Private Highway, One-Way Street:

The Deklein and Fall of Canadian Medicare?

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Few trends could so thoroughly undermine the very foundations of our free society as the acceptance by corporate officials of a social responsibility other than to make as much money for their stockholders as possible.

Friedman, 1962

For-profit health care is an oxymoron. The moment care is rendered for profit, it is emptied of genuine caring. This moral contradiction is beyond repair. It entails abandoning values acquired over centuries of professionalizing health care into a humanitarian service.

Lown, 1999

Most institutions on the scale of the NHS end not with a bang but with a whimper…one possible endgame is that the middle classes lose confidence in the service and begin to make other arrangements.

R. Smith, 1999a

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Executive Summary

Scope and Definition

- "Medicare" has two meanings for Canadians: the entire range of health care services, or only those (mainly physicians and hospitals) mandated and governed by the *Canada Health Act* (CHA). This paper focuses on the narrower legal meaning of Medicare, as does the recent Alberta proposal to fund CHA-mandated services delivered on an overnight stay basis in privately owned and operated facilities. Nevertheless there is considerable confusion in the minds of the public, and concerns about access to or private costs of other health care services (e.g. home care and pharmaceuticals) may create a pervasive anxiety about the health care system overall that then generates concerns about the sustainability of the narrower core of physicians and hospitals.

- The label "private" in the context of health care is being used in many different ways by different people for different purposes. The most basic distinction is between payment for and provision of health care services. The financing for health care may be drawn from public or from private sources: this is logically independent of whether the services themselves are provided by public or private agencies. But the distinctions on the provision side are not always as clear as on the financing side. At one end of the spectrum is provision of care by government employees working for government agencies. At the other end are purely for-profit, publicly traded corporations, such as drug and equipment manufacturers and some providers of laboratory and long-term care services. Most health care is provided by not-for-profit and "not-only-for-profit" organizations that respond to motivations and "bottom lines" that are very different from those of for-profit corporations. A unique feature of the recent Alberta proposal that is the principal focus of this paper, is to allow private for-profit facilities to be the site of overnight care covered under the CHA.

Extending Private, For-Profit Provision: Risks and Benefits

- One of the principal justifications offered for the Alberta proposal is that of "meeting unmet needs", of expanding service capacity to deal with shortages and waiting lists for care. But this argument seems at best seriously incomplete. Alberta cut provincial hospital spending by 30% between 1992 and 1995. The 1999 level was still 15% below that of 1992. Over that seven years, Alberta's per capita hospital expenditures fell from 6% above the Canadian average to 6% below. To reduce public hospital expenditures and then turn around and argue the need for private hospitals or equivalent facilities to meet shortages of capacity seems disingenuous at best, unless the argument is being made on efficiency grounds.

- If there is a case for opening up the hospital sector to for-profit overnight-stay facilities, then, it must rest on an argument that such facilities can provide care more efficiently than is possible in public hospitals, AND that the public as purchaser will

be able to capture any such realized efficiencies through lower expenditures. In short, the belief must be that private sector organizations, operating under the incentive of profit opportunities, can provide as good or better quality care at lower cost.

- The evidence, alas, does not support this belief. Health care organizations that are motivated strictly or primarily for-profit behave differently from those with more diverse objectives. They adopt whatever behaviours will maximize the margins of revenue over cost. A fundamental "tension between profit maximization and medical appropriateness" is reflected in distortions in patterns of patient management and medical decision-making so as to generate higher margins. In less competitive environments, charges and use of services (whether or not appropriate) tend to be higher among for-profit firms. In more competitive environments, for-profit organizations appear to find ways to reduce their costs of operation and protect their larger operating margins.

- But the same powerful incentives that encourage cost control within the organization also strongly discourage passing savings on to purchasers in lower prices. To the extent that reduced costs of care in for-profits do represent real efficiencies, and not just lower quality, the benefits of these cost reductions appear to be absorbed by shareholders as higher profits, and in other administrative and overhead components of operating margins.

- Ownership can also affect clinical decision-making in more insidious ways. The most troubling of these concern "self-dealing" by physicians who have an equity interest in services to which they can refer their own patients. Physicians with such arrangements have been shown to have very much higher rates of referral, for services carrying much higher charges, than physicians without such an equity interest.

- In the extreme, the irresistible imperative to which for-profit corporations must respond can force them to "do whatever it takes" to maintain and increase earnings. There has recently been a spate of high-profile indictments and convictions for fraud in the for-profit health care sector. . They have involved corporations that are among the industry leaders (perhaps that is how they came to be "leaders"), the biggest companies in their fields, and the pattern of behaviour is systematic.

- Various forms of questionable behaviour – including criminal fraud – do occur outside the for-profit sector, and clearly not all for-profit corporations engage in fraudulent practices. But payers dealing with for-profit providers will have to be prepared to pay the additional cost of monitoring, suppressing, and where necessary prosecuting such behaviour, or to bear the financial consequences. Whether or not explicitly accounted for, these costs become part of the administrative overhead associated with for-profit provision.

- There are many reasons why any efficiency gains that might be achieved, are more likely to flow through as profits for shareholders/owners of facilities rather than as savings to individuals or governments. Under current arrangements, physicians are reimbursed by the public plan for the provision of their professional services. But surgical services are provided in not-for-profit facilities whose capital and operating costs are funded through separate (public) budgets. The Alberta proposal opens up new opportunities to bill privately for the facility (capital and operating cost) component, in effect transferring those facility costs from hospital global budgets to the private fee-for-service sector. This will necessitate negotiating reasonable fees for that component, on the basis of overhead cost information from the public sector, as well as a clear idea of the nature and volume of services to be provided in the private facility. But there is no readily available information on the costs of providing surgical services in public facilities, and such information on the private side would be proprietary. Because relative costs are likely to be a black hole, the setting of overhead/facility charges will reduce to a matter of relative negotiating skill and persuasion, with the information advantage being held by the private facility owners.

- The introduction of private, for-profit hospitals will open up a variety of "cream-skimming" opportunities. If surgeons are able to work in both public and private systems – as they are at present in Alberta – and have an equity interest in the private facility, it will be economically advantageous to steer their most straightforward cases, and higher paying patients, to the private facility. Cost shifting is as effective as cost reduction in improving the bottom line of the private, for-profit, organization. In addition to serving the less complex and costly Canadian patients, we might expect a private facility to market its services to Americans. Indeed, if a private clinic could attract a sufficiently large American clientele, it would have no economic incentive to care for Canadians at all – unless they were prepared to pay extra, in some form or other. In this case, public sector shortages and waiting lists allegedly faced by Albertans would be exacerbated, not alleviated, by private care.

- The private hospital also provides motivation and opportunity to promote additional, uninsured or "not medically necessary" services, which carry substantial profit margins. These services may appear to be merely "offered" to patients, to choose or reject. But they may be packaged with the insured service such that in practice they are not optional. Or the patient who accepts and pays for these "optional" services may be placed on a much shorter queue. The patient will typically have no way of evaluating the real value, let alone the true cost, of the extras.

- This is precisely what has transpired for cataract surgery in Calgary. Most Calgary cataract patients pay an average of $400 out-of-pocket (some have paid up to $700) for the procedure. For this the patient receives a foldable lens implant, offered as being of higher quality, and a variety of other services which can include a video of the procedure. The foldable lenses themselves can be manufactured at a cost in the range of $25. Purchase prices appear to be highly variable, but these lenses are offered as an insured service at public hospitals in Lethbridge. Since foldable lenses

may be easier to insert, these lenses may in fact pay for themselves in reduced procedural time. The question of relative quality has not yet been resolved.

Illusions of Efficiency

- Most potential sources of "efficiency" are likely to be more illusion than reality. If the private provider is able to move service provision from a unionized to a non-unionized environment, wage and benefit costs may be reduced for essentially the same mix of personnel. This provides no real gain in efficiency because the same resources are being used up in providing services. Unless the regional authority is able to negotiate contracts that ensure such cost savings accrue to the public benefit (see above), this will simply be a transfer of income from those providing the care, to those holding the shares. To the owners (who may include non-Canadians) it is additional profit – unequivocally a good thing. The workers, and the Alberta public, might take a different view.

- Another "efficiency illusion" is that it is cheaper to "buy" by contract than to "make" in the public system, because "buying" avoids the necessity of investing large amounts of public capital. But the capital must still be paid for, and governments can raise funds more cheaply than private firms. A second consideration may be that contracting on a pay-as-you-go basis appears to be a more flexible approach. But this too is an illusion. The buyer's flexibility is the contractor's risk, and investors must be compensated for accepting risk. There is no free lunch from private investors.

- A third form of efficiency illusion arises from the fact that capital expenditures by governments show up as public expenditures at the time they are made. Private contracts, involving long-term commitments, are in effect a form of long-term indebtedness, but only the current year expenditures show on the government books. A government that is trying to show low public expenditures, to an electorate most of whom are not accountants, may find this form of illusion, of "off-budget" financial commitments, politically valuable.

Market and Regulatory Potential?

- Buyers who are unable to judge the value/appropriateness of services, or their true cost, or who are constrained in their choices, fare badly in private markets, and will find themselves paying too much, for services they do not need. The advantages (for buyers, or those they represent) of a competitive process are also dependent upon the presence of multiple independent bidders. Without this, any benefits that do arise from private provision are more likely to accrue to the providers themselves. It is difficult to imagine how such competition can be achieved in the Alberta setting, even in large urban centres. It should come as no surprise that the advocates of an expanded role for private hospitals in Alberta are not simultaneously calling for a more openly competitive delivery system.

- As an alternative, we might look to regulatory oversight. But in the health care sector, direct public regulation shares with private contracting those same problems of informational disadvantage, not to mention the difficulty of enforcement. The complexity of the regulatory task has led almost all countries toward a mix of direct regulation, delegated self-regulatory control, and non-profit provision, with a very limited role for for-profit firms. A great irony is that the outstanding exception, the United States, has the most heavily regulated health sector. Experience in that country demonstrates that detailed regulatory oversight is singularly ineffective at creating the conditions for efficiently functioning health care markets.

Free Trade Agreements – Lots of Uncertainty, Lots of Risk

- As if all of this were not enough to put anyone off embracing private, for-profit hospitals, there is another larger trap here, one that may catch not only Premier Klein and the people of Alberta, but the rest of Canada as well. The Alberta proposal risks undermining Medicare across the whole country, by exposing it to the full force of the "liberalizing" thrust of current international trade agreements. Both the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS) of the World Trade Organization have as their over-riding objective the removal of all barriers to international trade in goods and services in any form, including health care services, and correspondingly the reduction of the jurisdiction and powers of national governments.

- All sectors of the economy that are not explicitly and exclusively reserved for public action are to be open to international trade and competition, if not immediately then as soon as possible. Countries where the hospital sector is opened up to a mix of public and private ownership, or where there is private insurance or user fees, are unlikely to be able to sustain an exemption for this sector. And the agreements have been explicitly designed as a one way process. Once a sector is no longer eligible for exemption, it is extremely unlikely that eligibility could ever be restored. Under NAFTA, for example, if a government chooses to enter a new field of activity, or return to one previously vacated, it incurs potentially prohibitive penalties in the form of compensation to any commercial interest that can claim lost business opportunities. These rivers are all flowing toward international waters. And Canadian governments are not salmon.

Summing Up

- But if there are so obviously other ways of "meeting unmet needs", if the alleged benefits of opening up over-night-stay hospital activity to private for-profit organizations are almost certainly either illusory or accrue only to shareholders, and if the free trade risks associated with such action are so immense and widespread, why does the premier of Alberta press ahead with such blinkered determination? Given this government's past record of explicit support for the introduction of private medicine with private payment, this proposal may be a stalking-horse behind which it continues to pursue the real long-term agenda of establishing a publicly subsidized

private tier of health care delivery and payment. Yet this is an outcome that, as the government itself has made clear, Albertans definitely do not want.

- Stripped to the bone, the Alberta proposal appears to be little more than taking lousy odds on a very small payoff, and gambling with the health of Canada's health care system, for the sake of a few Alberta health care providers who would stand to gain considerably in the short term. It is troubling that the rest of Canada has been so slow to take notice of Alberta, and that the premier has taken so little notice of Albertans' vehement objections.

A: Introduction

Alberta and private health care -- again

Amidst growing concerns (at least some of which seem justified) among the Canadian public about whether *their* health care system will be there for them if/when they need it, the Government of Alberta has again fanned into flame the smouldering issue of the role of the private sector in Canada's health care system. Premier Klein's proposal, declared on November 17, 1999, to introduce legislation allowing private, for-profit facilities to offer over-night care, has raised the spectre of a parallel private hospital system potentially undermining Medicare. The provincial government argues, to the contrary, that private facilities will be under contract to the Regional Health Authorities and will be reimbursed for all insured services through the public Medicare program. They will add much-needed capacity to provide additional insured services for Albertans. Where is the threat in that? After all, physician services have long been provided by private practitioners and funded through public Medicare.

Yet if the proposal is as straightforward as the premier suggests, why has it aroused such controversy? Who, after all, is against strengthening the capacity of Medicare to provide necessary services? On the other hand this initiative is not wholly new. Twice in the last four years the premier has brought forward proposals to extend the scope of private delivery, and has withdrawn them in the face of intense opposition and controversy. Why is this objective so important to the Premier? There would seem to be more at stake here than meets the eye – and there is.

On closer examination, the apparently innocuous extension of the role of private facilities comes with dubious benefits, but considerable risks to the integrity of the public system. We describe these risks in some detail. Since the ostensible justification for the proposal is the strengthening of Medicare, we offer, in a companion paper (Rachlis *et al.*, 2000), some constructive suggestions for how this might be accomplished without the risks entailed in extending the role of the private sector.[1]

The meaning of Medicare: Specific program or general system?

We note at the outset, however, that Medicare has two meanings for Canadians, and it is important to keep these distinct. In common parlance, "Medicare" is often used to refer to the whole range of health care services provided in Canada, from hospitals and physicians' services through to home care and drugs. These are financed and regulated in a number of different ways. Only the services of hospitals and of physicians are governed by the terms of the *Canada Health Act*, which provides for federal financial contributions to the provinces in support of programs conforming to federal standards.

