CAN). Market saturation for American HMOs has led these health care giants to seek to capture new markets abroad by acquiring lucrative government-run facilities. The industry has received backing for its foreign-acquisitions policy from the U.S. government, the World Bank, and the Inter-American Development Bank. Health service corporations target the public funding behind foreign health care systems. The WTO's Secretariat calls the health sector of the OECD countries a "domestic economic giant."

Already, powerful lobby groups have formed in many countries to promote the interests of the service industries. The Coalition of Service Industries in the U.S. is a large group of service corporations with ties to the White House. It includes the major energy, insurance and financial giants as well as the major pharmaceutical companies and the newer players in the health care field, including HMOs. "Historically, health care services in many foreign countries have largely been the responsibility of the public sector," says the Coalition. "This public ownership of health care has made it difficult for U.S. private-sector health care providers to market to foreign countries."

The European Services Network and the European Service Leaders Group represent similar networks of European service transnationals. These corporate lobby groups are not just powerful in establishing policies and priorities in their own countries; they are influential players in the international bodies that set global rules on health care. They work intimately with World Bank and IMF officials.

The WHO and Codex

The World Health Organization (WHO), a United Nations agency, has been increasingly underfunded in recent years. The U.S. has withheld its contribution several times because it disagreed with the agency's policies favouring breast feeding over the use of infant formula. This has left the WHO less powerful than in the past.

In 1998, the WHO Executive Board proposed a resolution promoting public health over commercial interests. As a result of industry lobbying, the resolution was rejected by the World Health Assembly and returned to the Executive Board. The WHO now says that it wants to enter into more cooperative arrangements with industry in the health sector. Large transnational corporations such as Nestlé already send more delegates to international WHO forums on standards than most governments do. The WHO is also one of a number of UN agencies that form UNAIDS, which is in partnership with five major pharmaceutical companies, some of whom, such as Johnson & Johnson, have been charged by the International Food Action Network with violating the WHO's own infant formula code.

The Codex Alimentarius is a joint WHO and Food and Agriculture Organization (FAO) food standards commission that harmonizes worldwide food quality standards. However, food giants now dominate the twenty-eight committees of the Codex. One study found that 81 percent of non-governmental delegations in committee meetings setting food standards, particularly in infant nutrition, were industry representatives; that Pfizer, a pharmaceutical transnational, has more staff in its marketing department than there are in the whole of the WHO, gives an indication of the relative size of the private sector players involved.

The Trade Lobby

The jurisdiction in which transnational corporations would come to have the greatest influence, however, is in the area of free trade. For them, the biggest barriers to profit are domestic regulations. Rules to protect the environment, health, and food safety are seen as non-tariff barriers to trade. Domestic laws that require some local economic and job enhancement from foreign investment cost them money. Government monopolies on services such as health care and education bar large service corporations from entering nation-state "markets" and making money. Rules designed to nurture local small business, local farmers, or national culture "discriminate" against foreign transnationals.

As legal trade expert Steven Shrybman explains, "In the simplest of terms, the essential goal of trade agreements is to deregulate international trade. They set out detailed rules intended to constrain the extent to which governments can regulate international trade or otherwise 'interfere' with the activities of large corporations. Trade agreements provide extensive lists of

things governments can no longer do.” So it can come as no surprise that the big business lobby in every country is deeply involved in its government’s trade agreements, or that it goes to great lengths, including financial intimidation, to get its way.

It was the Business Council on National Issues (now the Canadian Council of Chief Executives) in Canada and its partners in the U.S., who first proposed a free trade agreement between the two countries to their respective governments. The close association between the governments of the day and leading corporations on both sides of the border has been thoroughly documented. These corporations openly spent millions of dollars to sell free trade to a wary public.

As well, the Department of Foreign Affairs and Trade (DFAIT) was meeting with the big business community in Canada over the doomed Multilateral Agreement on Investment (MAI) for three years before it would admit to the Canadian public that such an investment treaty even existed. The original MAI blueprint, which governments of the members of the Organization for Economic Cooperation and Development (OECD) were ready to adopt almost as written before they were forced to back off by a massive public campaign, was drafted by the International Chamber of Commerce in Paris.

In the U.S., more than five hundred corporations and business representatives have been officially credentialed as security-clear trade advisors to the U.S. government on the World Trade Organization (WTO). These include the U.S. Chamber of Commerce, numerous Fortune 500 companies, the Business Roundtable, and a host of industry and service-specific lobby groups.

In Japan, senior members of the Keidenran, the Japan Federation of Economic Organizations, advise the government on trade policy. The Committee on Trade and Investment is chaired by the CEO of Mitsubishi, and the Committee on Environment and Trade is chaired by the CEO of Nissan.

In Europe, the Commissioner of the European Union on WTO Policies and Administration maintains direct links with the European Round Table of Industrialists. The European Community has set up the European Services Network of transnational service industry representatives, led by Andrew Buxton, chairman of Barclays PLC, to “advise” European Union advisors on the key barriers and countries on which they should focus in WTO negotiations.

Transnational corporations now host international trade meetings. The Seattle WTO meetings in 1999 were co-hosted by Bill Gates of Microsoft and Phil Condit of Boeing, who raised \$10 million (US) for the event. At the 1997 APEC Summit in Vancouver and the 2001 Summit of the Americas meeting in Quebec City, corporations could buy their way in to meet with negotiators and senior politicians: the more they paid (payments that might be made in gold, diamonds, or platinum), the more access they were allowed to heads of state.

When the U.S. Congress was debating whether to allow China into the WTO, top business executives issued a warning to federal lawmakers: vote against this deal with China and we will hold it against you when it comes time to write cheques for your campaigns. Phil Condit publicly warned each member of Congress that their “friendliness to business” would be assessed by how they voted on this bill. “We aim our donations at people who support free enterprise and what we see as the free enterprise system,” he said in a written statement also signed by several other corporate leaders.

Services and Trade

Before the WTO came into force in 1995, world trade was ruled by the GATT (General Agreement on Tariffs and Trade), a trade agreement whose mandate was to systematically dismantle the world's tariffs (import taxes). Since the creation of the GATT in 1948, there have been eight "rounds" of negotiations, each consisting of a series of meetings, spread out over several years, to negotiate a fixed agenda of issues.

The first six rounds concentrated exclusively on tariff reductions. But the last two rounds, the "Tokyo Round" (1973-1979) and the "Uruguay Round" (1986-1994) began to target "non-tariff barriers": the rules, policies, and practices of governments, other than those pertaining to tariffs, that can have an impact on trade. Governments began to negotiate for rules on "trade-related" items concerning agriculture, genetically modified foods, environmental regulations, and financial and social services.

The changes in these rounds coincided with the growth of the ideology of the Washington Consensus and the creation of global corporations and corporate lobby groups, each intent on adding its sector to the trade talks. This is also when citizens' groups around the world started to sit up and take notice of these until-now obscure meetings.

Nothing was more controversial than services. The Third World, stung by the assault on its services by the World Bank and the IMF, absolutely refused to add services to the negotiations. But the global services industry was gaining momentum and power.

Mega-mergers were taking place in the telecommunications, finance, airline, publishing, insurance, and other service sectors; the new giant transnationals wanted to take down government monopolies in their fields in every country in the world, and they needed free trade to do so. At the same time, global health care, education, food services, maintenance, and security corporations were forming to break into a newly emerging for-profit market in areas that had been exclusively serviced by governments on a non-profit basis. They were not about to give up their goal of an unregulated global market for their "products" and they knew that international trade rules were essential to their plans.

PART SIX

Globalization and Free Trade

IN THE MID-1980S, AMERICAN SERVICE CORPORATIONS, PARTICULARLY IN THE BANKING AND FINANCE sector, decided that they needed some extra clout in order to force a services agenda onto the Uruguay Round talks just getting under way. Services were still very contentious with the majority of the world's developing countries and with countries of the North that had popular universal public programs. So the service companies decided they needed an example of a successful bilateral free trade agreement that would include services to take to the global trade negotiations as a prototype. As they cast around for the perfect partner their hooks snagged Canada.

Canada First

Canada was ideal. Brian Mulroney's Conservatives had just been elected and the spanking new Prime Minister's first act had been to announce to a blue-chip audience in New York that his country was "up for sale," and he promised to take down barriers to American goods and investments. The service companies set up the American Coalition for Trade Expansion with Canada, made up of 600 powerful corporations. It was led, not coincidentally, by American Express, a financial services company that had long pursued free trade in services at the GATT. For American Express, this was more than a business goal: it was a mission. Harry Freeman, the company's executive vice-president, called free trade "the Lord's work."

As Allan Taylor, then CEO of the Royal Bank, noted in 1986, "A Canada/U.S. agreement which includes services could be the catalyst for multilateral cooperation. Freer trade breeds more free trade—putting pressure on other countries to come into line as the multilateral negotiations proceed." On January 1, 1989, the Canada-U.S. Free Trade Agreement was signed and became the first free trade agreement in the world to include services, albeit with exemptions for public services. (As a reward for its leadership in negotiating the deal, American Express was granted banking status in Canada by the Mulroney government in a secret cabinet meeting on November 21, 1988—election day.)

A more comprehensive agreement governing trade in services was included in the North American Free Trade Agreement (NAFTA), signed four years later. For the first time, service companies of other NAFTA countries were granted "national treatment" status. This meant that a country or a community could not give any preference to a domestic service provider over a foreign service provider. As well, countries were now required to provide "most-favoured-nation" status to foreign service companies. This meant that the companies of all signatory countries had to be treated the same; one couldn't discriminate among them on the basis of, for example, concerns about the ethical behaviour of a company (or the government of its country of origin) in the provision of a service elsewhere in the world. NAFTA granted service companies, especially financial services companies, the right to set up shop in other NAFTA countries and, at the same time, prohibited governments from requiring them to do so in order to create local employment.

In other words, NAFTA spelled out what governments could no longer do to regulate the trade in services. While exemptions were carved out for government contracts and subsidies, as well as for social programs, education, and health care as long as these sectors remained public, a blueprint for international trade in services now existed. If governments wanted to add a new sector, such as health care, it would be subject to all of the conditions specified by the treaty.

Global Services Negotiations

Armed with the Canada-U.S. FTA and then NAFTA, the global services industry became involved in the Uruguay Round talks with renewed vigour. This time, it had more success. When the Round ended with the creation of the WTO in 1995, a new negotiation on services, the General Agreement on Services (GATS) was launched as well. The services corporations have never looked back.

