PUBLIC PAIN, PRIVATE GAIN

The Privatization of Health Care in Ontario

A Report to the Ontario Health Coalition

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This is a summary of a longer and more comprehensive study by Paul Leduc Browne titled "Tipping the Balance: Health Care Restructuring and Privatization in Ontario." The full report is available from the CCPA and will be published shortly.

Text boxes have been supplied by the Ontario Health Coalition.

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Introduction

Medicare is Canada's most cherished social program. At its best, it provides medical care for all our ills, regardless of their severity and without requiring direct payment. Treatment is accessible to everyone, with no discrimination on the basis of income, age, gender or location.

In every poll that ranks Canadians' priorities, health care is always found at the top of the list, well ahead of education, tax cuts, and even employment.

In a democracy, governments are expected to share the priorities of the people they represent. In Canada, that means they would exert every effort to maintain and protect Medicare, and guard against any deterioration of its quality and accessibility. Such efforts would have broad public approval.

Instead, our governments—federal and provincial—have presided over its slow but steady debilitation. In Ontario, the signs are everywhere that this province's cuts to health care have created a crisis. Overcrowded emergency rooms, nursing shortages, waiting lists for surgery, rising user fees, cancer patients being sent to clinics in the United States—all reflect a serious breakdown of Medicare and the emergence of an inequitable two-tier structure.

Most alarming of all is the creeping privatization of health care in Ontario and across the country. More and more often, people are being asked to pay privately for services that formerly were paid for publicly, or are being forced to seek and pay for care from private for-profit agencies.

This growth of privatization raises a disturbing question: Has Medicare been deliberately underfunded at the behest of the large private health-care corporations? Has it been weakened for the very purpose of facilitating the private takeover of its most potentially profitable services? If so, it would explain the federal and provincial governments' betrayal of the public interest in this most vital social program.

The spectre of privatization is certainly very real in Ontario. The Harris government has made no effort to hide its commitment to the privatization of public services in general. In a speech in February 2000, for example, Finance Minister Ernie Eves said the government would entertain any "reasonable" proposal from private firms seeking "a financial stake" in public institutions and infrastructure. "Everything is on the table," he said. "If the private sector can find a way of providing services currently provided by the government in a way that is more cost-efficient ...then we are ready to listen."

Referring specifically to Medicare in a speech the same month to a Tory Party policy conference, Premier Mike Harris warned that medical costs were bound to escalate, and that "one issue that needs to be discussed is to what extent people

will be required to cover their own health-care costs."

This echoes a recurring claim being made by influential business and private health-care officials. They contend that Medicare as we have known it in the past is no longer affordable. They argue that the aging of Canada's population and the hefty prices of new medical technologies are raising costs beyond the ability of governments to pay. This in turn allegedly makes more private health-care provision inevitable, if not preferable.

The evidence suggests that the balance is indeed tipping towards privatization in Ontario. To be sure, the Harris government has not said or done anything (yet) to suggest it plans to throw the hospital sector open to competition from private hospitals, as Premier Ralph Klein has done in Alberta, nor has it said that doctors will be allowed to bill patients directly for all services currently insured by the Ontario Health Insurance Plan (OHIP). But privatization can take many paths and many years to develop. Medicare is far too popular in Canada for any government to undermine it openly and rapidly.

We should keep in mind that the massive cuts to social spending in the 1990s came only after the federal government and the business community had spent the previous 10 or 12 years persuading Canadians that the cuts were unavoidable. They did so with a barrage of alarmist cries about the supposedly disastrous results of ignoring the huge national debt.

The public was brainwashed into believing that the debt had been incurred by overspending on "too generous" social programs, and that the only way to keep from crashing into the "debt wall" was by cutting back substantially on the funding of Medicare, education, unemployment insurance, social assistance, and other pillars of a caring and sharing society. (The truth, of course, was that all but a small percentage of the rise in the national debt had been caused by the sharp and repeated increases in interest rates during the 1980s.)

Similarly, the people of Ontario today, having been subjected to the same propaganda blitz, are witnessing the piecemeal privatization of health care in the province. Private sector business strategies and management ideologies are being injected into the public health care system. Public funding is being frozen or cut back. Publicly-delivered services (especially by hospitals) are being curtailed or rationed. And costs are stealthily being shifted from the public purse to patients' pocketbooks.

Privatization of this kind is not the result of a series of isolated events. Nor does it emanate from specific government policies or from decisions by hospital boards, or even from the actions of private corporations. Rather, it is a **process.** It proceeds in several stages and levels that Pat Armstrong graphically describes as a "cascade."

The cascade starts with the federal government when it embraces the right-wing ideology. It then enters into "free trade" agreements with other countries. It creates a fiscal crisis that it says can only be alleviated by drastic cuts in social spending. It slashes unemployment insurance and welfare benefits so as to eliminate "labour market rigidities" (i.e., push down wages). It further reduces its debt / deficit by slashing transfer payments to the provinces, including those

that make up the federal share of health care funding.

The provincial governments have also adopted these destructive agendas, both ideologically and in practice. So they zealously seize on the federal cutbacks as an excuse to cut their own social spending and to reduce their own transfer payments to lower levels of government. Health care and social services at the community level soon become less accessible, less affordable, and less effective.

The cascading effect continues when this 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 worsening health care problems is through further privatization. Those with above-average incomes set an example by turning to privately-provided services for better quality and access. Thus adandoned by the upper and upper-middle classes, the public system no longer retains universal support and becomes even more vulnerable to political subversion.

Chapter 1
Health Care: A Right or a Commodity?

Canadians expect to receive the best possible health care whenever they need it. They look upon it as an entitlement, and indeed it is—or used to be.

The right to health and to health care is even enshrined in Canadian law, as well as in the covenants of the United Nations. It is considered a right of citizenship: the right to be treated as equals, irrespective of race, creed, or **ability to pay.** But it also helps **make** us equal—equally free to participate in the economy, in society, and in public life. It is, in short—or should be—a fundamental right in any truly democratic system.

This right to health care, however, can only be guaranteed if it is publicly provided and funded. It cannot be assured if health care is treated as just another commodity to be left to the marketplace to provide. The private health-care business, like any other private enterprise, is driven by the need for profit. It diverts money away from care into the pockets of its shareholders. It ignores those who cannot afford its services. It focuses exclusively on curative rather than preventive medicine.

Given these proclivities, market-driven health care may be effective for the wealthy, but it fails all tests of adequacy for working people, the poor, the elderly, and the very sick. This is why Canada's health care system was devised to make its services publicly funded and delivered, universally accessible, and actuated by need rather than personal income levels. In short, health care was intended to be a basic right, not a commodity to be bought and sold.

The effect of privatizing health services, then, is to commodify them—which is to violate the fundamental principles on which Medicare was created.

The Cascading Process Begins

It was the proponents of the health-care-as-a-business model who led the long and successful campaign to undermine Medicare and thus set the stage for its privatization. They began at the federal level, knowing that, although the provinces have jurisdiction over health care, it is beyond their financial capacity to fund it adequately on their own. They need federal help to defray their share of the annual overall cost (as of 1998) of some $80 billion.

