Special REPORT
PRIVATIZATION

The coming about of Bill 33

Implications of the Chaoulli judgement

Duplicative private insurance
Consequences for health professionals

Specialized medical centres

FIQ SPECIAL REPORT
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SPECIAL Report PRIVATIZATION

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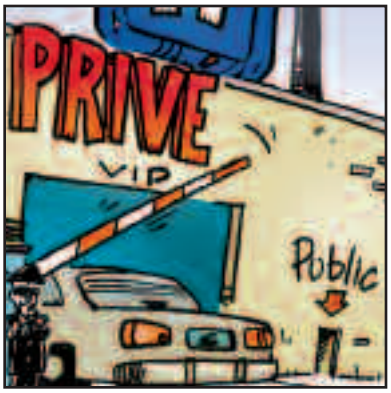
In view of providing members with information on current issues, the Federation has decided to produce a new publication: FIQ Special Report.



Bill 33 was adopted in December 2006. Thus, in this publication, all references to Bill 33 refer to S.Q. 2006, c.43.

In the sixties and seventies, before the introduction of hospital insurance and health insurance, health-related expenses were the number one cause of household debt in Quebec. When a family member fell sick, besides the anxiety engendered by the illness, the family often had to grapple with financial difficulties. Even access to care was not guaranteed.

Collectively, Quebec people decided, in line with their values of solidarity and sharing, that they could insure themselves against the risk of ill health by guaranteeing that everyone would have universal access to health care, regardless of the patient's ability to pay.

A Word from the President

In 2003, like now, Jean Charest's team campaigned relentlessly repeating that the Liberal government's priority was to improve the health services offered to the population. However, after the elections, it quickly put forward its true priorities and its hidden agenda. Thus, the government announced with great pomp that it would undertake to reengineer the State. Practically speaking, this meant that it was about to privatize certain public services and that it intended to attribute a good part to the private sector, already drooling at the prospect of the potential profits.

Yet, the Charest government had to readjust its discourse following the popular discontent sparked by its claims. But this adjustment was only cosmetic and it switched to the term *modernisation* which has a more positive connotation.

The Charest government has multiplied its attacks against workers and the union movement. It regularly invokes the urgency of the situation to force anti-union legislation through under a gag order. Thus, Bill 31 modified Article 45 of the Labour Code in order to promote sub-contracting, and Bill 8 prohibited the unionization of home childcare providers.

In December 2005, the seriousness of the situation was once again invoked to pass a special law (Bill 142) imposing working conditions on public service employees, though negotiations were making headway.

In the health-care sector, there were also many neoliberal-type measures. For example, Bill 25, initiating the forced mergers of institutions and creating local integrated services networks, considers the private sector as a party to the delivery of health services.

Regarding Bill 30, the main purpose of its adoption was clearly to weaken the union movement in the health-care network, by limiting the number of union certifications (divide to conquer) and weakening its bargaining leverage by decentralizing, to the local level, the negotiation of 26 matters related to the working conditions of health-care professionals

In December 2006, the Charest government struck again invoking the urgency of the situation to pass four controversial bills. At that time, the attention of the media focused almost exclusively on the bill establishing the opening hours and days for commercial institutions (Bill 57). This debate, although important, drew the attention of the public away from legislation that is crucial for the future of the Quebec health system: the adoption of Bill 33.

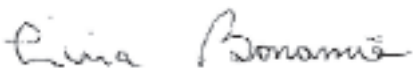
In Fall 2006, the FIQ participated in the *Commission des affaires sociales – Special consultations on Bill 33*. The Federation then took a stand against the adoption of this bill and it was not alone to do so. A group of researchers and jurists also took a stand against the latter, in particular on the matter of the introduction of private funding and private services in the field of health. The *Coalition of Physicians for Social Justice* took a similar position.

Nevertheless, true to itself, the government only listened to the promoters of the private sector and the insurers who will undoubtedly benefit from this legislation. Its choices are strictly political and bear no relation to the principles of free of charge nature, accessibility and universality of health care described in the Canada Health Act.

Bill 33 represents a very real danger because it opens the way for a two-tier system, offering privileged access to health care for the wealthy, financed by all taxpayers who will have no choice but to wait for their turn in the public sector.

Since this Act will undoubtedly have important repercussions on the continuity of the public health system, but also on the organization of care and working conditions in the network, the Federation offers you this *FIQ Special Report: Privatisation*. The FIQ hopes this will help to shed light on the issues at stake in Bill 33 and encourage you to discuss it with those around you.

In solidarity,



Lina Bonamie

An apostle of freedom of choice creates havoc in our institutions

The common denominator of the causes defended by Dr Chaoulli is his deep loathing for all regulations that come from the State.

