

Privatized Health Care Won't Deliver

Table of Contents

Executive Summary	1
Introduction.....	2
Defining the terms of the debate	3
Health care finance: Public, private not for profit, and private for profit.....	3
Public and private delivery: Public, private not for profit, private not only for profit, and private for profit.....	4
Summary: definitions of public and private health care	6
The impact of different ownership models for health care financing and delivery.....	7
Financing the System: A publicly financed system is more equitable and more efficient.....	7
User fees: Brain dead ideas brought back to life.....	9
Financing the System: A Private Bureaucracy Costs More Than a Public One.....	10
Financing hospital construction and operation with Public Private Partnerships (P3s).....	12
Summary: for profit financing of health care	13
Delivering care: In general, for profit care is more expensive and of poorer quality ..	14
Why is for-profit care more expensive and of poorer quality?.....	15
More reasons to prefer non profit care: externalities, fraud, contracting costs, and the human propensity to greed.....	17
Doctors can't be on both sides of the Medicare fence.....	19
Summary: If it sounds too good to be true, it probably is.....	19
There are not for profit solutions to our current health care problems	20
Not for profit surgical clinics	20
Cue the use of queuing theory	23
The Alberta Bone and Joint Health Institute kneecaps long waits for surgery	24
Let's not forget, the best medicine is prevention.....	25
Conclusion.....	25
Endnotes	26

Executive Summary

Markets are the most efficient mechanism to provide most goods and services. But, markets aren't the best way to distribute everything. For example, we publicly fund and administer fire services. We don't rely upon people to purchase firefighting insurance. What if everyone but one on the block had such insurance and his house caught on fire? Would we wait until the fire moved to someone else's house before we called the firefighters? And would different fire services compete with each other? It sounds like a nightmare.

Some Canadians have long asserted that health care should be more private. Today they claim that we could fix the problems with our public system, especially waits and delays, through more private for profit involvement in financing and delivery of services.

However, solid evidence shows that more for profit finance would increase administrative costs and decrease equity. More for profit care delivery would also raise costs, while decreasing equity and risking quality. So-called public private partnerships appear to increase overall costs.

Both Ontario Conservative party leader John Tory and the Canadian Medical Association have recommended that doctors be allowed to work in both the publicly paid and private pay systems. However, there are a number of serious dangers associated with this policy, which is why Ontario currently forces doctors to decide which system in which they wish to practice.

But, most importantly, we don't need to turn Medicare over to commercial interests to get the high quality, timely, affordable health care we deserve. Using models already in operation and with very little additional money, Ontarians could have same day access to their regular primary health provider, less than one week waits for routine specialty care, and less than one month waits for routine elective surgery.

Those advocating more private for profit funding and delivery say their way promises faster service and lower costs. On closer scrutiny, these claims ring false. Let's not add for profit problems to our health care system. We already have the not for profit solutions at hand. Let's raise our voices to demand the politicians implement them. And, then let's roll up our sleeves and get to work fixing Medicare for all of us.

Introduction

Markets are the most efficient mechanism to provide most goods and services. But markets aren't the best way to distribute everything. For example, we publicly fund and administer fire services. We don't rely upon people to purchase firefighting insurance. What if everyone but one on the block had such insurance and his house caught on fire? Would we wait until the fire moved to someone else's house before we called the firefighters? And would different fire services compete with each other? It sounds like a nightmare.

And, all legal markets require a government-run court system to enforce contracts. For many good reasons, it is illegal for private citizens to use force. And virtually all markets require some form of legislation and/or regulation. Governments regulate capital markets (like stock exchanges) because otherwise charlatans will beat out honest financiers. Governments establish and enforce labour and environmental standards so that businesses can't compete by polluting the environment or reducing labour standards.

Some Canadians have always asserted that health care should be more private. Today they claim that we could fix the problems with our public system, especially waits and delays, through more private for profit involvement in financing and delivery of services. However, a closer look shows that more for profit participation would likely raise costs, while decreasing equity and risking quality. And, most importantly, we don't need to turn Medicare over to commercial interests to get the high quality, timely, affordable health care we deserve. There are lots of examples of public sector solutions to health care waiting lists and other problems besting our system. .

This paper starts by defining terms. It turns out the word private health care can mean a lot of things. The word "private" can be applied to a large for profit firm like American hospital corporation Humana which is listed on the New York Stock Exchange or a small community not for profit service for home bound seniors. Clear language is very important to the debate because too frequently people fight over words not ideas. Then the paper reviews the evidence on the private financing and for profit ownership for its impact on patient outcomes, health care costs, and other factors. Finally, the paper presents examples of non-profit solutions to our present problems with delays and access.

Defining the terms of the debate

There are two key aspects to health care services – how do we pay for it – health care financing -- and how do we provide it – health care delivery. We could have either public or private finance and either public or private delivery. Furthermore, private could mean private for profit or private not for profit. To make this even more confusing, there is a category of health care delivery which is called “not only for profit”.

Health care finance: Public, private not for profit, and private for profit

When someone claims that they should be free to buy health care the way they buy food and automobiles they are asking for more private health care financing. This is often referred to as “two-tier” medicine because, of course, people would only pay privately for something if they thought it was better than what they were offered in the public system. The main political focus here has been on undue waiting. As the Romanow Report concluded, “long waiting times are the main, and in many cases only reason some Canadians say they would be willing to pay for treatments outside of the public health system.”¹

In Canada about 70% of health care is financed publicly and about 30% privately.² Twenty five years ago about 76% of funding was public. Canada’s rate of public finance is just marginally less than the average for the Organization for Economic cooperation and Development (OECD) countries for 2005 of 72.1%.³ But almost all of the countries with comparable standards of living to Canada have a higher proportion of public spending. because the average is brought down dramatically by the US, Mexico, and Greece, where the public proportion of spending is less than 50%. Germany has 77% public proportion of spending, France 80%, Denmark and Norway 84%, Sweden 85%, and the UK 87%.

Every country has its own pattern for determining what is in the publicly covered basket of services. In Canada, the federal Canada Health Act mandates the provinces to provide first dollar coverage for medically necessary hospital and physicians services. As a result 91% of hospital bills and 99% of physician bills are paid publicly.⁴ Most of the balance of hospital spending is for semi-private (two beds) and private rooms (one bed) and almost all of these bills are paid by private insurers. A hospital patient is not asked to pay out of pocket for a semi-private or private room if there are no other rooms available in the hospital. In practice almost all Canadian hospitals, particularly those which have been built or renovated in the last 25 years have only semi-private and private rooms.

The public purse also pays for most capital and research, but pays only 46% of prescription of drug bills and only 4% of dental bills. In Ontario, the public proportion of overall health spending is 67%.⁵ Ontario has always had a slightly greater proportion of private spending because the province has more manufacturing jobs which typically provide private health insurance for drug, dental, optical, and sometimes other services.

About half of private funding comes from out of pocket payments by patients and the other half is paid for by private health insurance. Some out of pocket payments involve direct payments for services not covered by public or private insurance, such as cosmetic surgery. Other out of pocket payments involve services where there is some insurance coverage and some, so-called “patient participation” for funding. For example, residents covered by the Ontario Drug Benefit (ODB) program typically have to pay a small portion of each prescription up to an annual maximum. These outlays are variously called “co-payments”, “extra bills”, or “user fees”. The total annual maximum is referred to as a “deductible”.

In Canada today the private insurance industry is mainly for profit. But there are some not-for-profit firms as well including Green Shield Canada which provides drugs, dental, and other benefits to 1.2 million Canadians. Before Medicare, physician-run not for profit insurance companies provided insurance to millions of Canadians. Another not for profit firm, Blue Cross provided a significant portion of private health insurance in Ontario until it was sold by its owners, the Ontario Hospital Association to a for profit company, Liberty Mutual of Massachusetts in 1994.

Public and private delivery: Public, private not for profit, private not only for profit, and private for profit

Some argue, such as Ontario Conservative Leader John Tory, that we should preserve public finance but that we need more private competition to make public delivery more efficient and timely. These folks claim that as long as the public purse is paying we will maintain equity of access and that we need more private sector efficiencies to deal with our waits and delays for care.

One of the many ironies of the Medicare debate is that almost all of Ontario’s health care services are already delivered by private providers. Very few services are directly delivered by the public sector, i.e. government. The Ontario government used to directly own ten psychiatric hospitals but only four remain in North Bay, Whitby, Thunder Bay, and Penetanguishene. Now most psychiatric inpatient services are provided by private not for profit general hospitals. Most Ontario homes for the aged are owned directly by municipalities.

In Ontario, almost all hospitals are private not for profit corporations, even though they are governed by the Public Hospitals Act. Private not for profit corporations are regulated through the province's Corporations Act.⁶ They are not controlled by government. They are not allowed to use surpluses for anything other than corporate purposes, i.e. they cannot draw surpluses out as private profits.

