

# Health Care, Limited

## The Privatization of Medicare

A Synthesis Report prepared by the CCPA  
for the Council of Canadians

with guidance from CCPA Research Associates  
Pat Armstrong, Hugh Armstrong, and Colleen Fuller

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ISBN: 0-88627-244-0

November 2000



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# Introduction

**F**ew politicians, when they die, leave behind precious legacies. Two who did are Pierre Elliott Trudeau and Tommy Douglas.

Trudeau's legacy is the Canadian Charter of Rights and Freedoms.

Douglas's legacy is Medicare.

We may disagree on which of these two legacies is the more important. The enshrinement of basic human rights has helped minority groups and is clearly of great potential benefit to others. A public health care system could be considered to have a more direct value—financially as well as physically and mentally—to all of us.

Ironically, one of the basic rights omitted from the Charter of Rights and Freedoms is the right to enjoy optimum health. Had it been included, it might well have been invoked to preserve Medicare. Article 25 of the United Nations' Universal Declaration of Human Rights says that "everyone has the right to...medical care and necessary social services..." This historic document, however, is not binding on the UN member nations who signed it, so they

are free to ignore Article 25 and all the Declaration's other laudable Articles—and most do.

The federal government has the means, through its spending powers and the Canada Health Act, to defend and extend public health care services. This Act sets forth the five basic principles of a public health care system—public administration, comprehensiveness, universality, portability, and accessibility (**see accompanying box**)—and these principles, if enforced and funded, would keep Medicare safe.

In recent years, however, the federal government has significantly reduced spending on health and repeatedly failed to enforce the Act, most noticeably refraining from using it to halt or limit the growth of privatization. Indeed, Health Canada, on a few occasions, has gone so far as to specifically register its approval in writing for provincial policies that clearly violate the Canada Health Act. (**See Chapter 2.**) Such failures to enforce the Act by Ottawa have drawn sharp criticism from the Hon. Monique Bégin, who

## The Canada Health Act's Five Principles

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."

1. **Universality:** The health care insurance plan of a province must entitle 100% of the insured persons of the province to the health services provided for by the plan.
2. **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."
3. **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.
4. **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.
5. **Portability:** The health care insurance plan of a province a) 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 b) must provide for the payment for the cost of insured health services provided to insured persons while temporarily absent from the province.

steered the legislation through Parliament when she was the Liberal Health Minister in the early 1980s.

It is hardly surprising, then, that our health care system has deteriorated in recent years. Its quality and accessibility have been steadily eroded by the failure of the federal and provincial governments to maintain the public system and to extend it in ways that would both meet current needs and prevent privatization.

Many Canadians are now fearful that Medicare will fall short of meeting their health care needs—a fear that is being used to support further privatization.

The Canada Health Act, and the federal spending power, can and have been used to prevent privatization such as extra billing, and the federal government has done so even in the face of strong opposition from the big provinces. Indeed, Medicare itself was implemented in spite of opposition from the large provinces. What it takes is political will.

The problems that now beset Medicare in Canada are many and complex. Some relate to the fee-for-service nature of medical treatment, the focus on curative rather than preventive practices, and the increasing reliance on new technologies. These approaches all ig-



nore the socioeconomic determinants of health, both within and outside the health care system. Health ministers and officials increasingly acknowledge that factors such as adequate incomes, housing, nutrition and schooling are central to optimum health, and researchers have long documented the impact on health of poverty, unemployment, poor housing, and lack of education. But Canadian governments have yet to implement strategies for improving health by addressing these socioeconomic conditions. On the contrary, in recent years they have cut back on the social spending that is essential to health preservation and instead have used the research on these health determinants to justify cutbacks on care.

In other words, while governments publicly agree that social services and economic safeguards should be maintained at high levels to ensure optimum health, they are systematically underfunding and undermining them, to the detriment of many thousands of Canadians, and ignoring the ways such health determinants apply within the health care system. Most of the victims of these cutbacks are women, given that women are the main beneficiaries of social programs, and the majority of care recipients and providers.

Most hospital workers, for example—from nurses and technicians to housekeepers, from laundry workers to dietitians—are female, and thus have been especially hard hit by layoffs and the resultant overwork and stress imposed on those who remain.

The inevitable deterioration of the quality of care they can give also impacts on their patients, most of whom are also women. Part of this deterioration reflects the failure to apply the research on health determinants to care within institutions and to the work of care provision. It is ironic that many hospitals, because their laundry, cleaning and food budgets have been cut, are having trouble maintaining the levels of cleanliness and nutrition that are needed for safe patient treatment. Yet the most important contribution Florence Nightingale made was to clean up the hospitals and ensure there was fresh air.

Women suffer, too, from the arbitrary relocation of care from hospitals and other institutions into the community. This is another aspect of privatization, and it often forces the relatives of sick or disabled patients—again, mainly women—to provide care in the home. This is onerous and unpaid work that frequently imposes so much strain and stress that the health of the “conscripted” home care-givers is itself impaired.

Many books and studies in recent years have exposed and analyzed the threats to Medicare in exhaustive detail. This report, while drawing heavily on their findings, does not attempt to cover the same wide range. Instead, it focuses mainly on the privatization process. Why? Because the “reforms” and “restructurings” of Medicare have been mainly about privatization, re-

ardless of how they have been presented to the public.

Privatization involves a range of processes, some of which are obvious while others are quite difficult to see. Take the funding issue, for example. Since 1986, cuts in federal transfers to the provinces for health care have reached a staggering total of nearly \$36 billion, peaking in the 1995 federal budget when the Chrétien government slashed payments to the provinces by 33%—from \$18 billion to \$12 billion. The provinces used these shortfalls as an excuse to chop their own funding to hospitals, thus precipitating a “crisis” of staff and bed reductions, long waiting lists for surgery, clogged emergency rooms, and growing public fear and alarm.

This engineered “crisis” fed claims that Medicare was unable to meet the needs of the sick because of its alleged incompetence, waste and inefficiency. The “solution,” Canadians were told, was to turn badly mismanaged health care services over to the “more efficient” private sector, or to adopt for-profit methods such as competitive bidding and Total Quality Management within the public sector.

This “solution” fit nicely with U.S.-style care. The huge for-profit health management organizations (HMOs) that dominate the health care system in the United States have long sought to exploit the lucrative potential of Medicare in Canada. An American public relations firm with HMOs as clients has referred to our Medicare system as “one of the largest unopened oysters in the Canadian economy.” With the explosive growth of corporate power that accompanied the globalization of business, the signing of free trade deals, and the promotion of the corporate agenda by most governments in Canada came the opportunity to pry open the oyster.

The private delivery of health services, of course, is not new in Canada. Medicare—defined by Health Canada as “universal, comprehensive coverage for medically necessary hospital, inpatient and out-patient physician services”—was never free of private sector participation. It is an insurance scheme that is publicly financed but mainly privately delivered by independent doctors and other professionals, and by private not-for-profit hospitals and other facilities.

### **How governments privatize health care**

The privatization of public services occurs when governments—

- stop paying for or providing a service;
- still pay for a service, but turn it over to the private for-profit sector;
- still pay for a service, but require the patient to assume part or all of the cost;
- still provide and pay for a service, but use private sector methods in managing and delivering it.
- send care home, where families, friends and volunteers, most of whom are women, are expected to provide unpaid care

Some private laboratories, clinics and ambulances have also been permitted, although they all have to be licensed and regulated to qualify for public funding. The big difference now, however, is that for-profit firms are being allowed or invited to deliver these publicly-funded services and the not-for-profit ones are adopting management strategies taken from these corporations. And this has profound consequences for costs, quality, access, care work, and accountability.

But the shift to for-profit firms and for-profit management techniques is not the only form of privatization. Costs have also been privatized. Over the past decade, the balance between public and private spending on health care has shifted significantly. Private costs, including out-of-pocket payments by individuals, premiums paid to private insurers, and premiums paid by employers to workers' compensation plans, have all risen. The public share, which accounted for about 75% in the 20 years following the introduc-

tion of Medicare, fell to 70% nationally by 1997. Some provinces, however, have privatized their health care systems even more aggressively, with Ontario's public share dropping to 66.9% in 1998, and Alberta's to 69.4%.

All three forms of privatization—of delivery, of methods and of costs—are linked to a fourth: the privatization of care work. More and more of the care has been shifted to the household and the volunteer community, where women in particular are expected to take on the extra work without pay or training.

Why has the trend to privatized health care accelerated? How does it undermine Medicare and even threaten its survival? Will NAFTA and the expanded General Agreement on Trade in Services make Medicare even more vulnerable to corporate intrusion?

These and other crucial questions about Canada's most cherished social program are addressed in the following pages.



# Chapter I

## Privatization: Proliferation

Canada's public health care system, from the outset, has been based primarily on the **public funding but private provision of care**. Most hospitals and other institutions are owned by a wide variety of organizations, not by the state. Most doctors are in private practice, and most services such as homecare are purchased by governments from other organizations. However, although some government money goes to for-profit institutions, most of it—up to now—has gone to non-profit providers. Physicians have mostly operated as individual professionals, rather than as business people, and, with a few isolated exceptions, hospitals have been run on a not-for-profit basis.

