

**Presentation by the  
Alberta Federation of Labour  
to the  
Commission on the Future of Health Care in Canada  
April 30, 2002  
Calgary, Alberta**

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**G**ood afternoon. My name is Les Steel and I'm here on behalf of Alberta's largest union organization, the Alberta Federation of Labour.

When most people think of the labour movement, they think of things like collective bargaining and strikes. And it's true that these are some of the most important things we deal with. But over the last few years, the big issue for our members has been health care.

At conventions, local meetings and in casual conversations, our members have been telling us that they're worried about the future of public health care in this province. And it's not just our members in the health care sector. We have over 112,000 members in this province – from nurses to pulp and paper workers, from people who work in hospitals to people who work in refineries. And they're all telling us the same thing: they're telling us that Medicare matters.

That's why our federation has played such a prominent role in the campaigns against cuts and privatization. It's why we helped lead the fight against Bill 11 two years ago. And it's why we're so pleased to be here this afternoon.

I could try to do a lot of things today. I could talk about history. I could talk about how unions here in Alberta and across the country fought to create Medicare. Or I could tell you about the impact that budget cuts have had on jobs and services in the health sector.

But I won't do any of that.

Instead, I would like to spend my time this afternoon speaking in a language that's understood in the corporate towers here in Calgary and in the boardrooms on Bay Street. And that's the language of economic self interest.

Too often, those of us who fight to defend public health care rely exclusively on moral arguments. We say that Medicare is about fairness and equity. We say that it is an expression of our best impulses as a nation – that it reflects the importance that Canadians place on things like community and compassion.

All these things are true. Canadians support Medicare because it reflects our values. But unfortunately, that's not enough.

The reality is that there are powerful people, in business and government, who are pushing to dismantle Medicare. And these people are not going to be persuaded by appeals to sentiment.

The good news for those of us who believe in public health care is that there is a strong economic case for defending our system – and even expanding it. So this afternoon, that's what I intend to do. I will make the economic case for Medicare.

**W**hen it comes to making the financial case for public health care, the first thing that has to be done is dispel myths.

The biggest myth, of course, is the one saying that health care costs are spiraling out of control and that Medicare is unsustainable. We've heard this argument over and over again from our Premier and almost everyone associated with the provincial government.

The assumption that Medicare is unsustainable is the starting point for all the arguments in favour of privatization, and it is the bedrock upon which the Alberta government has built all of its plans for reform.

But, there's one small problem: our government has its facts wrong. Health care costs in Alberta are not out of control. In fact, after years of deep cuts here in Alberta, our per person spending on health care has only recently returned to the level it was at 15 years ago. And as a percentage of our provincial economy, we currently spend less than any other province.

To put things in perspective consider this number: four point seven. That's the percentage of our economy spent by the province on health care. The big irony here is that Alberta is ground zero for market medicine in Canada. It's the place pushing hardest for market reform – but it is also the place where public health is most affordable.

**T**he second myth that has been clouding the debate over Medicare here in Alberta is what can be called the myth of infallible markets.

Members of our government and many prominent people in the business community take it as an article of faith that the free market is always cheaper and more efficient than the public sector.

A few years ago, one of our provincial finance ministers got up in the Legislature and declared that the private sector is always thirty percent cheaper than the public sector. He had no proof, no studies. He just pulled the number out of a hat because it seemed about right to him. That's what we have to deal with in this province – an almost fanatical belief in the magic of markets.

The problem is that – at least when it comes to health care – markets are not magical. Countries like Britain, Australia and New Zealand have all experimented with privatizing parts of their public health systems. And in all of these cases, they've come to regret it.

But we don't have to leave the country to find proof that privatization doesn't do what it's boosters promise. In fact, we don't even have to leave this city. About five years ago, the Alberta government and the Calgary Regional Health Authority decided to privatize cataract surgery here in Calgary.

