Why Not Privatize 101

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Thank you for this introduction and this opportunity. It's an honour to help contribute to the legacy of Derrell Dular, with whom I had the privilege of serving on the OHC Board for several years.

My task today is to help make the case against privatization in health care. In one sense, this is *simple*. We know that for-profit care usually means lower quality, more precarious jobs with less pay and fewer benefits, more scarce resources spent on administration, and less effective regulatory oversight.

In another sense, privatization is *complicated.* This has been underscored by the many contributions to the brainstorming session just now. In my 10 minutes, I'll outline *two analytical frames* for examining privatization: (1) its forms, and (2) the basic criteria for assessing these forms.

First, *forms of privatization.* The most prominent forms concern who pays for and who provides or delivers the care. The privateers know that we want health care to be free at the point of service. We would much rather pay for it through our taxes. Any visible move to private payment is known by Canadian politicians, from Harris and Harper, from Ford to Kenney, to be for them a dangerous "third rail". In a stealthy move, however, right-wing politicians and their supporters do claim instead that we don't care who delivers the care.

And sometimes, in desperation, we don't care. If a surgical procedure, for example, is unavailable through medicare, or if the anticipated wait time for it is deemed excessively long, some are prepared, reluctantly, to pay privately, and perhaps go into debt to do so. Some may even join patient groups funded by the drug companies to lobby for expanded public payment to treat their specific condition.

The *connection between who pays and who delivers* can be illustrated by the example of super-expensive drugs, some with very limited or no additional value, and not covered by provincial drug formularies. In the pandemic context another would be PCR tests needed for school, work or travel, but accessible quickly only through private purchase from their

manufacturers and distributors. In long-term care an illustrative example is the employment, by family members who can pay for it, of private companions deemed needed for residents.

On *who provides*, we happily have very few for-profit hospitals in Canada. But the story doesn't end there. As public funding for hospitals and doctors is cut back, or was not comprehensive in the first place, insurers rush in. They offer out-of-hospital coverage for drugs, rehab and other therapies, mental health services, homecare and so on. Even doctors' notes. About 30% of health care costs are borne either by individuals out of pocket or by (mainly) private insurance, revealing again the connection between who pays and who provides, as we are held responsible as individuals and families for more of our care.

There also exist *several other, interconnected forms of privatization* I can briefly list. One is the *contracting out* by facilities of specific services, not only food and laundry, but also building maintenance, security, and beyond, including management. *Decision-making* can be moved to outside consultants, often employed by large firms like KPMG or Deloitte. *Business practices* (such as just-in-time delivery or continuous quality improvement) and *business language* (such as bottom line or business plan or customer) can infect public institutions. Perhaps most insidiously, care work can be sent to another type of private, *the private household*, where it is done primarily by unpaid, generally unrecognized women.

I could elaborate on the forms at length, but instead will say a few words about criteria. Conventionally, students of public policy consider three main criteria: the *quality, efficiency, and accessibility* of a proposed or established policy. There are often trade-offs to consider. High quality, for instance, can come at the expense of cost efficiency and/or universal accessibility, as the US system demonstrates so clearly. Some Americans receive excellent, insurance-funded care; others get poor or no care.

However, *privatization fails on all three criteria*. Take *quality*. For-profit nursing homes usually have higher rates of infection and death, of hospitalization and of verified complaints than do their non-profit and municipal counterparts. This should come as no surprise, as they, and for-profit firms throughout health care, spend less on staffing and training than do the non-profit and public entities. And they divert revenues from care to the pockets of senior executives and owners.

For-profit organizations tend to *cost* more. In their pursuit of profit, they and their public funders incur much higher transaction costs. The presumption of dishonesty means that both

parties to a contract (all three or more parties to a P3 contract) must have their own staff and detailed documentation in order to keep a wary eye on each other. [Think of William Osler Hospital or the Royal Ottawa.]

Then there is *accessibility*, with its equity and equality implications. I will leave it to Paulette to focus on these important negative effects of privatization, especially for women here in Canada and across the globe.

Instead, I'll mention a fourth criterion we could and should invoke: *democracy.* Trade secrets make it difficult to "pierce the veil" of what's going on in health care. Particularly in the US and the UK, and increasingly in Canada, ownership and operation are obscured by multiple layers, with holding companies, real estate investment firms, franchised operations, partnerships, and subsidiaries of various kinds all involved. They also make the attempts to regulate them both more necessary and more detailed. Such attempts are often more futile as well, and are typically aimed at staff and specific homes, not at underlying structures (funding arrangements, credential provisions, governance policies, etc.) The pursuit of profit conflicts with accountability to, and direction from, the public.

I'll close by reiterating that privatization is *complicated.* It can be "grey and fuzzy", as someone remarked this morning. It has many intersecting forms and negative outcomes. What I'm offering today are some *analytical tools* to help us combat it.

But privatization is also *simple*. As Nancy Pelosi of the US Congress put it, speaking about attempts by those who would privatize Veterans' Affairs in her country, they "don't want to make it better. They want to make a buck."

Thank you.