The GATS is one of more than twenty separate agreements administered by the WTO, including the GATT and others in areas such as intellectual property, agriculture, and investment. Like the other agreements, the GATS gains its authority from the WTO, which holds all of the powers and enforcement tools of a global government. Under the WTO's dispute settlement mechanism, member countries can challenge the laws, policies, and programs of other countries. The losing country in a dispute must abide by the decision of the unelected trade tribunals or face severe fines and permanent economic sanctions. In effect, the WTO has the authority to strike down any domestic law, policy or program judged to be in violation of strict business-friendly trade rules.

The GATS is what is called a "multilateral framework agreement," which means that its broad commission was defined at its inception and then, through ongoing negotiations, new sectors and rules are to be added. Essentially, the GATS is mandated to restrict government actions in regard to services through a set of legally binding constraints backed up by WTO-enforced trade sanctions.

GATS Attack

Through rules on "domestic regulation," which would more appropriately be called "domestic deregulation," the repeated rounds of GATS negotiations are designed to expand the takeover of service delivery by transnational corporations in such critical areas as: health care; hospital care; home care; dental care; child care; elder care; education—primary, secondary, and post-secondary; museums; libraries; law; social assistance; architecture; energy; water services; environmental protection services; real estate; insurance; tourism; postal services; transportation; publishing; broadcasting; and many others.

Article VI:4 of the agreement compels governments to demonstrate that their domestic regulations, standards, and laws are "necessary" to achieve a WTO-sanctioned objective, and that no less commercially restrictive alternative is available. It is no wonder then that the European Commission says, on its Web site, the GATS is, "first and foremost an instrument for the benefit of business."

The GATS agreement covers all service sectors and modes of supply as well as most government measures, including laws, practices, regulations, and guidelines—written and unwritten. No government measure that affects trade in services, even when its aim is environmental or consumer protection, to ensure that a service is universally available, or to enforce labour standards, is beyond the scope of the GATS.

The potential for harm of the GATS to the world's poor has prompted many international organizations and agencies who seldom become involved in political issues to speak out against it. *Médecins Sans Frontières* (Doctors Without Borders) is one example. Another is Save the Children, an international charity operating in more than seventy countries. In a recent publication, Save the Children warned that opening up health care to private companies in the Third World could have dire consequences:

The commercial presence of such companies in the health sector threatens to exacerbate existing problems of equity, quality and capacity. Commercialization of health services has already been shown to exclude whole communities from access to care...GATS undermines a country's ability to regulate its health services: restricting domestic regulation in order to remove "unnecessary" trade barriers threatens to drive down regulatory standards rather than raising them to provide the best possible guarantee of public health.

Negotiators in the current talks are pressing to make the rules restricting domestic regulation even more stringent. The U.S. and Europe want guaranteed, irreversible access to domestic markets, and governments are under greater pressure to list more of their services and exempt fewer. The new talks are aimed at developing new GATS rules and restrictions to further restrict the use of government subsidies, such as those used to support public works, municipal services, and social programs.

The GATS and Canada

At present, public services provided by government are technically eligible for exemption. Hence, the Canadian government is claiming that our programs will be safe if we choose to exempt them. But under GATS article 1.3C, for a service to be considered to be under government authority, it must be provided "entirely free." That means that the sector in question must be completely financed by government and run entirely on a non-profit basis. This is clearly not the case for the health care sector anywhere in Canada any longer. The WTO itself has been very clear on its interpretation of this article; wherever there is a mixture of public and private funding, such as exists in Canada, the service sector should be opened up to foreign corporations.

Absolutely *nothing*, including health care, is off the GATS "table." Going into the 1999 WTO Ministerial meeting in Seattle, the Canadian government's official, published position on GATS negotiations was that consultations would proceed even in "areas of particular sensitivity, such as health, education and transport." Already, almost one hundred countries, including all of Europe, have listed some sectors of health care with the GATS, opening up their health care systems to foreign-based corporate competition.

Canada, astonishingly, listed health insurance for inclusion. In a 2001, comprehensive report on GATS and health care for the Canadian Centre for Policy Alternatives, social policy analyst Matt

Sanger documents that by listing health insurance, the very backbone of medicare, the Canadian government has exposed our public system to “national treatment” challenges from foreign private insurance companies, and has allowed a foreign-owned commercial insurer operating in Canada to assert its right to process Canadian health insurance claims and records from outside the country.

Under GATS, hospitals and regional health authorities would be vulnerable to a GATS challenge. Especially at risk are provinces, such as Alberta, that are already permitting public funding of private, for-profit hospitals. Reports Sanger, “A successful trade challenge could give a virtually unlimited number of commercial hospitals beyond our borders a claim on Canada’s public funding for health care, exposing Canada to trade retaliation and potentially overwhelming the capacity of provincial and federal governments to contain costs and the quality of care.”

Further, listing Canada’s health insurance under the GATS regime has exposed Canada to trade threats that will restrict our options for health care reform, such as the inclusion of home care or pharmacare under the Canada Health Act, both of which were promised by the Chrétien Liberals in their 1993 Red Book.

An American public relations firm with HMOs as clients has referred to Canada’s medicare system as one of the largest “unopened oysters” left anywhere. The intention of the United States to use the WTO and GATS to pry our oyster open is a matter of public record. According to the U.S. Trade Representative’s Office:

The mandate is ambitious: to remove restrictions on trade in services and provide effective market access. Our challenge is to accomplish significant removal of these restrictions across all services sectors, addressing measures currently subject to GATS disciplines and potentially measures not currently subject to GATS disciplines...

The United States is of the view that commercial opportunities exist along the entire spectrum of health and social care facilities, including hospitals, outpatient facilities, clinics, nursing homes, assisted living arrangements, and services provided in the home.

NAFTA’s Impact on Health

Despite government claims that NAFTA has no impact on health, this trade agreement is being used to erode health and environmental regulations and standards in Canada. NAFTA was the first international trade agreement in the world to allow a private interest, usually a corporation or an industry sector, to bypass its own government and, although it is not a signatory to the agreement, directly challenge the health laws, policies, and practices of the government of another NAFTA country.

Chapter 11 of NAFTA gives American corporations operating in Canada the right to sue for lost profit if any level of government enacts a new law or regulation that affects its business deleteriously. This right applies even if the government is acting with the full consent of its people and in reaction to new evidence that a particular practice or product is dangerous. Chapter 11 has been used to knock down a number of Canadian health standards.

In June, 1997, the Chrétien government legislated a ban on the cross-border sale of MMT, a gasoline additive whose sale has been outlawed in many countries and which many environmentalists believe causes attention deficit disorder in children. When he was in opposition, Jean Chrétien called MMT “a dangerous neurotoxin” and said it could have “truly horrific effects.” In introducing the bill, the government declared MMT a public health hazard.

However, the company that manufactures the product is an American company and, as such, has compensation rights under NAFTA’s Chapter 11. Virginia-based Ethyl Corp. launched a \$350 million (CAN) NAFTA challenge against the Canadian government. Rather than pay this much money and risk the embarrassment of losing a NAFTA panel, the Chrétien government agreed to reverse its legislation, pay the company \$20 million (CAN) as compensation for its costs, and write a letter of apology containing a stat’s lymphoma.

Connecticut-based Crompton Corp., with over \$3 billion (US) in sales in 2000, filed notice that it is seeking a reversal of the ban as well as compensation of \$150 million (US) for lost business. Ironically, one of the catalysts for the Canadian ban was that lindane is banned for use on canola in the U.S., and Washington had warned Ottawa that it would start blocking imports of crops treated with the pesticide from Canada. American canola growers, meanwhile, consider Canada’s use of lindane to be an unfair competitive advantage.

NAFTA and the Tobacco Lobby

NAFTA was also used to give American tobacco companies the power to dictate Canadian health policy. When it first came to power in 1993, the Chrétien government faced criticism over cigarette smuggling. Canadian cigarette manufacturers were exporting cigarettes to the U.S., not for U.S. consumption, but to smugglers who were reimporting them to Canada for sale on the black market. The Chrétien government “resolved” the issue by lowering tobacco taxes to reduce the incentive for cross-border smuggling of Canadian cigarettes. This had the dual corporate advantage of returning profits from the smugglers to the tobacco companies, and reducing the retail price of cigarettes in Canada. The U.S. tobacco giants were very happy.

But the move raised a storm of criticism among children’s advocates and health and anti-smoking groups in Canada. And it cost federal and provincial treasuries almost \$1 billion in the first year alone. The whole thing could have been avoided with an export tax imposed at the Canadian factory gate; but under NAFTA, such export taxes are illegal.

To offset criticism because of the terrible health effects of lowering taxes on cigarettes, especially on youth, the Commons Health Committee was poised to recommend the plain packaging of all cigarettes to discourage their use. Appearing before the committee on behalf of U.S. tobacco giants that owned Canadian brands was Julius Katz, former chief U.S. NAFTA negotiator. The statement he carried in his accompanying brief was prepared by another former U.S. trade representative, Carla Hills, now working for the tobacco industry as well. The message was that any such action would violate NAFTA. Roy MacLaren, then Canadian trade minister, objected weakly that health was exempted in NAFTA. Katz replied that the exemption did not apply to intellectual property, including trademarks. The idea was quietly abandoned.

NAFTA and the Insurance Transnationals

NAFTA has affected health care directly. It removed a law imposing a 25 percent ceiling on foreign ownership in the insurance industry, a rule that ensured Canadian control and government regulation of the sector. As Colleen Fuller documents, this led very quickly to the integration of the North American insurance industry. What were once three national markets, in Canada, the U.S., and Mexico, were merged into a single continental market. This also allowed the profit motive to invade the Canadian health insurance sector in a new way.

The first big takeover in the industry was very controversial. In 1995, Boston-based Liberty Mutual, one of the world's largest insurance transnationals, with assets worth more than all Canadian health insurance companies combined, took over Ontario Blue Cross (OBC), a non-profit insurer wholly owned by Ontario's publicly funded hospitals and managed by the Ontario Hospital Association. OBC had been seeking a private buyer; with over 2 million clients, its board of directors decided it was time for it to get into the "managed care" business.

At the time of the acquisition, Liberty said it planned to use Canada, "as a base for exporting managed care services world-wide." As Fuller points out, this sale constituted the loss of a non-profit alternative to the competitive, for-profit insurance industry, as well as the loss of a company in which the public had invested. Liberty was soon followed by other U.S. insurance giants such as Aetna, which promised to "redefine the way health care is provided."

The American private insurance industry is a powerful player on Capitol Hill and lobbies hard to maintain a private health system in the U.S. This lobby spent \$169 million (US) in the 1999-2000 U.S. federal election in support of its political friends; only the big drug companies spent more. Aside from wanting into the Canadian market to invest in current insurance opportunities, private American insurance companies are hard at work promoting a private insurance model for Canada. They are the direct beneficiaries when currently listed health services are removed from medicare coverage.