So the federal government, going back to the late 1930s, established a presence and played an active role in many areas constitutionally under provincial jurisdiction—including health care. By setting national standards in the Canada Health Act and more generously subsidizing the "have-not" provinces, Ottawa made sure that Canadians in all provinces and territories would enjoy equal access to quality care. Any province tempted to stray from the five core principles of Medicare enshrined in the Act—universality, comprehensiveness, accessibility, portability and public administration—would risk

having its federal transfer payments cut proportionately.

In the late 1970s, however, as the cost of Medicare kept rising, Ottawa pulled out of formalized cost-sharing and moved to a system of block grants to the provinces. This arrangement was legislated in the Established Programs Financing (EPF) bill passed in 1977. Under EPF, the three major programs—hospital insurance, Medicare, and post-secondary education—were changed from cost-sharing to a block funding system that combined cash payments with transfers of federal taxation powers (or tax points).

It seemed to be a satisfactory arrangement for a few months, but soon came a series of EPF transfer cutbacks—first by the Trudeau government under its "6-and-5" anti-inflation program, then by the Mulroney government's Bill C-96 in 1986 which restricted the increase in the EPF to 2 percentage points below the annual growth of GNP. (If, for example, the economy were to grow by 3%, the provinces' EPF payments would be increased by only 1%.) This was followed by the Tories' 1990 federal budget which froze the EPF per-capita cash transfer to the provinces for two years, and then their 1991 budget which extended the freeze until 1995.

This five-year freeze entailed enormous losses of revenue for the provinces—losses that posed serious threats to national health care standards. Compounding this huge EPF shortfall was the Mulroney government's imposition in 1991 of a "cap on CAP"—CAP being the Canada Assistance Plan under which the federal government shared the cost of social assistance and social services with the provinces on a 50-50 basis. The "cap on CAP" targeted the three "richest" provinces—Ontario, Alberta and British Columbia—limiting them to a maximum increase in this transfer of 5% per year. This led to wide disparities in the amounts individual provinces received from Ottawa for their recipients of social assistance.

In the context of a deep recession and the mass layoffs precipitated by the Canada-U.S. Free Trade Agreement, these cuts had a devastating impact on provincial finances. But the shrinkage of federal transfers tightened even more when the Chrétien government, in its 1995 budget, combined EPF with CAP to create a new block funding program called the Canada Health and Social Transfer (CHST). In addition to eliminating CAP's cost-sharing for social assistance and social services, for health care, post-secondary education, social assistance and social services the CHST reduced the total federal cash transfer to the provinces by another 33%, from around $18 billion to approximately $12 billion.

Federal cash transfers to Ontario for health care under EPF peaked in 1993-94, while the tax component continued to rise. The truly crushing blow came in the wake of the 1995 federal budget. Prior to this budget, Ontario's combined EPF / CAP cash payments from Ottawa totalled $6.2 billion. In the next fiscal year, it fell to $4.7 billion, and a year later to $3.8 billion. The increased federal transfer payments announced in the 1999 and 2000 federal budgets will bring it back up to $5.3 billion by 2004, but this will still be below the level it was in 1990-91—and even less when the increases in inflation and population growth are taken into account.

The Harris government has complained often about these federal cutbacks. But its displays of outrage should be weighed against its policy of repeatedly cutting income taxes—and thereby reducing its own capacity to fund health care. Surely a government genuinely concerned about health care would try to offset the federal cutbacks by retaining—even increasing—its own financial resources.

Clearly both levels of government are pursuing the same underlying social agenda, which involves cutting all income-security programs that benefit working people and the poor. The cuts to social assistance and unemployment insurance—and even to post-secondary education—have been made openly and blatantly. But the much higher levels of support for Medicare require the politicians to be more cautious and gradual in dismantling it. So they continue to pay lip service to the Canada Health Act and its five basic principles while stealthily undermining them.

In the case of the Harris Conservatives, their "common sense revolution" is a potent brew of privatization, underfunding, and downsizing, all key elements of their free market ideology. According to this right-wing doctrine, the private sector is a more efficient mechanism than government for delivering social programs and allocating society's resources. A strictly capitalist system supposedly provides the greatest individual freedom, giving everyone an equal opportunity to compete in the market and succeed or fail on the basis of their hard work and ability. The role of the state should be to ensure that the rules of the marketplace and the sanctity of private property are respected, but beyond that

Table 1
Federal transfers to Ontario under EPF and CHST, actual and estimated, 1991-2004
($ millions)

	1990-1991	1991-1992	1992-1993	1993-1994	1994-1995	1995-1996	1996-1997
Total EPF health entitlements	5,289	5,474	5,565	5,651	5,719	5,862	
EPF health tax EPF health cash	2,767 2,522	2,717 2,757	2,665 2,899	2,729 2,923	2,850 2,869	3,071 2,791	
EPF + CAP total transfers and CHST	9,485	9,849	10,085	10,320	10,536	10,739	9,651
EPF tax transfers and CHST tax	4,077	4,003	3,927	4,020	4,199	4,525	4,864
EPF + CAP and CHST cash	5,409	5,846	6,158	6,300	6,337	6,214	4,787
	1997-1998	1998-1999	1999-2000	2000-2001	2001-2002	2002-2003	2003-2004
EPF + CAP total transfers and CHST	9,315	9,717	10,968	11,571	11,921	12,211	12,527
EPF tax transfers and CHST tax	5,428	5,862	6,129	6,328	6,570	6,852	7,165
EPF + CAP and CHST cash	3,887	3,855	4,840	5,243	5,351	5,359	5,361

Source: Federal and Provincial Relations Division, Department of Finance, Canada

Catch-22

Esther, living at Huron Park, is 54 and has arthritis. She can't take the medication prescribed by her physician because its cost—$101 a month—is beyond her means. Her arthritis limits her to part-time work, which means she is denied coverage under her employer's benefit plan. Her annual income is only $14,000 a year. She is caught in a classic Catch-22 situation: prevented from earning more because of her arthritis, but unable to alleviate the arthritis because she can't afford the medication.

the market should be left free to run the economy. All forms of regulation or restriction—even those legislating minimum wages, unemployment insurance and basic trade union rights—are regarded as undue interference in the "free" market.

This market-driven creed, as adopted and implemented by the Harris government after its election in 1995, called for "government to do business **like** a business—by focusing on results and putting the customer first," to quote from the **Common Sense Revolution** campaign platform. This means cutting red tape as well as "fat" and "non-priority government spending," reducing taxes, selling off government assets, and trimming government staff.

The Ontario Management Board in 1996 approved a new service delivery system designed to "help ministries choose the most appropriate delivery option for a particular program." Under this framework, each ministry was directed to prepare an annual "business plan," outline its restructuring proposals, and devise measures for redesigning and delivering programs more efficiently, using alternative delivery methods.

Since then, the Ministry of Health, along with other ministries, has dutifully produced annual "business plans" that openly refer to major program areas—hospitals, medical care, drugs, etc.—as "core businesses." As might be expected, the alternative service-delivery options considered by the ministry included privatization (defined as "[selling] the asset...to a private sector business"); franchises and licencing; public-private partnerships; buying outside services; transferring responsibilities (to municipalities, transfer-payment agencies, or non-profit organizations).

