BRIEF TO THE NORTH WEST LOCAL HEALTH INTEGRATION NETWORK

THE CANADIAN UNION OF PUBLIC EMPLOYEES

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Introduction
Across the province, over 60,000 CUPE hospital, long-term care, home care, and social service employees are directly affected by the creation of Local Health Integration Networks. We live and work in virtually every city, town, village, regional municipality, county, and district in the province. As the largest union of both health care and social service workers in the province, many CUPE members work for employers that fall under the responsibility of the North West Local Health Integration Network.

CUPE represents a variety of health care employees: dietary workers, personal support workers, registered practical nurses, cleaners, operating engineers, secretaries, ward clerks, porters, carpenters, clerical workers, cooks, lab assistants, etc. CUPE bargaining units are often referred to as 'service' or 'office' units.

Not surprisingly, most CUPE members in LHINs affected bargaining units are women. While spending on other areas (e.g. pharmaceutical drugs and supplies) has risen very significantly, spending on the services provided by CUPE members has been tightly constrained.[1] In Ontario, the real health care cost drivers are soaring costs for drugs and equipment supplied by trans-national corporations.[2]

CUPE takes great pride in our long-standing campaigns in favour of universal, accessible, comprehensive, publicly funded and publicly delivered health care and social services. We are very concerned about the impact of LHINs and health care 'integration' on these principles and so have taken some pains to date to apprise the community of pour concerns. We believe we may have to step up our activities, not just as CUPE members, but also with the community.

Centralization, Consolidation, and Privatization
Once again, the Ontario government wants to "transform" health care and certain social services – this time by creating Local Health Integration Networks (LHINs) and passing Bill 36 ("The Local Health Services Integration Act"). This new legislation gives government and the LHINs new powers to restructure public health care and social services.

Health care and social service workers in Ontario have been through restructuring repeatedly. These experiences have not been positive. Instead, exhausted and demoralized workers have been left to pick up the pieces and make our health care and social services work.

We have raised a number of concerns about LHINs, integration, and the Local Services Health Integration Act reforms. At this point we would like to flag five issues:

1. Promoting local community control;
2. Promoting and protecting community providers, services and jobs;
3. Stopping competitive bidding;
4. Promoting and defending public delivery of health care and social services; and
5. Protecting collective bargaining and collective agreements.

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[1] So, for example, spending on Canadian hospital support services has shrunk as a percentage of total hospital spending. Indeed in recent years it has shrunk in absolute terms. See *National Health Expenditure Trends, 1975-2002*, Canadian Institute for Health Information.
[2] See the Change Foundation's *Financial Review of Ontario Hospitals Trends in Financial Results 1997 to 2003,* pages 7-8 for the huge cost increases for these items: "Over the past six years, these expenses have risen from 18% of total operating expenses to 24%." Ontario government expenditures on pharmaceutical drug programs have also seen staggering increases. The government must deal with the large cost increases originating from for-profit health care.

We have specific proposals regarding each of these issues and ask that you respond to our concerns both at this meeting and, if necessary, after this meeting.

[1] Community Control and Community Services

The LHINs cover vast and very diverse areas. The North West LHIN is particularly large, stretching from Hudson Bay through Red Lake, Kenora, Rainy River, Sioux Lookout, Atikokan, and on past Thunder Bay, Geraldton and Marathon. The LHIN boundaries have been formed based on hospital referral patterns, overriding municipal, provincial, and social boundaries. We have noted that the LHINs are not "local" as they are not based on communities, and they do not represent communities of interest. As a result they appear to lack political coherence. So it will be difficult for the people living within a LHIN to have a significant voice over the direction of that LHIN.

The autonomy of the LHINs from the government is modest. With the Local Health Services Integration Act ("Bill 36"), Cabinet may create, amalgamate, or dissolve a LHIN.[3] A LHIN is defined as an "agent of the Crown" and acts on behalf of the government. LHINs are governed by a board of directors appointed by Cabinet and paid at a level determined by Cabinet. The Government determines who will be the Chair and Vice-chair of LHIN boards. Each member continues on the Board at the "pleasure" of Cabinet and may be removed at any time without cause. The government will control LHIN funding, and each LHIN will be required to sign an accountability agreement with the government. Indeed, the government may unilaterally impose this even if the LHIN does not agree to the "agreement". In addition, the LHINs integration plans must fit the provincial strategic plan.[4]

So LHIN boards are primarily responsible to the provincial government rather than local communities. This is in contrast with a long history of health care and social service organizations in Ontario, which, as a rule, are not appointed by the provincial government. For example, the provincial government does not appoint hospitals boards. Hospitals have doggedly pointed out the need for better care in their communities, with significant success. The previous government attempted to cut hundreds of millions of dollars from local hospitals, but when local hospitals helped to point out to their communities the problems this created, the government reconsidered. The cuts were reversed and the hospitals were allowed to continue to provide decent (if still under-resourced) care.

Recently, however, governments have found ways to blunt criticism of under funding. **The key was to replace community boards with government controlled boards.** So CUPE was concerned when we saw government-controlled boards implemented with LHINs. The results of this experiment in Community Care Access Centres (CCACs) suggest that it can have serious negative effects.

CCACs were taken over by the provincial government in 2001. CCACs immediately ceased pointing out to the public their need for adequate funding. **The result? Their funding was flat lined for years and home care services were cut back dramatically.** Tens of thousands of frail elderly and disabled lost their home support services. In total, the effect was a reduction of 115,000 patients served from April 1/01 - April 1/03 and a cut of 6 million hours in services - a 30% drop.[5] As one government report calmly noted:

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[3] The experience in other provinces is that government soon changes the regional health authority boundaries, usually making them larger. Notably, this is precisely what is happening to CCAC boundaries.

[4] Bill 36 does require LHINs to "engage the community" and establish a health professionals advisory council (s.16).

