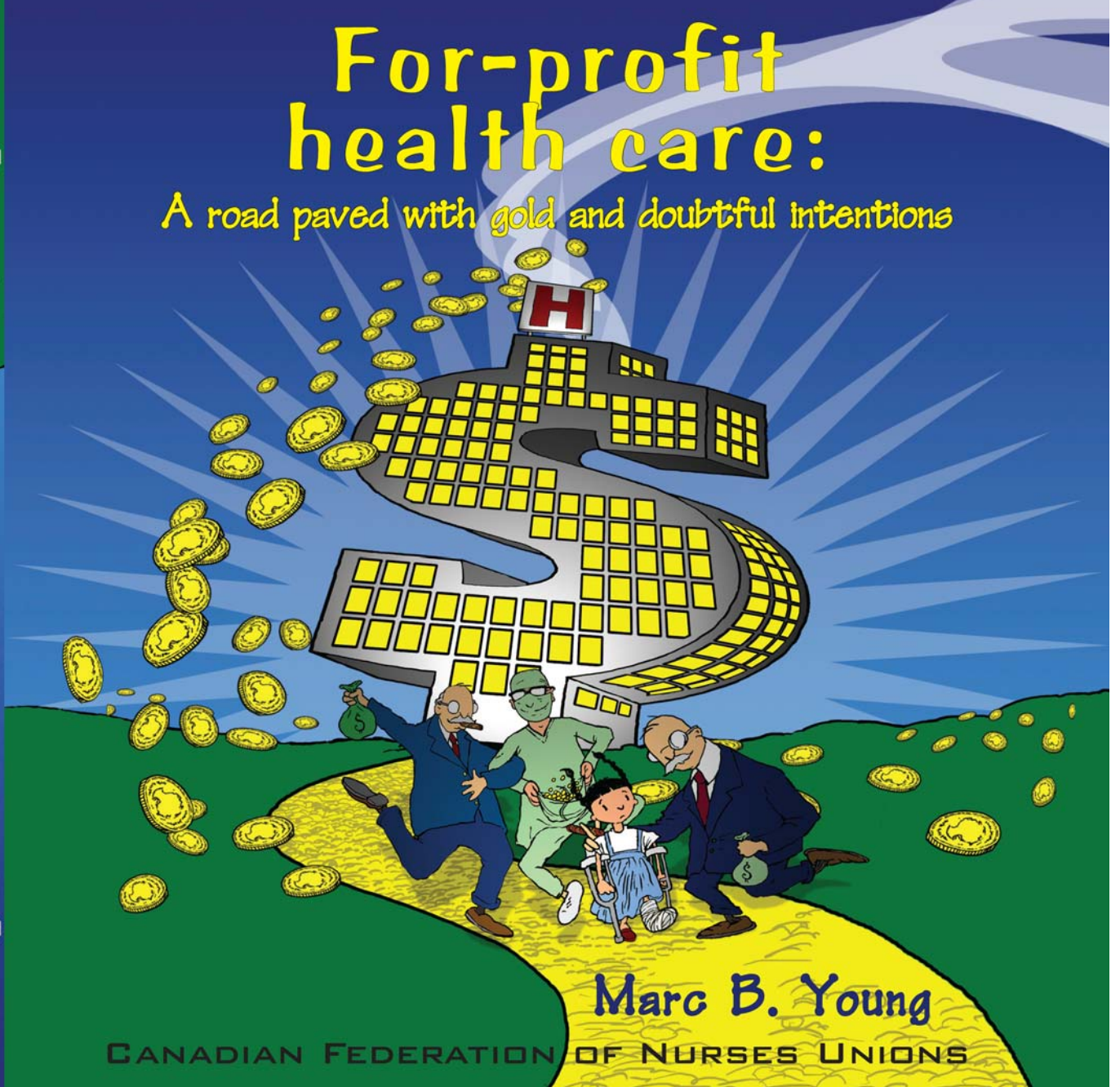
For-profit health care:

A road paved with gold and doubtful intentions



Marc B. Young

CANADIAN FEDERATION OF NURSES UNIONS

CFNU For-profit health care

FCSII Soins de santé à but lucratif

For-profit health care:

A road paved with gold and doubtful intentions

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First Edition September 2008
ISBN: 978-0-9784098-2-1

Printed and bound in Canada by Plantagenet Printing

The illustrations in this book including the cover were drawn by Dirk Van Stralen.
www.dirkvanstralen.com

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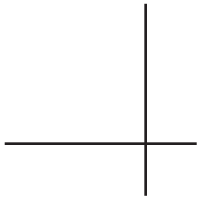


Canadian Federation of Nurses Unions' Vision for Health Care

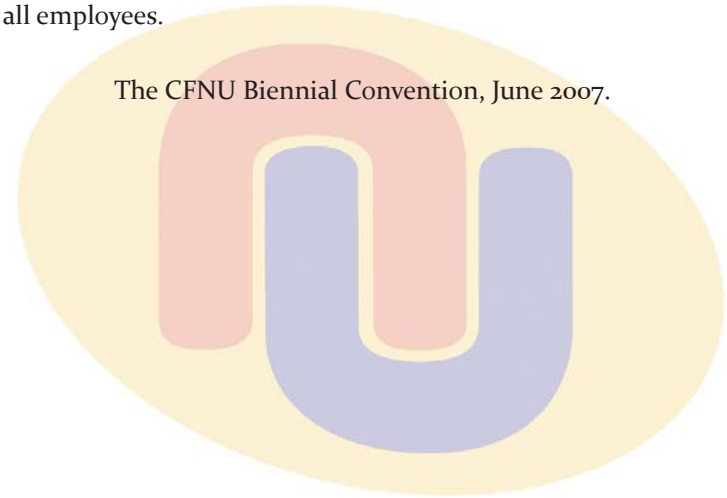
The Canadian Federation of Nurses Unions (CFNU) believes in a healthcare system that is universal, accessible, comprehensive, publicly funded, administered and delivered.

