Unsafe Practices: Restructuring and Privatization in Ontario Health Care

by Paul LeDuc Browne

Public health care, the crown jewel of social programs, has worked extremely well for Canadians. Yet Ontario today is witnessing piecemail privatization in health care: the introduction of private-sector business strategies and management ideologies into the public health care system; reductions and stagnation in pubic spending in the sector; the restructuring and rationing of publicly delivered services; cost shifting from the public purse to the individual household.

In this book, Paul Leduc Browne shows how these unsafe practices have pervaded Ontario's health care system, from hospitals to home care, laboratory to ambulance services, long-term care to primary care. Unsafe Practices argues that privatization, spearheading the neo-liberal attack on social citizenship, is robbing Canadians of their common heritage of universal public services.

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Preface

Medicare has often been described as Canada's most cherished social program. It is not hard to understand why. Its practical value is second to none. Of all the afflictions that human beings may suffer, those that directly affect their very bodies are both the most menacing and the most universal. Even when it does not threaten our very existence, illness disrupts the normal course of our lives; it may precipitate economic ruin and social isolation by making us unable to work. Medicare promises everyone access to relief and even a cure, without requiring direct payment in return and without distinction of age, gender or region of origin. Medicare has worked, and worked well for Canadians.

"I realized just how valuable medicare is the night I had to rush my three-year-old son to emergency at two o'clock in the morning," says Pierre B., a school teacher in Timmins, Ontario. "My son was immediately looked after, and no one asked us whether or how we would pay for the care. It gives us such a sense of security, knowing that health care is there whenever we need it."

At its best, medicare reflects all that is noblest and most efficient about the welfare state. It ensures that the universal risk of ill health is equitably shared by all, in effect transferring part of the economic burden of care from the unhealthy and "unwealthy" to the healthy and wealthy.1 As a universal, accessible, comprehensive, portable, and publicly administered system, medicare is the strongest remaining pillar of the welfare state.2 The others have either been discarded as public policy priorities (full employment, universal family allowances and old age pensions), or been gutted (unemployment insurance).

But medicare also holds such a deep appeal because it speaks so eloquently to our sense of identity. It is a story of communities emerging from war and a colonial past to build new institutions in their own image--and which reflect back to them a new, bolder image. Furthermore, it is a tale about how communities pulled together to triumph over sickness, death, and the power of money.3 It has all the ingredients of a gripping epic. It's hardly surprising that it should appeal so to Canadians.

Today, Canadians are extremely worried about the future of medicare. Survey after survey shows that health care is the number one priority, far ahead of education, tax cuts, and even employment, long the issue of greatest concern. For example, in an Angus Reid poll conducted in December 1999, 62 percent of respondents ranked health care as the main priority for the government, 49 percent felt education was the most important issue, and 25 percent pointed to poverty instead (respondents were allowed to cite two issues).4 Overcrowded emergency rooms, nursing shortages, waiting lists for surgery, patients being sent to the United States for cancer care, skyrocketing costs----if daily media reports are true, Canada's health care system is breaking down. And while medicare remains enormously popular, opinion surveys indicate that most citizens are very worried about its viability. In the Angus Reid poll, 71 percent of respondents agreed with the statement that Ontario's health care system is in a crisis.

Efforts by the federal government to deflect and defuse such worries have failed. The announcement of increased health care funding in the 2000 federal budget was clearly meant to appease voters' fears; instead public anxiety has only become more inflamed.5 The provincial premiers' reaction can only have thrown more fuel on the fire. They have repeatedly hinted that federal failure to transfer far greater sums to them for health care could result in drastic changes to the system, in particular privatization. Ontario Premier Mike Harris raised the spectre of user fees for health care.6

What is privatization? It is perhaps most often thought of as the sale of government assets, such as land or companies, to the private sector. But it can take many other forms as well.