[5] Ontario Health Coalition, "OHC Backgrounder: Homecare Privatization – The End of 100 Years of Non-profit Home Nursing?" May 2003.

> As prices went up and funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently without provincial co-ordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support.[6]

There were increasing restrictions on supportive care that helps people stay in their homes. People could not get a bath or other supportive care like help around the house unless there was also a nursing requirement. The result was that more people ended up in the hospital or long term care facilities, as they were unable to take care of themselves at home. People just could not stay in their houses. The number of visits for acutely ill people was also standardized in at least some areas – so someone coming out of a hospital with a heart bypass would get the same number of visits whatever their circumstances – e.g. a young man with support in the home and an elderly widow with no family nearby. People could of course fight for more services but the objective appeared to be to download as much as possible on families, with women bearing the brunt.

Government controlled regional agencies have been a poor model for health care and social service reform, appearing to insulate government from decisions to cutback or privatize services by creating another level of government that will catch much of the "flak".[7]

Different LHINs, Different Levels of Funding, Different Levels of Care? LHINs are supposed to be given powers to fund and manage health care and social services. We understand that there are wide variations in the funding going into the various LHINs on a per capita basis.

Home care in Ontario operates through government controlled regional bodies that purchase home care services (i.e. CCACs). So it is notable that home care services vary by region. Indeed, even the service cuts that followed the government take over of CCACs in 2001, "occurred independently and without provincial coordination" according to a government study.[8]

The Ministry of Health and LTC has told us that they expect the various LHINs to use similar funding formulas to fund for the various sub-sectors. The Ministry has also indicted that there will be a gradual movement towards more uniform funding levels for each of the LHINs based on the population and health status of those served by the LHIN. We would welcome, however any clarification the LHIN can provide us on how it believes LHINs should be funded by the provincial government.

The role of the LHIN in funding? On a related matter, we are also interested in the LHIN's view of the role it will play in funding providers. Will the LHIN take much of its direction from the province, or will it establish its own method of funding hospitals, homes, CCAC and other providers?

Strengthen Community Control: Elsewhere we have asked the provincial government to require strong community control of the LHINs. But the LHINs themselves can also take steps in this regard:

- Community controlled organizations should be maintained and enhanced

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[6] Elinor Caplan, *Realizing the Potential of Home Care,* 2005, p. 59.
[7] We understand that CCACs are now supposed to be given more local control.
[8] Elinor Caplan, *Realizing the Potential o f Home Care,* 2005, p. 59.

- LHIN should establish a health sector employee advisory committee, made up of union representatives and representatives of non-unionized employees.
- All LHIN meetings must be open to the public
- The LHIN should also broadcast its meetings via the web, to make them accessible to people in all parts of the LHIN
- LHIN documents and reports must be made available to the community in a timely fashion.
- The LHIN should also create a list of organizations that wish copies of the LHIN's reports and send its reports out to these organizations as a matter of course as soon as they are available.
- The LHIN should make publicly available the funding formula (or method) it uses for funding the various sorts of providers.

Other recommendations related to local community control are found at the conclusion of section [2].

[2] Protecting Local Community Services

Under the new legislation, LHINs and the government have a wide range of tools to restructure public health care organizations. First of all, the LHINs have their funding powers to "facilitate" consolidation (s. 25). They also have accountability agreements with health service providers. While these powers may appear sufficient, much more powerful tools have been given to the LHINs, the Minister of Health and cabinet to force consolidation.[9]

- LHINs are given the power to issue compulsory "integration" decisions requiring health care providers to cease providing a service, or to transfer a service [s. 26(1)].
- The Minister may order a provider to cease operating, amalgamate, or transfer all of its operations, subject to certain restrictions [s. 28].
- The Bill allows cabinet until April 2007 to order any public hospital to cease performing any non-clinical service and to transfer it to another organization [s. 33(1)]. This means that the Government can centrally dictate how all non-clinical services are to be provided by hospitals, including through privatization. The Bill gives cabinet the authority to contract out these services despite the wishes of the hospital. There is no definition in the Act of "non-clinical service" and so this definition may be a matter of considerable controversy.

The government refers to this restructuring as "integration", stating that the goal is the creation of "seamless care" and a true health care "system". But LHINs restructuring will not unite hospitals, homes, doctors, laboratories, home care providers, and clinics as in other provinces. Moreover, we are seeing signs of the expansion of price-based competitive bidding that will fragment, not integrate providers. And plans to spin work off to for-profit corporations, private clinics, and regionally based support service providers will also mean more fragmentation and *less* integration, as set out below.

[9] Indeed before the legislation was introduced, the Minister had put considerable emphasis on the LHINs funding power: In a major April 2005 speech where he raised the idea of hospital specialization and a new surgical role for clinics he noted: "Local health integration networks will have the power to do funding and from that power is going to be the capacity to get that kind of stuff done." Source: Rob Ferguson, "Plans under way to open cataract surgery clinic," *The Toronto Star*, Fri 08 Apr 2005 Page: A13.

Integration and Service Cuts
It is apparent that a goal of this reform is to constrain costs by "integrating" services. In particular, support and administrative service integration seems to be a focus.

Even before the LHINs have been given funding responsibilities, some Ontario hospitals have developed budgets that will see cuts to direct health care services. As Provincial Affairs Columnist, Ian Urquhart, notes:

> Ordinarily, this would be the subject of heated public debate. But most of the proposed cutbacks have remained confidential to date and, accordingly, there has been little public backlash.[10]

The *Peterborough Examiner* took on the idea of keeping the discussion of the proposed cuts at the local hospital secret. Their argument is worth noting:

> Local hospital officials miss the point when they say that keeping budget negotiations secret until all the details have been approved is less stressful for everyone involved. …It is hard to believe that several weeks of protests from doctors, patients and their families, municipal politicians and the community at large had no effect on the outcome. …People can deal with news, good or bad, but they need all the information. In fact, they have a right to deal with it, and to decide for themselves whether their voices have an impact.[11]

We note that when local communities have found out about hospital cut backs, there have been vigorous, spontaneous fight backs.