[1] There is no "magic bullet" -- bullets generally kill rather than cure – but there are a number of quite specific policies and practices that hold considerable promise.

The Alberta proposal, and most of this paper, relate to these programs, "Medicare" in its narrow meaning.

The alternative proposals for improvement that we offer in the companion paper (Rachlis *et al.*, 2000) do, however, address the effectiveness of the public system as a whole, not just Medicare narrowly defined. Some of the more fruitful avenues take us into long-term care and home care, and the regulation and financing of pharmaceuticals. The solution to the annual crisis in emergency wards, for example, may lie not in building more acute care beds, but in a comprehensive program of flu immunization in an expanded public long-term care sector.

In the minds of the public, however, the separation may not be nearly as precise. Perceived problems with access, now and in the future, to the full range of needed health services, including expensive drugs, long-term care, or home care, become bound up in heightened anxiety about the adequacy of the Canadian health care system as a whole. This generalized anxiety then translates into perceptions of the inadequacy of "Medicare" as narrowly defined. People who are concerned about access to new and expensive drugs conclude that "Medicare is in trouble", unaware that these problems arise largely because drugs (outside hospitals) are not and never have been covered by Medicare. Their exclusion leaves the way open for "passive privatization" -- moving costs from public to private budgets as a side-effect of otherwise desirable changes. Reductions in hospital lengths of stay, for example, move the costs of associated drugs and post-operative care from the hospital budget to patients and their families. "The problem with Medicare is not that it covers too much (as some would have us believe) but that it covers too little."[2]

B: What Does "Private" Mean?

The ambiguity of "private"

The label "private" in the context of health care has always been used in many different ways by different people for different purposes (Stoddart and Labelle, 1985). This makes meaningful communication, and the assessment of competing claims, virtually impossible. Accordingly, we begin by offering a basic taxonomy of the various meanings that might be attached to the term, in so doing drawing key distinctions between public and private in the health care context. The skeleton of the taxonomy is contained in Figure A.1.

Who pays for care?

The most basic distinction is between *payment* for and *provision* of health care services (Deber *et al.*, 1996). The financing for health care may be drawn from public or from

[2] The original architects of Medicare, Tommy Douglas and Emmett Hall, always envisioned Medicare in this more comprehensive and more logical form. But the compromises required during its introduction first delayed and eventually lost this broader vision.

private sources: this is logically independent of whether the services themselves are provided by public or private agencies. A private practitioner, for example, may (as in Canada) provide medical services that are reimbursed through a public insurance program. Similarly, a public health service (as in Sweden or the U.K.) might impose user charges (private payments) for some of its publicly provided services. Public health services such as well-baby home-visiting by public health nurses are Canadian examples of public provision with public payment, as are psychiatric hospitals, while most dental care in Canada is privately provided and paid.

Public funding, in turn, can be drawn from general taxation (as in Canada) or from social insurance funds (as in Germany or France). The latter are, in general, more regressive[3] and more restrictive, being typically based only on wage income up to a ceiling. But both detach the financial liability of the individual from the experience or expectation of use of services.

Figure A.1:

The Many Meanings of "Private"

Payment for Health Care Services
- Public
  - Taxes
  - Social Insurance
- Private
  - Out of pocket
  - Private insurance
    - without public subsidy
    - with public subsidy

Provision of Health Care Services
- Government Organization
- Non-Government Organization
  - Not for Profit Institution
  - Private Firm with Well-defined Owners/Residual Claimants
    - Mixed Motives: Professional and Profit
    - Purely For-Profit Motive

Private financing takes the form either of out-of-pocket payments by users of services or

[3] A regressive form of finance takes a larger share of the income of people at lower incomes; a progressive form takes a higher share from those at higher incomes. A "flat tax" would take the same proportion of income – not the same amount – from people at each income level. In Canada, the overall tax system – all taxes combined -- is either roughly proportional or moderately progressive, depending upon the analyst's assumptions about tax shifting.

private purchase of insurance coverage for some defined set of benefits. The latter may be purchased by individuals, but is more commonly purchased by employers on behalf of a group of employees and their dependents. A principal reason for employment-based coverage is that in Canada, as in many other jurisdictions, this expense is deductible for tax purposes by the employer, but is not taxable in the hands of the employees. This form of public subsidy, or foregone tax revenue, is referred to as a *Tax Expenditure Subsidy*, and in Canada now amounts to three to four billion dollars.

Providers of Care – A spectrum of ownership and of motives

Like financing, provision of health services can be public or private. But the distinctions here are not always as clear as on the financing side. At one end of the spectrum is provision of care by employees of one or other level of government, working for government agencies -- e.g. services of public health departments. At the other end are purely for-profit, publicly traded corporations, such as drug and equipment manufacturers and some providers of laboratory and long-term care services.

It is important to emphasize that "purely for-profit" means exactly what it says. To paraphrase Red Saunders (not Vince Lombardi) "[Profit] isn't the most important thing. It's the *only* thing."[4] Publicly traded firms have a legal and financial obligation to their shareholders, and to them alone. Claims to a broader social role, education, say, or the advancement of human health and happiness, are usually just corporate image advertising.

The bulk of health care in Canada, however, is provided by institutions that lie between these extremes. Hospitals are (so far) strictly not-for-profit agencies; any surplus of revenue over expenditures must be returned to the reimburser or ploughed back into operations. There is no "residual claimant" legally entitled to pocket such a surplus as income. Whatever motivations may lie behind hospital behaviour, profit is not among them.

Private physicians, on the other hand, have a clear title to the net revenues of the practices that they own – that is their net income. But the presumption behind professionalization, and the substantial protections that it provides against the open competition of the marketplace, is that profit *per se* is not the predominant motivation for practice behaviour. Physicians are expected to offer and recommend services to their patients on the basis of their best judgement as to what will benefit the patient, not the practice bottom line.

Mixed motives – professionalism versus profits

Yet the motivations are always mixed, and recognition of the need to protect and enhance the role of professional judgement, and limit that of profit-seeking, lies behind traditional

[4] Coach Lombardi explained to his Green Bay Packers that "Winning is not everything. It's the only thing." And they did.

prohibitions on "fee-splitting"[5], and on physician ownership of pharmacies and drug firms, as "unethical". The danger in such arrangements is that they give the physician a direct financial incentive in recommending particular additional services that may not be justified by the patient's condition. The reality of these dangers is clearly illustrated by recent examples of "self-dealing" by U.S. physicians who own their own diagnostic facilities (see below). Both the rates of referral of patients, and the prices charged for referred services, are dramatically higher when the referring physician has an ownership interest in the facilities.

A more subtle variant on this relationship arises when a physician sets up, with the financial support of a drug firm, a diagnostic facility (such as a bone mineral density screening clinic) that will lead to long-term prescriptions of that company's drug. Patients on the drug will need to return regularly to the clinic for monitoring and re-screening. Both practitioner and drug company now have a direct financial interest in the number and frequency of referrals to the clinic, and the proportion of patients identified as "requiring" therapy. The patient is now a lifetime "customer" of both practitioner and (for profit) drug firm (Green et al., 1997).

Other subtle forms of "fee splitting" have a long-standing history in relationships between individual practitioners and strictly for-profit firms, particularly drug firms. The insidious practice of providing perks (e.g. trips to conferences, meals and entertainment) is an old but still very troubling story (Wazana *et al.*, 2000; Tenery, 2000). More recently, physicians have begun to be paid substantial sums for enrolling their patients in drug trials (Eichenwald and Kolata, 1999). This both reduces the cost to the company of recruiting patients for its own trials, and forms a financial relationship that can be helpful in marketing the drug post-approval. The physician's motives, in choosing to prescribe a particular drug to a particular patient, become less clear.

In addition to enrolling patients, the physician may be accorded status as a "researcher" and authorship rights on the publications emerging from the trial, whether or not the physician actually puts 'pen to paper'. Again, this relationship ties the physician to the drug in question, and is likely to have an influence on subsequent drug prescription decisions. In addition, if the physician has an academic base, the number of such publications could influence the level of academically-derived income and status. This, in turn can enhance the physician's influence over both other colleagues, and students.

The case of private laboratories provides another interesting example of mixed motives. Laboratory services in Canada are treated as medical services, either funded through hospital global budgets, or reimbursed as billable items in the provincial medical fee schedule. As such, they must be provided by a licensed medical practitioner. Yet west of the Ottawa River, large for-profit publicly traded companies dominate the laboratory sector. Their billings must pass through one or more individual pathologists (corporate practice of medicine would violate the medical practice acts) but these are in some form of legal and financial relationship with the laboratory company. If that pathologist is also

[5] "Fee-splitting" refers to the practice of paying a percentage of the fee received from a patient to another practitioner who referred that patient. In other settings it might be called a "kickback".

a shareholder in the company, again mixed motives emerge. And if the pathologist also happens to be the director of a hospital laboratory, the pattern of financial incentives becomes even more complex.

As we go across the spectrum of provider organizational forms and embedded motivations, from more professionally motivated to more profit motivated, the incentives increase for both "revenue enhancement" – increased sales – and "cost control" per unit of service. The concern over the latter is that it may lead to quality degradation and patient selection, along with or instead of increased efficiency of production. The concern with the former is that it may lead to increased output of inappropriate services – the original argument against "fee-splitting" – as well as increased efforts to circumvent price controls.

Private delivery and private payment: Distinct in logic but not in practice

The categories in Figure A.1 are logically distinct, but dynamically linked in important ways. Most obviously, private insurance coverage requires that there be private out-of-pocket payments for insurers to reimburse. Correspondingly private insurers tend to advocate a limited role for public insurance – mopping up the bad risks and those with few personal resources – and substantial user charges in whatever public coverage is provided. On the other hand, as noted above private health insurance typically depends upon the provision of a quite substantial public tax expenditure subsidy. It is an open question as to whether private insurance could survive on any significant scale without public subsidy, but in any case unsubsidized private insurance is politically unlikely in Canada and not common world-wide.

The form of organization of the provision of care has in practice been associated with the advocacy of particular forms of payment. Not-for-profit organizations and their employees tend to exert continuous pressure for more **public** funds, with less interest in private funding. Self-employed practitioners, with a mix of professional and profit motives, have tended to argue for more **private finance on top of** a public system. For profit drug firms, however, have so far successfully fought off universal coverage, and preserved a **mix of public and private insurance and out-of-pocket payment** – an American-style system with an American-style pattern of cost escalation.

Finally, there are linkages across the different forms of provision. Private motivations tend to push across the spectrum of organizational forms from the purely profit-driven sector into the purely professional or mixed-motive sectors – see above. The evolutionary dynamic appears to be toward a mix of motives ever more dominated by financial or profit considerations. From the perspective of for-profit firms the concern to protect professional motives and behaviour from the intrusion of financial considerations is turned on its head. On the contrary, the most profitable strategy is to subvert professional motives, and to tie the financial interests of the practitioner as closely as possible to the objectives of the for-profit firm.

The over-riding message of the above is not that private (or public) provision is fundamentally good or bad. We already have a system with significant components of both public and private provision, and with several different forms of the latter. But the devil is, as usual, in the details. Different forms of private organization embody different patterns of incentives -- different mixes of professional and financial motivations. Different financial motivations, in turn, lead to interests in different mixes of public and private payment.

C: Extending Private, For-Profit Provision: Rationales, Risks and Benefits

Could private, for-profit hospitals help meet "unmet needs"?[6]

As noted above, Premier Ralph Klein is very explicit that his proposal addresses the provision of medical services, and does *not* change the source of financing. What then is the basis for opposition? Alternatively, however, one might ask what is the rationale for his determination to push through a measure that is obviously very controversial, and that may carry substantial (and not widely understood) risks to the entire institution of Medicare, both inside and outside Alberta? Do the benefits outweigh those risks? To whom would such benefits accrue?[7]

One of the principal justifications offered is that of "meeting unmet needs", of expanding service capacity to deal with shortages and waiting lists for care. Premier Klein has referred to "shortages of beds and doctors, waiting lists, crowded emergency rooms, and streams of wealthy Canadians heading to the U.S. for treatment" (Klein, 1999) But in and of itself, this argument seems at best seriously incomplete.

Claims of "underfunding" and unmet needs are as old as Medicare itself. They do not seem to depend on actual levels of provision. Some alleged indicators, like the streams of Canadians heading south, are largely fictitious (Barer *et al.*, 1999; Katz *et al.*, 1998). Others, like waiting lists and seasonally crowded emergency rooms, are real but linked more to organizational and managerial problems than to overall resources (McDonald *et al.*, 1998). Even if such claims do now correspond to a genuine shortage of services, however, they do not make a case for *private* delivery.

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[6] Section 1 of the Alberta legislation, Bill 11, very specifically *forbids* the operation of a "private hospital". What it permits are "designated surgical facilities" in which patients may remain overnight (or presumably longer, if necessary) – i.e. hospitals in all but name. The Bill also contains language that appears to address a number of the concerns raised below, but on careful reading seems to offer address without redress.

[7] An obvious answer, of course, is to the private company that secures the contract. The Alberta government's proposal does not arise in a vacuum; it is a specific response to the Health Resources Group (HRG) that has been "lobbying tirelessly for the change proposed by Klein" (Cairney, 2000). HRG is the Calgary corporation, now providing private hospital services to WCB and other private clients, that has every expectation of receiving a contract from the Calgary Regional Health Authority to provide inpatient services. Its former CEO, Jim Saunders, moved to that job after being the Chief Operating Officer of the CRHA (Fuller, 1998).

As opponents have quickly noted, such a rationale would provide equal reason to expand *public* capacity. After all, the Alberta government has previously imposed radical funding cuts on the public system. Between 1992 and 1995, Alberta cut provincial government spending (per capita) on hospitals by 30%, from $874 to $614. Premier Klein subsequently admitted that there was no plan behind these draconian cuts. "It would have been nice to have had a vision, but there wasn't a common one at the time" (Steinhart, 1996). Some of this funding was later restored, but by 1999 provincial government spending on hospitals was still estimated to be 14.5% below the 1992 peak, at $747 per capita (Canadian Institute for Health Information, 1999).

