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10 reasons to join the fight against for-profit health care

1 You are more likely to die in a for-profit hospital or clinic than a not-for-profit facility.

2 You and your family may find yourselves without health care when you need it. You may be turned away unless you can pay.

3 You'll have to pay out-of-pocket for your health care, through user fees, insurance premiums or co-payments. You may put off medical attention if you have to pay for it – putting your health or that of a loved one at risk.

4 You'll likely have to wait longer for treatment, unless you can afford to pay extra.

5 You won't be guaranteed acceptable standards of cleanliness and food quality. Support services keep health care facilities safe, clean and free of deadly infections. Cutting corners costs lives.

6 You won't be sure the staff delivering care are adequately trained, or fairly treated. High turnover means poor health care.

7 You won't be guaranteed coverage for the care you need. If you change or lose your job, or get laid off, you could find yourself without coverage.

8 You risk having to sell everything you own and declaring bankruptcy to pay for unexpected medical expenses.

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9 You and your union will have to fight for health coverage at the bargaining table. You'll face a cut in your benefits package to make room for health insurance and you'll likely have to trade off demands such as pensions, wages and job security for coverage you now take for granted. If you work in health care, you'll face a cut in wages, benefits and job security.

10 You are part of the front line of defense against privatization and contracting out of **any** part of the health care system. Together, we can defend jobs and services, and ensure every penny of health spending goes to care – not profits.

If you are a health care support worker, your job is on the line. If you are a woman, poor, young, old, have children, if you are a person of colour, have a disability, or if you are in another vulnerable group, you are even more likely to feel the damaging effects of private health care.

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10 more reasons why for-profit health care is a bad idea

1 Care will suffer

Private health corporations cut corners on quality to ensure profits. A recent study on private hospitals published in the *Canadian Medical Association Journal* found for-profit hospitals had higher death rates than not-for-profit hospitals.

A similar study comparing for-profit and not-for-profit clinics in the US found the same result – dialysis patients were more likely to die in a for-profit clinic.

Corporations providing long term care for profit have been sued in the US for providing care below the standards required by law. One major way to increase profits is to cut back on the number of staff. Studies in the US show nine out of ten nursing homes have inadequate numbers of nurses and aides resulting in unacceptable levels of care and hundreds of deaths each year.

2 Waits will increase

It is a myth that private health services will shorten waiting times. A study of waiting times for cataract surgery in Manitoba showed that waits increased when physicians operated in both the private and public sectors. In Alberta, cataract surgeries in the public system in Edmonton had shorter waiting times than in Lethbridge, where surgeries were contracted to the private sector.

3 Costs will rise

Private health care means higher administration costs with fewer dollars actually going to direct patient care. In the US, the world's largest privatized health care system, health care spending accounts for 14 per cent of the total value of goods and services produced (GDP) – and leaves 42 million Americans without coverage. Canada's public not-for-profit system is more efficient, providing better results and universal coverage while consuming only nine per cent of GDP.

4 The rich will jump the queue

Private clinics will let those who can afford to pay for private diagnostic services jump the queue for treatment in the public system. Those who can't afford to pay – most likely women, children and the marginalized – will either be denied treatment or face long waits.

5 Canadian tax dollars will boost corporate profits

Private health care diverts tax dollars from patient care to corporate profits. Private clinics, contracted services and public private partnerships all use public dollars to subsidize private profits. In Ontario, federal funds intended for medical equipment have already been given to a for-profit company to buy diagnostic equipment. Every penny of health spending must go to care – not corporate profits.

6 Canadians will pay more

Canadians will have to pay out-of-pocket for health care. These charges will come in the form of user fees, extra-billing, increased premiums or concessions at the bargaining table in order to hold on to a decent health benefit package. In a two-tier health system, Canadians will risk bankruptcy as they struggle to pay for private health services for themselves or a loved one.

7 Some will have no coverage

Without a universal public health care system, 42 million Americans in 2002 had no health coverage whatsoever. Over 58 million Americans will, at some point in their lives, find themselves uninsured.

8 Privatization threatens the principles of the Canada Health Act

Universality – For-profit health care is 'metropolitan' health care. Provinces that are 'small markets' and rural and remote areas will not be profitable 'cost-centres' for business. As a result, corporations will not want to provide service to these areas.

Accessibility – Private, for-profit health care will let those who can pay jump the queue. For-profit hospitals and clinics will limit beds or services to guarantee full capacity – and maximum profits. This will mean fewer beds will be available – and smaller communities may go without.

Portability – Some provinces will privatize more than others, resulting in a patchwork quilt across the country. Canadians may be covered for services in some provinces but not others.

Public administration – Health funding may flow directly to for-profit health care corporations with little or no accountability. For-profit corporations will manage and administer large sums of public money without government oversight.

Comprehensiveness – Under pressure from corporations and tax cuts, provinces are 'de-listing' services or excluding new services from Medicare. As a result, public health coverage is shrinking.

9 Trade agreements could lock in privatization

Privatization undermines any health care protections the Canadian government claims exist under NAFTA and GATS. For-profit care weakens our argument that these services should be considered social services provided by the public sector. When governments allow health care to be privatized, it becomes very difficult to reverse the process and restore public services. Two studies commissioned by the Romanow Commission confirm these dangers are very real.

10 Communities – and workers – will pay the price

Public health care is a major employer (hospitals, long term care, home care, community health clinics, public health units, day centers, etc.). Health support services are especially threatened by contracting out and privatization. Public food service, cleaning and laundry jobs pay family-supporting wages and give workers – mainly women, people of colour and new immigrants – decent jobs and working conditions.