In a funny way, this turned out to be a positive thing for supporters of public health care because it allowed the Consumers Association of Canada to compare the results here in Calgary, where the system was 100 percent privatized, with the systems in Edmonton and Lethbridge, where they remained public.

What the CAC found was that waits for cataract surgery were actually twice as long in Calgary's privatized system as they were in public systems in Edmonton and Lethbridge – and costs were higher.

None of this should have come as a surprise. For years now, people have been studying the differences between public and private delivery in health care. There are literally hundreds of academic reports from Canada, Britain, Australia and the United States. And almost all of them come to the same conclusion – namely that privately delivered health care is more expensive than the public alternative.

There's a story I like to tell to illustrate the overwhelming weight of evidence against privatization in health care. During the Bill 11 debate, the AFL wanted to find out what information the government was using to back up its claims about the benefits of privatization. So we filed a Freedom of Information request asking for background documents and research.

Four months later, we got a thin envelop back – with one, six-page document from a right-wing think-tank called the Atlantic Centre for Market Studies. One document. And it turned out to be more of an opinion piece than anything, with no references to real studies. That was the sum total of the Alberta government's research on Bill 11. That was their evidence – all of it.

That compares to the hundreds of articles and studies in publication like the New England Journal of Medicine, the Lancet in Britain and the Journal of the American Medical Association – all showing that privatization doesn't make sense. One thin document versus a mountain of evidence from respected sources. That's the state of the debate here in Alberta.

That brings us to the current situation – and the current challenge.

Two-and-a-half months ago, Don Mazankowski handed down his report on health care reform and it was quickly endorsed by our provincial government. In effect, Mazankowski's recommendations have become the blueprint for health policy in Alberta.

From our perspective, there are two big problems with this.

First, the Mazankowski report is based almost entirely on the myths I've just been talking about. It's based on the myth that we can't afford Medicare. And it's based on the myth that privatization is the only way to save the system.

But as we've seen, the sky isn't really falling when it comes to health care spending – and privatizing delivery isn't going to save us any money. So the whole Mazankowski plan is a house built on shifting sand.

The second big problem with the Mazankowski report is that its recommendations aren't just misguided – some of them are downright dangerous from an economic point of view.

In many ways, it's a case of not appreciating what we've got. As it stands right now, Medicare provides stability and security for individuals and families. We get the care we need and we don't have to worry about draining our savings or losing our homes to pay for it.

But it's not just individuals who benefit from our public system. Medicare has also been an incredible bargain for business because it removes the burden of having to pay for private health insurance for employees.

Just a few months ago, the federal government and the consulting firm KPMG released a study showing that it's cheaper to do business in Canada than any other industrial country.

Our low dollar played a big part in this ranking. But Medicare was also a big factor. By removing the need for private health insurance, Medicare turned out to be a huge competitive advantage for our businesses – especially when it came to competing with firms in the U.S.

What does this have to do with the situation here in Alberta? Well, one of the key recommendations of the Mazankowski report is to find “alternative sources for revenue” in health care.

I don't know about you, but it seems to me that there are really only three potential sources for revenue in health care. Either it's paid for out of general tax revenue as part of a single-payer public system. Or it's paid by private insurance or directly out of the pockets of individual patients.

So when the Alberta government talks about “alternative sources of revenue,” what they're really talking about is shifting the cost for health care from the public sector onto the backs of individuals and businesses.

The Mazankowski report outlines a number of scenarios for how all of this might be accomplished. They talk about Medical Savings Accounts and Variable Health Premiums. They talk about de-listing services. And they've already implemented the recommendation about increasing existing health premiums.

The bottom line with all of these options is that Medicare is going to cover less and patients are going to have to pay more.

The Alberta government seems content to leave things there. They seem to think that once they've shifted health costs off the public sector's books they will simply be able to wash their hands of the whole matter.

But life is not that simple. The truth is that there will be a huge economic price to pay for downloading health care onto families and businesses.