Chapter 2
The Impact of Privatization

The Harris government launched its attack on Medicare scarcely a month after being elected in 1995. Its much-ballyhooed anti-deficit program included a $132-million reduction in health spending. This was followed by a massive cut of $800 million in hospital budgets over the next four years, along with the imposition of user charges for the Ontario Drug Benefit Plan and for hospital patients waiting for beds in nursing homes.

One of the consequences of these cutbacks—probably one of their intents—was to speed up the privatization process that had already begun in the hospitals. Many had long since been reducing the length of stays and treating growing numbers of the sick as out-patients. The effect was to shift more and more patients from insured hospital treatment to uninsured nursing home and home care.

The immediate impact of the cuts was to create a crisis in health care—a crisis similar to the one that then Education Minister John Snobelen told his officials had to be created in the education system in order to justify wide-ranging reforms.

In the spring of 2000, the Harris government spent millions on a TV advertising blitz claiming it had vastly increased its health care spending while the federal government had sharply cut its share. The charge against Ottawa was true, but the Ontario government was less than candid in portraying its own health care funding figures.

As the figures in Table 2 clearly show, the province's total operating expenditures on health care declined in constant dollars for four years in a row, before finally recovering to 1993-94 levels in the 1998-99 fiscal year. On a per capita basis, they fell from an average of $1,765 in 1995 to $1,686 in 1999. Funding increases in 1999 and 2000 brought them back to 1995 levels, but have failed to restore all the money lost since 1995.

In fact, contrary to the TV commercials, the provincial government's spending since 1995 has not kept pace with inflation and population growth, resulting in a cumulative loss to Ontario's health care system of $2.2 billion.

In such a climate, it is not surprising to find that the balance between public and private health care spending in the province has been tilting toward the private sector since the Harris Tories were first elected. That balance was roughly 70% public and 30% private in 1995. By 1997 it shifted to approximately 62% public and 38% private—the highest private sector share of any province. (The national average was 30.6%.) Projections indicate that Ontario will have continued to hold that dubious distinction through 1998 and 1999.

The substantial increase in private sector health spending came mostly for drugs and the services of professionals other than physicians (mainly dental and vision care). This is consistent with a trend observed for Canada as a whole, with the higher increase in Ontario most

Table 2
Ontario Government Spending on Health Care

Fiscal Year	Health Care Operating Expenditures[1] ($ millions)	Health Care Price Index, Ontario[2] (1992=100)	Real Expenditures (1999 $ millions)	Ontario Population[3] (thousands)	Real Per-Capita Expenditures (1999 $)
1994-1995	$17,599	103.9	$19,107	10,828	$1,765
1995-1996	$17,607	104.0	$19,097	10,965	$1,742
1996-1997	$17,760	105.1	$19,061	11,101	$1,717
1997-1998	$18,284	107.1	$19,257	11,260	$1,710
1998-1999	$18,868	110.6	$19,243	11,412	$1,686
1999-2000	$20,444	112.8	$20,444	11,549	$1,770
2000-2001	$21,076	115.6	$20,562	11,699	$1,758
2001-2002	$21,708	117.9	$20,763	11,850	$1,752
2002-2003	$22,339	120.3	$20,948	12,004	$1,745
2003-2004	$22,971	122.7	$21,118	12,160	$1,737
1st term (99-00 minus 94-95)	$2,845	8.6%	$1,337	721	$6
1st and 2nd terms (03-04 minus 94-95)	$5,372	18.1%	$2,012	1,333	($28)

1. Health Care Operating Expenditures, Public Accounts and Ontario Finances, 2000-2001 through 2003-2004, 1999 Ontario Budget.
2. Statistics Canada, CANSIM Matrix P106085, inflation projected at 2.5% in 2000-2001, 2% per year thereafter.
3. Canadian Institute for Health Information. Population growth projected at 1.298% 2000-2001 forward.
Source: Bill Murnighan, "Health Care Spending in Ontario," Ontario Alternative Budget Working Group, Paper No. 8, April 2000

lately associated with the introduction of user fees for prescription drugs for seniors and welfare recipients.

The average Ontario citizen was paying $84 a year more in 1999 than in 1994 in out-of-pocket health care costs. With a population of over 11 million, this means that nearly $1 billion more is flowing into the private health care market from people's wallets and private insurance plans.

Of course, such figures only show us the shifts in cost that occur when individuals are willing **and able** to pay more out of their own pockets, or agree to higher private insurance premiums. **What remains unknown is the cost to those who cannot afford higher private sector prices, and who thus forgo treatments, services and products they had previously been able to access.** They do not show up in the statistics—nor does the additional suffering and impairment of their health to which they are subjected.

It is worth noting that combined public and private health expenditures as a percentage of GDP declined in Ontario from 9.7% in 1992-93 to 9.5% in 1994, to 9.3% in 1995, to 9.2% in 1996, and to 8.9% in 1997.

Re-engineering Health Care

The Harris government's Bill 26, the "Omnibus Bill" passed in November 1996, enacted and modified many laws,

including the Health Insurance Act, the Health Care Accessibility Act, the Ministry of Health Act, the Ontario Drug Benefit Act, the Prescription Drug Cost Regulation Act, the Public Hospitals Act, the Independent Health Facilities Act, the Regulated Health Professions Act, and the Physician Services Delivery Management Act. Among its many provisions, this legislation—

- empowered the Minister of Health to change the financing and operation of public hospitals, and even to order their shutdown or amalgamation;
- allowed private medical facilities, such as laboratories, to be established without tendering, and removed the requirement that preference be given to Canadian non-profit organizations, thus opening the door to U.S. for-profit firms;
- gave the Minister of Health the power to dictate where in the province physicians may practise;
- cut pay equity payments for women and gave hospitals new powers to roll back wages;
- implemented drug user fees under the Ontario Drug Benefit Plan; and
- forced thousands of hospital patients waiting for beds in nursing homes to pay a daily charge for room and board.

The implementation of these entrepreneurial reforms to health care in Ontario was entrusted under Bill 26 to the Health Services Restructuring Commission (HSRC), which was vested with sweeping powers to restructure the province's hospitals. In fact, the hospitals' share of provincial health spending—although historically the largest single share—had been declining steadily since the 1970s. It was 55.5% in 1975, 52% in 1980, 49.9% in 1985, 46.5% in 1990, 44.6% in 1995, and 43.9% in 1998.