Privatizing health support work will hurt cities and towns, especially small communities. Private contractors pay lower wages, offer fewer benefits, and rely on part time and casual labour. They are also less likely to do business in smaller communities. This can have a devastating impact on a local economy.

For-profit health care will also hit employers hard. And as the cost of benefits rises, employers will look to cut costs, often on the backs of workers and communities.

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P3 hospitals: The secret is out

The secret is out on public private partnerships (P3s) in hospitals. They don't improve service or provide good value for money.

But P3s do fundamentally change the ownership of Canadian hospitals from not-for-profit to for-profit. Health funding and service delivery will be altered forever.

What is a P3 hospital?

P3s are the latest attempt to privatize public facilities and services. They are modeled on the British private finance initiative (PFI) introduced by Margaret Thatcher in 1992. Under these schemes, a private corporation may finance, design, own and operate the building, leasing the hospital back to a health authority or a local hospital board for a profit.

There are several proposed P3 hospitals in Canada – the MSA hospital in Abbotsford, BC, the Vancouver General Hospital, the William Osler Centre in Brampton, Ontario, the Royal Ottawa Hospital and a hospital in Uxbridge, Ontario. New Brunswick and some local health authorities in other communities are also promoting P3 hospitals as the solution to their needs.

Why P3s?

P3s are a clever ploy to deceive taxpayers. First governments choke off public funds to build new hospitals. Then they propose P3s with 25 to 60 year lease arrangements, claiming the leases are not debt. Canadians are blackmailed by this logic into accepting P3s as the only way to get a new hospital. Nothing could be farther from the truth.

P3s fail the test

P3 hospitals mean fewer beds, longer waits, lower quality of care and fewer jobs. At the Edinburgh Royal Infirmary in the UK, the P3 resulted in 30 per cent fewer beds and 25 per cent fewer staff – and the 30-year lease arrangement cost the public £1.8 billion more than it would had the hospital been owned publicly.

P3s cost more

It costs the private sector more to finance construction. For example, in the UK private financing added 39 per cent to the cost of P3 hospitals in North Durham, Carlisle and Worchester.

As well, British corporations re-finance their loans after construction at a lower rate without changing the P3 agreement with government. This results in windfall profits for corporations and the loss of hundreds of millions of pounds for taxpayers.

A debt is a debt

P3s do not reduce public debt. While an accounting dodge may shift leasing costs to operating budgets, auditors are not fooled in Canada and the UK. Locked-in lease payments for 25 – 60 years are still a debt to government.

Whether you are tied into a 30-year lease or a 30-year mortgage, they are both long-term financial obligations. But the mortgage will cost you less – and you have full control of your asset.

Quality of care suffers

P3s reduce staffing levels to make profits. Waiting times increase as beds are cut. Shortcuts in the design are good for corporate profits but jeopardize quality care. Cutting corners has meant improper ventilation and air conditioning, water and sewage leaks, electrical problems and crowded work areas.

Local economies are hurt

P3 hospitals destroy good paying jobs. Workers get lower wages, fewer benefits, no pensions, no job security, no union protection and poorer working conditions.

When P3s fail …

- Projects remain unfinished. For example, the Bodmin Hospital (UK)
- Corporations are bailed out. For example, the Edinburgh Royal Infirmary (UK) will need £24 million per year in handouts so that it can break even
- Supposed savings evaporate. For example, the Dartford and Gravesham Hospital (UK) didn't deliver on the promised £12 million savings – and in fact, required an additional £4 million to meet commitments

P3 hospitals don't deliver value for money

P3 contracts always build in a percentage return to corporations for 'risk' yet experience shows that the real risk remains with taxpayers, patients and workers.

In Abbotsford, BC, a PricewaterhouseCoopers report set the private sector advantage at a slim one per cent and only then if collective agreements were ripped up and labour legislation changed.

For-profit hospitals are bad for your health

P3 hospitals are a giant step toward fully private hospitals. You are more likely to die in a for-profit hospital than in a not-for-profit one. Patient death rates are 2 per cent higher in for-profit hospitals – 9 per cent higher for newborns.

Doctors at the largest for-profit hospital in the US (owned by Tenet) are being investigated for conducting unnecessary heart surgeries in order to make more money.

What's the alternative?

That's no secret. We need new hospitals. Governments can borrow at a much lower rate of interest than the private sector can. Keep it public. It just makes sense.

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For-profit clinics: A public health hazard

For-profit clinics are the thin edge of the wedge for health care privatization. A recent boom in the number of for-profit clinics across Canada represents a new attack on Medicare.

There are already 20 private MRI* clinics across the country and Ontario recently announced plans for 20 additional for-profit MRI and five for-profit CT* clinics. A for-profit MRI clinic in Nova Scotia is operating without any government regulation. For-profit clinics also operate in BC, Alberta and Québec.

For-profit clinics are dangerous to your health

A major study published in the November 2002 issue of the *Journal of the American Medical Association* found there is an increased risk of death in for-profit dialysis clinics compared to not-for-profit clinics.

Private clinics promote unnecessary diagnostic tests. They appeal to the "worried-well" – healthy individuals who want to allay concerns and are willing to expose themselves to an unnecessary dose of radiation. A whole body CT scan is the equivalent of 400 – 500 chest X-rays.

False positives are common. Unnecessary scans increase the number of false positives leading to unnecessary biopsies and increased costs to the public health system.