In an effort to help people understand just how big that price will be, we at the AFL have done a little research.

First, we looked the health costs currently carried by businesses in Canada and then we compared them to the costs in the U.S.

According to the Canadian Life and Health Insurance Association, the average Canadian employer pays about \$93 per employee each month for extended health benefits to cover uninsured services like vision and dental care.

That may sound like a lot, but in the U.S. employers are paying between 2 and 3 times more for health benefits. In some cases private health insurance companies are charging American employers premiums of up to \$600 a month per employee.

Of course, at this point, no one in the Alberta government is talking about moving completely to an American-style system. But they ARE talking about drastically reducing what's covered by the public system.

For those of us in the labour movement, our preference would be to maintain a comprehensive and fully funded public system. But make no mistake – if the Alberta government goes ahead with plans to limit what's covered publicly, then unions will have no choice but to fight for supplementary private insurance at the bargaining table. It will become one of our top priorities.

What are the implications? As it stands right now, there are 275,000 unionized workers in this province. So if supplementary private insurance health insurance costs another \$50 per month per employee that's an extra cost to Alberta businesses of \$165 million per year. And if supplementary insurance costs an extra \$100 per month, that's a cost of \$330 million per year.

And that's just the unionized workforce. In order to attract and retain people, many other employers are going to have to buy supplementary insurance as well. And this will be on top of the millions many of them are already spending to cover Alberta's newly inflated public health premiums.

In the end the Mazankowski plan may end up saddling businesses with hundreds of millions – many even billions – in extra, on-going costs. This will drive up the cost of doing business in Alberta; it will reduce the competitive advantage that we currently enjoy because of Medicare; and it will probably mean the loss of thousands of jobs as companies scramble to pay the bills.

**B**y nature I'm not a pessimist. But when I look at what's being proposed I can't help feeling gloomy. Businesses are going to be hit hard. And so are working people and their families. You can bet that many of the new costs for supplementary insurance will be downloaded onto workers, either through cuts to their wages or by forcing them to pay a share of the premiums. And you can bet that many people won't have any supplementary insurance at all.

In fact, I think we're going to end up with a two tier-system where some people have full health coverage, mostly as a result of having good jobs – but where a majority will be forced to rely exclusively on a shrunken public system.

Looking at all this, I can't help but ask: Is this what we want?

Do we want to give up the economic advantage that Medicare gives us?

Do we want to be at the mercy of private insurance companies for our health care?

Do we want to pay deductibles and co-payments and run the risk of having our claims denied?

Do we want to feel locked into our jobs because they have benefits that might not be available elsewhere?

The really galling thing is that none of this is necessary. If our public system was really on the verge of collapse, then maybe Canadians could be convinced to accept privatization and private insurance. But here in Alberta, there is no crisis. Yes, there are some cost pressures. And, yes, there are always things we can do to improve the system. But there is absolutely no reason why we should embrace the kind of radical reforms being proposed by the Klein government. There would be absolutely no benefit – and the costs would be unacceptably high.

**S**o where do we go from here?

Like most of the other groups and individuals who've made presentations to this commission, the AFL has a long list of recommendations for health care reform – and we've attached them to our document. However, given the time constraints I won't go through all of them. Suffice it to say that we think what's needed is careful reform within the public system, not dangerous experiments with privatization.

As advocates of public health care, we obviously hope to see a report from this commission that recommends things like primary care reform, an expanded homecare system and the introduction of a national Pharmacare plan.

But we also need your help to stop our provincial government from going too far, too fast.

In that regard, we would like to encourage you to do three things in your final report.

First, we'd like to see a clear and authoritative discussion on the issue of health spending. We've tried to debunk the argument that Medicare is unsustainable. But the message is not getting out. We urge you tackle the subject and remind people that Medicare is not only affordable, it's so good that we can't afford to be without it.

