

WHOSE HEALTH CARE?

Challenging the Corporate Struggle
to Rule Our System

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and Natalie Mehra



Socialist Project
Socialist Interventions Pamphlet Series

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The Socialist Project does not propose an easy politics for defeating capitalism or claim a ready alternative to take its place. We oppose capitalism out of necessity and support the resistance of others out of solidarity. This resistance creates spaces of hope, and an activist hope is the first step to discovering a new socialist politics. Through the struggles of that politics – struggles informed by collective analysis and reflection – alternatives to capitalism will emerge. Such anti-capitalist struggles, we believe, must develop a viable working class politics, and be informed by democratic struggles against racial, sexist and homophobic oppressions, and in support of the national self-determination of the many peoples of the world. In Canada and the world today, there is an imperative for the Left to begin a sustained process of reflection, struggle and organizational re-groupment and experimentation. Neither capitalism nor neoliberalism will fade from the political landscape based on the momentum of their own contradictions and without the Left developing new political capacities. We encourage those who share this assessment to meet, debate and begin to make a contribution to a renewed socialist project in your union, school and community. For more information on the Socialist Project check our web-site at www.socialistproject.ca or e-mail us at socialistproject@hotmail.com.

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INTRODUCTION: DEFENDING HEALTH CARE IS NOT ENOUGH

Sam Gindin

Most Canadians reject a private health care system that is driven by the accumulation of profit, that limits people's access to the size of their wallets and provides health in exchange for the risk of financial debt. Affordable public health care – for one's own family and as a shared right with others – is something worth defending.

Defending public health care is not enough. It doesn't prevent a slower 'death by a thousand cuts.' Indignant government campaign speeches against privatization only lead to more subtle forms of privatization – privatization by stealth. Even where privatizations are curbed, the rules under which hospitals are run are transformed so they reflect the thinking and practice of competitiveness and commercial values, not social values. Cutbacks may be checked today, but revived tomorrow after tax cuts or an economic downturn lead to budget deficits that 'demand' new restraints. Any problems in the health care system that do occur lead to

Most Canadians reject a private health care system that limits people's access to the size of their wallets and threatens financial debt.

public frustrations which are then politically manipulated to develop support for 'repairs' and 'innovations' (based on giving private corporations greater control over our health).

At the same time, examples from abroad are brought into the debate – sometimes via misinformation, sometimes without reference to the larger context, and sometimes presenting defeats as victories – to convince us that our resistance is futile, that we are swimming against an inevitable tide. And because we are overwhelmed by defending the health care system, we forget that our health care system is incomplete. Health care depends on much beyond itself – from the impact of poverty on a minority, to the working conditions many of us face, to the polluted air we breathe.

We need to both extend health care and place the fight for health care in a broader context. The attack on health care is part of a broader corporate offensive taking place throughout the world. This offensive's promises of security and rising living standards have been widely exposed as false. Like a virus, neoliberal ideology (the freedom of corporations, not the expanded freedom of people) is permeating every sector of society, and health care increasingly lacks a sufficient firewall or political antidote. Unless we wage a larger battle for a different kind of society, health care will be marketized and eventually eroded. The struggle over the future

of health care, then, provides us with a vital opening for a larger struggle to expand its underlying principles.

Only defending our health care system will eventually place us in indefensible positions. Health care costs have been escalating and some services are not what they should be. If we ignore these realities, we risk losing even what we have. Our response must be twofold. First, we must reject the privatization of health care. The privatization of our health care system is in fact a cause of the existing system's problems.

Second, the health care issue is indeed (as the corporate supporters of increased dependence on private health care constantly remind us) about free, equal, and democratic choices. We do have to decide how much of a priority health care is in itself, and in the context of a society that prides itself on freedom, equality and democracy. But the privatization of health care will only expand the choices of an enriched few (defined by their ability to pay for health care as a commoditized service) while weakening the choices of the majority (by undermining their access to public health care as a right). Arguments that budget-crunching alone dictate that government can no longer pay for rising health care costs creates the illusion that private health care will cost less and provide better service. Yet we live with a tell-tale example of the ramifications of a private system to our immediate south, where the lesson is, as even General Motors has belatedly recognized, that the more privately-oriented the health care system, the higher the overall costs and the worse the human care.

Addressing cost and service concerns require the expansion and improvement of our health care system, not its commercialization and contracting of its work at the sacrifice of quality.

Important questions need to be asked regarding the costs of health care.

- * Why is public pharmacare not a concern? If the drug companies make money by selling new medicine, will it be in their interest to both prevent sicknesses and effectively research the potentially negative and long-term side-effects of medicine at the same time?

- * Are expensive new health care technologies being used and allocated appropriately? Expensive corporate-generated technologies drastically escalate health care costs as hospitals, managed like mini-corporations, see new equipment as way to attract 'customers.' This leads to waste, a distortion of care, and a misuse of technological potential.

- * How should doctors be paid and how should we relate their role in the public health care system to their role as private practitioners?

- * How should hospitals be run? Certainly, all large institutions suffer from bureaucratic problems. But turning hospitals into corporations adds anti-social

goals to existing bureaucratic irritations. Rather than turning hospitals into corporations with a tiny and overpaid yet theoretically savvy managerial class at the top, we should invent new models of social administration that allow for a deeper democratization of health care. A new model could include greater input from those people receiving the service and more importantly, those workers that provide the services: doctors, nurses, technicians, and other hospital workers, that have hands-on experience.

Given what we are up against, health care won't be saved without a much greater public commitment to political mobilization than we've seen to date. This pamphlet hopes to contribute some tools for discussing over the present and future of health care; it also hopes to support present and future political struggles over health care. The articles that follow are written by both activists who work at the base of the health care system and academic-activists who have studied the recent transformations in our health care system. In this pamphlet, rigorous research and critical analysis is fused with popular political struggles to defend and extend our health care.

In section one, Hugh Armstrong outlines the core principles of the *Canada Health Act*, analyzes its limits (do we really have socialized medicine?), and points to where the *Health Act* gives us political ammunition for moving ahead with a new strategy.

In section two, Pat Armstrong warns us of the various ways that privatization is already potentially infiltrating and undermining the public health care system.

In sections three and four, Colin Leys and John Lister each examine neoliberal health care reforms in Europe, especially in England which has been used as a battering ram to push reform in Canada. Leys and Lister debunk the argument that putting corporations in charge of health care adds to our health, rather than sacrifices it to profits.

In section five, Joel Lexchin challenges the operations of the private pharmacare industry, which has managed to escape public anger in spite of its responsibilities for much of the rising costs and practices that border on irresponsibility in improving health.

In section six, Mike Hurley discusses how the health issue is seen by health care union members, the political education undertaken by the unions, and the forms of political mobilization.

In section seven, Natalie Mehra, the Provincial Coordinator of the Ontario Health Coalition (OHC), assesses the Coalition's shortcomings and achievements and points to the OHC's immediate objectives and the need for a longer-term strategic focus.

The Limits of Privately-Negotiated Health Care

U.S. unions, trying to defend their members in the absence of social programs in the post-war period, ended up with privately negotiated health care plans. For a while, this gave a minority of American workers some significant protection. But as the domestic and international economies changed, the contradictions of this 'private welfare state' became evident. Such private plans were not really insurance; they were dependent on the strength and survival of the individual companies concerned.

[In 1954, Canadian Ford workers negotiated medicare benefits that were fully-paid for by the company – an exception to the decades' pattern which generally saw workers going through long and difficult struggles to catch-up to their more powerful parent (the UAW only won this benefit in 1961). But unlike the case in the USA, this was part of the wider move to public health insurance in Canada that came to fruition in the mid-sixties. While many Canadian unions compensated for the inadequacies in the public health care system by topping-up aspects of their collective agreement, union successes did not always translate in the provincial governments improvement of the system for Canada's non-unionized workers.]

The limits of the American system have been especially highlighted in the present at General Motors, where the company has attacked the health care plans it previously negotiated with its American union, the UAW, because of the disadvantages GM faces relative to its Japanese competitors. The Japanese companies have both a public health care system in their export base at home, and a younger workforce with consequent lower health care costs within the USA.

The response of the American union has been astonishingly narrow. Rather than seeing this as an opportunity to build towards getting health care on the national agenda and leading a fight on behalf of all American working class families, the union has defensively argued that GM is demanding too much in the way of cuts. Rather than placing itself at the centre of a fight that might even revive the fortunes of the American labour movement, the union has reduced the issue to how much American workers should now give up.