Entrepreneurs who own private clinics are often not physicians or radiologists. A harbour tour boat operator owns the Canadian Diagnostic Centre in Halifax and a retired physics teacher owns Quinte MRI. They think nothing of cutting costs by having the scans read off-site, sometimes off-shore, by unknown radiologists with uncertain credentials, increasing the risk to the patient.

For-profit clinics lead to "queue jumping"

When private clinics sell diagnostic services to those who can afford to pay, these patients can then access treatment in the public system ahead of others. This is called "jumping the queue" and contravenes the accessibility and the universality principles of the *Canada Health Act.* For a health service to be accessible nothing should impede its delivery, either directly or indirectly. For it to be universal, medically necessary health care must be available to everyone.

Why are there long waiting lists?

Long waiting lists are a direct result of government under-funding of both equipment and operating costs. Some governments don't provide capital funding for MRI or CT scanners. It is left to hospitals and charitable organizations to raise funds for new equipment.

The Ontario government has deliberately ignored recommendations from the Ontario Association of Radiologists (OAR) for 38 new MRI and 25 new CT scanners to meet growing needs.

Clinics in community hospitals cost less

The OAR found that private clinics in Alberta cost 21-25 per cent more than public clinics. The Alberta government purchased six new public MRI machines in the last two years and ended contracts with private clinics.

Community hospitals reduce overhead cost because they offer clinic services in an integrated health environment. They are exempt from business and property taxes, provincial sales tax and much of the GST.

There is no profit or management fee.

Trained staff works within the public system and not siphoned off to the private sector.

Taxpayers subsidize corporate profits

DC Diagnostic (now part of CML) received more than $9 million from the federal government's $1 billion medical equipment fund to buy diagnostic machines for its Ontario for-profit clinics. The money, awarded by the Ontario Ministry of Health and Long Term Care, purchased ultrasound machines, mammography units and X-ray machines and conveniently came at a time when the company's shares needed propping up.

Who are the major for-profit players?

Canada Diagnostic Centres (formerly Western Canada MRI) operates clinics in BC, Alberta and Québec. Paperny, a former big-ticket organizer for Jean Chrétien's Liberals and a BC Liberal Party campaign director. The Paperny family and holding company, Madacalo Investments, gave $37, 329.82 to the Liberal Party of Canada between 1993 and 1997.

Canadian Medical Laboratories (CML) recently acquired DC DiagnostiCare and operate MRI clinics in BC and Alberta.

Quinte MRI operates clinics in New York, Québec, Missouri and the Cayman Islands.

US-based multinationals are preparing to move into Canada through mergers and acquisitions. *Insight Health Services* has 140 fixed and mobile centres in the US. *Syncor International* operates over 80 centres in the US and five other countries. **Alliance Imaging** is one of the largest operators in the US with over 325 centres in 48 states. *Medical Resources Inc.* has over 60 diagnostic imaging centers in the US. *Wellbeing Inc.* jumped immediately after the Ontario announcement to say they plan to open 12 for-profit clinics.

Cost of an MRI or CT scan in a private clinic

MRI $475 to $850 depending on the area scanned and contrast used

CT from $690 for a heart scan to $2100 for a full body scan and virtual colonoscopy

*** Glossary**

MRI – Magnetic Resonance Imaging scans produce detailed pictures of soft body tissue and organs without using ionizing radiation making early detection of cancers, neurological and musculoskeletal diseases possible

CT – Computed Tomography scans are a three-dimensional "window" into the body through which doctors can see brain, spine, joint and internal organs, allowing for early diagnosis

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Workers pay the cost of **de-listing**

Workers and their families take a major financial hit when public health care is privatized. As provincial governments cut services from the list of what is covered under Medicare (known as “de-listing”), more and more health care costs are shifted into private insurance plans funded on the backs of workers.

Workers fought hard for Medicare. If de-listing continues, we will have to fight hard to keep coverage – and it may mean difficult tradeoffs at the bargaining table.

Health insurance is at the top of bargaining agendas in the US, before wages, benefits and working conditions. American workers look to the Canadian system with envy. We must not let our public system be destroyed by de-listing and privatization. Publicly funded, publicly delivered health care is the best deal for workers – and the economy.

What’s wrong with private insurance?

Private insurance costs more

- Valuable health resources go to administrative costs, advertising and profits for owners and shareholders
- In the US, private insurance companies make profits by shifting costs to employers, who in turn download those costs to workers through high deductibles, co-payments and premiums
- In 2001, deductibles in the US increased by more than 30 per cent for typical employer-based plans. Premiums are rising by 20 per cent a year
- A single-payer, universal system like Canada’s is the most efficient system, costing less for everyone

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Private insurance limits access to care

- As private insurance moves into areas that used to be covered by public insurance, access to care will depend on your ability to pay, employment and family status
- Private and employer packages rarely provide comprehensive coverage. The extent of coverage will be different for everyone
- Sick people will have the greatest problems getting insurance to cover the costs of care
- As costs increase, coverage falls. Sometimes it's not enough to cover basic surgical procedures

Private insurance offers less security

- Linking coverage to jobs means that when workers lose their jobs, they lose their health care
- Two million Americans lost their coverage last year due to layoffs
- In the US, 42 million people have no health insurance and 58 million people have been forced to go without insurance for a year or more at some point in their lives
- When employers go bankrupt, entire health insurance plans disappear

Private insurance means poorer health

- When you don't have health insurance, you put off health care. Most often this results in more complex care down the road, increasing health costs
- Over 18,000 Americans die prematurely each year because they do not have health coverage

Across Canada, there is a growing list of services that are no longer covered by public health insurance, including some physiotherapy, hearing aid fittings and rehabilitation services.