The CFNU believes in a healthcare system that includes superior quality acute care, primary health care, public health, mental health service, long-term care, home care and a national pharmacare program.

The CFNU believes in a health care system that treats all people equally regardless of gender, religion, ethnic origin or financial status.

The CFNU believes in a healthcare system that provides a safe, quality work environment for all employees.

The CFNU Biennial Convention, June 2007.



1. Introduction: the parameters of our discussion

One afternoon in 2006 the telephone rang in the communications office of a nurses' union. On the other end was a political advisor from one of the provincial ministries. The caller was interested in arranging a meeting between government officials and union leaders. His objective: to "explain" the province's alternative financing method for hospital construction, popularly known as Public-Private Partnerships (P3s), to the union leadership. The government wanted to get the nurses on side, to convince them to back the private financing of health infrastructure.

The staff person who took the call said something like, "a meeting is always welcome, so give me the details, but you know our union is against privatization."

The ministry official replied in either genuine or theatrical amazement: "But our financing method isn't privatization! These hospitals will be owned by the public sector. No one will pay to be taken care of. This is the most pro-public government in the history of..." More was said, all of it polite.

Perhaps the reader doesn't have to be reminded that by the time of this call numerous rallies led by unions and provincial health coalitions against P3s had already taken place. The government's idea that a slick presentation could win them the support of unionized registered nurses and allied professionals was no doubt naive.

What was probably not false about the conversation was that it betrayed at least some genuine confusion, or disagreement, about just what privatization in health care is. The ministry voice on the phone was ready to agree that for-profit health care might be ugly. He just wanted to deny that his government was in the business of offering it. So it is important, for our purposes, to identify privatization policies with reasonable precision before discussing the ways in which they might threaten Canadians' well-being. In this paper, we will touch on: the role of for-profit players in healthcare provision and funding; the private financing of infrastructure; the downloading of payment responsibility for services from provincial health plans to patients themselves (generally called de-listing); and the quest to introduce "market principles," broadly speaking, into care.

Supporters of more for-profit care (a more useful adjective than "private" in a country where most hospitals are neither state-owned nor cash generators for shareholders) frequently begin their case by making the point that the Canadian system is already mixed. Providers of those health services not covered by provincial hospital and physician-care plans abound and derive their revenue either from patients' out-of-pocket payments or private insurance plans. Approximately 30% of healthcare expenditure in Canada presently flows from such sources, according to the World Health Organization. Most residents (not including seniors and those receiving social assistance) rely on private plans or their wallet to pay for pharmaceuticals, at least when out of hospital. They pay for dental care in a similar fashion. Pharmacies are commercial enterprises, offering a hodgepodge of essential and non-essential products and services. At neighbourhood clinics, professionals offer health services like chiropractic treatments and massage therapy, proven beyond any reasonable doubt to be medically necessary but generally not covered by the public purse, at least not any longer. For their part, most physicians are small-scale entrepreneurs who employ support staff and get almost all their income from the province.

We won't know if you're treatable until we've had a look at your wallet.

So Canadians already live in a culture of public and private, commercial and not-for-profit medical activity. Don't get excited, advocates of more privatization say: Let's just make adjustments.

Healthcare firms and insurance companies can, runs one argument, help make our system better – while earning money in the process. Direct-to-consumer advertising could be public education without cost to the public.

Our reply to this point of view, to be fleshed out in the following pages, is fairly straightforward. That for-profit activities are widely present in Canadian care hardly means they're a good thing or that they should be expanded. One key virtue of Medicare is that it limits the scope of those medical services offered on the basis of ability to pay rather than patient need. Our system is a public pledge to the sick that they will not be abandoned – indeed, that all reasonable means available to medical science will be employed to return them to health, regardless of the position in the market they occupy. Medicare's weakness, in our view, is that it doesn't limit the scope of profit-making sufficiently, and that over time, not-for-profit care hasn't been comprehensively extended beyond physician and hospital services – although this was the intent of the system's founders.

A system blind to patients' wallet size

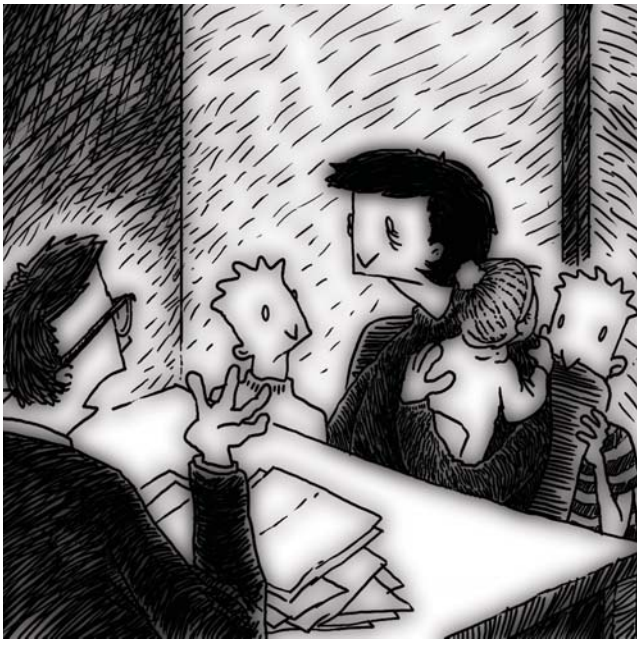
Therefore, our discussion, while tackling the claim that care and government accounts might be improved by more for-profit activity, will also explore the desirability of expanding that share of health spending covered by public revenues and furnished by non-profits. Why would we proceed on the assumption that universal coverage and treatment blind to patients' wallet size has hit some sort of natural or economic ceiling? Canadian nurses assume that improved care is the top priority. The quest for new sources of business for insurers and other entrepreneurs doesn't figure in their set of motivations.