Dr Jacques Chaoulli, who likes to compare himself to nothing less than Gandhi, is a physician of French origin who has been practising in Quebec since 1986. His path has been full of obstacles and he seems to take pleasure in confronting the authorities.

Thus, as soon as he obtained his license, Dr Chaoulli contested the obligation to practise in outlying regions for the first three years of service. Afterwards, he opposed the law that obliges general practitioners with less than 10 years of service to devote part of their work to activities deemed to be a priority. After having received a $12,000 fine for his stubbornness, Dr Chaoulli demonstrated alone in front of the National Assembly and began a 30-day hunger strike. Finally, seeing that this was a lost cause, he chose to opt out in order to offer home care services, travelling aboard an emergency vehicle with a non-statutory roof light, which led to more problems with public authorities.

Nevertheless, in spite of many incidents and mischief, Dr Chaoulli became a public figure and obtained the attention which he seemed to want when he undertook his crusade against public health insurance. In particular, he stood against the ban on private insurance to cover the costs incurred for health services delivered by a non-participating physician. According to him, this ban contravenes the individual rights protected by the Quebec and Canadian charters of human rights and freedoms.

In short, the common denominator of the causes defended by Dr Chaoulli is his deep loathing for all regulations that come from the State. He believes that a socialist system systematically stifles individual freedom, for reasons which he considers unfounded. Finally, Mr. Chaoulli's complaint was examined together with that of Mr. George Zeliotis, a patient who also contested the ban on private insurance on the basis of the Quebec and Canadian charters of rights.

The coming about of Bill 33: a response to the Chaoulli decision

Last December, Bill 33 was passed in near total anonymity. Indeed, Quebec media were probably too busy covering the annual holiday drive and reporting on the last minute Christmas shopping spurt to pay much attention to this bill that will have important repercussions. At most, some media mentioned that the bill was passed, stating that it was the Liberal government's response to the Chaouilli decision.

What is the situation, in reality? Who is Mr. Chaoulli about whom there is so much talk? What does the Supreme Court decision say and what solutions could have been considered? Did the Liberal government simply abide by the ruling of the Court or did it take advantage of the situation to impose its wheeler-dealer agenda, using the Chaoulli decision as an alibi?

First instance judgements

A first decision was delivered in 2000, by the *Superior Court of Quebec*, which rejected the petition lodged by Mr. Chaoulli and Mr. Zeliotis. According to the judgement, this ban was designed to promote the overall health of all Quebec men and women, regardless of their financial situation.

Two years later, the *Quebec Court of Appeal* rejected the petition for the same reasons, adding that the request concerns an economic right which is not protected by the Charter. Finally, the two appellants brought their case before the highest court of the country, the *Supreme Court of Canada*.

The Supreme Court decision

On June 9, 2005, the highest judicial authority of the country handed down its decision. With a divided decision (4 in favour and 3 against), the Supreme Court ruled in favour of the appellants, at least in part. Thus, in its judgement, the Court ruled that the prohibition of private insurance contravenes Article 1 of the *Quebec Charter of rights and freedoms* in regard to every human being's right to inviolability, when the waiting time for access to the service is deemed unreasonable. Moreover, although the Court recognized that the ban on private insurance was introduced to protect the public system and thus guarantee universal access regardless of a person's capacity to pay, it concluded that this ban is not essential. According to the majority opinion, other Canadian provinces (New-Brunswick, Newfoundland, Nova Scotia and Saskatchewan) allow private insurance and this does not compromise the existence of the public system.

It is important to stress the fact that the ban on private insurance is ruled to be unconstitutional only in the case where the waiting time for access to services is unreasonable, though this term is not defined by the Court.

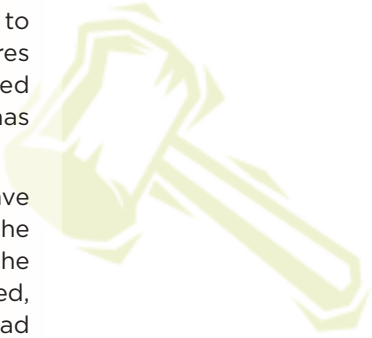
Moreover, it is rather outrageous to see that the Supreme Court justices based their decision on data regarding waiting lists provided by the Fraser Institute, a neoliberal *think-tank* whose credibility and impartiality are highly contested. Indeed, the *Commission MacDonald Report* noted that the data from the Fraser Institute comprise many methodological biases which have the effect of boosting the results.

