The Creeping Privatization of Health Care in New Brunswick

NB Health Coalition
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The Creeping Privatization of Health Care in New Brunswick and Recommendations to Strengthen Public Health Care

Report for the NB Health Coalition
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1. Introduction

Privatization is creeping in health care systems across Canada and the world and New Brunswick is no exception. As governments cut back on needed health care spending, they look to the private sector to carry out essential services despite public opposition and evidence of its failure to adequately provide health care for everyone.

New Brunswick made some gains in public health care access in recent years largely due to advocacy efforts of public sector unions, specifically those organized in the New Brunswick Health Coalition, and

citizen groups like TransAction NB and the New Brunswick Midwives Association. The government of New Brunswick began funding gender-confirming surgeries in 2016, catching up with all other provinces that already fund the service. The Gallant government also started funding midwifery services in 2016; four midwives are currently being funded in a pilot program (CBC, Feb. 19, 2016). Citizens in Caraquet successfully organized for several years to keep their hospital open. Recently, the Concerned Citizens of Charlotte County, a St. Stephen citizens group created to keep hospital services at the Charlotte County Hospital, and the New Brunswick Council of Hospital Unions (CUPE 1252), stopped Horizon Health Network from closing operating room facilities at their hospital. However, on September 24, 2016, Health Minister Victor Boudreau clarified that only surgeries using local anesthesia will be done at the hospital. Surgeries where a person is "put to sleep" will no longer be done in the hospital (Ross, 2016). Also recently, the government has expanded the role of nurse practitioners in the public health care system and has made investments in a Home First strategy and in health care workplace violence prevention initiatives, according to the NB Nurses Union.

Despite these gains, advocates of public health care have to remain constantly on guard to stop efforts to privatize health care services, which would erode the quality and access of these services. For example, the New Brunswick Health Coalition successfully lobbied the Graham government to stop several privatization plans in 2009. Mike Murphy, New Brunswick's Health Minister during the Graham government, wanted to bring in private diagnostic clinics including mammography, CAT scans and MRI. The government also proposed renting operating rooms to doctors for in-province or out-of-country patients (what some called health tourism) and making funding to hospitals performance-based, in other words, linked to the number of patients they were treating and the types of services they were providing.

When services become inadequate, the private sector often steps in to fill and profit from the need. Private MRI clinics have set up in the province in recent years. Premier Shuttle, a private company, is currently lobbying the New Brunswick government to change the Emergency Measures Act to allow it to transport non-life threatening patients between health care facilities in the province. The New Brunswick Council of Hospital Unions is worried about how the private shuttle could open the doors to privatization of ambulance services in the province. The unions are also concerned about the care of patients in such a vehicle; the shuttle does not have medical staff or equipment.

Dental care, eye care, mental health care and rehabilitation services such as physiotherapy and occupational therapy are examples of care delivered in private clinics with some services covered by Medicare and employer health insurance programs. These health services are not addressed in this report but should be further studied for ways to reduce further privatization of these services and for opportunities to enhance the accessibility and quality of these services to the public.

This report attempts to first argue why the dream of universal public health care for all is still relevant today, then it provides a scan of how privatization is affecting or could affect various health services in New Brunswick, with a focus on prevention-based primary health care, senior care, extra-mural care, prescription drug coverage, and blood plasma. The privatization of kitchen, cleaning and laundry in health care facilities is also examined. Consequences of privatizing health care for patients, health care workers, rural New Brunswickers, seniors, women and bilingual services are outlined in section 4. A

summary of recommendations aimed at enhancing public health care follow in section 5.

The research for this report for the New Brunswick Health Coalition was conducted from June to September 2016 and includes information and opinions gathered through interviews with researchers from unions representing workers in the health care system (CUPE, NB Nurses Unions and the NB Union of Public and Private Employees). Information was also gathered from media reports, and documents from the unions, NB Health Council, health coalitions in other provinces, Statistics Canada, health research institutes and peer-reviewed journals. Interestingly, information requests to the government for this report were delayed since a third party (Medavie EMS) was mentioned in the information requests. The government had to check with that party about releasing the information. The information received on privatization in health care in New Brunswick was redacted to a point that many sentences, paragraphs and some entire pages had not been made available for reading. The experience in attempting to gather information about health care privatization plans from the government for this report has demonstrated that public accountability and transparency is being compromised with the involvement of a third party with private interests.

2. A dream still in the making: free health care for all

Canada is known for its public health care system but the system is not without threats or challenges. Tommy Douglas, voted "The Greatest Canadian" in a 2004 Canada-wide survey of CBC viewers, is known as the father of medicare in Canada. Douglas was the first leader to introduce a single-payer, universal health care program in North America. Saskatchewan under Douglas' leadership was the first province to introduce medicare in 1962 (Brown and Taylor, 2012). The Canada Health Act, passed in 1984, effectively banned extra billing and user fees in Canada's health care system. A progressive health care system was created in Canada but more work needs to be done to ensure equal access (Silnicki, 2014).

Violations of the Canada Health Act are on the rise in the form of user fees, access charges and extra billing. The violations are affecting equitable access to health care (Meilli, 2016b; New Brunswick Nurses Union, 2014). Further concerning is a legal challenge currently in motion that threatens Canadian public health care. Dr. Brian Day, owner of the for-profit Cambie Surgery Centre in Vancouver, launched a constitutional challenge in 2009 that entered the courts in September 2016. The challenge aims to get rid of provincial health legislation that limits for-profit delivery of medically necessary services. The suit argues that the rules violate the Canadian Charter of Rights and Freedoms. While the case is being heard in British Columbia, the case will likely end up in the Supreme Court of Canada if it is appealed. Dr. Day's legal challenge threatens to implement a U.S.-style two-tier health care system that is not accessible to millions of Americans because of the involvement of private insurance companies and unaffordable fees on services (B.C. Health Coalition, 2016).

Canada has one of the world's best known national health insurance systems, where payments for health services are covered collectively through a progressive tax system. Canada has a single-payer system that prohibits insurance coverage for health care services provided by its national health program. Health care services in Canada are promoted as having no out-of-pocket premiums, co-

payments or deductibles like in the U.S. However, premiums and co-payments are found in some health care services, including New Brunswick's new prescription drug plan. Canada's health care system is also celebrated for having no competing private insurance or multiple tiers of care for different income groups, where practitioners and clinics pay predetermined fees for services and do not have complex billing procedures as in the case of the U.S. (Waitzkin and Hellander, 2016).

Sometimes advocates of private health care or politicians will use the private ownership that exists in the delivery of health care to argue for more privatization, saying it has always existed in the system. However, a more complete public ownership of health care in Canada is a dream that has yet to be fully realized, but must be, and any moves to privatize the essential service must be stopped while privatized services should be brought back into the public sector. Some countries such as Scotland, Sweden and Cuba have a national health service system where payments for health services are also publicly-financed like they are in national health insurance systems but health care infrastructure through which the services are delivered are also publicly-owned and most health professionals are state employees in national health service systems (Waitzkin and Hellander, 2016).