Many Ontario long term care facilities are not for profit including Baycrest, the Yee Hon Centre, and Villa Colombo. Ontario's community health centres are not for profit corporations as are many home care providers including the Victorian Order of Nurses, St. Elizabeth Nurses, and the Red Cross.

Private for profit corporations have historically had a small role in Canada's health care system. In Ontario, however, they comprise a significant portion of long term care delivery and a growing portion of home care delivery through such corporations as Extendicare, Central Park Lodges, and Compare.

To add to the confusion there also three hospitals in Ontario regulated by the Private Hospitals Act.⁷ The Act was actually drafted in 1973 to restrict the development of more private hospitals. The best known is the Shouldice Hospital located in Thornhill which is internationally known for its one procedure, inguinal hernia repair.⁸ The National Post and Canadian Medical Association President Dr. Brian Day have accused federal NDP leader Jack Layton of jumping the queue for care by using the Shouldice Hospital for a hernia operation.⁹ However, Layton jumped no queue because all Shouldice's services are covered by Medicare. The Hospital is privately owned by the family of the original Dr. Shouldice. But, its hospital division is funded by a global budget and any surplus there must be used for patient care. In fact, during the 1990s, the Ontario Ministry of Health "clawed back" the surpluses. The hospital could not even use them for research.¹⁰

The Shouldice Hospital is really an example of another type of health care delivery entity, the not only for profit firm. University of British Columbia economist Robert Evans coined the term to refer to small clinics and doctors' practices to distinguish them from larger for profit firms, especially those with shareholders and traded in public stock markets.¹¹ As University of Toronto Professor Raisa Deber notes, "Shouldice is a small business that is run on principles similar to those of a doctors' practice, and not a corporation where profits are the driving force."¹²

Some say that we shouldn't be scared of more for profit health care because doctors' offices are small businesses. However, physicians' offices are qualitatively different from other small businesses such as corner stores. A doctor does have to ensure that there is a surplus from their office operations because that is their income. And, doctors must run their practices not only according to sound business practices and general commercial regulation, e.g. obeying labour laws for relations with staff, obeying environmental laws regarding waste disposal, etc.

However, they must also follow the rules for their profession laid down by the their self-governing College of Physicians and Surgeons. That's why Evans refers to them as "not only for profit firms".

On the other hand, the directors of public corporations (because they are traded on public stock markets) have a fiduciary responsibility to make as much money as possible for shareholders. As the late economist Milton Friedman said, "...there is one and only one social responsibility for business – to use its resources and engage in activities designed to increase its profits so long as it stays within the rules of the game, which is to say, engages in open and free competition without deception or fraud."¹³

Summary: definitions of public and private health care

In the acrimonious debate about public and private health care, words are often used loosely. It is important to understand the terms of the argument. First we need to distinguish between how we finance health care and how we deliver it. We can have public, private not for profit, and private for profit financing. We also have public, private not for profit, and private for profit delivery. In addition, much of health care is delivered by doctors offices and small clinics which should be referred to as private not only for profit organizations. As we will see, the key distinction is between for profit firms on one side and public or not for profit organizations on the other. Now let's look at the implications of different ownership models for health care financing and delivery for health outcomes, costs, and other factors.

The impact of different ownership models for health care financing and delivery

Financing the System: A publicly financed system is more equitable and more efficient

Overall, public finance for health care is more equitable and less expensive than private insurance. Of course, the main reason we have Medicare is that when Canadians had to pay directly for their own health care or for private insurance, many found health care unaffordable. One story from the book “Life Before Medicare” of a young farmer with terminal cancer in Saskatchewan tells what it was like back in those days:

“This young woman refused to leave her home and as the disease progressed the pain was excruciating. When her husband went to work she had him lock the door, so no one could come in answer to her screams of pain. Her screaming and suffering lasted for two months, but she never gave in. Her whole being was dedicated to saving her husband and family the debt of medical care that would have ruined him.”¹⁴

Today Canadians pay very little for care from doctors and hospitals. As a result, an international survey found that Canadians were among the least likely to report that they did not seek health care because of concerns about costs.¹⁵ Low income Canadians surveyed were even less likely to forego care because of costs concerns than upper income Americans.

Of course, we still have serious problems with equity in our health system. For example, Ontario is one of only three provinces which require a three month wait before an immigrant can get OHIP coverage.¹⁶ New immigrants and refugees are eligible for coverage from the Interim Federal Health Program.¹⁷ However, this program mainly covers emergency care for serious conditions, not routine care for chronic conditions.

At the Scarborough Hospital free clinic for immigrants and refugees¹⁸ one in six patients comes for prenatal care and 60% of these had deficiencies in their prior prenatal care. The average stage of presentation was 23 weeks, very late for a Canadian woman to first seek prenatal care. Estimates vary widely but there are likely between 50,000 and 200,000 people in Canada without full legal status and approximately half live in Toronto.¹⁹

At the beginning of Medicare, almost all serious, expensive care was provided in hospitals. However, with the explosion of out of hospital treatments, although there are no charges for physicians' care, patients have to pay privately for their drugs and medical devices. This helps to explain the finding that Canadians are more likely than people in other countries (except the US and Australia) to report that they pay more than \$1,000 US per year out of pocket for health care.²⁰

Dental care is only guaranteed to be publicly funded if care is required in hospital -- a rare event in 2006. Many communities offer limited dental care for children or other special populations. As a result there are large disparities in access to oral health.²¹ Ontario children born outside of Canada have twice as many diseased teeth as those who were Canadian born. And Ontario aboriginal children have up to five times as many diseased teeth as other Ontario children who were Canadian born.

As the Toronto Star recently documented, many poor Torontonians forego badly needed dental care because they cannot afford dental fees.²² Twenty-five year old Jason Jones used his wife's entire life savings of \$600 to have all his teeth removed because they had decayed to the bone, exposing nerves and causing excruciating pain.

Needed pharmaceuticals are also not available for many Canadians. A 2006 study found that 3% of Canadians spent more than 4.5% of their incomes on prescription drugs and another 8% spent between 2.5 and 4.5% of their incomes on drugs.²³ While some well to do Canadians have high drug bills, the poor are much more likely to get sick than the rich and they are ones who have to choose between buying medicine and feeding their children.

The Ontario Drug Benefit Plan offers more generous coverage for seniors than in most parts of Canada. Ontarians not covered by the ODB or private insurance are eligible for the Trillium Drug Plan which provides catastrophic coverage for Ontario residents who expend more than a certain percentage of their incomes on drugs. A family of two with a net income of \$20,000 would pay \$400 a year for drugs while a family of four with a net income of \$60,000 would pay \$2,089 before being eligible for Trillium coverage²⁴

User fees: Brain dead ideas brought back to life

Not surprisingly, there is lots of evidence that when people have to pay out of their own pockets for health care, they are much less likely to get needed services. What is surprising is how frequently people claim health care user fees would somehow save money for the system while still ensuring patients got the necessary care. Some claim that user fees would save money by reducing frivolous use of the system. Others believe that they would bring in much-needed revenue. Clearly, they cannot accomplish both missions! In fact, user fees tend to discourage the poor and the elderly from entering the system. But there are no overall savings. Nature abhors a vacuum, and the health care system detests unused capacity. As a result, any beds or doctors freed up because the sick poor can't get desperately needed care end up being used by the well-to-do for more trivial matters.²⁵

We even have a natural experiment from Saskatchewan to back this up.²⁶ When Medicare started under the CCF government in 1962, there were no user charges to see a doctor. However, Ross Thatcher's Liberals came to power in 1964 and implemented user fees for doctors and hospital care in 1968. The NDP eliminated the charges after it won the election of 1971. Afterward, researchers were able to look at changes in use over time by different groups. They found that there had been a small drop in use of doctors' services, but there was no change in overall health care costs because there was no change in hospital use, which was responsible for the vast majority of expenditures. Further analysis revealed that the poor and the elderly reduced their visits to doctors, but that there was an increase in the use of doctors by middle- and upper-income groups.

Some claim that user fees are benign because they discourage only frivolous use. However, a US study involving fairly healthy adults showed that user fees led to a 20 per cent increase in risk of death for people with high blood pressure because they were less likely to see a doctor and get their blood pressure under control.²⁷ The same study showed that user fees were just as likely to discourage appropriate care as inappropriate care.²⁸

And, that's a big problem with user fees. The average person doesn't know whether their symptom warrants medical attention. Of course we need to better inform people about their own health and how to take care of minor illnesses. And, we need to expand options to emergency rooms such as nurse advice lines and full service primary health care practices. But when a child has a fever, most parents don't know whether it's the flu or the onset of meningitis. Do we really want them to make the decision about whether to seek health care on the basis of whether that will leave enough money to pay the rent?