Privatization is a process whereby activities, assets, costs, or control are shifted from the public to the for-profit private sector. The latter, in other words, replaces the public sector in doing, owning, paying for, or controlling something. Such a shift may assume an "explicit and direct" or "implicit and indirect" form. The former includes:

- **"disposing of state-owned assets, including land, infrastructure, and state-owned enterprises, through sales, leases, or liquidation" (transferring ownership);**
- **"substituting state-financed but privately produced services for state-produced services, as in contracting out, the distribution of vouchers, and other forms of payment for private provision."**

The "implicit and indirect" forms of privatization are:

- **"the disengagement of government from a sphere of service provision," either abruptly, so that citizens immediately have to purchase an equivalent in the marketplace, resort to charity, supply their own service, or do without--or slowly, by attrition, as governments gradually starve services of financial and other resources, encouraging citizens to look elsewhere for an alternative to deteriorating services;**
- **"the deregulation of entry into state-owned monopolies."7**

Put another way, the privatization of public services occurs when governments:

- **cease altogether from paying for a service or providing it;**
- **still pay for a service, but no longer deliver it themselves, or do so less, instead turning to the private for-profit sector to do so;**
- **still provide the service, but require someone else, such as the user, to assume part or all of the cost;**
- **still provide and pay for a service, but manage and deliver it along the lines of a commercial, for-profit enterprise.**

Some of the key policies and policy instruments associated with privatization are service reductions, contracting out, public-private partnerships, cost shifting (user fees, de-listing, de-insuring), commercialization, and organizational restructuring.

Canada's health care sector is a mixed economy. The government pays for care by physicians and in hospitals, as well as for a range of related aspects of care. Individuals must pay for most dental care, prescription drugs, and a number of other items, privately. Most care has been delivered by independent professionals working on a fee-for-service basis, such as physicians, dentists, optometrists, psychiatrists, occupational therapists, physiotherapists, and midwives, or non-profit institutions, such as hospitals.8 Private

corporations supply drugs and medical equipment, operate some nursing homes, and so on.9

Privatization in the Canadian context means changing the composition of the mixed economy of health care at the levels of governance, financing, or service delivery.10 Increasingly, for example, individuals are being asked to pay directly, or via private insurance, for at least a part of some services that used to be publicly insured, or are having to seek care from private, for-profit firms. For those without the money, this means doing without needed care, or relying more on the unpaid labour of family, friends and neighbours.

In general, the consequences of privatization are higher costs, diminished access, less efficiency, lower quality of care, and loss of public control over these vital services:

[H]ealth care is not a commodity like others. It does not benefit from market-based reforms. For-profit competition increases costs, drives up administrative efficiencies, creates barriers to equal access for all people, and can threaten quality of care. Private, for-profit health care has been proven conclusively to be a bad idea for almost everyone.11

Health-care privatization is very much in the headlines, as the Alberta government expands the role of private clinics in that province. The debate about the pros and cons of such a move rages across the country. The spectre of privatization is certainly very real in Ontario. The Harris government has long espoused an ideological commitment to privatization. And while it has promised not to weaken medicare, it has proclaimed its openness to outright privatization of public services in general, and its eagerness to promote so-called public-private partnerships. In a February 2000 speech, for example, Ontario Finance Minister Ernie Eves stated that his government would entertain any "reasonable" proposal from private corporations seeking "a financial stake" in public institutions and infrastructure: "Everything is on the table, every idea will be considered, every concept will be explored. If the private sector can find a way of providing services currently provided by the government in a way that is more cost-efficient and improves the quality of that service, then we are ready to listen."12 Premier Mike Harris made similar remarks about health care in a speech the same month to a Progressive Conservative Party policy conference. Warning that health care costs are likely to escalate substantially, the premier "said one issue that needs to be discussed is to what extent people will be required to cover their own health-care costs. 'I can't answer that,' Mr. Harris said when asked how much people will be required to pay in the future. 'It may be that they'll pay for even less out of their own pockets.'"13

Influential voices around the Ontario government are calling very explicitly for privatization. Their common theme is that medicare is financially unsustainable, mainly because of the cost of new technology and the aging of Canada's population, and because Canada's national debt is too great to allow for deficit-financing. Some also claim that any public system is intrinsically likely to be inefficient and wasteful.14

Declaring that hospital funding will need to increase by 600 percent by 2004, the president of the Ontario Hospital Association told the Standing Committee on Finance and Economic Affairs of the Ontario Legislature that more private spending on health care will be needed in the future, because the public sector will not be able to meet the needs in an era of balanced budgets.15 The Fraser Institute, a right-wing Vancouver organization with ties to the Ontario government, has long called for medicare, indeed most public services, to be supplanted by private market-based alternatives.16 Member of Parliament Keith Martin, a leadership candidate for the Canadian Alliance, says that the shortage of money for medicare can be remedied by creating a parallel private health care system, entirely paid for with private money: "People accessing private services would no longer be draining the public system, thereby leaving more money and better care for those still in the public system. The private system would in effect be strengthening the public system."17 (As if Mr. Martin's private system would not drain money, talent, resources, and political support away from the public system even more rapidly!)