Health care in New Brunswick faces many challenges. The challenges include long wait times at the hospital's emergency rooms, a shortage of family doctors, an aging population and lack of access to certain health care services in certain parts of the province and for certain members of our population including migrant workers.

The NB Health Council's most recent report card gave the province an overall "C" grade in 2014. The areas where the arms-length government agency noted that the province is performing below-average include: Coverage of prescription drugs; wait times; screening tests; hospital readmission rates; and the use of emergency rooms and hospital beds for cases that could be treated in the community. Private health care will not solve any of these problems and will further exacerbate them, creating a system that delivers health care based on privilege.

Medical professionals, unions and health care advocates argue that privatizing New Brunswick's health care services violates the spirit of the Canada Health Act that requires every province to have a public health system that is administered and operated on a non-profit basis by a public authority. Adding a private company to the mix of public health care delivery means that health care is affected by profit motives and competition concerns of corporations.

As revealed in section three of this report, the private sector continues to try to gain access to health care and turn an essential service into a commodity. The moves are backed by politicians who promise to "fix a broken health care system" or to improve access to health care when really they are facilitating for-profit entries into the public health care system. Opponents of public health care include private insurance companies and their policy think tanks including the Atlantic Institute for Market Studies and the C.D. Howe Institute. Small business organizations and regressive taxpayer federations continue to oppose universal health care coverage. However, the experience of privatized health care elsewhere makes a strong case for further investment in public health care, including prevention-based primary health care.

The 2004 Canada Health Accord between the federal government and the provinces expired on March 31, 2014. The Harper Conservative government refused to renegotiate it. The Canadian Health Coalition estimates that Canadians will lose $36 billion in federal funds for health care over a 10 year period without an accord in place. New Brunswick will receive about $715 million less in federal funds for health care in the next ten years without a health accord. The Trudeau Liberals promised to renegotiate a new Health Accord and long-term funding agreement with the provinces and territories before getting elected in 2015 (Meili, 2016a). The Harper government announced a new funding formula that was not negotiated with the provinces in late 2011. The government committed to a 6 per cent annual increase in 2014 to 2016 and a minimum 3 per cent annual increase between 2017 and 2024. The Trudeau budget tabled in March increased transfer payments to the provinces by 2.8 per cent for 2017-18, below the 3 per cent minimum promised by the Harper Conservatives (Patterson, 2016). The Trudeau government is under pressure to reverse the Harper government's funding model, move to a per capita Canada Health Transfer model and implement a 6 per cent escalator for federal transfers to the provinces to reach a minimum goal of 25 per cent federal funding of provincial health care costs. The federal government currently funds 22 per cent of a province's public health care budget (Butler, 2016). As reported by the *Telegraph-Journal* on Sept. 30, 2016, in response to provinces, including New Brunswick, calling for a return to Canada annual Canada health transfers increases of 6 per cent, Federal Health Minister Jane Philpott told physicians gathered at the Canadian Medical Association meeting in August 2016 that more money will not solve health care problems (Huras, 2016). Minister Philpott said that the Trudeau government will only increase annual Canada health transfers by three per cent on the eve of a Premiers' meeting on Oct. 17, 2016 (Galloway and Grant, 2016).

Despite a mountain of evidence of how private health care fails to deliver health care, privatization is creeping in as described in the following section. However, there are strong arguments to fight for a public health care system. Doctors, nurses, medical professionals, health care workers and others with experience and knowledge of health care have proposals to make health care work better for all residents in New Brunswick, proposals that do not involve falling into the privatization trap.

3. Scan of health services and privatization schemes

Health care, an essential service, should be funded publicly and delivered publicly without the interference of profit-based corporations. However, health care became the target of cutbacks during the neoliberal era and a place for the private sector to make money (Whiteside, 2014: 162). Privatization of health care became a growing concern with the private sector ready to fill the gaps in services created by the cutting of funding. Privatization is a term used to refer to the transfer of work from the public sector to the private sector. Privatization usually follows cuts to public services and attempts to lower costs, especially labour costs. Sub-contracting or outsourcing is one form of privatization, whereby a private company is awarded a contract to perform work (Stinson, 2006). Public-private partnerships is one way that health care is currently being privatized in New Brunswick while Social Impact Bonds, an experiment in other places, is another method of privatization that New Brunswickers should monitor and oppose.

Public-Private Partnerships

Public-private partnerships (P3) are one of today's popular privatization schemes in health care. P3s have developed out of an ideological commitment to privatization in a time of austerity, when false choices are presented to the public. P3s, around since the early 1990s, are sold to the public as part of the austerity myth that tells the public that there is not enough money for health care and that P3s offer an innovative way of delivering public services. P3s threatened public health care as well as other public infrastructure and service provision and erode democratic control, transparency and accountability (CCPA, 2015; Whiteside, 2014: 170). Austerity and P3s are mutually reinforcing in their effect and intent: a public austerity discourse normalizes P3 development, and the higher cost but poorer value P3s create conditions, which justify more austerity (Whiteside, 2014: 171). There were about 200 P3s in Canada in 2012. A number of New Brunswick nursing homes operate as P3 facilities. P3s are promoted for having no upfront public spending attached to them but rarely do they result in reduced public sector costs because of more expensive private financing and the presence of the profit motive (Whiteside, 2014: 162).

Cost overruns at P3 health care facilities in Ontario and Quebec have been criticized by the province's auditor generals. At a rally against privatization of health care in Saint John's, NL in 2015, Yvette Hynes, Vice President of the Registered Nurses Union of NL, said, "Look no further than Ontario, where a report recently released by the auditor general shows $8 billion in higher costs due to the P3 privatization of Ontario's hospitals and public infrastructure. In the end it was the tax payers who ended up paying more" (Brake, 2015). Ontario's Auditor-General Jim McCarter noted in his 2008 report that when the Brampton Hospital was built, it was 129 beds short and $300 million over the original estimated cost (Silnicki, 2014). The McGill University Health Centre in Montreal was estimated in April 2016 to cost $1.5 billion but the cost increased by 50% to $2.2 billion in the next two years, according to Quebec's Auditor General. The Centre hospitalier de l'Universite de Montreal (CHUM) was projected to cost $1.4 billion in 2006 but had increased a whopping 81% to $2.5 billion just two years later (CUPE, 2011).

Social Impact Bonds

Social Impact Bonds (SIBs) provide another route to privatization that could affect health care. SIBs involve governments contracting out services to an intermediary group bond-issuing organization. The intermediary is responsible for raising capital from independent investors (banks, foundations, individuals) and for hiring and managing non-profit service providers. If the project achieves its objectives, the government repays the investors with returns based on the savings the government has accumulated. SIBs have been used in the U.S. and England. There has been interest in SIBs in Atlantic Canada, British Columbia, Alberta and Ontario. There are concerns that SIBs lead to privatization of essential services, lower wages and job cuts. SIBs are touted as risk-free and innovative ways of solving social problems. However, SIBs are loans from investors who want repayment at market rates. The bonds usually involve higher transaction costs due to professional fees of consultants, accountants, lawyers and evaluators who are involved in setting up and administering the contracts. Governments also provide tax breaks, grants, guarantees and other subsidies to the bond-issuing organization. The U.K. has spent more than $1 billion on tax breaks, grants, subsidies and

guarantees for SIBs. Private interests involved in SIBs still want to maximize returns. SIBs are also evaluated in terms of performance and not in terms of interest to the public good (New Brunswick Union, n.d.).

