RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

Briefing Note: Safeguarding Universal Access with Not-For-Profit Financing and Delivery of Health-Care Services

Medicare has been the defining Canadian institution since its implementation, and there is an abundance of experience and research on the problems with two-tier health care and for-profit delivery of health care. However, threats to Medicare continue. Privatization advocates achieved a victory in the June 2005 Supreme Court Chaoulli decision. While the decision applied only to private health insurance in Quebec, it is widely seen as an opportunity for attempts to expand two-tier health care across the country.

That opportunity has been taken up by the Canadian Constitutional Foundation, which has filed a statement of claim in the Superior Court of Justice which included an attack on virtually all aspects of the single-tier provision of health care in Ontario. It challenges the Health Insurance Act, the Commitment to the Future of Medicare Act, and the Independent Health Facilities Act which prohibit: direct billing of patients; extra billing; private insurance for insured services; and facility fees.[1]

While we are very supportive of the government and opposition parties' strong policy stance on single-tier delivery, we are urging the government to take stronger measures to defend not-for-profit delivery. We are looking for the opposition parties to support us in our efforts to influence government in these areas.

There is considerable evidence on the differences of cost and outcomes between for-profit and not-for-profit delivery across sectors. Studies show that the quality of care in for-profit institutions is lower.[2] [3] [4] [5] [6]The most conclusive evidence comes from systematic reviews and meta-analyses of all available peer-reviewed literature on for-profit vs. not-for-profit health care, which found higher patient mortality rates in for-profit as compared to non-profit centres.[7] [8] Furthermore, worse outcomes also came with higher costs: a systematic review and meta-analysis of all available peer-reviewed literature in the *Canadian Medical Association Journal* concluded that for-profit hospitals charge a statistically significant 19 per cent more than not-for-profit hospitals.[9]

Canadian evidence from the long-term care sector found that staffing levels were higher in not-for-profit facilities than in for-profit facilities,[10] and health outcomes were better in not-for-profit facilities.[11] [12] As one set of researchers concluded, differences in staffing were likely to result in the observed differences in health outcomes.[13] A review of North American nursing home studies between 1990 and 2002 similarly concluded that for-profit homes appeared to deliver poorer quality care in a number of process and outcome areas.[14]

Issue: Public-Private Partnerships (P3s) or Alternative Financing and Procurement (AFPs)

RNAO calls for:

- Establishment of an immediate and indefinite moratorium on Infrastructure Ontario's AFP projects in the hospital sector. Do not approve or announce any additional AFP projects for which contracts have not been signed.
- For projects where contracts have already been signed, deepening the commitment to full transparency by providing total disclosure of all financial aspects of these agreements. An argument of commercial confidentiality is inappropriate when taxpayers' dollars are at stake, and the principle should be established that bidders who are not ready to accept full disclosure should not bid. Furthermore, lack of full disclosure compromises the credibility of government claims about the benefits of AFP.
- For projects where AFP contracts have not been signed, the financing method should be shifted to a traditional (non-AFP) method of financing.
- Announcement of an immediate review by the provincial auditor of the value-for-money assessment of AFP projects. This is essential to provide the government, and the public, with a complete and accurate assessment. RNAO asks that:
    - The review includes auditing and independent verification of the accuracy and completeness, as well as the underlying assumptions, of the public sector comparator, and the successful proponent's final offer and their financial model.
    - The review assesses the risk transfer to the private sector. This review should include an assessment of whether AFP shifts only the timing of project cost increases and delays. In particular, it should determine whether cost increases and delays are merely shifted to a period prior to contracts being signed from a period after contracts have been signed under the traditional financing approach.

Background

- In the lead up to the 2003 election, Premier McGuinty promised to bring the Royal Ottawa Hospital and William Osler Health Centre in Brampton into the public system. Shortly after the government was elected, it announced that the projects in Brampton and Ottawa would proceed. The contracts were modified only to provide for public ownership.
- Subsequently, the government announced a program of alternative financing and procurement (AFPs) for hospitals and other public infrastructure. Its position is that AFPs are not P3s because they will remain publicly owned and controlled. However, they will be privately financed, and the government has not committed to public operation. Many of the problems associated with P3s arise from private financing and operations.
- The rationale provided by the government for choosing this method of financing is that they established controls that they believed would deliver value for money and would transfer risk to the private sector. The government has also made efforts to increase transparency through the value for money assessments, and by making project agreements and contracts public. These efforts were responses to the well-documented evidence that the costs of public-private partnerships (P3s) tend to be higher, while the quality of the service is reported to be poor.[15] [16] [17] [18] [19]
- The evidence is mounting that efforts to correct these deficiencies and increase transparency have not been successful. It appears that AFP financing is not providing the on-time and on-budget construction that had been hoped for.
    - The Bluewater Health Hospital in Sarnia is a recent example. News reports indicate that over the course of a year, the cost of the hospital increased from a