Alberta was not, of course, unique; hospital funding was cut all across Canada after 1992. But the national average bottomed out at $742 in 1997, only 10.3% below its 1992 peak of $828. The preliminary national estimates for 1999 are $796, only 3.9% below the 1992 level, suggesting that most of the cuts have now been restored – although without adjusting for either inflation or population aging. Hospital spending in Alberta – a relatively high-income province -- fell from 5.6% above the national average, to 6.2% below, a relative move of about 12% in seven years.[8] Moreover, relative to provincial GDP, the Alberta government's expenditure on hospitals was, in 1999, estimated to be 22.4% below the national average (2.01% vs. 2.59%) (Canadian Institute for Health Information, 1999).

There is nothing magical about the national average. But it would seem difficult to argue, in the face of these numbers, that Alberta would be out of line were it to increase resources for public hospitals. Nor is the Alberta government likely to be short of money in the near term. There is thus no basis for the claim that increasing support for public hospitals is not an option. By February of 2000, the Alberta government seems to have reached the same conclusion; its most recent budget includes a substantial increase in health spending. But that decision would appear to undercut much of its argument for private hospital care.

The new budget also appears to fly in the face of the Premier's earlier and quite valid point that "[m]oney alone won't fix the problem. It never has." (Klein, 1999). In this he is in agreement with the conclusions of a series of Royal Commissions and other public inquiries and consultative bodies over the past fifteen years, down to the National Forum on Health in 1997. Thirty-five years (up to about 1992) of adding ever more money to the health care system was not sufficient to 'meet the needs" or end the underfunding claims. Nor has it in any other country in the developed world. In 1977, the American political scientist Aaron Wildavsky formulated the Law of Medical Money; "…costs will increase to the level of available funds." (Wildavsky, 1977:109). There is never enough.

Accordingly most observers of health care systems have concluded, as has Premier Klein, that indeed "the status quo [but with more money] is not an option." Much more attention must be given to the more effective management of the considerable resources

[8] The national average of course includes Alberta, so the move relative to the rest of the country was even greater.

already going into the Canadian health care system, to pruning away the inappropriate, ineffective, and unnecessary activities and finding more efficient ways to deliver effective care. In short, both "Doing the Right Things", and "Doing Things Right." Despite the present atmosphere of "crisis" and widespread public concern there is in fact still room for disagreement over whether more money is needed, and if so how much. But there is no doubt that, although progress has been made on some fronts, many important changes must still be carried through if public confidence is to be restored.

The Premier's proposal cannot therefore be justified on the ground (whether or not solid) that health care services in Alberta are inadequate to meet the public's needs. Rather it must rest upon a presumption that contracting with a private, for-profit provider is a more cost-effective way of meeting those needs than simply restoring some of the funding previously cut from the public system. The province, or its regional authorities, face a "make versus buy" decision. The Premier would appear to believe that his proposal is a more efficient approach to expanding the supply of needed services, that private sector organizations, operating under the incentive of profit opportunities, can provide as good or better quality care at lower cost.

But are for-profit providers more efficient? A look at the evidence

Perhaps they can, but the case is far from self-evident and to date has not been made. A certain ideological school holds that private, for-profit organization is by definition more efficient than public, in all fields of endeavour. But if one looks for evidence and argument, rather than expressions of faith, most of the current evidence indicates that, in the delivery of health care services, public and not-for-profit systems have a significant cost and/or quality advantage. The standard arguments supporting for-profit organization, however relevant elsewhere, are simply inconsistent with the realities of health care.

The evidence on the comparative costs, quality and effectiveness of private for-profit firms relative to public and not-for-profit comes (predictably) largely from south of the border, where there has been ample experience with a mix of public and private financing, and a rich mix of non-profit and for-profit delivery arrangements. The most directly relevant research evidence is that which compares for-profit and not-for-profit hospitals. But there is also a significant body of evidence from mental health, rehabilitation hospitals, HMOs and even home care, and a quite separate but clearly related literature on the effects of various forms of fee-splitting, or physician self-referral. These literatures examine a variety of indicators, including "efficiency", profit margins, costs, and quality.

A comprehensive and detailed review of that literature would be a monumental task well beyond the scope and intent of this paper.[9] But a consistent theme emerges from the findings of virtually all studies. Health care organizations motivated strictly for-profit *do* behave differently from those with more diverse objectives. In broad summary, and just

[9] Partial reviews can be found in Taft and Steward (2000) and Woolhandler and Himmelstein (1999). The Taft and Steward study is particularly useful in demonstrating how the Fraser Institute reaches its idiosyncratic conclusions (Zelder, 2000).

as the discussion in part A above would suggest, they adopt whatever behaviours will maximize the margins of revenue over cost. These behaviours differ according to the external environment – the nature of their product, the forms of reimbursement, and the extent of competition from other organizations. But however they are achieved, for-profit firms show larger margins.

Studies of U.S. hospitals, for example, have found that in the years prior to price-sensitive "managed care" purchasing, "investor-owned chain hospitals charged significantly more, and were more profitable, than all other types of hospitals except freestanding for-profits …" (Renn *et al.*, 1985 p.219). "…[T]otal charges … and net revenues per case were both significantly higher in the investor-owned chain hospitals, mainly because of higher charges for ancillary services…[and] significantly higher administrative overhead costs..." (Watt *et al.*, 1986, p.89) "…[I]nvestor-owned chain hospitals generated higher profits through more aggressive pricing practices rather than operating efficiencies…" (*ibid.*). The researchers conclude "[I]nvestor-owned chain hospitals did not have lower costs of providing patient care services than did comparable not for profit hospitals, and thus were not more efficient." (*ibid.* p.95).

A study of California hospitals found that "both costs and charges were higher in for-profit than in not-for-profit hospitals….for profit chains…used aggressive marketing and pricing strategies to generate high rates of profitability and growth" (Pattison and Katz, 1983, p.347). The investor-owned chains used basic services (room charges) as "loss-leaders" for high margin ancillary services: "…for all profitable ancillary services, the number of service units administered per patient-day or per admission was higher in the investor-owned chain hospitals than in the voluntary hospitals. In the case of clinical laboratories and pharmacies, the difference was extreme" (p. 350). These findings led Pattison and Katz to suggest that "…the tension between profit maximization and medical appropriateness may lead to different styles of medical practice in [investor-owned] hospitals" (*Ibid.*).

Furthermore, in the environment of retrospective reimbursement that characterized the U.S. prior to the predominance of managed care, increased competition was found to be associated with lesser, rather than greater efficiency (Robinson and Luft, 1985; Wilson and Jadlow, 1982).[10] The nature of the competition among hospitals in that reimbursement context served, perversely, to raise costs and lower efficiency.

What behaviour is most profitable? That depends on the context

Reimbursement processes in the U.S. have become much more price sensitive since these studies were done: "[w]hat the previous system rewarded, the new system will apparently

[10] Wilson and Jadlow also found that in the particular hospital department they were studying, nuclear medicine, for-profit hospitals were more efficient in their use of both staff and capital. More recently Griffiths *et al.* (1994) found for-profit renal dialysis facilities to be more efficient than not-for-profits. These findings suggest that in specialized clinical areas with a limited range of activities, the powerful incentives of for-profit ownership *can* lead to increased efficiency. But in the earlier study these efficiencies were dissipated as the environment became more competitive – possibly in marketing activities.

penalize" (Pattison and Katz, 1983, p. 353). Not surprisingly, one finds a change in the comparative findings. For- profit hospitals continue to show higher overhead costs and profit margins (Woolhandler and Himmelstein, 1997),[11] but studies are now showing for-profit organizations with charges comparable to those in not-for-profits, and with lower costs of production (Sear, 1991). (On the other hand, Meurer *et al.* (1998) report higher charges for hospital treatment of childhood asthma at for-profit than at non-profit and public hospitals.) These lower input costs, however, appear to be associated with evidence of lower quality or poorer outcomes in for-profit settings (Garg *et al.*, 1999; Himmelstein *et al.*, 1999).[12] Concerns about "the tension between profit maximization and medical appropriateness" remain.

In this new environment, there is some evidence that for-profit organizations *are* finding ways to reduce their costs of operation and protect their larger operating margins. But apart from concerns about the deterioration of quality, it would appear that the same powerful incentives that encourage cost control within the organization, also strongly discourage passing savings on to purchasers in lower prices. To the extent that reduced costs in for-profits do represent real efficiencies, and not just lower quality, the benefits of these cost reductions appear to be appropriated by shareholders as higher profits.

Indeed Silverman *et al.* (1999) find that when Medicare expenditures are analysed on a population-wide basis, regions with high levels of for-profit provision show significantly greater overall spending (per capita, age-adjusted). Moreover, regions in which all hospitals converted (between 1989 and 1995) to for-profit status showed much more rapid rates of cost escalation than those where all hospitals remained not-for-profit. "…our data do not demonstrate any cost savings associated with for-profit ownership. Our findings are consistent with the possibility that for-profit hospital ownership itself contributes to higher per capita costs..." (*Ibid.* p. 425).

Furthermore, the finding of higher costs was not limited to the hospital sector. "Spending in for-profit areas was greater than in not-for-profit areas in each category of service

[11] Altman and Schactman (1997a) argue that higher administrative costs should not be regarded as problematic, if they are associated with lower costs overall – efficiency, after all, requires management. They reported, on the basis of an unpublished ProPAC study, that costs per Medicare case treated were lower in for-profit hospitals, even though overhead margins were higher. This finding, however, was based on a misunderstanding. They inadvertently compared data unadjusted for hospital teaching status. When the data were adjusted, their initial conclusion was reversed (Altman and Schactman, 1997b).

[12] Studies based on hospital-wide mortality rates show a more mixed pattern. Hartz *et al.* (1991) and Kuhn *et al.* (1994) found higher adjusted mortality rates in for-profit and public hospitals than in private, not-for-profits. Shortell and Hughes (1988), however, found no association between ownership and overall mortality rate. More recently McClellan and Staiger (2000) find not-for-profit hospitals to have lower mortality rates than for-profit hospitals for elderly heart disease patients, after adjusting for hospital size, teaching status, urban or rural location, and patient demographics. The authors find, however, that this difference disappears, and indeed the for-profits have a slight advantage, when adjustment is made for location. For-profits, in their study, tend to be located in areas with worse outcomes overall. Since it is unclear why they should choose to locate in such areas, one is left with the chicken –and-egg question: are the areas with concentrations of for-profits lower quality overall *because* they have a concentration of for-profits? If so, adjustment for "location" adjusts away the effect of interest. In any case, McClellan and Staiger observe that quality variance within ownership group is much greater than the difference between groups, leading them to conclude that factors other than ownership status dominate.

examined: hospital services, physicians' services, home health care, and services at other facilities" (p.420). The observation of a spending differential for all types of services is significant because of the potential for cost-shifting across sectors. "[I]t has been well documented that for-profit hospital firms inflate their revenues by discharging patients early from the acute hospital (for which they receive a fixed payment regardless of length of stay) to a rehabilitation hospital owned by the same firm (which receives additional payments)" (Himmelstein and Woolhandler, personal communication).[13]

Profits versus professionalism again – conflicting physician interests

These observations are consistent with more general findings that economic incentives modify patterns of patient management and medical decision-making. As emphasized in Section B above, "… ownership does affect clinical decision-making" (Schlesinger *et al.*, 1989, p.255). The most troubling of these concern "self-dealing" by physicians who have an equity interest in services to which they can refer their own patients. Physicians with such arrangements have been shown to have very much higher rates of referral, for services carrying much higher charges, than physicians without such an equity interest (Hillman *et al.* 1990; Swedlow *et al.*, 1992; and also Mitchell *et al.*,1992, but see O'Grady, 1993). The profitability of these non-arm's-length arrangements for both clinics and practitioners has led to a significant expansion of so-called "joint ventures".

The conflict of interest and potential for skewing clinical decision is obvious. "[A] doctor who thinks there should be no concern about self-referral as long as it is disclosed and…monitored is analogous to a purchasing agent … who discloses to the … CEO that he has a vested interest in certain vendors with whom he does business… the CEO would probably fire the purchasing agent on the spot." (Relman, 1992). Nor has this situation escaped the attention of regulators (Crane, 1992; Priest, 1996). More recently attention has shifted (back) to the range of ways in which for-profit drug companies have entangled the economic interests of prescribing physicians with the marketing of the company's products. The objective is to shift the balance of professional and economic considerations bearing upon the prescribing decision (Wazana, 2000). Attempts by the AMA's Council on Ethical and Judicial Affairs to police physician interactions with drug companies have recently been undermined by the CME [continuing medical education] imperative. "In the last several years … [i]ndustry money and influence has permeated virtually all levels of physician CME in the form of complimentary meals and entertainment, consultation fees, and pseudo-CME courses" (Tenery, 2000, p. 392).

Monitoring and prosecuting fraud -- a neglected cost?

The attempts by for-profit firms to influence medical decision-making, while ethically very questionable, are for the most part within the letter of the law -- although the law in the United States has been changing to try to deal with them. More recently, however, several cases have emerged in which prominent firms or their employees have been

[13] Studies of rehabilitation and psychiatric hospitals show patterns similar to those in acute care (McCue and Thompson, 1995; Dickey, 1994; McCue *et al.*, 1993). For-profit facilities show higher revenues and expenses per adjusted discharge, and higher profits.

convicted of outright fraud, on a major scale, and heavily fined or jailed. The intense pressure for escalating earnings imposed by the private capital market has led in these cases to deliberate criminal behaviour. Several of these prosecutions are currently on-going.

For example, executives of the giant Columbia-HCA hospital chain in the United States have recently been convicted, fined and jailed for fraud in the latest stage of a wide-ranging and long-running prosecution by the U.S. Department of Justice. While Columbia-HCA declares that the company did nothing wrong, others believe that these convictions could lead to further indictments, and strengthen a case that could cost Columbia-HCA as much as $1bn. USD (Heldman, 1999). National Medical Care (now Fresenius Medical Care North America), the world's largest provider of kidney dialysis services, has just been convicted of fraud and fined a record $486 million USD. Prosecutors described National Medical Care (NMC) as a deeply corrupt company, and are continuing to investigate the activities of its executives (National Post, 2000).