The following section will examine different types of health care services (prevention-based primary care, senior care, extra-mural care, prescription drug coverage, blood plasma, cleaning, food and laundry services) and describe a picture of that care or service in New Brunswick, including its status and the threats or level of privatization in each of those services. Each section concludes with a list of recommendations by the NB Health Coalition that call on the New Brunswick and Canadian governments to both stop privatization of that health care service and strengthen public investments that will enhance the services.

3.1. Prevention-based primary health care system

The NB Health Council recommended in their 2014 report card that a concerted strategy be developed to improve health promotion and disease prevention in the province: "This strategy should consider the determinants of health, and focus first on four key areas: achieving healthy weights, lowering high blood pressure rates, improving mental health and preventing injuries." The government of New Brunswick has done some community health needs assessments and have begun assembling family health teams. However, a more comprehensive approach to prevention-based primary health care is needed. Building a prevention-based primary health care system will reduce emergency room visits, stays in hospitals and chronic diseases, which are costly to treat (NB Health Council's 2015 Primary Health Survey). Prevention-based primary health care is a cost-saving way of delivering health care, but more importantly it is a more humane way of delivering health care. As agencies divert resources to those who are most ill and vulnerable, lower-needs patients also suffer, many of them becoming sicker.

The New Brunswick government must allocate adequate resources to developing a comprehensive public prevention-based primary health care system. A network of community health clinics is an essential piece of a primary health care system. These clinics have a sound knowledge of their patients and community; use clinical guidelines and provide evidence-based care; use and share information through electronic medical records; and have effective patient flow processes. Community primary health clinics will require collaborative care teams that offer integrated services. Teams should include not only physicians, nurses, nurse practitioners, but a variety of other workers such as dieticians, mental health workers, occupational and physiotherapists and social workers.

The NB Health Coalition recommends:

1. The New Brunswick government develop a comprehensive public prevention-based primary health care system;

2. The New Brunswick government invest in community primary health clinics to expand services and ensure integrated services.

3.2. Senior care

Seniors require different levels of care, including nursing homes and home support services. Emergency rooms and beds at New Brunswick's hospitals are occupied with seniors, many who are not acutely ill but have chronic illnesses and are forced to go to hospitals for health care. John McGarry, CEO of Horizon Health Network, said in an interview to CBC in November 20, 2015, that 25 per cent of hospital beds are alternative level care, the term for seniors who need a spot in a nursing home or health care support other than hospital care.

Nursing homes

Long-term care facilities or nursing homes is just one type of service that seniors access. The 4,500 nursing home beds in New Brunswick (Patriquin, 2016) is not sufficient. Across the province, there are 62 nursing homes, which are owned and operated by the non-profit sector and three that are owned and operated by the private sector through Shannex. The private sector will be involved more deeply in this kind of care because the Gallant government has announced that all new nursing homes will be Public-Private Partnerships (P3s). In Miramichi, the government closed two nursing homes; the Mount St. Joseph and the Miramichi Seniors Citizens Nursing home and built a new one through a Public Private Partnership, adding a total of 15 new beds. The facility drew criticism when it was revealed that it would be a P3 facility and when it was not clear whether workers would lose their jobs or have to reapply for jobs that paid less than their previous jobs at the old nursing homes. CUPE Locals 1256 and 1277, who represent the workers at the new nursing home, while not happy that the new nursing home will be a P3 model celebrated a provision in the Request For Proposals that stipulated that all current workers be transferred to the new home, maintaining their seniority, benefits, wages, pensions and collective agreement (New Brunswick Council of Nursing Home Unions/CUPE, 2016). The New Brunswick Nurses Union also negotiated a guarantee of its members' collective agreement rights for the change over to the new homes as well, but still remains opposed to the construction of P3s.

Numerous auditor general reports throughout Canada, including New Brunswick's have criticized P3s. These reports mention how profit affects services and lead to frequent cost overruns and compromised transparency and quality of care (CCPA, 2015). A report by New Brunswick's Auditor General argues that comprehensive long-term plan is needed to care for our aging population and must include a multi-faceted solution involving nursing homes, other long-term care facilities, extra-mural care, family support and other options. The 2016 Auditor General's Report revealed that nursing homes are operating at 98% capacity and that demand is growing at a concerning rate (CUPE, 2016). New Brunswick had the second highest median age in Canada at 43.9 years old in 2013. The province's median age is expected to reach between 49.1 and 51.1 years in 2038 (Bohnert et al., 2015). The average age of residents in Campbellton–Miramichi, approximately a third of the province, is 49.4, making it the second-highest amongst Atlantic Canada's 15 economic regions, according to Statistics Canada (Patriquin, 2016). The proportion of New Brunswick's population aged 65 years and older will go from 17.6% in 2013 to 30.9%-32.6% by 2038 (Bohnert et al., 2015).

Besides controversial P3s, the New Brunswick government announced in the March 2015 budget that

it would look at the income of seniors when calculating how much they pay for long-term care. The government proposed charging seniors up to $175 per day for stay in nursing homes, up from a cap of $113. New Brunswick's maximum daily nursing home rate of $113 is already the highest in Canada (CBC, 2015). A provincial campaign spearheaded by the Coalition for Seniors and Nursing Home Residents' Rights forced it to back down.

Another major concern of people living in nursing homes and the workers who care for them is the food they eat. The New Brunswick Association of Nursing Homes, representing all 65 nursing homes in the province, expressed concerns over nutrition and care of its residents in early 2016. The association said the 2 per cent reduction in food funding at a time when the price of food is continually rising and an increase in the number of unregulated care staff will adversely affect patients in long-term care facilities (CBC, March 2, 2016). Seniors may live out their lives only eating frozen foods and not a fresh vegetable in a nursing home. Food shortages have also been experienced in health facilities in Vancouver, British Columbia that are managed by Sodexo in 2016. Accusations of elder abuse in that region are being registered with reports of nursing home residents being given "Boost," a high protein drink, as a meal replacement when there was a food shortage (Dobbin, 2016).

Senior care facilities and home support services

Besides nursing homes, seniors in the province have access to two other types of care provided either by the private sector or the non-profit sector. Seniors who do not need care or very little care can receive what is called assisted living or Level 1 and 2. They have access to facilities that are owned and operated by the private sector, such as the Shannex facilities that are in Fredericton, Saint John, Miramichi and Moncton. Many small businesses throughout the province provide services to seniors in their homes such as meals, light housekeeping, laundry, companionship, errands and personal shopping. These services are mainly provided by private companies such as Co-Aid, Shannex, Integrity Home Health Services or non-profits such as Red Cross and Centre de bénévolat de la Péninsule acadienne. There are approximately 56 home support agencies in New Brunswick, serving 8,500 clients.