Implications of the Chaoulli decision

The Supreme Court decision obviously has repercussions and calls on the legislator to take action in order to abide by the decision.. We must remember that, since the decision is based on unreasonable waiting times for access to health services, the Quebec government has the obligation to take measures to reduce waiting times. That is all. To do this, there are many and varied solutions; these are in no way limited to what the Charest government has proposed.

A priori, one of the possibilities which the Charest government could have considered in its response to the Chaoulli decision was simply to invoke the exemption clause (notwithstanding clause) and, thus, be exempted from the application of the ruling. Instead, the Charest government simply repeated, over and over, that it had to respond to the Chaoulli judgement, that it had received a court order and that it had to comply. In fact, it was not obliged to do so. Why then did the government insist as it did? Is there something in the wind?

The Charest government's response to the Chaoulli decision is disproportionate and goes far beyond what it was obliged to do. It appears obvious that the Chaoulli decision was an alibi for the Liberal government to do what it had wanted to do for a long time, that is open up health services to the private sector.



The Chaoulli decision is based on unreasonable waiting times for access to health services.

Bill 33 in three points

1 Centralized management of access to health services

With Bill 33, the Liberal government introduced a centralized system of management of access to health services. The FIQ considers that this measure could considerably improve the organisation of care, which will necessarily have an incidence on waiting lists.

The centralized management of access to health services makes it possible to better organize services and budgets according to needs. This measure would have been amply sufficient to settle the problem of waiting lists.

Presently, waiting lists are managed by medical specialists or hospital activity centres. Consequently, it is very difficult to evaluate where the needs are more glaring and to determine the places where a patient could be cared for more quickly. This measure for the centralized management of access to health services makes it possible to better organize services and budgets according to needs. For example, at present, it appears that, between 20% and 30% "... of the names should not even appear on [the waiting lists] [...], because the patients have obtained the service elsewhere, they no longer want or need the service, or they are no longer alive."[1]

Moreover, since they are not the result of a transparent process and they do not promote the accountability of managers and professionals, waiting lists can be used as a bargaining lever "for the distribution of resources between the various medical and surgical specialties."[2]

Since the abnormally long waiting lists are often the product of poor management and poor use of available resources, the setting up of a centralized management system will certainly have many beneficial effects on access to specialized services. In short, this measure would have been amply sufficient to settle the problem of waiting lists and could have been an adequate response to the Chaoulli decision. We must not forget that the Chaoulli decision ruled that the ban on private duplicative insurance contravened the *Quebec Charter of Human Rights and Freedoms* if the waiting time for access to health services was too long. Nevertheless, the Liberal government chose not to limit itself to this, but to go much further.

2 Specialized medical centres

Another measure introduced by Bill 33 provides for the setting up of specialized medical centres (SMC). According to the law, there are two types of SMCs: centres which have exclusively physicians who have "opted in" and those which have exclusively physicians who have "opted out."

An physician which has "opted in" is a physician registered with the *Régie de l'assurance-maladie du Québec (RAMQ)*; he/she therefore practices exclusively in the public system and his salary is paid for by the government.

When a physician has opted out, he is no longer registered with the public health insurance plan; consequently, he no longer has the right to practice in public institutions nor to accept payment with the health insurance card. The physician who chooses to opt out can bill clients directly for his services. Only around one hundred Quebec physicians have chosen to opt out of the public system. The fact that few physicians have opted out can be explained, in part, by the fact that very few people can afford to pay the high professional fees of physicians who have "opted out."

The citizens of Quebec will pay by way of their income taxes for the profits made by the SMCs for services that could have been offered in the public system.

According to Bill 33, regional agencies can, following consultations with the minister, the representatives of physicians and institution managers, contract out certain surgeries and other types of medical services to small SMCs, which are nothing else than small private hospitals. The decision to contract out certain medical services to the SMCs is not necessarily taken on the basis of the length of the waiting lists, as the White Paper had stated[3], but rather on the basis of the *efficiency and effectiveness benefits* of having recourse to the private sector.

Regarding SMCs with physicians who participate in the plan, these for-profit centres will now be able to make profits by receiving patients from the public sector for hip, knee and cataract surgeries, or for any other specialized medical treatment determined by ministerial regulation. Thus, although the act in principle limits recourse to SMCs to the three previously-mentioned elective surgeries, the door is open to a much broader field of surgeries which can be transferred according the whims of the Minister. The wording of the Act opens a Pandora's box and we have reason to worry that all ambulatory surgeries could eventually be directed to the private sector, via the SMCs.

Moreover, when contracting certain medical services out to private centres, the citizens of Quebec will pay by way of their income taxes for the profits made by the SMCs for services

that could have been offered in the public system. Yet, regarding the health entrepreneurs' profit, we have two observations.