So what does the medical and economic evidence from other industrialized countries have to say about the impact of privatization? How can we make Canadians healthier? How can we better cure people who do get ill, or assist them to manage their medical problems when that is the best that can be achieved, in ways that make the best use of our financial and other resources? What if our governments roll out the welcome mat for primary care clinics where prosperous patients pay hundreds or even thousands of dollars, ostensibly for medical services not covered by provincial

plans, and in the process manage to see unhurried physicians – while millions of other Canadians can't even get an appointment?

The factors underlying good (and bad) health

A few other points by way of introduction. Any discussion of the priorities of a healthcare system has to recognize a key paradox: good health is not chiefly due to treating illness, and yet our health system is almost entirely devoted to repair. Socio-economic factors are by a significant margin the most important causes of good (or bad) health – as the 2002 Romanow Commission noted. In other words, the most important "ingredients" of sound mind and body are housing, clean water and good food, exercise, access to knowledge, a natural environment that has not been poisoned, a safe neighbourhood, and a workplace free of danger and excessive stress – determinants generally not considered part of health care's traditional turf. Even if this book does not focus on these determinants, it is important to keep them in mind as we proceed. Repairing bad health is an unpleasant and often costly fall-back. Everyone senses that prevention ought to come first, that it is a large component of the answer to both healthcare cost and patient suffering. Unfortunately, prevention gets more lip service than action.



Health care costs money. You'll just have to learn to prioritize.

This is largely due to the contradictions built into our market-driven world. Authorities may tell people to eat well, to emphasize fresh vegetables and whole grains. They may urge citizens to exercise. But for every good-food message people hear, they will be told many times more often, in constantly repeating television advertisements, that they should "do what tastes right" and indulge their appetite for beef with added bacon, sandwiched between a soft bun; or they will be force-fed the message that carbonated sugar-water is the real thing; or that they should take the advice of major automotive companies and drive absolutely everywhere, with the result that their legs, heart and lungs spend most of the day at rest.

...a universal, single-payer health system is less expensive and more efficient than a private or mixed alternative.

And while stress might be a significant cause of poor health, and be closely linked to overwork (or under-work, as the case may be), a reduction and redistribution of the workweek would only make us uncompetitive – or so note our political and business elites. Thus, we should learn some deep breathing activities for the office or factory.

In short, when it comes to prevention, not all our oars are rowing in the same direction. Contradictions such as those just mentioned should be kept in mind as we consider ways to improve Canadian health care. Nor are they out of place in a paper devoted to pondering how expanded market forces in the realm of health might negatively impact our lives.

Values…and the value of a dollar

A final introductory consideration. Dr. Danielle Martin, a member of the board of directors of Canadian Doctors for Medicare and an articulate backer of preserved and enhanced universal care, observed in a recent interview that "defenders of Medicare do themselves a disservice by talking about values...when the case is really economic."[1] Without denying that values have meaning, Dr. Martin probably wants to assert that, when it comes to policy, values which may not be universally shared can't hold a candle to the following hard-headed assertion which she believes to have been

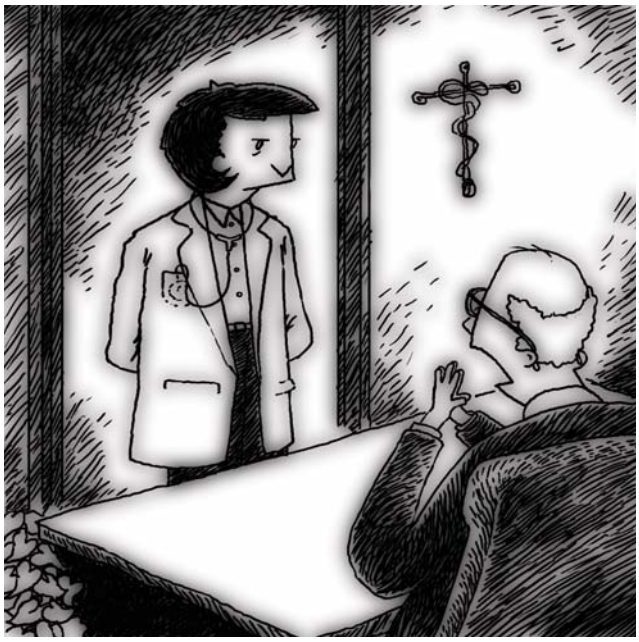
amply established by the literature: a universal, single-payer health system is less expensive and more efficient than a private or mixed alternative.

This could be a valuable point. Yet one senses that questions of efficiency don't quite exhaust the discussion. Those who favour a greater space for private care often assert that basic health services should be available to all, but they are not offended by the notion that extra, private money might purchase additional services or faster attention for some. In fact, this provision suits such persons' moral system quite well. They want "choice" and probably don't think their desire should be trumped by overall savings. Or, to describe their perspective more generously, perhaps they think that their right to personal purchase won't do anyone – or the system – any harm. Equality is a "value" they don't necessarily subscribe to, at least in all its forms. These Canadians and their intellectual defenders make an additional point: we buy and sell things all the time, including goods essential to health, like food and housing. Those with more money have the opportunity to acquire more expensive and usually higher quality groceries – that's a given. What is so different about health care?

Our answer to this question is at least as much about ethics as about conventional notions of economic efficiency. Nurses are open to the view that all goods and services necessary to human health and development should be made available according to need rather than capacity to pay. Morally speaking, we believe that optimum outcomes for all constitute the highest social objective. So health care, strictly understood, is in one sense perhaps not so special after all. Yet it remains true that more than in the case of food or housing, healthcare costs can fluctuate wildly from individual to individual. Justice seems to insist that the person who requires an operation potentially priced at tens of thousands of dollars shouldn't bear the double burden of a crisis both physical and financial. Principles of equality demand that in such a case society intervene to cushion the blow of "bad luck," to do all it can to equalize that person's opportunities for security and happiness.