Second, we'd like you to address some of the specific proposals that are being considered here in Alberta – like Medical Savings Accounts and Variable Health Premiums. As it stands right now, Alberta is the only province considering these kinds of radical measures. But there are other

conservative governments waiting in the wings. So please, take a close look at what's happening here and join us in saying "no way" to the Alberta way.

Finally, and probably most importantly, we're asking that you write a report that offers hope – a report that inspires Canadians to believe in public health care again. Here in Alberta our leaders have clearly given up on Medicare. And I get the sense that the same thing is happening in other provinces. The problem is that Canadians look at all this doom-and-gloom and they feel paralyzed. How can we expect ordinary people to stand up for public health care if their leaders won't?

What Medicare really needs is a passionate advocate. I know that as a federally appointed commissioner there's a need to be impartial and even-handed, especially during the consultation phase. But once you've heard from Canadians and once concluded – as we are confident you will – that Medicare makes sense ... once you've done all these things and are preparing to release your final report, please take the gloves off. Now more than ever Medicare needs a champion. I'm confident that you will be up to the challenge.

## Appendix I

### Conclusions

- 1) Policies currently being pursued by the Klein government in Alberta will hurt working Albertans. High health premiums, de-listing and the introduction of annual caps on service will all result in much higher out-of-pocket costs for individuals and families. Albertans will have an unpalatable choice if they have exhausted their “Medicare Accounts” or if they require services no longer covered by Medicare. They will either have to pay out of their own pockets, purchase supplementary private insurance – or go without treatment. The AFL finds all of these options unacceptable.
- 2) If provincial governments go ahead with plans to de-list services or limit coverage in any other way, then the labour movement will have no choice but to bargain for supplementary health benefits to cover the gaps. This will be an extremely negative development because it will undermine the competitive advantage conferred by Medicare and drive up the cost of doing business in Canada. This, in turn, will have an effect on jobs. Put simply, policies that shrink Medicare are job killers.
- 3) If the Medicare “umbrella” is shrunken (as governments in Alberta and B.C. are suggesting) then more and more people will be forced to turn to private insurance to guarantee full health coverage. This will lay the ground work for a two-tier health system in Canada. On the first tier we will find wealthy individuals and people whose employers can afford to pay for private supplementary health insurance. On the second tier we will find millions of people who can’t afford supplementary insurance and who must rely exclusively on the shrunken public system. As in the United States, access to “good health care” will depend largely on who you work for. If you lose your job with an employer with a good insurance plan, you will also lose access to top-tier service. The AFL finds all of this unacceptable.
- 4) The Alberta government is trying to scare people into accepting radical changes by warning that health costs are spiraling out of control. But all the evidence shows that this is a lie. Alberta is actually spending substantially less on health, as a share of the overall economy, than it did ten years ago. Yes, there is some need for change. But what’s really needed is careful reform within the public system. The last things we need are user fees, contracting out and private insurance.



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## Appendix I I

### Recommendations

#### **Solutions for an affordable public health system**

*There is no doubt that Medicare is facing some challenges. But privatizing services and forcing patients to pay more are not our only options. In fact, all the evidence suggests that the best and safest approach is to pursue reform within the public system. We need to support change – but not change that will destroy the crowning achievement of Canadian social policy. Here are a few ideas.*

**Pharmacare** – Rapidly rising drug costs are one the major “cost-drivers” in health care. Yet, drugs administered outside the hospital setting are not covered by Medicare. We need to bring prescription drugs under the Medicare umbrella – so that patients can get the treatments they need, and so that government can use its clout as a single bulk-buyer to control costs.

**Home Care** – We need to decide what care setting (home, hospital, long-term facility) is best for each patient’s needs, and fund all levels of care adequately. Home care and long-term care should not be the “poor cousins” of acute care. That leads to understaffing, poor quality of care, and adverse outcomes for patients. If doctors deem that a patient should receive health services in their homes, then those services should be covered by Medicare – the umbrella must be expanded to cover them.