On the one hand, the services delivered in the private sector may , in the end, cost the government more, in order to generate profits for the private medical centres. This fact is corroborated by numerous statistics to the effect that overall health expenditures are higher when the private sector is involved.[4]

On the other hand, if private centres succeed in offering services at the same cost, or at a lower cost, as the public sector, we need to question where the savings will come from, knowing that around 80% of health expenditures are related to staffing. For it would be rather surprising that profits be reaped from the salary of the physicians who are shareholders in these private medical centres. Thus, who will pay for the profits of the shareholders? Health professionals? Support staff? The safety of patients? These questions remain unanswered and highly disturbing.

As for the SMCs with physicians that have opted out, all the expenses will be paid for by the patients who will then be reimbursed by their private insurance plan. In some cases, the Minister has the possibility of transferring public sector patients to these medical centres at great cost, at the expense of the State. Once again, the private sector will grab funds coming from taxpayers for its benefit, funds which could serve to improve the public system. This embezzlement of funds raises a fundamental question: should income taxes be used to increase the wealth of investors who are already millionaires, or to improve the accessibility and quality of services to which everyone is entitled?

The ramifica

The Rockland Medical Centre

The *Rockland Medical Centre MD* is a very good example of the possible ramifications of Bill 33. Thus, the controversial opening of this medical centre, which made the headlines less than one month after the law was passed, leads us to believe that the owners of the centre, located close to its potential clientele (between Outremont and Mont-Royal), had been ready to offer services to their wealthy clients for some time. They were only waiting for the blessing of Minister Couillard's bill.

Nevertheless, it seems likely that this medical centre is not in accordance with spirit of the law adopted under a gag order in December 2005; as a matter of fact, the RAMQ is currently examining whether or not it is legal. Indeed, Bill 33 maintains the separation of medical practice by specifying that the SMCs with participating physicians are private institutions where all the costs incurred for specialized medical services are paid for by the government, when the patient is referred to these services.

However, the physicians of these medical centres are authorized to bill patients for a very limited number of related fees, like medication and anaesthetics. The *Superior Court of Quebec* recently obliged the government to reimburse more than 13 million dollars to at least 40,000 women who have had to pay illegal incidental expenses in private abortion clinics.

Yet, at the *Rockland Medical Centre MD*, medical specialists are physicians who have opted in (their salary is therefore paid for by the government), but there is a whole range of accessory expenses which are paid for by the patients. For example, a surgery for a inguinal hernia will cost the patient $1300 for incidental expenses such as the salary of the nurse and support staff, the rental of the operating room, etc. The medical act, however, is paid by the RAMQ.

The medical centre in question also entertains an ambiguity which is not in compliance with the law and which will confuse more than one client. Thus, in the same medical centre, general practitioners have opted out of the RAMQ plan while medical specialists have opted in. What's more, the fees of medical specialists will be covered by the RAMQ for orthopaedic surgeries, as stipulated in Bill 33, but will they be covered in the case of the sinus surgery, ear drum surgery or diagnostic endoscopies also offered at this centre?

With such a system, straddling the private and public sector, we have the worse-case scenario: a two-tier system which offers privileged access to health care for the wealthiest sectors of society, funded by all taxpayers, who will have to wait their turn in the public sector sorely affected by the loss of resources to the private sector.

tions of Bill 33

Associated Medical Clinics

More disturbing yet, Bill 33 stipulates that a regional agency can ask a minister to authorize that a specialized medical clinic be associated to a hospital centre in order that it may dispense a certain number of surgeries. The SMC then becomes an *Associated Medical Clinic (AMC)*. To do this, the agency, the hospital institution and the private medical centre must conclude an agreement, for a maximum of 5 years, in which certain details are stipulated as prescribed by law.

Yet, Bill 33 is pernicious in that the specialized services which can be contracted with the AMC are not established and are not limited to the hip, knee and cataract surgeries. Thus, an AMC can be a professionals' private office, a laboratory or a specialized medical centre with physicians who participate in the public plan, which virtually opens the door to a slew of services being contracted out to the private sector.

In short, the government wishes to implement public-private partnerships in the delivery of health services to the population. Yet, when we consider the innumerable horror stories experiences in relation to PPPs in particular in Anglo-Saxon countries, it is spine-chilling!

Public-private partnerships are based on the neoliberal premise that the private sector is, by definition, more efficient than the public sector.

PPPs

Public-private partnerships (PPPs) are based on neoliberal premise that the private sector is, by definition, more efficient than the public sector. Thus, by way of PPPs, a government hands over to the private sector the delivery of a public service and, in exchange, the government pays fees for services rendered. For neoliberals, this type of partnership has the advantage of transferring the risks to the private sector, which together with its great efficiency, would result in considerable savings for the government.