We might add that in Canada health care happens to be a sphere where we have made important progress in limiting market forces – in the interests of the vast majority of citizens. Why give up egalitarian gains won in this field simply because equal improvements have not yet been made in certain other areas essential to a full human life?

II. Advancing the case for private players



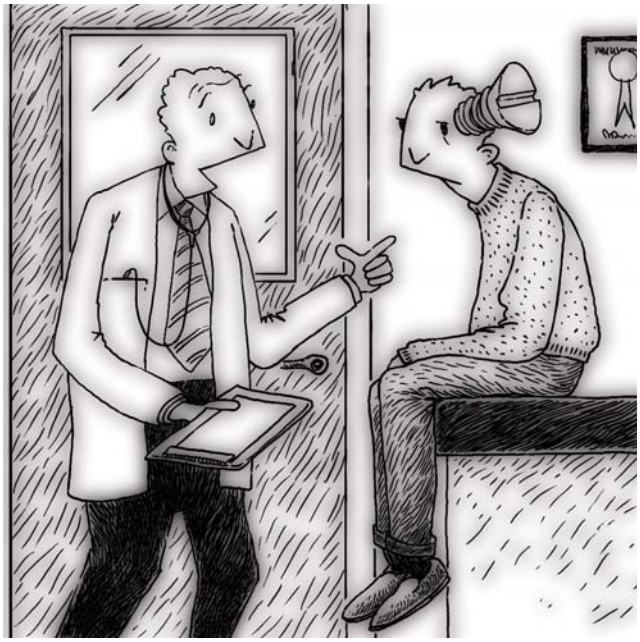
We need them to think Medicare plus - but it's still about profit.

No doubt the highest-profile organization in Canada promoting an expanded role for the private sector has been the Canadian Medical Association (CMA). Is this a surprise from a professional set that has, for the most part, historically offered grudging acceptance to Medicare, at best, and downright hostility at worst? Has that always included some who are hard-pressed to distinguish between principles of professionalism and political ideology? Perhaps not.

Yet those enjoying the political upper hand in their organization have been savvy in their latest approach. President Brian Day, an orthopaedic surgeon and founder/co-owner of the for-profit Cambie Surgery Centre in Vancouver, is well aware that Canadians are attached to Medicare. Dr. Day himself asserts a commitment to universal coverage and rarely misses an occasion to remind critics that he does not advocate the implantation of the American health model in Canada. But Dr. Day also knows that Canadians are frustrated with the system's shortcomings.

Those who languish for hours in an emergency room, or exceed medically recommended wait times for a surgical procedure, or fail to find a family physician, are potentially open to a greater role for for-profit health providers and private insurers. And that is the gist of the CMA's

case. Starting from the premise that wait times are the chief demon plaguing Canadian care, particularly when it comes to procedures such as joint replacement surgery, coronary bypass operations, cataract surgery, magnetic resonance imaging (MRI), and radiation therapy, the Association has urged governments to fill the breach by laying out the welcome mat for for-profit providers. The CMA puts it this way in a 2007 policy paper, *Medicare Plus: It's Still About Access:* "To the extent that the current public infrastructure constrains capacity, governments should consider contracting publicly funded services to the private sector."[2] To be sure, the Association is aware that any developing private sector would have to share human resources with the public sphere. In the absence of a substantial increase in physician supply, the result of such a contracting-out initiative could only be additional stress on the public system. So it is at least partially in this context that readers should understand the CMA's most recent campaign to pressure the federal government to fund the training of more doctors. Without a larger pool of physicians to draw from, the numbers permitting any increased role for private medicine don't add up – even in the minds of such an initiative's backers.



No insurance to cover this procedure? Wow, you really are screwed.

In a complementary recommendation from *Medicare Plus,* the doctors also repeat their call for a Health Access Fund to back individual recourse for patients facing excessive wait lists. That is, patients waiting in the queue for a procedure longer than the medically recommended period of time

should, say the doctors, be able to access funds to help them obtain treatment away from home, either in another province or out of the country. In this instance, the CMA is not explicit about whether it envisages all such costs falling to the public tab, or just a portion.[3] Clearly, were the latter to be the case, Canadians could end up with an additional subsidy for those who are able to foot the bill for the remaining costs not covered by the Fund. In the guise of doing us all a favour, the physicians would effectively be calling for public assistance to those able to purchase (still more) private insurance.

Documenting the costs of wait times

Without a larger pool of physicians to draw from, the numbers permitting any increased role for private medicine don't add up.

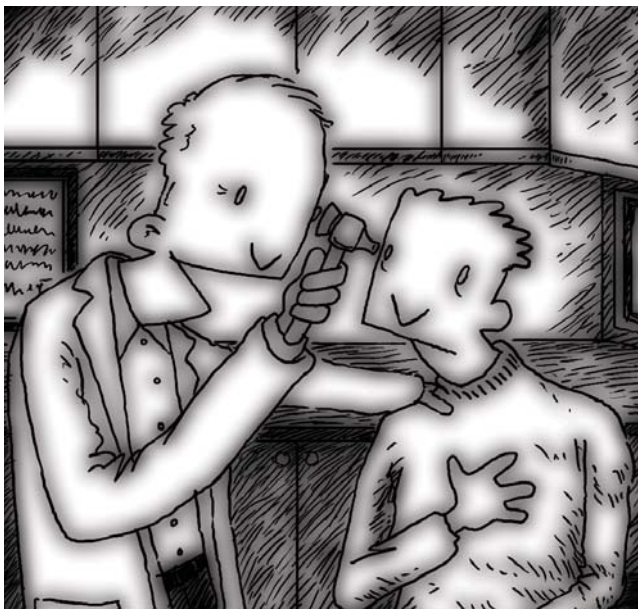
In January 2008, at an event hosted by the exclusive National Club in Toronto, the CMA sought to further bolster its case by pointing to the ramifications of wait times, releasing a study produced by the Centre for Spatial Economics. In *The Economic Cost of Wait Times in Canada,* this enquiry's authors determined that in 2007 the country as a whole was $14.8 billion poorer due to patients "waiting longer than medically recommended for just four key procedures..." – those mentioned above save radiation therapy. "In turn," continued the study, "this reduction in economic activity lowered federal and provincial government revenues by a combined $4.4 billion in 2007."[4]