The New Brunswick announced a three-year Home First strategy in 2014 aimed at helping seniors in New Brunswick remain in their homes and communities for as long as possible. The strategy tries to keep hospital admissions, lengthy hospital stays, and transfers directly from hospital to long-term care facilities as last resort options. Instead of following the path of Ontario into a complex and costly patchwork of increased private home care services, New Brunswick should continue to expand the Home First Strategy within the public sphere.

There are 17 adult day centres operating in New Brunswick. The provincial government announced in 2015 that it would add 100 new respite spaces in day centres across the province. The day centres provide respite for caregivers, meaningful activity outside of the home for persons with dementia and cognitive impairment, and rehabilitation or maintenance of levels of functioning. A new adult day centre for individuals with dementia opened in Fredericton with support from the Home First Strategy in 2015. According to Cathy Rogers, New Brunswick's Minister of Social Development in 2015: "Research has shown that when family caregivers are provided with appropriate support, they are

able to keep their family member with dementia at home an average 557 days longer than caregivers who did not receive support" (Social Development, 2015).

A 2015 poll done for the Canadian Alliance for Long Term Care, a body representing long term care providers that deliver publicly-funded health care services, confirms that a majority of Canadians want the federal government to take action to help ensure that seniors have access to long-term care. Specifically, 92 % of respondents believe the federal government should ensure that long-term care homes are prepared for the rising number of seniors with dementia and 85% of Canadians surveyed believe the federal government should lead the development of a comprehensive national dementia strategy.

The absence of a centralized structure for long-term care results in higher costs for both users and the government, services that are not comprehensive and a lower quality standard of care. CUPE New Brunswick, representing workers in the long-term care facilities, argues that the government should organize a provincial public system that would offer quality services, pay employees fairly and prevent the draining of seniors' savings (CUPE, 2016). "I see hospitals, nursing homes and home care as the Health Care Triangle: all three corners have to be public and work in tandem," argues Daniel Légère, president of CUPE NB.

The NB Health Coalition recommends:

1. The New Brunswick government invest in public long-term care facilities and abandon the P3 model in long-term care facilities;

2. The New Brunswick government support the different care needs of seniors, including dementia care;

3. The New Brunswick government increase funding for healthy food for seniors living in nursing homes;

4. The New Brunswick government better coordinate the different care offered to seniors, including hospitals, long-term care facilities and home care;

5. The New Brunswick government invest in accelerating the implementation of the Home First Strategy, recognizing that many seniors prefer to stay in their own homes.

3.3. Extra-mural care

New Brunswick's extra-mural program provides home health services to New Brunswickers of all ages in their homes and communities. The program was set up to be an alternative to hospital admissions, to promote early hospital discharges and to provide seniors with an alternative to or delay in entering nursing homes. The services are publicly funded and delivered through the regional health authorities. Extra-mural workers include 450 nurses, physiotherapists, occupational therapists, respiratory

therapists, dietitians and others who provide difference services. The workers also provide health education, chronic disease self-care, post-surgery care, stroke recovery, medication management, dementia/Alzheimer's disease support, among other services. Since the extra-mural care program allows patients to stay out of hospital or long-term care facilities longer, the catching of life-threatening infections is prevented and physical and psychological declines is slowed down (Ferguson, 1987; Grant and Church, 2015).

The New Brunswick government announced in February 2016 that they had signed a Memorandum of Understanding with Medavie EMS to explore combining extra-mural services with services that it already manages, Ambulance New Brunswick and Tele-Care 811 (Huddle, 2016). Medavie EMS, a private non-profit company and subsidiary of Medavie Inc., a large organization with operations across Canada and beyond, does not have the same accountability as government does to the public. The profits it generates are not re-invested in the public good and do not stay within the province, the same way that a public corporation must invest their returns back into public coffers. The returns are instead held in trust, unused or only used to serve the interests of Medavie EMS.

The NB Health Coalition recommends:

1. The New Brunswick government invest more in extra-mural care, day programs, assisted-living spaces and respite care to keep the elderly, including those with dementia, out of more expensive hospital care that does not serve their needs and may actually make them sicker and shorten their lives;

2. The New Brunswick government does not sign an agreement with Medavie EMS to take over the extra-mural and Telecare programs.

3.4. Prescription drug coverage

Canada is the only developed country with a universal health care system that does not include universal prescription drug benefits. One in five Canadians struggle to fill prescriptions due to cost, while pharmaceuticals are some of the world's most profitable corporations (Butler, 2016). Provinces provide some publicly-funded drug insurance for certain members of the population such as seniors and people living on social assistance. Many Canadians pay for prescription drugs out-of-pocket or through private or workplace insurance. According to the Canadian Institute for Health Information, 34.3% of private expenditures on prescription medications in 2010 was paid for out-of-pocket (Hennessy et al., June 2016).

Around 20 per cent of New Brunswickers lacked drug coverage before New Brunswick's Drug Plan was established in 2014 (Owens, 2014). Some uninsured New Brunswickers pay thousands of dollars every year for medications (Poitras, 2013). Canadian households spent an average $476 on prescription medications in 2011. Households with heads older than 55 years old spent more, an average annual rate over $600. Out-of-pocket expenditures related to medications and health care has increased over

time, especially for households with the lowest incomes (Hennessy et al., 2016). An estimated 10 per cent of Canadians report that they do not take their prescribed medications because of costs. Another report estimates that one in five Canadians cannot afford their medications (Hennessy et al., 2016: Romanov and Marchildon, 2015). When those with illnesses do not take their prescribed medication, they end up in hospital emergency rooms, costing the health care system that way. Mortality rates are also higher for those who do not take their prescribed medication (Hennessy et al., 2016).

The New Brunswick Drug Plan, instituted on May 1, 2014, is intended to provide coverage for prescription drugs that are on the New Brunswick Drug Plan formulary for uninsured New Brunswickers. The plan benefits New Brunswick residents who have a Medicare Card, do not have existing drug coverage or have existing drug plan but do not have coverage for a specific drug or have reached their yearly or lifetime maximum for drug coverage. The plan benefits those who wish to retire but cannot afford to lose the drug coverage provided by their employer (The New Brunswick Drug Plan).

The New Brunswick Gallant government dropped the previous government's mandatory requirement in late 2014, making the drug plan voluntary, and they also lowered premiums. Premiums were lowered to $200 for those making less than $17,884/year and for those with children or a couple with or without children making less than $33,519/year, down from the minimum $800 premium established by the previous Alward government (CBC, December 9, 2014).

The plan’s costs was to be covered by plan members, government and employers who did not have a workplace drug plan. The business lobby, spearheaded by the Canadian Federation of Independent Businesses, forced the government to back down, so now the plan’s costs are covered by plan members through yearly premiums and co-payments they pay at the pharmacy and also by government. The plan's premiums are based on income. Members will have to pay a 30 per cent co-payment for drugs, to a maximum of $30 per prescription. Program premiums and drug co-payments can be claimed as eligible taxable medical expenses (The New Brunswick Drug Plan).