**Healthcare Teamwork** – We need more teamwork among health care providers combined with alternatives to fee-for-service payment for doctors. However, changing how we pay doctors is not enough on its own. We need to make better use of other providers like nurse practitioners, pharmacists and mental health workers – and do health promotion as well as treatment.

**Evidence-based Decisions** – Decisions about health care need to be based on evidence of effectiveness, with flexibility to meet individual needs. Too often, we are paying for expensive technologies and treatments without a clear understanding of their benefits (especially in relation to cheaper alternatives). More has to be done to ensure our governments and health authorities fund proven treatments and technologies, as opposed to simply throwing money at the “latest thing.”

**Health Education and Promotion** – More focus needs to be placed on health education and promotion – dealing with both lifestyle behaviours and social determinants of health. The best way to control costs in health care is to keep people healthy. That means we have to start paying much more attention to issues like poverty, education and inequality. Better educated people, people with jobs, people who are well housed, people with hope – all of these people are less likely to suffer ill health.

**Stable Funding** – We need to guarantee stable funding for provinces and health authorities.

The spending roller coaster that we've seen in Alberta over the past few years – big cuts followed by big increases – has made it very difficult to make long-term plans.

**Keep the System Whole (and Keep it Public)** – Evidence from around the world shows clearly that privatizing public health care from within doesn't work. With public delivery, we know that all of our tax dollars are going directly to front-line care, as opposed to private delivery where at least some of the money will be siphoned off for things like marketing, billing and investor profits. Private operators also undermine the public system by enticing key personnel to “jump ship” for higher salaries and benefits. This has the perverse effect of driving labour costs up in the public sector and creating staff shortages. So far from “relieving pressure” on the public system, privatization may actually make a bad situation worse. The bottom line is that Medicare works best when all parts of the system are public and accountable.

## Appendix III

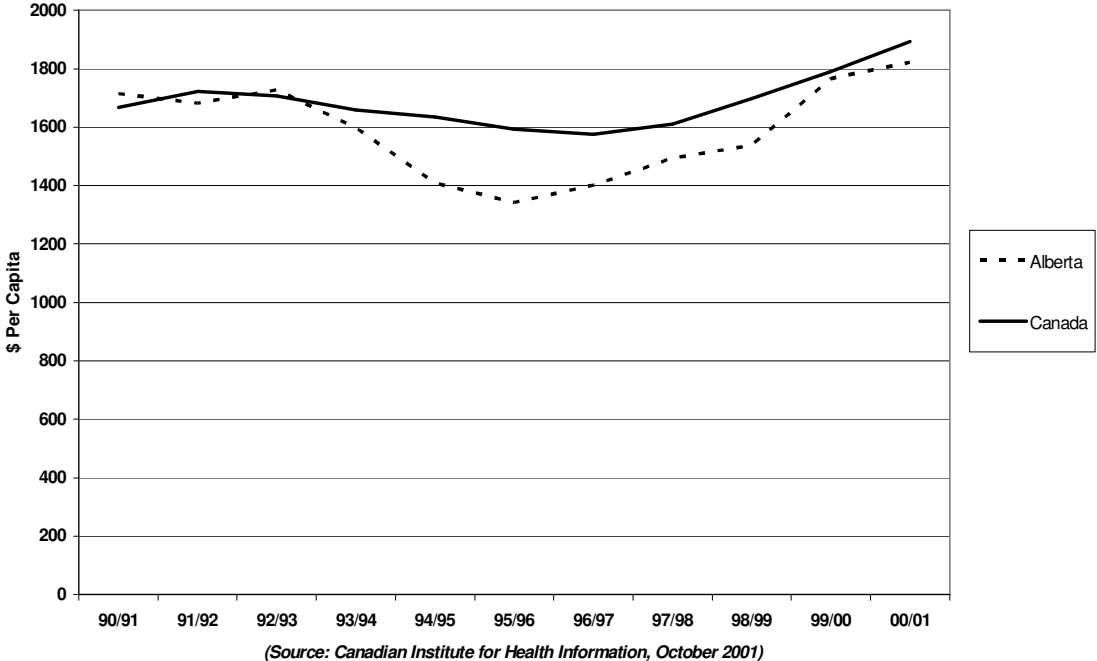
### The Truth About Health Spending in Alberta