Between 1989 and 1998, 64 Ontario hospitals were merged or closed outright, reducing the total number of hospitals in the province from 262 to 198, a 24.4% decrease. Table 3 shows that the number of acute-care beds fell by 33%, the number of chronic-care beds by 28.2%, the number of psychiatric beds by 16%, and the number of rehabilitation beds by

Table 3
Hospital Beds in Ontario, 1989-1998, by Year and Category

Year	Acute beds	Chronic beds	Rehab beds	Psych beds	Total beds
1989-1990	33,387	11,353	2,048	2,442	49,230
1990-1991	31,891	11,451	1,975	2,365	47,682
1991-1992	29,813	11,405	1,902	2,279	45,399
1992-1993	27,929	10,913	1,926	2,228	42,996
1993-1994	26,097	10,592	1,905	2,132	40,726
1994-1995	25,386	10,325	1,853	2,138	39,702
1995-1996	24,014	9,639	1,890	2,102	37,645
1996-1997	22,084	8,678	1,875	2,098	34,735
1997-1998	22,367	8,149	1,815	2,050	34,381
% change, 1989-1998	- 33.0%	- 28.2%	- 11.4%	- 16.0%	- 30.2 %

Source: Based on data provided by the Ontario Hospital Association

Stan's diabetic daughter

Stan, in Cobalt, has a daughter with juvenile diabetes. She is 22. When she turns 23, she will no longer be eligible for coverage under Stan's benefit plan. The cost of her supplies and medication is over $3,000 a year. Stan's family does not qualify for coverage under the Trillium Drug Benefit Plan. His daughter is just finishing school, and Stan is worried about her future. Unless she can find a job with a good benefit package after she graduates, the cost of her medication and supplies will be more than the family budget can absorb.

11.4%. Overall, the number of beds was reduced by 30.2% in 10 years.

The loss of so many beds led to shorter stays in hospitals and to a sharp rise in out-patient treatments. The number of people discharged from hospital fell by 5.9% between 1995-96 and 1996-97, while the discharge rate (the number of people discharged per 100,000 of population) fell by 7.1% during the same period.

Since 1996, 39 hospitals (33 public, six private) have been ordered closed by the Health Services Restructuring Commission, which was established under Bill 26. Six psychiatric hospitals have also been ordered closed by the Minister of Health. Forty-four other hospitals were amalgamated in 14 new multi-site corporations, and the HSRC also proposed that 100 more hospitals be combined in 18 networks or clusters.

The Commission's rationale for closing hospitals and forcing others to amalgamate was that they contained unused space that was being heated, lit and maintained, wasting resources that ought to have been used for much-needed new care. This reasoning, however, ignored the fact that most of the unused beds were not being used because the money needed to keep them open had been cut by the government. (The cuts had been excused as a way of shifting hospital care to allegedly more efficient community care, yet the community care resources had still not been created at the time the hospital budgets were slashed.)

The HSRC had to admit that its restructuring operations were very costly—that in fact they would cost the government $100 million more than they would save. Although the Commission had originally estimated the cost of its directives to hospitals at $2.1 billion, the Provincial Auditor calculated that the total costs could well reach nearly $4 billion. And the Ontario Hospital Association estimates that hospitals will have to raise about $1 billion to cover their share of the government-mandated restructuring, and another $1.6 billion for routine capital projects.

All this money, in effect, has flowed—and is still flowing—out of actual health care and into the pockets of the construction firms, developers and management consultants hired to do all the restructuring work. The private sector has profited at the expense of the thousands of nurses and other health care workers

whose jobs have been eliminated. The hospitals, too, are heavily in debt, with accumulated deficits of around $2.3 billion—a crisis that has prompted the OHA to plead for billions more in funding from the provincial and federal governments.

The Harris government's rationale for setting the size of grants to hospitals is tied to a funding formula that is supposed to relate or conform to each hospital's level of "efficiency." The Provincial Auditor, however, found that, as of September 1998, 34% of the hospitals rated as efficient were incurring deficits, while 10% of those considered inefficient were reporting surpluses. This badly flawed formula calls into question the whole process of restructuring.

The strongest criticism of the closures, however, rests on the crucial issue of social justice. Poor people tend to get sick and require hospitalization more often than other people. In Ontario, hospital admissions are almost twice as high among the poor as among the well-off. This is fine as long as both groups have equal access to hospital care, which is provided under Medicare to everyone. But if shrinking hospital space forces people to seek care elsewhere, the poor are put at a serious disadvantage. Public home care is rationed, and private home care, at $15 an hour or more, is beyond the reach of the poor—and of many in the middle class, as well.

The hospitals still in operation have been forced to respond to the budget cuts inflicted on them by doing a lot of internal restructuring. They have laid off staff, increased the use of temporary and part-time workers and volunteers, and contracted out services such as laundry, housekeeping and meals. Some have hired management consulting firms to advise them on how to cut costs and reorganize their operations. Entering into the "public-private partnerships" so favoured by the government—for laboratory services in particular—has also been a popular strategy for many hospital administrators.

The big story behind the financial squeeze on hospitals and their laboratories has been the consolidation of a private-sector oligopoly. Three major private laboratory companies—MDS Inc., Dynacare, and Canadian Medical Laboratories—now control close to 90% of the market. These private labs have been able to skim off the cream of the business, leaving the less lucrative work to the public sector.

The driving force behind laboratory privatization is supposedly the private sector's greater efficiency. But several studies conducted over the last 20 years indicate that in fact private laboratory services are more costly. The implication of these studies is that OHIP's laboratory costs could be reduced by $200-to-250 million a year if all lab business were returned to the public sector. This, incidentally, is about the same amount that seniors and social assistance recipients are now obliged to pay in user fees for prescription drugs.

"Rationalizing" the Workforce

One way hospitals have tried to offset budget cuts is by downsizing and "rationalizing" their staff. In addition, there has been a shift to casual positions from permanent positions in both the hospital and community sectors.

Studies have linked downsizing to greater workloads and stress, worsening morale, lower job security, and escalat-

ing levels of absenteeism and sick leave. All hospital workers—housekeeping, laundry and dietary staff as well as nurses—have been the victims of layoffs that have had a seriously detrimental impact on patient care. The nursing staff was cut by nearly 4,000 between 1994 and 1999, resulting in what a study conducted for the Ontario Hospital Association described as "lower levels of cleanliness, reduced patient supervision, increased stress, and less nursing time per patient" in most hospitals. A 1999 CUPE study found that overall staff in the hospital sector dropped 154,000 in 1995 to 128,000 in 1998. CUPE attributed most of this lost of 26,000 jobs to government cuts.

A major study published in the Canadian Medical Association Journal indicated that "reported errors" had increased significantly between 1992 and 1997: "Misadventures rose from 18 to 30 per 10,000 for in-patients and 5.2 to 11.6 for day surgeries. Complications rose from 330 to 500 per 10,000 for in-patients and from 65.2 to 95.1 per 10,000 for day surgeries. Adverse drug reactions rose from 104 to 162 per 10,000 for in-patients and from 8.1 to 10.8 for day surgeries."

Responding to these and other damning reports, Health Minister Elizabeth Witmer announced in March 1999 that $130 million would be invested "to enable hospitals to employ over 3,300 new permanent nurses over the next year." The minister also promised that additional funding increases would "create over 12,100 full and part-time permanent positions over the 1998-99-to-2000-01 period."

Her promises and figures were greeted with skepticism by nursing organizations and by the media, which called them inflated and unlikely to materialize. Barb Wahl, head of the Ontario Nurses' Association, said much of the new money earmarked for hospitals to hire nurses could well end up being used to pay down part of the hospitals' enormous debt.