This is all the more ironic and disappointing when General Motors has itself virtually invited a broader response. Along with Ford and Chrysler, GM has acknowledged, in letters to the Canadian auto union, the relative advantages of the Canadian system (inspired no doubt by their savings of some \$4/hr in Canada – about \$8,000 per worker - for health care costs).

In its latest annual report, GM notes that in other industrialized countries, '...governments cover a much greater portion of employee and retiree health care costs' and that even though overall health care costs in the United States '...were about 15% of gross domestic product, at least 30% higher than in the next-most expensive country', the reality according to even GM is that 'America's high health care costs don't buy the best care. In fact...the U.S. ranks 12 out of 13 industrialized nations in indicators like infant mortality and life expectancy...It's simply not acceptable for over 45 million Americans to be without health care coverage...' [General Motors Corporation 2004 Annual Report, p.7].

1. THE CANADA HEALTH ACT – CORE PRINCIPLES

Hugh Armstrong

Medicare, the system that provides hospital and physician services without charge at the point of service, is far and away Canada's best-loved social program. It is not 'socialized medicine' as claimed by its fierce opponents in the private health insurance industry (and in organized medicine south of the border). Nonetheless, embedded within its core principles are socialist values and interests worth defending on their own terms and for how they make concrete and familiar the broader socialist vision.

The medicare principles are set out in the *Canada Health Act*, legislation supported by all parties in Parliament when it was adopted in 1984 with the express aim of prohibiting "extra billing" and other user charges imposed on individual patients for insured services. As a condition for the federal government transferring medicare funds to the provinces, the provinces were expected to observe the *Act's* five basic principles or criteria, along with its prohibition of user charges. Federal enforcement of the *Act*, however, has historically been lax, but the *Act's* core principles continue to be embraced by the vast majority of Canadian citizens. In what follows, the socialist implications of the *Act's* five core principles are addressed.

i) *Universality* means that everyone must be covered by the provincial plan under uniform terms and conditions. 'Everybody in, nobody out' is a way of reflecting and reinforcing social solidarity. "Uniform terms and conditions" is an explicit rejection of privilege based on class position or any other characteristic, such as sex, race, age or region.

ii) *Accessibility* entails the rejection of privilege in that it bans financial and other barriers that would impede or preclude access to hospital and physician services. These services are to be provided according to individual need, not according to individual income or wealth. In addition, the accessibility principle contains a second, less well-known requirement. Physicians must receive "reasonable compensation" and hospitals must have the costs of the insured services they provide covered by their provincial plan. In other words, the system is not to be operated on the basis of sacrifices by its workers (about 80% of whom are women).

iii) *Comprehensiveness* is in a strict sense limited to the insured services, that is, to "medically necessary" hospital and physician services. In the hospital setting this includes, for example, accommodation and meals, nursing services, drugs,

equipment and supplies, diagnostic tests, surgical services and facilities (including dental surgery in hospital), radiation and physiotherapy. But as patients are moved ‘quicker and sicker’ out of hospital, they fall outside medicare’s scope and have to pay privately for some of these services, notably prescription drugs and physiotherapy. Nonetheless, the comprehensiveness principle does speak to the goal of a rationally planned, integrated system, and the *Act* does allow provinces to extend the scope of medicare services to include items such as nursing homes, home care and ambulance services.

iv) *Portability* is usually taken to mean that we can travel to other provinces and, to a lesser extent, outside the country, without fearing that a sudden illness or injury will impose a disastrous financial burden on us. When we move permanently, the province we leave continues to cover us for three months until coverage in our new home province kicks in. And for emergency care while visiting another

province, the home province is required to reimburse fully the province in which this care is provided. (Québec in particular has a record of violating this provision.)

Embedded within medicare, Canada’s best-loved social program, are socialist values and interests worth defending.

Another, implicit aspect of portability is of particular importance to socialists and to workers generally. Medicare coverage is tied to province of residence and not to employment. This helps to redress the imbalance between workers and employers. In the USA, by contrast, workers are frequently pressured to stay in bad jobs for fear of losing the health insurance provided as part of the pay package. Moreover, they seldom have much control over the terms of their coverage, and often find themselves in a strike or lockout situation over health insurance. A universal public system also serves large employers, in that as the Big Three auto-makers know all too well, the cost of insuring current and retired workers can imperil the viability of even the largest firm.

v) *Public administration* involves running each provincial plan on a non-profit basis by a public authority accountable to the provincial government that appoints it. By comparison with the confusing, fragmented and costly situation in the United States, the success of the public administration of Canadian medicare explodes the myth that private, market-driven corporations are more efficient and effective than public agencies.

None of this is to argue that all is well with medicare. As suggested above,

successive federal governments have lacked the political will to enforce the *Canada Health Act* principles. The transformation of hospitals into service sites where only the sickest patients receive excellent treatment (and for only brief temporal periods) has undermined the *Act's* stated protection of many important components of health care. But with a publicly regulated and financed system at the centre of health care, and with the continuing public support for this system, we at least have the democratic and collective opportunity to make progressive changes while preventing regressive ones. Indeed, precisely because medicare is so popular and its principles so consistent with socialist principles, it constitutes a vital arena for socialist activism.

As Roy Romanow put it in his recent *Commission on the Future of Health Care*, medicare is as sustainable as we want it to be. While there is no scientifically correct social health care expenditure, the evidence is abundantly clear that the for-profit financing and private delivery of care is more expensive, less readily accessible, and, for most of us, of lower quality. What is not sustainable is for-profit fragmented health care.

Medicare's popularity, efficiency and effectiveness in Canada make it a particular challenge for the privateers, inside government and out, who want to pry open the 'unopened oyster' of Canadian health care as an outlet for capitalist investment. In the face of public sentiment, the privateers must resort to privatization by stealth. The next sections of this pamphlet sketch how capitalists seek to sow confusion by mixing up different forms of privatization, and what is being done to thwart their efforts.



Maria Podger and Bonnie Synder, Homecare Workers, Guelph, ON

TIMELINE OF THE *CANADA HEALTH ACT*

In 1947, Saskatchewan's CCF (now NDP) government established the first provincial health care system, insuring hospital care for its population. Tommy Douglas, the charismatic leader of the CCF, was consequently elected as a federal Member of Parliament where he continued to fight for the development of a Canada-wide medicare program.

In 1958, the Conservative federal government passed legislation to contribute to provincial and territorial hospital insurance plans: any province installing a hospital plan would get 50 cents on the dollar from Ottawa. By 1961, all provinces and territories had insured hospital-care programs.

In 1962, the Saskatchewan government moved beyond hospitals to extend health care insurance to cover doctors' services. In 1966 the federal Liberals introduced legislation to cover the delivery of wider medical care services, including doctors' services, across Canada. By 1972, all provinces and territories were covered under the expanded range of insured medical care services.

In 1977, as part of the social reverses that later came to be identified as 'neoliberalism,' the federal government (Liberal) radically changed the system in place, removing the conditions on how the provinces and territories could spend federal health care money and reducing funding. The squeeze on the provinces eventually led – again in the context of neoliberal ideology and practices – to the introduction of user fees and a drift towards what a 1979 Royal Commission on Health Services concluded was leading to a two-tiered system that threatened the accessibility of health care services.

In response to public mobilizations and pressures, the *Canada Health Act*, reflecting the basic principles cited above, was passed in 1984.

2. DIMENSIONS OF PRIVATIZATION

Pat Armstrong

"The implied conclusion that timely access to health-care services will be improved with the establishment of a parallel private scheme flies in the face of all the evidence with which I grappled for 18 months as a royal commissioner," Roy Romanow, head of the Royal Commission on the Future of Health Care in Canada, *Toronto Star*, September 17, 2005

On June 9th, 2005, the Supreme Court of Canada struck down a Québec law which prevented people from buying private health insurance to cover medically necessary care already covered by the public health insurance plan. This decision seems to open the door to more privatization of Canadian health care. At the same time, it provides the opportunity for public debate about privatization. In order to engage in that debate however, it is important to understand what is meant by privatization. Privatization comes in at least six forms and presents a host of problems:

The privatization of costs.