As many studies have concluded (and as the next chapter will show in detail), there is a significant difference between for-profit and not-for-profit provision of care. For-profit businesses, no matter how professional their staff, have as their overriding goal the pursuit of profit. By their very nature, they will always have trouble reconciling

their role of offering the best possible care with the imperative of reducing costs so as to maximize their profits. Obviously, one problem with for-profit organizations is that at least some of the money goes to profit rather than to care. Less obviously, perhaps, the search for profit means they are prone to—

- saving money by reducing the quality or quantity of services when they are paid for by governments or insurance policies, to the detriment of patients;
- making money by offering special services, such as movement to the front of the waiting line, but at a price many patients can't afford;
- increasing earnings by providing only highly profitable services, leaving the less profitable ones to government and charity;
- reducing their costs by paying their employees and care-givers inferior wages and benefits, by substituting workers with little or no training for those with more preparation, by

speeding up the work and reducing the number of providers;

- selling more by pressuring patients to buy additional costly services they don't really need; and
- closing down and moving away when profits fall, leaving patients with no care services.

Despite these drawbacks of privatization, the recent “reforms” and “restructurings” of Medicare, rationalized as improving its efficiency, put all the emphasis on the bottom line and on both for-profit methods and services. Administrators, bureaucrats, corporate executives, and politicians increasingly promote health care as a business, to be provided with business methods and approaches. When they talk about health care, they use the language of investment and return on investment, cost-benefit analysis, risk management, product lines, stakeholders, cost containment, restructuring and privatization.

This new technocratic approach represents a big shift. North America used to be dominated by an ideology that emphasized the **curative** approach, and invested all power with the physicians. This was an **aristocratic** model, in that a small élite monop-

olized medical knowledge and wielded absolute power in the health care system. In recent years, however, this aristocratic model has been challenged by a vision of integrated, holistic health care in which physicians share knowledge and power with many other health care professionals, and in which patients rather than doctors are regarded as the true centre of the process. We could call this the **democratic** model.

The technocrats have been able to exploit dissatisfaction with traditional aristocratic medicine and the desire for change to push through massive changes to our health care system—changes that are leading away from the social right to health care and the democratic model and towards privatization with its **corporate** model. Outcomes now tend to be measured by business criteria and the number of body parts fixed, not on the basis of caring for patients.

This new approach is conducive to privatization, a process that takes several forms:

- privatizing the costs of health care by shifting the burden of payments to individuals or their private insurance plans;

## Paying twice

“The Canada Health Act is the only set of rules people in Canada have in order to know their entitlements to health care. These rules are now blurred and citizens no longer understand what they will or should receive for the heavy taxes they pay. They either accept ideological arguments about ‘being able to pay,’ or worry about what is going to happen in the future. And they purchase more health insurance, forgetting in the process that they have already paid high taxes for a ‘free,’ universal, and comprehensive health care system.”

—*Monique Bégin, former federal Minister of Health*

- privatizing the delivery of services by contracting with private for-profit providers, and by shifting care from public institutions to private households where it is mainly women who are expected to do the work without pay;
- privatizing management practices within the health care system by adopting the managerial techniques—such as “total quality management” and “re-engineering”—developed for the for-profit private sector; and
- hiring for-profit firms to provide the laundry, food, cleaning, and other services within hospitals and other institutions.

The costs of all this privatization, discussed more fully in the next chapter, are enormous—not only for those in need of care and for those who provide it, but also for Canadian democracy as a whole. Work in the institutions has become more onerous, less collegial, less satisfying, and more dangerous as the focus on cuts and chemicals increases. The same thing has happened to caring work in the home. The ill and disabled tend to get more treatment but less care, and the results can be dangerous to their health.

It is informative to look at how privatization and its effects have been developing in some provinces.

In Quebec, for-profit private 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, convalescence and rehabilitation centres, private physiotherapy and radiology clinics, and medical clinics providing state-of-the-art diagnostic services.

Expanding rapidly are 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. Examples include the Medisys Health Group, which now has 450 permanent staff and nearly 2,000 contract workers, mostly nurses, and the U.S. multinational Olsten Corporation.

Many hospitals and other institutions, responding to budget cuts, are embracing management practices developed in the for-profit private sector, often for goods production. “Efficiency” has become the watchword in managing the province’s health and social services. The influence of the U.S. health care system, dominated by large corporations fixated on competition and profit, is being felt.

In short, the transfer of the operation of health and social services to the private sector is not simply a change in service-delivery methods. It also reflects the ascendancy of an economic approach that emphasizes managerial efficiency and performance, defined mainly in monetary terms, not in terms of care, access or quality.

As might be expected, the privatization in Quebec means a drop in the government’s budget for health and

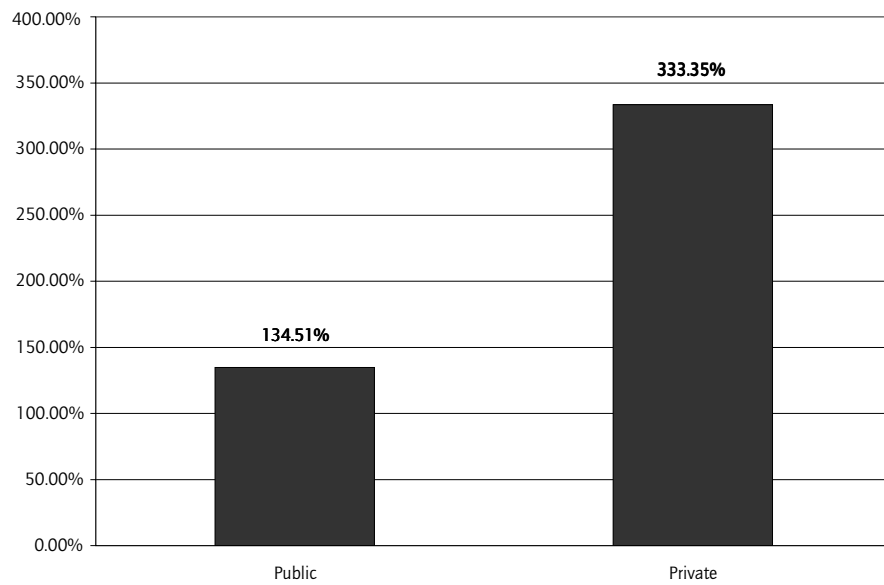
social services. Spending fell from \$13.17 billion in 1994 to \$12.61 billion in 1998. This means that public spending per person per year for these services fell to \$1,608, the lowest of all the provinces. Quebec can thus “boast” the sorry record of having gone from the

province with the highest percentage of public funding in 1980 (81.5%) to being one of the two provinces with the lowest percentage (69.1%) in 1998.

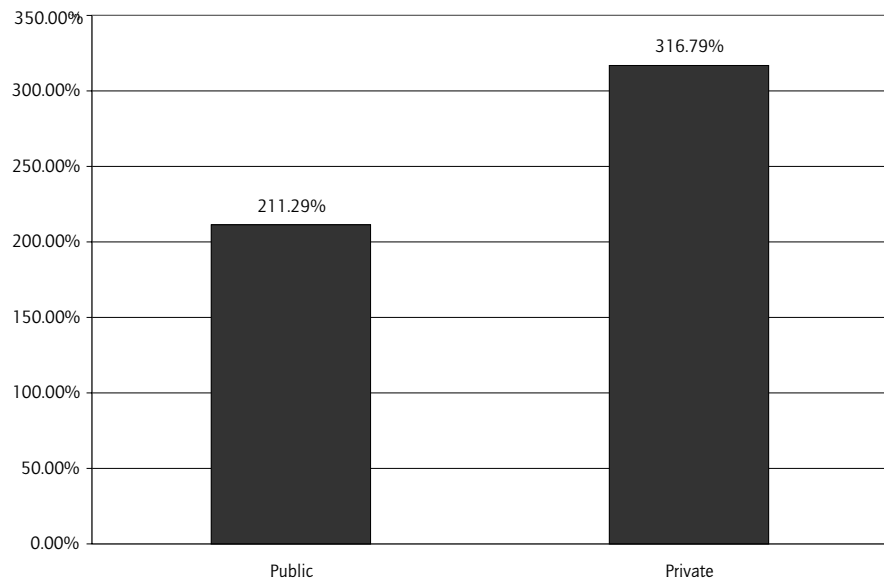
In Ontario, the privatization of health care is being pursued more aggressively than in any other province,

**Percentage change in public and private health expenditures, selected provinces 1980-1999**

**Quebec**



**Ontario**



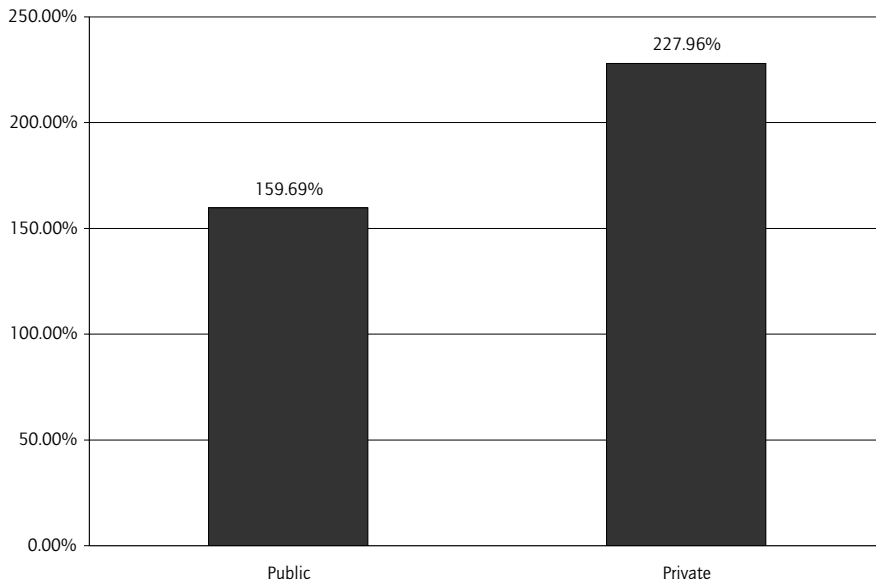


except perhaps Alberta. More and more often, people are being asked to pay privately for services that were formerly paid for publicly, or are being forced to seek and even pay for care from private for-profit agencies.