Off to Buffalo

Christine, of Burlington, was diagnosed with breast cancer in December. An oncologist referred her to Cancer Care Ontario for radiation treatment, but the waiting lists were so long that she had to be sent across the border to Buffalo. She had to drive there every Sunday night and return home every Friday for seven weeks. While there, she received five-minute radiation blasts five days a week. She encountered about 200 more Ontario cancer patients who had also been sent to Buffalo for treatment. When Christine's radiation therapy was finished, last February, she went back to her oncologist, who told her he couldn't take her on because he already had a full patient load. She was referred to a "Healthy Breast" clinic for the necessary follow-up, but the next available clinic would not be till August 2000. This six-month wait for follow-up services could adversely affect the outcome of her treatments.

Private Fund-Raising

In addition to closures, outsourcing and layoffs, government cutbacks have affected hospitals in other ways. Take, for example, their MRI machines, which cost $2.5 million each to buy and another $1 million a year to operate. To continue running them, many hospitals have had to rent them out to insurance companies, veterinarians, professional athletes, and the Workplace Safety and Insurance Board, among other customers. The private payers thus go automatically to the head of the queue, leaving everyone else needing MRI scans to wait their turn—a graphic example of the kind of two-tier system being created by government underfunding.

Hospitals are increasingly having to rely 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 through charitable funding drives. The Toronto Hospital even issued $281 million worth of bonds to pay for new capital spending.

Long-Term Care

As well as home care, long-term care facilities have become attractive to governments as alternatives to chronic-care hospitals. Care in these hospitals is funded at $200 per day, while in the long-term care institutions it is $90 a day.

According to 1998 government statistics, Ontario has 498 nursing homes and homes for the aged, serving 57,000 people. Some are run by the public sector, some by for-profit firms, and some by non-profit organizations. All are funded in some way by the provincial government.

Four years ago, the then Minister of Health, Jim Wilson, introduced changes in government policy that led to an increase of up to 15% in the funding for homes run mainly by private and for-profit operators, while the non-profit institutions saw their funding decline. He also abandoned a government guarantee that each patient in a nursing home would receive a minimum of 2.25 hours of personal care a day, as well as the requirement that nursing homes have at least one registered nurse on the premises around the clock.

These "reforms" led to a further deterioration in the quality of care in these homes as they responded predictably to the cuts by trimming staff and the time devoted to looking after patients. The influx of patients transferred from hospitals because of funding cuts put even more pressure on these homes. A 1999 study by Pat Armstrong and Hugh Armstrong on health care restructuring in Ontario expressed concern that "long-term care facilities now have to deal with a patient population of whom 60% require heavy care, estimated to be 3.5 hours per day or more...They take on average four or more medications each day, and nearly a third require special treatments ordered by their doctors, ranging from catheters to ostomies to oxygen."

A survey of 2,800 care providers in these homes was conducted in 1997 by the Canadian Union of Public Employees and the Service Employees' International Union. More than nine out of ten respondents reported a "significant decline" in the quality of care over the preceding year. Nearly 80% reported that the units where they worked were short-

staffed, while workloads and patients' needs were increasing. The report blamed these problems on two developments: 1) the transfer of sicker patients from hospitals and chronic-care facilities to nursing homes and homes for the aged, and 2) the government's elimination of minimum standards of care.

In the face of growing public concern, the 1998 Throne Speech promised a massive increase in the funding of long-term care. Health Minister Witmer announced that the government would spend $1.2 billion over eight years to enhance long-term care in Ontario, in particular by creating 20,000 new spaces in nursing homes and homes for the aged. She predicted that this infusion of extra money would generate 70,000 new jobs.

Again, however, these promises met with less than acclaim by critics who pointed out that not a penny of the $170 million allocated for long-term care in the 1996 budget had yet been spent. Even if the government did deliver on its 1998 promised expansion of long-term care, it would still be insufficient to meet the expected demand. In the Ottawa-Carleton region, for example, the 1,313 new long-term beds that would be created over the next eight years would not even be enough for the 1,643 people already on the waiting list for such beds. Waiting lists across the province had more than 17,000 names on them in 1998.

In spite of successive promises, transfer payments from the province to long-term-care facilities, like health care spending in general, declined between 1994-95 and 1997-98, when measured in constant dollars and on a per capita basis. While 1998-99 witnessed an increase over the two preceding years, it still lagged behind 1994-95 and 1995-96 (**see Table 4**).

Ambulance Services

The provincial government had full responsibility for funding ambulance services since the 1960s, but in 1997 the Harris government—in return for assuming the full burden of funding education—transferred many services, includ-

Table 4
Provincial Transfer Payments for Long-Term-Care Residential Services, 1994-2000, in Constant Dollars (1992=100)

Year	Transfer Payment ($ Current)	Health Price Index (1992=100)	Transfer Payment (1992 $)	Population 75 and Over	Ratio $/75+ Population
1994-1995	1,146,312,000	103.9	1,103,283,900	530,256	2,081
1995-1996	1,167,745,000	104	1,122,831,700	551,058	2,038
1996-1997	1,150,789,000	105.1	1,094,946,700	574,154	1,907
1997-1998	1,212,840,000	107.1	1,132,437,000	597,604	1,895
1998-1999	1,345,876,000	110.6	1,216,886,100	621,575	1,958
1999-2000 (est)	1,426,053,000	112.8	1,264,231,400	N/A	N/A

Source: Public Accounts of Ontario, 1994-1999, Expenditure Estimates, 1999-2000, Statistics Canada.

ing the entire cost of land ambulances, to the municipalities. They were given a two-year transition period, after which (on Jan. 1, 2000) they were to be fully responsible for funding land ambulance services and for delivering or contracting for those services. Following a determined fightback by ambulance workers, the province later extended the transition period by another year, and increased its funding contribution to 50% of total ambulance costs.

Critics argued that this change would plunge Ontario back into the inefficient, chaotic and inequitable situation that had existed prior to the 1960s. Even David Crombie, who chaired the government's "Who Does What" Commission, advised against downloading ambulance services to the municipalities, arguing that property taxes are not an appropriate base for any social service. The Ontario Hospital Association also questioned the wisdom of this move, as did most municipalities, which feared being exposed to a new source of escalating costs without having the means to meet them.

The Ontario Public Service Employees Union and the Canadian Union of Public Employees, for their part, voiced concern over the permission for privatization given the municipalities by the province. They felt this would open the door to for-profit ambulance services. These operations, being motivated mainly by profit-seeking, would lead to cost-cutting in the form of wage and benefit cuts, layoffs, and the replacement of highly-trained workers with less-qualified ones.

For the past year, OPSEU and CUPE ambulance workers have been engaged in a campaign to preserve a publicly delivered ambulance service. Many municipalities have decided to keep these services "in-house," but it is too soon to tell what the ultimate effects will be on Ontario's ambulance services.

User Charges and De-insured Services

Premier Mike Harris and other government ministers promised after their election in 1995 that they would not introduce any new user fees for services in health care.

Only a few months later, however, in September 1995, the government announced its intention to make seniors pay more for drugs. The passage of Bill 26 imposed a $2 "co-payment" per prescription on seniors receiving the Guaranteed Income Supplement, as well as on welfare recipients. In addition, individual beneficiaries of the Ontario Drug Plan earning more than $16,000 a year, and families with incomes over $24,000, were hit with a $100 annual deductible and a pharmacist's dispensing fee of up to $6.11 per prescription. These new user fees took a total of $215 million from the province's lowest income earners in 1998-99.