The *Canada Health Act* prohibits extra billing and all other financial and non-financial barriers that would impede or preclude access to "medically necessary" hospital and physician services. The trick here is that there is no definition of "medically necessary" in the *Act*. Although this lack of definition has helped make the plan flexible in ways that can work for both providers and patients, it has also allowed provinces to define some services as no longer medically necessary and therefore to charge fees or even the entire costs of tests and services. Governments have been able to 'delist' services, removing eye exams and physiotherapy from the public health system. As a result, people (or their insurance companies) pay the cost, or they go without care.

Invisible in the public accounts are the rising indirect costs to the health care system associated with the shift of care to private households (which can be taken as a response to the cutbacks). When patients are sent home from hospitals sicker and quicker, the costs of medicines and other things they need are no longer covered. When patients are shifted from hospitals to long-term care facilities, the protection against fees no longer applies. Governments can also privatize costs simply by failing to create needed services, such as those required for Aboriginal persons with AIDS. Because women tend to have fewer economic resources than men, because women are less likely than men to have private insurance coverage

and because they are more likely to have responsibility for the children, it is women who especially suffer the inequalities of this form of privatization. More generally, the more that one's access to money determines one's access to care, the greater the social inequality.

Governments justify this form of privatization by citing rising costs, especially those costs associated with an aging population. This ageist justification assumes that elderly persons always cost society more and contribute less to it. But rising drug costs are the primary source of increases in health care spending. Drug costs could be much better controlled, for example, through government regulation and bulk buying. Equally important is the fact that elderly persons require higher resources from the system only in their last years of life. Age alone does not determine health care costs. Aging is not as great a threat to viable health care as it is

The privatization of health care comes in at least six forms, all of which undermine democracy and social equality.

regularly portrayed by the media. Canada's aging generation is in much better health than previous ones, and this is the result of good universal health programs, education and solid pensions.

This form of privatization is also justified as a means of preventing the abuse of "free" services, which assumes that people will think twice about using health care if they have to pay directly. There is very little evidence to support this claim. There is good evidence to indicate that rising costs for individuals mean that more go without necessary care. Not getting care for diabetes, for example, when it is first required, can mean greater costs for the individual and for the government in the long run. Finally, the privatization of costs is justified as a means of improving choice. But it is a choice based on purchasing power, and a denial of choice for those who lack the ability to pay.

The privatization of service delivery.

With very few exceptions, Canada's hospitals are owned by municipalities or by non-profit organizations such as churches. In other words, care delivery is often private but not for-profit. What is changing is not a move from government to non-government but rather a move in the system from not-for-profit toward for-profit delivery. Care within public institutions is increasingly being contracted out to for-profit firms. Public-private partnerships are being introduced and entire services are being taken over by the for-profit sector. Research in the UK, the USA, and Canada, tell us that such services cost more, often deliver poorer quality care

to the female patients, and typically pay the mainly female labour force significantly less.

The work most frequently contracted out is the cooking, cleaning and laundry, work traditionally defined as not only “women’s work,” but also as unskilled work and thus as worthy of less pay. In British Columbia, outsourcing has resulted in job losses for 10,000 unionized workers and foreign ownership of Canadian services. Wages have been cut in half, benefits have been eliminated or drastically reduced, and job security is increasingly abolished. The neoliberal contract conditions often ensure this is the case. Contracting out divides workers and tends to pit them against each other as they work within the same institution but

Governments are contracting out services to public-private partnerships or handing public services over to for-profit corporations.

have different employers and different conditions of work. The majority of these workers are women. A high proportion of them are new Canadians and women of colour. The deterioration of the working conditions in health care reverberates

throughout the economy, contributing to low wages for women in other sectors.

Public-private partnerships (P3s) usually encompass entire institutions. British Columbia and Ontario, for example, have started to build hospitals as public-private partnerships. A for-profit firm not only builds the hospital but also designs and manages it, and operates the cleaning, laundry, maintenance and security services. The same problems arise as they do for services that are contracted out to other firms. The major difference is that now the private partner seeks profit from the entire capital and much of the operation of the hospital, diverting resources from care.

Governments contract out services and embrace public-private partnership deals, and in effect, hand over entire public services to capitalization by for-profit firms. These firms are only interested in parts of public health care that can be efficiently delivered in an assembly line fashion to generate quick financial returns. Cataract surgery, for example, which can be performed quickly thanks to research conducted by public institutions, is now undertaken by for-profit facilities. In many instances, public insurance schemes pay for the care. When something goes wrong or a case is complicated in some way, the patient and the costs are expediently shifted back to the public system. The for-profit sector thus ‘cherry picks’ services; it provides and generates money from basic services as it desires, and when it errs, the public system pays the bill and eventually becomes more costly.

The rhetoric of “rising costs,” “wasteful practices” and “lack of funds” is used to justify privatization. Given that wages and salaries for providers account for most of the expenditures within health care, the main way money is saved is through reducing the labour-force and its pay. Such reductions in the quantity of workers and their wages can severely compromise the quality of health care without saving the government money. When building hospitals, private firms can borrow money at higher rates than the government can. Thus, governments have to meet this cost also. This form of privatization is very popular with firms seeking profit because it gives them the best of both worlds. Governments guarantee both payments and profits.

Managerial strategies imported from the for-profit sector.

Health care is increasingly conceptualized and practiced as a for-profit enterprise even when it stays in the public sector. We thus see “business plans” and “business strategies,” “product lines” and “outcomes.” The justification is based on a belief that practices from the for-profit sector are necessarily more efficient and effective, and as such, are applicable to health care. This belief does not stand up to the evidence. For example, recent research shows that heart surgery costs in the United States are almost double those in Canada, with no better outcomes for patients. The terrorist attacks in Britain show that you cannot run hospitals at 95% or 98% capacity as you might a hotel, because you always need space to respond to an emergency or even the daily variations in illness. But lack of evidence for the superiority of for-profit methods has not prevented a massive move throughout the world to adopt such methods.

Women are the overwhelming majority of paid and unpaid providers. So the reorganization of care to make it more efficient in market terms primarily affects their labour. And what affects their labour affects patient care. Time-motion studies are used to reorganize, control and speed-up the work, leaving providers, according to more than one provider we have interviewed, “with no time to care” and “not enough hands.” They feel guilty about the quality of care they provide, and often put in unpaid overtime to make up for the care deficit. Patients see and feel the speed-up defined as efficiency. The patients feel guilty as well when they ask for care.

The privatization of responsibility.

Canadians are increasingly urged by the media to take responsibility for their own health. We need only look at women’s magazines to know that health is discussed as a women’s responsibility. No one escapes this targetting. The new government focus on “the problem of obesity” is an example of the shift in responsibility for health to the individual and away from governments. Of course, the shift

in costs to individuals is another example of the shift in responsibility, as are the strategies to reduce hospital stays and restrict other types of institutional care.

This form of privatization is often justified with claims of individual empowerment and of demands for health promotion. Yet it ignores the ways which the existing structures of inequality and political-economic power shape our individual and collective ability to take responsibility and independently shape our health.

The privatization of care work.

With the dramatic expansion of public health systems following World War II, paid health care work expanded enormously. Most of those hired to do the work were women, although they were directed by the mainly male doctors. Until the 1960s, much of the care work in institutions was provided by unpaid nurses-in-training or by women defined as doing the work as a labour of love. Brought together in large workplaces,

Privatization is often justified in terms of individual empowerment, yet ignores the unhealthy social inequalities it results in.

these women fought hard to make their paid care jobs decent in terms of pay and conditions. They fought hard to get the work recognized as both skilled and valuable. The resulting rise in costs has become one

justification for cutting back on formal care. Another justification is often taken from the women's health movement itself, the claim that institutional care is bad while care in the community or at home is good.

Increasingly, this work is being sent home to be carried out by women or expected of women even when their relatives and friends are in institutional care. It is characterized as sending care back home, implying that women have shirked their duties there. As Canadian women put it to the National Forum on Health in 1997, women are being "conscripted" into unpaid care work. And there is nothing natural, traditional or unskilled about cleaning catheters, applying oxygen masks and dressing wounds. In spite of talk about returning care to the home, most of this new care work was never done there and there is no evidence that the care provided in the past was all good care. But this does not prevent women being blamed for not providing care nor does it prevent them from feeling guilty. Nor does it protect men entirely from such work, as men too are left to take on more homecare work when there are no women around and services are reduced.

The privatization of decision-making.