- In tiny Picton, a capacity crowd of at least 500 turned out at the local community centre in September when three critical care beds, laboratory services and day surgery at the Picton hospital site were threatened.[12]
- In Ajax, 1,100 rallied when the obstetrics/paediatric program came under threat in December.
- In Sarnia, over a thousand rallied at City Hall in August despite crippling heat, and 21,000 people signed a local petition when the government ordered the hospital to cut its deficit, threatening palliative care.[13]

These spontaneous campaigns often achieved significant success. Communities strongly support local delivery of services; a lesson that we believe LHINs should keep closely to mind.

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[10] See Ian Urquhart, "Cuts feared as hospitals try to balance budgets," *The Toronto Star*, Wed 26 Oct 2005. Also note the controversy over keeping budget cuts secret in Peterborough: Trevor Wilhelm, "Hospital's ER doctors fear cuts," *The Peterborough Examiner*, Friday, September 30, 2005,Page: A1 / FRONT; the editorial, "What's up? Public must hear details of planned cuts before they are final," *The Peterborough Examiner*, Friday, September 30, 2005, Page: A4, and "Hospital Budget Shrouded in secrecy; unclear if BGH will run deficit for 05-06," *Brockville Recorder And Times*, Wednesday, September 14, 2005, Page: A4, Byline: BY Nick Gardiner.

[11] "What's up? Public must hear details of planned cuts before they are final," *The Peterborough Examiner*, Friday, September 30, 2005, Page: A4

[12] "Picton hospital not safe yet: Doctors, politicians fear service cuts despite budget reprieve," *The Kingston Whig-Standard*, Monday, September 26, 2005 Page: 6, By-line: Bruce Bell.

[13] "Local health care petition headed for Toronto," *The Observer* (Sarnia), Wednesday, October 12, 2005; "Planned cuts protested," *The Observer* (Sarnia) Thursday, September 15, 2005 Page: A1, By-line: Jack Poirie; "City rallies against cutbacks: Health minister expected in Sarnia today," *The Observer* (Sarnia), Thursday, August 11, 2005, Page: A1 / FRONT, By-line: Neil Bowen.

Will integration constrain costs? We would caution that recent experience shows that integration and consolidation does not necessarily mean constraining costs. The most recent government experiments with integration or consolidation have been associated with increased costs. The merger and closure of hospitals directed by the Health Services Restructuring Commission (HSRC) in the 1990s did not lead to reduced spending on hospitals and health care – indeed, there has been a significant increase in spending. And many HSRC directed hospital-restructuring projects left a shambles for health care workers to clean up.

The second instance of government-led centralization of services in the 1990s was the centralization of jail services. Two large, centralized jails were built along with a new centralized facility to cook and chill jail meals. The result did not impress the provincial auditor general. Existing institutions actually produced food more cheaply. And the new cook-chill facility was only able to supply six institutions instead of the promised ten. Despite a decline in the average inmate count, operating costs for institutional services increased by 19% over four years.

Support Services Targeted For Integration
The government first backed plans to regionalize hospital support services. Dozens of hospitals across the north have begun plans to consolidate supply chain and office services through the Northern Ontario Hospital Business Services (NOHBOS). Likewise, with government support, 14 hospitals in the Greater Toronto Area plan to regionalize supply chain and office services by turning work over to another new organization, Hospital Business Services (HBS). At first, the hospitals told us that this organization would take approximately 1,000 employees out of the hospitals, turn over a significant portion of the work to for-profit corporations, and sever roughly 20-25% of employees.[14]

We are now informed that, at least until after the next election, the transfer of hospital staff to HBS is on hold. But we remain very concerned that such plans are only temporarily delayed.
Like so much of restructuring, these moves will have a major negative impact on hospital support workers. But, they certainly will ***not*** create "seamless care" for the patients. Instead, they will create more employers and bring in more for-profit corporations into health care. In many respects, it will create *more fragmentation*. This we fear could become a theme of LHIN led restructuring.

Clinical and Social Services Threatened: While much of the explicit focus to date has been on support services, we are also concerned about attempts to centralize clinical and social services. Recently the Ministry and the hospitals have established a committee to identify "core services" for small hospitals, and there has been *some* discussion from the Ministry about reducing the number of hospitals providing certain procedures.

The large, socially diverse areas covered by the LHINs, also suggest that there will be significant conflict over resource allocation. What services will the LHIN provide in each area of the LHIN? Unlike government, LHINs will not be able to increase revenue. Smaller communities may be the first to see their services "integrated" into other communities. So we are very concerned that smaller communities are especially threatened.

Clinical Fragmentation: There have also been some attempts to move surgeries right out of hospitals and place them in clinics. The case in point was the recent creation of the Kensington Eye Clinic. This clinic (in the recently closed Doctors' Hospital in Toronto) is supposed to remove 1,700 procedures from hospitals and do an additional 5,000 cataract surgeries.

[14] The severance numbers are extracted from *Hospital Business Services Prospectus*, December 2004, Appendix F.

But the creation of new surgical clinics only fragments health care, creating more employers and more destinations for seniors to run around to as they tend to their health care needs. It also raises the possibility of the establishment of for-profit surgical clinics. Indeed, when the Health Minister announced his interest in surgical clinics in the spring of 2005, the chosen sponsor of his speech (University of Toronto academic John Crispo) proposed private sector clinics providing two-tier care as soon as the Minister sat down.

A better solution would be to create surgical clinics in the facilities and organizations in which we are already invested. Hospitals have the infrastructure needed to support these surgical clinics. There is no need to duplicate their human resource, stores, payroll, purchasing, cleaning, food, laboratory, and other support services.[15] Hospitals also have the resources to deal with emergencies that may occur during operations. And this would actually help advance the "seamless care" that this reform is supposed to create!