Bill 26 also freed hospitals to charge a room-and-board fee of $26.94 a day to patients in acute-care hospitals who "refused" to move to a chronic-care facility. This fee was raised to $42.01 a day—or $1,277.95 a month—in 1999. It was estimated that 20% of the beds in Ontario's general hospitals—about 5,000—were occupied by patients waiting for a spot in a nursing home.

The user fees were accompanied by the delisting of 22 services from the OHIP benefit schedule, along with limiting pay-

A paramedic's lament

Roger has been a paramedic in the Burlington region for many years. He is deeply concerned about the decline of Ontario's system of emergency response services since the Harris government downloaded responsibility for ambulance services to the municipalities two years ago. For many municipalities, says Roger, the operation of an emergency response system is beyond their financial and operational capacities. Currently, patients are being charged $45 for all trips by ambulance unless they are between hospitals, and Roger fears this charge will soon be substantially increased by cash-strapped municipalities or the private operators to whom the service has been awarded in some communities.

ment for eye examinations to once every two years instead of yearly, and limiting the funding of flu and travel immunization vaccinations to "high-risk" patients.

Doctors

Bill 26 antagonized physicians by challenging their freedom to do business. It proposed a 10% clawback for billings under $251,000, 33% for billings between $251,000 and $276,000, 67% for billings between $276,000 and $301,000, and 75% for any billings above $301,000. A yearlong dispute with the doctors ensued, culminating in a five-week strike by some specialists in the fall of 1996. When a settlement was reached, Health Minister Wilson warned that new user fees might have to be introduced to pay for its estimated $300 million annual cost.

During the dispute with the doctors, Wilson said the government had plans to "introduce legislation to recognize and strengthen the role of the nurse practitioner in primary care." The passage of this legislation, Bill 127, serves as a useful example of the intersection of community health care with a managerial model of cost containment. However, the Harris government has been slow to follow through with implementation of Bill 127, suggesting that perhaps the Bill may have had more to do with its negotiations with the medical profession than with a real commitment to enhancing the role and numbers of nurse practitioners.

Meanwhile, relations between the government and the doctors have improved considerably. Physicians have been permitted to bill patients directly for services they could not charge under OHIP, such as writing notes to employers for sick employees, providing information to Workers' Compensation, doing consultations over the phone, and transferring files to other doctors.

The latest agreement on compensation for the province's physicians, a four-year deal reached in April 2000, calls for increasing fee-for-service payments by 1.95% in the first year and by 2% in each of the three following years.

Conclusion

Despite its protestations to the contrary, the Ontario government has in fact reduced spending on health care in real per capita terms over the second half of the 1990s. It has also vested itself with the power to override the decisions of local authorities and boards, while downloading services on them without their consent.

Individual citizens have been obliged to pay more out-of-pocket charges and user fees for health care—especially, and shamefully, those with low incomes who can least afford them.

Faced with massive budget cuts, hospitals and other health care institutions have moved further down the road to commercialization, adopting private-sector management strategies, contracting out work to the private sector, and entering into public-private partnerships. They have also been forced to rely more on private funding and charitable donations.

The cumulative impact of all these cutbacks and restructuring on individuals and families is being felt in higher costs, lower levels of care, and greater anxiety about the future of Medicare.

Chapter 3
Home Care

Home care has been defined as "an array of services which enables clients incapacitated in whole or in part to live at home, often with the effect of preventing, delaying or substituting for long-term care or acute care alternatives."

Home care is comprised of two service streams: professional services, such as nursing, occupational therapy and physiotherapy; and home support services, such as homemaking, personal care, housekeeping, and transportation. It may also include the provision of meals, respite care, medical equipment and supplies, adult day programs, and counselling.

When adequately supplied and funded, home care may offer an attractive alternative to some forms of institutional health care. Progressive health care reformers have long believed that those in need of care should have the choice of receiving it at home if it can be provided there safely and effectively. But they also stress that this can only be a reasonable option if the necessary resources and infrastructure are in place. Unfortunately, the Ontario government, like most others in Canada, has not created these resources before embarking on an intensive campaign to shift care from institutions to the home. Although extolling the greater benefits of home care for patients, government leaders are obviously motivated mainly by its cost-cutting benefit for them.

Redirecting care away from institutions to the community enables the government to reduce overall costs, including the major cost of wages. A great deal of home care is provided by unpaid family members or volunteers. The government has downloaded costs onto them by transferring care from the hospitals, where it is publicly and fully insured, to the home, where it is not insured. This is a classic example of cascading privatization, leading to the replacement of paid public sector workers with unpaid or underpaid private providers.

The largely unregulated home care workforce in Canada comprised about 75,000 visiting homemakers and 55,000 nurses in 1996. Most homemakers are female part-time employees who are usually paid little more than the minimum wage, and given few fringe benefits. Home care nurses in Ontario receive on average $3 to $5 an hour less than their counterparts in the hospitals.

According to the Ontario Community Support Association (OCSA), which represents non-profit agencies, personal-support workers make $5 to $8 less in the community sector than in the hospitals and long-term care facilities. Home care workers' weekly schedules are often distorted by split shifts and staggered work weeks. The low pay and uncertain work schedules generate a high staff turnover in home care, but, because of the mounting demand for and spending on these services, home care is ironically the fourth

Safety being cut, too

Sarah is a nurse who has spent the last 20 years working in nursing homes in the London area. She says the appalling increase in the workloads and pressure imposed on her and other staff members in recent years has left them badly fatigued and stressed out. So much so that they are much more prone to accidents. Sarah herself has had so many car accidents recently that her car insurance was raised by a large amount. "In all my years of home nursing," she says, "I have never had so many accidents, nor seen so many involving my co-workers. We're continually worn out from having to take care of more and more patients. This is one of the serious hidden costs to the workers in a badly underfunded health care system."

fastest-growing job category in the province.

Most home care, however—as much as 85%, according to the OCSA—is still provided by family members or friends, many of whom have to make sacrifices in terms of lost work time and out-of-pocket expenses. A study by the Conference Board of Canada found that one in four Canadian workers provide care or support of some kind (feeding, dressing, bathing) to an elderly relative or friend. The percentage of people in the "sandwich generation"—those who look after both children and older relatives—has increased from 9.5% to 15%. Most of them report experiencing sleep deprivation, anxiety, guilt and isolation. Depression and deteriorating health are also common among family caregivers. Elder care is also being provided by older children and elderly spouses.

Rationing

The most important thing to keep in mind when considering home care is that, unlike physician and hospital care, it is not covered by the Canada Health Act. One of the consequences is that, while hospitals are not allowed to turn away patients, home care agencies do not have the same obligation. And the federal government can do nothing about these restrictions of health care because home care is not covered by the Canada Health Act.

The upshot is that home care is rationed—by regulation as well as by limited spaces and costs. The Ontario government in 1999 introduced regulations that defined eligibility for homemaking services and for the maximum amount of nursing, homemaking and personal support services. Under these rules, persons would be eligible if they required personal care, or if their caregivers required assistance with homemaking services, or if they required constant supervision. The regulations also set limits on the amount of nursing, homemaking and personal services—in terms of hours and visits—that a person may receive in various circumstances.