The report reveals and repeats important and worrisome facts about Canadian care. Patients waiting for treatment are often not able to work; family members, generally women, often take considerable blocks of time away from their employment to care for a loved one hoping to get into the OR soon; what's more, they lose income in the process. Tests and other procedures, all of which cost, may multiply, and it is fair to blame the economic losses arising from these interventions on wait times, provided they have to be undertaken due to *excessive* delays in treatment. More drugs are, in this scenario, prescribed and taken. In his address presenting the study, Dr. Day made moving reference to patients he has known who, while waiting to undergo a procedure, became addicted to painkillers or sank into grim depression.

For another reason as well the authors of *The Economic Cost of Wait Times* can be commended for only estimating the bill for patient delays beyond the medically recommended periods, as

determined by the Wait Time Alliance (an association made up of 16 medical specialty societies). It would be a serious intellectual failing on their part to suggest that Canadians could concoct a system where *no* waiting for medical procedures occurred and revenue maximization could be pursued by all working-age members of society at virtually all times (when out of the OR). Illness inevitably and not undesirably entails pauses in productivity. Moreover, wait times of some sort will always occur; either physicians will spend some periods "idly" expecting patients to arrive (in a system with little illness and injury or a rationing scheme that keeps the poorer individual at home) or busy doctors, even if in good supply, will require patients to "line up" for at least a while. Health care cannot closely approximate the just-in-time automotive parts sector.

Still, the data presented in *The Economic Cost of Wait Times,* in provincially weighted national averages, does provoke justifiable alarm. For example, the authors determined that when it comes to patients waiting longer than the roughly 180 days (from specialist to surgery) recommended for joint replacement, the average delay approaches one year – although the median patient wait time is less than 100 days. No doubt this statistic hints at numerous in-the-flesh stories of anguish and frustration. When it comes to MRIs, the median patient wait time actually exceeds the "medically reasonable" benchmark by about 30 days.

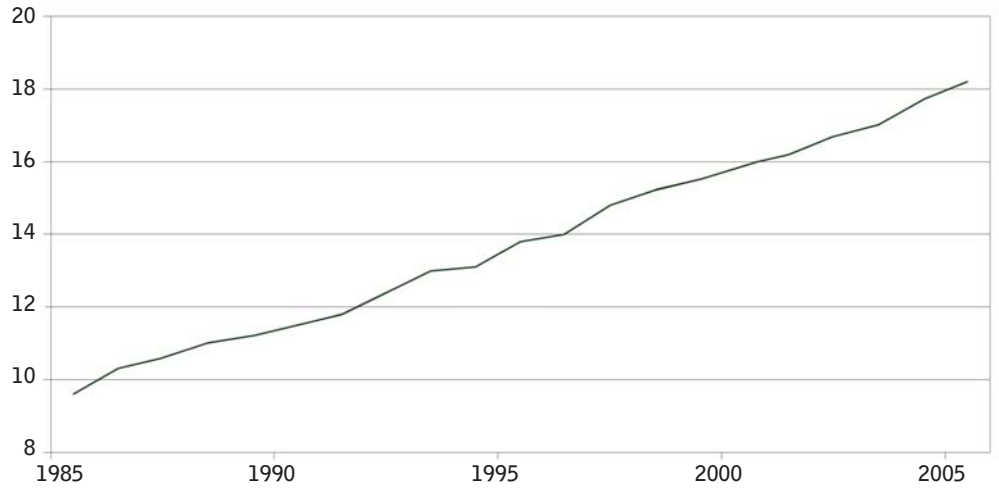


WOW! Do I ever see a lot of de-listed medical services in there.

Yet a careful reading of the document reveals a finding that could prove at least somewhat embarrassing to its sponsors. Out of the $14.8 billion social price tag for excessive wait times,

it turns out that $13.8 billion are explained solely by these very MRI delays! In other words, excessive joint, cataract and heart waits together cost us $1 billion, according to the study's authors.[5] Now that is no paltry sum. Policy makers must take note. But this conclusion clearly has a dampening effect on the alarm bells sounded by the CMA. Soon after the release of the CMA study, University of Calgary

1. Total Expenditure on Pharmaceuticals and Other Medical Non-Durables as a Percentage of Total Health Expenditure Canada, 1985-2005
OECD Health Data, 2006, http://www.oecd.org

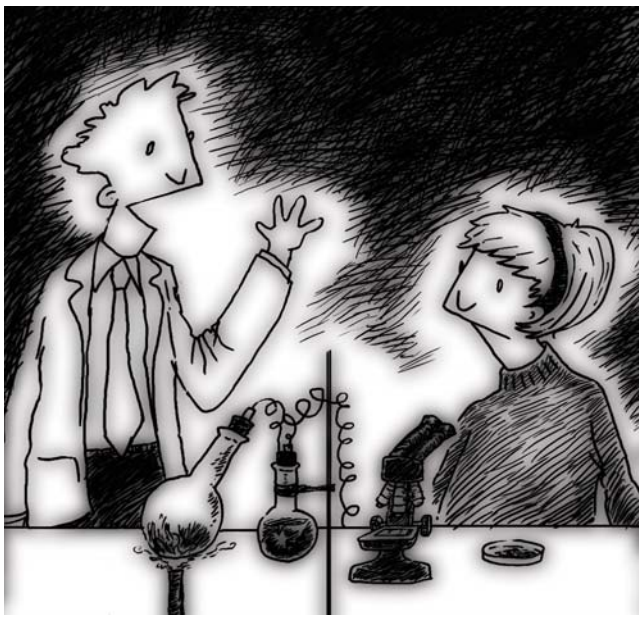


health policy analyst Steven Lewis took aim at the assumption that all MRIs are medically necessary. Lewis told the *The Canadian Press* that experts actually have little idea of precisely what benefits have accrued from the sharp increase in the use of this technique over the last 10 years. And he implied that costs might be ballooning more from overuse and "wasteful service" than from under-capacity.[6]