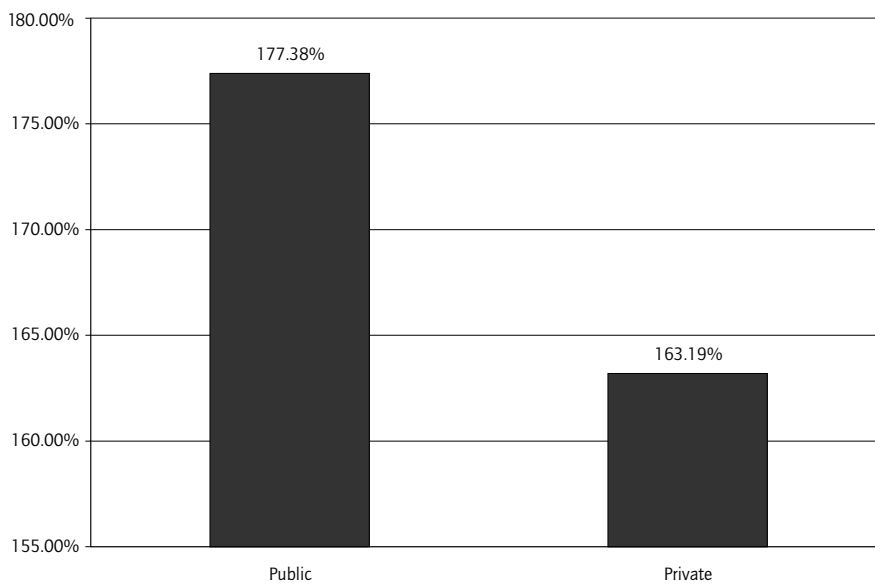
The Harris government has made no effort to hide its commitment to privatization. Finance Minister Ernie Eves

has said the government welcomes any “reasonable” proposal from for-profit firms wishing to provide services currently provided by the government. “Everything is on the table,” he said. And Premier Mike Harris, in a speech earlier this year, warned that the escalation of medical expenses raises the question as to “what extent people will

### Alberta



### British Columbia



Based on CIHI data

be required to cover their own health care costs.”

The Harris strategy seems to have been to create a “crisis” in health care that would justify and speed up the privatization process. In addition to cutting hospital budgets by a massive \$800 million dollars in the late 1990s, his government amended several provincial laws that gave the Minister of Health sweeping powers to “restructure” the hospitals, the power to order hospital shutdowns or amalgamations; the power to allow private medical facilities, such as laboratories, to be established without tendering; the power to impose drug user fees under the Ontario Drug Benefit Plan; and the power to force thousands of hospital patients waiting for beds in nursing homes to pay a daily charge for room and board.

The Ontario government gave the power to close hospitals in the province to an “independent” commission, whose decisions were not subject to appeal. By 1998, 64 Ontario hospitals had been merged or closed, and the number of acute-care beds had fallen by 33%. The hospitals still in operation have responded to the cutbacks by laying off staff, increasing the use of temporary and part-time workers and volunteers, reorganizing work to make everyone work harder and contracting out services such as laundry, house-keeping and meals.

One of the results of the squeeze on hospitals and their laboratories has been the consolidation of a for-profit

oligopoly. Three major private lab companies—MDS Inc., Gamma/Dynacare and Canadian Medical Laboratories—now control nearly 90% of the market. These private labs skim off the cream of the business, leaving the less lucrative work to the public and non-profit sector.

Hospitals have also come to rely more heavily on private funding. This takes many forms, including making franchise deals with companies like Tim Hortons and Second Cup, selling advertising space on their walls, renting out their equipment, and raising money for considerable parts of their budgets through charitable funding drives.

The home care sector is also undergoing a switch from public to private payers, and from non-profit to for-profit providers. More private payment is required because less care is provided in hospitals, while other institutions have not been built to fill the increased demand foreseen by the Health Services Restructuring Commission as a necessary complement to hospital closures. More for-profits provide care, largely because the government introduced “managed competition,” making it easier for the for-profit firms to win an increasing share of the work. And as the non-profit providers are forced to adopt the same management strategies and operational structure as the for-profit companies, they become more attractive targets for takeovers and buy-outs by the private sector operators.

Managed competition and private for-profit provision are clearly at the

heart of the provincial government's agenda. This is, after all, a government committed to replacing public governance, oversight and control with private ownership and control through the market. Ontario, as Premier Harris is so fond of reminding us, is indeed "open for business."

Little wonder that the province's public share of health expenditures shrank from 72.9% in 1990 to 66.9% by 1998.

While it is clear that some forms of privatization are occurring in both Manitoba and Saskatchewan, their scale and scope has so far been less than the levels reached in other provinces such as Ontario and Alberta. This is at least partly because of the stronger commitment to Medicare shared by the NDP in these provinces, whether while forming the government or as a strong opposition party. In any event, privatization has not been pursued in these

provinces with the conservative ideological fervour that has been evident elsewhere in the country. Some regional health bodies in both provinces, however, have been allowed to contract out non-medical services, such as food preparation and cleaning services, to for-profit suppliers.

Nevertheless, privatization has made incursions into the health care systems in both prairie provinces in recent years. This is the case even though privatization has been driven more by funding shortfalls than by a belief that the private sector can provide care more cheaply and efficiently. In both Manitoba and Saskatchewan, health care reforms aimed at controlling costs have shifted care out of institutions into the community. This in turn has opened the door to for-profit providers to offer care and support services, although their performance has been far from impressive. In fact,

### Public subsidies, private profits

The large private medical laboratories operating in Ontario—in particular Gamma-Dynacare Medical Laboratories Inc. and Medical Data Sciences (MDS) Inc.—are guaranteed an estimated \$275 million in public funds every year, no matter how well or poorly they operate.

How did this happen? Prior to 1998, the Ontario government divided the \$145 million it allotted for medical testing among two dozen labs, which got work based on their quality and service. But the big labs were starting to lose business to smaller labs, so the big ones lobbied the Harris government to pass O.Reg.2/98, which divides the money based on the market share each laboratory had in 1995. For Gamma-Dynacare and MDS, this ensured that they receive 60% of the \$415 million (now risen to \$458 million), while sharply reducing the shares of the subsidies going to the smaller labs.

Incredibly, because the regulation was made retroactive to 1995, the smaller labs were forced to pay back to the larger ones all the revenues they had earned above their 1995 market shares.

Says Dr. Joseph Kurian, owner of the small Alpha Laboratories Inc. based in Don Mills, "The main purpose of this regulation is to eliminate the small labs so there will be an oligopoly. That was its sole purpose."

—*Eye newspaper.*

the Manitoba government's first experiment in contracting out some home care services to a private U.S.-based corporation—Olsten Health Services—in 1997 lasted only a year, after which the services were restored to public provision. **(See box for more details.)** This restoration of the public service clearly demonstrates both that privatization is a problem rather than a solution and that it can be reversed, given popular support and political will.

Saskatchewan has prohibited the establishment of private, for-profit health clinics. Indeed, for the most part, health reforms in Saskatchewan have not directly transferred publicly-delivered health services to for-profit providers. But, by shifting more responsibility for care-giving to families, the province has indirectly created a market for private health care and home support services.

By 1997, 130 private clinics were offering minor surgical procedures in Manitoba. However, most of the privatization of health care services on the prairies has not occurred in blatant transfers to the private sector. It has been effected in a less obvious way by moving the delivery of medical services outside of traditionally defined hospitals. Take physiotherapy and occupational therapy, for example. As is the case in all provinces, in Manitoba they are considered insured services when provided on a physician's referral in a hospital. However, these services are not insured when provided in private clinics, although many clients

have their fees covered by private insurance or the Manitoba Workers' Compensation Board. Many people patronize these private clinics rather than wait months for treatment in a hospital, even if they have to pay the \$35-to-\$40-per-visit fees out of their own pocket.

Still, the pace of privatization in the prairies is markedly slower than in most other parts of the country. One indication is that 74.8% of health costs in Saskatchewan, and 74.5% in Manitoba, are still publicly-funded.

In Alberta, the Tory government has long favoured "partnership" with the private sector in providing health care services. Indeed, its 2000-2003 Business Plan explicitly calls upon "individuals to take responsibility for their health in their communities, in collaboration not only with the Ministry and providers of health services, but with a wide variety of parties, including other Ministries, other levels of government, **and the private sector.**" (*Emphasis added.*)

This statement, coming shortly before the introduction of the controversial Bill 11, suggests the government's intention to allow further expansion of the for-profit sector.

Bill 11 allows the conversion of the Grace and Holy Cross hospitals in Calgary from non-profit to for-profit status. This is by far the longest, most visible leap toward rolling back universality and establishing an explicitly two-tier health care system to be made by any provincial government. It also

## Privatization reversed in Manitoba

In 1996, the Manitoba government announced its intention to privatize 25% of personal care services provided by the Manitoba Home Care Program, and predicted this move would reduce costs by as much as \$10 million. The following year, a one-year contract was awarded to Olsten Health Services, a U.S.-based corporation—but to provide 10% of the care, not 25% as originally planned.

