Ontario Health Coalition Summary & Analysis of The Ontario Chamber of Commerce's Health Reform Report Released Today

March 15, 2016

The Ontario Chamber of Commerce report adheres to what has become the predictable formula of "create a crisis then privatize" used by the pro-privatization forces in Canada, virtually all of whom come from for-profit health care industry that wants more privatization to expand its own market share and profits.

- The report overstates health spending repeatedly. For the record, health spending has been declining as a share of the Ontario budget for years. According to the Ministry of Finance's figures in the 2016 Ontario Budget, health spending is 38.7% of the budget, not the 50% repeatedly misreported in the Chamber's report. (2016 Ontario Budget page 288.)
- The report then claims health care is unsustainable based on the overstated figures and crisis rhetoric.
- The report then says Ontario should respond to the crisis by expanding for-profit privatization.
- To distract from the terrible record of health care privatization in the U.S., the report falsely characterizes European and Australian health care examples.

There are quite a few errors of fact in the report. Some examples:

- The U.K. Health system is not one system as the Chamber's paper assumes. Wales, Scotland and Northern Ireland have their own governance over health care. While England has adopted a number of market-based and privatization schemes – that, not incidentally, are highly controversial among its own population -- other regions have decisively rejected them. Far too numerous and complex to cover here, the English reforms have resulted in some very poor outcomes. Vital local health services and emergency departments have been shut down, mass protests have erupted, outrageous costs for privatization have been exposed. In the extreme case, a number of giant hospitals in London were left teetering on the cusp of bankruptcy, requiring further public bailout as a result of the toxic combination of P3 (public-private partnership) privatization which the Chamber is advocating and payment-for-procedure funding changes.

  In fact, multiple British Medical Association Journal studies report that it is generally accepted that private clinics in England (Independent Sector Treatment Centres) are paid higher prices for surgical procedures. This finding is echoed in pro-privatization think tanks' reports. Indeed the U.K. Department of Health has publicly admitted that higher prices are paid to the private clinics. In general, actual prices are shielded from public scrutiny under commercial confidentiality provisions. Former Health Minister

Frank Dobson reports that the private clinics were being paid 11% more than public hospitals for the same procedures.

Overall, the Chamber's report is gravely inaccurate in its simplistic synopsis of what has happened to Britain's once-model National Health Service.

- Australia's health system is also used as an example to support privatization. Again, the use of this example in the Chamber report lacks grounding in evidence. In Australia the seminal study on wait times has shown that patients were able to access care more quickly if they were wealthy as a result of privatization, leaving those with lower incomes behind, and that wait times increased in the public health system as privatization took resources out of public hospitals. A 2015 study also shows that Australia's private hospitals "cream skim" taking the lighter less complex care patients and leaving the more expensive heavier care patients for public hospitals.

- The Canada Health Act was not written to standardize what is considered medically necessary, as is claimed on page 10 of the Chamber report. It was written in response to massive public pressure to stop extra-billing of patients. (This is re-emerging as a serious problem as private clinics are taking over more diagnostic and surgery services that used to be provided without user fees by local public hospitals.)

- The report claims that Ontario has not moved to electronic health records and has limited access to what the Chamber is calling the "latest technologies" such as MRIs. This is not correct. By the end of 2015, 2/3 of Ontario patients 80% of family doctors had electronic health records, according to government data. Similarly, the Chamber's claims about MRIs, is more than a decade out-of-date. MRIs are not new technology and, in any case, Ontario has vastly increased the number of MRIs and the efficiency of the use of MRI equipment over the last decade-and-a-half. According to a 2012 report by Canada's health data collection agency, the Canadian Institute for Health Information, Ontario has a much higher rate of MRI usage than other provinces (including those that embraced privatization). In fact, according to Ontario's Auditor General in his 2012 audit of private clinics, the Ministry of Health estimates that 1 in 5 MRIs in these clinics is medically-unnecessary. The Chamber should research more deeply the issues of technology, appropriate use and value. The report's authors would also do well to look at extraordinary expenditures on e-health internationally and the problems that have been encountered for a fuller understanding of the pros and cons of early adoption of new technologies in complex systems.

- The report is internally contradictory. For example, it cites limited integration of health care providers as a factor resulting in fragmented care. Then it goes on to call for privatization of existing delivery systems. The public non-profit parts of health care *are* integrated and team-based (hospitals, community health centres). The *dis*-intgrated parts (home care, for-profit clinics) have been disintegrated in an effort to privatize them. Formerly non-profit home care, was carved up and put out to competitive

> bidding to bring in for-profit companies, for example. Ever since, the home care system has suffered from massive redundancy in which there are thousands of billing rates and contracts and administrations, profit taking, and extra tiers of administration to create the structure to privatize it. Patients are now forced to travel all over for care, from one private clinic to another private lab, to a private so-called "home care" wound clinic as a result of the dismantling and privatization of our local public hospitals. To cite dis-integration as a problem and then claim privatization as a solution is to utterly disregard what has happened in Ontario's communities over the last decade-and-a-half.

The report claims that patients want health and wellness but can only get disease management. We disagree. Patients want and need appropriate treatment, compassionate care, and effective disease management when they are sick. In general, the public likes the ideas of health promotion, illness prevention, but those terms are often ill defined. Some of Ontario's finest models for health promotion and prevention exist in Community Health Centres that are publicly-governed team-based health care providers. Expanding the network of Community Health Centres would improve care and prevention under the public health care system without privatization. Similarly Aboriginal Health Centres and Nurse-Practitioner Led Clinics provide excellent care and more fully utilize the health care team while upholding public governance structures. There are many non-profit community health and social services that do vital promotion and prevention work, and this has nothing to do with privatization.

Ontarians need a continuum of care is reliable and accessible when they need it, as well as meaningful promotion and prevention. Health promotion and prevention should not be used cynically in an attempt to dismantle public health care and promote privatization.

At the national level, public health care would be improved if it were expanded not dismantled. Canadians need a public drug coverage program and the principles of equity and compassion embodied in the Canada Health Act should be parlayed into a new act that covers home and continuing care for the elderly and those with chronic illness.

At the Ontario level too, there are actions that the government can take that would improve health care including: reinstatement of proper health system planning including capacity planning; integration of home care into one public non-profit system to ensure funding goes to vital care and support services; better management to curb overuse of drugs and unnecessary tests; restored funding to hospitals; an end to P3 (public private partnership) privatization that Ontario's Auditor General reports has cost $8 billion more than if a proper infrastructure management process and public financing were used to build new hospitals and infrastructure; renewed attention to the social determinants of health including housing, environment, income and food security that improve health outcomes throughout life.