The New Brunswick Drug Plan covers drugs listed on the New Brunswick Drug Plan formulary, a list of more than 5,000 drug products including many high cost drugs such as Soliris and Remicade. Drugs will continue to be added to the formulary. Drugs authorized for sale and use by Health Canada that are not listed on the formulary may be requested. The New Brunswick Drug Plan covers prescription drugs only. Vaccines, medical devices, supplies and equipment (e.g. diabetic supplies, ostomy supplies, oxygen, etc.) are not covered by the New Brunswick Drug Plan. The plan will consider requests for reimbursement of brand name drugs in the case of a reaction (e.g. anaphylaxis, edema, respiratory distress, serum sickness) to a non-medicinal ingredient contained in a generic product (The New Brunswick Drug Plan).

The New Brunswick Medical Society, Canadian Cancer Society in New Brunswick and the New Brunswick Diabetes Association have also spoken in favour of the new plan. Anne McTiernan, CEO of the Canadian Cancer Society in New Brunswick, said: "It will address both the financial barriers for people accessing drugs, whether it's cancer or a mixture of chronic diseases, for both people of low income and for people facing catastrophic costs" (Poitras, 2013).

The government claims that the plan will assist in ensuring continuity of care from the hospital to outpatient and community settings; reduce visits to hospital emergency rooms, reduce the frequency and duration of hospitalizations; improve patient outcomes and quality of life; remove financial barriers to drug coverage for people moving from social assistance to employment; and prevent residents from falling into poverty due to high drug costs (The New Brunswick Drug Plan).

New Brunswick's drug plan, which contains elements of a catastrophic drug plan, is different than other catastrophic drug plans in other provinces. All models of catastrophic drug coverage found across the country involve high deductibles, amounts of money that patients must pay upfront to access prescription drugs they need before they are reimbursed through the public system. The deductibles are set at a percentage of household income, ranging from 3 per cent of income in some provinces to an astounding 10% in others. Drug plans with high deductibles do not provide access to necessary medicines. Only patients with extreme needs for medications receive coverage under catastrophic drug programs and those who do qualify often must wait until the prescriptions are filled and paid for before the system assists them. Research has shown that many patients choose not to fill their prescriptions because of cost. The New Brunswick Drug Plan provides coverage without deductibles. However, the New Brunswick Drug Plan collects premiums. In comparison to health care funded by taxpayers, "premium financed drug benefits will essentially be a hand-out to the rich because the premiums force lower income people to pay a much higher share of income toward the system" (Morgan, 2013).

The Gallant government wants to reduce the numbers of provincial drug plans from over a dozen to one or two. Commenting on the consolidation of New Brunswick's drug plans, Health Minister Victor Boudreau said: “Some of them have different maximums, they may have different co-pays, they may have different premiums, some there are no premiums, some there are premiums based on income... there are going to be winners and losers because we are going to have to make some adjustments, which means some people are going to be affected either positively or negatively... It’s virtually impossible for that not to happen if you’re trying to bring 14 plans into one” (Huras, 2015).

The New Brunswick Drug Plan is an improvement to the previous system that left approximately 70,000 New Brunswick families with no drug coverage at all (New Brunswick Nurses Union). However, measures must be taken to improve access to prescription medication, specifically, a national universal pharmacare program must be implemented. Using CIHI data professor Steve Morgan has estimated that a national pharmacare program could save New Brunswick roughly $180 million/year (Mackenzie, 2016).

Canadians pay more for their drugs as a result of fragmented drug plans and the lack of a national formulary that ensures equitable drug coverage across Canada. Canada has the second highest prescription drug costs of all OECD countries. Private coverage through employment plans leave many people without coverage, including minimum wage earners and temporary or seasonal workers. Many Canadians with private or public coverage still cannot afford the co-payments and deductibles associated with their prescription medication costs (Romanov and Marchildon, 2015).

According to the Council of Canadians, 91% of Canadians want a national pharmacare program. The organization also supports the creation of a publicly funded national drug approval agency to ensure the safety, monitoring and quality of prescription drugs. The federal and provincial governments must negotiate a pharmacare plan and protect health care and pharmaceutical policies from international trade agreements. Investor agreements currently on the table, such as the Comprehensive Economic Trade Agreement (CETA) between Canada and the European Union, and the Trans-Pacific Partnership (TPP) between Pacific Rim countries including Canada, increase drug prices and make governments vulnerable to expensive lawsuits from big pharmaceutical companies when they feel their profits are threatened by any government regulation or oversight.

The NB Health Coalition recommends:

1. The New Brunswick Drug Plan be expanded to include more drugs and medical equipment and that employers who do not have a workplace drug plan contribute their fair share to this plan;

2. The New Brunswick government administer the drug plan;

3. The New Brunswick government works with the other provinces to convince the Canadian government to develop a national universal pharmacare program;

4. The Canadian government protect health care including drug coverage from international trade agreements.

3.5. Blood Plasma

Over 30,000 Canadians were infected with HIV and Hepatitis C through blood transfusions in the 1980s and early 1990s. A Royal Commission Inquiry chaired by Justice Horace Krever on the blood scandal recommended the creation of a new blood agency and stricter regulations. Justice Krever's report said that the Canadian blood supply should be governed by five basic principles: blood is a public resource, donors should not be paid, sufficient blood should be collected to preclude imports from other countries, access to blood and blood products should be free and universal, and safety of the blood supply system is paramount. The Krever report also recommended whole blood, plasma and platelets be collected in quantities that meet domestic needs. The World Health Organization and other international health agencies agree that blood and plasma donations should be done on a voluntary global basis by 2020. Canada created and authorized a new arm's length agency, Canadian Blood Services, to implement Justice Horace Krever's recommendations (Canadian Health Coalition, 2016).

While it is illegal to sell blood in Canada, only Quebec and Ontario forbid the sale of blood plasma, the part of the blood that transports nutrients, hormones and proteins to parts of the body that need it. The plasma protein products are used by people with immune weaknesses, such as hemophiliacs, cancer patients and burn patients.

New Brunswick is set to become the next location of a private blood plasma company. Canadian Plasma Resources, a private company that operates in Saskatchewan, wants to open a plasma clinic in Moncton in 2017. The clinic would pay blood plasma donors with a $25 VISA gift card for each donation. The New Brunswick government supports the company and has offered payroll rebates to set up a $40 million clinic with 40 professionals.

The New Brunswick government is currently arguing that 70 per cent of the blood plasma products used in Canada come from international markets, mostly from the U.S. and 70% of those people have been paid. Canadian Blood Services currently collects plasma from voluntary donors and provides the product to American pharmaceutical companies that then sell the drugs back to Canada at a discount. Canadian Blood Services agency plans to double or triple the amount of plasma it collects to meet demand (Chilibeck, 2016). Studies have shown that people no longer voluntarily donate their plasma once payment for plasma starts and competition between voluntary non-profit blood agencies and for-profit companies that paid donors led to a shortage in blood supply in Austria and Germany in 2006 and 2007 (Canadian Health Coalition, 2016).