Free Trade's Time Bomb

The worst danger in NAFTA, and its planned successor, the FTAA, however, lies in the creeping privatization of health services. It is very simple: if a government allows any currently exempt sector, such as public services, to become privatized, or even partially privatized, the sector no longer qualifies for trade exemption status. For-profit companies from other NAFTA countries must now be allowed to enter the sector as competitors.

In a widely respected legal opinion written in March, 2000, trade expert Steven Shrybman, of Sack Goldblatt Mitchell, showed that under the current rules of NAFTA, Canada's health care could come in for a challenge in the future. To qualify for an exemption, health care services must be "social services established or maintained for a public purpose." The U.S. is clear, Shrybman asserts, that as soon as any health care service is supplied by a private firm, whether it is on a profit or non-profit basis, it falls under NAFTA's Chapter 11 rules.

Alberta's Bill 11 has opened up the door to privatization for all of Canada, said the opinion, because once U.S. health corporations gain a legal footing, under NAFTA, in Alberta's health

care system, it will be impossible to stop them from entering other provinces. Under the FTAA's extended services provisions, foreign service corporations will gain competitive rights to the full range of government health services, and will have the right to sue any government that resists for financial compensation.

This is an increasing threat as private health companies move into Canada. As Fuller points out, North America's health care services, medical devices, supplies, and distribution markets are larger than the automobile, steel, and transportation sectors combined. And they are dominated by corporations based in the United States which are gaining a powerful foothold in Canada.

The Canadian health care market is potentially worth at least \$95.6 billion (CAN) to private providers. There are about 250 large corporations, most of them U.S.-based, now operating here. With every privatization, they acquire new rights under NAFTA either to enter our market and compete with the Canadian non-profit sector for public funding or to sue for compensation if they are denied access. If a future federal government, for instance, attempted to bring home care under the jurisdiction of the Canada Health Act, it would have to be prepared to pay billions of dollars in compensation to the American corporations already operating in Ontario and other provinces.

The reality is simple: once privatization is established in any public sector, it is almost impossible to reverse. With time, the Canadian government would no longer be able to afford to publicly fund health care as it would have to be prepared to give equal access to such funding to private contractors from the U.S.

The FTAA

The Free Trade Area of the Americas (FTAA), the planned successor to NAFTA, will make matters substantially worse. With a population of 800 million and a combined GDP of \$11 trillion (US), the FTAA would take jurisdiction over the largest free trade zone in the world. But it will do more than expand the free trade agreement to the rest of the Western Hemisphere; as proposed, the FTAA significantly expands coverage of the service industries, thereby putting the health care systems of every country at risk.

The services proposals of the FTAA are very broad, calling for "universal coverage of all service sectors," including the "rules, procedures, decisions, administrative provisions, or practices" of every level of government. Proposals to exempt certain vital public services such as health, education, and social services are qualified by the criterion that to be exempt, a sector must be entirely free of competition: a criterion met by almost no public service in any FTAA country. In any case, no country has yet proposed a clear exemption for any public service, including health care.

As well, the FTAA contains new constraints on domestic regulation of service corporations, and protective measures for domestic providers. Combined with the services proposal, these measures are a deadly recipe for health care in the Americas. Foreign, for-profit health service corporations from anywhere in the hemisphere could gain the right to establish a "commercial presence" anywhere in North, Central, or South America.

Foreign corporations could have the right to compete for public dollars with public institutions such as hospitals, nursing homes, and health clinics. Standards for health care professionals would be subject to FTAA rules, and would be reviewed to ensure they are not an impediment to trade. Foreign-based telemedicine services would become legal. And no country would be able to stop trans-border competition from low-cost health care professionals.

The governments of the hemisphere appear poised to extend the “investor-state” provisions of NAFTA into the new agreement. If these are included, then if any government at any level—federal, provincial, or municipal—attempts to resist these developments and maintain services under domestic control, every service corporation of the hemisphere would have the legal right under the investment provisions to sue for financial compensation for lost revenues.

That the real goal of this services/investment juggernaut is to reduce or destroy the ability of the governments to provide publicly funded services (because these are considered “monopolies” in the world of international trade), is demonstrated clearly by the words of Organization of American States (OAS) Deputy Trade Director Stephenson: “Since services do not face trade barriers in the form of border tariffs or taxes, market access is restricted through national regulations. *Thus the liberalization of trade in services implies modifications of national laws and regulations, which make these negotiations more difficult and more sensitive for governments.*” (emphasis added)

PART SEVEN

Structurally Adjusted Canada

IT IS IMPORTANT NOT TO SEE CANADA AS A VICTIM OF THE TRADE DEALS. THE CANADIAN government under Jean Chrétien has taken a leadership position in promoting the values of the Washington Consensus. Canada was an ardent supporter of the MAI, an early proponent of the WTO, and plays a prominent roll at the GATS. Sergio Marchi, Canada's trade ambassador to the WTO and a former trade minister, was, until recently, the chair of the new "round" of GATS negotiations. Upon taking office in 1993, Jean Chrétien merged the old Department of External Affairs with the Department of Trade, creating DFAIT and giving the trade secretariat increased powers relative to both foreign affairs and most other departments.

While the funds of other departments were cut in the 1995 budget, funds for trade development in DFAIT almost doubled. DFAIT launched the Team Canada trade missions, which enlist senior politicians to shill for Canadian business around the world. As one department official explains, "We used to go with lists of political prisoners we wanted released. Now we go in with lists of companies that want contracts."

DFAIT also acts as a watchdog over other departments, both federal and provincial, to ensure that any and all policy proposals they are considering do not violate trade rules. It has a chilling effect on those areas of government which are responsible for the protection of the cultural, environmental, or health rights of Canadians.

Abandoning the Precautionary Principle

The "Precautionary Principle" allows countries to control or ban substances that it has concerns about, but about which they do not yet have full, treaty-proof evidence of harm. As long as a country's measures are in keeping with its own health and environmental standards, it doesn't have to get approval from the trade panels. This principle is particularly crucial to controlling the introduction of new drugs and chemicals to the country, to allow for testing to that country's standards.

It is widely believed in environmental and health circles that Canada is actually opposed to the inclusion of the Precautionary Principle in domestic health and environmental legislation, because of a concern about finding itself in contravention of trade agreements such as the WTO and Chapter 11 of NAFTA. Rumours circulating on Parliament Hill that Trade Minister Pettigrew had dictated an anti-Precautionary Principle policy in a confidential cabinet memo led Liberal MP Clifford Lincoln, in an October, 2000, exchange at a parliamentary Environment Committee meeting, to ask trade department officials if it were true. Nigel Bankes, a senior official in the DFAIT admitted, "On that specific question, has the department been arguing against simple references to the Precautionary Principle? I think you are correct. I'm aware of at least one instance of that."

Intellectual Property

Another “structural adjustment” Canada has undergone is in bringing its drug patent and intellectual property laws into global conformity. Both NAFTA and the WTO contain provisions to protect “intellectual property” that are being used by transnational drug companies to deny affordable medicines to millions of people around the world.

“Intellectual property” refers to types of intangible property, such as patents, which generally grant holders an exclusive right to the use of something such as a design, trademark, or formula. Trade rules on intellectual property extend this exclusive right, often held by corporations, to the other signatory countries to the agreement. Intellectual property rules in trade agreements set enforceable global rules on patents, copyrights and trademarks that have gone far beyond their initial scope of protecting original inventions or cultural products; they now permit the patenting of genetic lines of plants and animals, promoting the property rights of corporations over the genetic heritage and traditional medicines of local communities.

The impetus for an international system of intellectual property protection was the rise of the knowledge economy. Wealthy countries such as the U.S. and the countries of Europe wanted to maximize their returns on knowledge through licences on their patents across the globe. Seventy percent of U.S. export earnings are now linked to intellectual property; intellectual property provisions of the WTO protect the spread of American economic and cultural hegemony.

The stakes are so high in the knowledge economy that applications for patents in the U.S. have skyrocketed from 150,000 a year in the late 1980s, to 275,000 today. In October, 2000, alone, there were patent applications for 126,672 human gene sequences. The figure for February, 2001, was 175,624. Needless to say, very few patents are held in the countries of the South, even though they are often the original source of the knowledge being patented.

TRIPS

As of January 1, 2000, all member countries became subject to the rules of the WTO Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS). By 2006, each of them must have legislation in place providing twenty-year protection for pharmaceuticals. This will grant the drug companies exclusive monopoly rights to market their drugs and medications in all WTO member countries for a twenty-year period. The TRIPS Agreement has become a powerful weapon for the pharmaceutical industry and its government allies to use in prying open profitable markets for their products around the world, especially in developing countries.

More than 2.5 million people die every year from AIDS-related illnesses. There are more than 32 million men, women, and children infected by HIV/AIDS in developing countries. AZT and 3TC, the basic antiretroviral drugs in the West, would keep them alive and well, but the price tag is \$10,000 (US) to \$15,000 (US) per patient per year—well above the annual income of most people in the Third World. There are alternatives: cheap copies of life-saving medicines called generics, made mainly in Brazil, India, and Thailand, whose national laws allow them to ignore drug patents in cases of dire human need. Thailand says it could supply South Africa with

HIV/AIDS generics that cost \$200 (US) per person a year, and the South African government wants to import these drugs now. But forty-two pharmaceutical companies, including giant GlaxoSmithKline, have retained virtually every patent lawyer in South Africa to block these imports. The United States had already forced Thailand to abandon its patent laws in the early 1990s, and has recently launched a WTO/TRIPS challenge against Brazil for its manufacture and use of generic antiretroviral drugs. A similar case is pending against India. Quite simply, trade-enforced patent laws are killing millions of people.

At the Fourth Ministerial meeting of the WTO in Qatar, in November, 2001, a "deal" of sorts was reached whereby developing countries appear to be given a little more flexibility to use generics in times of medical emergencies. This development was hailed by some as a breakthrough for poor countries. But the zeal of the drug companies and the U.S. government to enforce the TRIPS agreement seems little abated. In any case, the wording of this "side agreement" renders it purely political; it has no legal standing. TRIPS still reigns.

The Drug Bullies

A handful of companies dominate the pharmaceutical industry—Merck, Pfizer, GlaxoSmithKline, Eli Lilly, Bristol-Myers Squibb, and Johnson & Johnson—and they wield enormous clout. There was a time not long ago when these and other corporate giants were merely the size of nations. Now, after a frenzied two-year period of pharmaceutical mega-mergers, they are behemoths that outweigh entire continents. The combined worth of the world's top five drug companies is twice the combined GDPs of all of the countries of sub-Saharan Africa. U.S. industry profits have soared in recent years to 36 percent, a rate of return on investment that is more than twice the U.S. average. The drug industry is far and away the most profitable major industry in the U.S.