PPPs were introduced in Great Britain, in the nineties, and they were well-know under the name *Private Finance Initiatives*, PFI. However, in the past years, the British government gradually stopped having recourse to PPPs on account of their inefficiency and outrageous cost. Nevertheless, the Charest government maintains that the success of the British PPPs must be a source of inspiration if we are to be in tune with modern and developed countries.

The British experience provides numerous examples which illustrate the limits of the profits/public tandem. Thus, despite the opening of 38 hospitals with PPPs, over 12,000 beds were closed in order to control overall costs and ensure the profitability of the private sector. More disturbing yet, the conception and construction of hospitals respond to the needs of investors more than to those of users.

Bill 33

Duplicative private insurance

Duplicative insurance is a type of private insurance which covers services already offered in the public system which remains universal. With it, all Quebec men and women continue to finance the public health system with their taxes and those who so wish (and who can afford to) pay an extra amount for private insurance coverage. Thus, those who wish to have a private insurance plan pay twice for the same service.

Duplicative private insurance covers services already offered in the public system.

Some say that this type of insurance has the advantage of preserving the best of the two worlds. On the one hand, universal access to health services would be guaranteed with the maintenance of the public system by way of taxation; on the other, the private sector would complement the public sector by welcoming patients with private insurance. However, the introduction of private duplicative insurance can have serious repercussions on the public system.

Thus, by way of Bill 33, the Charest government introduces the possibility for individuals to hold private insurance in order to cover the cost of a hip, knee or cataract surgery performed in a SMC by physicians who have opted out of the public system. For the time being, this measure applies only to episodes of care related to these three surgeries. However, the government could extend the private insurance coverage to other specialized services by mere regulation, after *examination by the appropriate committee of the National Assembly*. This is clearly insufficient to guarantee that private insurance will not apply to all outpatient surgeries.

Combined to the setting up of SMCs, Bill 33 opens the way for a private parallel health system, based on the patient's ability to pay. Thus, more fortunate patients will henceforth be able to avoid waiting lists by being operated in an entirely private specialized medical centre. These patients will then be reimbursed by their private insurance plan. Was this truly the spirit of the Chaoulli judgement? Did the Supreme Court decision oblige the Charest government to go that far? The answer is no. It appears that the Chaoulli judegement provided a wonderful alibi for the Liberal government to introduce a two-tier health system which would benefit essentially the more well-to-do in our society, health entrepreneurs and private insurance companies.

Myths about the privatization of health services

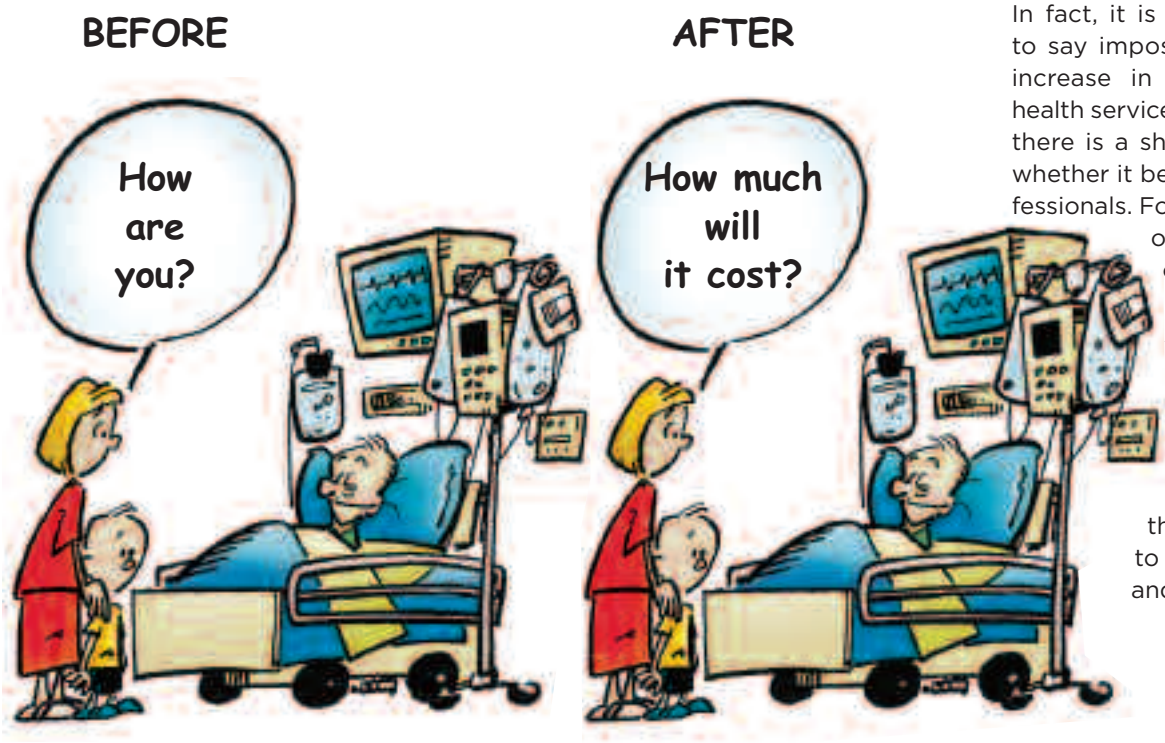
Bill 33 provides for the creation of private specialized medical centres and the introduction of duplicative private insurance; these measures go beyond the prescription of the Chaoulli decision and are, in fact, a political decision. What are the arguments put forward as justification by the promoters of these measures?