CUPE members will oppose moves to hive work off into small workplaces outside of central bargaining with little or no bargaining power. Transformation of health care should not proceed with the goal (tacit or otherwise) of creating low wage ghettoes.

Community Service Agencies

Many community service agencies have become "LHINs affected" agencies—we estimate 40 province-wide. Typically LHINs affected community service agencies provide social and community services, as well as some health services. They are usually only partially funded by the Ministry of Health and Long Term Care.

Many community organizations have been around for a long time and have built themselves up, piece by piece with funding from a variety of sources, provincial, municipal, charitable, and even federal. As needs grew, organizations grew. Payments for rents, mortgages, computer systems, and administrative staff may all be threatened by the loss of just one major funder. Staff cuts may make employee benefit plans very expensive for smaller organizations. So the "ripple effect" of LHIN funding decisions may well have an impact beyond the services directly funded by the LHIN.

We urge the LHIN to recognize its shared funding responsibilities and recognize that LHIN funding cuts may have an impact on the viability of an organization providing many other services to the community. These impacts must be considered.

Given the small size of many community agencies, employees of community agencies are especially concerned that they will be caught up in LHIN directed integration. We urge caution in this regard. We also note that integration is already beginning to happen in some parts of the province without a lot of consultation of the larger community. These moves may pre-empt LHIN decisions.

Community agencies focus on community based neighborhood services. The agencies gain much of their currency and vibrancy through their close connection with the community and volunteers. Staff often works for less money than they could earn elsewhere because of their commitment to their work. Changes in service delivery could quickly undermine this goodwill. We urge the LHIN to recognize this goodwill and act with caution when it comes to any attempts to integrate services.

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[15] Michael M. Rachlis, *Public Solutions to Health Care Wait Lists*, Canadian Centre for Policy Alternatives, December 2005.

There are real concerns that placing community agencies under the sway of a larger regional board will erode the local community roots and community control of community agencies. Community agencies are often reflective of their communities and their boards are accountable in many ways to their communities: community based advisory committees play an important role as well as direct election of community boards.

Community agencies provide a tremendous variety of programs that are community specific. We are concerned that this sort of variety could be overlooked by a LHIN. The Ministry of Health and Long Term Care liaisons with community agencies has often played a positive role. In many cases the MOHLTC liaison has become very familiar with the community agency and its programs. They are not distant bureaucrats. We hope that the LHIN will continue and deepen these relationships, meeting with community agency staff and coming to know the services in each community.

Management of community services through data tracking can create problems. From our experience it often comes with a de-emphasis on services to the community. We have even seen telephone intake for mental services, never actually meeting the person! In community services not everything fits neatly into little boxes on a forum, people are too unique and services too variable.

Some community agencies have some ability to move their funding to respond to community needs. Limitations on the flexibility that does exist will make these organizations less responsive to community needs. We are concerned that LHINs will limit flexibility.

We are also concerned that a large, regional board (like the LHIN) may not recognize the valuable work of community agencies, especially given the variety of services, some fitting quite specific community needs. Unique, community specific programs may not neatly fit into region-wide priorities. Programs that meet specific community needs, but which may be controversial across a wider region, may be at particular risk (e.g. harm reduction models may be controversial, or programs aimed at the homeless in mixed income neighborhoods).

Although community agencies play a vital role in their local communities, they are small organizations relative to other organizations within the LHIN. As small organizations, they may be especially fearful of offending a funding organization, and may be reluctant to make their voices heard forcefully. Community agencies, their volunteers, and their employees must not be drowned out by larger organizations. They have little resources to lobby. Given the small size of community agencies, we urge the LHIN to recognize that they are fragile and could be destabilized. They will not be easy to replace.

We are finally very concerned that unions will only hear about the changes to service delivery proposed by LHINs afterwards. But LHINs open up tremendous uncertainty for us as workers in community agencies. The LHIN must recognize us as a key component in the reforms it hopes to move through the system and take effective steps to involve us in the process.

Protect Local Services and Access to Care: "Integration" may remove jobs and services from local communities hampering access. Support services are likely the first target, but direct clinical care and social services are also under threat. Reductions in community control and provincial government accountability increase the likelihood of these threats.

- The LHIN should make maintaining providers, services, and jobs in local communities a top priority.

- Particular care should be taken when dealing with community agencies. These organizations have deep roots in the communities, but are also fragile.
- LHINs must provide a public accounting of costs borne by patients if they are proposing to consolidate or move services.
- The LHIN should create and make public patient impact assessments for any integrations or amalgamation of services.
- Transportation subsidies should be paid by the LHIN if the required service is no longer provided in a given community. No purpose is served if "integration" creates new costs for residents.
- The LHIN should prevent increased fragmentation. Specifically, it should prevent the transfer of work from existing public, not for-profit employers to new entities such as clinics or support service providers.
- Support the creation of health care 'hubs' in smaller communities so that health care providers in smaller communities are vibrant and effective providers of a broad range of health care services.
- The LHIN should only exercise its powers in the public interest, with public interest defined to include preservation of the public, not-for-profit character of our health care funding and delivery system.
- The LHIN should not order integrations. The power the LHINs have to withhold funding is power enough to encourage consolidations. The LHIN should not transform the health care system unilaterally; otherwise there is no reality to the claim that we are enhancing local decision-making and no point in retaining provider governance structures.
- The LHIN power to withhold funding to force integration should only be exercised where necessary in the public interest and where integrated services remain publicly delivered on a not for-profit basis.
- The LHIN should do an annual survey of unmet needs and report unmet needs in a specific annual report released to the public.

[3] Contracting for Services

A number of key aspects of Ontario's health care system indicate that Ontario has a relatively efficient health care system. The Ontario government spends less on health care than any other province except Alberta as a percentage of the province's Gross Domestic Product. Despite being a relatively rich province, Ontario also spends less per capita on health care than seven other provinces.[16] Acute inpatient hospitalizations per 100,000 population are the second lowest in Canada and the number of hospital beds has fallen by approximately 19,000 since 1989-90, from a little over 49,000 to about 30,000.[17]

This record should affect decisions about the introduction of for-profit or market based models that turn health care services into commodities.