Dr. Martin, for her part, says that when it comes to magnetic resonance, "the relation between demand and need is not clear. A social expectation has been created." Observing that MRIs often reveal aspects of a patient's condition that will be investigated – without leading to a change in

treatment – Martin suggests physicians need better clinical practice guidelines to determine when an MRI is appropriate. Certainly, many patients pay a considerable emotional price as they wait for MRI access and all health professionals would agree that they deserve empathy and support. But again, it is far from certain that this service is always prescribed appropriately. Possibly, the authors of *The Economic Cost of Wait Times* identified an expense that has less to do with under-capacity in the public sector than excessive reliance on a novel medical machine. And could it be that wait times for MRI access for those who really need it have actually been exacerbated by this very overuse?

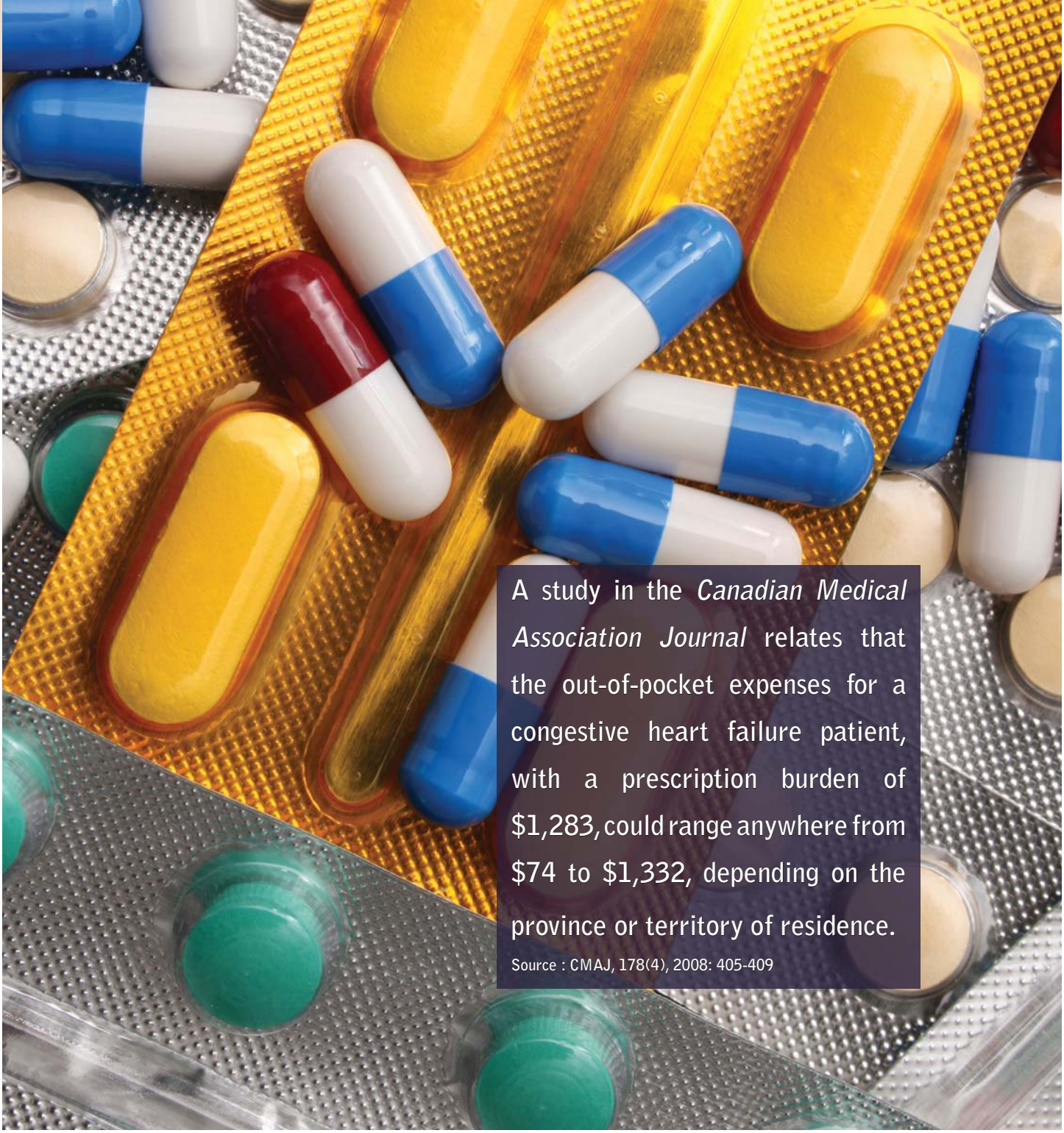
From the CMA's perspective, however, booming demand for these devices, somewhat scarce in Canada in comparison to several other OECD jurisdictions, provides an opportunity for investors to further develop net-works of diagnostic clinics. Canadians would thus gain access, in greater numbers and at greater speed, to the latest in medical technology. Some clients would also be drawn from what Dr. Martin calls the "worrying well."



I've created a new miracle drug! All we have to do is wait for the marketing department to tell us what disease it might cure...