While the criminal activity at NMC appears to have stopped after the company was purchased by a German firm, another German giant, the Bayer pharmaceutical company, is the centrepiece of a recent expose in *Fortune* magazine (Behar, 1999) concerning criminal activities carried out by firms contracted by the company as part of its world-wide "dirty little war" against manufacturers of generic drugs.[14] And closer to home, Ontario has launched suits in both Ontario and Wisconsin courts against National Medical Enterprises -- one of the largest health care corporations in the United States – to recover a total of $305 million in billings for excessive, inappropriate and unnecessary mental health care services provided to patients recruited or "lured" from Ontario to residential facilities in the U.S. NME has previously pleaded guilty to criminal charges in the U.S., and paid out over $700 million to settle "the largest case of health-care fraud in American history" (McCann, 1998).

The point to note is that these are not "fly-by-night" companies, fringe players in the world of for-profit health care. They are the industry leaders, the biggest companies in their fields, and the pattern of behaviour is systematic. (Perhaps that is why they have been so successful.) This behaviour is a natural outgrowth of the drive for profit, inserted into the world of health care provision. As a former manager of a number of Columbia/HCA hospitals (and member of the Saunders/Lombardi school) in the U.S. recently pointed out, "Columbia hospitals exist to make money – period." (Lagnado, 1997).

That is not to say that various forms of questionable behaviour – including criminal fraud – do not occur outside the for-profit sector, nor that all for-profit corporations inevitably engage in fraudulent practices. But it does point clearly to the need for careful, continuous, and costly, monitoring. Furthermore, the scale of these fraudulent activities and the prominence of the perpetrators are something quite new, and appear to date from

[14] Nor is such behaviour confined to the pharmaceutical industry. Documents recently made public by the tobacco giant BAT reveal an extensive and long-term covert corporate strategy of promoting smuggling and tax evasion (Maguire and Campbell, 2000).

the change in the U.S. reimbursement environment, referred to above, superimposed on a sector with a large for-profit component. The charges, convictions and settlements now being reported reflect behaviour over the past five to ten years – in the Ontario case they go back to the late 1980s. Payers dealing with for-profit providers will have to be prepared, as the Ontario government has discovered, to pay the additional cost of monitoring, suppressing, and where necessary prosecuting such behaviour, or to bear the financial consequences. Whether or not explicitly accounted for, these costs become part of the administrative overhead associated with for-profit provision.

Is evidence from elsewhere relevant? Profit motives are the same everywhere

The evidence on the relative prices, costs, quality, and general behaviour of for-profit and not-for-profit organizations in health care is extensive, and largely consistent, but one might question its relevance. The Alberta Government's proposal does not involve privatizing an entire hospital or delivery system, but rather the provision of overnight care to patients in specialized facilities providing a very narrow range of surgical services. Potentially, this would permit provider teams to organize patient flow for maximal efficiency, as well as to hone their skills and provide high quality care. The Shouldice Hospital in Ontario, specializing in hernia repair, and the Gimbel eye clinic in Calgary are given as examples (see also note 10 above).

Such a question, however, would miss the main point from the body of empirical evidence. "[T]he tension between profit maximization and medical appropriateness" is inescapable, and universal -- for physicians. For-profit firms suffer from no such "tension headaches". Their task is only to find ways to induce the physician to resolve the tension in favour of profit – and they are very good at this task.

The case for specialized and streamlined surgical clinics, as both more efficient and potentially of better quality, seems plausible and might be persuasive. But if so, such clinics can equally well be established within the public hospital system. Why contract for these services from for-profit corporations? An answer might be that there are organizational and incentive features of large, not-for-profit institutions that make more efficient provision difficult to achieve in practice. The objectives of the institution, or its members, are not necessarily congruent with those of the public that support it. But the incentives that drive for-profit organizations can also lead to behaviour that subverts public objectives. The pursuit of private profit is only to a limited extent consistent, for well-understood reasons, with the purposes of a public health care system. When the two come in conflict, will it be possible in practice to ensure that public objectives prevail? In light of the evidence on for-profit behaviour reviewed above, the answer would appear to be "No". Demanding as the task of improving public sector efficiency may be, it *has* been done, and the odds of success look better than those from introducing for-profit delivery.

"For-profit", not "private", is the issue: Motives matter most

It is important to be clear that the concern is with the *for-profit* delivery of clinical services, not with their *private* delivery. After all, most physicians practicing in Canada today are already private 'entrepreneurs'. They simply derive the majority of their professional income from provincial medical insurance plans. But the Alberta proposal introduces two subtle but crucial changes.

First, under current arrangements, physicians are reimbursed by the public plan for the provision of their professional services. But surgical services are provided in not-for-profit facilities whose capital and operating costs are funded through separate (public) budgets. This proposal opens up new opportunities to bill privately for the facility component, in effect transferring those facility costs from hospital global budgets to the private fee-for-service sector.

Second, the revenue from these latter billing opportunities becomes accessible to non-physician corporate interests, whose motivations are entirely profit-driven – a move along the spectrum described in Section B above, away from professionally-dominated motivation. While only a licensed physician can bill for professional services, the facility itself may be owned by a publicly traded corporation or by a partnership involving non-physicians.

Privately profitable strategies with public costs
(i) Transparency – what <u>are</u> the costs?

This raises a number of issues, of transparency, of cream-skimming, of appropriateness of services, and of opportunities for extra-billing. The issue of transparency arises from the necessity to negotiate a reasonable fee for the facility component, to cover all non-professional (capital and operating) costs. This will presumably require some comparison with costs in the public sector, as well as a clear idea of the nature and volume of services being provided in the private facility. But there is no readily available information on the costs of providing surgical services in public facilities; the cost accounting frameworks have simply never been developed. And such information on the private side would be proprietary. In short, there is no official information on which to base the comparative costs of surgery in public and in private facilities. In the case of cataract surgery, informal estimates suggest that the facility fee paid by the region may be 50%-125% higher than the cost of equivalent care in the public system (Armstrong, 2000; CBC, "The Magazine", February 29, 2000).

The Calgary Regional Health Authority has not revealed the details of its contracts, and not surprisingly the private clinics are not advertising the true cost of providing the procedure. One might have expected that if the private option represented a 'good deal', the Health Authority would have made the cost information known.

Privately profitable strategies with public costs
(ii) Cream-skimming and cost shifting

Apart from the adequacy or availability of the information base, comparative costing is hampered by the possibility of a variety of types of cream-skimming. If surgeons are able to work in both public and private systems – as they are at present in Alberta – and have an equity interest in the private facility, it will be economically advantageous to steer their most straightforward cases to the private facility. This represents another modern form of "fee-splitting" – introducing an additional economic motive to influence the professional's judgement. It also makes difficult or impossible the comparison of unit costs between the two systems.

Furthermore, to the extent that the private facility is able to offer a more congenial working environment – regular hours; pleasant surroundings; no shift work; predictable caseload – it may be able to siphon off the more competent and productive support personnel. If the private facility is also non-unionized, it may gain a further cost advantage. And finally, even if costs for comparable patients were available, these will depend in part on the relative volumes of patients in the public and private facilities, the size of the bases over which their respective overhead costs can be spread.

Because relative costs are likely to be a black hole, the setting of overhead/facility charges will reduce to a matter of relative negotiating skill and persuasion, with the information advantage being held by the private facility owners. Without very carefully detailed analysis and oversight, it will never be possible to compare costs in the public and private systems.

Opening up private facilities for overnight stays may also open up other profit opportunities through cream-skimming higher paying, as well as lower cost patients. In addition to serving the less complex and costly Canadian patients, we might expect a private facility to market its services to Americans. The huge discrepancy between fees in Canada and those in the U.S. leaves plenty of room for undercutting the latter while still charging well above Canadian rates (*Vancouver Sun*, 2000). If a private clinic could attract a sufficiently large American clientele, it would have no economic incentive to care for Canadians at all – unless they were prepared to pay extra, in some form or other. In this case, the shortages of physicians and other personnel allegedly faced by Albertans would be exacerbated, not alleviated, by private care.

These practical problems arise from the inherent mis-match between the objectives of a public health care system, and those of a private, for-profit organization. Profit is the difference between the revenues of an organization, and its costs; accordingly for profit organizations focus on increasing revenue and decreasing cost.

Privately profitable strategies with public costs
(iii) Extra-billing the patients under a new name

But revenues can be enhanced both by increasing price, and by increasing volume. If prices for insured professional services are constrained – as by a provincial reimbursing agency – the natural response is to create an expanded product line. Overhead or facility services can be sold to the province as part of the insured service; ambience or amenity services can be sold directly to the patient but tied as closely as possible to the insured service. The separations become fuzzy, to the patient and to the province. The public objective may be value for money; the private objective is simply money.

Canadian physicians have always chafed at the constraints imposed by globally negotiated fee schedules and have argued for the opportunity to extra-bill their patients for their professional services. The private clinic provides motivation and opportunity to promote additional, uninsured services, which carry substantial profit margins. These services may appear to be merely "offered" to patients, to choose or reject. But in practice they may be packaged with the insured service such that they are not optional extras but part of the overall service. In any case the patient is typically at a substantial informational disadvantage, with no way of evaluating the real value, let alone the true cost, of the extras.

These concerns are more than just speculation. There is already information available from for-profit health care providers in Alberta (Armstrong, 2000). In Calgary all cataract surgery is done in commercial clinics, and eighty percent of Calgary cataract patients pay an average of $400 out-of-pocket (some have paid up to $700) for the procedure. For this the patient receives a foldable lens implant, offered as being of higher quality, and a variety of other services which can include a video of the procedure (Armstrong, 2000). The foldable lenses themselves can be manufactured at a cost that "probably does not exceed £10 [$25] anywhere" and "are generally sold at three to ten times this price", depending upon the negotiating power of the purchaser (Allan, 2000, pp. 73-4). [15] As Allan notes, while development costs are high, the market is massive. Thus there is plenty of room for negotiating price discounts.

How does the cataract patient know that the "superior quality" lens on offer for several hundred dollars extra provides no additional advantage in therapeutic outcome, or that the price she is being charged is several times the actual cost, or that in public hospitals in other jurisdictions[16] the extra cost of the foldable lens is simply absorbed by the hospital? Perhaps she could find out, if at the time of the offer she could contact a number of

[15] The price paid by clinics in Calgary is unknown, but if bulk purchasing yields such major price advantages, the obvious strategy for providers is to purchase through a provincial or national purchasing agency and make the lens available as a Medicare benefit. Purchasing "at retail" is just stupid – except for those collecting the marked-up price from patients.

[16] In Lethbridge, for example, all cataract surgery is done in public hospitals, and the foldable lens implant is provided at no charge to the patient (Armstrong, 2000). The public hospital has much less incentive to market services or to mark up charges over costs, because no individual in the organization can take the profit home as income. It would be worth finding out how these lenses are purchased, and at what price to the hospital?

different ophthalmologists, not all associated with the same private clinic, and knew what questions to ask, and was willing to go through the referral process again. Perhaps….but it does not happen. Just before going into surgery is a bad time to begin haggling over prices. But if the buyers of these services are unable to judge their value or cost, or are constrained in their choices, the increase in clinic revenues represents cost without benefit to the provincial population.

One might hope that the Regional Authority as a public agency, or provincial government that established it, might act as a "prudent purchaser" on behalf of patients, or at least provide information and advice, to remedy the information gap. Instead, only the initiative of a voluntary organization, the Alberta branch of the Consumers' Association of Canada, brought these practices to light. The Regional Authority seems to have taken no interest or if anything to have acted as the agent of the private interests.

Privately profitable strategies with public costs
(iv) Increased services do not necessarily meet needs

As for volume of output, the presumption of both advocates and opponents of private care is that more services are needed – and will be provided. But it must be remembered that volume of output contributes to profit, whether or not it contributes to meeting needs, so long as it is sufficiently reimbursed. Providers of care may not like to talk about them, but inappropriate and unnecessary provision coexist with unmet needs, and these problems are more severe in a fee-for-service environment. Fee-for-service medicine has for decades been critiqued on the grounds that it provides a strong economic incentive to over-servicing. Indeed the Auditor-General of Alberta raised the same concern in his 1996-1997 Report: "In past years…I noted that the fee-for-service payment system contains no obvious strategy to promote more cost-effective services, or discourage unnecessary services. … Some believe that a volume driven payment system poses the risk of encouraging the provision of unnecessary services" (Valentine, 1997, p. 128).

The check on economically-driven over-provision is the professionalism of the provider, and his/her sense of responsibility to the patient. In the words of the American Medical Association, "..physicians are not simply business people with high standards…in the special calling of healing…they are the fiduciaries of their patients. They have different and higher duties than even the most ethical business person" (AMA, 1992). For-profit organizations recognize no such duties – the shareholders do not grant them that luxury. A shift in organizational motives, away from professional concerns and toward those of the bottom line, will be associated with greater pressure to "sell" and less professional restraint. The for-profit setting strengthens the incentive to over-servicing, both because facility costs are now on the table, and because of the change in mix of ownership and motivations.

The profit-driven pressure to expand output underlies confusion as to the influence of profit motives on costs. For-profit organizations have a powerful motivation to control unit costs, but no interest in controlling total costs of care. On the contrary, the pressure

to increase service provision (sales) will be reflected in increased total costs for health care. If the increased output does in fact meet real needs, then more services at lower cost appears as a clear gain. But once again, while the public objective is value for money – effective care efficiently provided – the private objective is just money. So long as the service is reimbursed, at a price sufficient to cover its cost, the contribution to health is irrelevant. The sale is its own justification.

There may be risks associated with selling products or services that do no good at all, or do actual damage. The latter may abruptly turn off or indeed reverse the flow of money. On the other hand, there is ample evidence that health products can maintain their markets after being found on evaluation to be useless or harmful. Clinical services of dubious value also enjoy remarkably long survival times.

The point is not that people and organizations in the non-profit sector do not also behave badly on occasion, but rather that the more intense the pressure to produce profits, the more likely it is that sales will over-ride other considerations – even to the point of overt criminal behaviour. There are an increasing number of examples of such behaviour.

Minimizing unit costs -- increased efficiency, quality dilution, or income redistribution? It depends.

Moreover the efforts to minimize unit costs can take a number of different forms. Some are consistent with wider public objectives, others pose a direct threat. In general, cost reduction is achieved either by using fewer or less costly inputs in producing services or goods, or simply paying lower prices for those inputs. If the former yields the same volume and quality of outputs, which in the health care field ultimately means equivalent effects on patient health and satisfaction, then the cost reduction is a pure gain in efficiency – as good or better care at lower cost – and public and private objectives coincide. If on the other hand cost reduction is associated with poorer health outcomes, then public objectives have in fact been sacrificed to private profit.