The drug companies operate like a cartel, seeking to exercise monopoly control. They have been enormously influential in putting intellectual property on the global free trade agenda and provide perhaps the best evidence that free trade is anything but. For they do not seek a competitive, open international drug market, but a closed and protected monopoly for their products.

The companies argue that they put a great deal of money into research to produce their designer drugs. But much of this research money comes from government subsidies and, therefore, the research is publicly funded. And their profit margins were huge even before the TRIPS Agreement came into force. Médecins Sans Frontières reports that Glaxo Wellcome made \$589 million (US) on one AIDS drug in 1999 alone, recouping more than twice its research and development costs in just this one year.

As well, research costs are dwarfed by the cost of marketing the drugs. Marketing is where the companies really spend money, and this is why they are seeking long-term monopoly protection. Only the U.S. and New Zealand permit advertising of prescription medicines to consumers. Consumer drug advertising in the U.S. rose by 35 percent in 2000. Merck spent \$161 million (US) to promote its arthritis drug, Vioxx, in 1999; this is more than PepsiCo spent to advertise Pepsi or Budweiser spent to advertise beer. As a result, sales of Vioxx in the U.S. alone quadrupled in one year.

The drug giants have a great deal of clout with governments. George W. Bush was elected in no small part due to the American drug companies and their lobbies, such as the Pharmaceutical Research and Manufacturers Association. They also spent an unprecedented \$197 million (US) to elect Republicans friendly to free trade to Congress in the 2000 U.S. election, making it the biggest and costliest corporate campaign in U.S. political history. This powerful drug lobby, which employs 625 high-paid lobbyists (more than the 535 members of Congress), targeted twenty-six House races; only four of the industry-backed candidates lost.

The Drug Bullies in Canada

As in the U.S. and Europe, the major transnational drug companies are present and powerful in Canada. Eight of the top ten companies in Canada with over \$100 million in annual sales are foreign-owned brand-name corporations. They account for almost 90 percent of drug sales revenue, and spend \$1 billion every year to promote their products. As in the U.S., they have formed powerful ties with the government of the day. And, as in the U.S., they have used the intellectual property regime of the trade agreements to gain monopoly rights and patent protection for their products, allowing them to maintain artificially high prices. To do this, they had to kill a Canadian law that had kept drug prices low for decades.

In 1968, as part of its commitment to its newly passed medicare bill and to keep drug prices affordable for all Canadians, the Trudeau government passed "compulsory licensing" legislation that created a thriving generic drug industry in Canada. The law forced brand-name pharmaceutical companies to allow the production of knock-off drugs in exchange for a 4 percent royalty. But the foreign drug companies were very unhappy with this situation; when Brian Mulroney was elected, they moved in to have the law changed. They found a friend in both the Mulroney Tories and NAFTA, which contained intellectual property rights provisions for drug patents.

In 1993, knowing that NAFTA'S passage was imminent, the Mulroney government passed Bill C-91, repealing the compulsory licensing system and extending monopoly protection for corporate drug patents from seventeen to twenty years. They had already extended patent exclusivity for the drug companies, most of which were American transnationals, up to ten years with the passage of Bill C-22 in 1987. Regulations under the new law also gave the brand-name drug companies a unique legal privilege by granting an automatic twenty-four-month injunction preventing Health Canada from approving a generic equivalent in response to an allegation of, not proof of, patent infringement. This differs from patent dispute resolution in any other industry. With the passage of Bill C-91, Canada became the only other country, besides the United States, to give this special protection to the big drug corporations.

As a result of abandoning the compulsory licensing system for a regime that protects the monopoly rights of giant drug transnationals, Canadian drug prices soared. Between 1987 and 2002, spending on prescription drugs increased 342 percent. Prescription drugs are now the fastest growing component of health care costs. Green Shield Canada calculates that the cost of new prescription drugs is rising by about 21 percent a year. Canada now spends more on drugs than on physician care.

Coverage for those who cannot afford the high cost of prescription drugs varies from province to province. But what is certain is that many Canadians cannot afford the drugs they need. Several provincial drug plans have recently had to announce increases in deductibles for seniors, Nova Scotia to \$350 a year from \$215, and Quebec to \$325, from \$175. In December, 2001, British Columbia announced that it will increase user fees and deductibles for its drug plan. More than three million Canadians now lack any drug insurance at all; another six million have inadequate coverage. According to Health Canada, in Ontario alone, almost two million people have absolutely no drug coverage whatsoever, and another 700,000 have inadequate coverage.

Corporate Friendly Liberals

While in opposition, the Liberals took a strong position against monopoly patents for the drug giants. During the 1993 election campaign, they made repeal of Bill C-91 an issue. Brian Tobin called the Conservative government "back-room muggers" and said they were stealing money from the poor, the sick, and the elderly. Bill C-91, he declared, would "rape them daily in the cost of their drugs." Opposition Leader Jean Chrétien actually stopped for a campaign photo-op at the North York headquarters of Apotex, a leading Canadian generic company, and said that his government would accept the moral obligation to keep drug costs down. He promised a five-year review of Bill C-91, should his party come to power.

At the 1997 review, an all-party parliamentary committee was presented with the hard evidence of just how dramatically Bill C-91 had affected drug prices in Canada, punishing poorer citizens, especially seniors, just as the Chrétien Liberals had predicted when they were in opposition. By this time, however, the Chrétien government had become a best friend to the big pharmaceutical companies and a promoter of unregulated free trade; Health Minister David Dingwall made it clear that the whole review exercise had been a sham. Because of NAFTA, he said, the government could never consider tampering with the drug patents. Prime Minister Chrétien pleaded for understanding. Canada was bound by trade agreements "unless an epidemic broke out or something like that," he said.

Then in 2001, the Chrétien Liberals passed another law giving even more rights to the drug companies. The only concessions Canada had kept from its former drug patenting regime were to allow Canadian firms to produce and stockpile generic equivalents of patented medicines for future commercial sale before the patent period has expired and a grandfathering of seventeen-year patents for pharmaceuticals approved prior to 1989.

Through the WTO/TRIPS regime, the European Union challenged the "stockpiling" practice and the U.S. challenged the grandfather clause; the WTO ruled against Canada in both cases, and, in spring, 2001, Canada passed Bill S-17, bringing Canada into compliance with the new rulings. The patents for roughly thirty commercially significant drugs had come under the grandfather clause; these were granted three more years of grace before the generic firms could sell cheaper versions of the medicines, producing a windfall of \$200 million for the big pharmaceutical companies.

During hearings for Bill S-17, then Industry Minister Brian Tobin was reminded of his former position on drug patents by Senator John Lynch-Staunton. The Senator remembered that Tobin predicted that Bill C-91 would cause "festering wounds...inflicted on the exposed ankles of Canada's poorest citizens." Why the change? Lynch-Staunton asked. "Senator," replied a smil-

ing Tobin, "you obviously have not heard that there was a very effective ankle cream developed as a result of the drug regime in this country. The ankles of this country are in very good shape."

For a while, it seemed that Canadians concerned about rising drug prices had a friend in former Health Minister Allan Rock who openly chastised the brand-name drug companies for being greedy. It is widely rumoured that as health minister, Rock clashed with John Manley when he was industry minister over Manley's strong support of trade patent rules.

But upon becoming industry minister in the January, 2002, cabinet shuffle, Allan Rock defended the patent system. "I believe firmly in the law. I want to protect the law on patent rights," he declared in his first official statement. He added, "The patent law is there to protect and encourage innovation and to reward those who have new ideas. That's how civilized societies do that, by granting a period of market protection, so people who have innovated can be rewarded."

A Clear Agenda

It is fortunate, indeed, for the transnational drug companies operating in Canada that they have friends in Ottawa, for they have very specific goals. They want to block the export of Canadian generic AIDS drugs to the Third World. They want to be allowed to advertise drugs directly to consumers, as they do in the U.S. The industry is also worried about a proposal to require better cost-benefit analyses of new drugs before they are approved by Health Canada. Currently, drugs must be shown to be safe and effective, but not necessarily good value for the price they command.

The drug companies also want to protect their privileged position at the Health Protection Branch of Health Canada, the agency whose mandate is to ensure that our food and drugs are safe for use. The Branch is under new marching orders from Industry Canada to run more as a commercial enterprise and has been told to "make Canada the preferred place of business from a regulatory point of view." With its funding slashed to the bone, the Branch now depends on fees paid by the transnational drug companies to provide at least 70 percent of its budget for drug approvals, making the companies "clients" of the Branch.

Another high priority of the brand-name drug companies is to preserve the regulations governing patents. And they are lobbying to protect their privileged status under the 1993 patent regime which allows them to stop Health Canada approval of a generic drug dead in its tracks simply by alleging patent infringement.

For example, as thoroughly described by Glen McGregor of The Ottawa Citizen, Anglo-Swedish pharmaceutical giant AstraZeneca has enjoyed a Canadian patent on Losec, a drug used to treat ulcers and heartburn, giving it the exclusive right to market the drug in Canada. Losec is a money-maker for the company; its global sales in 2000 were well over \$6 billion (US). Two years ago, AstraZeneca's patent expired and the Canadian generic Apotex announced that it was ready to go to market with a much cheaper version of Losec.

This should have been a win/win situation. AstraZeneca has made huge profits on the drug, repaying its original investment many times over. Canadians would now have access to a much cheaper version of the drug and provincial governments would save money. Losec sales in Canada account for approximately 3 percent of Canada's annual \$11.4 prescription drug bill. In Ontario alone, the generic Losec would save the government \$38 million each year.

But AstraZeneca has taken advantage of Bill C-91, the drug patent legislation that says that a government cannot approve a generic drug if there are disputes over its patent status in the courts. As McGregor explains, a brand-name company can keep a generic product off the market for at least two years simply by alleging a patent infringement. In a process called “ever-greening,” AstraZeneca has filed successive challenges to Apotex that could keep its product off the shelf for years. The giant drug company got approval from Health Canada to sell its product as a tablet, instead of a capsule, and acquired twenty-year patent protection on the drug in its new form. It also filed new patents on minor modifications of the drug, such as the coating of the pill, changes in the amount of drug contained in each pill, and changes affecting the drug’s interaction with antibiotics.

Each new patent has given AstraZeneca another way to impede Apotex, and other generic drug makers in Canada, by invoking successive two-year injunctions against their products. This process is time-consuming and expensive for AstraZeneca. But it is well worth it; the company figures that it will earn more than \$1 million in sales in Canada every day the generic version is kept off the shelves. What is much harder to understand is why the Canadian government, seeking new sources of funding for medicare, will not challenge this terrible corporate abuse of power that is costing ordinary Canadians so much money.

One Happy Family

One answer may be the close bond that now exists between the ruling Liberals and the foreign drug companies.