Some Canadians, such as Fraser Institute Foundation President Michael Walker, claim that user fees in Sweden "manage demand without cutting people off."²⁹ However, Swedish research demonstrates that even their small user fees are more likely to discourage poor

Swedes from getting health care than their well off compatriots.³⁰ As Saskatchewan premier Lorne Calvert puts it, “The problem with user fees is that if you set the costs too high, you deter people from obtaining necessary health services, but if you keep the fees low and waive the cost for people with low incomes, the administrative costs soon outweigh any financial benefit.”³¹

The scientific evidence supporting publicly financed care is long and strong. So why do discredited ideas like user fees keep coming back? Dr. Bob Evans and his colleagues have repeatedly examined this issue and refer to user fees and related ideas as “zombies.”³² That’s because they have been killed off repeatedly by the scientific evidence, but, just like zombies, they keep bouncing back to life to wreak havoc. Evans notes that’s because the “zombie masters” are truly immortal. Private finance strategies (from user fees through private insurance to medical savings accounts) all tend to benefit the wealthy, the healthy, and those who want to sell services. At the same time, private finance tends to disadvantage the poor and the sick. With the political support of the rich and of aspiring business people, it is not surprising that these zombies are so resilient. They will always be brought back to life because they serve some very rich and powerful people.

Financing the System: A Private Bureaucracy Costs More Than a Public One

After twenty-five years of unremitting attacks on the state, most Canadians are primed to believe that all you have to do is replace a sign with the word “public” in it with one that says “private” and you will have automatically made something at least 15% more efficient. But, it turns out that private health insurance is always more expensive than public health insurance. There are two main reasons. First, the administrative costs of private insurance are a nightmare and second, a single-payer public system can control prices much better than a multitude of private payers.

In the US, where most people rely upon private health insurance, each of the roughly one thousand companies selling policies has its own actuaries, sales and marketing people, computer systems, and so on. The administrative costs also add up in hospitals and even in doctors’ offices. The average US doctor needs a full-time person just to do billing and reconciliations. An average Canadian doctor’s secretary, on the other hand, spends just a couple of hours a month on these tasks. In most Canadian provinces, doctors have 98%+ of their claims paid within 30 days.

In the US, huge resources are devoted to screening out sick people to prevent them from acquiring insurance, and then denying claims, and fighting appeals. As a result, the US system has three and a half times Canada’s per capita cost for administration despite tens of millions of

Americans lacking insurance coverage.³³ In the whole of the US economy, still by far the biggest in the world, five out every 100 dollars are spent on administration of their health system.

We even see the same trends in Canada. The administrative costs of our public spending are only 2.7% of expenditures but it costs over twice as much – 6.6% to administer the private expenditures.³⁴ As some Canadians discover if they apply for health insurance for foreign travel, sick people are routinely rejected or have to pay astronomical premiums. And, it is very costly for individuals and companies to process claims.

But, there is another reason why private insurance tends to increase costs. A single payer publicly funded system is a monopsonist purchaser, i.e. the public system is the main or only buyer. As a result public systems can bargain hard with providers and reduce prices. That's one of the reasons why health care workers sometimes feel squeezed at the bargaining table and make their claims political. Most of them don't have a lot of private options.

In private systems, health care providers get to negotiate with a lot of different payers, including patients who pay out of their own pockets. Of course sometimes doctors and hospitals get stiffed by patients who don't have health insurance and can't or won't pay. But, then they can charge very high prices to patients with good insurance or fat wallets. The resulting "price discrimination", as economists call this practice, leads to massively higher prices overall.

The top US health sector earners, insurance company CEOs, routinely make millions of dollars a year.³⁵ In fact, in one year, US Health Care Company president, Leonard Abramson, made over \$20 million.³⁶ In demand medical specialists can make millions and are sometimes wooed like major league sport free agents by prestigious hospitals. Administrators, senior nurses and other professionals also routinely make more than their Canadian counterparts. But, Canadian staff nurses and non-professional staff (e.g. orderlies, housekeeping and dietary personnel) tend to make higher incomes in Canada. This reflects a general Canadian trend towards equity in pay compared with the United States. Here the rich tend to be less rich and the poor tend to be less poor.

Not surprisingly, the mainly private US health system has the pretty much the highest health care prices anywhere.³⁷ This explains why the US spends the most on health care but its citizens receive fewer health care services. They're paying more for each service but they're receiving less of them.

Financing hospital construction and operation with Public Private Partnerships (P3s)

Advocates for more private-sector involvement in health care suggest that governments contract with commercial firms to build and manage hospitals and other health facilities. In 1992, the British Conservative government introduced the Private Finance Initiative, or PFI, to facilitate the building of public works. The concept has since spread and is widely being touted in Canada under the name of “public-private partnerships,” or P3s.

There are a couple of key claims behind P3s. The first is that the public sector is less efficient than the for profit sector at organizing the construction of large capital projects. The second assertion is that a P3 helps to get around the problem that government accounting rules increasingly will not allow the amortization of capital expenses the way individuals finance their homes through mortgages.³⁸ When governments buy a bridge or a hospital they must spend all the money now, even though the benefits accrue through decades. But, with a P3, governments aren’t technically buying something because they claim they are simply making payments to the P3 owners or financiers³⁹

The Rae government used a P3 to build Highway 407 north of Toronto and the Harris government started P3S for hospitals with plans for Brampton and Ottawa. The McGuinty government now plans to use P3s to build hospitals in up to 33 Ontario communities.⁴⁰ In some of these examples, the for profit sector is just providing the capital and running the construction. However, in other P3s a for profit partner will contract with the hospital board to provide services such as maintenance or even general management. British Columbia, Quebec, and Alberta are also actively investigating using P3s to build new health facilities.

The concept behind P3s, as stated by their proponents, is that the private sector provides the capital and takes on the risks while the public sector reaps the benefits. However, it is difficult to transfer the risks to the private sector when we are talking about public infrastructure projects. The public is usually still on the hook. For example, the Ontario provincial auditor concluded, regarding Highway 407, “We observed that, although cited as a public-private partnership, the government’s financial, ownership and operational risks are so significant compared to the contracted risks assumed by the private sector that, in our opinion, a public-private partnership was not established.”⁴¹

In Australia, governments have had to bail out two P3 hospitals.⁴² The Victoria state government had to buy the La Trobe Hospital from a private firm because it was losing so much money, it could “no longer guarantee the hospital’s standard of care.” Private companies might go bankrupt or one of their officers might abscond with their assets, but patients will still need care. There is no way of transferring that risk to the private sector.

Another problem with P3s is that the private sector always pays higher costs for capital than the public sector. Even the poorest province in Canada is rated a better risk by financial markets than the most profitable private company. P3 advocates say the extra capital costs are worth the overall better efficiency. But, this has not been borne out in practice. A group of British researchers concluded that the UK capital costs for their Private Finance Initiative are twice what they would have been if the hospitals had been publicly constructed.⁴³ To quote Richard Smith, the editor of the British Medical Journal, “The schemes produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital.”⁴⁴

In Ontario, the P3s have already run into problems. In May 2007, Lewis Auerbach, former director Audit Operations for the Auditor General of Canada, concluded regarding the William Osler Health Centre P3: “So far, the WOHC P3 has had cost increases, space decreases, flexibility decreases, -- and all of this with little transparency in the various early stages of the project...the decision process and documents I have reviewed, have only increased my concern that the P3 arrangement for WOHC is much poorer value for money than a comparable project with public financing and operation.”⁴⁵

Auerbach concluded that the Ontario government was paying 1.35% higher interest charges during the life of the project than if they had financed the capital themselves. While the government and the hospital maintain that construction has been on schedule and on budget⁴⁶ but a senior doctor at William Osler argued: “Of course it will cost more, but it was the only way the government would let us build our new hospital.”⁴⁷ Despite the ongoing controversy about P3s, it seems pretty safe to say they are not a panacea for rebuilding our public infrastructure.

Summary: for profit financing of health care

For profit financing of health care means less equity for health care services and higher overall costs. Most wealthy Canadians would be better off with more private finance because they would likely pay less for their own private care than they currently pay in taxes to maintain the public system. However, most middle class and poor Canadians would be worse off and some would see their lives devastated if they developed a serious illness. Private health insurance tends to cost more than public insurance because private finance leads to higher administrative charges and higher prices.

Public private partnerships (P3s) for construction and operation of health facilities appears to cost more than if these activities are carried out by the public sector. A key reason is that P3s pay at least 1% higher interest rates for capital than a government would pay.

Delivering care: In general, for profit care is more expensive and of poorer quality

Some claim that as long as the public pays, it doesn't matter who delivers clinical service. Ex Liberal Senator Michael Kirby has recommended that governments put their clinical services up for bidding.⁴⁸ Ontario Progressive Conservative Party leader John Tory is also recommending that patients should be able to go to for profit clinics and access services with their health card.⁴⁹ This option is intuitively appealing because competitive bidding does lead to efficiencies in some other sectors. However, the evidence is clear that this policy doesn't work in health care.