What is notable about these regulations is that they are entirely concerned

with establishing eligibility and its limits, not with establishing rights to these services. This is consistent, of course, with a cost-cutting rather than a service-oriented approach to health care. Setting limits on care, in any event, is questionable, given the steady increase in the number of home care recipients who are seriously ill or recovering from surgery, and the growing number of frail elderly clients.

Ministry of Health officials claim they are motivated by a concern for family caregivers and that the eligibility criteria are designed to help them. This implies, however, that friends and relatives are regarded as the main source of eldercare—not by default, because the resources are missing, but **because they ought to be.**

Additional guidelines circulated by the ministry give priority access to those at risk of dying, those in urgent need of care within 24 hours, or those who would otherwise have to be hospitalized. While it is natural and commendable to give those in the greatest danger first access to care, the implication again is that such services are not and cannot be made available to all who need them. If they were, there would be no need for setting such priority guidelines.

Funding

It might appear that the government is sincere about improving and expanding home care services, since they have been allocated a growing share of public health care spending over the past 20 years. The 1980s in particular saw substantial annual increases averaging over 25%. However, as one provider agency executive put it, "We had a hospital-laden health care system, with just pennies put into home care. Spending may have gone up 500%, but 500% of a penny is still not very much."

Evidence of the rapid rise in demand can be found by looking both at the number of clients CCACs have served and at the number of professional visits and homemaking hours provided. As shown in Table 5, between 1996-97 and 1998-99, the total number of CCAC clients rose by 20.2%. As for the number of homemaking hours and visits by nurses

Table 5
Rate of Increase of Average CCAC Professional Visits and Homemaking Hours, 1996-1999

	# of Nursing Visits	# of Homemaking Hours	# of Physiotherapy Visits	# of Occupational Therapy Visits	# of Speech-Language Pathology Visits	# of Dietetics Visits
1996-1997 Average	154,433	398,809	12,450	9,952	4,117	1,919
1997-1998 Average	178,460	468,893	13,359	11,239	4,421	2,246
% Change, 1997 to 1998	15.6	17.6	7.3	12.9	7.4	16.9
1998-1999 Average	201,953	498,248	14,645	12,609	4,947	1,586
% Change, 1998 to 1999	13.2	6.3	9.6	12.2	11.9	-29.4
% Change, 1997-1999	30.8	24.9	17.6	26.7	20.2	-17.4

Source: Based on data submitted by CCACs to the Ontario Home Care Administration System (OHCAS).

and other professionals, provided by CCACs from 1996 to 1999, all increased significantly, by 30.8% for nursing vists and by 24.9% for homemaking hours.

The Harris government increased funding for in-home services by 29.2% in real terms (constant dollars) between 1996-97 and 1998-99. In the six years from 1994 to 2000, the increase was 37.3%. These increases, however, though relatively large, served barely to keep pace with the rising volume of professional visits and homemaking hours purchased by CCACs. Because of the rapidly rising demands on their services, most CCACs have had to hire more support staff and recruit more professionals. But, despite the extra funding, 16 CCACs are reportedly still facing a deficit, and have resorted to longer waiting lists or to reducing the amount of services they offer. There are no statistics on real needs in the community, but evidence is mounting that many people are in need of care that neither the province nor the CCACs are providing.

The Toronto Community Care Access Centre, for example, reports "a disproportionate number of clients who are homeless or under-housed, have mental illness, are HIV-positive or have AIDS, are disabled or elderly and living alone." All are challenging to serve. The Centre's original base funding of $55 million fell short of meeting its growing needs, which it estimated would require another $70 million. "We were forced to drastically cut expenditures...[which ran] counter to our philosophy of providing support for the health, well-being and quality of life of our community."

Other CCACs, including ones in Ottawa-Carleton, Cornwall, and Haldimand-Norfolk, report having to set limits on visits or put more people seeking care on waiting lists.

In February 2000, the Windsor-Essex CCAC made the news 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 been receiving daily one-hour visits from a homemaker who cleaned the apartment and cooked his dinner. This service was stopped 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.

His case graphically exposes the shortcomings of the government's eligibility criteria for care, as well as drawing attention to the downloading of costs involved in the forced transfer from institutional to home care.

Once again, the cascading nature of health care privatization is revealed:

- The Ministry of Health decides to adopt business practices, which involve pressuring institutions to offer the cheapest form of care, which in turn leads to shifting patients from acute care to chronic care and long-term care facilities, as well as to the home.
- The Ministry cuts funding to hospitals, forcing them to ration their resources, contract out services, treat more people as out-patients, and send in-patients home sooner.
- More people are compelled to seek home care, but home care too is ra-

Unaffordable user fees

Rob lives in Copper Cliff, where he is self-employed. He has a family of four but lacks a drug or dental plan. After being involved in a traffic accident and suffering whiplash, he was sent for physiotherapy two or three times a week. But he had to stop the treatments after two months because he was being charged $25 beyond OHIP for every visit—an extra user fee that he couldn't afford on his limited family budget. Rob and his wife have not seen a dentist for several years because their budget can only pay for dental treatment for their children. Rob is worried about anyone else in his family becoming seriously ill, because the substantial extra payments now required for most kinds of health care in Ontario would be beyond his ability to pay.

tioned and is far more costly because it isn't covered by Medicare.

The upshot is that, under privatization, those with money are able to purchase needed services, while others have to do without, or at best settle for inadequate care. Many have to rely on the help of family or friends, but inequalities abound in terms of income and gender. Low-income seniors and poor women of all ages suffer high levels of unmet needs. Men's needs are more likely to be met because they are looked after by women, but many women such as widows and single mothers cannot readily count on someone to look after them.

Managed Competition

The Harris government's mechanism for selecting home care providers and allocating public funds is very much in keeping with the alternative service delivery model it favours. This mechanism—

- leaves the setting of home care policy and overall budgets to the government, but vests the power of spending public monies and selecting service provider agents with the autonomous CCACs;
- severs the general functions of purchasing services, coordination, assessment and case management from the specific functions of service delivery by nurses and home support workers: the CCAC performs the general functions, but contracts out service delivery to for-profit and non-profit agencies;
- turns the CCACs into brokers for the purpose of tendering services, receiving bids, selecting winners, and managing competition;
- opens the competition to all agencies and organizations, whether old or new, for-profit or non-profit.

The managed competition system has had several serious problems.

1. One of the most obvious problems is that different providers will win contracts when they come open. This undermines continuity of service, which in turn undermines the trust between provider and client. Because of the

very personal and intimate nature of the services provided by nurses, therapists and support workers, building a relationship of trust is crucially important. This is only possible, however, if the same providers care for the same clients on a long-term basis. Such a relationship is impossible to establish and maintain when a client-driven system is converted into a funding-driven competitive system.