Recently, however, we have seen a move towards *priced-based contracts* for services in Ontario health care and social services.

Cancer Care Ontario has ceased to be a provider of cancer care services and instead purchases services using a price based system. Likewise the new "wait times" strategy is based on the establishment by the Ontario government of prices for the various priorities.

[16] Canadian Institute of Health Information, *Preliminary Provincial and Territorial Government Health Expenditures Estimates 197419-75 to 2006-2007*, November 2006.

[17] Ontario Hospital Association, "Key Facts and Figures," January 18, 2005.

These services are then purchased though contracts with various providers. The hospitals have indicated that pricing of services will expand significantly.

Indeed the government increased funding for this system $222.5 million in April to purchase 154,000 medical procedures and announced in September an additional $49.4 million for 127,266 procedures.[18] While, relative to overall health care spending, wait times spending remains a relatively small proportion, we are concerned about this expanding, as some have indicated a desire to expand its scope. We have a number of concerns.

First, moves away from global budgeting will decrease the autonomy of local hospitals to meet local needs.

Second, market or commodity-based systems disadvantage smaller communities whose small size prevents them from providing the services at the price demanded. We are concerned that this market-based system will be expanded, forcing the consolidation and centralization of health care services. This would ignore the risks associated with traveling longer and farther before receiving decent health care services.

Third, even this first step has increased inequality.

> "The incomes of some Ontario medical specialists have risen by more than $100,000 last year after doctors began performing more procedures to reduce wait times in government-targeted areas such as cataract surgery and diagnostic tests. Driven in large part by the provincial Liberals' $611-million wait-time reduction strategy, the number of doctors earning more than $476,000 in 2005-2006 rose to 1,450, according to health ministry data. That's up 56 per cent compared to a year earlier when 928 physicians earned more than the high-income threshold set by the government… [N]early half of all ophthalmologists in the province earned average incomes of $719,000 each last year. That's up $120,000 compared to 2004, when the province's 133 top-paid eye specialists earned an average of $598,000 each… Targeted spending to reduce wait times for MRIs and CT scans meant the province's 374 top-paid radiologists -- those earning more than $476,000 -- earned an average of $652,000 in 2005, up $116,000 over a year earlier."[19]

Other commodity-based health care systems have been unsuccessful: A price-based contract system has been in place for nine years in home health care. Community Care Access Centres (CCACs) purchase homecare services via contracts established though a competitive bidding system. The results have been extremely negative. The most reliable figures show that the percentage of homecare nursing market share provided by for-profit corporations increased from 18% in 1995 (two years prior to the introduction of competitive bidding) to 48% in 2001.[20]

As contracts come up for renewal, homecare providers regularly lose contracts, and workers who have no successor rights, are laid off. In Cornwall, homecare staff have lost their jobs at

[18] Ministry media release: "McGuinty Government Continues to Reduce Health Care Wait Times," April 28, 2006. Ministry Media release, Improving Access to Key Healthcare Surgeries and Procedures Across Ontario, September 12, 2006.

[19] "Doctors' pay soars: Doing more procedures to reduce waiting time," *The Windsor Star*, Wed 04 Oct 2006. Page: A7 Section: News Byline: April Lindgren

[20] For a detailed discussion of this and other issues regarding home care and competitive bidding, see the Ontario Health Coalition's March 31, 2005 report *Market Competition in Ontario's Homecare System: Lessons and Consequences* at http://www.web.net/ohc/Homecare.htm.

least three times since competitive bidding was introduced. A recent snapshot study identified *over 1,000* home care workers in Ontario who were laid off due to contract loses over an eight-month period.[21]

Faced with this uncertainty, many of the workers naturally decide to work in other, more secure sectors, even if they love home care. A recent report on home care to the Ministry of Health and LTC found that fully 57% of the home care workers surveyed had changed jobs in the past 12 months.[22] No industry, let alone a vital industry like health care, can sustain this sort of turnover and provide excellent service. The report also noted that 40% of home care workers surveyed indicated that they felt not too secure or not at all secure in their jobs and that the average wage for Personal Support Workers (a major home care occupation) is approximately $12 per hour.[23] That is about $5-$6 an hour less than what they would earn in a hospital.

Despite all these problems, the price to the province for home care services actually went up after competitive bidding was introduced.[24] The effect of price increases on the amount of home care services provided was a sharp reduction in the services provided. Here is what a government review notes:

> As prices went up and funding levels remained constant, CCACs had to discontinue certain services in order to maintain balanced budgets. These changes occurred independently without provincial co-ordination and clear communication. The emphasis shifted from homemaking services to the provision of personal support. Clients and service providers told the CCAC Procurement Review that these changes were particularly difficult because it was unclear which services CCACs provide.[25]

The problems with competitive bidding became so severe that the government has suspended the bidding process some time now. **It is vitally important that LHINs do not use such a price-based contracting system to fund health care and social services.**

The Experience in Social Services

Competitive bidding is also doing damage in social services with its introduction by Human Resources and Skills Development Canada. The new bidding process has, *in the first round of proposals*, disrupted over a third of the long-standing arrangements with community organizations. Three organizations are losing so much of their funding that they will have to close their doors. Four contracts have been awarded to the for-profit sector. Clients have no idea where they will be served, if at all, while the programs and linkages created over decades of work are being lost. Laid off social service workers are being forced to re-apply for their same jobs – at a lower rate of pay and benefits.

Agencies that provide home care also often provide some social services. So we find the experience of small community based home care agencies instructive and worrisome. It is very clear from the experience in home care, that smaller agencies will be severely disadvantaged if a competitive bidding model is adopted. The administrative costs associated with the bidding process are considerable. Larger for-profit organizations can distribute the costs across the entire province (or country). Unlike community-based agencies, they simply move on to other communities if they do lose a contract. This would be completely unthinkable for a community-based agency. Central Neighbourhood House has been based in central Toronto for decades.

