CANADIAN FEDERATION OF NURSES UNIONS

November 2011

PRIVATIZATION

CANADIAN FEDERATION OF NURSES UNIONS BACKGROUNDER

The situation in Canada

Down from 74.5% in 1990, Canada's health care was approximately 70.6% publicly funded in 2009 — below the OECD average of 71.7%.[1]

Privatization harms the public system

Some claim that opening the door to private care would relieve pressure, but this is untrue.

- For-profit care providers avoid emergency and complicated cases and focus on patients in good overall health, who are well-insured.[2]
- When complications arise, patients are offloaded onto the public system which is forced to absorb these difficult cases and expensive procedures. Low-risk, low-cost and high-reimbursement patients are referred back to their own clinics.[3]
- Private clinics often encourage nurses to keep their employment status in the public system in order to avoid paying their benefits packages, thereby obtaining a public subsidy.[4]
- It is estimated that if 10% of specialist capacity in hip and knee surgery were diverted to the private sphere, average wait times for both procedures would increase by at least 20 days in the public system.[5]
- The Winnipeg Maples Surgical Clinic bought an MRI and lured two technicians away from the public sector; a 20-hour per week reduction in services at the Health Sciences Centre ensued.[6]
- A report *Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada,* released in October 2008, found wait times were highest where privatization was most advanced due to the diversion of financial and human resources from the public sector to private providers. "In at least two provinces, hospitals have been forced to reduce or close down public services due to shortages worsened by staff poaching from nearby for-profit clinics."[7]

Private care: less efficient, more costly

- Efficiency levels at physician-owned centres in the US are often worse than their community hospital counterparts.[8]
- Cataract surgery wait times in Calgary's private clinics were typically more than double those in Edmonton and Lethbridge, cities where a great majority of procedures are done publicly.[9]
- Health spending per capita is 85% higher in the US private system,[10] yet Canada ranks equal or better in health outcomes.[11]
- Predicted savings of privatization deals often turn in to unexpected public costs. *The Telegraph* in the UK revealed that the cost of NHS deals agreed to since 2007 would go up by 25% between 2011 and 2014, and the difference would have to be found in "efficiency savings."[12]

The myth of P3 benefits

In recent years the push towards privatization has taken on a new catch-word: 'public-private partnerships' (P3s). P3s claim to offer quick access to capital and promise to offload financial risks from the public to the private sector.

- The British Commons Select Committee concluded that P3s, or PFIs (private finance initiative) as they are known in the UK, do not provide good value. Andrew Tyrie (Conservative MP) said: "PFI means getting something now and paying later... We can't carry on as we are, expecting the next generation of taxpayers to pick up the tab..." The report expressed concerns that the system was rigged in favour of approval of PFIs and concluded: " The Committee has not seen any convincing evidence that savings and efficiencies during the lifetime of PFI projects offset the significantly higher cost of finance. Indeed, the report raises concerns that the current Value for Money appraisal system is biased to favour PFIs. It identifies a number of problems with the way costs and benefits for such projects are currently calculated."[13]

- Former British Health Minister Frank Dobson notes that, with the rise of P3s, administrative costs in the NHS ballooned from 4 to 15%,[14] while general and senior managers in the NHS rose from 1,000 in 1986 to 26,000 in 1995.[15]

- A study in the *British Medical Journal* relates that the high costs of British P3s have forced managers to find savings elsewhere: external subsidies, the diversion of funds from clinical budgets, the sale of assets, appeals for charitable donations, and, most disturbingly, 30% cuts in bed capacity and 20% reductions in staff in hospitals.[16]

Canada's public-private partnerships

P3 ventures in Canada have not proven any better.