As more care is delivered by private and foreign corporations, fewer of

the decisions are open to public scrutiny and influence. More of the decisions are based on money and made by those with the most money. As care is reorganized, more of the decisions about how long and how much care is provided are taken out of the hands of patients and providers.

In sum, privatization is not one process but many. It is about a shift in who provides care, who pays for it, how and where it is provided, and who is responsible for it. These forms of privatization are often difficult to see, especially when governments keep promising to defend our public system and the *Canada Health Act*. Indeed, governments often argue that privatization is the means for doing just that. Combined, these processes are not only undermining equal access to quality care but also the people's faith in Canada's most popular public program. The best defence of public care has been public support, so this undermining is the most dangerous of all.

The evidence is clear that a public system offers the possibility of the most equitable, accessible and efficient quality care. It also offers the only possibility for collective, democratic decision-making. It is essential that Canadians use their democratic rights to ensure that privatization does not further undermine their public system.



Mary-Ellen Van Light and Peggy Hamer, Unit Clerks, Oshawa, ON

3. FALSE ARGUMENTS, CLASS ARGUMENTS

Colin Leys

Health care must remain a right of citizenship for two fundamental reasons: for the sake of democracy, and for the sake of good health care.

We need equal access to health care for the same reason that we need equal access to schooling and university; real democracy cannot survive without a basic equality of life chances for every voter, and health care is crucial for that.

But health care, like education, also needs equal involvement of all citizens. So long as judges depend on the same health services as janitors, judges (and politicians and senior policy-makers) will see that they are adequately funded and well run. As soon as the powerful stop relying on it, it starts to be allowed to decline. The rich don't use it and they don't want to pay taxes for it.

The propagandists for the rich – the Fraser Institute and the like – use three main arguments. One is that the share of national income devoted to health care is already too high. But there is no particular proportion of the national income which should be spent on health care. The fetishism around this is due to the fact that health care in Canada and most other rich countries is financed out of taxes, and the more affluent don't want to pay what only a few decades ago was seen as their reasonable share of the cost of services enjoyed equally by everyone. The fact that 14 per cent of the national income in the USA – half as much again as in Canada and the UK – is spent on health care doesn't arouse concern in the US media. Why? Because only some of this is paid for out of taxes. The rich can buy their own health care on the market, without having to pay much in taxes for anyone else's.

The second argument advanced by the right is that private provision, driven by competition, is more efficient. Yet all the evidence points the other way. The U.S. is the best source of evidence on privately-provided health care. As pointed out above, while spending 14 per cent of one of the highest national incomes in the world on health care, the US market system leaves between 45 million and 75 million people (depending on how you measure it) with no health coverage at all. In addition, the administrative or 'transaction' costs of health care in the USA, where every procedure and swab has to be recorded and billed for, where hospitals and doctors advertise to get patients, and where legal fees and fraud make off with huge sums, are conservatively estimated to consume no less than 25 per cent of all health care spending – double the UK figure (and more than four times what the UK percentage was in the 1970s, before Mrs. Thatcher started to 'marketise' the National Health Service). And the health of U.S. citizens is no better than those of any other OECD country. On some indices their health is significantly worse.

The third argument is that 'two-tier' provision as it operates in Europe

brings in additional resources – from the ‘top-up’ fees paid by the better-off for speedier service or ‘enhanced’ treatments – and gives more satisfaction. This is really a call for private access to better health care, and would hardly be worth challenging if it were not that appealing to the ‘European model’ is apt to seem persuasive. If it works in France or Britain, people may feel, why not in Canada too?

But in fact the European experience doesn’t support this argument at all. What is really going on at the moment is a world-wide drive by the private health industry to open up tax-funded (or ‘social insurance’ funded) health care as a huge source of almost risk-free revenues. Its lobbyists have captured the WTO and the OECD and to a large extent the WHO, so that European governments are under huge pressure to open up their health care systems to ‘market providers’, and they have increasingly succumbed to this pressure.

Britain is a leading example. Not content with already having a two-tier system, with expensive, mostly company-paid health insurance for the affluent, Blair’s government has committed itself to the creation of a full health care quasi-market, in which the publicly-owned National Health Service or ‘NHS’ hospitals will have to compete with supposedly more efficient private providers. But the story so far shows that the privatizers’ arguments are completely false.

We must ensure that health care, for the sake of democracy, remains a right of the citizen, not a right of the consumer.

NHS hospitals no longer get annual budgets, as in Canada, but are paid for each completed individual treatment, at prices set nationally by the gov-

ernment, and any private health care provider that wants to can bid to treat NHS patients at these prices. The idea is that competition from private providers will make the NHS hospitals more efficient. So private health care corporations were invited to begin by setting up ‘Independent Sector Treatment Centres,’ surgical clinics specializing in highly standardized, low-risk surgery – mainly cataracts and hip and knee replacements – which were seen as offering the best prospects for the supposedly more efficient private providers to make a profit. But the government then found that none of them was willing to do this at the prices paid to the NHS. So in desperation the government is paying them 40 per cent more than NHS prices – and guaranteeing them a supply of patients for five years; i.e., not competition, but featherbedding! The reality is that NHS hospitals, with internally well-integrated services treating all types of illness and surgical needs, can do it far more cheaply – and more safely.

Whether private health care corporations will go on getting special deals from the British government allowing them to make money, in spite of being less efficient than the public hospitals, remains to be seen. What is plain is that they offer no magic formula for being cheaper.

The other slogan used by the British government in support of its drive to bring in private providers is ‘patient choice.’ By the end of next year people are supposed to be able to choose to be treated at any hospital in the country – including any private hospital that will treat them at NHS rates. A survey by the government’s own Consumer Council showed, however, that the great majority of people don’t want to choose between hospitals, any more than they want to choose between post offices. What they want is to have a really good hospital near them. When Prime Minister Blair had a heart problem last year he didn’t want a choice, he wanted good care, promptly, and got it in an NHS hospital in London. Very few people want anything different.

To take another European example, France is often cited as showing the

The European experience shows that private and two-tier health care provision is expensive and socially divisive.

advantages of a ‘two-tier’ health service, including private provision. In fact, very little in the French system is really for-profit. All hospital medical costs (as opposed to the ‘hotel costs’) are covered by in-

insurance premiums paid to state-controlled insurers, or by the state, and paid at rates set by the state which are the same for private as for publicly-owned hospitals. The popularity of the French system seems largely due to having been better financed than most, and setting very few limits to what either patients or doctors could do.

But this has made it expensive, and the French government is currently on a campaign to cut costs by introducing restrictions, chiefly by instituting some limited ‘gate-keeping’ for access to specialist care, to stop what the French call ‘medical nomadism’ – people seeing several different doctors for the same complaint – and also by trying to limit excessive spending on drugs and sickness benefit (income support for people certified as ill by their doctors), and false billing by doctors. But an earlier de-listing of a vast range of useless drugs already caused a strong public reaction. Now the government is aiming to cut costs through a new system of inspection and penalties. It is not clear that this is going to save more money than it costs (in increased monitoring, a huge IT program to create a universal patients’ records system, etc), and it will certainly be resisted.

The French system thus does not support the idea that ‘two-tier’ insurance and private provision makes for cheapness or efficiency. Private provision in

France is actually very limited, and shows no signs of boosting efficiency in the rest of the system. If anything, private sector pressure to keep fees high has contributed to making the French system exceptionally expensive.

In general, what the European experience shows is that private and ‘two-tier’ provision is both more expensive and socially divisive. The decisive ‘no’ votes in both France and the Netherlands on the proposed EU constitution, which endorsed the private provision of public services, show that people understand this. West European governments, at least, will encounter more and more resistance to any further attempts to privatize health care and make it less egalitarian. Canadian governments should beware of putting the ambitions of their friends in the health care industry before the wishes of the electorate.



Louis Rodrigues and Jill Babcock, Dietary Workers, Kingston, ON

4. NEW LABOUR'S HEALTH REFORMS: BACKWARDS TO THE FUTURE

John Lister

Britain's newly-appointed Health Secretary (Patricia Hewitt) wrote a controversial article for the *Guardian* newspaper in the summer of 2005 in which she claimed the posthumous endorsement of the Labour Party's post-war pioneer Health Minister Aneurin Bevan for New Labour's National Health Service (NHS) reforms. In doing so she displayed both her ignorance of history, and the intention of Blair's government to undo one of the Labour party's greatest historic achievements, which was to sweep away an unfair 'market' in health care, and establish a new, modern, universal service.