The drug companies in Canada have also formed close ties to the governing Liberals through their powerful lobby machine called Canada’s Research-Based Pharmaceutical Companies (Rx&D)—formerly the Pharmaceutical Manufacturers of Canada. Its president is Murray Elston, a former Ontario Liberal cabinet minister whose ties with the federal Liberals are so deep that he chaired their annual fundraising event, the Maple Leaf Dinner, in November, 2001. Jacques Lefebvre is now the director of public affairs for Rx&D. He went there straight from Sheila Copps’s office and he still works in her leadership campaign. Former Liberal Health Minister Marc Lalonde has also worked as a lobbyist for Rx&D.

The Ottawa Citizen has documented the intimate relationship between the industry and the government, including the hiring of senior Liberal backroom strategists and former aides to cabinet ministers by Rx&D members to lobby the government. GlaxoSmithKline Canada has retained Warren Kinsella, former aide to Jean Chrétien; Michael Robinson, who has close ties to Finance Minister Paul Martin; and Jeff Smith, former aide to Heritage Minister Sheila Copps.

Merck Frosst hired Gary Anstey, a close friend and former executive assistant to former Industry Minister Brian Tobin. Derek Kent worked as press secretary to former Health Minister Allan Rock until he joined Veritas in 2000. Veritas is a communications consulting company specializing in health-related issues. Among its clients are Bristol-Myers Squibb, Glaxo, Upjohn, Schering Canada, and Merck Frosst. Chris White is a former executive assistant to former International Development Minister Maria Minna who represented Canada at an international symposium that discussed AIDS drugs for developing countries in 2000. In the summer of

2001, Mr. White joined Glaxo as a full-time lobbyist and initially registered to lobby his former minister—a violation of the government’s conflict-of-interest code.

“For every lobbyist we can hire, they’ve got seven,” says Jim Keon, president of the generic pharmaceuticals group, the Canadian Drug Manufacturers Association. “In our industry, you live and die by patent rules. Knowing the system, knowing the politicians, knowing the staffers, has proved to be very valuable to these companies.”

Just how much clout these global drug giants have in Ottawa became clear in October, 2001, when the Ministry of Health bought the anti-anthrax drug Cipro from the generic firm Apotex instead of from Bayer, which holds the patent. When Bayer threatened to sue, then Health Minister Allan Rock immediately worked out a deal with the two companies in which Bayer agreed to supply the drug at a lower price and got the contract, while the Canadian taxpayer remained on the hook to honour the government’s deal with Apotex as well. (Apotex later agreed to release the government from its contract if its version of ciprofloxacin was not used.) Now, as industry minister, it is Allan Rock’s job to deny countries like South Africa and Brazil the same rights in a much worse crisis.

The Liberals Abandon Medicare

It is becoming blatantly clear that successive federal governments have abandoned an honest commitment to medicare. While they mouth the words about defending Canada’s most cherished social program, they have cut funding, shifted responsibility to the provinces, allowed foreign transnationals into the sector, looked the other way when provinces broke the Canada Health Act, and done nothing to curb the skyrocketing costs of drugs.

But there is a more insidious story to be told here. The Chrétien Liberals have actually abandoned medicare because it is in the way. The Chrétien Liberals view health care as an industry, one in which Canada has expertise to export to the world. They are, in fact, actively, if quietly, seeking global markets for Canada’s health care industry. The twist is, of course, that we cannot ask other governments to open their health services sectors unless we are prepared to reciprocate.

Matt Sanger documents how Industry Canada and the Department of Foreign Affairs and International Trade are working together to expand global markets for Canadian health services exports. The approach adopted by the federal government, working closely with commercial health corporations, is to identify the “barriers to market access” that exist in other countries and that block Canadian health industry exports. These barriers in other countries are often exactly the kind of domestic protections that have been put in place in Canada to keep health care accessible, public, and non-profit. (Health Canada is not the only department selling its wares internationally. Canada Post is negotiating to operate the postal service of Bulgaria on a for-profit basis. Bulgaria must sell off its state assets in order to qualify for a \$300 million (US) loan from the International Monetary Fund. Under the rules of international trade, Canada might be required to open its postal service to competitive bids as a right of reciprocity.)

DFAIT’s “Trade Team Canada” committees commissioned a series of studies which define the Government of Canada’s export promotion priorities. The Canadian International Business

Strategy (CIBS) reports, which guide interdepartmental committees in their work, have singled out health care, especially telehealth and home care, as a high priority area for export growth. Citing a claim that the potential global market for direct patient telehealth services is now estimated to be worth at least \$800 billion (US), the CIBS targets the domestic regulations and standards in other countries that would prevent Canadian, for-profit telehealth companies from entering those markets.

Sanger points out that the measures Canada has targeted for elimination are of crucial importance to the viability of any country's health system: maintaining professional standards and qualifications, guarding against malpractice and fraud, containing costs, and ensuring patient privacy and confidentiality. "To identify them as 'barriers to market access' for Canadian telehealth exports is to target in other countries, the counterparts to the regulatory regimes which support the Canadian health system."

Shockingly, Industry Canada recognizes that the commercialization of Canadian health care is a necessary condition for the promotion of Canada's health exports abroad. In a 1998 report on sector competitiveness, the department praises health "reform" practices such as reduced public funding, increased revenue generation, and increases in privately funded services. The CIBS claims that Canada has the potential to capture 10 percent of key world telehealth markets by the year 2005, "provided domestic barriers to growth are addressed."

In another, earlier report on future markets for Canada's health services, the department says that the small size and domestic orientation of Canada's health industry renders it uncompetitive and calls for the consolidation of Canadian providers with "foreign" companies to make them competitive. While Industry Canada recognizes that profiting from "market potential" is primarily the responsibility of private companies, "governments have an important role to play in setting the business climate at home, in managing the Canadian regulatory regime, and in supporting international business development."

Business in the Lead

Not surprisingly, big business is sitting at the head of the table as these studies are being designed and decisions are being made. The chair of the Medical and Health Care Products & Services SAGIT (Sectoral Advisory Group on International Trade), which advises DFAIT on trade in this sector, is none other than Brian Harling, vice-president of corporate affairs for MDS Inc., a company that led the commercialization of diagnostic health services in Canada and has become what Colleen Fuller calls "Canada's largest and most aggressive health and life-sciences corporation." MDS Inc. and other health care corporations have direct access to International Trade Minister Pierre Pettigrew and all of the trade negotiators. In a March, 2000, letter to the Minister, Harling made it clear that Canada has to be prepared to open up its own barriers to trade in health care. "The SAGIT is supportive of any opportunities for Canadians to increase their ability to offer their services internationally. Members cautioned that there would be a price to pay, i.e. granting similar opportunities to foreigners."

It is a wonder, then, that Pierre Pettigrew could look Canadians in the eye and assure them that new services negotiations do not pose a threat to medicare while, at the same time, his negotiators were listing health insurance as a tradeable commodity under the GATS. And it is a won-

der that former Industry Minister John Manley can aspire to become prime minister of this great country even though he presided over a department openly undermining the principles of the Canada Health Act. Or that Health Minister Anne McLellan can claim to speak as the national voice of medicare when she herself has publicly supported opening the Canada Health Act to allow for private hospitals, and when her own department has forged a partnership with DFAIT and Industry Canada to promote a thriving domestic, for-profit health care industry in Canada for export.

Ed Aiston, director general of the International Affairs Directorate of Health Canada, has said that his department has come to the realization that, "investment in health is beneficial to the Canadian economy and part of the understanding in our Department that Health Canada is not only a regulatory body but also needs to be an ally of the Canadian business community." Aiston says that Health Canada's goals include efforts to harmonize the regulatory framework governing Canada's health sector with global rules—efforts that will "make us key partners in the Canadian export of medical and pharmaceutical products and in the promotion of foreign investment in Canada." He adds that these initiatives are "carried out in full recognition of the lead of Foreign Affairs and International Trade Canada and Industry Canada."

What can one say of such hypocrisy? The Chrétien Liberals were elected in no small measure on their promise to protect medicare, our most cherished social program. The vast majority of Canadians support medicare and want it strengthened, not weakened. But the Liberals, like the Mulroney Conservatives before them, have aligned themselves, politically and ideologically, with the big business community. In doing so, they have adopted all the soul-destroying values of the global economy. These values cannot coexist with the values of public health care—values such as equity, justice, and democracy. These politicians, along with many of their provincial counterparts, have betrayed the Canadian people.

PART EIGHT

The Way Ahead

HOW WILL ORDINARY CANADIANS SAVE MEDICARE? WELL, WE CAN START BY GETTING INVOLVED, really involved.

Commissions, Commissions

Right now, health care is at the top of the country's political agenda. Provincial governments are threatening that, without more federal money, they will be unable to deliver quality care. There are two federal inquiries—The Commission on the Future of Health Care in Canada, led by the former Saskatchewan Premier Roy Romanow, and the report (a five-volume opus) of the Senate Committee for Social Affairs, Science and Technology led by Liberal Senator Michael Kirby.

On the question of why the federal government would set up two inquiries on Canada's health care system at the same time, one can only speculate that it wants options. If the Romanow Commission, for example, were to echo the recommendations of the earlier report of the National Forum on Health Care, whose 1997 report called for a strengthened universal system, the Chrétien Liberals will likely have a competing set of recommendations before it in the Kirby report, and can announce that Canadians are "divided" on the subject.

We can only hope that the Romanow Commission takes such a position, as early reports from the Kirby Committee leave no doubt about its for-profit bias. Its very language is commercial, including such terms as "consumers," the "health care industry," and "customer service." The Canadian Labour Congress says that volume four of the preliminary Kirby Committee papers on issues and options could be called "Let us count the ways we can entrench for-profit health care into the public system." This might not be a surprise, considering that Senator Kirby has been a director of Extendacare, a for-profit, long-term care corporation, since 1985.

Then there are a number of recent provincial reports, including that of the Clair Commission in Quebec, which called for the adoption of a policy framework of partnership with the private sector and contracting-out of new, long-term care and nursing home facilities; the Saskatchewan Commission on Medicare, which rejected user fees and called for primary care health centres with multidisciplinary, health service teams and the provision of prescription drugs as part of the public health system; and the January, 2002, report of the Alberta Premier's Advisory Council on Health, led by former Conservative Deputy Prime Minister Don Mazankowski, now a director with Great West Life Insurance.

As expected, Mazankowski's report, *A Framework for Reform*, stirred up a storm of controversy around the country. It called medicare an "unregulated monopoly," and called for more private sector involvement, delisting of many currently listed services, requiring patients to pay some of their medical bills, and more choice, competition, and "accountability" in the system. Premier Ralph Klein immediately endorsed the spirit of the report and announced increases in health premiums that could cost some families another \$500 a year.