Our fight

CUPE members are on the front line, fighting to improve standards of living for ourselves, our families and our communities. We are mobilizing to defend our jobs and the services we provide. Workers were a key part of the fight for health care that's available to all – no matter what you earn, where you live or whether you have a job. Keeping public health care strong – and expanding it – is a life and death struggle for workers.

Private insurance is unreliable and unfair. It creates different classes of people, with the rich assured the best care. It also diverts health care dollars away from quality services to line corporate pockets. We must fight to ensure every penny of health care spending goes to care – not profits.

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BC attack on support services a warning for other provinces

In 2002, the British Columbia government launched an all-out attack on health support workers and collective bargaining, an attempt to clear the way for mass privatization of public health care. It's part of a much broader attack on poor people and working people that also zeroes in on other public services for cuts and corporate sell-offs.

The BC government agenda is a direct attack on the most vulnerable, including immigrant women, poor people, students, seniors, Aboriginal people, people of colour and people with disabilities.

Empty promises

During the last election, BC Liberal Premier Gordon Campbell promised to protect health care and respect contracts. He lied. The BC government is planning the biggest mass layoff of women workers in BC history, terminating about 20,000 health jobs as the first step to privatize $700 million in services. Another 7,500 jobs are to be chopped in both clinical and support areas as a result of service cutbacks. Many of these women are workers of colour and new immigrants.

Some of those workers may be rehired into privatized jobs, but at drastically reduced wages. This undoes decades of struggle for pay equity. Communities across the province will also take a direct hit – the economic impact of wage cuts alone could top $150 million a year.

Tearing up contracts

In January 2002 the government rammed through a law known as Bill 29. Bill 29 strips workers of hard-won rights and protections, tearing up contracts negotiated by members of the Hospital Employees' Union/CUPE.

Under Bill 29, health support workers lost their job security and contracting out protection. There is no consultation and no protection when work is sold to the private sector. Contract provisions restricting layoffs were also stripped from collective agreements. Bill 29 gutted bumping rights and wiped out gains won through years of struggle that gave community social services workers wage parity with other health care workers. The government has also prohibited unions and workers from suing the government for damages.

The law essentially gives BC health authorities free rein to contract out and privatize health support work. Some have wasted no time. Security services, laundry, dietary and housekeeping workers have all been hit.

HEU has lost several hundred members so far. While the major cuts are behind schedule – thanks to strong resistance from HEU and a broad-based provincial fightback – between 5,000 and 6,000 members' jobs are on the line in the coming months.

Closing facilities

The BC government has been ruthless in its attack on communities and their health care facilities, targeting 50 facilities so far. Four hospitals have already been closed and another four are slated for closure. Another six hospitals have lost so many services they're hospitals in name only. A further eight hospitals have been downgraded, meaning they've lost a significant department such as an emergency room, or lost most acute care beds. Two long-term care facilities have been closed, and another 26 are on the chopping block.

Pushing privatization

On the heels of Bill 29, the government brought in a budget that slashed spending for health care and other services to fund tax cuts to the rich. Starving services of cash increased the pressure on health care employers to privatize – and gave some a convenient excuse.

The government followed through in its attack on health support services with an aggressive push for public private partnerships (P3s) in all areas of health care, including hospitals. Privatizing support services is a major source of profit in P3 hospital schemes.

The ground had been prepared for privatizing support services by underplaying and misrepresenting the central role health support work plays in healing. Right wing think tanks compared health support work to hotel work, suggesting health

workers were overpaid. The Liberals said the government wasn't "in the business" of services like laundry.

Sweetheart deals and union-busting tactics

Multinational corporations, taking their cue from the Campbell government, are organizing their own assault. Public exposure short-circuited Sodexho's secret scheme to prevent HEU members from being rehired after their positions were converted into low-wage, privatized jobs. Sodexho approached another union to try and cut a sweetheart deal, but instead they had the whistle blown on them.

Suspicion of other wrongdoing and collusion abounds. Evidence from one health authority showed Sodexho may have been given the inside track on a deal to privatize management of laundry, housekeeping and dietary services.

HEU has filed freedom of information requests to show the flimsy or non-existent evidence that underpins the government's privatization plan. The requests seek to fully expose the government's cosy corporate connections.

Fighting back

HEU members are fighting back – in the streets and the courts, through community mobilization and organizing drives, building public pressure.

- HEU is working with other unions to challenge Bill 29 using the Charter of Rights and Freedoms to argue the bill robs workers of their right to equality and freedom of association.
- CUPE BC and HEU are coordinating a strong joint bargaining strategy, ensuring a united front between community social service workers and the broader health care sector going into the next round of collective bargaining. Bargaining priorities include: no concessions, regaining job security and successor rights, wage parity, a pension plan, and workload issues.
- Massive demonstrations are delivering a strong message to the provincial government.
- Community campaigns have strengthened local coalitions and local fights to protect public services. These campaigns have helped elect municipal representatives who support public services.
- HEU has successfully exposed the serious flaws and dangerous consequences of the government's privatization schemes, undermining the government's ability to make a coherent case for privatization.
- Where services have been privatized, HEU has fought to organize the workers.

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Cleaning and housekeeping workers: Critical to care

Hospital patients and nursing home residents are extremely vulnerable to infection.