In the US, kidney dialysis has been run for many years according to pretty much the same competitive bidding process proposed by Kirby and Tory. Therefore, it provides a particularly good lesson for what we might expect in Canada with a similar course of action.

The United States dialysis system is a universal program. The US Medicare program, which provides coverage for people over 65, also covers all Americans with kidney failure regardless of their age.⁵⁰ The Medicare program decides which dialysis centres to fund by using a competitive bidding process. Roughly three-quarters of dialysis is conducted in for-profit facilities and one-quarter in non-profits.

Over the years, several small studies had compared the quality of care in the two sectors, but they did not have the statistical power to draw significant conclusions. In 2002, a large Canadian group led by McMaster University cardiologist Dr. P.J. Devereaux published a paper in the Journal of the American Medical Association collating the evidence on the quality of dialysis care in the United States.⁵¹ They found that patients attending for-profit dialysis clinics had 8 per cent higher death rates than those who got their care at non-profits. For-profit clinics had fewer staff and less well trained staff. They also dialyzed patients for less time and used lower doses of key medications. These results suggest that in the US there are 2,000 premature deaths every year among people on dialysis because their care is being provided by for-profit clinics.

Dr. P.J. Devereaux's group also published an overview of all the individual studies that had compared mortality rates for for-profit and non-profit hospitals.⁵² The group found fifteen studies that met their rigorous methodological requirements. Overall, adults had 2 per cent higher death rates in for-profit hospitals, while the newborn mortality rate was 10 per cent higher. The investigators estimated that if all Canadian hospitals were converted to for-profit status, there would be an additional 2,200 deaths per year – more than die every year from ovarian or stomach cancers.⁵³ The investigators found that for-profit hospitals tended to have fewer staff and less well trained staff. These factors have been found to be associated with higher death rates in other studies of quality care in hospitals.⁵⁴

Currently in Canada, all dialysis is provided by not for profit organizations, there are very few for profit hospitals in Canada, and private surgery clinics have just developed in the last decade.

Most provinces mainly use not for profit organizations for long term care but a few provinces including Ontario do have a mix of for profit and non profit long term care facilities (LTCFs). In Ontario approximately 60% of LTCFs are owned by private for profit firms while in BC the comparable figure is about 30%.⁵⁵ Recent studies in both of these provinces have demonstrated that for profits have lower levels of staffing despite the same funding.^{56,57} Because of the tremendous needs for physical assistance for residents, staffing levels have been found to be strongly related to care outcomes.⁵⁸ Studies from both BC and Manitoba have found better patient outcomes in not for profit LTCFs than in for profit homes.^{59,60}

A recent New York Times investigation documents similar phenomena in the United States where most long term care is now provided by private investor owned firms.⁶¹ The new owners of a Tampa nursing home, who also bought 48 other nursing homes in 2002, cut the number of registered nurses by 50%. Typically the returns on investment have been very good in this sector, specifically because of cuts to staff.

It also appears that for-profit care tends to be more expensive than non-profit care. In June 2004, Dr. Devereaux's group published a study which concluded that American for-profit hospitals are 20 per cent more expensive than non-profit facilities on a case-adjusted basis.⁶² Another study found that US Medicare costs were higher and increasing faster in communities where all beds were for-profit compared with communities where all beds were non-profit.⁶³ Spending was growing fastest in those communities that converted all their beds to for-profit care during the study period. Spending fell the most in those communities that converted all their beds to non-profit care.

Why is for-profit care more expensive and of poorer quality?

The major problem with for profit care is that market mechanisms don't work very well unless certain conditions are met. One of the key requirements for establishing a functioning market is so-called "perfect information". In other words, all parties and potential parties to any transaction should know exactly what a good or service costs and its performance characteristics. That way, consumers can always choose the most efficient producer and this market signal will keep other producers focussed on improving efficiency.

However, most health care transactions do not come close to meeting this pre-requisite. As Dr. Bob Evans notes, the pervasive and serious asymmetry of information between providers and patients for most services means that it is impossible to establish a proper market.⁶⁴ That is why we have so much regulation of health care's supply side. The provinces don't just let anyone perform surgery, prepare medicines, or dispense them. It's too dangerous. Even the advocates

of a “free market approach” to health care don’t recommend the elimination of professional licensure legislation or government drug regulation. That’s one of the reasons why the death of Toronto real estate agent Krista Stryland after liposuction raised such concern.⁶⁵ Journalists and spokespersons immediately raised concerns that a family doctor was permitted to perform the procedure instead of there being a requirement for a certified plastic surgeons.

In a paper for the Romanow Commission, University of Toronto professor of Health Policy, Dr. Raisa Deber, identified four barriers to establishing effective markets for health care services:⁶⁶

Low contestability Firms must be able to easily enter or exit a market to establish effective competition. That’s why so many economic teaching examples concern small enterprises such as lemonade stands. If a small child sees another selling lots of lemonade on a hot day for \$2 a glass, he won’t find it that difficult to get into business himself. Perhaps with a little help at home, he mixes some lemon juice, sugar, and water, makes a sign announcing his product will sell for \$1, and then enters the lemonade market. Other children on the block might then get into the market and eventually terrific lemonade might sell for 25 cents a glass. The seller of the \$2 lemonade doesn’t endure much hardship when she closes her business. She just takes in her table and the lemons will go to some good purpose over the next 2 weeks. There’s no layoffs, no severance pay, and no dinning collection calls from angry suppliers. Aren’t markets wonderful?

But the economic realities of health care are a lot different. It’s very hard for new firms to enter the market. There are large capital costs. You can’t just hire anyone to do work in an operating room and the trained doctors and nurses might not be available. As a result, there would be little competition for clinical care in most parts of Canada. This market condition can also lead to “lowballing,” whereby after a government or health authority gives up its own surgical capacity, it is at the mercy of the contractor when the initial contract expires. It can also lead to the current situation in BC where the government is contemplating giving 10 years of guaranteed funding to for profit clinics to get them into the market.

Cream skimming This means that given the opportunity, providers will choose easier than average patients but attempt to be paid at the average rate. For example, suppose we follow Mr. Kirby or Mr. Tory’s prescription and start contracting out surgery, such as joint replacement procedures, that can be performed safely in an out of hospital setting on healthier patients (e.g. 50 year old marathoners). But more complicated patients (e.g. 80 years olds with heart disease) will continue to need their surgery performed at a publicly funded hospital, so that in case something goes wrong they can quickly get intensive care. If we simply pay both the for profit clinic and the hospital the same fee, then the public system will be overpaying the clinic and underpaying the hospital. Even when we attempt to adjust for case mix, there will always be an incentive to cream skim within any case mix group, for example by only choosing wealthy or well educated patients.

Low measurability When the public sector buys concrete we know what we're getting for our money. That's because hundreds of thousands of times each day North American construction projects assess the concrete being poured with a "slump test", which tests the rigidity of uncured concrete. Lower slump concrete is stiff, and higher slump concrete is more fluid. And, although the slump of concrete required depends upon the application, the test is transparent, reliable, valid, and the results are available in real time.

In contrast, our present health information systems often do not provide accurate costing of specific services, especially on a case adjusted basis. Dr. Wayne Hildahl is the director Winnipeg's Pan-Am clinic, which is now an operating unit within the Winnipeg Regional Health Authority. But, up until he sold the clinic to the Province of Manitoba in 2001, Dr. Hildahl was the owner. He notes now that when he negotiated with the provincial government before the takeover, he knew his costs down to the penny but the Ministry of Health knew neither his costs nor the costs within the public system. Interestingly, when the government took over the clinic, the negotiated price for cataracts fell by 30%.⁶⁷ Hildahl no longer had to keep his books private or make a profit.

High complexity Even if we could deal with measurability, we face another barrier to prudent purchasing of health care. When we're buying concrete we want the right slumped concrete at the lowest price. But when we're buying health care services there are usually multiple goals. Some of them conflict with each other. Others are best attained when the service is included within an overall system of care. For example, long-term institutional care is a very complex service with multiple goals – maintenance of life, preservation of dignity, good medical care, stimulating recreation, etc. From time to time, these goals may be opposed to each other. As Professor Deber notes, even a blood test, which in itself is a precise measurement, only attains value when it is embedded within an overall system that ensures that it is ordered on appropriate patients and interpreted correctly. A Request For Proposal cannot cover all the possible outcomes of interest from a complex service. In reality, the main focus tends to be price.