When the contract came up for renewal, however, the government decided to let it expire, and all services were brought back under public administration. This decision coincided with the release of a CCPA-Manitoba study that reported FBI investigations of Olsten for alleged improper Medicare billing in the U.S. Other concerns about Olsten—and of privatization in general—that may have influenced the government’s decision included the claims that a privatized system results in lower wages that make it hard to attract and retain qualified caregivers; that it leads to a loss of control over standards, planning and administration, and thus to over-billing; that clients tend to be pressured to purchase additional costly but unnecessary services and products; and that it does not provide for an effective appeals procedure.

allows physicians to practise in both private and public institutions. Indeed, Premier Ralph Klein has sought to justify this measure by citing as his rationale “the shortages of beds and doctors, waiting lists, crowded emergency rooms, and streams of wealthy Canadians heading to the U.S. for treatment.” Carefully omitted from this list of problems is the underfunding that caused them, for which Klein’s government must share the blame with Ottawa.

Alberta’s legislation to allow the public financing of insured services provided by for-profit hospitals strikes at the heart of the Canadian health system. With their fees paid partially by provincial health insurance, such commercial institutions directly challenge the Medicare principles of universality and accessibility. In exchange for an additional private fee, these facilities offer quicker access to insured (and perhaps different quality) services, thus violating the universality requirement that all insured citizens be entitled to insured services “on uniform terms and

conditions.” And, because they would inevitably exclude those unable to pay the private fee, these hospitals would violate the accessibility principle, too.

One might think that the federal government, as the protector of the Canada Health Act, would have intervened to oppose Bill 11, or at least warn against the consequences of violating the Act. It not only failed to do so, but actually gave its consent in writing for doctors in Alberta to work in both public and private sectors at the same time. Documents obtained under the Access to Information Act included a memo by an official in the Alberta Department of Health, Robyn Blackadar, praising the federal government for reversing its policy that doctors wishing to enter private practice had to opt out of Medicare. “Without Health Canada’s agreement on the principle that it is acceptable for physicians to work in both the public and private sectors,” Blackadar’s memo stated, “the existing private policy [Bill 11] would have been impossible to implement.”

Former Liberal Health Minister Monique Bégin, who played a central role in the development of the Canada Health Act, has accused the current Liberal government of allowing serious and frequent violations of the Canada Health Act, particularly in Alberta. She was horrified when the federal government officially signed an agreement with Alberta in 1996 that provided, among other things, for the privatization of clinics and for doctors to be allowed to practise in both the private and public systems. "These principles," she declared, "go completely against the tradition and the spirit of the federal legislation."

In British Columbia, the government has tried to minimize the participation of large private corporations in its health care system by maintaining funding levels for acute care and physician services. It has also limited to some extent the impact on providers, through province-wide adjustment schemes involving the unions. But its opposition to privatization is far from being complete. In the past, it has given support to companies such as InterHealth Canada Ltd., a for-profit corporation that pursues international contracts for Canadian health sector firms. It has also contributed \$10 million to a venture capital firm managed by the multinational MDS Inc. to provide start-up funds to health companies in the province.

B.C., like other provinces, has embarked on a relocation of health services from its public institutions to the community. This does not necessarily

lead to privatization, but, unless steps are taken to ensure these services remain covered by the public health plan, privatization is the likely result. This is what is happening in B.C. as out-patient services are moved out from under the insured umbrella of the acute care sector into a non-insured, partially-insured or privately-insured arena.

Privatization in turn impedes access to services by low-income patients. Two forms of cost shifting are increases in co-payments and the removal of services from the province's Medical Services Plan. In 1998, for example, the deductible for Pharmacare, excluding seniors and other eligible enrollees, was raised from \$600 a year to \$800. A year later, user fees for physiotherapy and other supplementary services delivered in a private clinic increased from \$7.50 a visit to \$10.

Private insurers in B.C. are expanding the scope of services offered on their health plans, both as a consequence of delisting and in response to new commercial products and services marketed by health companies. In addition, individual providers in private practice are being encouraged to "opt out" of the Medical Services Plan, which many see as offering inadequate reimbursement.

B.C. remains a province where privatization has made relatively few inroads compared to others, but all of the abovementioned activities threaten to impose financial barriers to patients of modest means who require care or treatment and to shift care work onto unpaid providers, most of whom are women.

# Chapter II

## Privatization: Problems

**W**hat's wrong with privatizing health care? Plenty. The more that Medicare is privatized, the more it will come to resemble the largely private, for-profit system that prevails in the United States. The many problems that have developed there—documented in multiple studies—should serve as a deterrent to adopting the U.S. model in Canada.

Up to now, what differentiates our system from the one in the U.S. is who pays and who profits. For less per-capita government spending (US\$1,599 in the U.S., US\$1,444 in Canada), we cover everyone for a wide range of high-quality, basic services, whereas the U.S. system covers only the poorest, the oldest, the disabled, and the military. Approximately 44 million Americans have no health coverage at all. Americans pay as much in taxes for health care as we do and, on top of that, pay high rates for private, individual health insurance, out-of-pocket expenses and for insurance through

their workplaces, if their workplace offers it.

One reason for this is that in the U.S. much more public money goes to profit rather than to patient care. Another reason is that our non-profit system is more efficient and effective. A third is that more services are sold, even if they are unnecessary, in the effort to increase profits. These reasons explain why American expenditures on health care continue to rise while ours remain relatively constant.

In the U.S., because of the lack of central coordination and a single payer, huge amounts of money are squandered in administration costs that could be avoided. Moreover, the many payers in the U.S. are not able to negotiate prices as low as can the provincial governments in Canada. This is one reason Americans flock to Canada in their thousands to purchase our much cheaper prescription drugs.

The purpose of for-profit corporations is to maximize profits, which means that money that could be in-

vested in services goes instead into the pockets of shareholders. The imperative of profit maximization overrides all other considerations, because it is a company's basic **raison d'être**. This is why, in the health care field, for-profit operators often add on extra and more lucrative services that patients may not need, engage in "cream-skimming" (taking on only clients whose needs are most easily and cheaply met), offer less and worse service, substitute those with little training for those with more, and pay employees lower wages and benefits.

One of the claims made by the operators and advocates of private clinics is that they are needed to reduce long waiting lists for the services they provide. There is no evidence to support this claim, especially where physicians operate in both public and private institutions. A 1998 report from Health Canada concludes that, "There is no evidence to suggest that offering a private sector option will result in shorter waiting times in the public sector. Greater access to private care appears to be generally associated with longer public sector queues..."

A study of waiting times for cataract surgery by the Consumers' Association of Canada found that Alberta patients whose eye doctors practise in both public hospitals and private clinics not only have the longest waiting times, but also are paying the largest user fees. "Remarkably," the consumers' group concluded, "instead of being the solution to rising costs and

longer waits, increased reliance on private business and the introduction of new sources of private payment has been the **cause** of many of these problems."

Missing from the debate about private clinics so far is the importance of maintaining universal access to quality health care. Because private clinics serve only those willing and able to pay, equity is eroded and access becomes increasingly tied to one's ability to pay. Our public health care system is cherished by the great majority of Canadians because currently they all benefit from it and have a stake in preserving it. But when those who can afford to do so turn to private health care, the support and funding for our public system wanes, and waiting lists for public services grow longer.

Despite this reality, however, Canadian governments and institutions continue to shift more and more of the responsibility for provision and payment to for-profit companies and to individuals. They are also adopting American for-profit practices in the public sector, allegedly as a means of both improving care and reducing costs. The more probable outcome, based on the U.S. experience, is that the quality of care will decline and the costs increase. For several reasons.

First, the for-profit system is inefficient. Research solidly shows that the Canadian single-payer system works more efficiently and cost-effectively than does the U.S. system. Privatization does not reduce overall health ex-



## Race to the bottom

"High-quality health care is increasingly the casualty of a corporatized medical marketplace striving for excessive profits. This race to the bottom must be stopped by limits on how much every patient's premium dollar goes to profits rather than medicine...Unless action is taken soon to stem the managed care industry's reckless cost-cutting, the rationing of high-quality health care will result in more deaths and injuries from medical negligence based solely on the HMO industry's pursuit of profit."

—Harvey Rosenfield

*Consumers for Quality Care (U.S.)*

penditures because the basis of the for-profit system is selling more and charging more. That is how firms maximize their profits. They also pursue this goal by cutting wages and staff, and forcing the remaining employees to work harder, impairing morale and often the quality of care.

Second, privatization leads to inaccessibility and inequality. In a for-profit system, more of the money comes from individuals and employers. As a result, costs increase. Those employers who provide health care pay more for labour than those who do not. And individuals with the ability to pay more have greater access than those who do not. Those without the ability to pay risk going without needed treatment or, in the case of serious illness, having their savings wiped out and incurring heavy debts. In the U.S., medical bills are the leading cause of personal bankruptcy. In 1996, one out of eight American families spent 10% of their incomes on insurance premiums (on top of what their employers may have paid), in addition to out-of-pocket expenses for services and supplies.

Third, the shift from hospital to home care places heavy burdens on

family members, the vast majority of them women, who have to provide most of the care in the home—without pay. They are expected to not only feed, bathe, toilet and walk the sick, but even to clean incisions and change dressings, help with physiotherapy, and attach and monitor complicated equipment. These difficult duties, coming on top of housework, child-care, other domestic chores, and their paid jobs, place a crushing burden on many women that often takes a crippling toll on their own physical and emotional well-being. In many cases, they are also forced to carry more of the costs for services and products purchased from the for-profit sector. Clearly, some households are much better equipped to provide these services than others. The result is increasing inequality in care and more unpaid work for women.