In 1948 Bevan and the Labour Party boldly nationalised the flagging network of 2,700 voluntary and municipal hospitals, to create the National Health Service, one of Europe's first tax-funded, comprehensive health care systems. Health care was no longer a commodity affordable only by the well-to-do, or a fitting opportunity for charity: universal entitlement was facilitated by a service with no charges, free at point of use, with the risk shared across the whole population.

Billions are now diverted from National Health Service (NHS) budgets to create a new, expanding private sector.

It was not perfect. There were problems of capacity, of course, and the government also consciously made compromises which left some relics of the pre-NHS private sector intact – pay beds

and private practice for consultants, and allowing GPs, who had refused point blank to join the new NHS on a salaried basis to remain as 'independent contractors'. But what for Bevan were concessions, to ensure the passage of ground-breaking changes, have for Hewitt and Blair become a point of principle. Billions are now diverted from NHS budgets to create a new, expanding private sector, which has now been expressly set free to poach staff from NHS hospitals.

The first announcement of the new Health Secretary was that £3 billion was to be set aside to buy services exclusively from private providers – NHS hospitals would not be able to compete for this funding. Under John Major the NHS was buying less than £200m worth of treatment from private hospitals a year. This will have increased ten-fold by 2007. Up to 15% of elective surgery will be hived off to private hospitals, leaving NHS trusts to cover the remainder.

To make matters worse, two existing, modern, showpiece NHS treatment centres are also to be privatised as part of the same package of proposals: this is neither expanding capacity nor supporting patient choice, since existing high qual-

ity NHS services will no longer be available in these areas. The Labour government has also proposed an equivalent policy to create a new private sector in primary care services, while family doctors (GPs) are being encouraged to act even more like small businesses, and allowed to retain unspent surpluses from ‘practice-based commissioning’ which cuts costs by diverting patients from hospitals. The government argues that the improved performance of the NHS since 1997 is down to “the hard work of NHS staff, a doubling of the NHS budget, and the government’s program of reform”: she is right on two out of three. The ‘reforms’ have raised serious doubts over whether the money is being wisely spent.

A survey of over 40 countries shows that for 15 years Britain (especially England) has gone farther and faster down the road of market-style reforms than any other country in the world: but there is no evidence that these reforms improve efficiency or cut costs. Thatcher reforms of the early 1990s fragmented the NHS into purchasers (health authorities and GP Fundholders) and providers (NHS Trusts): they massively increased administrative costs, and boosted numbers of senior managers.

The decline in the public sector has entrenched inequalities in health status among rural areas and Aboriginal communities.

New Labour came into office in 1997 pledging to scrap the costly and wasteful internal market system, and began to do so – only to turn rapidly back towards the current policy,

creating a market in which the NHS competes on unequal terms with a private sector free to pick and choose the most profitable areas and treatments. Government plans to buy treatment from private hospitals serve both to siphon cash out of NHS budgets and to increase costs. Private sector care, especially for-profit care, costs more in almost every country where it exists alongside public provision.

In Germany, fee for service payments for privately insured patients receiving out-patient treatment were 40% higher than equivalent payments made through Statutory Health Insurance. In Korea’s insurance-based system, private hospitals charge up to five times the equivalent public sector hospital costs – but, like for-profit hospitals around the world, refuse to invest in facilities in deprived areas where health need is greatest.

In Australia, where the government has pumped in huge subsidies to divert working people towards private health insurance, the private sector has become increasingly dominant in key areas of health care: a majority of physicians are in the private sector; private hospitals provide 30% of Australia’s beds and carried out 53% of surgical procedures in 2000-01. Almost 45% of the population is now covered by private health insurance. However 70% of health spending still

comes from state and federal governments.

The decline in public sector investment has left severe and entrenched inequalities in health status and access to care among rural areas and Aboriginal communities. And public sector hospitals have been under pressure, with rising admission rates and waiting lists and reduced income from private insurers. As

'Patient choice' turns health care into a commodity and makes private-sector involvement and all dominant principle.

with the private sector around the world, private hospitals in Australia favour minor elective surgery, with almost 50% of their total caseload being day cases.

In a detailed examination of official data, Richardson and colleagues find evidence that private hospitals are both more expensive and more likely to make use of high-cost procedures than public hospitals. If the \$1,500 million subsidy to private health insurance in 1996-7 had been allocated to public hospitals, their capacity would have increased at least 14% – a far larger expansion of capacity.

Ignoring the evidence, New Labour “modernisation” reinvents failed policies. Competition, which in the 1990s brought dislocation and widened inequalities under the Tories, and was shown to increase costs in Sweden, is coming back – this time as “payment by results,” with prices fixed centrally. This will have potentially devastating consequences for many local services. Competition also means Foundation Trusts, controversially imposed with a wafer-thin vote in Parliament, which ape the failed experiments that were dropped in Spain, and brought soaring debts in New Zealand and privatisation in Sweden. The policy aims to turn NHS providers into free-standing, entrepreneurial public corporations that act like private companies.

The Blairite mantra of “patient choice,” turning health into a consumer commodity, and making private sector involvement into an all-dominant principle, also conspicuously turns its back on the very successful health services which provide choice but separate public and private sectors in Sweden, Denmark and Norway. Instead New Labour looks to the failed, costly ‘free market’ model which has left 46 million uninsured and huge inequalities in health care in the USA.

But in the Private Finance Initiative (PFI – equivalent to the Public-Private Partnerships or P3s in Canada) New Labour leads the world: while previous governments invested in public assets, Blair’s team have perfected a device to suck limitless billions from the public purse to line the pockets of shareholders, while forcing Trusts into crisis and chronic deficits as they struggle to pay the rent on high-cost shoddy buildings with too few beds.

When the first wave of PFI hospitals were signed off in the late 1990s the average capital cost of a new hospital was £75m. This has since spiralled into the stratosphere, with a number of schemes now above, or close to, £1 billion, and several more in excess of £400 million. The first schemes have already been refinanced, bringing huge additional windfall profits to the PFI consortia, but leaving the public sector stuck with hefty bills.

The costs are staggering. Annual payments on a £420m scheme in Central Manchester came out in 2004 at £51m per year, index-linked, over 38 years, £30m of which was the ‘availability charge’ for the building itself. The combined costs of PFI payments, residual NHS interest charges and facilities management was to total £64m a year – almost 20 per cent of the Trust’s total revenue.

This type of increased overhead costs – and restricted capacity – have already helped to force most of the operational PFI hospital Trusts deep into deficit. They face restricted options for economies, since all support services are incorporated into legally-binding, index-linked, contractual payments to the PFI consortium, and Trusts retain discretion only over clinical budgets. Hence the nonsense of the £120m Queen Elizabeth (PFI) hospital in South-East London operating with wards closed, and a £10m deficit. With the prospect of a new system of Payment by Results that will offer only a fixed charge for each item of treatment, PFI hospitals from next April will be at a huge disadvantage, with bloated, fixed overhead costs, and inadequate capacity.

Where big PFI projects do proceed, they will drain vital resources from community health care and mental health budgets, leaving a lop-sided pattern of care for a generation to come. These economic facts of life seem likely to bring the demise of several lumbering £1 billion schemes: but smaller ventures are still proceeding. PFI for the NHS remains a high-cost, high-risk way of building facilities which unlike previous NHS buildings, are not public assets but liabilities weighing down on the local health economy.

PFI sums up New Labour’s ideologically-driven, backward-looking “modernisation,” which has begun to re Commodify and privatise public health care, increased costs and overheads, demoralised and alienated staff, undermined planning, and done nothing to ensure equal and improved access to care.

5. PHARMACARE: A PRESCRIPTION DRUG COMPANIES WON'T OFFER

Joel Lexchin

Canadians have been promised a public system for prescription drugs since the early 1960s when it was proposed by the Royal Commission on Health Care. However, despite repeated promises in the ensuing decades from the National Forum on Health and even the Liberal party itself during the 1997 election, a public system still remains beyond our grasp.

As a result 3% of Canadians, or about 1 million people, are considered uninsured because they pay more than 4.5% of their gross family income for prescription drugs and an additional 3.3 million who pay 2.5-4.5% of their income are labelled underinsured. According to a recently published study from Toronto's Hospital for Sick Children, a significant number of children lack timely access to necessary medications because of economic problems.