The most contentious recommendations centred around how to structure patients' payments for treatment: the report called for further study on "medical savings accounts" (MSAs), a plan by which a set amount of cash would be put into a separate account for each individual Albertan's yearly health costs. Money is deposited into the account each year, either through the payment of premiums or through a joint payment of premium and government supplement. This money is then paid out for the individual's health care, with leftover funds being rolled into the next year. If more money is required than is in the account, then the individual must pay his or her own costs up to a predetermined maximum, at which point the government would chip in. The adoption of this proposal would take the government out of the health insurance sector altogether, opening it up to private insurance companies and the governance of the trade agreements.

Because the leftover money is rolled over into the account for the next year, MSAs have the effect of rewarding the healthy and punishing the ill. People could "shop around" for services with the money: healthy people would be able to buy top-of-the-line diagnostic and preventative health care services; those suffering from a chronic illness, or a catastrophic illness early in life, would end up scraping the bottom of the health care barrel. The availability of private health insurance to those healthy and wealthy enough to afford it would add another layer to this inherent inequity. Not surprisingly, this proposal, like much of Mazankowski's report, is considered a direct challenge to the Canada Health Act.

The True Experts

It is very important that Canadians become involved in the processes of these commissions and studies. Not being an expert on an issue as complicated as medicare makes many people feel inadequate; they feel unqualified to appear before a panel or to submit a brief in writing. This works to the advantage of the government; if it can establish a bureaucratic, inaccessible process that intimidates people who have concerns and opinions, but are not authorities in the field, it can control who appears before the commissions and make the outcomes difficult for non-experts to understand or criticize.

This is wrong. *Every Canadian is an expert on health care.* We have all come to rely on medicare. Some of us have experienced a deterioration in access in recent years. Some of us have had to pay user fees, or fight to get decent home care for our parents. Older Canadians are experts on what life in Canada was like before medicare; no "expert" who wasn't alive in the 1930s and '40s can really tell us what a fee-for-service system means for those who cannot pay. Canadians need to speak up about what we know, what we have experienced, and what we want.

Around these commissions and beyond (for this debate will not end when these reports are tabled), today's Canadians have to learn from our parents and grandparents who did not wait for experts, professionals, or specialists to give them permission to fight for their rights. Ordinary Canadians from one end of the country to the other fought hard for our right to medicare. Unless we put up a similar fight now, and put in motion a counterweight to the corporate juggernaut on the other side, we will surely lose universal health care in Canada. Now is the time for Canadians to speak out loudly and firmly: medicare is not a privilege; it is our birthright, and we will not allow it to be taken from us a piece at a time.

We won't be alone. There are a number of national, provincial, and local organizations working to save medicare who are happy to share materials, fact sheets, and briefs with other Canadians. The Canadian Health Coalition (CHC) is an umbrella organization with many members. In its excellent submission to the Romanow Commission, *Standing Together For Medicare: A Call to Care*, the CHC presented a detailed set of recommendations on protecting health care from commercial exploitation and trade agreements, federal financing of health care, needed extensions to the Canada Health Act to include home care and pharmacare, and a whole host of other areas.

A number of unions, including the Canadian Labour Congress (CLC) and the Canadian Union of Public Employees (CUPE) work closely with citizens' groups such as the Council of Canadians, and have also presented detailed briefs to the Romanow Commission. Nurses are taking leadership in this fight. The Canadian Federation of Nurses' Unions, the largest federation of nurses' unions in Canada, representing 120,000 registered nurses, has been at the forefront of the fight not only to protect universal health care, but also to create better working conditions for front-line health care workers. Also involved are the Canadian Nurses' Association and provincial nursing registration bodies.

Every province has local groups and coalitions, such as Alberta's Friends of Medicare, and the Council of Canadians has over seventy local chapters keen to work with others to save and expand medicare. Contact information for these national and provincial groups is given at the end of this chapter.

New Beginnings

Canada's health care system is at a crossroad; every Canadian must become involved in this vital dialogue about our future. At the beginning of this new millennium, we have a unique vantage point. We can go back into our history and choose to re-commit to the aspects of the original system we want to retain, while building a system that will work for Canada now and in the future. For example, while Canadians continue to cherish the public delivery of health care, they want more local control and to be seen as knowledgeable partners in their own care. In a country with an increasingly diverse population, a "one-size-fits-all" model is less and less attractive or realistic. And the reality is that the provinces, more than ever, are the major parties in organizing and providing health care for their citizens. It is unlikely that, after being handed so much authority by federal governments intent on minimizing the national presence in health care, the provinces will be willing to hand it back easily. And yet, without a strong federal presence in the protection and enforcement of national standards and values, the system will break up into a patchwork of regional programs, and Canadians will once again be subject to punitive conditions in some provinces.

Terence Sullivan and Patricia Baranek argue that there are essentially three possible scenarios before Canadians: the *Rigid* scenario, which would mean muddling along more or less as we have been, watching the system deteriorate over time; the *Retail* scenario, in which consumer "freedom" trumps the current rights of citizenship, the scenario clearly preferred by the current governments of Ontario, Alberta, and British Columbia; and the *Resilient* scenario, in which new federal transfer conditions are imposed on the provinces to extend a base of flexi-

ble public coverage to home care, long-term care and pharmaceuticals, but which would allow each province to design its own plan under the federal standards to qualify for federal transfers.

Sullivan and Baranek admit that federal-provincial squabbling has hindered the creation of such a new health care project for Canada. But even if the federal government were to pour a lot of money into transfer payments, without a renewed joint commitment to the principles of the Canada Health Act, this money would function as a “green poultice” on a set of problems that require political resolve, not just more money.

So it is time for ordinary Canadians to demand a renewed commitment to the Canada Health Act in order to renew our collective commitment to a publicly funded, universal, accessible, non-profit health care system that is every Canadian’s birthright. A national health program should be based on foundations that every Canadian can articulate.

Foundations of a National Health Program

1) Profit is Not the Cure

The most pressing problem with Canada’s health care system is that the profit motive has caused some costs to spiral. This has given some provincial governments and medicare opponents an argument for privatization. Costs for our health care system are out of control, they argue; the system needs the “discipline” of the market to bring them into line.

A recent study on health care costs done by the Canadian Institute of Health Information clearly shows that the growth in health care spending from 1998 to 2001 was greater than in any other four-year period in the past twenty-seven years, and that costs are going to continue to climb. (It is important to remember, however, that, even with this growth, health care spending in Canada is still lower as a percentage of GDP than it was in 1991.) While hospital costs still account for the largest share of expenditures, they are decreasing over time, as many people are being sent home to be cared for. The major factor in *rising* costs, says the Institute, are spiralling drug prices and wage hikes for health care administrators and physicians. Both of these areas are outside the jurisdiction of the Canada Health Act, although the regulation of drug patents, the single biggest factor in the cost of drugs, is the sole responsibility of the federal government.

Some CEOs of hospitals are making \$500,000 a year, and administrative costs due to the high salaries paid to professional managers in medical institutions are constantly increasing. While most doctors are hard-working, honest, and conscientious, the system has allowed some to rake in huge salaries and perks, such as bonuses and houses offered as incentives to relocate. In Ontario, more and more doctors are being exempted from government-imposed caps on how much individual physicians can bill. In 1999-2000, 471 Ontario doctors were exempted; several of these billed in the million-dollar range. And, as documented earlier, drug prices under the NAFTA-imposed patent regime have allowed the big pharmaceutical companies to cream off huge profits as prices rise and rise some more.

Let us be very clear: it is not the public, non-profit part of the system that is driving costs up. When health care is treated as a public service, it can be delivered very well at low cost. When it is a business, it must realize a profit for someone in the system. Investors expect profits in the range of 15 percent annually. The more the health care system is run as a business, the more it

will be squeezed for profit all the way down the line. (Ironically, to make money in health care, the private sector must promote opportunities for health care services; hence, it is more profitable to put the emphasis on illness rather than prevention.)

Study after study in other countries show that market forces in health care cause costs to rise and efficiencies to fall. For-profit hospitals and clinics cost more to operate, charge higher prices, spend far more on administration, and often provide poorer services than non-profit institutions. Private operators must pay for expensive marketing campaigns and invest time in investor relations. And private clinics make waiting lists longer. Channelling funds to the private sector makes the wait for the vast majority, who can't afford private care, much longer.

New Zealand predicted up to a 30 percent reduction in its health care costs with privatization. In fact, there was a 30 percent *increase* in costs as well as a substantial increase in waiting time for treatment. With the privatization of their health care system, 40 percent of Australians found themselves with no public insurance whatsoever and thus were relegated, when sick, to second-rate teaching hospitals.

In Great Britain, which decided it could have it all, a universal health care system and private health insurance schemes, medical specialists are allowed to treat private patients (who go to the front of the waiting list) in public institutions, thus leading to a doctor-drain from the public service. Meanwhile, according to Dr. David Wright of McMaster University, the drive to keep health care costs down has led to registered nurses' salaries so abysmally poor that recruitment and retention in the profession constitute a crisis.

If medicare is privatized, the Canadian Federation of Nurses' Unions argues, the cost won't be reduced for governments, who will have to offer health insurance to their own workers. And business will come knocking on the taxpayers' doors looking for tax subsidies for the new health insurance costs they will incur as well. The providers of private health care will want tax breaks too. Privatization is a losing proposition for all but the big insurance companies, private service providers, and drug companies.

It is essential that Canadians not allow this debate to become one of rich versus poor. A healthy society is good for all. One of the reasons that many countries originally adopted a public health system was to stem the spread of communicable diseases such as typhus, polio, tuberculosis, and sexually transmitted diseases. Being wealthy did not guarantee personal safety then. It will not guarantee it now. A society divided by the ability to pay for basic health would be the worst possible outcome for our country.

The Canadian people must insist that the profit motive be removed from our health care system at all levels of government; that the federal government strictly enforce the Canada Health Act in order to ensure universal access to services and immediately move to halt the practice of extra-billing, user fees, and private hospitals, by whatever name they are called; and that a moratorium be placed on public/private partnerships.

2) Medicare Only Went Halfway

The rise in the cost of the private sector operating in Canada's health care system can be traced back to the compromise made when medicare was first implemented in 1966. As Colleen Fuller

points out, Canada adopted a hybrid of a fully public system, that would have been run like public education, and a private system, such as the one that has grown up in the United States. Medicare is a tax-based, public insurance system that pays for health services supplied mainly by the private sector.

Over 95 percent of hospitals in Canada operate as private, non-profit entities, and are run by community boards, volunteer organizations, municipalities, or regional health authorities. Hospitals are funded by governments to provide publicly insured hospital care, which often does not include the full spectrum of outpatient rehabilitation, counselling, nursing, home care, dental care, or long-term care. Most doctors and specialists are private entrepreneurs who negotiate fee-for-service payments with provincial governments through their professional associations.