This is very much at odds with public opinion. The December 1999 Angus Reid poll showed that 55 percent of Ontarians would favour raising taxes for health care, 66 percent rejected a two- tier health care system, and 65 percent were against putting "major limits on the health-care services provided to Ontarians." The majority therefore seems clearly in favour of increasing public spending on health care, maintaining levels of service, and rejecting a two-tier system.18

Of course, statements by politicians, businessmen and advocacy groups are not in themselves proof that privatization really is occurring. However, analysis of government policy and spending shows that the balance is indeed tipping in that direction. To be sure, the Ontario government has not said or done anything to suggest that it will throw the hospital sector wide open to competition from private hospitals, nor has it said that doctors will be allowed to bill patients directly for all the services that are currently insured by the Ontario Health Insurance Plan. The Harris government has repeatedly expressed its support for the Canada Health Act. But privatization can take many roads and many years to arrive. Medicare is too popular in Canada for any government to challenge it openly.

It should be recalled that the huge cuts to social spending of the mid-1990s only came after the federal government and business interests had spent a decade changing Canadians attitudes with concerted and constant propaganda about the supposedly disastrous implications of the national debt19 and a host of piecemeal changes to social programs (which Ken Battle referred to as "social policy by stealth"). Similarly, Ontario today is witnessing piecemeal privatization in health care: the introduction of private-sector business strategies and management ideologies into the public health care system; reductions and stagnation in public spending in the sector; the reduction, restructuring and rationing of publicly delivered services (especially hospitals); cost-shifting from the public purse to the individual household.

Privatization is not a one-off event, or even a number of isolated incidents, but a process. It amounts to much more than this or that specific government policy, decision by a hospital's board of directors, or action by a private corporation. Pat Armstrong has evoked the useful metaphor of a "cascade" to describe it. This is how the cascading effect looks:

The federal government adopts a neo-liberal policy framework, enters into "free-trade" agreements with other countries, and in the name of competition begins dismantling social programs to eliminate "labour-market rigidities" (i.e. to push down wages). As part of this process, it invokes its fiscal crisis, saying that the national debt is unsustainable and that public spending must be reduced. Federal transfer payments to the provinces (including for health care) are one of the main targets of the cuts.

The provincial governments themselves heartily embrace the neo-liberal or neo-conservative agenda. They too reduce transfer payments to lower levels of governments, slash social programs, rewrite labour legislation and regulations in favour of employers, and adopt private-sector managerial ideologies and practices, in the form of an "alternative service delivery" program.

Forced by the provincial government's cost-containment agenda to reduce their own spending, and driven by the same private-sector ideology, institutions and agencies adopt their own private-sector practices, such as total quality management. Health care and social services become less accessible, less affordable and of lesser quality.

Diminished quality and access are then used by neo-liberals as evidence that the public sector is inefficient and that further privatization is necessary. Meanwhile, those with money seek better quality and swifter access in the private sector. Abandoned by (at least part of) the middle class, the public system no longer garners universal support and becomes very weak politically.20

Chapter 1 tells of the first two waves in this cascade: (1) the federal government's reduction in transfer payments to Ontario; and (2) the Ontario government's neo-conservative agenda, its "alternative service delivery" ideology, and the equivocal wrapping--the integrated health system--in which this agenda has been sold and justified. Together, these are the story of privatization as the economic, political, ideological and administrative attack on Canada's social welfare state.

Chapter 2 follows the cascading movement through the different components of Ontario's health-care system: the Ministry of Health's overall spending envelope, hospital restructuring, the privatization of services, such as laboratory testing, the impact on the workforce, long-term institutional care, ambulance services and public health, new user charges, and primary care.