Real per capita government spending on health care in Alberta dropped dramatically in the mid-90s. Over the ten year period, 1990-2001, it increased by a very modest 6.3 percent between 1990-91 and 2000-01 – with all of the increase coming in the last two years. Despite this recent jump, Alberta still spends 3.7 per cent less per capita on health than the Canadian average (compared to 16 per cent less than the national average in 1995-96, when the Klein cuts were at their deepest).

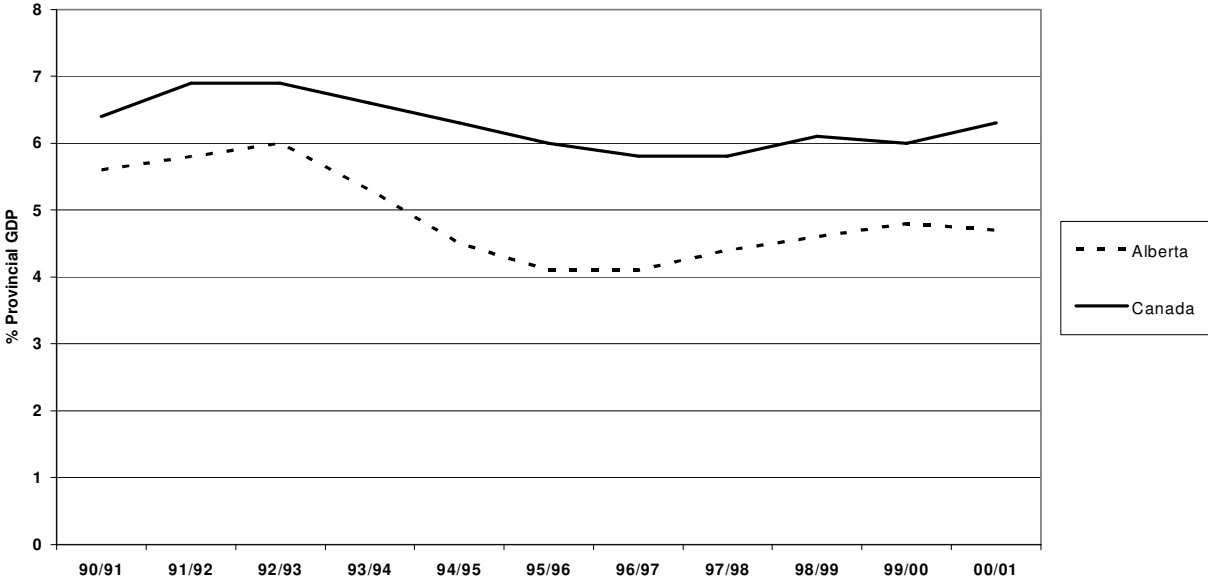
As a share of the overall provincial economy, health spending in Alberta has actually declined substantially over the past ten years – from 5.6 percent of GDP in 1990-91 to 4.7 percent in 2000-01. Alberta has always spent less as a proportion of its GDP on health care than other provinces, and that gap appears to be widening.

Based on these figures, it's clear that the Alberta government is wrong when it says that costs are spiraling out of control. Spending on health has increased only slightly – and most of this jump can be attributed to one-time investments in long-overdue capital projects. The bottom line is that, while costs are always a concern, there is no crisis in Alberta.