Acknowledging and enumerating the system's shortcomings

Medicare Plus reiterates crucial points about the economics of our current public/private patchwork system, identifying pharmaceuticals, for example, as the leading cost drivers in health spending in

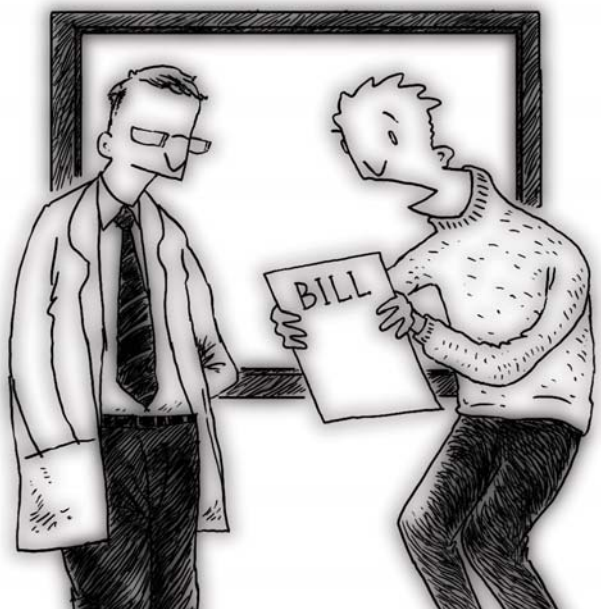


A study in the *Canadian Medical Association Journal* relates that the out-of-pocket expenses for a congestive heart failure patient, with a prescription burden of $1,283, could range anywhere from $74 to $1,332, depending on the province or territory of residence.

Source : CMAJ, 178(4), 2008: 405-409

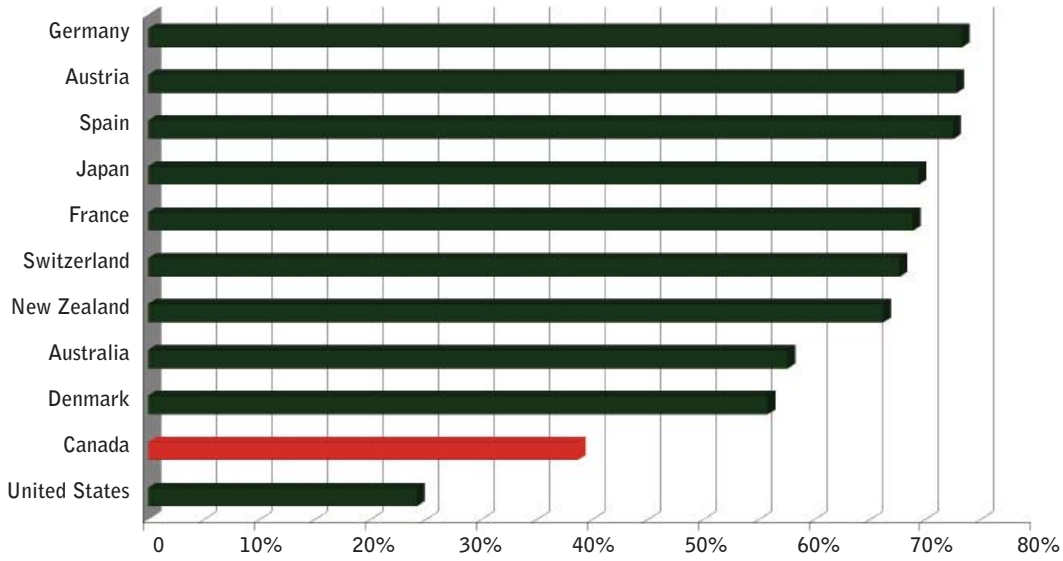
The Canadian Medical Association estimates that 4 to 5 million Canadians do not have a family physician. The Canadian Nurses Association predicts a shortfall of 113,000 nurses by 2016. There are currently 126,000 unfilled nursing positions across the United States, and one study has predicted that hospital nursing vacancies there will reach 800,000, or 29%, by 2020.

recent decades. In the 1986-2006 period, prescription drugs as a percentage of total health spending climbed from 7% to over 14%, it observes. According to the Canadian Labour Congress, since 2000, spending on prescription drugs in Canada has climbed at an 11% annual rate. One two-author team has calculated that since 1980, "the annual increase in prescription drug costs" could have financed "the services of 3,500 new physicians every year."[7] So what is it about drugs, or our established policy of providing them, that is so inflationary? In its 2006 document *More for Less, A National Pharmacare Strategy,* the Canadian Health Coalition – no friend of the CMA when it comes to prescribing cures for the system – notes, "the rapid rise in drug costs is primarily due to the ongoing substitution of newer, more expensive drugs in place of existing, less expensive products." And yet, citing 117 products introduced in Canada between 1998 and 2002 and data from the Patent Medicine Prices Review Board, the Coalition concluded that less than 13% of these new items actually offered "substantial improvements" over existing medicines.[8] In short, the process by which new generations of drugs arrive on the shelf is most often a tale of pointless price increase; drug multinationals seek to boost profits and private insurers in turn scramble to protect their bottom line. What is more, Canada's patent laws grant new drugs a full 20 years of monopoly protection, rendering obsolete the competitive pricing benefits garnered by the introduction of generic substitutes.



WHOA! I thought you were supposed to cure me with medicine, not market principles!

2. Public Spending on Pharmaceuticals as a Percent of Total Spending on Pharmaceuticals
Canadian Institute for Health Information (CIHI), Drug Expenditure in Canada, 1985-2007
www.cihi.ca



So while public sector expenditure on health care as a percentage of GDP has been steady (even declining in the 1990s and rising previously, as economist Raisa Deber has noted, mainly because economic growth slowed during the recession of the '80s), overall spending has been primed by spikes in insurance premiums several times greater than the rate of inflation. The CMA seems to acknowledge this reality.

