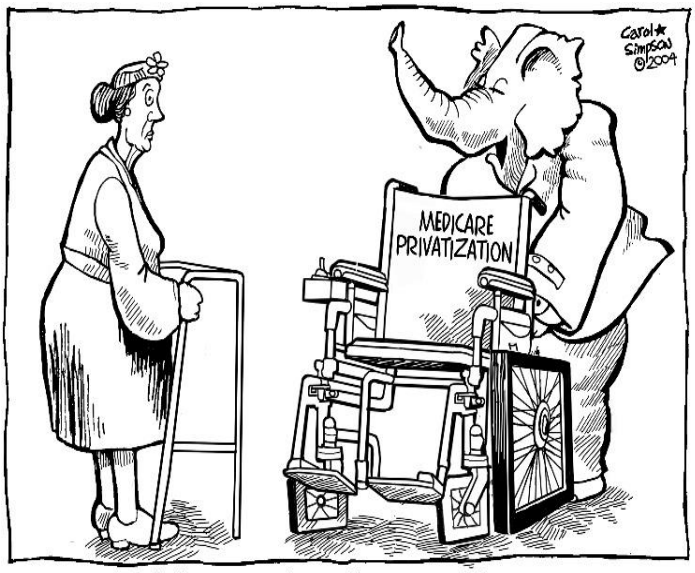
CARE WATCH
Advocating Quality Home & Community Care

Private Matters, Public Concerns: Examining Privatization in Ontario's Health Care

Public and private

When we talk about our health care system, especially when the system is being restructured, discussion turns to the balance between public services (provided by government) and private services (provided by entities other than government). It's a dynamic balance, which shifts constantly and depends on each government's policies and programmes.

Privatization specifically refers to the transfer of a property, business, service, or role from a government to a private entity. It can also refer to a private entity's responsibility for new structures or services, or, more generally, to the private sector's role in health care.



"Care to take it for a spin?"

Why worry about privatization?

Canada's most popular federal programme, and one of its defining characteristics, is Medicare, which comes to life in a series of provincial and territorial insurance plans. To receive federal funding, these plans must conform to the principles of the *Canada Health Act* – public administration, comprehensiveness, universality, portability, and accessibility. Medicare applies to all residents of Canada's provinces and territories (in addition to being covered by Medicare, Indigenous and Métis peoples also have access to other federal health benefits).

Medicare and the *Canada Health Act*, however, concentrate on where and by whom services are delivered rather than on the services themselves, and home care and community support services are not included. These services are therefore not subject to the same principles and requirements, leaving them without the same protections. When Ontario's system is undergoing wholesale restructuring, this lack of protection puts home care and community services in peril and opens them to greater privatization.

What could privatization mean?

Care Watch advocates for quality care that enables senior citizens, at all income levels, to remain in their homes and communities safely, productively, and with dignity. We see privatization not as universally negative, but as carrying certain risks and, at times, as contrary to the public interest.

- ***Privatizing funding*** means we are collectively (through government) paying a smaller proportion of the cost of health services, and individuals, regardless of financial ability, are paying for more. Affordability and accessibility are threatened. Wealthier people may be able to jump the queue and those less privileged may see their services delayed (or even denied). The inequities that already exist could become even worse.

- ***Privatizing coordination and management of services*** can compromise care. The new Ontario Health Teams are expected, like the local health integration networks (LHINs) they replace, to be non-profit corporations. However, their service planning and delivery decisions aren't subject to public scrutiny. In addition, they may contract out planning, managing, and delivering services to other providers – including for-profit corporations. When the same organization assigns, manages, and delivers care, and also controls resources, it can set limits unilaterally and provide services on grounds other than client need – a form of hidden rationing.

  Another form of privatization is to make clients, families, and caregivers responsible for coordinating and managing services. The effort of navigating a highly complex system (which at times frustrates professionals) simply to obtain needed services drains health and resources. When governments promote self-directed funding and care, they are transferring responsibility for purchase, coordination, or management of health services to individuals – implicit privatization.

- ***Privatizing delivery of health services*** is not, on the surface, a bad thing; the majority of Canada's (and Ontario's) health services are already delivered by private entities (individuals and organizations). There are, however, some caveats. In the quest to maximize profits, for-profit organizations can lower the quality of service, select clients with less intense health and resource needs, and pay their workforces inadequately. Large corporations can engage in predatory pricing and business strategies that undercut non-profit service providers and eliminate them as competitors. All providers – whether for-profit or non-profit – must be held to the same standards, consistent reporting, and stringent oversight.