More reasons to prefer non profit care: externalities, fraud, contracting costs, and the human propensity to greed

Not surprisingly, non-profit health services are much more likely than for-profits to expend resources on linking different organizations together to plan community networks,⁶⁸ engage their communities and enlist volunteers,⁶⁹ and to provide continuing education and training programs.⁷⁰ Scratch any community group planning services or advocating for care and you'll find all sorts of staff from non-profit organizations who have been encouraged to spend time on these activities, even if they present no revenue opportunities for the organization.

Professor Deber concludes that when measurability is low and complexity is high, non profits are more likely to provide services beyond what is precisely specified in their contracts. Health care is a complex human activity which American analyst Marc Bendick suggests is perfectly suited to non-profit organizations.⁷¹ Rather than attempting to define all service requirements in an RFP, Bendick suggests that we should allow non-profit organizations to work out the specific program details with their intimate knowledge of their specific complex circumstances.

Fraud is a minor issue in the Canadian health care system. But it is a major problem in the US for-profit health system. In 2000, American health care company HCA (formerly Columbia/HCA) was fined nearly \$1 billion (US) for systematically defrauding the US Medicare program.⁷² Similarly, Olsten Corporation agreed in 1999 to pay \$60 million (US) to settle a suit with the Medicare program.⁷³ The only comparable Canadian health care fraud also involved a for profit provider. In 2001 Ron and Loren Koval were convicted of defrauding investors of \$90 million to fund non-existent medical equipment for the for-profit King's Health Centre in Toronto.⁷⁴

Even public sector organizations have to be concerned about rogue employees. But, there is no remotely comparable example of this kind of fraud among Canada's non-profit health providers.

For profit advocates don't mention the high costs associated with developing requests for proposals, negotiating contracts, and providing oversight. The US system has over triple the administrative costs of our system but even all those lawyers and accountants have not stemmed the massive fraud in their system. How much extra would it cost our system to pay for this extra administrative and legal work? And, if the advocates of for profit contracting aren't including billions in their plans to ensure the contracts are in the public interest, why should we take anything they say seriously?

Finally, let's not forget plain, old fashioned, human greed. For profit firms, especially those whose shares are traded in stock markets, need to make profits and, they also need to grow their profits over time to raise their share prices. That means they can't be content with a limited profit stream. They will want to diversify their products and access more markets.⁷⁵

According to the Canadian Medical Association and the Ontario Progressive Conservative party proposals, ⁷⁶ for profit clinics would be able to sell non-Medicare services. And, doctors would be allowed to work in both the public, non profit system as well as the for profit sector. This situation quickly migrates into formal two-tier health care when patients can get access to services more quickly by going private and paying for an enhanced service as well. Now we're back to user fees for access.

Doctors can't be on both sides of the Medicare fence

There are a number of serious dangers associated with permitting doctors to “double dip”, which is why currently Ontario currently forces doctors to decide which system in which they wish to practice.

Professor Raisa Deber points out that the patients will only resort to private pay when they cannot get the services they feel they need within the public system.⁷⁷ Therefore, if a doctor is practicing in Medicare AND selling services privately, he will only have a market for his private care if the public service is seen as inferior. In Alberta in the 1990s, this led to for profit clinics selling “enhanced services” on top of their Medicare covered services. For example, at one cataract surgery clinic, an extra \$750 was asked for an improved lens, a video of the procedure, and the surgeon's prayers prior to the procedure.⁷⁸ Buying the improved lens also led to faster care.⁷⁹

Dr. Brian Day, the current president of the Canadian Medical Association owns the Cambie Surgical Centre, a for profit surgical facility in located near the Vancouver General Hospital. The Cambie Surgical Centre does work on contract for the BC Workers Compensation Board, the Ministry of Health, as well as servicing individuals who walk through their doors with enough money to cover the surgery. The British Columbia Nurses Union alleges that some Vancouver area patients have been told by their doctors that they can get around the long wait for surgery in a hospital by paying extra to have the procedure performed by the same doctor in a private clinic.⁸⁰ The union has gone to court to force the provincial government to enforce their own legislation and produced these patient stories as part of their court submission.

Mr. Tory says that he has surgeon friends who have told him they would like more operating room time than they can get at public hospitals. He says that we won't have to worry about doctors leaving the public system because they will just do extra work at private clinics. However, given that there is a finite pool of health professionals, where parallel public and private systems exist, the private system tends to siphon doctors and nurses away from the public system, thereby lengthening waits in the public system.⁸¹

In fact, exactly this situation occurred recently in Winnipeg. The private Maples Surgical clinic purchased an MRI and hired 1 full-time, and 1 part-time MRI technician away from the public Health Sciences Centre.⁸² As a result, the Health Sciences Centre had to eliminate 20 hours of service per week, which led to longer public sector queues.

Summary: If it sounds too good to be true, it probably is

Those advocating more for profit care say that there are numerous advantages for Medicare. Faster service! Lower costs! Keeping our doctors in Canada! On closer scrutiny, it is too good to be true. Perhaps it's as simple as Dr. Devereaux's comment that, “Private for-profit facilities

typically have to generate 10 to 15% profits to satisfy shareholders. Not-for-profit facilities can spend that money on patient care.”⁸³

Winnipeg’s Pan-am clinic director Dr. Wayne Hildahl says that when he was a commercial operator he used his profits for family vacations and bigger cars. But, now when his good management leads to a surplus, he plows it back into patient care, the clinic’s aboriginal health professional initiative, or other public purposes.

There are not for profit solutions to our current health care problems

We have known for a very long time how to improve our health services. Twenty years ago in 1987, the Ontario Health Review Panel⁸⁴ chaired by Dr. John Evans made the following observation:

“There is a remarkable consistency and repetition in the findings and recommendations for improvements in all the information we reviewed. Current submissions and earlier reports highlight the need to place greater emphasis on primary care, to integrate and coordinate services, to achieve a community focus for health and to increase the emphasis on health promotion and disease prevention. The panel notes with concern that well-founded recommendations made by credible groups over a period of fifteen years have rarely been translated into action.”

It is beyond the scope of this paper to outline all the needed reforms for Canada’s health system. The reader is referred to other publications for a more comprehensive treatment.⁸⁵ This section shows that there are solutions to waits and delays in our system, the issue which most threatens the political support for our publicly financed and non profit delivery model. There are two broad strategies to develop non profit answers to health care wait lists:

- Establish more specialized non profit short-stay surgical clinics
- Adopt lessons learned from queue-management practices in other sectors.

Not for profit surgical clinics

Sometimes it is argued that we should contract out surgery to for profit out of hospital surgical clinics because they can set up efficient, patient-friendly, assembly lines for care. Widespread

coverage of surgical clinics in British Columbia and Quebec have given the impression that this model is only open to the for profit sector. However, the largest out of hospital surgical clinics in North America are actually Canadian not for profit organizations.

Toronto's Queensway Surgicentre, a division of the Trillium Health Centre (a public hospital), is the largest not-for-admission surgical centre in North America. And the Winnipeg Pan-Am Clinic is a close second. In late 2005, the Ontario government funded the Kensington Eye Centre in downtown Toronto. It now performs more than 7,000 cataract surgeries per year. (See text box for further information on Kensington.)

The Trillium Health Centre was created from a 1998 merger of the Queensway General Hospital in the Toronto suburb of Etobicoke and the Mississauga Hospital 5 kilometres farther west in the city of Mississauga. Its 23 acre site includes an urgent care centre open from 8:00 AM until 10:00 PM, a cardiac rehabilitation centre, a diabetes education centre, and a day-surgery facility. The Surgicentre houses eight operating rooms in its 23,000 square feet. The Surgicentre performs nearly 20,000 procedures per year including 3,500 cataract surgeries. Other common procedures include cystoscopy (examination of the bladder) and breast, orthopedic, and gallbladder surgery. The facility has the capacity to perform 30,000 surgical day procedures annually.

Trillium has reduced costs by moving services to the Queensway ambulatory site. An internal evaluation demonstrated that day surgery costs were 10% lower at Queensway than at the Mississauga site even though the Queensway patients required a slightly higher acuity of care.⁸⁶ The Trillium Health Centre is taking advantage of its integrated structure to move day surgery patients and the needed staff from its higher cost inpatient hospital to its ambulatory care facility.

These clinics achieve the benefits of specialization and innovation normally ascribed exclusively to the private sector, while reducing overall administrative costs and providing broader societal benefits.

Toronto's Kensington Eye Clinic focuses on cataracts

Starting in 2003, then 72 year-old Toronto resident Mary Wong^I noticed that the vision in her left eye was deteriorating. Her family doctor diagnosed her with a cataract in 2004 and in 2005 referred her to an ophthalmologist^{II} who was affiliated with a downtown teaching hospital. It took five months for her to be seen by the ophthalmologist and then it took another eleven months to have her surgery. During this time, a cataract began to form on her right eye and Mary was increasingly disabled. She could no longer see well enough to take the subway and found herself progressively isolated from her friends and relatives.