To keep health care facilities safe, clean and sterile, cleaning and housekeeping workers need specialized knowledge and training. They also need experience and a great deal of dedication.

Careful attention to detail is essential to minimize the risk from exposure to sharps, chemicals and hazardous waste. Special cleaning procedures are required as they work around expensive medical equipment.

Hospital cleaners help protect and improve the health of patients by eliminating bacteria and preventing disease. As well, workers have regular contact with patients during the course of their duties, playing a crucial role in their care.

Public sector housekeeping and cleaning staff are a critical part of the health care team.

On the front line

Health care housekeeping and cleaning staff are the front line of defense against antibiotic-resistant 'superbugs', viruses, infections and other potentially life-threatening organisms.

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Each area of a health care facility requires a different procedure and specialized skills:

Operating rooms must be sterile and immaculate. With a fifteen-minute turnaround time between patients, workers must be fast and efficient. Cleaning blood and body parts, including human tissue, bone chips and teeth, can be unpleasant and dangerous. Working around sensitive high-tech equipment requires special care.

In **dialysis units**, the risk of cross infection is high so sterility is crucial. Under constant pressure to speed patient turnover, 22 beds must be stripped and freshly made every hour.

In **emergency rooms**, stretchers and other surfaces are often covered with difficult-to-clean fluids like blood and vomit and must be cleaned quickly between patients.

In **radiation rooms**, workers must wear protective clothing. After cleaning, the room is monitored for radiation. If "hot spots" remain it must be cleaned again.

Cleaning and housekeeping workers require extensive training. Formal college-based programs exist, but most hospital cleaning skills are acquired on the job. Training is usually provided by nurses or by other health care professionals.

Cleaning and housekeeping workers provide direct patient care. Hospital cleaners spend a minimum of 20 minutes a day with patients. As a result, workers often become close to patients and their families, providing emotional support while ensuring their safety from bacteria and contamination.

Continuity is key

When qualified and well-trained support staff are not in place, patient care suffers. Other health care professionals, technical staff and families must work harder to fill in the gaps.

Not only does this affect the quality of care, it is a poor use of human resources at a time when hospitals are understaffed and have difficulty recruiting and retaining staff.

Low pay + poor working conditions = high turnover

In his 2000 hospital review, Scotland's auditor general found turnover among private cleaning contractors was almost twice as high (40 per cent) as among in-house cleaning staff. The report also found contracted-out cleaning provided less flexibility and lower quality service.

In Britain, the National Health Service was forced to invest more than CDN $77 million in a crash program of hospital cleaning after an audit revealed that most of the hospitals relying on private contracts failed to meet national cleaning standards. In addition, contracting out has fragmented the health care team and created obstacles to integrated patient care.

Cutting corners kills

In the US, where privatization of cleaning and housekeeping services is more widespread than Canada, a recent investigation found that cuts in cleaning and infection control standards contributed to 103,000 patient deaths in 2000.

The *Chicago Tribune* establishes a link between soaring infection rates and a 25 per cent cut in hospital housekeeping staff since 1995, combined with poor training and a high-turnover, low-wage workforce. The Tribune concludes that 75 per cent of these deadly infections were preventable.

The same study points to a US Centres for Disease Control and Prevention report that deaths linked to hospital germs are the fourth leading cause of death among Americans – behind heart disease, cancer and strokes.

In Australia, contracted-out cleaning has meant lower standards and higher infection rates. Experts warn of the dangers in handing control over cleaning to outside organizations, resulting in "uncoordinated and inconsistent" cleaning. Inflexible contracts make it hard to quickly alter cleaning standards to respond to new hazards, and hospitals are spending scarce time and money resolving disputes.

Keep it public

If cleaning and housekeeping jobs are contracted out to companies that hire unskilled workers at lower wages, the health of patients across Canada will deteriorate.

Privatizing cleaning and housekeeping services puts an essential part of our health system at risk.

Contracting out CUPE members' work undermines public health care.

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Laundry service workers: Critical to care

Sterile linens and gowns are essential to protect the health and safety of patients and workers.

To ensure the highest standards, laundry workers in health care facilities require specialized skills and training. Care and attention to detailed procedures are needed to protect workers from exposure to bacteria and infections. As well, the powerful chemicals and high temperatures required to clean and sterilize linens pose risks.

Workers come into contact with dangerous substances including sharps, drugs, chemicals and bodily fluids. They are particularly susceptible to salmonella and scabies from contaminated linen.

The specialized knowledge and skills needed to avoid contamination are acquired on the job. Non-health sector laundry workers do not have the skills and knowledge to keep patients and workers healthy and safe.

Public sector laundry workers are a critical part of the health care team.

On the front line

Different health facilities and departments require unique sets of skills.

> Operating room linens are made of a special fluid-resistant material, requiring separate laundering.
>
> Because of the sensitivity of surgical procedures, a higher degree of cleanliness and scrutiny is required. Each item must be checked carefully on a light table for holes, lint and loose fibers to ensure that patients are not infected by stray particles during surgery.

'Isolation' laundry is washed separately in manually-loaded machines, and special treatment is required for certain items.

Different fabrics must be washed separately, as they tolerate specific chemicals or heat levels.

One laundry worker, a CUPE member with the Hospital Employees' Union in British Columbia, says, "It takes weeks to learn the job and maintain continuity, but it takes months to learn to do the job efficiently."

Contracting out doesn't work

Contracting out laundry services is not cost-effective because it leads to high turnover. In one BC hospital, contracting out to a commercial laundry meant linens often came back out of order, soiled by other laundry and so tangled they had to be thrown out.