Fourth, when health care services are transferred from public to private hands, a major loss is democratic accountability. As long as care is provided by publicly-paid professionals in public institutions, it can be subjected to public scrutiny. There is a better chance that defects can be identified and corrected. But, once a service is moved

from the public to the private sector, it becomes much more difficult to monitor and to hold the private operator to account for shortcomings. Indeed, contracts for services are treated as necessarily confidential in order to protect the competitive process. At the same time, the privacy of patients may be at risk in corporations that share information within their vast organizations.

## U.S. studies

More than 20 studies have compared for-profit with not-for-profit health care. As Dr. Michael Rachlis notes, four of the most recent ones all favour not-for-profit delivery.

- Harvard physicians Woolhandler and Himmelstein, in a 1997 article in the **New England Journal of Medicine**, found, after analyzing data from all 5,201 acute care hospitals in the U.S., that for-profit hospitals were 25% more expensive per case than public facilities. Of the difference in cost, more than half (53%) was due to higher administrative charges in the commercial institutions.

- Some promoters of privatization in Canada claim that opening the health care market to competition would lead to more efficiency. But a 1999 study by Dartmouth University researchers, published in the **New England Journal of Medicine**, concluded that introducing for-profit hospitals increased community health care costs. They found that health spending was higher and increased faster where all beds were for-profit compared to where they were all not-for-profit.

- Some might argue that such higher costs are justified because they result in better quality health care. But Drs. Himmelstein and Woolhandler, in a 1999 article in the **Journal of the American Medical Association**, concluded that for-profit U.S. health maintenance organizations (HMOs) rated lower than not-for-profit HMOs on all 14 quality indicators measured by the National Committee for Quality Assurance. Their study covered 329 HMOs. The authors estimated that

### Turning a blind eye

Although the Ontario government in recent years has increased funding for the in-home services provided by Community Care Access Centres (CCACs), the added funding has failed to keep pace with the rising demand for such services. As a result, many CCACs have cut back on the range and frequency of services they provide to their clients.

The Windsor-Essex CCAC made the news last winter after a blind 81-year-old widower, whose homemaking service had been cut off, set fire to his apartment while trying to heat some soup. The man, John Paun, had previously been receiving daily one-hour visits from a homemaker who cleaned the apartment and cooked his dinner. This service was dropped by the CCAC on the grounds that Mr. Paun could still dress and bathe himself.

"What was I supposed to do, starve?" he complained to the firefighters who arrived to put out the blaze.

there would be 5,925 more breast cancer deaths annually in the U.S. if all HMOs were for-profit.

- Another 1999 **New England Journal of Medicine** report, by Johns Hopkins researchers, investigated all dialysis centres in the United States. It concluded that patients receiving care at for-profit facilities had 20% higher death rates and were 26% less likely to be placed on a waiting list for renal transplantation than those attending not-for-profit centres.

## The profit motive

Investors in for-profit health care companies—like investors in any other private corporation—now expect returns of 15-to-20% annually—plus annual growth of at least 15%. The investors squeeze managers to make sure these profit and growth rates are achieved. Creating profits and achieving growth are conditions of employment for managers of for-profit health facilities. If they fail, they're fired.

It is important to keep in mind, however, that the individual private doctors who practise under Medicare are not exposed to the same pressures from managers to maximize their profits. Most physicians are well paid for their services and enjoy a comfortable standard of living. They are not being hounded to increase their "sales" by 15% every year by a corporation, and in any case their fees are negotiated and set under the terms of their agreement with provincial governments.

The for-profit health care companies, on the other hand, as they become established in Canada, are being put under pressure by the same demands for growth and profit that are made on for-profit HMOs in the U.S. Take MDS, for example. Associated with some of the largest American HMOs, it has become a major player in medical-lab services in Canada. MDS is a major investor in the Alberta-based Health Resources Group (HRG), which wants to open an overnight surgery facility in Calgary. In a recent "Investor Fact Sheet," MDS boasts of having "a strong record of growth and profitability. In 1998, the company achieved its target of \$1 billion in revenues two years ahead of schedule...A new target: \$2 billion by 2003...MDS has achieved... earnings per share over the past five years in excess of the 15% target established by the company..."

The giant American HMO, Physicians' Health Services (PHS), lists its organizational goals in this order: 1) maximize earnings; 2) maximize growth; and 3) become a world-class organization. No mention of "health" or "health care" or "patient," or anything else related to health care. Its goals could apply equally to General Motors or Pizza Hut.

In their book **Clear Answers: The Economics and Politics of For-Profit Medicine**, Kevin Taft and Gillian Steward express amazement that any government genuinely concerned about costs would seek to increase the role of

corporations dedicated to profits rather than caring for patients. “In remorselessly pursuing profit and growth,” they note, “these companies are doing exactly what is expected of them. [Promoting their takeover of health care services in Canada] is the height of folly. It lays the ground for financial disaster in health care.”

The shift from a service ethic to a commercial ethic, says U.S. health economist Donald Light, “is perhaps the most profound and costly danger for any health care system.” Analyst Bernard Lown, in the **Boston Sunday Globe**, is even more caustic. “For-profit health care is an oxymoron,” he writes. “The moment care is rendered for profit, it is emptied of genuine caring. This moral contradiction is beyond repair. It entails abandoning values acquired over centuries of professionalizing health care into a humanitarian service.”

## The cost of fraud

The drive to maximize profits in the private sector can sometimes lead to questionable—even criminal—practices, and the for-profit health care sector is no exception. The CEOs of several prominent HMOs in the United States have been charged and convicted of outright fraud, on a major scale, and either hit with heavy fines or jailed.

For example, executives of the giant Columbia-HCA hospital chain in the U.S. were recently convicted, fined and jailed for fraud in the latest stage

of a wide-ranging and long-running prosecution by the U.S. Department of Justice. National Medical Care, the world’s largest provider of kidney dialysis services, was also convicted of fraud earlier this year and fined a record \$486 million. National Medical Enterprises, another huge American HMO, has been forced to pay out over \$700 million to settle what has been called “the largest case of health care fraud in U.S. history.”

These are not small or “fly-by-night” outfits, but industry leaders, the largest in their field, and their pattern of behaviour is systematic—a natural outcome of injecting the drive for profit into the field of health care provision. As a former manager of Columbia/HCA hospitals repeatedly declared, “Columbia hospitals exist to make money—period.”

## Buyer beware

The inappropriateness of applying the methods of private enterprise to a social program like Medicare should be obvious to everyone. The competitive market can sometimes compel private firms to behave in ways that meet public objectives. But the conditions—informed buyers with the ability to assess the value of comparable products and to decide whether to buy them or not—are clearly missing when it comes to health care.

As Taft and Steward point out, normal market processes work well when 1) there are lots of sellers and buyers who can easily enter or leave the mar-

ket; 2) buyers are knowledgeable enough to make informed decisions, 3) products are standardized so that buyers can buy the same item from any seller, 4) prices are free to go up or down without interference, and 5) customers are free to substitute one product for another (e.g., hamburgers for pizza).

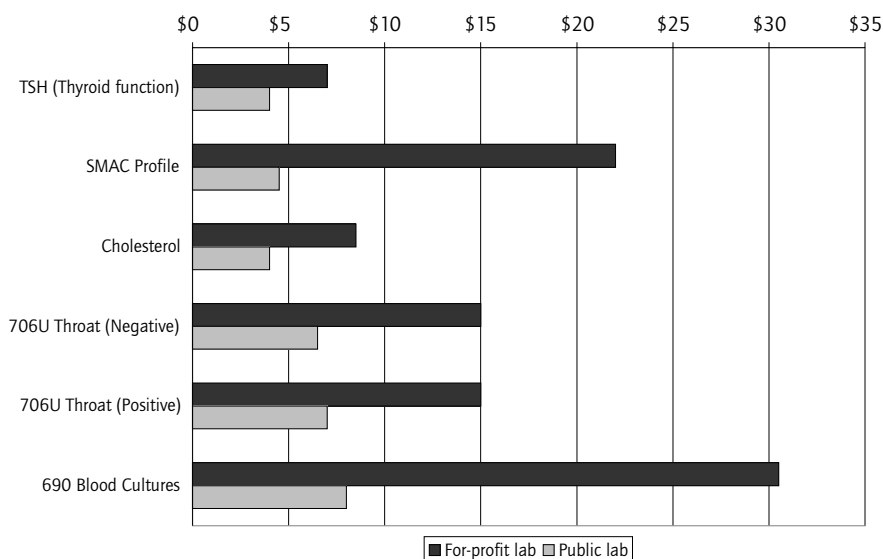
These conditions don't apply to health care. People who are sick lack the training and expertise of the doctors they consult. They can't diagnose or treat their own ailments. As Dr. Arnold Relman, former editor-in-chief of the **New England Journal of Medicine**, puts it: "Unlike the independent shopper, sick and worried patients cannot adequately look after their own interests...Personal medical service does not come in standardized packages and in different grades for the consumer's comparison and selection.

Moreover, a sick patient often does not have the option of deferring his purchase of medical care or shopping around for the best buy." There is also the problem of timing, since people usually cannot anticipate when they will contract ailments nor plan when and where they will need care.

In the commercial markets, shoppers can test-drive cars, try on new suits, or inspect show homes. They can return products for refunds. They can get repairs done under warranties. But how can a patient "test-drive" a cancer therapy or return an unsatisfactory therapy, drug or operation? Obviously, the "consumers" of health care are in no position to shop around. They have to trust their physicians and other providers to put patient treatment ahead of profits, trust their hospitals to put care ahead of profits, trust their governments to maintain a health care system that is not driven by profits.