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[21] OHC, *Market Competition in Ontario's Homecare System,* 2005.
[22] Elinor Caplan, *Realizing the Potential o f Home Care,* 2005, p. 23.
[23] *Ibid*, p. 25 and p. 28.
[24] *Ibid,* p.35.
[25] *Ibid*, p. 59.

If it loses it's funding, it will be gone, it will not move on. Large for-profits can also submit a bid knowing that they will take a loss in the initial contract in order to kill-off smaller community based organizations.

The competitive bidding model conflicts with some important features of community services agencies. Part of the work of some community agencies is to function as a community economic development agency. These agencies may have a mandate to hire from within the communities they service. Work becomes part of the service that the agency provides.

So competitive bidding has some very serious threats for community agencies. At best, competitive bidding will require smaller community agencies to change the scope of services they provide and specialize in niche markets.[26]

The Experience in Britain

Over the last two decades, Britain has introduced the purchaser – provider split in health care, leading to a massive expansion of privatization. Serious problems have arisen:

- **Openings for privatization.** With the split, every new contract has the potential to divert resources to the for-profit sector. For every £1 spent on National Health Service (NHS) staff in 1995, 71 pence was spent on procurement of goods and services from the private sector; by 2003, the figure was £1.15 for every £1 on staff.
- **Fragmentation.** While the Ontario government has sold LHINs as a way to integrate services, the purchaser-provider split has led to fragmentation in Britain. Funding comes by winning contracts. For its own survival, each hospital must now assess each cost as if that hospital stood completely alone in the health care system. But cost savings for a hospital can lead to cost increases for other health care providers.
- **The establishment of private clinics and the expansion of private hospitals.** Private diagnostic and surgical clinics have taken over work previously done in hospitals, despite costing more. The goal is now to have up to 640,000 surgeries carried out by private clinics each year. More work is also being done in private hospitals: services purchased by the public authorities from private hospitals will increase from £200m in the early 1990s to £2 billion pounds in 2007 – a 10-fold increase! Yet, a recent poll showed 89% against private provision of public health care.
- **Service Shifting:** For providers, services that are 'profitable' become the priority at the expense of other services. Even at this early stage of the introduction of the purchaser-provider split in Ontario, we are seeing signs of this: orthopaedic surgeons have already complained that the new Ontario wait time priorities [which are already purchased through a price-based system] are squeezing out other surgeries.[27]
- **Specialization:** Hospitals that cannot provide a service for the set price either have to subsidize it from other parts of their budget or give up providing that service. This is quite unsatisfactory where alternate hospitals are at some distance.[28]

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[26] Small home care providers advised Elinor Caplan of their difficulties with the competitive bidding-funding model in home care. Caplan made some specific recommendations to address this issue, in effect recognizing various problems. See her report *Realizing the Potential of Home Care*, 2005, pp. 6, 33, 39, 40, 42, 69, and recommendations 33-37.

[27] "Some doctors in Ontario say there's a downside to targeting specific medical problems in order to reduce waiting times for treatment," *World Report*, Broadcast Date: Wednesday, December 14, 2005 Time: 08:00 EDT, Network: CBC Radio

[28] For a useful discussion of the purchaser-provider split and the privatization of British health care, see Allyson M. Pollock, *NHS plc: The Privatization of Our Health Care,* Verso, 2004.

In Ontario, where distances are particularly large, this could add in a lot of travel. But even where distances are measured in several kilometers rather than several hundred, specialization creates special problems. Instead of being able to deal with all of their problems at one centre, health care services are spread out over many health care providers – creating a real problem for those with multiple health issues, especially for the elderly, the poor and their families.

All of this change in Britain has only led to serious problems for British health care: despite more than doubling funding since 1997, the service is running into a funding crisis, serious debts, operating theatres closures, layoffs, and service cuts.

We are concerned that the changes that came to Britain and Ontario home care may soon spread via the LHINs: repeated opportunities for privatization with each new tender for services, competition between services providers, increased fragmentation, increased private clinics and surgeries, and, with hospital specialization, more travel and the end of one-stop hospitals.

- Competitive bidding and other price-based contracting systems should be specifically excluded from the funding models used by LHINs

[4] Privatization

The Canadian public supports Canada's public health care system. It provides vastly more efficient and more effective health care than the for-profit insurance and delivery system used in the USA.

The higher costs and inequities associated with US for-profit health care insurance are well known and hardly need repeating. Administration costs are much higher and total costs per capita are much higher, wasting billions and billions of dollars and putting American industry at a severe disadvantage. Despite these extra costs, 45 million Americans have no health care insurance whatsoever, and tens of millions more have inadequate insurance. The very wealthy, however, do have health care security.

But the problems with the American for-profit health care system extend beyond insurance. For-profit delivery also creates major problems. A recent systematic review and meta-analysis compared death rates in over 500,000 adult patients receiving care in either for-profit or not-for-profit American dialysis facilities. The study found an 8% greater risk of dying in a for-profit facility. The results were extremely consistent across all the studies surveyed. They showed that if American patients received care in private not-for-profit dialysis facilities instead of for-profit facilities, approximately 2,500 lives would be saved each year.