Private profits are also increased, however, if costs can be shifted onto someone else's budget. From a private perspective, cost shifting is as good as cost reduction – because it *is* cost reduction. But from a system-wide perspective overall costs may not be reduced and may even increase. This is the essence of the "cream-skimming" problem – selection of the less complex, lower-cost patients while leaving the complex cases in the public system. "Privatize the profits, socialize the losses" is an old but still very effective formula for business success.

Costs may also be reduced by simply paying the suppliers of inputs less. In this case, even if there are no adverse effects on volume or quality, the coincidence of public and private objectives is not so apparent. If for example, the private provider is able to move service provision from a unionized to a non-unionized environment, wage and benefit costs may be reduced for essentially the same mix of personnel. This results in reduced costs, but from an economic perspective there is no gain in efficiency because the same

resources are being used up in producing services.[17] Rather, income has been transferred away from the workforce. The gainers may be either the provincial government – ultimately taxpayers – if the prices paid for the care fall, or the owners of the facility – the residual claimants – if they do not. A transfer from workers' wages to shareholder profits, consequent upon a shift of care to a non-union shop, with no change in public outlays or health consequences, is at best neutral from the point of view of general public objectives. But to the owners (who may include non-Canadians) it is pure profit – unequivocally a good thing. The workers may take a different view.

More Illusions of efficiency – private capital is not a charitable donation

Another "efficiency illusion" arises with respect to the costs of capital. The "make or buy" decision may be skewed by the impression that it is cheaper to "buy" by contract than to "make" in the public system, because "buying" avoids the necessity of investing large amounts of public capital. A moment's reflection, however, reminds us that since private investors are not in general charities – at least not on purpose – the price at which services are bought from a contractor will have to include an amount to provide a return on the capital invested. And since governments can raise capital more cheaply than private firms, the cost of capital will be greater when it is paid for through a private company. Private firms can of course also raise capital in equity markets, but share purchasers demand an even higher return, on average, than bond-holders, and in addition, as pointed out by Taft and Steward (2000) the firm incurs significant additional costs for "investor relations" – maintaining share value, and preserving future access to the equity market. Private markets can indeed generate almost unlimited amounts of capital – for a price.

A second consideration may be that contracting is a more flexible approach. Rather than making an irreversible commitment to, say, build a hospital that may last for decades, whether or not it remains needed, governments can simply contract on a pay-as-you-go basis. But this too is an illusion. The buyer's flexibility is the contractor's risk, and investors must be compensated for accepting risk. Either the contract terms must include compensation for early or unexpected termination, or the contract itself must be long-term. If the buyer insists on complete flexibility, it will come at the price of a substantially higher cost for the services themselves – to compensate for the risk. There is no free lunch from private investors.

Accounting illusions – private contracting as off-budget public borrowing

There is yet a third form of efficiency illusion that may be very real politically for governments. Capital expenditures by governments show up as public expenditures at the time they are made. Private contracts, involving long term commitments, are in effect a form of long term indebtedness, but only the current year expenditures show on the

[17] On the other hand if shifting production to a non-unionized environment permits more flexible and effective use or personnel, the substitution of capital for labour, or more generally the reduction of occupational "turf protection" and "featherbedding", then these efficiency gains are very real. This may be an unspoken objective of the Alberta initiative, but if so it is clearly not the only one.

government books. A government that is trying to show low public expenditures, to an electorate most of whom are not accountants, may find this form of illusion, of "off-budget" financial commitments, politically valuable.

All three forms of illusion have been very clearly and expensively illustrated by the Private Financing Initiative (PFI) in the U.K. National Health Service. "Investment under the Private Financing Initiative has cost more than public sector procurement. The annual charge for the use of privately financed facilities is between 9.1% and 18% of the original construction costs, whereas government can borrow at interest rates of 3.0% to 3.5%." "The amount of risk transferred to the private sector under privately financed deals has been exaggerated, leading to spurious attributions of additional value to private sector options." "The extra cost of private finance is disguised by the Treasur[y]…" (Gaffney *et al.*, 1999). "The Private Finance Initiative is presented as using private money to pay for the infrastructure developments that are needed for public services, but it is still paid for through the public purse… Unfortunately the schemes produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital." (R. Smith, 1999b)

Capital outlays may be a particularly sensitive issue in Alberta, where the long term effects of the hospital spending spree from 1978 to the late 1980s are still being felt. With oil money pouring in, and a rural electorate clamouring for their own hospitals, the building program was politically successful. The exceptionally high capital costs in those years could be paid for relatively easily; after all, there was more money coming in than anyone knew how to spend. But the longer-term effect was an oversupply of beds and institutions that pushed Alberta's operating costs well above the national average. It is now quite obvious that better use might have been made of the money in earlier years. The Alberta government may be understandably fearful of making old mistakes, but that is no justification for making new ones.

Harnessing the profit motive for public benefit – What prospects for "competition" or direct regulation in health care?

The above may appear to be simply a litany of possible problems, a "chorus of hypothetical complaint." But the sceptical reader should recall Lagnado's (1997) description, above, of Columbia-HCA hospitals, " [they] exist to make money -- period." The tremendous dynamism of for-profit enterprise is rooted precisely in the drive to survive, through identifying and exploiting any and all profit opportunities, however small. If the opportunity is identified, it will be taken (if not by you, then by your replacement).

How, then, are potential mis-matches between profit incentives and public objectives reconciled? Adam Smith described one mechanism two centuries ago, when he portrayed the self-interested businessman being "…led by an invisible hand to promote

an end *which was no part of his intention*" (A. Smith, 1937, p. 423, our emphasis).[18] The competitive marketplace can, albeit under quite restrictive conditions, compel private firms to behave in ways that meet public objectives. But the conditions – informed buyers of well-defined products in competitive markets with free entry and exit -- *are* quite restrictive (as Smith knew, even if many of his later celebrators have missed the point) and they obviously do not apply to health care.

Contracting in the commercial sector – the contrasts with health care

Contracting out for services – "buying rather than making" -- in private sector industries takes place in a context of multiple bidders offering to provide a well-specified service or product. The party letting the contract defines the specifications, and is normally able to maintain detailed oversight to make sure they are met. Competition among bidders both creates the incentive to minimize costs, and ensures that contract prices will reflect this. Product or service quality is monitored by the informed and interested buyer. And, in general, self-dealing would be severely dealt with if exposed. One would not expect the purchaser for a private corporation to be able to maintain a financial interest in the vendor(s) from which (s)he is buying.

The problems faced by a public buyer are in fact quite similar to the situation of an individual patient faced with the "offer" of additional uninsured services to be paid for out of pocket. Buyers who are unable to judge the value/appropriateness of services, or their true cost, or who are constrained in their choices, fare badly in private markets, and will find themselves paying too much, for services they do not need.

The advantages (for buyers, or those they represent) of a competitive process are also dependent upon the presence of multiple independent bidders. Such competition is not a sufficient condition, but it is necessary. In its absence, any benefits that do arise from private provision are more likely to accrue to the providers themselves. It is difficult to imagine how such competition can be achieved in the Alberta setting, even in large urban centres. Competitive bidding works best, from the buyer's perspective, when there is a surplus of providers. If as some claim the province is suffering from a shortage of key personnel, the market advantage accrues to the bidders. Potential suppliers, who are for the most part known to each other, can easily see that there is enough, and more than enough, work to go around, and can equally easily see the disadvantages to themselves of undercutting each other on price. The rapid development of some form of overt or implicit collusion or cooperative market sharing seems highly likely.[19] Accordingly it should come as no surprise that the advocates of an expanded role for private clinics in Alberta are not simultaneously calling for a more openly competitive delivery system.

[18] "I have never known much good done by those who affected to trade for the public good. It is an affectation, indeed, not very common among merchants, and very few words need be employed in dissuading them from it." (*Ibid.*)

[19] Collusion over prices, or agreements to share markets, are criminal offences under the federal *Competition Act*. But the *Act* does not apply to provincially regulated industries or occupations, such as providers of health care.

Yet they may end up with one, whether they like it or not (see below on NAFTA and WTO risks).

The absence of a competitive market could be overcome if the party letting the contract is so well informed about the process of production, and has a sufficiently powerful bargaining position, as to be able to bargain for the terms that a genuinely competitive process would have yielded. In reality, however, the informational advantage will all be on the side of the providers. The party letting the contract will not generally have even sufficient information to be able to specify the nature and quality of the product to be provided – or judge that of the producers. The problems of "cream-skimming" and lack of transparency of costs, arise precisely because the buyer is at an informational disadvantage with respect to the detailed nature and needs of individual cases, and cannot monitor exactly what is being provided and paid for. The problems faced by a buyer are nowhere better illustrated than in the circumstances of the cataract patient (described earlier) faced with the "offer" of a "superior" foldable lens to be paid for out of pocket.

If we generalize to the entire set of services for which a public purchaser enters into a contractual relationship with a private clinic (or clinics), and recognize that, in general, the public purchaser will be no better informed about the details of the services being purchased than the patient was about the lens, the "informational disadvantage" begins to 'live'.

These problems can arise in any contracting process in the health care sector, including public sector contracts. But they are exacerbated, not mitigated, when the contracting is with private, for-profit interests, and especially if the contracting providers are able to work both in the public and in the private sectors, and can direct patients to either on the basis of their relative profitability. The market provides no constraint on this form of opportunistic behaviour.

Regulating for-profit enterprise, or replacing (moderating) the profit motive – professionalism and self-regulation

In the absence, or ineffectiveness, of market competition to constrain provider opportunism, modern societies rely on various forms of public oversight and regulation in an attempt to align more closely private behaviour with public ends. But in the health care sector, direct public regulation shares with private contracting the problems of informational disadvantage and difficulty of enforcement. The complexity of the regulatory task has led almost all countries toward a mix of direct regulation, delegated self-regulatory control, and non-profit provision, with a very limited role for for-profit firms. A great irony is that the outstanding exception, the United States, has the most heavily regulated health sector. Experience in that country demonstrates that the detailed regulatory oversight is singularly ineffective at creating the conditions for efficiently functioning health care markets. Despite all the regulatory machinery, the American health care system is far and away the most costly, inequitable, and inefficient on this (and perhaps any other) planet.

It is possible that a regulatory framework might be devised that could overcome these problems. One might require providers to work either in the public hospital system, or in the private contracting system, but not both. One might forbid contractors from selecting patients individually, and require them to accept a "package" of cases, both simple and complex. One might forbid private contractors from accepting any separate payment from insured cases, or from caring for non-insured patients (e.g. Americans). One might require private firms to open their books to public scrutiny, regardless of proprietary concerns, so that their actual cost-structures could be ascertained. But the chances of achieving such transparency and foreclosing opportunistic profit-seeking are vanishingly small.

They vanish altogether in a political environment where the government has made it clear that it wishes to encourage the growth and prosperity of private delivery organizations, and is relatively unconcerned about side-effects. It was, after all, the government of Alberta, not the Alberta Medical Association, that requested from the federal government a "working understanding" providing, among other things, that the province would not be penalized, under the *Canada Health Act*, if its physicians worked and billed simultaneously in the public and private sectors. Regulating for-profit providers of health care in the public interest is, as the Americans have learned, a very difficult task at the best of times. It becomes inconceivable under a regulatory authority sympathetic to those private interests.[20]

Smoking in the powder magazine: International trade agreements and the threat to public health care

> ***"It's better to experiment than to plan"***
> Jim Dinning, Chairman
> Calgary Regional Health Authority
> CBC, "The Magazine", Feb. 29, 2000
>
> ***"There's no turning back"***
> Tom Saunders, CEO HRG
> (as quoted in Cairney, 2000)

But even if the government of Alberta could devise, and wished to implement, an "ideal" regulatory structure that would perfectly harness the for-profit drive to (almost) universally accepted public objectives, they would probably not be permitted to do so. There is a larger trap here, a trap that may well catch not only Premier Klein and the people of Alberta, but the rest of Canada as well. His proposal risks undermining Medicare across the whole country, by exposing it to the full force of the "privatizing" thrust of current international trade agreements. Both the North American Free Trade Agreement (NAFTA) and the General Agreement on Trade in Services (GATS) of the World Trade Organization have as their over-riding objective the removal of all barriers

[20] Indeed, some members of the regulatory authority may even participate in those private interests, which would appear to constitute an obvious and serious conflict of interest (Taft and Steward, 2000).

to international trade in goods and services *in any form, including health care services,* and correspondingly the reduction in the jurisdiction and powers of governments.

Appleton, for example, concludes that NAFTA "irreversibly protect[s] the trend towards private health care, while eroding the ability of governments to reverse this trend." (1999, p.87). Member governments are permitted to reserve certain sectors of their society from its provisions, and preserve their scope in these policy arenas, and Canada has done so with respect to "health". But the language of this reservation is far from clear.[21] "The difficulty is in ascertaining [its meaning] since the wording is clothed in a language more akin to diplomacy than law." (*ibid.* p. 95). The Canadian government favours a broad interpretation of the terms "social service" and "public purpose", thus ensuring a continued wide scope for public policy. But as of 1995 the U.S. Office of the Trade Representative "[held] that where commercial services existed, that sector no longer constituted a social service for a public purpose." (*ibid.* p.96).

Two major points emerge from the NAFTA, that are reiterated and reinforced in the GATS.

First, all sectors that are not explicitly *and exclusively* reserved for public action are to be open to international trade and competition, if not immediately then as soon as possible. Signatories bind themselves to accept this objective. Under Article 19 of the GATS, member countries are expected to pursue "a progressively higher level of liberalization" in any service sector involving a mix of public and private ownership. In a 1998 background note (WTO, 1998) the World Trade Organization Secretariat gave their interpretation of GATS to imply that countries where the hospital sector is a mix of public and private ownership, or where there is private insurance or user fees, cannot argue for exemption under Article 1.3.[22]

Second, this opening is a one way process. Jim Dinning may believe (or want us to believe) that he is simply engaging in a social experiment which, if unsuccessful, could be terminated. The WTO seems to take a different view and, in any dispute, would likely prevail. Tom Saunders is right (*supra)*. Once the Article 1.3 exemption is withdrawn it is unclear whether or how it could ever be restored. In any case for Canada, NAFTA is clearer. If a government chooses to enter a new field of activity, or return to one previously vacated, it incurs potentially prohibitive penalties in the form of compensation to any commercial interest that can claim lost business opportunities (Appleton, 1999). Once the dike is breached, it becomes impractical to get the water back onto the other side.