$140 million to at least $214 million when the contract was completed last month – an increase of 53 per cent.[20] The varying estimates for the costs of the program are an indication of the lack of transparency inherent in this complex form of financing.
    - The Ontario Health Coalition's recent analysis of the Brampton Civic Hospital indicates that following the outset of negotiations,costs increased by 186 per cent, or $300 million. There were significant reductions in the number of beds and operating rooms, and more than a two-year delay in construction deadlines.[21]
    - While the government disputes these figures, Thomas Walkom points out that even using the government's numbers, the hospital cost the taxpayers at least $130 million more than the current government estimated, and $200 million more than the former Conservative government promised.[22]
- In addition to the direct impacts on finance, delivery, and quality of each project, there are the broader political and policy implications of this method of financing. It creates a new and powerful stakeholder group – the private consortiums – whose clear long-term interest is the expansion of health-care privatization. Although this government has restricted the scope of the private intrusion into the public sector, these are decisions that a future government with a different philosophy could easily reverse, using the AFP structure created by this government to pursue a much more aggressive privatization strategy.

Issue: Competitive Bidding in Health Care

RNAO calls for:

- Abandonment of competitive bidding as a method of allocating funding for home care in Ontario.
- A commitment to ensuring that if the government refuses to abandon competitive bidding, it will implement a right of first refusal for not-for-profit providers.

Background

- Experiments in introducing competitive bidding in the health-care sector have proved unsuccessful both in Ontario and internationally. The reasons for this are extensive and complex. They include: our limited ability to fairly price and cost health-care services and different levels of complexity in these services; the expensive nature of systems required to capture and audit information; and low measurability of health-care services, which impedes effective performance monitoring.[23]
- For competitive bidding to be effective, we must be able to measure not only the services themselves, but also their quality. Yet we cannot effectively quantify these services, or their quality. Price, on the other hand, is easily quantified, and that leads inevitably to a competitive bidding process biased toward awarding on price rather than quality. This makes competitive bidding an expensive, inefficient way of attempting to ensure quality services and value-for-money in health-care services.
- Ontario's experiment with competitive bidding in home care has been a failure. It has resulted in:
    - A shift to for-profit providers (the share of the total volume of nursing services awarded to for-profit providers increased from 18 per cent in 1995 to an

estimated 46 per cent in 2001[24]), with the attendant loss of social infrastructure associated with not-for-profit providers.
    - Grave concerns about the quality of care[25]
    - Critical shortages of community nursing staff which are directly linked to system instability and worsened working conditions in this sector compared to others[26]

- During its first term in office, the government appointed Elinor Caplan to review and make recommendations on the competitive bidding process. During the consultation process, RNAO urged the repeal of the competitive bidding process. While Ms Caplan did not recommend that competitive bidding process be dismantled, her recommendations were aimed at increasing stability in the sector and improving quality of care. However, the government has been slow in implementing the report's recommendations.
- Between 2004 and mid-2007, there was a freeze on issuing new RFPs for home care in Ontario. The first publicly available results of these RFPs has generated a great deal of concern in Hamilton:
    - The RFP for nursing services in Hamilton has resulted in the failure of two long-term, non-profit providers, VON and St. Joseph's Healthcare -- which provide 80 per cent of home care nursing services in Hamilton -- to pass the initial, written proposal stage of the process.[27] [28] [29]
    - RNAO's Hamilton chapter has been working in collaboration with others in the area to express their concerns about the impact of the results of the RFP on the continuity of care for clients and the home health care workforce.

Issue: Local Health Integration Network (LHINs) and Competitive Bidding

RNAO calls for:

- A prohibition on LHINs using competitive bidding as a method for allocating funding to health service providers.

Background

- A number of factors result in continued concern among advocacy groups about the potential for LHINs to use competitive bidding as method of allocating funding among health service providers.
    - In other provinces in Canada, the regional health authority is both the funder and the provider of health services, while in Ontario LHINs will fund but not be a direct provider of services. This form of regionalization could accommodate competitive bidding for a wide range of health services, from those provided in hospitals to those in home care.
    - Despite proposed amendments from RNAO and others, the government refused to amend Bill 36 to prohibit LHINs from using competitive bidding to allocation funds.
    - Organized medicine, and particularly the president of the Canadian Medical Association, Dr. Brian Day, is advocating for a move to this form of funding for hospital services.[30]

The British Medical Association has identified many of the problems with this funding system:

- Many services become unprofitable and are at risk of being withdrawn. Examples from Britain include problems with child services and with services for patients with mental health needs or co-morbidities.
- Private providers "cherry pick" uncomplicated, low cost, and low risk cases, leaving the public system to deal with higher cost cases..
- The diversion of funds to private providers weakens the public system and makes planning more difficult.
- Collaboration between primary and secondary care is put at risk by competition for patients.
- Administrative costs are likely to rise and far exceed any potential benefits.[31]

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