Selling blood to the U.S. is further worrisome because of free trade agreements like NAFTA that could stop Canada from storing its plasma for domestic use since it may force its continued sale to the U.S. Canada may not be able to safeguard its own supply in the event of a plasma shortage or crisis (Canadian Health Coalition, 2016).

Canada currently has enough plasma for fresh transfusions but not enough for medicines. Canadian Blood Services have closed several voluntary plasma collection centres because they say they were over-collecting. Closed facilities should be reopened and new ones opened to meet demand. There are too few blood plasma collection centres in Canada; two in Alberta and one each in New Brunswick (Saint John), Nova Scotia, Newfoundland and Labrador and Ontario.

The Canada Food and Drug Act obligates the Minister of Health to regulate and protect Canada's blood and plasma supply. Health Canada should not grant a license to clinics that pay donors for blood or plasma.

The NB Health Coalition recommends:

1. The Canadian government deny a license to Canadian Plasma Resources and other companies that propose to pay donors for blood, plasma or other blood product;

2. The New Brunswick government ban payment for plasma, recognizing that payment impacts the safety of plasma products;

3. The New Brunswick and Canadian government work with Canadian Blood Services to develop a strategy to increase unpaid plasma clinics in Canada and move toward self-sufficiency in plasma supply.

3.6. Laundry, cleaning and kitchen services

The New Brunswick government announced intentions to centralize laundry services and privatize the management of cleaning and food services in New Brunswick hospitals in 2013 (Bishop, 2016; CUPE 1252, 2015). Privatizing such services is linked to dirty hospitals, a rise in hospital-acquired infections and poor quality food, which endanger the health and well-being of patients, according to CUPE 1252 that represents over 10,000 workers in the environmental and food services in hospitals (CUPE 1252, 2015).

Laundry services in New Brunswick were managed internally by FalcicorpNB. On Oct. 1, 2015, FacilicorpNB was merged into the new Service New Brunswick corporation along with the Department of Government Services, the New Brunswick Internal Services Agency and Service New Brunswick. Laundry services were centralized to two main sites, Fundy Linen in Saint John and an upgraded laundry facility at the Campbellton Regional Hospital. Georges L. Dumont Hospital in Moncton closed its laundry department in April 2016. Laundry from this hospital now goes to Fundy Linen. The province also announced $250,000 for the creation of a linen depot in Moncton, which will offer linen distribution and a 48-hour emergency linen supply in case there is a problem with laundry delivery from Fundy Linen. The facility plans to open in early 2017 and will be in a public facility with a workforce unionized through CUPE. CUPE 1252 workers are concerned about the spreading of infectious disease and the environmental impact associated with transporting laundry across the province.

In terms of the management of cleaning and food services in all the province's hospitals, the New Brunswick government was known to be in talks with Sodexo but has yet to sign a contract with Sodexo or another company. The Bathurst Chaleur Regional Hospital did have Aramark providing kitchen services but the services were brought back inside the hospital last year when Vitalité did not renew their contract. Through a transfer agreement, former Aramark workers remained in their union when they became hospital employees (Norma Robinson, personal communication, August 17, 2016).

The New Brunswick government has recently looked to British Columbia for advice on how to privatize public services. Perhaps one of the most devastating examples of privatization in the history of health care in Canada took place in British Columbia in 2002. Previously, as a result of numerous complaints of poor food quality, administrative waste, inadequate coordination and oversight, and low staff morale, food services at the province's hospitals were brought back in house to be managed by the hospitals. However, in 2002, the B.C. government passed Bill 29, allowing health authorities to override existing union contracts and contract out services such as food and cleaning services. Cleaning services in fourteen hospitals were outsourced to Sodexo. Aramark and Compass Group also got hospital cleaning contracts in the province. Sodexo layed off workers then rehired them with wages that were almost half of their previous wage, $10.15 an hour. Three-quarters of its workforce fell under the poverty line while 8,500 jobs were cut. The hospital workers described their workplace as a sweatshop (CUPE 1252, 2015). Within a year of the privatization in B.C.'s hospitals, there were media reports of dirty hospitals and the spread of bacteria, such as C. difficile, that tragically led to patient deaths (CUPE 1252, 2015).

The experience of contracting out food services in health care facilities in jurisdictions such as British Columbia, Ontario, Québec, the United Kingdom and various American states over the past twenty years shows that the corporations reduce their costs by reducing wages and hours of work through layoffs as well as making cuts to supplies and food ingredients. Patients are often forced to eat high-sugar, high-fat and highly processed foods. The privatization of the management of food services in British Columbia involved frozen food being shipped to hospitals where it was reheated and served. Low quality food may save money but it impacts the health of patients. A 2010 study by the Québec research institute, IRIS, called "New CHUM/CUSM: By Outsourcing Food Source?" showed the tendency of Canadian patients to eat less and lose weight in hospitals where food services were contracted out due to the poor quality of food. Low quality food does not always represent cost savings and may result in higher costs. In 1995, food costs went up 30.5% at La Providence Hospital in Magog, Québec. When the hospital ended the contract with Sodexo, costs fell by nearly 15% over five years. At the Montreal General Hospital, since food preparation was taken over by Sodexo, costs have increased steadily (CUPE 1252, 2015).

The New Brunswick government should abandon “rethermalized” food where frozen commercial meals are reheated in the hospital before serving. A significant number of health care facilities in the province serve rethermalized food, including the Saint John Regional Hospital, the Upper Valley Hospital in Hartland and the Perth-Andover Hospital. Some hospitals and long-term care facilities such as the Edmundston hospital have kitchen facilities that prepare fresh food in-house. Food cooked on-site is more appetizing, safer and more nourishing than rethermalized food. On-site food preparation also supports local food producers, which is as good for the local economy (CUPE 1252, 2015). According to Norma Robinson, President of the New Brunswick Council of Hospital Unions, there are no cost savings associated with rethermalized food as patients often do not eat the food and it ends up in landfills. She feels that rethermalized food is not much more nutritious than a TV dinner.

Vitalité Health Network recommended to the provincial government in June 2016 that food and cleaning services be looked after by the network and not a private sector company following proposals submitted by both groups. Vitalité estimates that it can save $3.4 million over a 10 year period if the services are kept in house. According to Vitalité's plan, six cafeterias would be closed and the network would explore different ways to bring food to patients. For hospital staff and visitors, other healthy options will be offered in vending machines (Bishop, 2016).

The three multinational companies, which dominate services in institutions such as hospitals, schools and prisons worldwide, Sodexo, Aramark and Compass Group, are linked to costly hospital-acquired infections, public relations scandals and lawsuits. Contracts with these multinationals also require costly extensive monitoring to ensure compliance (CUPE 1252, 2015).

According to the New Brunswick Health Council, which produces an annual New Brunswick Health Report Card, New Brunswick hospitals have maintained a low incidence of hospital-acquired infections such as C. difficile and Methicillin-resistant Staphylococcus aureus (MRSA) compared to other places in Canada. Cleaning protocols, such as those for disinfecting high-touch areas, depend on adequate staffing, training and cleaning supplies. Privatization would compromise patient safety by reducing cleaning staff and staff hours (CUPE 1252, 2015).