Items were returned that did not belong, while other items disappeared. Staff would take their uniforms home to wash them since they often came back dirty having been washed with heavily soiled items.

These concerns led the hospital to bring laundry services back in-house.

Higher costs

One of the largest nursing homes in Newfoundland and Labrador planned to contract out its laundry services to cut costs and avoid duplication. But an employer study revealed that contracting out would increase costs significantly.

As a result, laundry services remained in-house. The cost savings were so great, all previously contracted out laundry services in St. John's area nursing homes were also brought back in-house.

A consulting firm reviewed the performance of K-Bro, a US-owned, Alberta-based company, providing laundry services at a hospital in Cumberland, BC. The review looked at operational efficiency, overall costs and prospects for improvement.

The study recommended the contract with K-Bro be terminated. The hospital is now buying the plant and equipment and will operate the laundry directly.

Lost jobs, lower wages, poorer quality

At the same time, K-Bro has been awarded a contract to provide laundry services to health care facilities in the Fraser Valley – by shipping BC hospital laundry to Alberta.

Contracting out and moving laundry services to another province has cost two BC communities 43 jobs and $1.5 million in economic activity.

Worse still, it was recently discovered that K-Bro was laundering hospital birthing sheets in standard washers designed for personal laundry, exposing mothers and newborns to serious risks of infection.

In 1995, K-Bro sparked a strike by Calgary laundry workers that lead to a major wildcat walkout by other hospital workers including dietary, food service and maintenance workers and radiologists. The key concern was job security but strikers were also protesting the impact that contracting out would have on patients, workers and costs.

Keep it public

The evidence shows that when housekeeping services are contracted out, standards fall and turnover soars, endangering patients and adding costs.

Privatizing laundry services puts an essential part of our health system at risk.

Contracting out CUPE members' work undermines public health care.

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Food service workers: Critical to care

Healthy, nutritious food is critical to restoring and maintaining good health.

Food service workers in health care settings require specialized knowledge, matching each patient's diet to their needs. Dietary restrictions, allergies, cultural factors and personal preferences must all be considered.

Developing menus, purchasing ingredients and managing supplies all require special expertise. Preparing and presenting food that is nutritious, fresh and appealing requires a high level of skill and organization. Special care is needed to ensure that dishes are sterile and the kitchen is free from bacteria or disease.

In hospitals, mealtime can be a high point in a patient's day and an opportunity for human contact. When the food is appetizing and staff have the time to help, patients are more likely to eat – speeding their recovery. When that's not the case, more trays come back untouched and patients' health suffers.

Public sector food service workers are a critical part of the health care team.

On the front line

Food service workers monitor patients' food needs and eating habits.

Each patient has dietary restrictions and allergies that food services workers must be familiar with. Proper attention and care can mean the difference between life and death.

The dietary departments of hospitals and nursing homes include a wide range of specialized staff, each playing a role in ensuring patients and staff are provided nutritious, appealing food in a cost-effective manner.

Contracting out reduces quality

In the UK, hospitals, municipal councils and school boards have cancelled food service contracts with Aramark because they failed to meet quality standards and budget guidelines.

And closer to home, reduced quality and reliability of contracted out food services at the Toronto Hospital has led the facility to build a kitchen and bring dietary work back in-house.

Still, hospital officials will often overlook the long-term costs of contracting out in the interests of apparent short-term savings.

Increased Costs

Contracting out food services makes money for corporations but costs the public more in the end. Often, contract terms allow private investors to reap big profits during the early years of a "public-private partnership" food service operation. But once centralized food facilities require new money to replace worn out equipment, they become the responsibility of the public sector.

A Marrack Watts/KPMG study of a Winnipeg hospital concluded that keeping operations in-house would save $32.1 million over 20 years. The cost of buying prepared foods from private contractors was estimated to be 10 to 20 per cent higher than if the food was prepared in-house.

Mary Immaculata Hospital in Willingdon, Alberta terminated a contract for food services with Versa Services after they found it was cheaper to provide the service in-house.

Staffing sacrificed to bottom line

The St. Louis Post Dispatch interviewed about 700 nursing home workers about wages and working conditions. The workers said they were unwilling to accept poverty level wages for their demanding work that often requires overtime and double shifts. The study found that the "corporate focus on the bottom line frequently requires managers to operate homes with skeleton staffing."

Nine out of ten long-term care facilities in the Missouri-based sample are understaffed.

Private companies like Bitove, Aramark and Sodexho MS Marriott are anxious to benefit from health care privatization. The only way to profit is to cut corners and costs by replacing dedicated, experienced health care support workers with low-wage, inexperienced staff – a move that will lead to high turnover.

Patient health suffers

In 1996, New Brunswick's Atlantic Health Corporation awarded a contract to Bitove Corporation to replace in-house food preparation. Lower food quality undermined patients' health: 20 per cent of residents lost weight and another 20 per cent suffered from gastro-intestinal symptoms such as diarrhea, vomiting, cramps and gas.

A review of American government documents and court records reveals that hundreds of nursing home patients die from neglect in facilities with contracted out food services. Starvation and dehydration were found to be two of the three major causes of death.

Keep it public

Cutting corners for profit results in less variety, lower quality and poorer health. It also means fewer jobs and lower wages, undermining local economies and reducing local control.

Privatizing food services puts an essential part of our health system at risk.

Contracting out CUPE members' work undermines public health care.