Mary was thrilled to have vision restored to her left eye but she didn't want to wait another 1 _ years to deal with her right eye. Fortunately, her daughter heard from a family friend that the Kensington Eye Institute opened in early 2006. The Eye Institute is part of the Kensington Health Centre on the old Doctors' Hospital campus in west downtown Toronto. Mary's daughter phoned the institute and was referred to an optometrist in her neighbourhood who saw her the next week. He confirmed that Mary had a cataract in her right eye and referred her to the Kensington Eye Institute. Mary saw an ophthalmologist at the clinic within two weeks, had a pre-op history and physical with her family doctor the following week, and then was booked for surgery two weeks after that.

Mary came to the Kensington Eye Institute at 7:30 AM the day of her surgery. She was put into a special chair and given eye drops and some sedation. At 8:00 her chair was wheeled into the operating room and within a minute it was converted into a table. Within another minute the surgeon started removing her cataract and by 8:20 AM Mary was in the recovery area sitting with her daughter. By 9:00 AM Mary was ready to go home. She never even had to change out of her street clothes. She wore a loose blouse which unbuttoned up the front. This allowed the nurses to place cardiogram leads on her chest.

From start to finish, it took Mary only six weeks to have her right cataract removed compared with one and one-half years for her left cataract. In the traditional system, patients have to wait long periods for referrals and then for surgery. At the Kensington Eye Institute, patient flow is facilitated from referral to specialist to surgery. The Institute exemplifies several attributes of a high performing health system including accessibility, safety, patient-centredness, and efficiency.

^I Note there is no real Mary Wong. She is a composite

^{II} An ophthalmologist is a medical doctor who has taken specialty training in diseases of the eye and eye surgery. An optometrist has taken a four year university course in diseases of the eye after at least three years of undergraduate courses.

Cue the use of queuing theory

Queuing theory applications are used to maximize flow in such diverse areas as air traffic control and manufacturing. Rather than thinking of every wait list as a capacity or resource problem, we need to look at delays through the "lens of flow." While Canadians tend to assume that, if there is a wait for health care, there isn't enough of it, most waiting is not due to lack of resources.

For example, many breast patients have to wait for a mammogram, then wait for an ultrasound, and then wait again for a biopsy. The Sault Ste. Marie breast health centre reduced the wait-time from mammogram to breast cancer diagnosis by 75 per cent by consolidating the previously separate investigations. If a woman has a positive mammogram, she often has the ultrasound, and sometimes the biopsy as well, on the same day.

We could also eliminate waits for doctors' appointments. Family doctors often have delays of four weeks for appointments. The wait is typically shorter just before vacation and longer thereafter, but overall it is fairly stable. A doctor's capacity may be close to meeting demand, but he is servicing last month's demand today while postponing today's work until next month. If doctors could clear backlogs, then theoretically they could go to same-day service.

The Saskatoon Community Clinic serves more than 20,000 patients. In 2004, patients faced a four- to six-week wait for appointments. The centre temporarily increased resources to clear its backlog, redesigned some of its care pathways, and now provides same-day service. The Saskatchewan Health Quality Council has since taken "advanced access", as it is called to more than one-quarter of the province's family practices.⁸⁷ It plans to train all the provinces primary health care practices in advanced access and chronic disease management by 2010. Alberta has a plan to implement advanced access province-wide as well.⁸⁸

We could also dramatically reduce delays for specialist care. The Hamilton Shared Care Mental Health Program integrates the practices of 145 family physicians with 80 counsellors and 17 psychiatrists.^{89,90} As a result 1100% more patients are being seen for mental health problems. One might think that identifying more people with mental health problems would swamp the specialists. However, only 15% of patients see the psychiatrist directly. The psychiatrists spend most of their time meeting with the family doctors, mental health counsellors, and other professionals to discuss cases as a group. The psychiatrists are also available by telephone at very short notice. Because people are being looked after in primary health care, there was actually a 70% drop in referrals to the psychiatry specialty clinic.

This is the perfect learning system. The psychiatrists keep the primary health care staff continuously up to date on evidence-based guidelines for care. Knowledge transfer is implicitly built into care, instead of being bolted onto the outside.

The Alberta Bone and Joint Health Institute kneecaps long waits for surgery

In 2005, the Alberta Bone and Joint Health Institute initiated a pilot project to reduce waits for joint replacement surgery. The project is now the standard of care for hip and knee replacement in the Calgary, Capital and David Thompson health regions, and three other regions have expressed interest in adopting the model.

At the clinics established in the project, a multidisciplinary team assesses patients for their need and/or fitness for surgery. If changes need to be made before surgery (such as losing weight or quitting smoking), supports are provided. If patients are worried about how they'll cope after surgery, home care services are arranged prior to their operation. Patients are matched with a case manager who helps navigate them through the health care maze. The result of all of this up-front work has been a dramatic reductions in total wait times, delays and last-minute surgery cancellations.^{91, 92}

- ♣️ Wait times from a family doctor referral to the first visit with an orthopedic surgeon dropped by over 80 per cent, from 35 weeks to 6 weeks.
- ♣️ Wait times from first visit with an orthopedic surgeon to surgery plummeted 90 per cent, from 47 weeks to 4.7 weeks
- ♣️ Length of stay in hospital fell 30 per cent, from 6 days to 4 days
- ♣️ Overall waits from family doctor referral right through to surgery fell from 19 months to less than 11 weeks, almost 90%.

Dr. Cy Frank, executive director of the Alberta Bone and Joint Health Institute, says the goal was to reduce variations to make the system as predictable as possible. For example, Frank, who is also a University of Calgary orthopaedics professor, says in a sports medicine setting he found that each of the seven surgeons doing arthroscopy (the insertion of a small telescope into a joint to permit visualization of the structures) did the procedure differently.

"They were all using different drapes, different instruments," Frank says. "Then we told them their numbers and asked how they can justify this. Within a month they all gravitated to within 10 per cent of the lower case costs."

Let's not forget, the best medicine is prevention

Of course, the best way to reduce waits in our system is to eliminate the need for care. For example, far too many patients are re-admitted to hospital shortly after they have been discharged because they didn't get adequate follow up care. The Sault Ste. Marie Group Health Centre ensures that all patients with congestive heart failure are followed up by nurses after hospital discharge. The result was a 60% reduction in readmissions.⁹³⁹⁴ The centre's chronic disease management programs have been greatly assisted by its electronic health record which was implemented in 1997.

And, we could do a much better job preventing people from getting sick in the first place. A healthy lifestyle (consisting of a clean environment, a nutritious diet, physical fitness, supportive family and social relationships, and meaningful, safe work) could prevent over 80 per cent of cases of coronary heart disease,⁹⁵ type 2 diabetes (90 per cent of diabetes cases),⁹⁶ and over 85 per cent of cases of lung cancer and chronic obstructive lung disease (such as emphysema).⁹⁷ If the potential for prevention could be translated into reality for these four conditions alone, we could free up approximately 2900 hospital beds in this province.⁹⁸

Conclusion

There are some health care goods and services for which markets do work. There is no need for crown corporations to manufacture band aids. Many companies manufacture band aids. It's not difficult to get into this market. It's not hard to determine whether a band aid has met specifications. Cream skimming doesn't apply. However, the evidence on direct patient care is clear. Contracting out surgery tends to cost more and, if anything, leads to poorer quality. Parallel private systems allow those with resources to get faster care while the rest suffer longer waits. Allowing doctors to work inside Medicare and for private pay compromises equity and efficiency.

The good news is that there is no shortage of solutions to Medicare's problems, if the political will is present. Let's not add for profit problems to our health-care system. We have the not for profit answers at hand.

Endnotes

¹ RJ Romanow. Building on Values: The Future of Health Care in Canada. Final Report. Commission on the Future of Health Care in Canada. November 20002, page 138.

² The Canadian Institute for Health Information. Exploring the 70/30 split: How Canada's Health Care system is financed. Ottawa. 2005. Found at: http://secure.cihi.ca/cihiweb/products/FundRep_EN.pdf. Accessed December 21, 2005.

³ Organization of Economic Cooperation and Development (OECD) 2007 most frequently requested health data. Found at: http://www.oecd.org/document/16/0,3343,en_2825_495642_2085200_1_1_1_1,00.html. Accessed July 22, 2007.

⁴ CIHI 2005, *ibid*.

⁵ CIHI 2005, *ibid*.

⁶ For the Corporations Act see: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90c38_e.htm. Accessed September 15, 2007.

⁷ For Private Hospitals Act see: <http://www.search.e-laws.gov.on.ca/en/isyquery/80ea4947-b1cb-447d-b7cd-1d1cb112a162/2/frame/?search=browseStatutes&context=>. Accessed September 15, 2007.

⁸ See: <http://www.shouldice.com/hospital.htm>. Accessed September 15, 2007.