Fuller explains that Canada's model of public payment and private provision originally let Canadians build on the principles of non-profit delivery to establish an equitable health system. But as the role of for-profit businesses has expanded, the split between payer and provider has burdened Canadians with unnecessarily high costs. Canada's model has failed to achieve the full benefits one would normally expect to see in a tax-supported health system. These include the benefits of continuity and integration of services. Fuller writes:

Canada's health financing arrangements do not allow the governments that fund the system to manage services provided by private entities or to prevent private companies from duplicating services delivered in the hospital sector. Governments cannot tell companies to locate in sparsely populated rural communities or to ensure that a full spectrum of population health needs are met, because the mandate of private corporations is to provide a service if the service provides a return on investment—no more and no less.

While the 1984 Canada Health Act banned extra-billing and user fees and established clearer rights to health care for all Canadians, it did not define "medically necessary services," thus allowing the growth of a private industry in a number of fuzzy areas. However, with its five core principles, the Canada Health Act could be strengthened to address these concerns. Funding health care through an insurance mechanism is failing to protect and maintain Canada's non-profit system of delivery, and is obstructing the development of more affordable non-institutional alternatives such as community clinics and home care. It is time for Canadians to start thinking about a completely public, in both funding and delivery, health care system. The kind of health care system Canadians want will not materialize unless and until we bring services, as well as payment, into the public sector.

This would mean ending the fee-for-service method of paying doctors—a proposal that is less contentious than many would think. Doctors in private practice have high overhead costs and few benefits. As well, doctors who believe in service find themselves at a disadvantage compared to those who view their professions as a business. Increasing disparities in income and working conditions fuel anger among many doctors. A 1999 Canadian Medical Association physician questionnaire found that only 33 percent of doctors favour the fee-for-service arrangement.

Further, many services delivered by health care professionals other than doctors are not covered under medicare or the Canada Health Act, nor are services delivered outside of hospitals. These include home care, long-term care, rehabilitation services, primary health care, dental care, and

pharmaceuticals, when provided outside of hospitals. These omissions were not intentional; the covering of doctors and hospitals was merely seen as the first step in a more complete process. Since most health care was delivered in hospitals and by doctors at the time medicare was enacted, the coverage appeared adequate. But it is clearly inadequate today, as more and more care is shifting outside of institutions, and the cost of drugs is rising. Whether, for instance, MRI equipment is in or outside the confines of a hospital, MRI testing should be provided and paid for out of the public purse.

The Canadian people must insist that federal funding for health care be returned to at least 25 percent of total spending and tied to spending on health care; that this take place with the intent to move, over time, to a fully funded and serviced health care system; and that home care, long-term care, and pharmaceuticals be included in the plan and, as they are, the federal portion of health care funding should move to 50 percent.

3) Nurses Have Many Answers

Another consequence of the direction in which our health care system has been going is the devaluation of the role of registered nurses and other, front-line health care practitioners. Registered nurses provide 75 percent of the hands-on professional care in the system today. But Canada is short about 20,000 registered nurses and, if the problem is not addressed, the shortage will be five times worse by the end of the decade. There are many reasons for this development.

Registered nurses are poorly paid. Nursing departments and senior positions in nursing were removed with the restructuring of many provincial hospitals and health care systems. The result is that registered nurses operate more than ever under the direct control of doctors and administrators. They have also been sacrificed in cost-cutting exercises and qualified nurses have been replaced by unqualified caregivers in many provinces. And where home care has been privatized, registered nurses have had to accept lower wages, part-time work, and no benefits in order to stay employed. As a consequence, almost half the registered nurses in Canada are now part-time or casual.

Whether by design or by accident, this has meant the loss of registered nurses' voices in many health care institutions just as they were becoming more powerful. It is hard to be part of a "caregiver family" when you are running between three jobs. Those who still have full-time jobs are over-worked, over-stressed and disillusioned. Registered nurses lose more time to illness and injury than the members of any other profession in Canada. The entire nursing workforce is aging (the average age is 43.4 years) and approaching burnout.

Doris Grinspun, the executive director of the Registered Nurses' Association of Ontario, has an explanation. She says the new, denigrated role of registered nurses in the health care system is a reflection of the struggle between a caring paradigm that requires providing appropriate resources to enable care, and a health care system conceptualized as an industry where a concern for cost-cutting dominates. Registered nurses insist on quality care; they don't look to the bottom line. They see the patient as a whole person and have fought the "unbundling" of nursing care into a series of tasks distributed to various untrained and unlicensed "service providers." The new system in many hospitals that operate as a business, says Grinspun, is the "antithesis of patient-centred care."

Lieutenant Colonel (Ret'd.) Shirley Robinson, who served as a nursing officer in the Canadian military for thirty years and was director of nursing at the National Defence Medical Centre, finds this situation ironic. Registered nurses are assumed not to understand the hard realities of the bottom line, she says, even though when they ran hospitals, they were clean, efficient, safe, and inexpensive. Service was the goal. There were inspectors to ensure cleanliness, guard against wasteful practices, and fight infections.

Their main focus was the patient, says Robinson, and they knew what the patient needed. With registered nurses so overstretched, she asks, who is now defining quality care? "Not the doctors, you can bet on that. And not the CEOs. They never wiped a bum in their lives. Now the personal, physical, emotional and spiritual lives of patients are neglected." Robinson says that today, physicians, provincial governments, hospital CEOs, and hospital boards have all come to have too much power in the system. The power, she argues, should be in the hands of the public through those who work on the front lines in health care.

Meanwhile, Canada now has more doctors than ever before—one doctor to every 550 Canadians compared to one to 950 in the 1960s. In *Revitalizing Medicare*, Michael Rachlis, Robert Evans, Patrick Lewis, and Morris Barer note that, in spite of these statistics, a persistent rumour about doctor shortages continues to circulate. The apparent contradiction, these medical experts and practitioners argue, can be explained by the fact that, on average, each doctor is providing less comprehensive services. In general, fee-for-service schedules pay much more for procedural than for cerebral services. "Put more crudely" they say, "the health care system pays more to cut and prod than listen and think and during the past thirty years, physicians have responded to that by gradually shifting their practices away from those services that take up relatively more of their time per dollar of reimbursement."

As the system becomes doctor- and specialist-centred, it also becomes much more expensive. Patients are forced to go through doctors for help they could find through registered nurses, nutritionists, social workers, and other salaried caregivers. A system based on fee-for-service is bound to cost more money. Well-trained, eager registered nurses are being bypassed by the system in the name of cost-cutting, when they are actually part of the answer to rising costs.

Tom O'Brien, who helps federal and provincial nurses' unions such as the Nova Scotia Nurses' Union fight for their rights, says that the biggest irony lost on the movers and shakers who make these decisions is that registered nurses are consistently rated by the public as the most honest and reliable professionals of all—more trustworthy than physicians.

The Canadian people must insist that governments and decision makers in the health care system equalize the power base between doctors and other health care workers, especially registered nurses; that hospitals guarantee that a minimum of 70 percent of registered nursing positions be full-time and provide adequate and stable funding to ensure improved working conditions for registered nurses and other front-line health care practitioners; and that nursing unions be guaranteed a role in all decision-making about the future of health care.

4) Community-Based Primary Health Care is the Model

In *Towards a Sustainable, Universally Accessible Health-Care System*, a discussion paper for the October 2000 National Nursing Forum, five nurses' unions lay out a blueprint for an exciting

health care vision. It is called primary health care. As the authors explain, for decades, universally accessible, primary health care services have been recognized as critical for any really effective health care system. The concept of primary health care is a comprehensive approach to health care that includes all factors that influence health. The approach has won wide acceptance around the world.

Colleen Fuller sees it this way:

Such a system would be based on federal criteria, with community input and control, providing a broad spectrum of primary health, social, and related services available in one location in each community. Community-based clinics would feature teams to deliver a full spectrum of care, from family counselling and physiotherapy to inoculations and eye examinations; an emphasis on prevention, health promotion, education services, and community development; and salaried remuneration of physicians and other health care professionals.

This model is not to be confused with primary medical care, which is currently covered under the Canada Health Act and is delivered by physicians focusing on illness-oriented care at the expense of health promotion and illness prevention. Primary medical care underuses the knowledge, skills, and expertise of other health professionals, such as registered nurses, and it misses important opportunities to create health in the population.

Primary health care, on the other hand, includes concepts such as health promotion, illness prevention, rehabilitation, and preventive care along with curative care. The other key dimension to primary health care, says the report, is the strong community component, both in terms of decision-making and in terms of the importance of a community development, healthy community emphasis. Through delisting and other privatization practices, as well as the fact that home care and long-term care are not currently deemed to be covered by the Canada Health Act, the current delivery of primary health and preventative care is disorganized, underfunded, and threatened by a growing for-profit industry wanting to get its hands on this market.

The nurses' unions have identified five key elements to a comprehensive primary health care system: universal access to a defined range of primary health care services in which there would be no preconditions for care and no one could be dropped; services that are accessible twenty-four hours a day, seven days a week; Primary Health Care Groups (PCGs)—multidisciplinary primary health teams made up of physicians, nurse practitioners, registered nurses, therapists, social workers, midwives and other providers—would facilitate the provision of primary health care: the provision of services based on the needs of the community rather than the availability of the provider; and funding for the system would be based on the needs of the population served. It is clear that, for a primary health care system to be effective, the community would have to be a full partner with the PCGs.

There are many rewards of such a health system, not the least of which is a substantial reduction of costs. Most hospitals have patients in acute care beds who would be better served in good long-term care facilities or at home with adequate home care for less cost. By avoiding more costly intensive and chronic care later, valuable resources are saved for the system. Primary health care also provides a significant relief for emergency services, which also saves

money. All hospital emergency rooms are filled with patients who shouldn't be there but who have no alternatives. As well, properly funded and supported home care for the elderly, for instance, is often preferable and cheaper than institutionalization. If the profit motive were removed from elder care, more support could be given to home alternatives.

The Canadian people must insist that governments and decision-makers in the health system equalize the power base between the hospital sector and other health sectors such as elder care, home care and community care; that a true, community-based primary health care model with care available twenty-four hours a day, seven days a week, delivered by interdisciplinary teams of health care professionals be adopted; and that the federal government introduce legislation stipulating conditions for federal funding of these programs, including home care, long-term care, and pharmacare, on a 50/50 basis.

5) Economic Globalization is Wrong

The federal government and many provincial governments have endorsed the Washington Consensus principles and practices of economic globalization. These include deregulation, privatization, government downsizing, decentralization, global competitiveness, and free trade. The values embodied in economic globalization are anathema to the values that underlie universal, public health care.