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Fraud plagues privatized care

Privatization doesn't just divert health care dollars into corporate profits. It can also siphon money into criminal's pockets. As private health corporations push to expand their Canadian market share, many fear fraud will eat up an ever-bigger bite of our tax dollars.

Look at the King's Health Centre scandal. The owners of the Toronto clinic were convicted of fraud totaling almost $100 million – an early example of what may soon plague Canada if for-profit care is allowed to flourish.

Lessons from the States

A recent study by the Harvard Medical School concluded that "large scale fraud has become routine" in the American for-profit health care industry. The Federal Bureau of Investigation calls health care fraud "a growing trend," and has set up a special health fraud unit.

Between 1992 and 1999 the number of FBI health fraud investigations jumped fivefold, to over 3,000 investigations. During the same period, the number of FBI agents investigating health fraud quadrupled. Many states have also set up their own fraud squads.

The US General Accounting Office (GAO) estimates that as much as one-tenth of health care spending is lost to fraud – about $100 billion of the country's $1 trillion spent annually. The US Justice Department estimates more than half the $1.5-billion recovered from fraud cases between 1997 and 2000 was from the for-profit health care sector.

Investigations unearth major problems

The United States' largest for-profit hospital chain has been forced to pay more than $1.7 billion in criminal and civil fines to settle charges of defrauding federal and state-funded health care programs. HCA – The Healthcare Company, formerly known as Columbia/HCA – faced a long list of allegations involving improper laboratory billing, misreporting services as higher-priced procedures, and billing for home health services that were "medically unnecessary or never provided."

Eight whistleblower lawsuits charged that HCA inflated hospital costs to obtain higher government payments and paid kickbacks to physicians who referred patients covered by Medicare or Medicaid to its facilities.

Another investigation targets Tenet Healthcare, a major for-profit hospital chain. The FBI has zeroed in on a Tenet hospital in California, alleging patients were subjected to unnecessary – but profitable – heart surgeries, including artery bypass surgery and heart valve replacements. Federal officials are also investigating other Tenet hospitals that perform far more than the national average of high-cost procedures, and may have inflated charges for some patients.

In early December 2002, the largest settlement against a single hospital cost Lovelace Health Systems $24.5 million. The corporation settled to avoid a court battle over allegations about a decade's worth of fraudulent invoices. A whistleblower alerted officials to reports exaggerating the amount of Medicare reimbursement the hospital was entitled to. The company says it's all a big mistake.

The 1998 Harvard study cited a GAO estimate that nearly a quarter of all home care agencies, the majority of which are for-profit, commit fraud. In one example, prosecutors alleged HCA subsidiary Columbia Homecare broke anti-kickback laws when it bought home care facilities owned by Olsten Corporation – a company active in Canada under its new name Gentiva.

According to the Reporter, "Olsten sold the facilities for less than their fair market value in exchange for management contracts….[and] Olsten charged excessive management fees to make up the purchase price, and Columbia Homecare passed [on] these fees to the government."

Keeping corporations out of health care

The evidence is clear – for-profit care is prone to fraud. Fighting to ensure all health care services are publicly funded and delivered will guarantee that every penny of health care spending goes to care – not fraud or corporate profits.

* All dollar figures are US$, with the exception of the Kings' Medical Centre fraud.

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Health care needs more **funding**

Prior to 1977 federal and provincial governments shared health costs on a 50/50 basis. Today, federal cash transfers account for only 16 per cent of provincial health expenditures.

The shrinking federal commitment

The Liberals passed legislation in 1977 that ended the federal obligation to provide a fixed portion of health care spending. Throughout the 1980s funding was further eroded as the federal government increased cash transfers by less than inflation and population growth. As transfers declined so too did the federal government's ability to enforce national standards and control health care policy.

With the creation of the Canada Health and Social Transfer (CHST) in 1995, health care transfers were lumped in with funding for post-secondary education and social assistance. Cuts continued but it grew harder to track how the provinces were spending federal health care dollars.

As public spending on health care was rationed, private spending – out-of-pocket expenses, insurance premiums and negotiated health plans – grew. In 1975 public funding accounted for 76.4 per cent of the total health care bill. By 1986 it had fallen to 73.5 per cent and today it is only 70.7 per cent. Private payment for health services is increasing.

All of the facts point to a massive failure on the part of the federal government to protect and strengthen public Medicare.

New spending falls short of cuts

Despite the Liberal government's claim that they have replaced all of the cash cut from cash transfers, transfers to the provinces by 2003/04 will still be almost $10 billion short of what they would have been had they not been cut.

For the period 1993/1994 – 2003/04

Cash cut =	$34.6 billion
Cash replaced =	$24.7 billion
Shortfall =	$9.9 billion

If inflation and population growth are considered the shortfall is greater still.

Federal transfers fail to keep pace

Between 1993/94 and 1997/98 the federal cash transfer to the provinces fell from $18.8 billion to $12.5 billion, a massive one-third cut.

Between 1997/98 and 2000/01 health expenditures by the provinces and territories increased by $14 billion but federal cash transfers – for health, education and social assistance – increased by only $3 billion.

The 1999 federal budget boosted cash transfers by $11.5 billion on a one-time basis over five years. In 2000 the federal budget contained a one-time cash supplement of $2.5 billion for health care and post-secondary education. Still, the cash transfer in 2000/01 was $15.5 billion, well below the $18.8 billion in 1993/94.