⁹ McGrath A. Letter to the Editor National Post. See: <http://www.canada.com/nationalpost/news/editorialsletters/story.html?id=9b1ed89d-89cb-401c-ab55-4529d3c6fbe1>. Accessed September 15, 2007.

¹⁰ Personal communication with Dr. Derrel Urquhart

¹¹ RG Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984).

¹² Hernia hospital provides model of care. CTVglobemedia. November 25, 2002. See: http://www.ctv.ca/servlet/ArticleNews/print/CTVNews/20021125/shouldice_hospital_021125/20021125?hub=Health&subhub=PrintStory. Accessed September 15, 2007

¹³ There are issues also raised that corporations have "stakeholders" (consumers, neighbouring residents, etc.) as well as shareholders. However, Friedman's view remains predominant. See: *Mid American Journal of Business*. 2003;18(1) for different perspectives on this issue: <http://www.bsu.edu/web/majb/resource/pdf/vol18num1.pdf>. Accessed September 16, 2007.

¹⁴ *Life Before Medicare: Canadian Experiences*. Ed. S. Charters. Ontario Coalition of Senior Citizens Organizations. Toronto. 1995:79.

¹⁵ Schoen C, Osborn R, Huynh PT, et al. Taking the pulse of health care systems: Experiences with health problems in six countries. *Health Affairs*. 2005;10:w5-509-w5-525.

¹⁶ British Columbia and New Brunswick also have 3 month waiting periods. Quebec has a notional 3 month waiting period but it can be waived on request with proof of need. Ministry of Citizenship and Immigration. Found at: <http://www.cic.gc.ca/english/newcomer/welcome/wel-06e.html>. Accessed November 13, 2006. Right to Health Care Action Coalition. Policy paper on the 3-month wait for OHIP. September 2006. Mimeo.

¹⁷ Ministry of Citizenship and Immigration. Found at: <http://www.cic.gc.ca/english/applications/guides/5568ETOC.html>. Accessed November 11, 2007

¹⁸ Caulford P, Vali P. Providing health care to medically uninsured immigrants and refugees. *Canadian Medical Association Journal*. 2006;174:1253-1254.

¹⁹ Ontario Council of Agencies Serving Immigrants. The regularization of non-status immigrants in Canada 1960-2004: Past policies, current perspectives, active campaigns. Found at: http://www.ocasi.org/STATUS/Regularization_booklet.pdf. Accessed September 23, 2006.

-
- ²⁰ Schoen C, Osborn R, Huynh PT, et al. Taking the pulse of health care systems: Experiences with health problems in six countries. *Health Affairs*. 2005;10:w5-509-w5-525.
- ²¹ Lawrence HP, Leake JL. The US Surgeon Generals Report on Oral Health In America: A Canadian perspective. *Journal of the Canadian Dental Association*. 2001;67:587-595.
- ²² Walsh M. Why is he out of work? *The Toronto Star*. February 10, 2007. Found at: <http://www.thestar.com/News/article/180323>. Accessed September 17, 2007.
- ²³ More for Less: A National Pharmaceutical Strategy. The Canadian Centre for Policy Alternatives. 2006. Found at: <http://www.healthcoalition.ca/moreforless.pdf>. Accessed September 18, 2007.
- ²⁴ The patients still have pay up to \$2 for each prescription. Ontario Government. Application guide for Trillium Drug Program. Found at: [http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-S46850E-87~13/\\$File/trillium_bookE.pdf](http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/AttachDocsPublish/014-S46850E-87~13/$File/trillium_bookE.pdf). Accessed November 2, 2006.
- ²⁵ See Rachlis MM, Kushner C, Strong medicine: how to save Canada's health care system, chapter 6 for more details on the user fee debate.
- ²⁶ RG Beck, JM Horne, Study of user charges in Saskatchewan 1968–1971, in *User charges for health services* (Toronto: Ontario Council of Health, 1979).
- ²⁷ RH Brook, JE Ware, WH Rogers, et al., Does free care improve adults' health? *New England Journal of Medicine*, 1983;309:1426–1434.
- ²⁸ AL Siu, FA Sonnenberg, WG Manning, et al., Inappropriate use of hospitals in a randomized trial of health insurance plans, *New England Journal of Medicine*, 1986;315:1259–1266; B Foxman, RB Valdez, KN Lohr, et al., The effect of cost sharing on the use of antibiotics in ambulatory care: results from a population-based randomized controlled trial, *Journal of Chronic Diseases*, 1987;40:429–437.
- ²⁹ P Clarke, User fees: experts call them failed idea, *Medical Post*, November 19, 2002.
- ³⁰ S Elofsson, A-L Uden, I Krakau, Patient charges: a hindrance to financially and psychosocially disadvantaged groups seeking care, *Social Science and Medicine*, 1998;46:1375–1380; R Andersen, B Smedby, D Vagero, Cost containment, solidarity and cautious experimentation: Swedish dilemmas, *Social Science and Medicine*, 2001;52:1195–1204.
- ³¹ P Clarke, User fees.
- ³² RG Evans, ML Barer, GL Stoddart, User fees for health care: why a bad idea keeps coming back, *Canadian Journal on Aging*, 1995;360:360–390.
- ³³ S Woolhandler, T Campbell, DU Himmelstein, Costs of health care administration in the United States and Canada, *New England Journal of Medicine*, 2003;349:768–775.
- ³⁴ The Canadian Institute for Health Information. National Health Expenditure Trends, 1975-2006. Ottawa. 2006. Found at: http://secure.cihi.ca/cihiweb/products/national_health_expenditure_trends_1975_2006_e.pdf. Accessed January 5, 2007.
- ³⁵ Physicians for a National Health Program news September 2000. Found at: <http://www.pnhp.org/news/2000/september.php>. Accessed September 20, 2007.
- ³⁶ Himmelstein D, Woolhandler S. Why the US needs a single payer system. Found at the Physicians for a National Health Program website: http://www.pnhp.org/facts/why_the_us_needs_a_single_payer_health_system.php. Accessed Sept 20, 2007.
- ³⁷ Anderson GF, Reinhardt UE, Hussey PS, et al. It's the prices, stupid: Why the United States is so different from other countries. *Health Affairs*. 2003;22(3):89-105.
- ³⁸ McKenzie H. Financing Canada's Hospitals: Public alternatives to P3s. Ontario Health Coalition. October 22, 2004. Found at: <http://www.web.net/ohc/041020summary.PDF>. Accessed September 25, 2007.
- ³⁹ In the Ontario P3s the non profit hospital boards will own the hospitals after 30 years.
- ⁴⁰ Ontario Health Coalition. Status of P3 projects at RFQ or RFP state. March 7, 2007. Found at: <http://www.web.net/~ohc/P3s/P3updateMarch72007.pdf>. Accessed September 25, 2007.
- ⁴¹ Ontario Provincial Auditor, Annual report 1996, <http://www.gov.on.ca/opa/english/r96f.htm> (accessed December 28, 2002).
- ⁴² AM Pollock, J Shaoul, N Vickers, Private finance and "value for money" in NHS hospitals: a policy in search of a rationale, *British Medical Journal*, 2002;324:1205–1209.
- ⁴³ Pollock, *ibid*.

⁴⁴ R Smith, PFI: perfidious financial idiocy, *British Medical Journal*, 1999;319:2–3.

⁴⁵ Auerbach L. William Osler Health Centre P3: commentary on value for money benchmark and letters of assurance. May 9, 2007. Found at: <http://www.web.net/ohc/P3s/LAwohcMemoMay9Final.pdf>. Accessed September 25, 2007.

⁴⁶ William Osler Health Centre. Construction completed for William Osler Health Centre's Brampton civic hospital. July 3, 2007. Found at: http://www.williamoslerhc.on.ca/workfiles//WOHC%20Release%20july%203rd%20Final%20_2.pdf. Accessed. September 25, 2007.

⁴⁷ Anonymous. Personal communication. December 4, 2003.

⁴⁸ Standing Senate Committee on Social Affairs, Science and Technology (Chair Hon Michael JL Kirby). *The Health of Canadians – The Federal Role, Volume Six: Recommendations for Reform*. October 2002. Ottawa.

⁴⁹ Gillespie K. Tory's private health policy blasted. *Toronto Star*. September 20, 2007. Found at: <http://www.thestar.com/printArticle/258599>. Accessed September 21, 2007.

⁵⁰ Interestingly, consistent with the inconsistency in US health policy, US Medicare doesn't cover other types of organ failure, e.g. heart, liver, unless the patients are over 65.

⁵¹ PJ Devereaux, HJ Schunemann, N Ravindran et al., Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta analysis, *Journal of the American Medical Association*, 2002;288:2449–2457.

⁵² PJ Devereaux, PTL Choi, C Lacchetti, et al., A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals, *Canadian Medical Association Journal*, 2002;166:1399–1406.