### What lab tests cost:

#### Public laboratories versus for-profit laboratories



## The erosions of Medicare

The erosions of Medicare are taking place behind closed doors without real public consultation, let alone any public knowledge. In the case of the de-listing of services, for example, there exist no provincial or federal accountability mechanisms. There is absolutely no transparency in the process. Citizens learn they have to pay for something that used to be free while waiting in their doctor's office.

So, when one goes to an ophthalmologist in Quebec for a regular eye exam, this exam, which was free two years ago, is now \$40.

In a hospital, a patient with a broken leg who is told she also needs a leg-cast is told that, if she chooses the regular cast, it is free, but should she prefer the ultra-light cast (who wouldn't?), it will cost her \$85.

In Ontario, PSA tests for prostate cancer also used to be covered by Medicare, but now men are charged \$20 or more for a test that is surely as "medically necessary" for them as a mammography is for women.

—Monique Bégin

*Former Federal Health Minister.*

## Medicare's economic advantage

Those who are pushing to transform Medicare in Canada into the kind of profit-driven system that prevails in the U.S. seem unaware of—or choose to ignore—the enormous economic advantage that companies in Canada enjoy as a result of not having to pay for their employees' health coverage.

To his credit, at least one private sector executive—Toronto Dominion Bank CEO Charles Baillie—has publicly acknowledged that Canada's publicly-funded health care system is an economic asset, not a burden. Speaking to the Vancouver Board of Trade, he pointed out that "it would cost every business, large and small, more if they had to pay for benefits themselves. It would, in a very real sense, constitute a *de facto* increase in taxation—for employers or employees, or both...In an era of globalization, we need every competitive and comparative advan-

tage we have. And the fundamentals of our health care system are one of those advantages."

Baillie understands—if many other CEOs in Canada seemingly do not—that, if for-profit health care keeps growing in Canada, it will lead to higher overall costs, thus weakening one of our major trade advantages.

Chrysler, for example, estimated in 1998 that it spent US\$700 on health benefits for every car it produced in the U.S., but only US\$233 for each car it made in Canada. The magazine **Scientific American** estimated seven years ago that health insurance premiums added more than \$2,000 to the price of the average car manufactured in the U.S. It is not surprising, then, that labour negotiations in the U.S. break down more often over disputes on health care benefits than on any other issue. With most coverage in Canada provided by Medicare, health benefits are rarely in dispute in our labour-management bargaining sessions.

## Summing up

Taft and Steward summarize the problems with privatization this way:

- The basic purpose of private health care is to maximize growth and profitability.
- Investors expect (demand) returns of 15% and growth of 15% annually.
- Executives, in addition to running health care facilities, must devote substantial time and money to investor relations, marketing, corporate filings and securities requirements, and many other activities, many of which require expensive expertise.
- Stock options and other incentives to executives add expense, and fuel a powerful vested interest among executives and clinicians that drives up service demand, revenues, and—in the process—costs.
- Marketing—research, design, implementation, evaluation—is both necessary and expensive.
- Processing the multitude of private insurance schemes requires far more administrative resources than are needed with the universal plans of a public system, and so does the

detailed accounting for each part of care.

- Taxes on income and property must be paid, and so political contributions become strategically useful.

Since none of these costly procedures—including the high costs of lawsuits—are required of public health care providers, we shouldn't be surprised to learn that for-profit health care organizations consistently incur more expenses than their public counterparts, and that hospitals that convert to for-profit status invariably see their costs soar.

When it comes to **purchasing** rather than **delivering** services, the single-payer public system brings down costs because it is the only market for suppliers and thus can negotiate the lowest prices. In a competitive, multi-purchaser system, the sellers have the advantage and so prices are inevitably higher.

In short, privatization in all its forms costs more, while reducing access and quality of care for patients and creating worse conditions for providers.





# Chapter III

## Privatization: Private investors

**R**estructuring in the health sector has occurred very rapidly during the last decade, and on several different fronts. Much of this restructuring has occurred in response to the demands of corporate investors, both domestic and foreign, in health services provision, prescription drugs, and supplies. Not surprisingly, therefore, many of the changes have benefited these very same investors, adding unnecessary costs to the health system and negatively affecting public access to services.

These changes include, but are not limited to:

- reduced or constrained public funding for both services and infrastructure;
- increased private spending for health care, including out-of-pocket payments;
- an increase in the amount of public funds going to for-profit providers;
- the shift of out-patient hospital services (defined in the Canada Health Act as acute, rehabilitation

and chronic care) to providers located outside of the hospital sector;

- changes in the relationship between non-profit providers and public payers;
- consolidation within the private sector through mergers and acquisitions;
- an increase in foreign investors in Canadian health companies; and
- an expanding role for venture capital in the health industry.

### Restructuring

Restructuring in the health care sector begins at the top. Until the early 1990s, Health Canada took the lead role in setting and enforcing national standards, and ensuring that the provinces were upholding the criteria of the Canada Health Act. However, the department's role has shrunk during the last decade, while Industry Canada has assumed greater and greater responsibilities in the health sector. Health Canada now is in danger of being reduced to a regulatory agency with an

increasingly narrow range of responsibilities in the area of public health.

Health Canada's International Affairs Directorate was set up in the mid-1990s to work under the direction of Industry Canada and the Department of Foreign Affairs and International Trade (DFAIT). Its job, outlined by its chief executive, Ed Aiston, to an audience of foreign and domestic investors in 1997, is "managing the program of support to Canadian exporters of health care products and services and providing assistance in attracting foreign investment."

These activities complement those of Industry Canada, which promotes growth and expansion of the private health industry. Canada's health industries are growing annually by more than 30%, with annual revenues earned in the domestic market of almost \$2 billion. DFAIT also plays an important role in Canada's burgeoning health industry, working to attract foreign capital to support industry consolidation (mergers and acquisitions) and expansion. This focus on the global marketplace underscores the growing importance of transnational corporations, whether domestic or foreign-based, in our health sector.

Provincial governments are also hard at work to make room for health investors. Ontario and Alberta have explicitly embraced an increased role for the corporate sector, but all provinces have overseen the shift of outpatient services from publicly-funded hospitals to fee-for-service clinics.

Small stand-alone rehabilitation clinics, for example, are increasingly replacing hospitals as the primary venue for outpatient services, often delivered under contract to workers' compensation boards or private insurers.

These operations are targeted for acquisition by larger investors, both Canadian and American, who charge the public health insurance system as well as a user fee to the patient. Despite the clear violation of the Canada Health Act inherent in user fees for hospital services, provinces prefer to flout federal legislation rather than displease investors.

The fracturing of public authority is particularly stark at the provincial level, and is a kind of reverse reflection of the rapid consolidation occurring in the private sector. Some provinces have shifted many of their funding responsibilities to regional or local health authorities, and some have supported a shift to competitive tendering practices that favour large companies over non-profit and community-based (and accountable) providers.

This type of contracting-out has replaced public funding—almost entirely for some services (for example, home support)—with a NAFTA-friendly public procurement model in which corporations with the greatest resources can underbid non-profit competitors. Yet New Zealand, which pioneered competitive tendering for health services, is abandoning the practice in favour of a more efficient and

## From public to private

A Montreal hospital closed by the provincial government in 1997 is now operating as a private surgery clinic (in apparent violation of the Canada Health Act) which takes paying patients unwilling to wait for minor operations—and is doing so with the full knowledge of the Quebec government.

The Institut de Polychirurgie de Montreal, formerly the Guy Laporte Hospital, charges patients a "facility fee" of about \$400 per hour of operating-room time for things like hernias and varicose veins.

Surgeons from public hospitals in Montreal, Laval, and the South Shore perform the operations, charging for them under Medicare. It is clearly illegal, but the doctors say it's the only way to ease long waiting lists for minor surgery at the public hospitals—an 18-month wait for hernia repairs, for example. These long waits were caused by the government's wave of hospital closings in the mid-1990s.

"Everyone knows we're doing it," said Dr. Jacques Letendre, an anesthetist who owns the clinic on St. Joseph Blvd. E. with other doctors. "The government knows, the Health Department knows."

Although it contravenes the Quebec Health Act, the Quebec government has budgeted for the private clinic's operation, even collecting provincial sales tax rung up on patients' bills at the clinic, even though the fee is for a publicly insured service.

—*The Montreal Gazette.*

affordable public funding model of delivery.

## Who finances the health industry?

Changes in the public policy arena initiated during the last decade continue to ripple through the health sector in highly visible ways. What is less visible are the effects that changes in the marketplace are having on Canada's universal Medicare system.

The private market is a volatile and unstable environment at the best of times, and during the past 10 years its growing intrusion into the health sector has been reflected in the increased turbulence—and decreased access — many people are experiencing. As the Toronto-Dominion Bank increased its sizeable investments in the home care

industry during this period, elderly Canadians found it increasingly difficult to negotiate the growing number of barriers to home support and home nursing. Meanwhile, the Reichman family's real estate empire has expanded into the nursing home business where its company, Central Park Lodge, now holds the No. 1 spot. The Reichmans are also expanding south of the 49<sup>th</sup> parallel, using the fees it charges residents in Canada to proping up nursing home investments in the U.S. market.