Chapter 3 takes a more in-depth look at the transformations taking place in home care in Ontario.

Although privatization policies and cutbacks at each level impel other governments and institutions to follow suit, it must be stressed that those other governments and institutions are also driven to do so by their own dominant interests and ideologies. Federal cutbacks have encouraged Ontario to slash spending and privatize--but the Ontario government would have done so anyway on the basis of its neo-liberal ideology and the powerful business interests it serves, as I shall explain in Chapter 1. Similarly, as we shall see in Chapter 2, hospitals have been compelled by the provincial government to restructure and reduce their operations and staff. But certain management trends within hospitals have tended in the same direction. In other words, there are internal and external forces working together and reinforcing each other at each level of the process to promote privatization.

None of which is to imply that these changes were inevitable. On the contrary, public policy is about choices. At each level, different choices could have been made.21 To describe the trend that has been dominant is not to imply that it was the only one, or the only viable one. Indeed, at each level there are also citizens working to oppose privatization, either individually or through the associations, coalitions or unions to which they belong.22

The period studied here is 1995-2000. This should not be interpreted as an implicit statement that there was no privatization in health care in Ontario before 1995. Nor should it be thought that the intention was to single out the Conservative government for particular scrutiny or criticism. In many ways, the Harris government has walked on a path blazed by its predecessors. Had the resources available for the study been greater, it would have been fascinating and instructive to survey health care's evolution over a much longer period, certainly over the entire 1980s and 1990s. Unfortunately, that will have to await another book.

Endnotes

1 See Robert Evans, "Health Reform: What 'Business' Is It of Business?" in Daniel Drache and Terry Sullivan (eds.), Market Limits in Health Reform: Public Success, Private Failure, London, Routledge, 1999, 31.

2 The values of universality, accessibility, comprehensiveness, portability, and public administration are the five national standards of health care enshrined in the Canada Health Act (1984). For a discussion, see the annual reports on provincial compliance with the Canada Health Act published by Health Canada.

3 As Colleen Fuller puts it: "The creation of Canada's medicare system was the result of a long struggle, countless compromises, and a rejection by many millions of people of what existed at the time, in favour of what could be." (Colleen Fuller, Caring for Profit: How Corporations Are Taking Over Canada's Health Care System, Vancouver, New Star Books/Ottawa, Canadian Centre for Policy Alternatives, 1998, 12.)

4 Quoted in Richard Mackie, "Most Ontarians believe health care deteriorating," The Globe and Mail, January 17, 2000.

5 See the town hall meeting with federal Finance Minister Paul Martin on CBC Newsworld, March 1, 2000, for an example of such expressions of anxiety.

6 See Ontario Premier Mike Harris's remarks leading up to the signing of the 1999 social union agreement and following the 2000 federal budget (Ottawa Citizen, March 1, 2000; The Globe and Mail, March 1, 2000).

7 Paul Starr, "The New Life of the Liberal State: Privatization and the Restructuring of State-Society Relations," in John Waterbury and Ezra Suleiman, eds., Public Enterprise and Privatization, Boulder, Westview Press, 1990; and Paul Starr, "The Meaning of Privatization," Yale Law and Policy Review, 6 (1988), 6-41.

8 "The label 'private' in the context of health care is being used in many different ways by different people for different purposes. The most basic distinction is between payment for and provision of health care services. The financing of health care may be drawn from public or from private sources: this is logically independent of whether the services themselves are provided by public or private agencies. But the distinctions on the provision side are not always as clear as on the financing side. At one end of the spectrum is provision of care by government employees working for government agencies. At the other end are purely for-profit, publicly traded corporations, such as drug and equipment manufacturers and some providers of laboratory and long-term care services. Most health care is provided by not-for-profit and 'not-only-for-profit' organizations that respond to motivations and 'bottom lines' that are very different from those of for-profit corporations." (Robert G. Evans, Morris L. Barer, Steven Lewis, Michael Rachlis, Greg L. Stoddart, Private Highway, One-Way Street: The Deklein and Fall of Canadian Medicare? Vancouver, Health Policy Research Unit, Centre for Health Services and Policy Research, University of British Columbia, March 2000, Executive Summary, at http://www.chspr.ubc.ca>)