Per Capita Provincial Health Expenditure, Alberta and Canadian Average, 1990-2001 (1992 Constant Dollars)



### Alberta Government Health Expenditure as a Proportion of Provincial GDP, with Canadian Average, 1990-2001



(Source: Canadian Institute for Health Information, October 2001)

## Appendix IV

### The Economic Cost of Private Health Insurance

- In a recent study for the federal government, the consulting firm KPMG showed that it's cheaper to do business in Canada than any other industrial country. A big part of this competitive advantage was provided by our public health care system. KPMG found that American business spend about 25 percent of their payrolls on benefits – with private health insurance making up the lion's share. In contrast, businesses in Canada don't have to pay for private health insurance, so the overall bill for employee benefits is much lower (less than 15 percent of total labour costs). This "Medicare Advantage" is helping to make Canadian businesses more competitive.

*(Source: Competitive Alternatives: Comparing Business Costs in North America, Europe and Japan, KPMG, 2002)*

- The Conference Board of Canada has concluded that American employers pay 2 to 2.8 times that of their Canadian counterparts for health care benefits.

*(Source: The Economic Implications of International Education for Canada and Nine Comparator Countries, Conference Board of Canada, 1999)*

- The lower employer health costs in Canada lead to an overall cost advantage for Canadian products. Industry Canada found that in the automotive sector, the labour costs for cars built in Canada are 30 percent lower than in the U.S. The majority of this advantage is due to lower health costs. In Canada, health benefit costs are only 41 percent of U.S. costs — \$4.03 per hour compared to \$9.82 per hour.

*(Source: The Automotive Competitiveness Review, Industry Canada, Government of Canada, 1998)*

#### Corporate Health Care Costs, Canada and U.S.

| Company/Industry          | Canadian Sites<br>\$/Employee | Canadian Sites<br>% Payroll | U.S. Sites<br>\$/Employee | U.S. Sites<br>% Payroll |
|---------------------------|-------------------------------|-----------------------------|---------------------------|-------------------------|
| Business Service          | 3,306                         | 8.09                        | 7,493                     | 16.16                   |
| Pharmaceutical            | 6,505                         | 13.84                       | 12,457                    | 20.66                   |
| Auto Manufacturing        | 13,626                        | 22.82                       | 27,658                    | 34.21                   |
| Information<br>Technology | 5,794                         | 14.49                       | 15,045                    | 29.30                   |

Source: Conference Board of Canada, 1999

- In the U.S. in 1998, the average monthly premium for employer based health coverage was \$178 for singles and \$460 for family coverage. Since then, premium increases have ranged between seven and 11 percent each year making estimates of current premium levels close to \$600 per month for family coverage.

*(Source: "Job-Based Health Insurance, 1977-1998," Health Affairs, Vol. 18, No. 6, November/December 1999, pp. 62-77)*

- In Canada, employers pay only \$93 per month on average for extended health benefits for things like dental and vision care which are not covered by Medicare. If the Alberta government limits Medicare coverage and employers are forced to expand their private coverage, this figure is sure to rise dramatically.

*(Canadian Life and Health Insurance Institute website, 2002)*

- Individual workers would also end up paying much more under the restricted public health system proposed in the Mazankowski report. Right now, the average Canadian worker with an extended health plan pays \$21 per month in premiums for single coverage and \$53 per month for family coverage. In the U.S. the comparative figures are \$36 for singles and over \$150 for families. And the expenses don't stop there. The average American household spends \$1,959 per year on health expenses, not including employer premiums and payroll taxes. The comparable figure for Canada is \$806 per year.

