

# ON HEALTH CARE

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## **WILL THE PROVINCIAL GOVERNMENT PUSH PRIVATIZATION AND THE MARKET INTO PUBLIC HEALTH CARE?**

Advocates like Senator Wilbur Keon and former Senator Michael Kirby see models like the Liberal government's "local health integration networks" as vehicles for driving Ontario toward a market-based delivery system.

LHINs would purchase health care services on the open market. Hospitals, for-profit clinics, private emergency room management companies or whoever would bid for contracts and with each contract comes the threat of greater privatization.

With the government's recent introduction of prices for surgeries, the trend towards market based 'solutions' could be getting stronger.

While the government supports "integration" and "seamless health care," the introduction of the market goes in the opposite direction.

Community Care Access Centres (CCACs) introduced "managed competition" for home health care. The first result was that home care providers had to conceal their best practices from their competition. If they didn't, they'd lose their competitive edge and their contracts.

That's hardly health care "integration."

Any health care model that prevents providers from sharing best practices should be a non-starter. We aren't repairing widgets; we are talking about real people, real sick people.

Not surprisingly, market-based home care became a mess. Not-for-profits like the Victorian Order of Nurses (VON) were pushed aside by for-profit corporations. Health care staff experienced terrible working conditions. Personal support workers earned \$5-\$6 dollars an hour less than they would in a hospital or nursing home. Not surprisingly, staff frequently moved on to other work. One government study found 57 percent turnover in a single year!

For patients needing intimate, personal care, this just didn't work. It wasn't the sort of care anyone wanted for their mother or father.

To make matters worse, the price for home care services went up after managed competition was introduced, forcing big cuts in care. There were increasing restrictions on the supportive care that helps people stay in their homes, like giving patients a bath.

But, without these sorts of supports, the elderly and the frail just can't stay in their homes. Unless, of course, they have the funds to pay for home care — privately.

The whole situation became so bad that the government had to stop the bidding process.

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The government now wants to adjust the market model and bring it back. Can the expansion of the market model in other health care sectors be far behind?

England introduced a similar market model for a whole range of health care services. The results?

- More public health care funds handed over to for-profit corporations. Services purchased by the public authorities from private hospitals will increase from £200 million pounds in the early 1990s to £2 billion pounds in 2007 – a 10-fold increase! Yet, a poll showed 89 percent of the population are against private provision of public health care.
- More fragmentation of the health care system. Private diagnostic and surgical clinics have taken over work previously done in hospitals. Up to 640,000 surgeries will be carried out by private clinics each year.
- Erosion of general hospitals as hospitals specialize in a narrower range of services to win contracts.
- A 1,900 percent increase in private consultancy costs in the past 3 years.

And, despite doubling public funding, the English health care system is now beset with cutbacks and layoffs.

We are beginning to see some of the same issues in Ontario. For example, the government wants independent clinics to compete with public hospitals.

It's difficult to see how having even more health care providers creates "integration" or "seamless care." Already, seniors spend an enormous amount of time trailing about from one health care provider to another getting blood work done, having another test, seeing specialists, going to the hospital. Now, apparently, the idea is to add even more destinations.

A better solution would be to create surgical clinics inside the organizations we already have invested in — facilities like hospitals where we won't have to duplicate human resources, stores, payroll, purchasing, cleaning, and laboratory services. And in facilities — like hospitals — that are actually equipped to deal with the emergencies that can occur during operations.

Small and rural hospitals are at particular risk under the market model because they do not have the volume levels to perform a variety of procedures like a factory assembly line. Their ability to compete on price and to provide a range of services is dubious at best.

This threatens smaller communities and lower income families who just can't travel to distant health care facilities.

Rather than letting the market determine health care priorities, we need a different vision. Small hospitals should be a real hub for a whole range of services: primary care, diagnostic procedures, surgical procedures, rehabilitation, chronic care, and long-term care.

That would be real integration: the end of duplication, one-stop care for patients, and sufficient size and scope to achieve efficiencies.

This would also be consistent with the Ministry of Health's recent positive step to prevent hospital "alternative financing and procurement" projects from being used to privatize many health care support services.

We need to promote true public health care integration and not the open market and privatization.