Waiting lists

The shortage of nurses in Quebec is currently estimated to be around 1,500 nurses. It will rise to 4,466 nurses in 2010 and 17,119 in 2020.

The promoters of increased participation of the private sector claim that Bill 33 will solve, at least in part, the problem of waiting lists for elective surgeries. According to their reasoning, the presence of the private sector in the field of health increases the global supply of services. Thus, in their opinion, there should be more services available for the same population.

For example, patients who can afford to buy a private insurance policy could have an operation in a specialized medical centre with physicians who have opted out, which would reduce the waiting lists for patients in the public sector. Since the insurance is duplicative, this measure should be without consequence for the public sector which will continue to be financed by all taxpayers, as it is presently. Better still, these same promoters try to have us believe that the reduction of the demand for care in the public sector will logically reduce the expenses of the public system. Thus, new resources could be allotted to improve health services.



In fact, it is highly improbable, not to say impossible, that there be an increase in the global supply of health services for one simple reason: there is a shortage of labour force, whether it be physicians or care professionals. For example, the shortage of nurses in Quebec is currently estimated to be around 1,500 nurses. According to the forecasts, this situation of shortage will not be any better in the coming years, on the contrary. Thus, it is estimated that the shortage will rise to 4,466 nurses in 2010 and 17,119 in 2020[5]!

As for the shortage of physicians, the *Collège des médecins du Québec* indicates that there are currently 1.7 physicians per 1000 capita in Quebec, a lower ratio than in Canada (2.1) and elsewhere in the world (2.9). According to Yves Lamontagne, President of the *Collège des médecins*, this shortage will persist in the short and middle term, since the increase in the number of medical graduates will hardly compensate for the number of physicians who will retire.[6]

Since there is no available labour force, the private sector will have to recruit where human resources can be found, that is in the public sector. It will not be possible for the public sector to replace those who leave, on account of the shortage. Seeing its resources drained by the private sector, the public sector will therefore not be able to offer the same services, for lack of personnel. On this subject, a study covering countries of the OECD (Organisation of Economic Cooperation and Development), for the period from 1980 to 1997, demonstrates that the supply of services in the public system is systematically reduced when the part of the private sector increases.[7]

Thus, if the supply of services is reduced in the public sector, the waiting times, logically, should increase. This is actually what has happened in Australia when duplicative private insurance was introduced.[8] In Great Britain, the reduction of waiting times is not related to the introduction of duplicative insurance; it is the result of the large injection of public funds. A recent OECD study indicated that "...nothing allows us to say that this [duplicative insurance] reduces [...] waiting times in the public sector, which is the only possible choice for low-income groups." [9]

In short, countries where duplicative insurance was introduced such as Great Britain, Australia and New Zealand, have waiting times that are equal or greater that those that prevail in Canada. There are no documented cases which demonstrate that the introduction of duplicative private insurance has actually had a positive effect on the reduction of waiting times in the public sector. The only positive result of duplicative insurance on waiting times concerns patients who have private insurance. For these fortunate people, waiting time is in fact reduced. Indeed, according to the OECD, duplicative insurance poses *considerable problems of equity*, because it introduces a two-tier system based on the patients' ability to pay and not their needs.

Is this truly the system that Quebec people want? Has the Charest government explained the problems posed by duplicative private insurance? The answer is, of course, no. The underfunding of the Quebec health system and the weariness of Quebec people regarding the difficulty of having access to health care, together with the alibi provided by the Chaoulli decision, made it possible for the Liberal government to quietly pass a law which brings us back to the Duplessis era where the wealthy will receive adequate care and the less fortunate will have to wait for their turn.