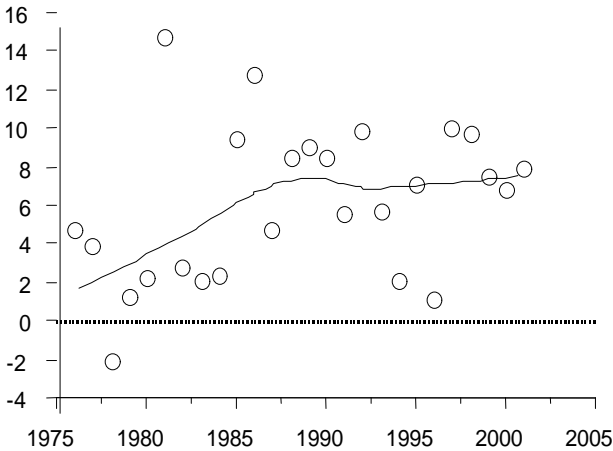
The poorest fifth of the Canadian population spends more money on out-of-pocket prescription drugs than the richest fifth. For people over 65 years it makes a significant difference which province one lives in when it comes to drug therapy. A low income senior in Saskatchewan with average drug use in 1998 would have paid \$500 out-of-pocket but the same person with the same drug use in Ontario would pay less than 1/10 that amount. Internationally, Canadian public spending on drugs as a percent of total drug costs or on a per capita basis ranks near the bottom of the list of industrialized countries. The only place that consistently has a worse record than Canada is the United States.

Proposals from public commissions led by Michael Kirby and Roy Romanow have abandoned the idea of first dollar universal drug coverage in favour of some form of catastrophic coverage. In the case of Kirby coverage would start once people had spent 3% of their annual income on prescription medication; Romanow suggests a \$1500 deductible. In 2003, the provincial First Ministers pledged "by the end of 2005/06, to ensure that Canadians, wherever they live, have reasonable access to catastrophic drug coverage." However, that pledge has now been superseded by the National Pharmaceutical Strategy that claims that by June 30, 2006 governments will have developed and assessed options for catastrophic pharmaceutical coverage.

Catastrophic drug coverage while better than nothing for those currently without coverage would still leave low income people vulnerable to high drug costs. In Ontario, the minimum wage of \$7.45 per hour translates into an annual income of just over \$14,000. If Canada adopted the Kirby proposal then that minimum wage person would be spending about \$425 per year on drugs; a considerable portion of her disposable income after accounting for shelter and food.

On equity grounds alone, there is a strong argument for Pharmacare, but

Annual % change in real retail prescription drug expenditures
Canada, 1975-2001



Source: Canadian Institute for Health Information 2001b; Bank of Canada (no date)

beyond equity Pharmacare will help Canada control rising prescription drug costs. Retail prescription drug costs are rising at about 8% per annum after controlling for inflation and since the late 1990s Canada has been paying more for medications than for doctors.

One of the main factors accounting for this continual inflation is the use of newer more expensive drugs in place of older, less expensive products. For example, by 1998/99 over half of the \$1.9 billion being spent by the Ontario Drug Benefit Program was on drugs introduced since 1992/93. An analysis done by Green Shield, a non-profit insurance company, found that the price of a prescription for generic drugs barely changed from 1997 while the price for one that contained new patented medications went up by 9% per annum.

Provincial drug plans have largely attempted to deal with rising drug expenditures by shifting costs onto users of the system. This was the approach that Québec used when it expanded its drug insurance system without increasing government expenditures. Prior to that change, people on social assistance were exempt from any co-payments and seniors paid \$2.00 per prescription. After the change those on welfare had to pay up to \$50 per quarter and the elderly were subject to deductibles and co-payments that ranged \$200 to \$925 per year. These charges meant a drop in essential drug use of more than 9% for welfare recipients and almost 15% in the elderly and corresponding increases in hospitalizations, physician visits and trips to emergency departments.

Encouraging the use of private drug insurance will also do little to either control costs or improve equity. Most private drug plans in Canada are much less aggressive in cost control measures than public plans and administrative costs in private plans run around 8% compared to 2-3% in large provincial plans.

Currently, the portion of insurance received through the workplace that is paid for by the employer is exempt from personal income tax. In the context of a progressive tax system (like Canada's), subsidizing private insurance through the tax system translates into higher subsidies for those earning higher incomes. In fact, the top 20% of the population receives a benefit more than three times greater than the bottom 20%.

Monopsony (i.e. single-purchaser) buying power like that used in the Australian Pharmaceutical Benefits Scheme leads to costs for individual drugs that

If the government was paying the bulk of the drug cost it would probably have much more of an incentive to ensure appropriate use.

are 9% lower than those in Canada. Other measures like tendering for generic products available from multiple companies and cross price subsidization (requiring lower prices for already

listed drugs in return for accepting new listings) that have cut the New Zealand drug budget by almost 50% stand little chance of success in a world of multiple payers.

Finally, Pharmacare has the potential to help improve the way that doctors prescribe. Today, pre-marketing trials test drugs on selected groups of patients. When the products are released on the market they are the object of intense promotional pressure and as such often end up being prescribed to large numbers of patients who were excluded from the clinical trials. This heavy prescribing takes place long before the full safety profile of new drugs is known and therefore exposes patients to potentially serious problems.

Half of the drug withdrawals from the market by the Federal Drug Administration in the U.S. between 1975 and 1999, occurred within the first two years of drug introduction. New drugs not only pose safety problems but for the most part do not offer any major new therapeutic benefits. Government figures (federal Patented Medicine Prices Review Board, 2005) show that only slightly more than 10% of all new drugs are significantly better than existing, generally much less expensive, medications. In a Pharmacare system, economic incentives and disincentives can be used to limit prescribing of new drugs but once again these disincentives are only going to be successful when they apply to the majority of prescribing decisions.

Furthermore, if government was paying the bulk of the drug costs it would probably have much more of an incentive to ensure appropriate use, if for no other reason than to keep costs down. In Australia, the federal government provides about \$20 million annually to the independent National Prescribing Service whose mission is to improve drug prescribing by doctors and drug use by consumers.

The usual argument mounted against a first-dollar Pharmacare system, similar to what already exists for doctor visits and hospitalizations is that it is unaffordable. To begin with this line of reasoning ignores the simple fact that we are already paying for prescription drugs to the tune of almost \$18 billion per year. The question is not can the country afford the cost but rather how will the cost be met?

Currently, government accounts for about 47% of all costs, private insurance covers 34% and the rest is paid out of pocket. If government were to pick up the entire tab then it is inevitable that public spending would increase, probably by about \$7.7 billion. However, even allowing for increased use of prescription drugs by groups now not covered at all or only partially covered, total spending on medications would actually drop by between 9-10% because of lower administrative costs and lower prices that could be achieved through national bargaining power.

Right now we are funding prescription drugs the way that Americans fund their entire health care system. We have rejected the American approach for doctors and hospitals because we have recognized that it is inefficient and inequitable. It's time to reject that approach to paying for prescription drugs. Pharmacare makes sense on all three grounds – equity, economic efficiency and improved prescribing.



Lori Davis and Barb Lingard, Nursing Aides, Oshawa

6. THE ONTARIO LIBERALS STRENGTHEN THE HARRIS' "REFORM" OF MEDICARE

Mike Hurley

The fate of health care workers is inextricably bound to healthcare policy. The salaries of health care workers are not responsible for the exploding costs of healthcare, yet health care workers face attack. The Ontario Liberal government is strengthening and deepening the neoliberal health care "reforms" of the Harris government.

The Harris Government Takes Aim At Medicare

The Harris Progressive Conservative government introduced Ontario's first public-private partnership (P3) hospitals at William Osler in Brampton and at the Royal Ottawa. The first Tory move was to cut \$1.5 billion from existing hospital budgets. Seventy-five percent of long-term care beds awarded by that government went to for-profit providers. Harris also allowed the introduction of private for-profit provision of cancer diagnosis.

Most insidiously, Harris introduced "managed competition" homecare. The ruthless competition that resulted, drove labour costs and services down and destroyed organizations like the Victorian Order of Nurses and Visiting Homemakers (VONVH) in Hamilton. When the Community Care Access Centres (CCACs) protested the lack of resources, they were placed under trusteeship. This happened while the government aggressively closed over thirty hospitals and 5,000 hospital beds on the theory that resources would be transferred to the community to absorb the need there.