⁵³ Canadian Cancer Society. *Cancer Statistics 2004*. From: http://www.cancer.ca/vgn/images/portal/cit_86751114/14/33/195986411niw_stats2004_en.pdf. Accessed February 14, 2005.

⁵⁴ LH Aiken, SP Clarke, DM Sloane, et al. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction, *Journal of the American Medical Association*, 2002;288:1987–1993.

⁵⁵ McGrail KM, McGregor MJ, Cohen M, et al. For profit versus not for profit delivery of long term care. *Canadian Medical Association Journal*. 2007;176:57-58.

⁵⁶ McGregor MJ, Cohen M, McGrail K, et al. Staffing levels in not for profit and for profit long term care facilities: Does type of ownership matter? *Canadian Medical Association Journal*. 2005;172:645-649.

⁵⁷ Berta W, Laporte A, Valdmanis V. Observations on institutional long term care in Ontario.: 1996-2002. *Canadian Journal on Aging*. 2005;24:71-84.

⁵⁸ McGregor MJ, Cohen M, McGrail K, et al. Staffing levels in not for profit and for profit long term care facilities: Does type of ownership matter? *Canadian Medical Association Journal*. 2005;172:645-649.

⁵⁹ McGregor MJ, Tate RB, McGrail KM, et al. Care outcomes in long term care facilities in British Columbia, Canada: Does ownership matter? *Medical Care*. 2006;44:929-935.

⁶⁰ Shapiro E, Tate RB. Monitoring the outcomes of quality of care in nursing homes using administrative data. *Canadian Journal on Aging*. 1995;14:755-768.

⁶¹ Duhigg C. At many home, more profit and less nursing. *The New York Times*. September 23, 2007

⁶² Devereaux PJ, Ansdell-Heels D, Lacchetti C, et al. Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis. *Canadian Medical Association Journal* 2004;170:1817–1824.

⁶³ EM Silverman, J Skinner, E Fisher, The association between for-profit hospital ownership and increased Medicare spending, *New England Journal of Medicine*, 1999;341:420–426.

⁶⁴ Evans, *ibid*.

-
- ⁶⁵ Lipo patient dies. Toronto Sun online edition. September 23, 2007. Found at: <http://www.torontosun.com/News/TorontoAndGTA/2007/09/23/4519164-sun.html>. Accessed September 23, 2007.
- ⁶⁶ R Deber, Health care services: public, not-for-profit, or private? Discussion paper #17, Royal Commission on the Future of Health Care, August 2002, http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/17_Deber_E.pdf (accessed November 4, 2002).
- ⁶⁷ Rachlis MM. Public Solutions to Health Care Wait Lists. Canadian Centre for Policy Alternatives. Ottawa. 2005.
- ⁶⁸ J Banaszak-Holl, S Allen, V Mor, et al., Organizational characteristics associated with agency position in community care networks, *Journal of Health & Social Behavior*, 1998;39(4):368–385.
- ⁶⁹ N Wolff, BA Weisbrod, EJ Bird, The supply of volunteer labor: the case of hospitals, *Nonprofit Management and Leadership*, 1993;4(1):23–45.
- ⁷⁰ MM Rachlis, The hidden costs of privatization: an international comparison of community and continuing care, in *Without foundation: how medicare is undermined by gaps and privatization in community and continuing care*, ed. M Cohen, N Pollak (Vancouver: Canadian Centre for Policy Alternatives, 2000).
- ⁷¹ M Bendick jr. Privatizing the delivery of social welfare services: an ideal to be taken seriously. In: *Privatization and the Welfare State*. Edited by SB Kamerman and AJ Kahn. Princeton University Press. Princeton, New jersey. 1989.
- ⁷² F Charatan. US settles biggest ever healthcare fraud case. *British Medical Journal*. 2001;322:10.
- ⁷³ Olsten settles fraud case. Found at CNN website: <http://money.cnn.com/1999/07/19/companies/healthcare/> accessed February 27, 2005.
- ⁷⁴ Ontario fugitives plead guilty in health centre fraud. Found at CBC website: http://www.cbc.ca/story/news/?/news/2001/03/27/kovals_plead010327 accessed February 27, 2005
- ⁷⁵ Evans RG, Barer ML, Lewis S, et al. Private highway, one-way street: The deKlein and fall of Canadian Medicare? University of British Columbia Centre for Health Services and Policy research. March 2000. Found at: <http://www.chspr.ubc.ca/files/publications/2000/hpru00-03D.pdf>. Accessed September 21, 2007.
- ⁷⁶ Canadian Medical Association. Medicare Plus. July 2007. Found at: http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/MedicarePlus/still_about_access.pdf. Accessed September 21, 2007.
- ⁷⁷ R Deber, 2002, *ibid*.
http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/17_Deber_E.pdf (accessed November 4, 2002).
- ⁷⁸ Walkom T. Tory's plan for two-tier health care. Toronto Star. September 23, 2007. Found at: <http://www.thestar.com/printArticle/259508>. Access September 23, 2007.
- ⁷⁹ Rachlis MM. A review of the Alberta private hospital proposal. Caledon Institute of Social Policy. March 2000. Found at: <http://www.caledoninst.org/Publications/PDF/1-894159-92-6.pdf>. Accessed September 21, 2007.
- ⁸⁰ British Columbia Nurses Union. Petition to the Attorney General of British Columbia and the Medical Services commission. December 20, 2006. Found at: http://www.bcnu.org/whats_new_media/news_releases/2006/pdfs/BCNU%20-%20Petition.pdf. Accessed September 18, 2007.
- ⁸¹ Tuohy CH, CM Flood, M Stabile, How Does Private Finance Affect Public Health Care Systems? *Marshalling the Evidence from OECD Nations*, *Journal of Health Politics, Policy and Law*, Vol. 29, No. 3, June 2004, pp. 374-375
- ⁸² Robson M. Clinic 'poaching' staff: Sale: HSC clinic scaling back MRI program after techs hired away. Winnipeg Free Press. November 25, 2005.
- ⁸³ McMaster University Department of Clinical Epidemiology and Biostatistics press release. November 19, 2002.
- ⁸⁴ Report of the Ontario Health Review Panel (Chair Dr. John Evans). Government of Ontario. Toronto. 1987.
- ⁸⁵ Rachlis MM. Prescription for Excellence: How Innovation is Saving Canada's Health Care System. HarperCollins Canada. Toronto. 2005.
- ⁸⁶ K White, Trillium Health Centre. Personal communication. January, 2005.
- ⁸⁷ See: <http://www.hqc.sk.ca/portal.jsp?1BUvYTFi2rUc1KuZxY5yjiBlzBf0QflQkUwK4QBZaJuUga+FLps26lzOVcA+lmY4>. Accessed September 2, 2007.

⁸⁸ Personal communication with Marianne Stewart, Vice President primary care, Capital Health Authority, Edmonton, July 17, 2007.

⁸⁹ Kates N, A-M Crustolo, S Farrar, et al., Mental health and nutrition: integrating specialists' services into primary care, *Canadian Family Physician*, 2002;48:1898–1903.

⁹⁰ Kates N. Managing chronic mental health problems in primary care. Presentation to Ministry of Health and Long-Term Care Expo. April 19, 2006. Toronto.

⁹¹ Canadian Institute of Health Information, 2006, *Waiting for Health Care in Canada: What We Know and What We Don't Know*. Available at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_07mar2006_e

⁹² Frank C, Dick D, Smith D, Wasylak T, Gooch K, Zernicke R. *Creating Sustainable Accountability through Collaboration, Relevant Measurement and Timely Feedback*. Healthcare Papers, 2006, Vol.7, No.1, pg 38.

⁹³ H Lee, D Garniss, R Oliver, et al., A community hospital-based heart failure program decreases readmission rates. Abstract for the meeting of the Society of General Internal Medicine, San Diego, May 2001.

⁹⁴

⁹⁵ MJ Stampfer, FB Hu, JE Manson, et al., Primary prevention of coronary heart disease in women through diet and lifestyle, *New England Journal of Medicine*, 2000;343:16–22.

⁹⁶ FB Hu, JE Manson, MJ Stampfer, et al., Diet, lifestyle, and the risk of type 2 diabetes mellitus in women, *New England Journal of Medicine*, 2001;345:790–797.

⁹⁷ Doll R, Peto R, Wheatley K, et al. Mortality in relation to smoking: 40 years' observations on male British doctors. *British Medical Journal*. 1994;309:901- 911

⁹⁸ From tabulations constructed from data from the Canadian Institute for Health Information. Found at: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=statistics_results_topic_hospital_e&cw_topic=Health%20Services&cw_subtopic=Hospital%20Discharges. Accessed November 10, 2006. These conditions were responsible for 950,000 hospital days or roughly 2870 hospital beds (at 90% capacity)..