9 "It must be recognized that it is an oversimplification to classify a country's health system as either public or private. Virtually every country employs some combination of financing and delivery models, relying on various public-private combinations in various sectors of the health system or for various groups of the nation's population. (...) Similarly, the public and private sectors are involved to a lesser or greater extent in service delivery, depending on the health sector within which services are provided (e.g., dental, vision, rehabilitation, long-term care), on the population group for which services are geared (e.g., state employees, veterans, the elderly), or on the perceived urgency of the services (acute versus chronic care, elective versus urgent surgery)." (Raisa Deber, Lutchmie Narine, Pat Baranek, Natasha Sharpe, Katya Masnyk Duvalko, Randi Zlotnik-Shaul, Peter Coyte, George Pink, Paul Williams, The Public-Private Mix in Health Care, in Striking a Balance: Health Care Systems in Canada and Elsewhere, Canada Health Action: Building on the Legacy--Papers

commissioned by the National Forum on Health, Volume 4, Sainte-Foy, Editions Multimondes, 1998, 439-440.

10 The or is important here. I disagree with the too narrow definition proposed by Lundqvist: "the active and conscious transfer of responsibility from the public to the private realm, involving three main activities: regulation, financing, and production." (Lennart Lundqvist, "Privatization: Towards a Concept for Comparative Analysis," Journal of Public Opinion, 8:1, 1, quoted by S. D. VanderBent, The Role and Value of the Private Sector in Home Health and Social Care Provision, Position Paper, Ontario Home Health Care Providers Association, March 1999, 6-7.

11 Kevin Taft and Gillian Steward, Clear Answers: The Economics and Politics of For-Profit Medicine, Edmonton, Duval House Publishing/The University of Alberta Press/Parkland Institute, 2000, 22.

12 Quoted by April Lindgren, "Ontario open to ideas on privatization," Ottawa Citizen, February 10, 2000.

13 Richard Mackie, "Harris calls on Canadians to weigh in on health care," The Globe and Mail, February 14, 2000.

14 See Ake Blomqvist, "Introduction: Economic Issues in Canadian Health Care," and William G. Tholl, "Health Care Spending in Canada: Skating Faster on Thinner Ice,"in Ake Blomqvist and David M. Brown (eds.), Limits to Care: Reforming Canada's Health System in an Age of Restraint, Toronto, C. D. Howe Institute, 1994; David Gratzer, Code Blue: Reviving Canada's Health Care System, Toronto, ECW Press, 1999.

15 Theresa Boyle, "Health system crash feared," The Toronto Star, February 17, 2000.

16 One idea very popular with the Right is the replacement of public financing of medical care by compulsory personal "medical savings accounts." See Gratzer, op. cit.

17 "A prescription for medicare, from MP Dr. Keith Martin," The Ottawa Citizen, March 11, 2000.

18 On the issue of who should deliver the service, opinion was more evenly split, however. Fifty- one percent of respondents said that "private-sector businesses [should not be allowed] to operate parts of our health-care system," but 47 percent said they should. But how should this be interpreted? What did they understand by "private-sector businesses"? Did they mean for-profit or non-profit enterprises, or both? Did the 51 percent of respondents mean that there should be less private provision of services, or even none at all? Or did they mean that there should be no additional private involvement, beyond the existing private share of financing and service delivery? Similarly, did the 47 percent who said that private-sector

businesses should have a role mean that the status quo should prevail, or did they advocate privatization, i.e. changing the mixed economy of health care in favour of the private for-profit sector?

19 See Ed Finn (ed.), The Deficit Made Me Do It, Ottawa, CCPA, 1993; Ed Finn and Duncan Cameron, Ten Deficit Myths, Ottawa, CCPA, 1995.

20 Pat Armstrong, "Privatization," presentation to the Ontario Health Coalition, Toronto, November 1997.

21 The alternative federal budgets published by the Canadian Centre for Policy Alternatives and CHO!CES: A Coalition for Social Justice since 1995 have demonstrated this for the federal government. The alternative Ontario budgets co-ordinated by the Ontario Federation of Labour have done the same for Ontario.

22 The vigorous resistance of the citizens of Alberta to their government's Bill 11 is a striking example of this.