Some well-meaning "progressives" advocated a policy of "de-institutionalization" in the health care system, but their naïve support for hospital closures was used by Harris to rationalize his attack upon the hospitals. Ironically, his government also cut services for those who were discharged into the community as a result of those closures.

Dr. Jane Aronson's study of twenty-seven people who were receiving homecare in the Hamilton/Niagara/GTA region during this period, provides details of not only the steady erosion of services, but also the entire loss of services and the high turnover in the number of caregivers who were staffing the homecare service. As a result of these changes in the system, homecare workers have seen their wages fall over a ten year period. As their employers lost contracts in bidding wars for services, workers lost seniority and benefits. There are no pensions. There are no guaranteed hours of work. Most workers are working twenty or fewer hours a week. They need two or more jobs to make ends meet. And it is this model of so-called "managed competition" which the McGuinty government has chosen to extend throughout Ontario's health care system.

McGuinty Commits to Public Healthcare

In the 2003 Ontario provincial election, Dalton McGuinty committed himself to rolling back the Harris' P3 hospital projects and the private magnetic resonance imaging (MRI) services. The Liberals denounced the "managed competition" that had devastated homecare. These commitments were, however, insincere. In fact, the McGuinty government has taken much of its health policy agenda directly from New Labour in Britain, where private ownership of hospitals and "managed competition" are ascendant.

In the winter of 2005, the McGuinty government will roll out fourteen Local Health Integration Networks (LHIN). With boards appointed by Order-In-Councils and its members paid by the province to attend meetings, the LHINs will buy health care from providers such as hospitals as well as from long-term care facilities.

As part of the process of turning hospital services into a commodity, the Ministry of Health has begun to survey hospitals to establish the price range for many services. In the example of the provision of cataract surgery, prices range from \$450 to \$2000 an eye and the province has decided it will pay \$750. Hospitals and other providers in a LHIN catchment area will then be asked to compete with each other to deliver cataract surgery, or births or hip replacements. The winners get the contracts and the losers will stop providing these services. There is absolutely nothing stopping a private "for-profit" corporation from bidding on these procedures.

For small, rural and northern hospitals, the economics of scale mean that these institutions cannot compete with larger and higher-volume centres. The closing of smaller community hospitals will be the unfortunate end result. Similarly, LHINs will buy care services for seniors. And facilities such as charitable municipal homes for the aged will find that they cannot compete with large private corporations such as Extendicare in obtaining contracts to deliver this care service across the LHIN region. Gradually the for-profit operators will push the not for-profit institutions out of health care.

Initially, in the CCACs, the large for-profit corporations bid low for homecare contracts, priced below cost and won work away from groups such as the Victoria Order of Nurses, who could not compete. Now, of course, those for-profit corporations are pricing their services higher.

The LHINs will force institutions to amalgamate their services and to transfer workers in support functions to contractors who will do laundry or food production or housekeeping across a large geographic region. Last year, Ontario passed legislation to facilitate this policy.

A recent study by the Canadian Union of Public Employees (CUPE) of contract workers employed by the multinational corporations and who are working

in housekeeping in Vancouver hospitals, gives us a glimpse of a potential future. These workers earn half what the housekeepers earned formerly in these facilities. If they complain they are fired. They are forbidden to speak to nursing or other hospital staff. This is the metamorphosis of work which was once valued, into work which is not. And the movement of women from decently paid employment, with benefits and pensions, into poverty.

Simultaneous with the LHINs, the Ontario government is pushing for the creation of corporations which will offer centralized services such as Information Technology, Materials Management, Administration of Joint Benefits and ultimately food and other support services. In Toronto we have the Hospital Business Systems project; in northern Ontario another one, with one for each LHIN district.

Health care workers will not go gently

These aggressive and insensitive neoliberal plans have little public support. Recent polling shows that only two percent of Ontario's population is aware of these changes. Beginning in the fall, hospital and long-term care workers will be mobilizing their communities in Ontario to resist the policy of "managed competition." CUPE has already briefed 400 leaders of its healthcare locals about the dangers of this policy and has adopted a vigorous action plan, which is well resourced and which includes an advertising campaign, the organizing of our members to take job action and the mobilizing of the general public with the help of the Ontario Health Coalition. In Britain, unfortunately, there really was no fight against managed competition or P3 hospitals. The unions' leaderships were too closely allied with the Labour Party and in some instances even prevented their members from asserting their interests.

In Ontario, the battle against the P3 hospitals has been joined with the issue of introducing "managed competition" through the LHINs. As noted elsewhere in this pamphlet, the Ontario Health Coalition organized a referendum in June, 2005, in St. Catharines, in which 13,000 citizens voted 95% against the P3s. Referendums are also planned for North Bay, Sault Ste. Marie, Hamilton and Woodstock. The campaign is determined to meet its objectives and is engaged in intensive community organizing, targeted at Liberal MPPs, especially since the provincial election is slated for October 2007.

Health care workers are at the forefront of the struggle to defend our Medicare system. They require the support of the Canadian public and all working people. The Liberals deserve to pay a high price for breaking their health care promises.

7. THE STRUGGLE TO PROTECT AND EXTEND PUBLIC MEDICARE: STRENGTHS AND WEAKNESSES

Natalie Mehra

Social movements struggling to protect and extend the public health system across Ontario and across Canada are overwhelmed by a tidal wave of privatization. We need to figure out our priorities, stay focussed, run a strong defensive fight and try to shift to the offensive. We have, in some critical ways, succeeded in spite of the powerful forces conspiring against us; in other respects, we are failing.

There are two major external assaults on the public health system in Canada, each led by different groups and interests, but ultimately linked and supported by an increasingly large and consolidated global private health industry seeking new markets for growth and profit. The first is the attack on the public insurance system, led by people associated with the private insurance industry, physician-specialists who want to extra-bill and the Conservative Party (both federal and provincial). The second is the attempt to create a health delivery system made up of for-profit private corporations looking to combine subsidization from the large public insurance system with the ability to extra-bill as an additional revenue stream. This includes, as noted elsewhere in this pamphlet, the desire to restructure the public service itself into the structure and culture of a competitive market. This second force is led by the private health delivery industry, and several prominent Liberals and large sections of the Liberal and Conservative Parties (again, both federal and provincial).

Social movements struggling to protect and extend the public health system across Canada felt overwhelmed by privatization.

ated with the private insurance industry, physician-specialists who want to extra-bill and the Conservative Party (both federal and provincial). The second is the attempt to create a health delivery system made up of for-profit private corporations looking to combine subsidization from the large public insurance system with the ability to extra-bill as an additional revenue stream. This includes, as noted elsewhere in this pamphlet, the desire to restructure the public service itself into the structure and culture of a competitive market. This second force is led by the private health delivery industry, and several prominent Liberals and large sections of the Liberal and Conservative Parties (again, both federal and provincial).

In building a social movement that can succeed against this well-organized, well-financed, and well-connected opposition, our main strength is that we outnumber them (the majority of Canadians are proud of Medicare and believe in a society that is socially just) and that we are right (the evidence is clear that a public health system is the most efficient and socially just solution to the problem of access to health care). We have been building an infrastructure to enhance our ability to organize, communicate and mobilize and creating processes within our organization to identify major threats and to construct strategies to succeed against them.

The health coalition has worked hard to organize at a community level

Public-Private Partnerships (P3s)

If hospitals are still run by administrators responsible to the public, why should we care if the buildings themselves are built and owned privately? Isn't this an easy way to leverage private money without affecting our taxes?

To begin with, the companies coming in aren't doing it to support our health care system. They see it as a profit opportunity and so will be charging the hospital for its 'services.' Because it costs the private sector more than it costs governments to raise money, and because of the profit add-on, this will end up costing all of us more than we'd pay if we did it publicly.

But that's just the beginning. These private companies aren't just coming in to be landlords. They see the buildings themselves as a golden opportunity to expand into more services – they bundle into the deals the services and management of the facility from patient records to cleaning, and add in the ability to raise their profits through new service charges and user fees wherever possible. Why not then offer to run the MRI clinics after hours as an additional revenue stream?

The point is that with this foothold inside the health care sector, they have a powerful base for moving on to bigger and richer things. 'Just let us do a little more', they will argue as they learn more about how the hospitals are run, 'and we will do it more efficiently' – which translates into wage cuts, outsourced jobs, bringing in the cheapest supplies (with quality checks linked to profits) and the erosion of services.