For home care and community services, we fear unchecked transfer of public services and responsibilities to private entities, along with reduced public scrutiny, may bring about a system only well-off seniors can afford. Low- to moderate-income seniors, seniors in rural and remote communities, those from various cultural and linguistic backgrounds, and those who are on their own and/or cognitively impaired may be left out.

Appendix – Some Contexts for Privatization

Medicare, which provides publicly funded health services to all Canadian residents, includes both public and private entities. These private entities may be individuals, groups, or organizations.

- ***A for-profit organization*** has owners, or shareholders. When it generates profits, these owners may receive dividends (or disbursements) and/or increases in the value of their ownership. The organization's motivation is to maximize profits and reward its shareholders.
- ***A non-profit (or not-for-profit) organization*** has no owners or shareholders. Revenue exceeding costs is considered operating surplus rather than profit. With no shareholders to reward, this surplus is available to support the organization's mission and activities – in health care, service to patients and the public.

Medicare encompasses many providers, services, and arrangements - public, private, and combinations of the two. A service may be funded by one source, managed by a second, and delivered by a third. For example:

- ***Health care financing*** is shared, with government paying for about 70% and individuals and/or insurance companies paying for the remaining 30%.[1] Government generates the funding through taxes; it then spreads the cost of health care across all taxpayers so that all have access to services.
- ***Costs for services deemed medically necessary*** are mostly covered by Medicare and other taxes. Included are the services of hospitals, physicians, nurses, surgical dentists, and public health agencies (for example, immunization). Only rarely, however, do governments actually deliver these services. Increasingly, key diagnostic services and procedures that can be done on an outpatient basis are being delivered by private entities, but still co-funded by government.
- ***Supplementary service costs*** are covered by a combination of government, insurance, and individual user fees or co-payments. Services include dentistry, medications, eyeglasses, mobility aids, and pharmacy dispensing fees. Some services are purchased privately; others have a user fee or co-payment.
- ***System planning, management, and coordination*** are government responsibilities, which governments may delegate to public agencies or non-profit corporations. Ontario's Ministry of Health is delegating system planning and funding to Ontario Health and regional and local planning to Ontario Health Teams, which replace the LHINs. Their considerations and decisions are no longer open to public scrutiny.
- ***Individual service planning, management, and coordination*** may be done by providers or agencies, but may sometimes fall to the client, family, or caregivers. Clients, family, or caregivers may also be responsible for coordinating and managing purchase and delivery of health services (under self-directed care arrangements).

[1]Karen Born & Andreas Laupacis. (2011). Public and private payment for health care in Canada *http://healthydebate.ca/2011/07/topic/cost-of-care/publicprivate*

- ***Long-term care residential services***, often called nursing homes, are funded and regulated by governments. Government pays part of the individual resident's costs, with the client covering the remainder. Various for-profit and non-profit organizations own and/or manage these homes. For example, some municipalities provide long-term care homes but outsource their management to private corporations.
- ***Hospitals*** are mostly non-profit corporations. Government funds them and, within the funding allocation and other requirements, they plan and manage the services they deliver. They are accountable primarily to their boards of directors.
- ***Physicians*** have traditionally functioned as small private, for-profit businesses, which bill the provincial insurance plan for a set amount for each service they perform (a fee-for-service arrangement). Some may also charge an additional fee to join their practice or provide services such as patient records, health reports, or prescriptions. A growing number, particularly of family physicians, are now being paid through salaries and other arrangements (for example, capitation, which gives the physician a set amount for each person enrolled in their practice).
- ***Other health professionals***, such as nurse practitioners, midwives, or physiotherapists, also function under similar funding arrangements. Dentists, traditionally small private, for-profit businesses, operate on a fee-for-service basis according to a fee schedule they negotiate among themselves. User fees are standard. Some insurance plans cover a portion of the cost of some services, but co-payments are still required.
- ***Home and community care services*** vary, with some delivered by non-profit and some by for-profit organizations. Most receive some government funding. Some services are delivered at no charge; others have a user fee or co-payment (often geared to income). Non-profit organizations also rely partially on charitable donations.