The funding of the public system

Another argument often put forward by the high priests of the privatisation of health care is that the State simply does not have the means to fulfill its ambitions. With the rise of health expenditures, exacerbated by a significant rise in the demand for health services related to the aging of the population, the current public health system would no longer be viable and, as a consequence, a major reform would be needed to transfer the costs from the public to the private sector.

First of all, we must point out that the disaster expected by those who want to privatize the health-care system is not around the corner. Once again, the apostles of free trade use bogeymen to scare the population and reach their ends. Thus, serious studies on the subject contradict the theses of those who call for a self-interested clear-eyed vision. One of these studies demonstrates that in Canada, between 1980 and 1997, the actual health expenditures per capita increased by 2,5% per year. Yet, the aging of the population accounts for only 20% of this increase.[10]

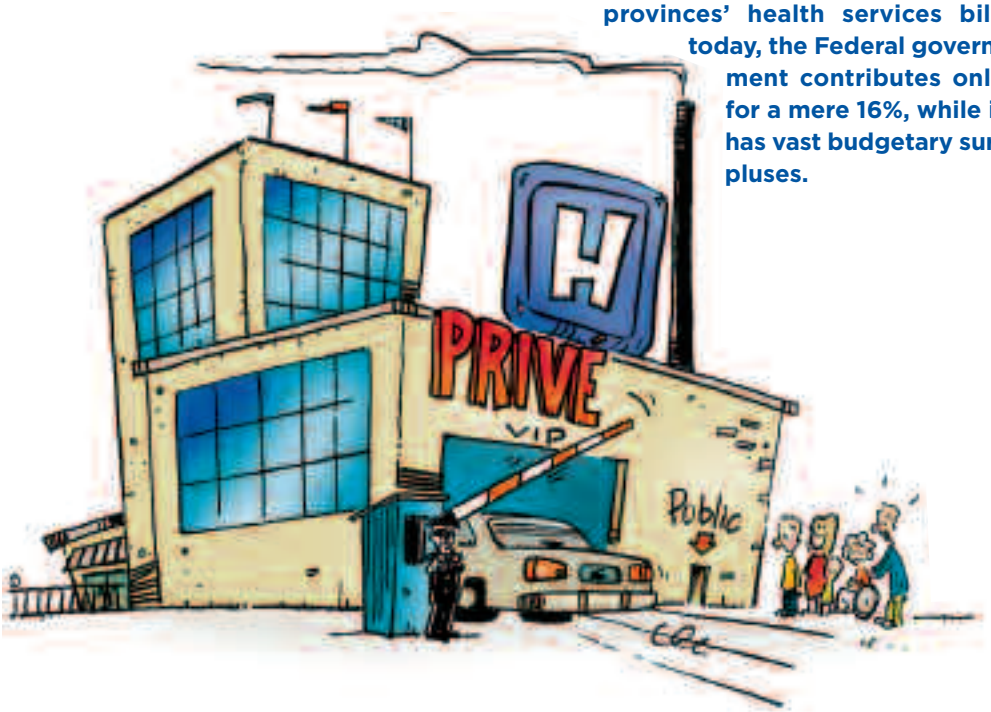
The proponents of a clear-eyed vision argue that the phenomenon will soar upwards when the baby-boomers reach the age of 65 years and over. Yet, the same study estimates that, for the period from 1998 to 2030, the true annual rise in health costs was 2.9%, that is 0.4% more than for the previous period. According to these same authors, the aging of the popu-

The aging of the population will have a marginal incidence on the rise of health expenditures in the next 30 years.

lation would only explain 31% of this increase, the cost of prescription drugs and new technologies having a much greater impact on the rise in health costs.[11]

Other studies conducted by varied and reliable sources such as the OECD, Department of Finance Canada[12] and the Canadian Institute of Actuaries[13] all arrive at the same conclusion: the aging of the population will have a marginal incidence on the rise of health expenditures in the next 30 years.

What are the motivations of those who invoke the non-viability of the funding of the public health system and the urgency of making the changes they deem necessary (that is the privatization of health)? The increase in health expenditures could be absorbed, at least in part, if the Federal government settled the question of the fiscal imbalance. Indeed, during the 1960s and 1970s, the Federal government contributed for the equivalent of 41% of the provinces' health services bill; today, the Federal government contributes only for a mere 16%, while it has vast budgetary surpluses.



Another important question to raise with regard to the funding of the public health system, is whether greater recourse to private funding in the field of health would help the government to make savings? The upholders of the neoliberal ideology have the firm conviction that private management is, by essence, efficient and less costly than public management which can only lead to the wasting and poor use of resources.