The seniors market is a lucrative one for an array of investors, according to Industry Canada, a "high growth area" because of "an increasing number of affluent, older citizens with chronic health conditions." High returns in Canada's health care market were also identified by King's Health

Centre, based in Toronto, a company that houses a wide range of common medical services and provides counseling, psychotherapy and diagnostic tests and nutrition programs. The emerging scandal involves fraud and racketeering—two classic and quintessential characteristics of American-style health care.

When King's first opened its doors in 1996, it was intended mainly to deliver deluxe health care services to rich executives. Critics warned it was the "thin edge of the privatization wedge."

Attention focused on two important questions:

- Could doctors who practised at this investor-owned clinic continue to bill OHIP or would they have to opt out of Medicare if they wanted to take money from private payers, as required by the Canada Health Act?
- Would the investors in King's—for example, Ron Koval and his brother, Greg—be getting any public health care money (said to be in scarce supply) to support their business?

## Contracting out cataract surgery seriously flawed—Consumers' Association.

The practice of contracting out publicly-insured cataract surgery to private clinics is seriously flawed, says the Alberta branch of the Consumers' Association of Canada.

In a report by Wendy Armstrong—"The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft"—the Consumers' Association charged that, instead of being a solution to rising costs, longer waits, and less-than-ideal patient care, the increased reliance on private business has been the **cause** of many of these problems.

Armstrong's study found that the growth of private cataract surgery clinics in Alberta has:

- increased public waiting lists;
- increased the cost of services, the price to patients, and the cost of health plan coverage to the community at large;
- created a number of conflicts-of-interest which jeopardize patients and taxpayers; and
- decreased public scrutiny, public accountability, and public control of the Alberta provincial health care plan.

"There are now two public health insurance plans in Alberta: the promise and the reality," said Armstrong. "The promise is that all medically necessary surgical procedures recommended by one's physician will be fully covered by the public plan. The reality is that many cataract patients in Alberta incur major out-of-pocket charges (up to \$1,500) for products related to insured surgery which their doctor has identified as medically beneficial."

She found that, the greater the reliance on private clinic services in a community, the higher the incidence and magnitude of charges to patients for services that are supposed to be fully publicly-insured, and the longer the waiting lists for surgery.

The number of private surgery clinics in Alberta increased from four in 1980 to 53 in 1999. The Consumers' Association study charged that the sharp cuts in public hospital capacity and legislation to facilitate contracting-out in 1994 have served as a "public bail-out of investors in private clinics...In Calgary, all eye surgery, from cataracts to corneal transplants, is now contracted out to private clinics."

King's founders initially said their plan was to offer services not covered under Ontario's health-care plan. But in the following years, the company argued, on the one hand, that they received little or no OHIP funds, and, on the other, that they were practically a public facility because they provided OHIP-funded services. "All we've done is look at the various opportunities which are in the non-OHIP arena, and simply consolidated them," said Scott Addison, a senior VP with the company, in June 1996.

Eighteen months later, however, Greg Koval, King's executive vice-president, argued that the Centre was almost a "public-private facility" because it also provided all OHIP-funded services to the public, as well as catering to executives.

In fact, King's 80 medical practitioners continued to carry on regular OHIP practices while working at the for-profit clinic, turning over 40% of their fees to the company to cover overhead and administrative costs. Addison said that indirect OHIP funding "allowed us to start the engine of the King's Health Centre and get that critical mass in terms of revenue."

In October 2000, a mere four years after it opened its doors, newspapers reported that Ron Koval had "mysteriously disappeared," along with an estimated \$12-to-\$50 million that allegedly belonged to King's investors and their main financial backer, the Bankers Acceptance Corp. Fraud investigators were called in to track the compa-

ny's missing funds and to lay criminal charges of felony against Koval and his wife.

"They are considered fleeing felons...not missing persons," a police source said the day after the couple disappeared.

Meanwhile, at the time of writing, the U.S. Secret Service had launched an investigation of its own for undisclosed reasons.

Another marketplace fiasco involves Columbia Rehabilitation, a former subsidiary of U.S.-based Sun Healthcare Group (SGH). When Sun acquired Columbia from MDS, Inc., in 1995, it helped finance an aggressive acquisition drive across the country that lasted until it was forced into bankruptcy in 1999.

Sun also faced a class action suit filed by its skilled nursing and long-term care facility employees, who charged that Sun forced them to work undocumented, uncompensated overtime to boost profits. The company was also the subject of accusations made by patients of poor quality care and even abuse in the Northeastern states. Since then, Columbia, whose Chief Medical Officer is a principal in Alberta's Health Resources Group, has been sold by the U.S. company, part of a reorganization which included layoffs of up to 10,000 employees across North America.

## **He who pays calls the shots**

In 1990, Columbia was a small company based in Kelowna, B.C. It had just two clinics when its new owner, Bill

Brown, began combing Bay Street for cash to finance a major expansion across the country. Brown raised \$10 million in venture capital funding from MDS, Inc., Manulife Financial, Prudential Insurance, and the Ontario Hydro pension fund. By this time, venture capital investors, along with banks, were plowing money into Canada's health sector in exchange for equity in a growing phalanx of new health care companies.

The opening of the controversial Alberta-based private hospital called HRG Health Resource Group, Inc. was made possible with contributions totaling \$3 million from three MDS-controlled venture capital firms during 1997 and 1998. Like Columbia, HRG plans to "go national," too, having registered in Ontario, British Columbia, and several other provinces.

The top venture capital investors in the health industry include Canadian Medical Discoveries Fund (CMDf), Working Ventures Canadian Fund, MDS Capital, Sofinov and BioCapital. Sofinov, based in Montreal, is a subsidiary of Caisse de depot et placement, and is the largest venture capital fund in Canada, backed by the CDP's \$105 billion worth of assets. Its investments take place in Canada as well as in the global marketplace. BioCapital, set up by the Solidarity Fund, has an investment fund of over \$1 billion, and includes many large institutional investors such as the Royal Bank.

MDS Capital Corp., a subsidiary of MDS, Inc., is one of the largest and most aggressive of the venture capitalists, supplying over \$800 million for new businesses in the health and biopharmaceutical sectors. Richard Lockie, MDS Capital's senior Vice-President, boasted in 1998 that the company earns an average annual return on investment of 30%.

In addition to its own investments, MDS Capital controls seven other venture capital funds, including:

- MDS Life Sciences Technology Fund, a \$187 million cache. Its investors include U.S.-based Teachers Insurance and Annuity Association, the Royal Bank of Canada, Mitsui & Co. Ltd. of Japan, and a syndicate of Taiwanese investors;
- MDS Health Ventures, which in turn controls MDS Ventures Pacific, and administers the B.C. Life Sciences Limited Partnership with the B.C. Government and the Royal Bank of Canada;
- The Canadian Medical Discovery Fund, with \$250 million and an investment portfolio of over 40 companies, including HRG Health Resources Group. CMDf's partners include the Medical Research Council (now the Canadian Institutes for Health Research), the Talvest Fund, the Professional Institute of the Public Service (PIPS) and CIBC Wood Gundy;
- University Medical Discovery Inc., a \$180 million fund established with the help of CMDf;

## Privatization: a cascading process

The cascading nature of privatization starts with the federal government when it embraces a neoliberal ideology. It then enters into “free trade” agreements with other countries. It creates a fiscal crisis that it says can only be resolved by drastic cuts in social spending. It slashes UI and welfare benefits, and reduces transfer payments to the provinces, including those that make up the federal share of health care funding.

The provincial governments, which have adopted the same neoliberal agenda, seize on the federal cutbacks to cut their own social spending and so reduce their own transfer payments to lower levels of government and public institutions. Health care and social services at the community level soon become less accessible, less affordable, and less effective.

This cascading effect continues when the diminished quality and access are cited by the free-marketeers as “proof” that the public sector is inherently inefficient and that the only way to “fix” the deteriorating health care situation is through further privatization.

Those with above-average incomes set an example by turning to privately-provided services for faster and better care. While it may be assumed that they are paying their own way, they are actually heavily subsidized by the public system and the fees are more like “tipping” to get to the front of the line. Thus abandoned by the upper and upper-middle classes, the public system no longer retains universal support and becomes even more vulnerable to political subversion.

- The Health Care and Biotechnology Venture Fund has \$60 million focused on start-up companies. In addition to a \$250,000 contribution to HRG Health Resources Group, the fund has also invested in Columbia’s former parent, Sun Healthcare, Saskatchewan-based BioStar, Inc., Hemosol, Inc. and AnorMED Inc.

Canada’s private health industry has changed enormously during the past 10 years as the market has forced a consolidation of entities through mergers and acquisitions. There are new kinds of investors involved in our health system, as well: foreign-owned companies such as Olsten’s or Aetna, who may be under criminal investigation back home, are the privatized face of Canadian health care, along with domestic and foreign venture capitalists and bankers.

These changes have been supported by federal and many provincial governments, both directly and indirectly. Trade liberalization is making it easier for global investors to solidify the gains of the marketplace, while public authority over health care has continued to fracture and weaken.

These developments are not good news for Canadians. However, there is an ironic ring of hope that surrounds the increased privatization of our health system. The aggressive nature of privatization in Canada, and the high cost we are paying to support profit-driven health care investors, is forcing us to think about how we fight for our principles. In addition to enforcing the Canada Health Act, we need to develop new methods of defending our health care system, and of expanding the principles of equity and universality.





# Chapter IV

## Privatization: NAFTA & the GATS

Canada's health care system is coming under increasing pressure from international trade deals, particularly NAFTA (the North American Free Trade Agreement) and the proposed GATS (the General Agreement on Trade in Services). These agreements, stripped of their complexities, are little more than charters of rights and freedoms for transnational corporations. One of their purposes is to facilitate and speed up the privatization of health care so that the transnational corporations (TNCs) in that sector—mainly U.S.-based HMOs—can penetrate Medicare and take over more of its services.

