

Hon. Pierre Pettigrew, PC
Minister of Health
Brooke Claxton Building
Tunney's Pasture
Ottawa, Canada

February 24, 2004

Dear Minister Pettigrew,

Re: Moratorium on “Public-Private Partnerships” for Hospitals in Canada

I am writing you on behalf of the Canadian Health Coalition on the issue of public-private “partnerships” for hospitals (P3s) in Canada. Today, across the country, concerned citizens are organizing local media conferences to alert the public to current provincial government plans to privatize hospitals – a core component of our national health care system.

Canada’s federal Health Minister must not stand idly by and watch provincial governments contract with private for-profit hospital consortiums that constitute a threat to medicare. We are requesting that you refer the question of public-private partnerships for hospitals to the Health Council of Canada. In the meantime, a moratorium must be placed on all health care contracts between governmental, private for-profit and private not-for-profit entities in Canada.

The Health Council of Canada should examine all the evidence in an open and transparent way pertaining to the cost, safety, impact on International Trade Agreements , and benefits. In particular all proposed contracts should be examined in an open and transparent way, including those with Healthcare Infrastructure Company of Canada, a corporate consortium, who is bidding on contracts to build and own for-profit hospitals in Ontario, British Columbia, Alberta and Québec.

The same private corporations are bidding on contracts across the country. They see the public health system as a potential place to make profits. The group of companies that has won the contracts to build the first two P3s in Ontario – a consortium of companies is also bidding on the B.C. projects. These corporations vying to take over our hospitals have controversial records in Britain where the most extensive experiment with P3s in the world has been a disaster.

P3s threaten the future of Medicare. They cost much more than public non-profit hospitals. Because the buildings and profit-taking suck up so much money, the clinical side of the hospitals gets cut. In Britain, an average of 30% of staff and 26% of hospital beds have been cut according to the prestigious *British Medical Journal*. These hospitals are not accountable – they answer to shareholders who are looking for profits not to the public like non-profit hospitals. They suck up so much money that they reduce the scope of services offered under the public health system. They provide both the incentive and the opportunity for for-profit corporations to push service charges, user fees and two tier healthcare in their endless search for more profits.

There is no evidence that the people running for-profit hospitals or clinics know anything more about running these facilities better than the people who administer them on a not-for-profit basis. The for-profit consortiums recruit the same managers and administrators. The big difference is that for-profits ownership do not have the same obligations. Their job is to serve the investors in the consortium, not the community. It is not in the public interest to transform public, not-for-profit, transparent, and accountable health care contracts into private, for-profit, and secret opportunities for corruption and fraud.

In the words of the Romanow Commission's Final report: *"Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible. In addition, as discussed in Chapter 11('Health Care and Globalization'), any decisions about expanding private for-profit delivery could have implications under international trade agreements that need to be considered in advance."*

In addition, opening up the not-for-profit health care delivery system to private for-profit delivery, including foreign investment, threatens the current protection for Canada's medicare system in the NAFTA and the GATS. This threat has been documented by the Romanow Commission in its research and final report.

For example, GATS Article 1:3(c) exempts any "service which is supplied neither on a commercial basis nor in competition with one or more service suppliers". How could this provision be applied to situations involving a mix of governmental, private for-profit and private not-for-profit delivery? [Jon R. Johnson, *How Will International Trade Agreements Affect Canadian Health Care?*, Romanow Commission Discussion Paper No. 22, September 2002, p.18].

It is no longer plausible for the federal Minister of Health to claim that ownership of health care delivery does not matter, or that medicare is fully protected from international trade agreement. This denial is no longer plausible in light of the evidence.

The federal Romanow Commission on the Future of Health Care in Canada found no evidence that a greater role for private for-profit health care delivery will deliver better or cheaper, or improved access. In deed the expansion of for-profit delivery into Canada's medicare system has been described as "a perversion of Canadian values" This is because "Canadians view medicare as a moral enterprise, not a business venture". (Romanow Commission, *Building on Values*, p. xx).

Sincerely yours,

Kathleen Connors, RN
Chair
Canadian Health Coalition