The NB Health Coalition recommends:

1. The New Brunswick government keep laundry services and the management of hospital cleaning and food services in-house and public;

2. The New Brunswick government adequately fund food for patients and long-term care residents and abandon "rethermalized" food and prepare fresh food in the facility's kitchens.

4. Consequences of health care privatization

The following section briefly describes consequences of privatization of health care for patients, health care workers, rural New Brunswickers, women, seniors and bilingual services.

4.1. Privatization and patients

Privatization of health care services affects patients in various ways, including

Privatization in health care is often accompanied by a cut in staff and resources in ways that lead to poorer health outcomes for patients and higher death rates (Barnes and Roche, 2015; Devereaux et al., 2002; McGregor et al., 2005, 2006; Rachlis, 2007). For example, an Ontario-based study in 2007 found that patients in private colonoscopy clinics were three times more likely to have an incomplete colonoscopy than those at an academic hospital (Silnicki, 2014). Studies of hospital care in Canada at the turn of the millennium demonstrate a 2 per cent higher adult death rate and a 10 per cent higher newborn mortality rate in for-profit facilities than in non-profit facilities (Devereaux et al., 2002).

When fees are introduced in health care, barriers are put in place for citizens who do not have the financial means to pay for the services so access to these services are denied to them. Experience with private health care elsewhere shows unequal access to care, where the least privileged in society suffer the most difficulties accessing services. Those who can afford to pay for health care are able to gain easy and quick access to health care while those who cannot afford to pay are forced to wait as they get sicker. Many succumbed to illnesses prematurely, their lives abbreviated needlessly, because timely, quality health care was not provided to them (Canadian Health Services Research Foundation, 2001; Dhalla, 2007; Duckett, 2005; Rachlis, 2007).

Politicians often peddle the idea that the private sector could shorten wait times for health services. However, the introduction of private health services has actually not reduced waiting times in the public sector, according to studies done in other countries. When privatization was allowed to creep into public health care in Britain, Australia and New Zealand, wait times actually increased (Duckett, 2005; Silnicki, 2014; Tuohy et al., 2004). The 2008 report by the Ontario Health Coalition, "Eroding Public Medicare: Lessons and Consequences of For-Profit Health Care Across Canada," found wait times to be longest where privatization was most advanced because financial and human resources

had been moved from the public sector to the private sector. Private providers also avoid complicated cases and prefer well-insured patients in good overall health. When complications happen, patients are moved to the public system, which is forced to absorb the difficult cases and expensive procedures. Conservative think tanks like the Fraser Institute reference models from European countries as the solution to wait times. However, European models actually have a higher degree of public health care in its system, usually 80% provided publicly and 20% delivered privately while in Canada, the split is 70% percent is public and 30% is private (Silnicki, 2014). Private advocates of health care argue that a two-tiered health care system would remove the richest Canadians from public health care wait lists and allow them to pay for their services in a private clinic. However, by doing so, health care providers are also removed from the public health care system, creating a shortage of health care professionals and longer wait lists for those who cannot afford to pay for health care (Silnicki, 2014). Solutions to long wait times lie in a more robust public health care system that provides adequate acute care beds, community health centres and strategies for treating those with dementia.

4.2. Privatization and health care workers

A health care system concerned first and foremost with profit seeks to reduce costs, including labour and supply costs. Quality health care for all is not the primary concern. Jane Stinson et al. (2005) summarized the motives and impacts of private health care sector:

> From a business perspective, high returns on investment in the service sector are predicated on low labour and supply costs. From a health care perspective, good quality services are predicated on well-trained and well-supported staff. Corporations are accountable to their shareholders, not to workers, patients, and local communities. The entrenched insecurity that workers experience is not an unintended by-product of privatization, but rather is directly tied to corporate goals of labour flexibility and low costs, in pursuit of the bottom line.

When work is contracted out, wages paid to health care workers can be slashed, sometimes by more than 40 per cent. “It is almost impossible for a housekeeping aide or dietary worker in a privatized health support job in British Columbia to achieve earnings above Canada’s Low-Income Cut-Off (LICO) standard, unless they are a full-time employee with no dependents,” stated the authors of a 2005 report, "The Pains of Privatization: How contracting out hurts health support workers, their families, and health care" (Tseghay, 2016).

British Columbia subcontracted out much of its health care services from 2003 to 2004. Approximately 8,500 cleaners, food service, laundry and security workers at hospitals and long-term care facilities in the province lost their jobs with the outsourcing done between October 2003 and July 2004 (Stinson, 2006). Newly privatized jobs in B.C.'s hospitals and nursing homes are criticized for its low pay, poor benefits, heavy workloads, inadequate training and lack of job security (Stinson et al., 2005). When cleaning positions in B.C.'s health care sector were outsourced, pay rates for the newly privatized workers, many of them immigrant women of colour, fell to 26 percent below the national average union wage for hospital cleaners and to levels that threw the workers into poverty (Barnes and Roche,

2015). Many workers in cleaning and food services in B.C.'s hospitals are women, women with children and immigrants who support family members abroad. Contracting out health care services endangers the well-being of workers and the patients they serve (Stinson et al., 2005). Privatization of health care reinforces poverty for immigrant workers, who tend to be employed in more precarious work and to have fewer options for work. "Fewer workplace rights, exploitative, exhausting work and low pay create conditions for the social exclusion of these workers, reinforcing sexual and racial divisions in society," noted Stinson (2006).

Health care workers are being forced to turn to social programs and services such as public housing and food banks to survive when their work is outsourced, which cost the public system more. Health care workers with low wages also pay less in income taxes, which means less funds for social services such as health care.

Plans to privatize sectors of health care have labour unions worried that successor rights will not be automatically guaranteed. Unions are demanding that a binding commitment be made to protect the collective bargaining rights of workers. Beyond how privatization affects their members directly in the workplace, unions continue to demand that health care remain a public service and accessible to all as documented in this report.

4.3. Privatization and rural New Brunswick

About half of New Brunswick's population lives in rural areas, according to Statistics Canada (Patriquin, 2016). P3 contracts and austerity measures disproportionately affect rural communities by cutting back on good-paying public sector jobs that help stimulate rural economies. Closing hospitals and other public services cuts permanent jobs and reduces salaries; all actions that harm rural communities, often forcing rural residents to move to urban areas.

Rural communities in New Brunswick are constantly fighting to defend their health care services from the province's chopping block. The New Brunswick Council of Hospital Unions applauds the recent successful efforts of the Concerned Citizens of Charlotte County, a St-Stephen citizens group created to protect hospital services in the region. On August 1, 2016, Premier Brian Gallant announced he would encourage Horizon Health Network to keep operating room facilities open at the Charlotte County Hospital. "Rural New Brunswick has already been hit hard by the last rounds of cuts. I think this government got the message: citizens will mobilize to fight to keep their right to public services," said CUPE Local 1252 president Norma Robinson. The Charlotte County community group collaborated with the Health Care Coalition and labour groups to mobilize local citizens. More than 500 people attended a rally in July 2016 against closing the surgical program in St. Stephen. "Every citizen has the right to the same quality of healthcare services in this province," said Robinson (CUPE 1252, August 2016).