As the Canadian Health Coalition explains, Canada's international trade policy objectives for the biotechnology, pharmaceutical, food, and health services industries are incompatible with its stated goal to protect Canada's health care system from the rules of international trade. Two of the government's stated policy objectives of "trade liberalization," the coalition notes in its brief to the Romanow Commission, are to extend private commercial activity in all sectors, including health care, and to reduce the jurisdiction and power of national governments, Canadian and foreign, in health services and health regulation.

Under the rules of international trade, Canada is absolutely obliged to reciprocate when other countries open their markets to Canadian pharmaceutical, biotechnology, medical device, home care, health information technology, and health industries. As well, governments in Canada have become captive to the demands of large corporations, which play an increasing role in economic and social policy, and which cultivate unseemly close political ties with elected representatives.

The Chrétien Liberals receive unprecedented corporate donations every year, including donations from the large insurance, pharmaceutical, and health industry companies. Many former Liberal advisors and MPs are highly paid lobbyists for the many private sector companies working to undermine universal social and health programs. It is impossible for any government to take principled, unbiased political positions when it is beholden to the private sector for financial patronage. In essence, Canada has adopted all the values of a "corporate state" and, in so doing, has abandoned its legacy of sharing for survival.

This has meant a new and different role for Canada on the international stage. As Matt Sanger points out, Canada is now undermining international efforts to develop universal health care. The tragic consequences of treating health as a market commodity are most starkly evident in

the AIDS pandemic in South Africa, he says, and our government's effort to "brand" Canadian health companies as "global healthkeepers" is morally repugnant.

Instead, Canada should join leading health experts in their efforts to build international mechanisms for addressing health as a "global public good." This would mean ensuring that international collaboration to advance health is not obstructed by trade rules, and strengthening the World Health Organization as a body to promote and oversee a public, universal future for health care.

The Canadian people must insist that Canada negotiate an airtight general exemption in all trade agreements for health care systems, including services and insurance, and negotiate the inclusion of the Precautionary Principle into all international trade agreements; that the Canadian government repeal Bill C-91, thus breaking the monopoly of the big drug companies in Canada, while negotiating changes to the intellectual property rights provisions of international trade agreements to break the same monopoly in other countries; and that Canada renew its heritage of enlightened internationalism by working to establish health as a global public good and supporting international efforts to bring universal health care rights to all peoples.

A Call to Action

Medicare, Canada's most precious social program, will not survive the current assault unless Canadians from all parts of the country, all walks of life, all ages, and all cultures come together to save it. Our universal system was won by ordinary people with an extraordinary dream; we must not allow it to be taken from us by those with a private or political agenda.

Medicare is threatened from within by those who would profit from the knowledge garnered by generations of dedicated health care professionals who believed in a public system, and from without by international trade agreements designed to force governments to relinquish their public services to the private sector. Waiting in the wings are powerful transnational health care and drug corporations who seek to gain control of health care services around the world for their profit. They are very determined.

If Canadians do not move quickly to save medicare it will be lost, and it will be very difficult to retrieve it later. We must do more than speak out, however, against the forces who would destroy public health care, and we must do more than defend the status quo. We must launch a proactive campaign for a national health program based on the completion of the original plan for medicare.

A community-based primary health care system is the answer to the question, "How will we save medicare?" We must embrace a clear, alternative health care system based on a workable, affordable and improved model. Canadians can have top quality, publicly funded health care that is fair and economically sound by embracing the best from the past together with the urgent changes that are needed.

There are so many other innovative ideas and recommendations to examine. In recent years, those who work on the front lines of health care have provided us with innovative and practical ways to save and improve medicare. The National Nursing Forum has called for a national health advisory council, which would bring together federal and provincial health officials as

well as practitioners and the public, to raise the level of collaboration among the various sectors of the system. This advisory council would be charged with establishing better cooperation among the different levels and sectors, monitoring programs, doing away with duplication, identifying “best practices” guidelines, and performing an accountability service.

But none of this can be realized if we continue on down the for-profit health care path we are currently on. Medicare is threatened as never before. Never has there been a more urgent time for Canadians to stand up and be counted. Write to your members of Parliament and your MLAs. Write to your local newspapers. Talk to your neighbours. Support registered nurses and let them know that you appreciate their vision. Go before the Romanow Commission and tell it how you feel. Join the Council of Canadian’s campaign to save medicare and come out to our meetings. Support the Canadian Health Coalition and your local coalitions as well. However you choose to do it, stand up and be heard.

If ever we Canadians took our public system for granted, now is the time to stop. As senior John Milne of Vancouver says, “it’s good to remind this generation who grew up on medicare that the bad old days aren’t any further away than the Beatles.”

Perhaps Kathleen Connors of the Canadian Federation of Nurses’ Unions put the case for medicare most poignantly in her submission to the Romanow Commission:

I, myself, have just recently experienced the system from the patient’s side of the bed. I was treated for uterine and bowel cancer for eighteen months. From 1999 through the year 2000 and into the first few months of this year, I received care in hospital, in my home and as an out-patient. The quality of care I received was great—though it’s plain to see that the system is under great strain.

But please be aware that, if I get another catastrophic illness, I will get great care again. Unlike our neighbours to the south, I will receive no call from some silver-tongued insurance agent saying, “Ms. Connors, hearty congratulations on your recovery and it’s been really great to have you as a customer, but unfortunately, you are no longer insurable with our company.”

We can all rest assured that we won’t get that call. At least...for now. That’s not exactly a comforting thought, is it?

APPENDIX

Standing Together for Medicare: A Call to Care

THE FOLLOWING STATEMENT WAS ISSUED FOLLOWING THE CONFERENCE ON THE FUTURE OF HEALTH Care, sponsored by the Canadian Health Coalition and the Canadian Labour Congress, October 12, 2001, Ottawa:

The peoples of Canada believe that health care is a fundamental right of every human being without distinction of race, gender, age, religion, sexual orientation, political belief, economic or social condition. Organizations representing millions of Canadians will mobilize to defend this right and to ensure that the following principles shape the future direction of the health care system.

- 1.** The recognition of the highest attainment of health as a fundamental right throughout life and the necessity of preserving public health through active measures of promotion, prevention, and protection including such determinants as housing, food safety, income, education, environment, employment and peace.
- 2.** The recognition of health care as a public good in which the few must not profit at the expense of the many. We affirm the need for a system of public health care, which is organized on the basis of public administration, public insurance, and the delivery of services on a public, not-for-profit basis.
- 3.** Opposition to any commercialization and privatization of health. Therefore the federal government must negotiate a general exclusion of health services and health insurance from all trade agreements.
- 4.** The need for the federal government to fully assume its responsibilities in respect to health, particularly by restoring and increasing federal transfers to levels sufficient to secure the integrity and enforcement of the Canada Health Act, 1984.
- 5.** The reaffirmation of the original vision of a truly comprehensive public health care system for Canadians providing a continuum of services. The next steps are the expansion of the public system to include a universal system of home care and long-term care services and pharmacare.
- 6.** The need to move away from a fee-for-service model towards a community-based, multidisciplinary approach to the management, organization and delivery of services and care. Levels of services must be sufficient so that the burden of care does not fall on families, mainly women.
- 7.** A health care system that is accountable through democratic participation and governance at all levels.
- 8.** The recognition that health care workers are critical to the effective operation of the health care system and that decent wages, working conditions and training opportunities are essential to high quality care and the retention of health care workers.

Regardless of where we live, it is now imperative to reaffirm the social values we all share. These values must guide our collective choices for future social and public health care. They are incompatible with the commercialization of all public services sought by the international trade agenda.

We believe all governments in Canada must adhere to these values, even though jurisdiction is largely a provincial or territorial matter. Therefore, the principles of the Canada Health Act should be enshrined in the laws of each province and territory.

We come together to commit to direct political action to ensure that governments throughout Canada protect and expand health care based on the foundation of the Canada Health Act, 1984.

What stands between Medicare and its destruction are the peoples of Canada.

Future generations are depending on our vigilance.

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Get Involved! Contacts for Action

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Call 1-800-387-7177 or visit our web site at www.canadians.org

Other Groups working on health care issues (not comprehensive list):

REGIONAL HEALTH COALITIONS

P.E.I. Health Coalition

Tel: (902) 892-9074

Fax: (902) 892-3878

Cape Breton Health Coalition

Tel: (902) 567-7878

Fax: (902) 567-7829

Health Action Coalition of N.S.

Tel: (902) 424-2296

Fax: (902) 424-2111

N.B. Health Coalition

Tel: (506) 488-2407

Fax: (506) 488-2980

Email: bigkranch@nb.aibn.com

Coalition solidarité santé

Tel: (514) 527-4577

Fax: (514) 527-4578

www3.sympatico.ca/louis.roy1/page6.html

Ontario Health Coalition

Tel: (416) 441-2502

Fax: (416) 441-4073

www.web.net/ohc

Manitoba Medicare Alert Coalition

Tel: (204) 944-9408

Fax: (204) 957-1508

Alberta Friends of Medicare

Tel: (780) 986-0463

Fax: (780) 986-7676

www.friendsofmedicare.ab.ca/

Saskatchewan Health Coalition

Tel: (306) 652-0300
Fax: (306) 664-4120

B.C. Health Coalition

Tel: (604) 734-3431
Fax: (604) 739-1526

Toronto Health Coalition

Tel: (416) 929-1545
Fax: (416) 929-8521
toronto_health.tripod.com/thc.html

NATIONAL GROUPS

Canadian Health Coalition

Tel: (613) 521-3400 (Ext. 311#)
Fax: (613) 521-9638
www.healthcoalition.ca

Canadian Federation of Nurses Unions

Tel: (613) 526-4661 and 1-800-321-9821
Fax: (613) 526-1023
www.nursesunions.ca

Canadian Union of Public Employees

Tel: (613) 237-1590
Fax: (613) 5508
www.cupe.ca

National Union of Public and General Employees

Tel: (613) 228-9800
Fax: (613) 228-9801
www.nupge.ca

Canadian Centre for Policy Alternatives (CCPA) - National Office

Tel: (613) 563-1341
Fax: (613) 233-1458
www.policyalternatives.ca

CCPA - B.C. Office

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The Tommy Douglas Research Institute

Tel: (604) 685-7277
Fax: (604) 689-4118
www.tommydouglas.ca

Medical Reform Group

Tel: (416) 787-5246
Fax: (416) 782-9054
www.hwcn.org/link/mrg/index.html

Parkland Institute

Tel: (780) 492-8558
Fax: (780) 492-8738
www.ualberta.ca/parkland

Save Medicare

www.savemedicare.com





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