Yet, facts contradict these statements. Indeed, it has been proven that private insurance requires general administraton fees which are much higher that public systems, for the reimbursement of agencies as well as service providers. For example, the total health expenses in Canada would be 10% higher if the Canadian system had the same management costs as the American system. "[...] [In this country], there are 85% more administrative managers than in Canada, 22% more support staff in the administrative non-financial sectors and 65% more personnel in the financial administrative sector."[14]

Besides the administrative fees, it appears that physicians who are owners of a medical centre tend to deliver an excessive number of services to their patient-clients, since it is profitable for them to do so.. Thus, a study conducted with 60,000 patients has shown that physicians who work in the private sector use X-ray equipment way more than their colleagues in the public sector. Thus, physicians in private medical centres have used this equipment 46% of the time in the case of respiratory problems (as compared to 11% in the public sector) and 54% of the time in

the case of lower back pain (as compared to 12% in the public sector)[15].

In short, the part of public funding in 1999 is estimated to be 60% of the total health expenditures in the United States, that is an amount of US$2,604 per capita, an amount slightly higher than that allotted in all western countries, with the exception of Switzerland. In proportion to the GDP, in the United States, health expenses represent 15.3%, while in Canada they represent 10%.[16] Thus, although the United States is the country where each individual spends most for health services, we must remember that 40 million Americans have no insurance coverage and therefore have no access to health care. Thus, our neighbours to the South pay more for less services!

In Great Britain, the situation is not any more brilliant. After more than 10 years of increased private sector funding in the field of health, the British Medical Association concluded that:

"[...] the facts continue to indicate that private initiatives in the field of hospitals are excessively costly and do not respond in a satisfactory way to our concerns regarding access to services, optimization of resources, transfer of risks and cutbacks in services. In our opinion, neither the advantages initially announced for private initiatives, nor the improvements proposed by the current government will offset the disadvantages."[15]

For its part, an OECD study concludes that, "Whatever its role in the health system, private insurance has the effect of increasing the total health expenditure. Most OECD countries have less control over the activities and the prices of the private sector than they have on the public plans and their service providers."[16]. Therefore, far from reducing total health expenditures, "in certain cases, private health insurance has in fact increased the public health expenses or public expenses in general."[16]

Consequences for health professionals

It is rather difficult to evaluate the consequences of the privatization of health on professionals since there are very little studies on the subject. However, two studies[17] carried out for the International Labour Organization (ILO) reached the same conclusion: in the majority of cases, the privatization of health services is related to the deterioration of working conditions and a drop in salaries for health professionals.

By draining personnel from the public system to the private sector, professionals working in the public sector are bound to end up with a heavier workload given the shortage of personnel and the very small variation in the demand for services. Moreover, it has been proven that the private sector is concentrated, profitability oblige, in non-urgent and less costly services and targets a lower-risk clientele The public sector will continue to treat the more acutely-ill and expensive cases, with less resources. And, given the possible rise in total health expenditures, it is difficult to imagine that the public sector would be inclined to offer better salaries to its professionals.

Moreover, while the private sector is liable to offer more advantageous salaries in the short term in order to attract care professional, this situation could well be reversed, in the middle term, given the profitability objectives of the private sector and considering that personnel costs represent close to 80% of the total health expenditures.

On the basis of facts, the following conclusions can be drawn:

- The funding of the health-care system is viable and is not threatened by the aging of the population. The increase in costs is related more to the skyrocketing prices of prescription drugs and the use of costly technology, which can both be controlled and regulated by an adequate intervention of the State.

- The various experiences in the OECD countries demonstrate that waiting lists in the public system do not shrivel away with the introduction of private funding. On the contrary, on account of staff shortage, access to elective surgeries could be the same as it is now, and even worse, except for wealthy people who can afford to pay for services in a private medical centre.

- The private sector is not any more efficient than the public sector, quite the contrary. Studies demonstrate that the greater the part of private funding, the higher are health expenses. The result is a more expensive system which, besides being inequitable, offers less services than the universal public system.

- According to the data of the ILO, private funding may exert downward pressure on the working conditions and salaries of health professionals.

In short, Bill 33 creates a dangerous precedent by opening the door wider to private funding and delivery of services, laying the groundwork for a two-tier system which will offer a privileged access to health care for the wealthier by reducing the quantity of resources available for the majority of the population.

This is not what the population wants nor the essence of the Chaoulli judgement which only obliged the government to remedy the problem of waiting lists and not to begin to privatize part of health-care services.

Health professionals, as front-line witnesses of the situation in the health-care network and as citizens, have an obligation to oppose this law and to make its content and consequences known. Social gains obtained through harsh struggles, must not disappear for the benefit of the wealthy, at the detriment of the values of solidarity and equity shared by all. Health is not a commodity, it is a right!

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