*(Source: The Economic Implications of International Education for Canada and Nine Comparator Countries, Conference Board of Canada, 1999)*

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## Appendix V

### **Private health – costly results from around the world**

The Alberta Conservatives are not the first government to propose increased privatization in health care. Over the past 15 years, dozens of governments in Canada and around the world have experimented with similar schemes - and in all cases these for-profit plans have failed miserably. Consider these examples:

#### **United States**

- The United States has the most highly privatized health system in the industrial world. But this market-dominated model has not saved Americans money or provided them with higher quality care. On the contrary, costs for health care in the U.S. are the highest in the world and have increased much more rapidly over the past 20 years than countries with public systems.
- The Americans now spend an average of \$3,701 (US) per capita for a system where 43 million people have no health coverage and another 50 million have inadequate coverage. This compares to Canada where we spend a total of about \$2,050 (US) per capita for a system in which everyone is covered.
- A Harvard University study, published in 1999, showed that administrative costs are nearly four times higher in American for-profit hospitals than they are in Canadian public hospitals.

#### **Britain**

- In the 1980s the Conservative government of Margaret Thatcher weakened Britain's National Health Service (NHS) by using tax dollars to help create a parallel, for-profit health system.
- Thatcher said private health care would lower costs and reduce waiting lists in the public system. But the opposite happened: costs in the public system sky-rocketed and waiting lists grew longer.
- Thatcher's plan back-fired because doctors and other medical staff could make more money in the private system. With fewer doctors available to work in the public system, waiting lists grew longer. The government was also forced to dramatically increase the amount it pays doctors in order to keep them working in public hospitals. The result: rising costs for taxpayers.

## **Australia**

- During the 90s, Australia began experimenting with increased privatization in its public health system. But the promised cost-savings and “efficiencies” never materialized.
- As part of the push for increased privatization, the government of the Australian state of New South Wales hired a private company - Healthcare of Australia - to build and operate the Port Macquarie Base Hospital, one of the biggest hospitals in the state.
- But a report released by the state’s auditor general shows that the NSW government could have saved \$93 million (Aus.) by building the Macquarie hospital itself. The auditor’s report also shows that the hospital now costs \$6 million (Aus.) more to run each year than if it were publicly operated.
- Other private hospitals in other Australian states have had similarly poor track records.



## Appendix VI

### **Private Health Care Failures in Canada**

Studies from other countries are illuminating. However, we don't actually have to go outside of our own country to find evidence about the pitfalls of privatization in health care. Consider these examples from Alberta and Ontario:

#### ***Calgary – Privatization leads to longer waits***

The Calgary Regional Health Authority (CHRA) has been contracting-out cataract surgery for several years. Supporters of this kind of privatization argue that it will shorten waiting lists by “relieving pressure” on the public system. But a study conducted by the Canadian Consumer Association (CCA) study revealed the following facts:

- In Calgary - where 100 per cent of cataract surgeries are now performed in private clinics – patients waited an average of 16 to 24 weeks for treatment.
- In Edmonton, where 80 per cent of cataract surgeries are done in public hospitals, waiting lists were five to seven weeks long.
- In Lethbridge - where 100 percent of cataract operations are performed in the public system - patients waited an average of only four to seven weeks.

In other words, people living in regions with a higher proportion of private surgeries actually wait longer for treatment than people living in regions where operations are still performed within the public system. Clearly, the argument that private health care “relieves pressure” on the public system is false.

#### ***Ontario – Longer Waits and Higher Costs With Privatization***

In a bid to reduce waiting lists, the Ontario government recently hired a for-profit company called Canadian Radiation Oncology Services to provide radiation treatments for cancer patients. But after more than a year of operation, the private company failed to improve upon the record of the public system – patients were still waiting as long as they always had.

To top things off, Ontario's Auditor General, Erik Peters, revealed that the private clinic was costing taxpayers \$3,500 per patient – \$500 more than the cost of treating patients in the public system. Peters criticized the government for failing to provide any evidence of cost savings before they privatized services. And he said not enough effort had been made to find solutions within the public system.

#### **What the experts say**

“No peer-reviewed study has found that for-profit hospitals are less expensive.” New England Journal of Medicine, August 1999

The Journal of the American Medical Association (JAMA) concluded that “market medicine is a failure” and that “investor-ownership is consistently associated with lower quality.”

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