We need to address the question of how hospitals are run and managed, of course, but at the same time we must try to get them to operate in ways that provide better services and respect to those doing the work – something not exactly at the top of the list for those looking for a safe new sector for profit-making.

and as broadly and deeply as possible. We pair, at every level in the organization, patient interests and those of careworkers/caregivers. We've created an infrastructure of over 70 local health coalitions along this model and routinely organize mass outreach and organizing efforts to move thousands or even hundreds of thousands of people to express support for the public health system and progressive reform.

During the Romanow hearings, we did this through a province-wide door-to-door campaign that reached half a million households. We regularly organize cross-province protests, media initiatives, lobbies and mobilizations. Currently, we're organizing plebiscites in every community in which the government intends to introduce private P3 hospitals. The first plebiscite in St. Catharines yielded over 13,000 votes (all but 200 opposing the privatization of the hospital). This deep community organizing has proven to be an effective counter-pressure on elected members of the provincial parliament.

Through this work, we have developed a deeper analysis of the issues, moved to more consistent monitoring of global trends and pressures, and become more sophisticated in our strategies. We have engaged and confronted policy makers within government, media and health institutions and have successfully bred a mobilizing culture in communities across the province. Every year for the last decade, the coalition has grown and extended its ability to reach tens or hundreds of thousands.

We have significantly reversed public perceptions of privatization as positive, and made the political context more difficult for those who want to dismantle the public health system.

The provincial government is attempting to move ahead with privatization through P3s, and by shifting hospital services into private clinics.

Our successes to date include: stopping the privatization of diagnostic clinics, including the reversal of the cancer care privatization; stopping the expansion of the MRI and

CT clinic privatizations; at least postponing some other planned privatizations; and protecting single-tier access for many acute care services.

Yet this is of course not enough. The provincial government is attempting to move ahead with privatization of hospitals through P3s, and a movement of services out of hospitals into clinics (so far, non-profit). The new capacity that has been built into the health system after we won re-funding has been largely privatized. The delisting and shrinking scope of services covered under the public health insurance system continues. The government is moving forward with plans to rationalize and regionalize the service workers in hospitals into large companies that will contract services for multiple hospitals across their regions. This will add to

the pressure to reduce the wages and working conditions for those workers, and will be ripe for for-profit privatization as it unfolds. Finally, the government is restructuring the entire health system to be delivered through competitive bidding systems by region through what they are calling Local Health Integration Networks (LHINs). These bodies will undoubtedly promote more privatization of delivery.

The difficulty in protecting medicare has, to some extent, developed as a result of incoherence within our own health system and as a result of domestic policy decisions that have weakened democratic control, contributed to the adoption of market mechanisms and trends within the public/non-profit system, turned over large sections of the non-profit/public health delivery system to for-profit providers, failed to address the core determinants of health, and failed to create a progressive model for managing demand and delivery. While our democratic systems and organized popular resistance have to some extent preserved the public system, the take-over of our democratic institutions and structures by corporate interests and the erosion of or lack of existence of democracy at every level of policy making – from legislatures to within health institutions and social service

agencies themselves – has threatened to destroy the current system.

We need, alongside mobilizing strategies, to develop policy options to enhance the public system and public supply of delivery within it.

A primary weakness in our movement is our inability to move to an offensive position that offers positive health system reforms. We are in an

almost entirely defensive fight regarding privatization. This means that even a partial victory may still entail a net loss. We need, alongside our mobilizing strategies, to do more work to develop policy options to enhance and extend the public system and public supply and delivery within it. We need to address and confront the future direction our health system is moving in. We need to reform health institutions and delivery systems, increase democracy within the system and at every level of government, and challenge its allocation of resources to the private sector.

The fastest growing costs in the health system include drugs, medical equipment and supplies – sectors that are entirely private and for-profit. Yet the focus of cost-containment has, almost without exception, been on restructuring and cutting back on the numbers of support workers and nurses, and the de-listing of clinical services. Our failure to address the private sector's ability to increase demand, and increase costs has meant that clinical services and conditions for workers continue to be restructured and cut while the private sector has continued to drive up costs

and reap substantial profits from the public purse.

Another problem and weakness is our failure to deal with the issue of Québec. The healthcare debate in Canada has taken place in a context of Québec separatism and withdrawal of the federal government from its traditional roles in infrastructure development, enforcement of the *Canada Health Act*, assurance of equality rights for citizens and nation-building. Our lack of a clear position on

The health care debate is taking place within the wider context of neoliberalism, fiscal restraint and tax system restructuring.

Québec has aided federal inaction with regards to enforcement of the *Canada Health Act* and the extension of the public health system to cover new nation-wide programs such as homecare and Pharmacare.

Finally, we cannot address the issue of health care without addressing the larger context. The health care debate is taking place within the wider context of fiscal constraint, a restructuring of the tax system to make it more inequitable and reduce the tax base, and a restructuring of fiscal federalism. At a broader level, it is taking place in a global restructuring that has led to increasingly unfettered corporate dominance and privatization, free trade, international investment deals, international intellectual property regimes and other extensions of corporate rights.

In the areas in which global movements have emerged to fight on these issues, some have been won in favour of social goods and services. But the weakness of a “one-off” campaign or even of consistent mobilization that does not take on the larger issues and the power of the global private health industry is evident. In the present context, diminished expectations across the progressive spectrum affect the ability to raise resources and generate the confidence that mobilization matters. Ultimately, our ability to carve out and protect space for public programs and income redistribution will rely on our ability to shift the entire paradigm of public policy here and globally.

This is not meant to be overwhelming. In fact, the fight to protect and extend the public health system is part of that work. However, it is only one part and needs to be parlayed into an effective challenge of the power structures and systems that have created the ongoing attack on the public health system. When struggles occur across all social movements and as a stronger and more diverse Left emerges, particular sectors are inspired to creatively deepen their strategic experiences, develop their sophistication, and start changing the political context in which we operate.

Conclusion

The accomplishment and longevity of our public health system is extraordinary given the forces arrayed against it. For over thirty years, despite enormous contrary pressure, the principles embodied in the *Canada Health Act* have endured, protecting Canadians' access to health care and enhancing our standard of living. It is critically important to protect the values and the economic model of the public health system. And it is important to recognize that the public system abounds with examples of dynamic and diverse community services, improved access and better prevention of illness that we can build on. Yet as the health system is reorganized, we are eradicating that model and mimicking the inefficiencies of the private market. In so doing, we are recreating the very problems public medicare was set up to mitigate.

Public medicare belongs to Canadians. We fund it and we rely upon it. We must insist that its principles be upheld now, and in the future. We must demand that our governments stem the tide of public money that is used to prop up a bevy of global corporations whose profitability depends on shrinking the scope of public services and deepening inequality. We must assert real community control over the systems and institutions that are intrinsic to our lives and the health of our communities. We must exert our influence to insist that we are citizens, not customers. We must protect health care as a social right, a democratic exercise and a collective responsibility.



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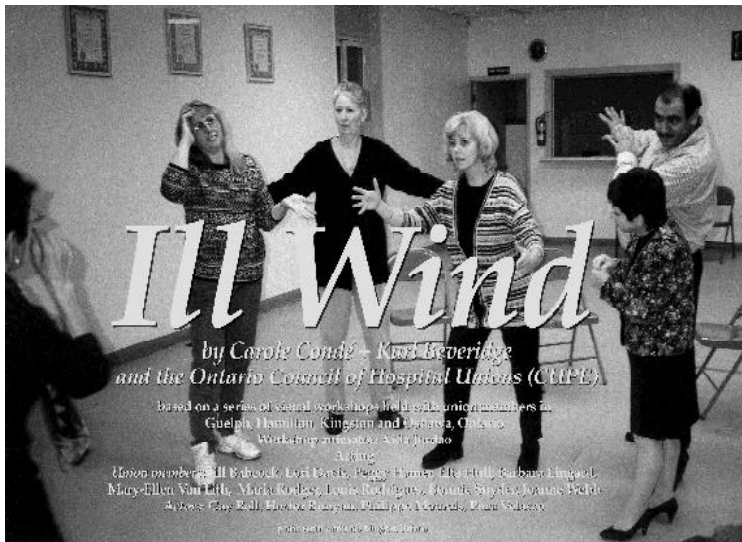
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