4.4. Privatization and seniors

Health care privatization threatens to make health care more expensive and out of reach for New Brunswick's seniors, many of whom live in poverty. About 50% of women retirees and 40% of men retirees in New Brunswick received the Guaranteed Income Supplement in 2011 (Government of New Brunswick Women's Issues Branch, 2012). These seniors, if they are single, receive a maximum amount of $551.54 monthly from the Old Age Pension Plan and a maximum of $747.86 monthly from the Guaranteed Income Supplement Program, for a maximum total of $1,299.40 per month or $15,592.80 annually, which is below the poverty line (Service Canada, 2014).

The vast majority of home care services in the province are in private hands. Many seniors either have to pay out of their pocket for care or they receive subsidies from the provincial government. One of the problems in having home care service in private hands is that it does not ensure equitable distribution of quality services across the province. Another problem associated with private home care delivery is the high turnover of workers because the workers are paid low wages and have no benefits. Sometimes seniors can have two or three different workers coming to their home in the same month, which can be disturbing for them.

New Brunswick's Home First strategy is a positive step in the right direction that aims to improve access to health care to seniors in New Brunswick. However, moves to privatize long-term care facilities and extra-mural services threaten to degrade these services or make them inaccessible for many of the province's seniors. A universal pharmacare program would also benefit seniors on medication.

4.5. Privatization and women

"Privatization is not gender-neutral. It threatens advances toward women's equality in the labour market and in the home," noted Jane Stinson (2006). Privatization also refers to the transfer of work from being public and paid to the private household where work is still mainly done by women and unpaid. Women still do more of the private household care, including the care of children, the sick and elderly in their households. Meanwhile, privatization for women workers in the health care sector usually means lower wages, fewer workplace rights, reduced health and welfare benefits, no pension coverage, less predictable work hours, more precarious employment, a heavier workload and more exploitative working conditions (Stinson, 2006).

When jobs were contracted out in the British Columbia's hospitals from 2003 to 2004, women workers went from being the highest-paid hospital cleaners in Canada to the lowest-paid. Their wages were slashed in half, from almost $20 an hour to $10.50 an hour. Their pension plan was eliminated, vacations were cut back to the minimum allowable and their 17-week paid parental leave was eliminated. Benefits were cut entirely for those working with less than 20 hours per week and thousands, mostly women, lost their jobs (Stinson, 2006). Scheduling of work hours also became more unpredictable, making it hard to plan childcare or time with family and friends (Stinson, 2006). Women workers reported not taking breaks and working more hours of work or at different jobs to make up for inadequate pay. Sub-contracted workers experienced adverse health impacts such as pain, numbness, migraines, pulled muscles, cuts and burns after less than one year of working for the

private contractors. However, approximately half of the 24 workers interviewed by Stinson (2016) did not take sick time because they were either afraid they would lose their job or they could not afford the few paid sick days.

4.6. Privatization and bilingual services

A bilingual health care system is essential in the bilingual province of New Brunswick. If health care services are privatized, the service no longer falls under the Official Languages Act that stipulates that citizens must be served in their language of preference, English or French. Health care needs to remain public so that the Official Languages Act can be applied. Patients must have a mechanism to complain if language services are inadequate because it risks their health.

According to a recent report by New Brunswick's official language commissioner, Katherine d'Entremont, the office received 240 complaints in 2015-16. The highest number of complaints were against the province's two health authorities and the City of Fredericton. The report noted that Horizon Health was not providing service in French in its emergency department at the Moncton Hospital, where only 15 per cent of employees had undergone second-language training. The report also stated that the Vitalité Health Network has to do more work on bilingual services in its hospitals in Grand Falls, Edmundston, and Moncton, where there were complaints about French-only signs, service and public address announcements. The report praised the New Brunswick Heart Centre, the province's only cardiac care centre based in Saint John, for the bilingual service it offers patients, who come from all areas of the province (Poitras, 2016).

5. Conclusion and recommendations

Canada's public health care system needs protection and further investment to ensure access to all. The provincial and federal governments must come up with a Canada Health Accord that prioritizes free health care for all. The New Brunswick government must increase pressure on the federal government to restore federal funding for health care in order to ensure universally accessible, transferable health care services. The federal government must reverse the Harper government's funding model to a per capita Canada Health Transfer model, and implement a 10-year accord with annual 6 per cent increases in health care transfer payments to the provinces, reaching at least 25 per cent federal funding of provincial health care costs. Instead of turning to the private sector to solve New Brunswick's health care woes, more public investment in health care is needed, starting with negotiating a new Canada Health Accord that works and invests in prevention-based primary health care. The governments must also work together to implement a universal pharmacare program and stop private blood plasma collection.

To recap, the NB Health Coalition recommends:

1. The New Brunswick government along with the other provinces and territories negotiate a new Canada Health Accord with the Canadian government that provides adequate health transfers to

the provinces;

2. The New Brunswick government develop a public prevention-based primary health care system;

3. The New Brunswick government invest in community primary health clinics to expand services and ensure integrated services.

4. The New Brunswick government invest in public long-term care facilities and abandon the P3 model in long-term care facilities;

5. The New Brunswick government support the different care needs of seniors, including dementia care;

6. The New Brunswick government invest in accelerating the implementation of the Home First Strategy;

7. The New Brunswick government invest more in extramural care, day programs, assisted-living spaces and respite care;

8. The New Brunswick government not sign an agreement with Medavie EMS to take over the extra-mural and Telecare programs;

9. The New Brunswick government expand the New Brunswick Drug Plan to include more drugs and medical equipment;

10. The New Brunswick government continue to administer the New Brunswick Drug Plan;

11. The Canadian government develop a national universal pharmacare program;

12. The Canadian government protect health care including drug coverage from international trade agreements.

13. The Canadian government deny a license to Canadian Plasma Resources and other companies that propose to pay donors for blood, plasma or other blood product;

14. The New Brunswick government regulate payment for plasma as a safety issue, recognizing that payment impacts the safety of plasma products;

15. The New Brunswick and Canadian governments work with Canadian Blood Services to develop a strategy to increase unpaid plasma clinics in Canada and move toward self-sufficiency in plasma supply;

16. The New Brunswick government keep laundry and the management of hospital cleaning and food services in-house and public;

17. The New Brunswick government adequately fund healthy food for hospital patients and long-term care residents and abandon "rethermalized" food and prepare fresh food in the facility's kitchens.

This report attempted to provide an overview of the creeping privatization found in New Brunswick's public health care system. While New Brunswick is catching up to other provinces on adding access to certain health care services such as trans health care and midwifery, the province is favouring privatization in health care by allowing P3s to enter the long-term care sector, contracting extra-mural care to Medavie EMS and allowing a blood plasma company to set up in the province. Advocates for public health care will continue informing public policy and pressing the government to fully realize the dream of free health care for all.

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