The results of this review are directly relevant to over 12,000 Canadians receiving dialysis. First, the studies included patients receiving publicly financed care in private not-for-profit and private for-profit dialysis facilities, a situation identical to what Canadian policy-makers have been considering. Second, the results are consistent over time, despite changes in American health care. Third, if Canada moved to for-profit dialysis facilities, the same large American dialysis chains included in the review would be purchasing Canadian dialysis facilities.[29]

Another recent meta-analysis study found that hospital deaths would increase by as many as 2,200 a year if Canada introduced U.S.-style private for-profit hospitals into the health-care

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[29] See attached study, P.J. Devereaux et al, "Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centres," Journal of the American Medical Association, November 20, 2002. A copy of media release and backgrounder are also attached.

system. The studies included data on 38 million patients in 26,000 U.S. hospitals between 1982 and 1995. The death rate in for-profit hospitals was 2 per cent higher than in not-for-profit facilities.[30]

A third meta-analysis of U.S. for-profit care concluded "Private for-profit hospitals result in higher payments for care than private not-for-profit hospitals. Evidence strongly supports a policy of not-for-profit health care delivery at the hospital level." The study found that care cost the patients 19% more at for-profit hospitals. Canadian governments would pay an extra $7.2 billion in annual health care costs if Canada switched to investor-owned private for-profit hospitals The meta-analysis used eight observational studies, involving more than 350,000 patients between 1980 and 1995. The studies had a median number of 324 hospitals.[31]

The higher payments for care at a wide range of investor-owned hospitals spanned a 12-year period, despite important changes to the American health care system. Payments proved greater in for-profit facilities for both publicly funded patients and privately insured patients.

Proponents of for-profit care usually do not wish to talk about the United States, even though it has the greatest experience with for-profit care, and as the reports above make clear, the problems of for-profit care have been associated with a variety of other changes in US health care. Canadians do not want that system.

But as proponents of for-profit health care often try to steer the debate away from the US example, it is perhaps useful to note that for-profit care has also come up short in other countries. One major attempt to introduce for-profit corporations into Ontario health care is public private partnership hospitals, or as they are nowadays sometimes referred to "alternative financing and procurement". Typically, large trans-national corporations privatize the financing of a new facility and a range health care support services.

This approach was developed in Britain in the 1990s and is now being exported (notably through British owned corporations like Carillion) to Ontario. The experience in Britain has been unfortunate.

The British government first labelled them "Private Finance Initiatives" or PFIs. British Medical Journal editorialists have a different name: "perfidious financial idiocy".[32] Not surprisingly, the British government, like the Ontario government, has started to use a new name.

Private financing substantially increases hospital costs. For-profit corporations cannot borrow money as cheaply as the public sector.[33] This is a key factor that drives up costs, an extra $174 million for the new Osler facility alone.[34] The other P3 hospital developed to date in Ontario will see extra borrowing costs of almost $88 million.[35] With hundreds of hospital projects required, the extra P3s costs seriously threaten health care affordability.

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[30] See the attached study, P. J. Devereaux et al, "A systematic review and meta-analysis of studies comparing mortality rates of private-for-profit and private not-for-profit hospitals". Canadian Medical Association Journal, May 28, 2002.
[31] See the attached study, P. J. Devereaux et al, "Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis," Canadian Medical Association Journal June 8, 2004. The media release associated with the study is also attached.
[32] Richard Smith, Editor, "PFI: Perfidious Financial Idiocy," British Medical Journal, 3 July 1999.
[33] See attached study, Declan Gaffney, Allyson Pollock et al. "The Private Finance Initiative: PFI in the NHS – is there an economic case?" British Medical Journal, 10 July 1999.
[34] See attached study by Hugh Mackenzie, "Financing Canada's Hospitals: Public Alternatives to P3s," October 2004.
[35] Ontario Health Coalition, "McGuinty Government Fudging Costs of Royal Ottawa Hospital P3: Hospital dramatically more expensive due to privatization" November 2, 2006.

A second factor is that health care funds are diverted to profits: shareholders in British PFI projects can expect returns on their investments of 15-25% per year.[36] The respected British paper the *Guardian* notes: "Construction companies engaged in the private finance initiative expect to make between 3 and 10 times as much money as they do on traditional contracts, the industry has admitted… The figures… were confirmed by the Major Contractors Group representing top PFI firms such as Carillion." (Sept 8, 2003.)

A third factor is the costs of negotiations and consultancy fees. The first 18 PFI hospital projects in Britain spent over $110 million on consultants –the lawyers alone got over $50 million. Incredibly, the contract for Coventry's Walsgrave Hospital was 17,000 pages. Reportedly, the two consortia vying for the deal asked for government cash to pay lawyers to read it all!

In their comprehensive evaluation of P3s in hospitals, the British Association of Chartered Accountants concluded that the costs were higher than those financed by the government, even though the hospitals were smaller than the ones they replaced and that hospitals with P3 contracts were more likely to be in deficit than the national average. As one Director noted: "Most PFI projects would fail the value for money test." [37]

Before the provincial election, the Ontario Liberal party wrote to CUPE and recognized that "P3 hospitals cost taxpayers more, while providing lower quality of services."

Costs Increase over Term of the Project

The first 14 British PFI hospitals saw an average increase of 72% between the time they were first proposed and the time the deal is reached. Since the P3, projects in Ontario were announced costs have increased dramatically. By the time of the project agreement the Osler project had increased 53% in cost.[38]

The Ontario government sometimes defends its P3 proposals by citing a study by the British Auditor General. In fact, that study tested only whether there was price certainty *solely for the construction element* of the deal *once the contracts were signed*. The study did not look at the huge increases in cost from the beginning of the deals through the negotiation of the contracts. Further, the audit office acknowledged that the study was based largely on interviews with PFI contractors and the construction industry – the same people who are the prime beneficiaries from these deals.

For-Profit Care: Increased Costs -- Decreased Care

British health authorities had to make up somewhere for the increased costs of P3 hospitals. The result has been a dramatic reduction in care. **On average, British P3 hospitals have had to cut 30% of beds. Staff cuts were commensurate.[39]**

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[36] Gaffney, Pollock et al. *Op.cit.*

[37] *Guardian*, PFI is more expensive than public funding," 11 October 2002 & "PFI is poor value say accountants," 12 October 2002.

