MEDICARE'S CRITICS
Back to "The Good Old Days"?

The airwaves are crackling, reams of newspaper columns are being written, TV news is full of it. Familiar faces and "experts" of whom we have never heard are endlessly talking about how we need to radically change the way that we fund and deliver health care in Canada. Here are a few of the key ideas - and the problems - that Medicare's critics are promoting.

"PPP"s
Public Private Partnerships

In December 2001, Ontario Health Minister Tony Clement announced the first two PPPs for hospitals in the country. These for-profit hospitals will be built in Brampton and Ottawa. The deal is this: a for-profit company or consortium builds the hospital and owns and runs all "non-clinical" services. They lease it back to the province under an approximately 30-year lease. After the end of the leasing period, the private company owns the hospital.

The problems? The first is that PPPs are expensive...*way* more expensive than building hospitals publicly. In Ontario, the full cost will not be revealed to us for quite some time. In Britain, a journalist George Monbiot, reported, "Between the first proposal for a hospital replacement or refurbishment and the conclusion of the final deal with private consortia, the British Medical Association has found the cost of the schemes has risen by an average of 72%". Vast sums of money went to profit, consultants, lawyers and more private borrowing. So, with a thirty-plus year lease, we bind our children into this expensive deal for an entire generation. After we pay more to build the hospital, give the private consortium a bunch of prime real estate and boost their profit margins, we have nothing to show for it. They own the hospital at the end of the leasing period.

The PPPs proposed by Clement are a very risky deal. Giving the private consortium control of all "non clinical" services puts profit-seeking corporations in control of key hospital functions. In Britain, private hospitals have resulted in a 30% reduction in beds. Profit is found through reducing costs: laying off staff, reducing numbers of beds, using the cheapest construction and design techniques.

Tried and Abandoned

In Ontario, the conservative government in the mid-80's planned for-profit hospitals in Mississauga and Hawkesbury. They pulled out when it became public that the scheme would cost the public $3 million more for the corporate profit.

In PEI, the government pulled out of its for-profit hospital project after it discovered that it would cost more than if the hospital were kept public.

Nova Scotia experimented with for-profit, leased-back schools. Again, the provincial government withdrew from these projects after it realized there were no cost savings to be had.

User Fees

Usually justified by the old idea that patients wontonly overuse the health care system, user fees are often talked about as a way to make people more responsible. But there is little evidence that patients actually overuse the system. In fact, in many ways, our access to health care is determined by our doctor: you can't just get a heart transplant because you feel like it, nor can you just pop in to see a specialist without a referral any more than you can get hoards of pharmaceuticals without a prescription. In fact, the recent reports calling for user fees do not bother to provide any evidence of patient misuse. Why? There isn't any.

Either way, the evidence is that user fees don't generally reduce costs. User fees were tried in Saskatchewan from 1968-1975. The poor and elderly cut back on seeing their doctors but higher-income people saw their doctors more often. Physicians got a raise. Health care costs didn't shrink. In Quebec, when the elderly and people on welfare had to pay user fees for prescription drugs, they took less medicine. They also got sicker and visits to emergency rooms increased. The evidence is that user fees are penny wise, pound foolish. They may reduce some costs in the short term, but cause higher costs in the long run as people neglect early treatment.

Medical Savings Accounts

Medical Savings Accounts (MSAs) could be more aptly titled "user fees for the sick". Generally the proposal is this: based on some kind of average health care usage, the provincial government will allot each person an amount of money per year to be spent on health care. Once that money is used up, we will have to pay - out of pocket or through private insurance - for care. The incentive not to use the health system is that if you don't use your allotment, you get it at the end of the year - in cash or in some kind of bonus.

With MSAs, we would pay people out of our public health dollars - for being healthy! But we would still need to pay for hospitals, nursing homes and other health care infrastructure. And we would still need a public, or - much worse - a private for-profit catastrophic medical insurance plan to cover people in emergencies. Those who could afford it would start to buy supplementary medical insurance to cover the costs between the level of the MSA allotment and the level at which the catastrophic medical plan would kick in. Not surprisingly, a U.S. Congressional Budget Committee study of MSAs found that they would cause costs to skyrocket.

Not only would MSAs cost more, but they would also mean that it would become harder to get health care when we need it. Under this scheme, once our MSA allotment is used up, we have to pay. MSA proponents gloss over what will happen to people who can't afford to buy health insurance and can't afford to pay for our care.

Why would anyone - who isn't a private insurance industry executive - support a scheme that is going to cost more, provide less coverage, create a huge and expensive administration, and violate values that we hold dear?

The problem with these "solutions of the future" is that they look an awful lot like the past. As previous generations can tell us, that past is nothing to go back to. Canadians already lived through a time when people were forced to go without life-saving or life-enhancing care because of inability to pay. That's why we created public Medicare in the first place. That's why we want to keep it and make it better.

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