- The Royal Ottawa Mental Health Centre was supposed to cost $95 million and hold 284 beds. It opened with 188 beds at a cost of $146 million.[17]

- Construction of the William Osler Health Centre in Brampton was supposed to cost $350 million and offer 608 beds. The hospital opened with 480 beds and the price tag had almost doubled.[18]

- The Ontario Auditor General, Jim McCarter, criticized the government in his 2008 report for the P3 cost overruns at the Brampton hospital. Other P3 hospital projects have fared no better. In North Bay the P3 cost balooned from $551 million to $1 billion and in Sarnia from $140 million to $320 million.[19]

- The McGill University Health Centre (MUHC) in Montreal was estimated in April 2006 to cost $1.482 billion but the cost increased by 50% to $2.225 billion in the next two years, according to Quebéc's Auditor General. In 2006, the Centre hospitalier de l'Université de Montréal (CHUM) was projected to cost 1.386 billion but that increased 81% to 2.515 billion two years later.[20]

P3 Hospitals: the wrong direction

The CUPE report, P3 Hospitals: the wrong direction, examines the history and impact of P3 hospitals and examines some of the faulty processes that have allowed them to be built in spite of overwhelming evidence that they cost more.[21] For more, see the Ontario Health Coalition's *Flawed, Failed, Abandoned: 100 P3s*.[22]

Private consortia, in fact, borrow at higher rates than the government. The economic rationale for P3s is the value gained by 'risk transfer,' but as the failure of privatized railways in Britain shows, it is always government that bears ultimate responsibility.[23] The profits expected by shareholders are found by reducing service, standards, or squeezing workers.

Pressure to privatize

- In 2005, the Supreme Court issued the landmark *Chaoulli* decision, striking down a ban on private insurance for publicly insured services in Quebec. By 2007, *Chaoulli* had already been cited in 31 decisions.[24]

- Quebec's Bill 33 allows the sale of private insurance for some publicly insured services.

- In its controversial July 2007 policy statement, the Canadian Medical Association (CMA) explicitly advocated the development of a private health system wherever public infrastructure constrains capacity.[25] Since then, the CMA has focused on more access to medical services while affirming support for the five principles of medicare as they did in a joint statement issued in July 2011 with the Canadian Nurses Association.[26] However, those statements fall short of opposing for-profit delivery unless it violates the principle of universal access. In 2006, a group of doctors came together to form Canadian Doctors for Medicare, an organization that supports publicly funded and delivered medicare and opposes increasing for-profit delivery.[27]

- The extent of privatization is unknown — most regions with integrated public/private services do not report the number of centres or amounts billed.[28]

- The report *Eroding Public Medicare* identified 89 possible violations of the Canada Health Act in five provinces. The report concluded "the federal government is not enforcing the *Canada Health Act* to protect patients from increasingly aggressive attempts to dismantle equal access to health care for all Canadians."[29]

- In November 2008, the British Columbia Nurses' Union went public with evidence that the BC government had instructed officials not to enforce laws against user fees.[30]

- The Fraser Institute released a report in April 2011, that calls for the abandonment of public health care as we know it. They suggest the *Canada Health Act* should be suspended for a five-year period and that a system of co-pays based on a percentage of the actual cost be introduced. As well they propose a parallel private system be introduced with for-profit providers competing for access to delivery of services. (Such change could not be introduced on a trial basis as the Fraser Institute suggests since private investment is not a revolving door and is protected under international trade agreements. This proposal, while promoted as an experiment, would effectively end Medicare.)[31]

The CMA recognizes that there is a great deal of "unregulated privatization" "creeping in through the back door" and threatens that wholesale privatization would follow, unless "all options are put on the table now." In other words we should accept some good privatization before we get a lot more bad privatization.[32]

Unfortunately this type of logic suggesting we should embrace what we are fighting against in order to avoid more of the same is a frighteningly common tactic to pressure us down the "slippery slope," as Sean Burnett of the Canadian Centre for Policy Alternatives calls it. Burnett argues that private financing cannot improve the health care delivery system as "It will only change who pays and who receives."[33]

Overstating problems — the real causes and cost drivers

- Despite some areas where action is needed, the wait times problem has often been overstated. Eight out of ten patients across Canada received priority procedures within benchmarks. CIHI suggests that 90%, not 100%, is a reasonable target. Some people waiting for a surgery, for example, may need to put the surgery off due to other medical complications.[34]