In September 2000 the federal government and provinces reached an agreement to increase cash transfers by $18.9 billion over five years – 2001/02 to 2005/06. An additional $2.3 billion was earmarked for medical technology, primary care reform and health information technology.

These cash infusions still fall far short of replacing the cash cut from the system over the past ten years.

Cuts erode quality, confidence

Health care, Canada's premier social program, took a big hit as a result of these cuts.

Emergency rooms were clogged, ambulances shuttled patients to available care, waiting lists increased, home care services were stretched, long term care beds were scarce, hospital wards closed, health care workers lost their jobs and workloads became close to unbearable. The quality of health care suffered.

The funding cuts and their negative impact fostered a climate of dissatisfaction undermining public Medicare. Preying on this discontent, for-profit corporations are poised to sweep into the $112 billion Canadian health care market.

Accountability is lost in the CHST

The CHST helps fund post-secondary education, social assistance and health care. But there is no way to tell where CHST cash transfers are spent.

Even within health care, these funds could be spent on direct health services or diverted to for-profit corporations to purchase equipment.

Canada's Auditor General Sheila Fraser says

> "It's clear that Canadians don't know how much of the federal contribution is intended for health care."
>
> "Parliamentarians are expected to make decisions on billions of dollars transferred to the provinces and territories for health care but they still don't have enough information to know the extent to which the *Canada Health Act* is being respected."

Romanow recommends reforms

In his report, Roy Romanow makes these recommendations:

- Create a separate Canada Health Transfer so that we can track federal health care spending
- Increase the federal share of provincial health expenditures to 25 per cent
- Add $8.5 billion in short term funding for programs including primary health care, home care and catastrophic drugs and add $6.5 billion to the base transfer by 2005/06

These funding increases are the <u>minimum</u> necessary to sustain our public health care system.

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A **who's who** of health care commissions and committees

Romanow Commission – Commission on the Future of Health Care in Canada

Roy Romanow, former Premier of Saskatchewan, was appointed by the Prime Minister to examine the sustainability of a universally accessible and publicly funded health care system. He issued his final report in November 2002.

Romanow left no doubt that a publicly funded, single-payer model of health care is sustainable and can be expanded. He is clear that public, not-for-profit health care is superior to private, for-profit care and that governments should not subsidize private health care with public dollars.

He did not, however, make specific recommendations to ban for-profit care and he failed to understand the importance of publicly delivered support services.

Unions, community groups, non-governmental organizations, health coalitions and the many individuals who appeared before the Commission can take credit for the many progressive recommendations in Romanow's report. They now need to lobby the federal and provincial governments to implement those recommendations.

Kirby Committee – Standing Senate Committee on Social Affairs, Science and Technology

In March 2001 the Senate asked its Standing Committee on Social Affairs, Science and Technology to examine the principles behind our health care system, its pressures and constraints, alternatives around the world and the federal role.

Committee chair, Senator Michael Kirby, has extensive connections to health care corporations, serving as a director of Extendicare, the long term care and home care giant.

The Committee's final report, released in October 2002, called on the federal government to increase health spending by $5 billion per year to fund a partial drug program and post-acute home care and palliative care. These proposals fall far short of Canadians' expectations for an expanded and strengthened Medicare system.

Not surprisingly, the Kirby Committee did not make any recommendations against the privatization of health care. In fact, the report says that ownership of health facilities and services does not make any difference.

Mazankowski Council – Premier's Advisory Council on Health in Alberta

In August 2000 Premier Klein established an advisory council, chaired by Don Mazankowski, to kick-start health care privatization in Alberta.

The Council was stacked with pro-privatization appointees including Mazankowski, who was the minister of privatization under Brian Mulroney. Maz's corporate connections include Power Corporation, Great West Lifeco and Investors' Group.

The Council's final report in December 2001 contained 44 recommendations. All 44 were accepted by the Alberta government, establishing the foundation for two-tier health care.

Fyke Commission – Saskatchewan Commission on Medicare

In June 2000 Kenneth Fyke was appointed by then Premier Romanow to head a Commission to recommend actions for the delivery of health services in Saskatchewan. The Commission reported in April 2001.

The Commission's recommendations on primary health care reform, specialized care, equity within the system, and the restructuring of health districts were favourably received by CUPE and other progressive organizations.

Clair Commission – Commission d'étude sur les services de santé et les services sociaux

In June 2000 the Québec government appointed Michel Clair to chair a Commission on the financing and organization of health care and social services. The Commission conducted public hearings and reported in January 2001 with 36 recommendations.

The recommendations promoted the private sector as a partner in financing health and social services. The Commission supported public private partnerships in contracting out diagnostic testing and minor day surgery; building long term care facilities; and purchasing and using new technologies. The Commission also recommended an expansion of physician-owned clinics.

Manitoba Public Health Consultations

In January 2002 the Manitoba health minister established a consultation process to examine the challenges and choices the government faces in delivering health services. A summary of the consultations entitled Health Choices was issued in April 2002. A final report has yet to be issued.

Newfoundland Primary Care Advisory Committee

In September 2001 the health and community services minister appointed Kathy LeGrow to chair a Primary Care Advisory Committee. The Committee reported in December 2001 focusing on the role of the family physician in primary care. The report advocated teamwork among family doctors and other health professionals.

New Brunswick Premier's Health Quality Council

Premier Lord appointed Michel Leger to chair the Health Council in January 2000. Recommendations in the January 2002 final report include: a community-based network of health centres, more nurse practitioners, and a patient charter of rights. The report did not recommend user fees, privatization or hospital closures.

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