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[21] The relevant Canadian reservation reads: "Canada reserves the right to adopt or maintain any measure with respect to the provision of…the following services to the extent that they are social services established or maintained for a public purpose: income security or insurance, social security or insurance, social welfare, public education, public training, health, and child care" (NAFTA, ann. II-C-9 as quoted in Appleton, 1999, p. 95).

[22] This Article exempts "government services" from other provisions of the GATS. A "government service" "is supplied neither on a commercial basis, nor in competition with one or more service suppliers."

As soon as the Calgary RHA puts in place a contracting arrangement with a private hospital, under WTO rules "the [hospital] sector should be open to foreign corporations." Article 19 then commits all of Canada, not just Alberta, to moving in this direction.[23] Failure to do so with sufficient rapidity to suit any one of its trading partners (read: the United States), could trigger a dispute settlement process under the GATS (Price *et al.*, 1999). And there may be no way back.

This is of course only the opinion of the WTO Secretariat, interpreting the intentions of the GATS from their particular perspective. One might well argue that, while in their opinion it is impossible to be just a little bit pregnant, the real world is more nuanced. Also the growing international understanding of the implications of the GATS is leading to growing opposition to its agenda. The Secretariat's interpretation may not turn out to be as authoritative as they might like to believe.

Here, as everywhere in the "Brave New World" of international trade agreements, what is most clear is that nothing is clear. As Appleton points out, disputes will have to be resolved by various tribunals applying international, not domestic, law, and until the case law has emerged from this process, the outcomes are impossible to predict. International law does not even define terms like "social services" and "public purpose".

What is certain, however, is that the Alberta government does not hold all the cards in this game, and cannot know or control the outcome. Its current proposal clearly expands the scope of private provision of health care, by corporate entities that have international links (Taft and Steward, 2000). Whether or not the proposed legislation would initiate the risk of NAFTA or WTO involvement, it certainly raises the probability, and (at least in the case of the WTO) for all of Canada. The genie that may be let out of the bottle is not one whose behaviour anyone can predict. Whatever assurances may be given about the limited and controllable effects of Alberta's initiative, there is no way for anyone to know whether they can be backed up. When the Alberta government's web site (http://www.health.gov.ab.ca/health_protection/questions.htm) responds to questions about NAFTA vulnerability with "Absolutely not", their confidence is absolutely baseless. On the international trade stage, Alberta is not even a player.

This inherent uncertainty encourages the differences of opinion over the seriousness of the threat posed by these international agreements. But the disagreements, at least in the public record, are remarkably asymmetric. Those who express concern – sometimes extreme concern -- support their argument with chapter and verse from the international agreements and supporting documents. Those who dismiss or ignore the problem, show a disconcerting unwillingness to provide argument or evidence. "No problem" seems to end the matter. If there is some basis for this nonchalance, it would be comforting to see it.

[23] Canada, not Alberta, is signatory to the GATS; the WTO considers that failure to meet the terms of the Article 1.3 exemption anywhere in Canada is a Canadian failure, and opens all of Canada to foreign corporate competition in the hospital sector.

So what is Premier Klein's real aim? "Two-tier" care by inadvertence, indifference, or stealth?

This leads one to wonder yet again why Premier Klein is so determinedly pushing this proposal in the face of public opposition in and out of Alberta. It raises questions about the sincerity of his commitment to the preservation of universal public coverage, if he is willing to take such risks with its long-term survival, for such uncertain and questionable benefits. Why does he insist on smoking in the powder magazine? Given this government's past record of explicit support for the introduction of private medicine with private payment, it is legitimate to consider whether this proposal may not be a stalking-horse behind which it continues to pursue the real long-term agenda of rolling back universality and establishing a private tier of health care delivery and payment.

Yet this is an outcome which, as the government itself has made clear, Albertans definitely do not want (Alberta Ministry of Health and Wellness, 2000). And such an interpretation would appear to be in direct contradiction to the Premier's very clearly expressed statements, that the proposed legislation will address only the *delivery* of services and that reimbursement of insured services will continue to be entirely public. But the qualification, "of insured services", may be significant in light of the experience with eye surgery in Calgary, and with private MRI clinics. The opportunity provided to the private eye clinics to make very substantial profits from "enhanced" and uninsured services is obviously very valuable to them.

Conceivably, this valuable opportunity may have been "purchased" indirectly in the form of very favourable terms offered by the private contractor to the Regional Health Authority. (These contracts, however, are not open to public scrutiny.) If so, this would amount to a saving in the public budget, offset by a substantial increase in costs imposed on patients. Private profits rise and public expenditures fall, raising the spectre of an unholy alliance between providers and government to foist a *de facto* two-tier system on an unsuspecting public. Such a change would precisely reverse the effect of Medicare, which has contained provider incomes while transferring costs from private to public budgets. Yet all "insured" services would still be covered.

The concurrence by the federal government in 1996 with a modified version of the twelve principles put forward by the Alberta government as a "working understanding" appears to open the door for much more of such *de facto* privatization of funding (Kennedy, 2000). Changing the definition of what is "medically necessary", as for example to include the timeliness as well as the nature of a procedure (an MRI is medically necessary, but an MRI *this week* is not) makes possible the transfer of a wider range of services from the insured to the uninsured category. Again costs are shifted from public to private budgets, though it remains technically true that all "insured" services are covered by the public plan.

Certainly the privatization of funding is an openly expressed objective of a number of Canadians of Premier Klein's political persuasion. The motivations behind *that* agenda are readily apparent from an analysis of its redistributional effects. Who would gain and

who would lose, in straightforward economic terms, from the opening up of a private market in health care in Canada for "those who can afford it"? (Proponents' claims of general benefit are easily shown to be false.) In briefest summary, when the burden of funding is shifted from the public to the private sector the healthy and wealthy gain at the expense of the unhealthy and unwealthy (Evans *et al.*, 1994). Medicare, or public funding in general, shifts the burden in the other direction. But there is more to the story, and we provide a more detailed analysis in the Appendix to this paper.

More generally, however, how is it that ostensibly reasonable people disagree so profoundly about whether to preserve our system or dismantle it? They disagree because despite the common rhetoric, they do not all share the fundamental values on which Medicare is based. To see this clearly, follow the money. Under privatization, despite claims to the contrary, more money goes to providers and shareholders, and services go to those who can afford them -- not necessarily those who need them.

Those who favour a public system are concerned primarily with equity of access on the basis of need, not ability to pay. They also favour a single bargaining agent -- the state -- to counteract the power of provider organizations *and* unions. They want to hold administrative costs down. Perhaps most fundamentally, they view health care as a public good to be used prudently and effectively, rather than as a commodity to be marketed for profit.

Is it possible that Alberta-style proposals are consistent with these same concerns? Certainly the rhetoric accompanying them would have us believe so. Yet the analysis above suggests otherwise. This inconsistency points to the possibility that the Alberta proposal may have quite different intentions, and its proponents fully understand what they want. Their position may be perfectly rational from their perspective, but must be cloaked in the vocabulary of enhancing Medicare in order to be more widely palatable. Know what they are up to and judge them by their deeds, not their words.

D: Summing Up -- Potential Benefits and Risks

The balance sheet just doesn't seem to balance

Premier Klein has put forward his proposal as a way of improving the Medicare system, of expanding its capacity to meet serious and growing needs for health care within the framework of universal public coverage for hospital and medical services. Yet if Albertans' health is threatened by a shortage of resources in health care, the obvious question is: "Why not just put them back?" into the public system where they came from. And indeed the Alberta government continues to do so. The case for the Premier's proposal has to rest on the argument that it is a more efficient, less costly way of increasing service capacity, that private facilities will yield more "bang for the buck". References to waiting lists, aging populations, and the largely fictitious "streams of wealthy Canadians heading south" are just window dressing that do not address this central issue.

The efficiency argument cannot be dismissed out of hand. In making it, the Premier is aligning himself with a wide range of Canadian analysts and investigative bodies, over many years, who have sounded the same theme -- ways must be found to improve the efficiency and the effectiveness of the health care delivery system. Unlike his proposal, however, most of these other calls for greater efficiency have been for improvements *within* the public delivery system. In this, there is no shortage of possibilities (Rachlis *et al.*, 2000).

And to a considerable extent, particularly faced with the very constrained budgets of the mid-1990s, the public system has responded. In the present environment, highly charged politically and amid the almost universal clamour of "shortages", it may be difficult to keep track of the fact that very substantial improvements in efficiency and effectiveness *have* been made in the 1990s, particularly in the hospital sector. Not everyone is happy about this, least of all those hospital workers who have lost jobs through "downsizing", but the gains are very real nonetheless, and are in fact well-known to all participants. They indicate that the public system can adapt and improve, given the right 'incentives'.

The critical point that cannot be over-emphasized is that the very powerful incentive driving for-profit organizations is to make profit. Period. It is not to improve the efficiency of the health care system, or to provide high quality care, or to advance the health of the population. If these turn out to be profitable strategies, well and good, they will be pursued as means to the over-riding end.[24] But they have no intrinsic value in themselves to the for-profit organization.

If instead the organization concludes that anti-social behaviour – cream-skimming the least costly patients, misleading or pressuring patients to pay privately for extra services, for example – is more profitable, then that is what it will do. The private capital market is unforgiving of failures to exploit profit opportunities, whatever their effects on the rest of the system or the community. Indeed as noted above several recent high-profile cases have shown that explicitly criminal behaviour is also acceptable, providing it promises profits and is expected to escape detection.

The evidence from other jurisdictions shows that in general private, for-profit delivery systems do not have a cost advantage over not-for-profit organizations, but that (in different studies and settings) they are more expensive and/or provide lower quality services. While there is some (mixed) evidence that for-profit firms can achieve economies in the unit costs of particular clinics or divisions, such economies are not passed on to purchasers. Moreover they introduce significant distortions into patterns of clinical decision-making, in ways that add to costs without corresponding benefit to patients, and there are increasing reports of large-scale criminal fraud.

[24] When Tom Saunders, CEO of HRG, "[insists that] in the larger scheme of things…it isn't about profit", he is not being "up front about HRG's profit-driven nature" (Cairney, 2000). HRG is not a registered charity.

In short, for-profit firms do whatever they believe is necessary to maximize their profits. Experience with the private delivery of ophthalmology services in Calgary shows that the opportunities to exert professional influence on patients and sell over-priced, highly profitable, and "medically unnecessary" services, are in fact taken up. For-profit delivery has been a vehicle for the introduction of extra-billing in another form.

In the private commercial sector, contracting with external, for-profit suppliers is normal practice, but takes place under conditions very different from those in the health care sector. Opportunistic exploitation by suppliers is held in check by informed buyers, selecting among competitive suppliers, within a well-defined regulatory environment. The difficulty or impossibility of creating these conditions in the health care sector, is precisely the reason that most societies have tried to limit the role of for-profit participation in health care delivery.

Conceivably, with a detailed information base and a tight and aggressive regulatory structure, regional authorities might be able to ensure that their contracting out of health care services met the standards of normal commercial enterprise. But that is far from assured in the most favourable of circumstances – we do not find examples in experience elsewhere. And the Alberta circumstances are far from favourable – the provincial government has not shown any inclination to try to put in place the necessary regulatory structure, or even any understanding of why it would be necessary. The flow of personnel between the provincial government, the CRHA, and HRG itself casts doubt on the possibility of an arm's length relationship.

There appears to be a complex web of business relationships linking members of the Regional Authority responsible for letting and monitoring contracts to those having an interest in provider firms -- and to the provincial government (Taft and Steward, 2000, Chapters 5 and 8; Fuller, 1998). These linkages create a potential for conflict of interest and "self-dealing."

Under these circumstances, it seems quite possible that purchaser and provider will take advantage of the several ways of showing illusory gains in efficiency described above. Some of the alleged benefits turn out to be accounting illusions. Private firms are not charities; they do not supply capital for free. In fact the costs of raising capital are greater through the private sector, but they are spread out over time and thus do not appear as such in the public accounts. Similarly any reductions in labour costs that result from shifting surgical work to a non-union, lower wage environment represent transfers of income from workers to either shareholders or taxpayers, rather than true improvements in economic efficiency.

It is easy to get confused in this area, and part of the intent here may be to confuse. But the overall costs of a health care system whose capacity has been expanded through this route will not fall and may well go up. In any case the risks to the integrity of the Medicare system are very substantial, and the benefits, relative to a policy of both increased funding and more aggressive pursuit of efficiency gains in the public hospital

system, have not been shown. It is hard to believe that Premier Klein would be willing to take such a bet with his own money, rather than with that of his constituents.

Nor is Premier Klein betting only on behalf of those who voted for him. As outlined above, the provisions of the General Agreement on Trade in Services suggest that opening the door to for-profit delivery in one part of a public health care system, also opens the door to entry by multi-national (in practice, mostly American) corporate interests into the whole system, nation-wide. This may not be the Premier's intent. Nevertheless, those south of the border looking for Canadian opportunities have precisely that objective. And once the window opens a crack, the WTO will try to ensure that *they*, not the Canadian proponents, get what they want. This process is unlikely to be under the control of national, let alone provincial governments.

Stripped to the bone, the Alberta proposal appears to be little more than taking lousy odds on a very small potential payoff, and gambling with the health of Canada's health care system, for the sake of a few health care providers who would stand to gain considerably in the short term. The suggestion that the Alberta government may be pursuing a long-term strategy to undermine and eventually replace Medicare with a system more responsive to the economic interests and concerns of these providers (and better-off Albertans) is inevitably speculative, though it seems consistent with ideological predisposition and past behaviour. But if that is not the objective, one is still left with the problem of making sense of the current proposal. What *is* the motivation for putting the entire national system of Medicare at risk?

Appendix

Opening the private medical market: who gains and who loses from "two-tier" care?