- A study of official queues for joint surgery in Alberta suggest that wait time data may be skewed: 11% of patients in that queue could not be contacted while another 14% were not really waiting for a procedure.[35]

- Since 1996, $250 billion in tax cuts have affected public finances much more than the $108-billion increase in health expenditures.[36]

- The critics of medicare claim that the costs are out of control, that an aging population will drive us over the edge and that the rising proportion of provincial budgets allocated to health care should alarm us. In fact the aging population is a slowly moving phenomenon that will increase health costs by less than 1% per year.[37]

- Public spending on health care is the most controlled of all health spending, and it is private-sector health spending such as pharmaceuticals that is out of control.[38]

- The apparent increase in health spending as a proportion of provincial budgets is actually a result of program cutbacks in other areas together with tax cuts. Provincial governments spend less and take in less as a percentage of GDP than they did in the early 1990s. Taxation revenue as a percentage of GDP has been reduced to where it was at the end of the 1960s. In short Canada can easily afford the modest increase to health care that our public system requires.[39]

- Canada's health spending as a percentage of GDP rose to 11.9% in 2009 and is expected to fall slightly to 11.7% once 2010 data is available. CIHI notes that this is expected as health spending as a percentage of GDP rises during periods of economic slowdown as it did in the early 1980s and early 1990s and falls during periods of economic growth.[40] CIHI further reports that "after removing the effects of inflation and population growth, [Canadian] health care spending per person is expected to increase by 1.4% in 2010, the lowest annual growth rate seen in 13 years."[41]

- According to OECD figures, Canada spends less on health than France and Switzerland as a percentage of GDP and well below the United States.[42]

- There is a severe shortage of health care professionals, which is stressing the public system. For this problem, the private sector has no answers other than to lure scarce health care professionals out of the public system. The cost of turnover is also high.

One in five nurses in the hospital sector leave their jobs annually, costing a minimum of $25,000 per nurse as a result of the transition (and much higher for critical care and other specialist nurses). Turnover also negatively affects patient care; medical errors are 38% more likely for every 10% increase in the turnover rate.[43]

- Drug expenditures in Canada rose from 9.5% of total health spending in 1985 to an estimated 16.3% in 2009.[44] A public Pharmacare plan could rein in these expenses without raising taxes.[45] The public sector funded 38.4% of total drug expenditure in Canada, the fourth lowest of 25 OECD comparator countries. The share of public coverage was highest in the United Kingdom, at 84.7%.[46] If Canada modeled its Pharmacare program after New Zealand's in how it tenders and prices drugs, Canada could reduce its current drug expenses by as much as $10.2 billion annually. With savings from dispensing fees, cheaper administration and removal of tax subsidies from private plans total savings could be $10.7 billion annually.[47] For more information please see the CFNU backgrounder, *A National Pharmacare Strategy.*

Public solutions

As the Health Council of Canada notes in their 2008 report, a lack of clearly defined terms and goals, accountability, information sharing and collaboration are stalling the path to reform. As they note, the funding for health care renewal "should be buying the reforms promised in 2003, not just more of the status quo."[48]

A lack of a pan-Canadian health human resource strategy means that provinces and territories are often competing with each other for health professionals instead of finding solutions together.

Public solutions to our health system's problems are already at work. With support and dissemination of best practices, much can be achieved.

- Innovators in Alberta cut wait times by 87% between the first orthopaedic consultation and surgery, reducing wait times from 87 weeks to 23.[49]

- North Vancouver's single "gate" for joint replacement procedures reduced the 11-month wait for initial surgical consultation to under one.[50]

- A Sault Ste. Marie breast clinic saw wait times from mammogram to breast cancer diagnosis fall by 75% in 2005-2006.[51]

This is a mere sampling of solutions waiting to be extended and reproduced.

Canada's nurses call for improvements within a public system committed to quality and universal care, a system that can and has worked for Canadians.

Canadians can learn more about their medicare rights.

The Canadian Federation of Nurses Unions and the Canadian Union of Public Employees have launched yourmedicarerights.ca to document and explain the effects of phenomena like user fees, co-mingling, and queue-jumping.

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