[38] See CUPE Fact sheet, "Ontario P3 Hospital Cost Estimates Keep Increasing"

[39] See attached study, Allyson Pollock et al. "The Private Finance Initiative: Planning the 'new' NHS: downsizing for the 21st century," British Medical Journal, 17 July 1999.

Loss of Accountability with P3 Hospitals
When financing and operation is handed over to for-profit corporations, it becomes unclear just who is in charge of what. The government is responsible for funding, the public hospital for some services and for-profit corporations for other services. Haggling and buck passing are almost assured.

Indeed, shortly after opening the Durham P3 hospital in Britain, a dispute arose over whether the hospitals or the corporations were in charge of portering. So a frontline ambulance (the only vehicle covering the whole of Durham at the time) and its crew were taken out of action for 35 minutes to move a patient about 400 yards. Buck passing may be compounded if (as has been the case in Ontario) a consortium of corporations wins the contract.

Secrecy
Even when it is clear that a corporation is the responsible party, commercial considerations make corporations reluctant to release information: private corporations like to keep information private. Once a decision to negotiate has been taken, all of the detailed discussions about the size, shape, cost, and service of the hospital take place behind closed doors. In Ontario, the provincial government continually promises that information about the P3s deals will be released. Instead, we have had to go to court to get any information.

The Problems with British P3 hospitals continue
PricewaterhouseCoopers recently reviewed the troubled financial position of a major English hospital: “The principal cause of the (Queen Elizabeth Hospital) Trust’s current financial difficulties is the high fixed costs of its PFI (private financing initiative) scheme,” the PricewaterhouseCoopers auditors found. The hospital’s chief executive says private financing is costing £9 million (about $18 million) a year more than a government loan. “Excluding the excess private financing costs,” say the auditors, “(Queen Elizabeth Hospital) is efficient relative to other hospitals.

Canadians Healthier
It is perhaps fitting to conclude this section with a note that recent research by Harvard academics suggests that the privatized American health care system has led to less healthy residents. The study[40] by Harvard Medical School academics compared health status, access to care, and utilization of medical services in the United States and Canada and compared disparities according to race, income, and immigrant status.

Compared with Canadians, US respondents were less likely to have a regular doctor, more likely to have unmet health needs, and more likely to forgo needed medicines. Disparities on the basis of race, income, and immigrant status were present in both countries but were more extreme in the United States. The study concluded that United States residents are less able to access care than are Canadians and that universal coverage appears to reduce most disparities in access to care.

Stop Privatizing Health and Social Services: Build Cooperation
Privatization and decreased cooperation between providers are major threats of price based contracting for services. Instead of integration, privatization will bring “disintegration” with the various providers in competition to win contracts. Specialization will increase inconvenience and travel for patients. The institution of price based service contracts and the expansion of privatization in health care and social services should not be part of health care reform:

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[40] Karen Lasser, et al. “Access to Care, Health Status, and Health Disparities in the United States and Canada: Results of a Cross-National Population-Based Survey,” American Journal of Public Health, 30 May 2006.

- The LHIN must not transfer nor encourage the transfer services to for-profit providers. Instead the LHIN should foster robust public, not for profit services.

[5] Impact on Bargaining Units

The change in health care delivery contemplated by these reforms opens up possibilities for enormous changes in bargaining units, collective agreements, and collective bargaining.

Health care and social service workers have been through many rounds of restructuring already. And we were always assured the various changes were for the best. But too much of this restructuring, simply consumed enormous energy and resources, exhausting health care and social service workers.

We are not convinced that the government fully recognizes the can of worms it is opening. As the workers faced with this change, we deserve, at a minimum, a fair process that will provide reasonable employment security and protect working conditions, collective agreements, and bargaining unit rights.

Employers have sometimes supported the idea of a province-wide transfer agreement to deal with the employment changes that integration may bring. In the past, similar agreements have eroded CUPE employment security provisions in collective agreements. As a result, CUPE has refused to sign such agreements. We caution against trying to repeat such an approach.

We take a broader approach to the labour adjustment issue.

1. Ban the transfer of publicly delivered clinical or non-clinical healthcare services to the private sector and end competitive bidding.

2. Respect collective agreements, central bargaining, and existing statutory protections.

3. Commit that the Hospital Labour Disputes Arbitration Act will be applied to any services integrated or transferred from public hospitals or other healthcare employers. Hospital and long term care bargaining has been based upon the use of the *Hospital Labour Disputes Arbitration Act* (HLDAA) for the settlement of contract disputes. Changes to this arrangement would put hospital and LTC labour relations in some jeopardy.

4. Commit that workers will not be laid off as a result of healthcare restructuring, but will be retrained or will be severed or retired with enhanced packages.

5. Resource health sector employers with additional funding to allow for enhanced severance and retirement packages.

6. Identify the demographics of the healthcare workforce. Identify the areas of skill shortage in the Ontario healthcare labour market, and fully resource retraining.

7. Enhance working conditions in the community sector: raise wages, encourage full-time employment, and introduce defined benefit pensions as well as benefits that are comparable to those in the institutional sector.

In summary,

- HLDAA should continue to apply despite any and all restructuring caused by LHINs.
- Collective bargaining in the hospital sector should continue to be determined through central bargaining.
- If hospital workers are transferred to new not-for-profit entities, they should continue to bargain as part of the central hospital bargaining process.
- LHIN should support a comprehensive settlement of labour adjustment issues on a provincial basis, as set out above.
- Finally, whatever changes occur, our collective agreements must not be overridden. The LHINs must not take any steps that override the terms and conditions of employment contained in freely negotiated or freely arbitrated collective agreements.

Concluding Remarks

For all these concerns, we have made some suggestions for how health care reform could unfold. But we urge the LHIN to take a considered and consultative approach. We had no sense before the last election that the government would embark on the path it has taken. We believe that a better approach would be to consult with local communities, health care workers, and the public about how health care should be reformed. That would be a much more satisfactory and much more democratic process.

We would like to thank the LHIN for considering our concerns and suggestions.