The standard argument for "two-tier" health care

"Two-tier" health care generally refers to the continuation of a universal system of public reimbursement for hospital and medical services (presumably without user charges) but with the addition of an "upper tier" in which "those who could afford it" could purchase care in whole or in part with their own money. This care would be provided by practitioners and organizations that may also serve and bill the public system.

The question of whether this would also open up a market for private insurance against the costs of care in this private tier is not always made explicit. The question is important, however, because as noted in Section B of the main paper, in Canada, as in the United States and several other countries (but not all), private health insurance provided through an employer enjoys a large and highly regressive, but hidden, "tax expenditure" subsidy from the public treasury. A "private" financing tier that was privately insured in this form would thus in reality generate substantial public costs, but "through the back door" as a tax concession rather than explicit public spending that shows up in the public accounts.

Advocates argue that this would increase the total amount of resources available for health care, and relieve the present pressure on the public system. This argument is logically erroneous and dangerously misleading. Although the proponents of this approach claim that it would improve health care for all Canadians, its actual effect would be to advance the interests of the relatively well-off at the expense of the general population.

Arguments for increasing the flow of private money – user payment or private insurance -- in the Canadian system typically rest on two fundamental propositions:[25]

1) Serious needs for care are now going unmet, because Canada's health care system is "underfunded" and desperately requires more money; and
2) Canadians are currently "taxed to the limit" and therefore no more public money can be allocated for health care.

It would appear axiomatic that unless private money is raised, from payments by the users of care with or without supporting private insurance, the health of Canadians will be increasingly threatened by the inadequacies of our health care system. (In effect

[25] There *is* an argument, derived from basic economic theory, that user charges (without private insurance) would lead to lower rates of utilization, lower overall costs (*less* money for health care) and greater "allocative efficiency". But this argument rests on several forms of confusion, and does not appear to play any role in the present debates, in Canada or elsewhere. It is confined to the academic economics journals.

"There Is No Alternative" (TINA) – Margaret Thatcher's slogan.) Day after day, the lurid anecdotes are assembled to drive this point home.

Flaws in the fundamental assumptions – both argument and evidence

In fact, each of these TINA propositions combines a logical *non sequitur* with an empirically unsupported factual claim, backed only by loud assertion. [As the sermon notes of the legendary Scottish preacher put it: "This point very doubtful. Shout like hell."] "Underfunding" claims are as old as Medicare, and are in fact made in all health care systems at all times. But those who make them confuse – often deliberately – the adequacy of care with the rate of reimbursement of providers of care. "More money" can mean either more services, or just higher incomes. The Reduced Activity Days campaign waged by B.C. physicians over the last few years makes the point clearly. They have been quite deliberately and explicitly withholding services – trying to create a shortage -- in order to protect their fee levels. They argue that the B.C. government has not been providing sufficient funding to pay for an increased number of medical services, but in fact the conflict is actually over the rate at which those increased services are to be reimbursed – the fee level.

As for whether the Canadian health care system really does now need more resources, rather than better management of the very considerable resources it already has, this point is open to legitimate debate. There certainly are an increasing number of observations and episodes that suggest significant shortages of particular personnel and services at particular times and places. But the question remains open as to whether these reflect an overall shortage, or simply the lack of overall system management.

For example, claims about long and growing waiting lists exist in an information vacuum. Individual physicians are, by and large, the custodians of the country's wait lists; there is little cross-physician list coordination, little systematic list management, no independent audit of lists, and so on (Sanmartin *et al.*, 2000). Yet again, the backlogs in emergency rooms are very real. But it seems equally clear that seasonal backlogs are not at all new, and reductions in acute bed capacity are not the source of the problem. Rather it appears that the current "crisis" reflects inadequate patient management, and capacity, in long term care. The wrong diagnosis could easily lead to egregious errors in prescription. (A more detailed discussion of alternative and more promising prescriptions is provided in Rachlis *et al.*, 2000).

As for taxation, even if Canadians really were taxed to the limit, a government that is running large surpluses and projecting even larger ones, can increase the flow of public money into health care without raising overall taxes. The trade-offs are between more public money for health care, or for other public services, as against cutting taxes (or debt reduction) – and indeed some of each is clearly possible.

No one enjoys paying taxes, and those who pay most – the wealthy – least of all. But Canadians are not in fact overtaxed relative to other developed nations; comparative

international evidence does not support the "taxed to the limit" rhetoric.[26] Furthermore, even if it were true there would still be plenty of room to put more public money into health care – if we wanted to. The Federal budget of February 2000 is an explicit political choice *not* to do so, to make large reductions in federal taxes instead, but it was not a forced choice.

The mis-match between arguments and policy: "Two-tier" health care does not address the problem that its advocates (claim to) perceive

But these are arguments for another place and time. The principal purpose of this Appendix is to show that:

> *Even if the twin TINA propositions above were both valid and beyond all question, they would not support an argument for the two-tier health care system outlined above.*

To see why, consider two alternative systems for raising private financing for health care to supplement public resources. One we might call one-tier health care with user charges, and the other would be a completely segregated private market for health care. Each of these would represent a possible response to the alleged circumstances described by the two propositions above -- unmet needs and no more public money. But both differ in critical respects from what is usually offered as "two-tier" medicine. These differences permit one to see more clearly the real effects, and presumably the objectives, of the latter policy.

One tier health care with user charges

Prior to the passage of the *Canada Health Act* in 1984, some provinces required hospital in-patients to pay a per diem charge for acute care. Extended care patients still pay such a charge, all across Canada. Earlier still, Saskatchewan briefly introduced a per visit charge for physicians' services. Provincial drug benefit plans, not covered by the *Canada Health Act*, all impose some form of user charge; one or more of: a deductible, a fixed charge per prescription, or a patient co-payment of some portion of the cost.
If the two propositions above held, Canadian governments might respond by requiring each recipient of hospital or physicians' services under the public plans – an office or emergency room visit, a specialist consultation, a day of inpatient care or a day surgery episode -- to pay one or more of these types of charges at specific pre-determined rates. The additional revenues raised by these charges would then be available to add to the public financing for health care.

[26] Nor, apparently, do most Canadians. The "tax revolt" seems to be largely a media event sponsored by the representatives of the wealthy. Polls consistently show that tax reductions rank low in the list of public priorities – the public would prefer more funding for health care and education. The federal budget of February 2000 has made major reductions in personal income taxation – an estimated $38 bn. or about 60% of the estimated federal surplus of $95 bn. over the next five years. But it has given most of the reductions to the wealthy – who really wanted them.

Proposals for such charges have come forward repeatedly over the years since Medicare was introduced – as noted above the present debate is not new. Their disadvantages have also long been recognized. "One tier plus user charges" raises serious concerns about both equity and access, as well as problems of administrative cost and feasibility. Correspondingly, schemes for alleviating those concerns and problems have almost as long a history. Yet these have never found political support.

Problems with user charges – and a partial response

First the concerns.[27] User charges that are uniform across the population bear much more heavily on people at lower incomes. Lower-income people tend also to be sicker, but even if illness were unrelated to income, the same level of charges represents a much larger share of the income of a lower-income person. Even if some people are exempt, as in practice they must be, the burden will still be regressive across those who must pay. And at any given level of income, the accident of illness will draw financial liability with it. If illness is random, and "unfair," so are user charges.

Second, in order to make any significant contribution to the costs of health care, such charges would have to be quite large. When hospital inpatient days cost upwards of $500 each, and intensive care goes beyond $1000, a $10 or $25 per diem is not going to be noticeable in the overall picture. It may not even repay the cost of collection. So the user charges will have to be financially significant to the individual patient, if they are to be financially significant to the system as a whole. But large user charges raise concerns – and indeed the reality – of access problems for those at lower incomes. Those concerns were what motivated Medicare in the first place.

Third, the collection of these charges would presumably be the responsibility of hospitals and private practitioners. These would then have to incur costs of financial administration and collections.[28] If there were various forms of exemption, these would create further administrative problems and costs to determine eligibility for exemption. The introduction of Medicare was associated with significant reductions of administrative overheads in physician offices, as bookkeepers were replaced with practice nurses (Enterline *et al.*, 1973). Sufficiently high user fees would invite the re-emergence of private insurance in Canada, with similarly high administrative costs. In the U.S., a complex payment system adds over ten percent to overall health care costs in the form of administrative waste motion (Himmelstein and Woolhandler, 1991).

Finally there are risks of "opportunism" by both governments and practitioners. How would one ensure that the new money raised in charges would go into increased health care spending? Some of it will be siphoned off into the inescapable administrative

[27] For a more extended analysis and critique of user charges in practice, see Barer *et al.* (1979) Evans *et al.* (1995); and Barer *et al.* (1998).

[28] User fees that were related to the actual costs of the care received by a patient would require a whole new hospital accounting system; in Canada hospitals cannot at present identify the costs associated with the care of an individual patient. And even under the most comprehensive accounting system individualized costs would be merely estimates, resting on a number of arbitrary assumptions.

activity noted above. Even if the remaining funds are somehow earmarked, and segregated in government budgeting, governments might still offset the increased revenue by reducing their allocations to health care from other tax sources. Alternatively, once permitted, and indeed expected/required to bill patients for some portion of the cost of their services, might some physicians not simply add to that bill, and pocket the extra? It is not difficult for a patient to notice the difference between a bill, and no bill. But it takes much more knowledge to compare the actual bill with the fee schedule and the approved user charge. Physicians who for years have believed that they should have the right to determine the price for their services (and so extra-bill their patients), and who now see government requiring the patient to pay, might quite understandably take the view that they, too, should be entitled to a bit extra. Why is billing the patient legitimate if government does it, but not if the practitioner does it?

But for thirty years, various analysts have suggested that some, at least, of these concerns could be mitigated by integrating user charges with the income tax system (Feldstein, 1971; Ontario Economic Council, 1976; Rice and Thorpe, 1993; Gordon *et al.*, 1998). One could, for example, simply cumulate the total payments made on behalf of each individual from public sources, and add this to taxable income. The amount of the user charge would thus automatically be adjusted to the user's ability to pay, and the problems of collection would be absorbed into the general administration of the income tax. No additional costs would be incurred by practitioners. If one is thoroughly convinced that the twin TINA propositions above do hold, and private charges must be imposed, then integration with the income tax is clearly the least complex and inequitable way to do so.[29] Yet in contrast with the advocacy of "two-tier" care, proposals for "one tier with tax-integrated user charges" have never drawn significant political support, or even public attention. Why?

There are of course a number of very good substantive arguments against tax-linked user fees as an alternative or supplement to universal, first-dollar coverage (Lewis, 1998). In general, tax-linked schemes have almost all the same problems as unlinked systems, though to a lesser degree. They may be less regressive overall than unlinked user fees, and indeed this is the argument made by Rice and Thorpe (1993) in the United States. But there, many patients are currently at risk for large, capricious and potentially ruinous out-of-pocket costs, and a tax-linked approach would mitigate this burden. In Canada, with full public coverage for hospital and medical care, a tax-linked user fee scheme would serve primarily to shift a proportion of the health care cost burden from taxpayers to users of care, from the healthy to the sick. And since the healthy tend to be richer than the sick, what is in theory a progressive form of revenue generation becomes in practice a regressive transfer. (It is very doubtful if the tax system would or could embody a sufficiently complex and sophisticated structure of rates, ceilings, floors, and exemptions to avoid a significant transfer of burden from higher to lower income people.)

[29] There are some obvious problems for very ill people who have very little money. Their "taxable income" and tax liability might be well above their actual income. But one could in principle adjust by formula the proportion of the cost of care that is actually added to taxable income, putting a ceiling, for example, on either the total amount or the proportion of income to be added.

The point here is not, however, that "one tier with tax-linked user charges" would be superior to Medicare on equity, efficiency, or any other grounds. Obviously it would not. Our point is rather that *if* one were firmly convinced of the validity of the TINA assumptions, and that private payments, whatever their faults, cannot and should not be avoided, then this would appear to be an obvious option. The contrast between the energetic advocacy of two-tier care, and the total lack of any public interest in tax-linked user charges, may offer clues as to the real basis for two-tier arguments.

The real agenda behind "two-tier" proposals

One major disadvantage of the tax-integration schemes may be their political transparency. They make it crystal clear that the user charge is a tax on illness, or at least on the associated use of health care. Of course all user charges, of whatever type, link financial liability to use of care – that is the very definition of a user charge – and as such function as taxes on illness, particularly if the revenues raised are a substitute for those that would otherwise come from other tax sources. But putting the amounts of liability right on the individual's T-4 slip leaves no room for rhetorical confusion. If you are sick, you pay, and the sicker you are, the more you pay. Faced with that brute fact, no jurisdiction has been willing to implement this option. User fees, yes, but tax linkage, no.[30]

But an alternative – or additional – explanation for its unpopularity may be found in what the "one tier" approach does *not* do . Unlike the "two tier" system, it does not give "those who can afford it" preferential access to (actual or perceived) superior quality care. Nor does it give the providers who serve "those who can afford it" the opportunity to increase their incomes by charging fees to "private" patients that exceed the fee schedules of the public plans. And it provides no market for private care insurers, drawing on the large but hidden public subsidy, to underwrite the costs of these benefits and thus add to the administrative overhead costs of the overall system. In short while it redistributes costs from the ill to the healthy, it re-distributes benefits only to a limited degree, if at all, in favour of the well-off and their providers, and the (would-be) financiers of care.

Viewed from this perspective, it may come as no surprise that suggestions for "one tier with tax-integrated user charges" have never drawn any public awareness, let alone political support.[31] On the other hand support for a "two-tier" system seems to be growing – though it may be that its advocates are simply becoming more strident.

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[30] A user charge is paid to a provider, and looks like a form of market transaction, a payment for benefits received. The fact that it is an alternative to taxation is not readily apparent.

[31] Indeed the only proponents seem to be economists, many of whom have a quite idiosyncratic view of the role of user charges. Drawing on elementary economic theory, and with little or no familiarity with the realities of health care, economists tend to think of user charges as a way of *reducing* overall costs and bringing about a more "efficient" allocation of health care. Despite logical fallacy and overwhelming empirical refutation, this view has persisted within a particular ideological school for whom a particular economic theory is a religious conviction rather than an analytic tool.