2. The competitive model favours the for-profit firms that are geared to private enterprise. But the main purpose of a for-profit firm is to maximize profits, so money that could be re-invested in services goes instead to the shareholders. Private contractors are also likely to offer less or worse service and to pay employees inferior wages and benefits.
3. The new competitive environment has taken its toll on the non-profit agencies. To have any chance of winning contracts, they have been forced to adopt many market-determined norms of "efficiency," such as cutting costs and downgrading employees' pay and working conditions. They are also covered by pay-equity legislation, whereas most private agencies are not. The Victorian Order of Nurses, for example, with its unionized workforce, has been particularly disadvantaged. Its efforts to cut costs to become competitive in the bidding process have triggered strikes that have seriously hurt the VON. The Windsor branch of the Red Cross was forced to shut down after 53 years of service to that community.
4. The bidding process itself is costly, arduous, and time-consuming. One non-profit agency reported that submitting proposals costs each bidder $10,000 to $20,000 a year and takes up a great deal of time by officials and clerical staff.

Conclusion

Market competition is supposed to lower costs, improve efficiency, enhance quality, and increase the variety and volume of services. In the case of home care in Ontario, it has admittedly driven agencies to cut their costs in the short run, but in the long run it is more likely to have the opposite effect. For one thing, it has led to the erosion of the networks of trust and continuity of care that are the foundations of true quality and efficiency.

The new system has tipped the balance from public to private payers, from non-profit to for-profit providers, and from paid to unpaid workers.

An ever greater share of care and dollars is being shifted from hospital care, which is covered by the Canada Health Act, to home care, which is not. Moreover, home care is now being run in Ontario under a system of managed competition in which for-profit service providers are winning an ever larger share of the work.

Home care funding has been increased, but not sufficiently to keep pace with the even greater increase of needs and services. Publicly-funded home care is rationed, with many in need having to pay for it out-of-pocket or through private insurance. Many others have to do without if they do not have informal care

provided by family, friends or neighbours—or be institutionalized in a nursing or old-age home.

It is too soon to predict the speed or the extent to which the non-profit providers of home care will be displaced by the for-profit ones, but already many non-profits have been compelled to adopt competitive structures and strategies—such as cutting wages, benefits and travel allowances—in order to survive.

Epilogue

Medicare has worked well for Canadians. They depend on it and believe in it. And yet, despite this strong support, they continue to be told that the system is not working, and that the only way it can be saved is through privatization.

Federal cutbacks have become a rationale for Ontario and other provincial governments to accelerate their own cutbacks, which in turn force and encourage the processes of restructuring, commercializing, contracting out and privatizing public services. Such assaults on the public sector, however, conform with the market-driven ideology of right-wing provincial governments like the one in Ontario, and would undoubtedly have been launched in any case. The federal cutbacks served as a convenient excuse for intensifying and speeding up cuts at the provincial level that would have been made, anyway, sooner or later.

On the pretext of easing the tax burden and focusing on the patient, governments ram through market-style "reforms." Hospitals respond to the cuts by adopting their own private-sector strategies, discharging patients too soon or passing them on to long-term care facilities or inadequate home care services. Many of the sick end up at home with little or no care. Many who are still well live in fear of becoming ill and not being able to afford privatized health care.

In Ontario, the process of privatization, pursued stealthily but steadily, has eroded public standards. Continued much longer, it will set the stage for an American-style two-tier system in which the quality and accessibility of care will increasingly be decided by the ability of an individual or family to pay for it.

Of course, given the enormous popularity of Medicare, it would be risky for any government to privatize it quickly, as the fierce opposition to Alberta's Bill 11 has demonstrated. To avoid an overwhelming public revolt, privatization has to be done quietly and gradually. Health care analysts such as Pat Armstrong refer to it as "privatization by stealth" or "creeping privatization."

The relentless propaganda claims that Medicare as we have known it is no longer affordable are taking their toll. The stage is being set for the middle classes to begin abandoning the Medicare ship and start climbing into the "lifeboats" of private insurance and private providers. (Little do they know that many of them will be thrown out of these lifeboats as insurance premiums rise and coverage proves far less comprehensive than they had been led to believe.)

Alberta's Bill 11, which allows private for-profit hospitals, could have repercussions far beyond that province's borders. Under the terms of NAFTA, all provincial governments could be allowed (or compelled) to follow Alberta's example or incur punitive trade penalties. Ontario's competitive bidding model introduced in 1997 for the awarding of home

Don't break a leg

Sharlene, who lives in Timmins, has a two-year-old son who broke his leg last spring. She took him to a hospital to have an X-ray taken, but there was no one there to read it, so she was asked to return the next day, when it was confirmed that the leg was indeed broken. However, because the boy was so young, his leg could not sustain the weight of a plaster cast. Sharlene's options were to pay $50 to have a fibreglass cast applied, or do without any cast and keep her son in bed till the bone mended. She decided she would somehow find the $50. But there was no one on staff at the hospital to fit the fibreglass cast, so she was asked to bring the boy back the following day. She did so, then had to pay another $15 for a shoe to go over the cast, plus $8 for a tensor bandage.

care contracts could also make this province vulnerable to NAFTA-imposed health care privatization.

The Ontario government has so far refrained from creating new private hospitals, but it has introduced "managed competition" in home care, ambulance services, and other areas. The process of privatization clearly continues, even though study after study have proved conclusively that publicly-funded-and-provided health care is much cheaper, more efficient, and more conducive to overall health.

The key question, then, is: why would any government want to privatize it? The only answer that makes sense is that privately provided health care generates profits—enormous profits—for the companies that provide it. Governments that favour and implement privatization are therefore acting in the interests of these big corporations—and against the interests of the people they were elected to represent.

As Robert Evans has pointed out, Medicare is a social program that redistributes wealth from the wealthy and healthy to the "unwealthy" and unhealthy. A single-payer system based on the income tax, such as exists in Ontario, requires the wealthy to pay proportionately more as long as the income tax system remains progressive. A system based on user charges would reverse the redistributive process, benefiting the wealthy at the expense of middle- and low-income citizens. This is why private producers, such as the big pharmaceutical companies, are opposed to a single-payer income-tax-based system. It would keep drug prices down and eat into their profits, whereas the user-charge / private insurance model would fatten their profits.

As Evans remarks, the proponents of privatization probably do not want a **totally** private system. The public system is much too bountiful a "cash cow" for the private companies. Their aim is rather to limit the public system in ways that would maximize their opportunities for profit, while leaving the unprofitable operations in the public domain. This would

offer scope for physicians and other private entrepreneurs to open private clinics funded through private insurance, especially if they could obtain public subsidies. They could then operate in both markets, continuing to see patients in public hospitals while also seeing others in private clinics. This appears to have been the underlying purpose of the private-hospital initiative in Alberta.

More public money can also be skimmed off by moving into laboratory services, home care, and ambulance services, and by developing new markets in public institutions for management strategies, drugs, technology and services, as has been happening in Ontario.

Thus the public system, instead of being strengthened and better funded, has now been turned into a source of booty for private corporations. Many corporations today prefer to "buy out" their competitors rather than invest in more plant and workers. In the same way, private companies are now poised to take over the ownership and delivery of key parts of the public health care system. The privatization of Medicare could more bluntly (and aptly) be called the plunder of Medicare by the private sector.

Canadian governments have invested massive funds and resources in building up Medicare and other public programs, services, and infrastructures. These were the property of the Canadian people, who paid for them through their taxes. Selling them off, closing them down, rationing them, charging user fees—all these privatizing actions benefit a small privileged élite while stripping the great majority of citizens of their rightful entitlement and heritage.

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