Lawyer Barry Appleton, an expert on trade agreements, has expressed the basic conflict between Medicare and NAFTA in this comment: "At its very heart, NAFTA protects the logic of the free market—an idea which inevitably conflicts with the nature of Canada's health care system. NAFTA is structured to protect and encourage government measures that increase access to markets. This results in NAFTA irre-

versibly protecting the trend towards private health care while eroding the ability of governments to reverse this trend."

Appleton pointed out that, "if governmental action harmed an investor's property [such as market share or good-will], that investor could make a claim for expropriation under NAFTA. Thus, whenever government leaves an area of health care to the private sector, its return will invariably be costly."

This is not abstract theory or speculation. Already, the terms of NAFTA have been invoked by corporations to overturn federal policies aimed at protecting Canadians' health. The Chrétien government's legislation to force the tobacco companies to convert to the plain packaging of their cigarette packs was withdrawn after two large tobacco firms, Philip Morris and R.J. Reynolds, protested that it violated the NAFTA investment and intellectual property clauses. The government's ban on the import of the Ethyl Corporation's toxic gasoline additive MMT was also dropped after Ethyl threat-

ened to charge Canada under NAFTA with expropriating its assets. The government apologized to Ethyl (for putting people's health ahead of corporate profits?) and paid the company \$20 million in damages and legal costs.

Both these NAFTA challenges achieved their goal of killing public health measures, even though neither dispute went to a dispute panel for judgment. There is now reason to fear that other NAFTA provisions could open up Canada's not-for-profit hospital sector to commercial competition. Alberta's Bill 11, for example, allows that province to license for-profit hospitals to provide insured health services for which they can also charge private fees. If this project were to involve foreign investment, a U.S. private health care provider wishing to do the same thing in Alberta, or any other province, could claim the right (under NAFTA's National Treatment section) to equally favourable treatment as that provided to a foreign investor in Alberta.

The most serious challenges to Medicare may come from U.S. corporations, powerfully aided and abetted by the U.S. government, which is determined to open up its trade partners' public sectors to corporate participation. Senior U.S. trade officials last year explained the American agenda for health care outside the U.S. to the British magazine **The Lancet** in these words: "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."

The federal government claims that it protected Medicare from the terms of NAFTA by "reserving" it as "a social service provided for a public purpose." But this is a fragile claim, both because the wording of the reservation is ambiguous and tortuously legalistic rather than clear, and because private firms have already been allowed into the delivery of health care in Canada, thereby setting precedents that open the door to further privatization. Indeed, the U.S. Office of the Trade Representative has bluntly stated that, "where commercial services exist, that sector no longer constitutes a social service for a public purpose."

Two major points emerge from NAFTA—points that are reiterated and reinforced in the GATS.

First, all sectors that are not explicitly **and exclusively** reserved for public action are to be open to international trade and competition, if not immediately then as soon as possible. Under Article 19 of the GATS, member countries are obliged to pursue "a progressively higher level of liberalization" in any service sector involving a mix of private and public ownership. In a 1998 background note, the World Trade Organization (WTO) stated that countries where the hospital sector is a mix of public and private ownership, or where there are user fees or private in-

insurance, cannot argue for exemption under Article 1.3 of the GATS, which provides for “services supplied in the exercise of governmental authority” to be excluded.

Second, the opening of health care to any form of privatization is a one-way process. Once an Article 1.3 exemption is withdrawn, it can never be restored. If a country (or any region of a country) chooses, for example, to allow even one hospital to be operated on a for-profit basis, the entire country may then be committed to allow this trend to spread throughout its territory. Failure to do so rapidly enough to suit one of its trading partners (read: the U.S.) could precipitate a dispute lodged with the WTO—one that the complainant country or corporation would have a good chance of winning.

The Canadian government is second only to the U.S. in its support for more liberalized trade, and has aggressively challenged the policies and regulations of other nations on behalf of Canadian companies, such as those mining and exporting asbestos in Quebec. Canada is especially prominent in the current negotiations to expand the GATS, which are being chaired by Sergio Marchi, Canada’s ambassador to the WTO and a former minister of international trade in the Chrétien government.

The GATS is a complex agreement that breaks new ground in its coverage of services, including health care. It applies to any government measure “affecting trade in services.” All such

measures, in principle, are covered by the GATS, including laws, regulations, guidelines, licensing standards and qualifications, and limitations on market access. As long as it affects trade in services (even potentially or incidentally), a measure introduced to achieve a health purpose is in principle covered by the GATS obligations.

The GATS applies to measures taken by any level of government—including provincial, regional and municipal authorities—and even to measures taken by non-governmental agencies exercising powers delegated to them by any level of government. Regional health authorities, regulatory bodies, and even not-for-profit health care providers are therefore covered by the GATS obligations.

It applies to most public services and does not distinguish between commercial and not-for-profit services. Any service, including health care, which involves a mix of public and private funding and delivery, is subject to GATS on the same basis as are totally commercial services.

Citizens’ groups and organizations opposed to the expansion of the GATS are sounding the alarm over its potential threat to Canada’s social programs, especially Medicare. They are mobilizing to put pressure on the federal government to have its trade negotiators build into this agreement stronger safeguards for our health care system and other key social services. The first drafts, unfortunately, do not reflect such a commitment.



# Epilogue

## Privatization: Winners and losers

**H**ealth is not just an absence of illness, but the well-being of the whole person. This well-being comes from secure employment and decent incomes, from safe physical and social environments, from food, clothing, shelter, jobs and joy. Health is therefore fundamentally related to the distribution of resources and power, which in turn are linked to gender and race—in short, to the political economy.

Health also comes from the care provided for those who become ill or disabled. The working conditions and job security of these care providers is critical to health. Poor work environments for providers necessarily undermine the quality of care, as well as the health of providers.

These are the key determinants of health. Instead of building a health care system upon these determinants, however, we have built a system based on the medical model of care. In this model, people are reduced to a variety of body parts suffering from ailments that can be cured or alleviated by doc-

tors on the basis of scientifically established procedures or drugs. Undoubtedly this approach has saved some lives and improved or prolonged others. We will always need “cuts and chemicals” to deal with a whole range of ills.

But the research on the determinants of health tell us that the medical model has serious limitations—primarily because it does not address these social and economic factors, either within or outside the health care system.

The “reforms” of our health care system that have been initiated by governments in recent years have worsened this neglect. They have consisted mainly of applying to hospitals and other institutions practices taken from the for-profit, goods-producing sector. But these “reforms” could work only if body parts could be treated like auto parts—and if the determinants of health could be completely ignored for patients and providers.

In this privatized assembly-line model, parts are processed as quickly

## From private to public

It is possible to reverse privatization. It doesn't often happen that a health service, once privatized, is transferred back to the public sector. But it happened back in 1993 in Prince Albert, Sask., and the publicly-supplied service turned out to be a lot less costly than when it was provided in the private sector.

Prior to 1993, laboratory services in Prince Albert were provided by a private lab on a fee-for-service basis, with the private pathologist directly billing the government's Medical Care Insurance Branch.

Then the Department of Health asked the Prince Albert Health District if the Victoria Hospital could provide all the lab services for the district. The answer was that the hospital could do so, with only some minor additional equipment (worth about \$50,000) and could provide the services for an annual cost of \$600,000, compared to the \$1.1 million a year the private lab was charging.

"Since the switch from the private to the public provision of lab services," said the Health District's CEO, Stan Rice, "we have provided the same level of service, to the satisfaction of most physicians in the community, and do so for even less than the \$600,000 a year we had projected. So the savings were even greater than anticipated."

as possible, with as little labour time as possible. Care is minimized because it is not visible or easy to measure, and is thus considered of little importance. The number of providers is reduced, and the work of those who remain is made more intensive and stressful, less satisfying and secure.

The framework for these changes is a neoliberal ideology and a set of international trade agreements that reflect and reinforce the emphasis on efficiency, with efficiency defined in for-profit terms. The application of market principles rationalizes and accelerates the transfer of services from the public to the private sector. Processed and released from health care facilities "quicker and sicker," Canadians are forced to rely more and more on either the unpaid care of relatives and friends, most of them women, or, increasingly, on care provided by the for-profit sector.

The result is widening inequality, fewer choices, and less skilled and accessible care. It will also bring greater costs in the long run, since for-profit provision has not only proved to be less effective in delivering quality care, but has also been fixated on increasing sales and expanding markets. If continued, it will inevitably lead—as it has in the United States—to more expenditures on health care, not fewer.

All this privatizing and downsizing necessarily decreases the choices of all Canadians. Less and less care is available on the basis of citizenship; less is open to public scrutiny and choice. More and more care is coming to be based on ability to pay. And the growing foreign ownership of private, for-profit providers means fewer decisions are being made in Canada by Canadians.

Instead of privatizing Canada's health care system, our governments

should be seeking to move it toward a true care model and away from the medical model. This can only be done by applying the determinants of health to the provision of services—by revitalizing and rebuilding a public system that recognizes that care parts are different from car parts and that health is a democratic right of all citizens. The Canada Health Act provides some of

the necessary tools, if the federal government is willing to use these tools effectively. More are needed, however, to transform the system, and this is only possible if Canada resists the entrenchment of corporate rights to health care in international agreements.

The hard reality is that health care in Canada can either be preserved or privatized. It can't be both.

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