Preferential access to superior care

Advocates of "two-tier" care argue that everyone benefits, when "those who can afford it" purchase some or all of their care in the "upper tier", because they leave fewer people to draw on the limited public resources in the universal system. But it is an essential feature of "two-tier" systems, that an upper tier implies a lower tier. Unless the care available in the upper tier is at least perceived to be superior, why would anyone voluntarily choose to pay for it?

At the very least the upper tier care must be more readily and rapidly available – no, or significantly less, waiting. The question of therapeutic equivalence is trickier. The most effective form of marketing is of course to create patient perceptions that outcomes are better in the upper tier. On the other hand if the general public come to view their health as being put at risk in the lower tier, this could set off a competitive cost expansion process. Political pressure to increase funding for the public system and close the perceived gap would be followed by further efforts at "gold-plating" in the private tier to restore it – quite likely inducing a medical technology "arms race". This situation would be ideal for providers in both sectors, since all expenditure is also income; but would leave payers, public and private, all worse off. A sufficiently rapid escalation of public sector costs would of course dash the expectations of "those who can afford it" for a reduced tax burden – as it has done in the United States.[32]

The most stable situation may be one in which "those who can afford it" believe that they are receiving therapeutically superior care, but the general public do not. It is not clear whether this can be achieved, but one might anticipate public statements that outcomes do not differ in the two tiers, combined with reassurance to the private patients that they *are* in fact getting better quality care. Since monitoring quality of care has always been the Achilles' heel of public accountability, the actual situation is likely to be obscure, particularly if the private tier is less open to public scrutiny.[33]

Preserving the private advantage: Manipulation of public access by private providers

Quite apart from the question of potentially different outcomes, however, the standard form of differentiation is waiting time. This is a very old story from the British National Health Service; long waiting times in the public system, short or non-existent in the private. But the heart of the problem in the NHS is that *the same* consultants are working both in the public and in the private system. The surgeon who deplores the extended wait times in the "underfunded" public system can offer the patient immediate care – in return for a private payment.

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[32] The United States, while having a public system only for the elderly, the poor, and certain other selected populations, now faces *public* costs (per capita) for health care that are among the highest in the world, in addition to private costs – insurance and out-of-pocket – that are several times those in any other system. Providers are very well off.

[33] The United Kingdom may offer an example of a two-tier system in which this division has been maintained for decades, but has now broken down quite dramatically as the central government has recently had to promise massive increases in funding for the public system. .

Without those deplorably long NHS waits, however, who would accept the private option, and how would the surgeon collect the extra income? This extra income is not trivial, it can amount to tens of thousands of pounds in ophthalmology (cataracts) and orthopaedics (joint replacement). But the surgeon who profits from the private care can also choose how to allocate his or her time and effort between public and private care. There are contractual obligations in the NHS, but they are not well monitored or enforced (Light, 1996). And most importantly, they are obligations in term of *time*, not productivity. Surgeon productivity is reported to be very low in the public system, much higher in the private, for the same surgeon. Standard economic interpretations of human behaviour would predict that surgeons would allocate their time and effort where they receive the highest return. If in the process they contribute to long waiting lists in the public system, so much the better; that serves to ensure a good supply of private patients.

Evidence of similar behaviour has been found in comparisons of cataract surgery in private clinics and public hospitals in Manitoba (Decoster *et al.*, 1999). Public waits are longer where there is a private clinic, and the same ophthalmologist sees patients in both. The economic motives faced by a practitioner who works "both sides of the street" in a two-tier system are both very clear, and very strong. He/she has both powerful motive and opportunity to ensure that public sector care remains inferior to private. And if people do not like the inferior care, the answer comes easily – put in more money! But the universal experience with waiting lists in two-tier systems is that putting in more public money never seems to provide anything like 'permanent' relief (McDonald *et al.*, 1998; Sanmartin *et al.*, 2000). Once one recognizes the economic motivations of those providing services in the upper tier, it is not hard to understand why.

The practitioners' interest in a two-tier system is clear, but what about the patients? Here the distinction between "two-tier" and "one tier with user charges" is critical. In the latter, more money is raised through user charges, to improve the standard of care *for everyone*. There is preferential access for "those who can afford it", insofar as the user charges price those who cannot out of the system, leaving more room for those who can. If the user charges are large, and access to private insurance is also income-dependent, this effect may be quite serious. But there is not a separate system with shorter waiting times or (actual or perceived) higher quality care for those who pay more. If the wealthy want more or better care, they must pay for a similar standard for everyone, through either taxes or higher user charges. And if the latter are tax-linked they will bear more heavily on those at higher incomes, though also more heavily on the sick at any income level.

"Those who can afford it" pay for themselves, but not for others. Higher charges, lower taxes, and better access to care

From the point of view of the relatively well-off, this option is at least superior to simply putting in more tax money. The Canadian tax system is either roughly proportionate to income, or progressive (see note 3 above); in any case higher income people pay more taxes than lower income people. They will pay a substantially lower share if health care finance is expanded through user charges rather than through taxes. But if the user

charges, for reasons of equity, administrative efficiency, and preserving access, are integrated with the income tax, much of this advantage disappears.

In contrast, a two-tier system permits the wealthy to purchase better care *for themselves*, without having to contribute to a similar standard for everyone else. If one accepts proposition #1 above, that the present Canadian system is underfunded not just in the sense that those who work in it would like higher incomes, but that it is incapable of meeting the health care needs of Canadians, two-tier care enables "those who can afford it" to ensure that at least their needs are met, first and best.

The claim that its advocates are also concerned to relieve the pressure on the public system, and leave more public resources for those who cannot afford to pay their own way, tends to be undermined by the common observation that advocates of two-tier care also tend to be advocates of lower taxation, and opponents of deficit financing, which in turn implies lower public spending. Yet health care is the largest single public spending program. As noted above, the present financial situation of the Canadian federal government is such that more public spending on health care does not require further taxation, only less tax cutting. (Provincial governments that have made a priority of tax cutting are, of course, placed somewhat differently.)

But even without lower public spending on health care, the oft-heard claim that allowing a second tier would relieve pressure on public waits simply rings false for anyone who bothers to spend more than a few seconds thinking about it. The second tier care can only be provided (in Canada) in one of two ways. It may be provided by practitioners "working both sides of the street" in which case we may expect the experience noted above in the UK, mirrored in other countries such as Israel (and beginning in Canada) to prevail. Or it may be provided by practitioners who work only in the second tier. In the latter situation, this would mean siphoning off already (allegedly) scarce personnel from the public system, to work in the private. It is hard to see how either scenario will shorten wait lists or times in the public tier. Only if the second tier did not 'use up' scarce Canadian human capital could it possibly lead to reduced wait times for patients in the public tier.

A completely segregated private market, but a small one -- The American "upper tier"

Some advocates of a two-tier system argue that Canada already has such a system, in the sense that "those who can afford it" can always go to the United States for immediate (and highly intensive, if not always more effective) care. So, why not open a private tier in Canada, and keep all that money here? The United States does indeed offer an upper tier, not just to Canadians, but to the world. But it differs from a domestic upper tier in a fundamental way. It is in fact an example of the case referred to above – from a Canadian perspective it is a completely segregated private market for health care.

Those who go to the United States for care – that is, the true "medical refugees" who go specifically for that purpose, not the snowbirds in Florida for the winter, or the visitor/accident victim -- must pay the full cost of their care, to providers who have no

interest in or control over any element of the Canadian system. They are certainly purchasing care with quicker or easier access or of perceived better quality, without having to contribute to a similar standard for other Canadians. But they also really *do* relieve the pressure on the Canadian public system, by removing needs (or demands) and lowering utilization, without using or diverting Canadian resources.

They do not relieve very much pressure, however, because they are very few. Systematic efforts to find such people in the U.S. health care system, either in border states or in high-profile "magnet" institutions, find remarkably small numbers (Barer *et al.*, 1999). And the findings are consistent with survey responses in Canada[34]. The "streams of wealthy Canadians" heading south for care unavailable in Canada, are a media fiction, deliberately promoted by those on both sides of the border who have an economic interest in portraying Canadian health care as underfunded or simply inadequate.

Highly publicized examples of Canadian provincial governments purchasing specific forms of care for their residents in the United States (such as the current situation in Quebec and Ontario for radiation therapy for some cancer patients) raise another set of issues. But they are not germane here, because these services *are* paid for by the public plan. This is not two-tier medicine, but "one tier with service imports."

Apart from not being there, however, the "medical refugee" has no other impact on Canadian health care. Canadian providers do not work on both sides of that fence; they have neither incentive nor opportunity to steer patients into a more remunerative care setting. Unlike the consultant in the British NHS, they cannot benefit by ensuring that the waiting lists in the public sector remain long.[35] Quite the contrary, the Canadian physician whose patient goes south loses the work, and the billings. (S/he may refer a patient south for professional reasons, but there is no economic incentive -–unless the Canadian provider has invested in a facility below the border.)

But the most striking aspect of Canadian "medical refugees" is the contrast between their huge numbers in the Canadian and American media (and therefore perhaps in the minds of at least some of the public), and their tiny numbers when they finally reach the United States (Barer *et al.*, 1999). (The loss rate at the border seems to be quite extraordinary.) There is just not much demand, in reality, for "upper tier" care that is truly segregated from the public system. So why do advocates believe that a two-tier system would fare better in Canada?

Would a domestic upper tier be larger than the foreign one?

There are, we believe, two principal reasons for this belief. The first, already discussed in detail, is the critical difference when providers can work simultaneously in the public

[34] The 1998 National Population Health Survey found 0.11% of respondents who had received care in the United States in the most recent year and had gone to the U.S. strictly for the purpose of receiving that care.
[35] Nevertheless, there may be advantages to keeping ones' own list long. Long waiting lists may be perceived by others as indicative of superior quality; they may also be an argument for a larger allocation of OR time or other hospital resources.

and in the private system. The universal experience is that when providers can work in both, they steer patients to the more remunerative setting, and ensure that it remains more remunerative by undermining the public system. This works; no amount of additional funding in the public sector will ever be permitted to close the quality gap.[36]

The second reason for expecting that a home-based upper tier might draw more patients was captured in the reference to the fact that Canadian "medical refugees" must pay the full cost of their care in the perceived "upper American tier". Fundamental insurance principles make it impossible for the private insurance industry to offer coverage for such care on an individual basis. Insurance companies do not, if they plan to stay in business, sell contracts to people who expect to need care. It is one thing to sell coverage to someone who is out of the country for other reasons, and happens to fall ill. But no insurer will (knowingly) sell coverage for an individual's choice to seek care out of the country. What sorts of people, after all would want to buy such coverage? Only those to whom a for-profit firm would not wish to sell it.

But an in-country private tier might be different, particularly if the coverage could be negotiated through an employer. In that case, the hidden public subsidy comes into effect. Premiums paid by an employer for an employee are tax-deductible expenses, but they are not a taxable benefit in the hands of the employee. The coverage is in effect purchased with "before-tax dollars". Thus private payments for upper tier health care, that are privately insured, would draw money out of the public treasury just as do public payments.

The differences are two-fold. The subsidy does not show up in the public accounts, as it takes the form of taxes not collected, rather than tax money spent. But since the subsidy takes the form of a tax exemption for a particular form of employment benefit, it is also most valuable to those in the highest income brackets. The larger your marginal tax rate, the bigger your subsidy from a non-taxed benefit. It is hard to see how such a subsidy could survive open public scrutiny; it does survive precisely because it does not receive public scrutiny.

Privatize the profits, socialize the losses – The implausibility of a self-supporting private tier

This form of subsidy to private care, however, arises only to the extent that it can be covered through employer-provided insurance coverage – as has happened with the private tier in the U.K. A more general problem is that of whether, even in the absence of private insurance, it is possible to have a truly segregated private system. The economic incentives for the providers in the private tier are very strong, to "privatize the profits and socialize the losses." Unexpected costs are transferred to the public system, and fees are

[36] In principle one might be able to imagine a completely segregated second tier in Canada, in which both physicians and the facilities in which they work were required to be "all in or all out". If they chose to bill privately for insured services, they could not bill the public plans at all. But this is not what advocates are calling for, and it is hard to see how such a truly private tier could be attractive to more than a small minority of physicians. (Most of their patients would probably be Americans.)

collected essentially for providing preferred access to public as well as to private facilities.

Private fertility clinics are a leading example of the former. The techniques for treating infertility significantly increase the probability of multiple births of low birth weight infants, requiring neonatal intensive care. This is extremely expensive, and is provided through the public system. The private contract between the fertility clinic and its patients includes no provision for these extra costs borne by the public, consequent upon the fertility treatment. In a truly segregated market the private clinic, or its customer, would be responsible for all the costs associated with the treatment.[37]

The latter case is illustrated by private MRI facilities in Alberta offering accelerated services for patients waiting for MRI in the public system. The private facility is permitted to offer patients an immediate MRI scan, at their own expense. The grounds for this are that the patient's condition does not appear to warrant an immediate scan, therefore it is not "medically necessary," is not an "insured service" under the *Canada Health Act*. But of course if, contrary to expectation, some condition is discovered by the private MRI that warrants "medically necessary" early intervention, that patient will proceed to the intervention. In effect, then, the private clinic is profiting by selling patients the possibility of earlier access to public facilities, of queue-jumping. (It is doubtful if patients have the necessary information or analytic skills to assess the relevant probabilities. In any case, for those with sufficient money, the probabilities don't much matter.)

A truly *private* private tier of health care within Canada is thus impracticable and probably impossible in reality, and in any case is not what proponents are advocating. Rather they contemplate a private tier interwoven with the public – in effect a "public-private partnership" supported by various forms of more or less invisible public subsidies. Providers, working in both systems, could influence both access and productivity in the public system, steering patients as they saw fit. Meanwhile "those who can afford it" would have ready access to (actual or perceived) higher quality care, without necessarily having to pay its full cost, and without having to pay the taxes that would provide a similar standard for the rest of the population. The attractions are obvious, and provide a sufficient explanation for the continuing popularity of this alternative. Whether they also lie behind the current legislative proposal in Alberta, and its antecedents, is an open question.

[37] And in the case of IVF treatment, those other costs are unlikely to stop with neonatal intensive care, and may include higher lifetime education, health care, housing, legal and other costs (Baird, 1997).

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