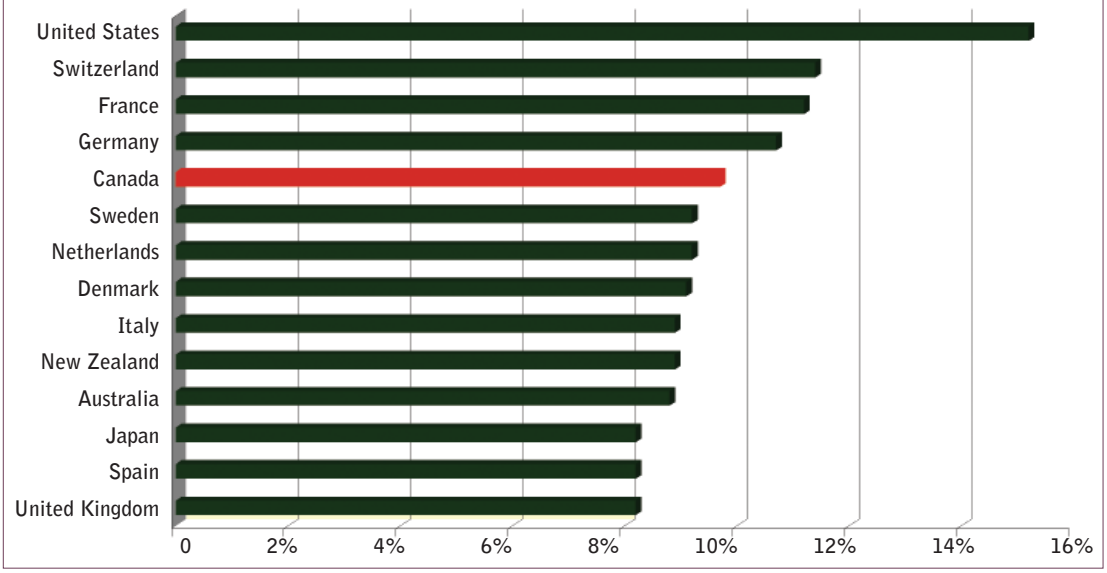
Medicare Plus proceeds to note that some 3.5 million Canadians are "uninsured or underinsured for prescription drug costs." Meanwhile, not much more than one third of workplaces, according to Statistics Canada, offer benefits. In other words, one likely has to work in a large or unionized company in order to have employer-sponsored insurance or have a spouse similarly placed. Yet job growth is primarily being fuelled by smaller enterprises, even as job loss

tends to occur in manufacturing sectors where pay tends to be higher and benefits more available. Furthermore, coverage by provincial plans is highly fragmented; seniors in Ontario, for example, pay substantially less of their prescription costs than do their equivalents in New Brunswick and Newfoundland and Labrador. The scenario is not especially encouraging.

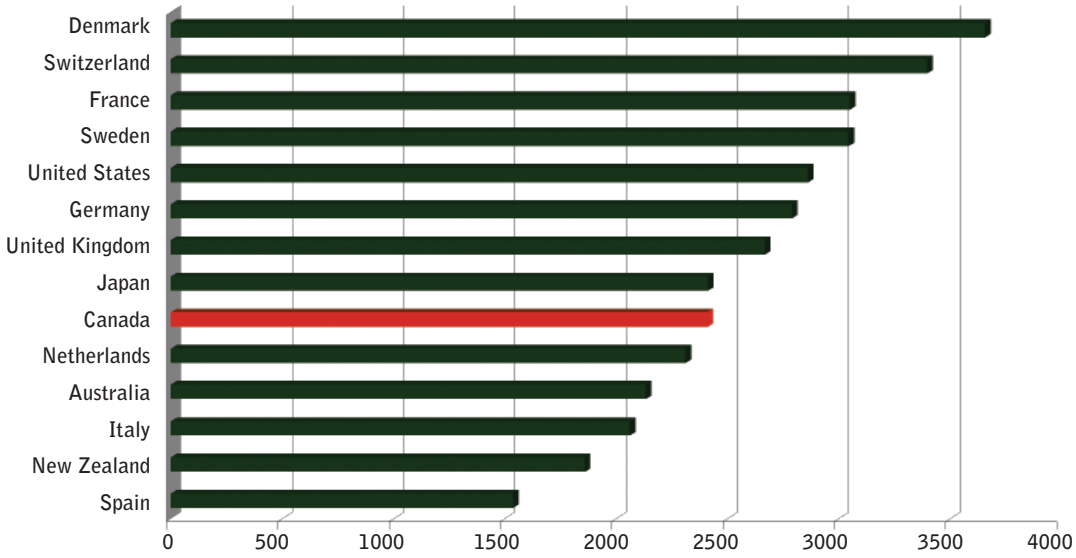
Not surprisingly, the CMA also underlines our system's current failure to provide universal access to primary care, reminding us that as many as 4.5 million Canadians are without a family physician. Many citizens are thankful they don't have to pay to visit the doctor; now, if they could only get into some MD's office! Canada has slipped dramatically in its physician-to-population ratio since the 1970s and is now below the OECD average of three doctors per thousand residents.[9]

Dr. Day, among others, has raised additional criticisms of Canadian health care that can't be

3. Government Expenditure on Health as a Percent of GDP
World Health Organization (WHO), Core Health Indicators, 2008
www.who.int/en



4. Government Expenditure on Health Per Capita (US$)
World Health Organization (WHO), Core Health Indicators, 2008
www.who.int/en



dismissed. How can painkillers, antibiotics, or crutches not be considered "medically necessary" and hence not guaranteed by provincial plans? Why has the term "medically necessary" not even been properly defined by policy makers? Why do patients pay for upgraded devices, like better casts, in not-for-profit hospitals? Why don't we debate private medical insurance and its role more openly? Or, to frame this last question in terms that better reflect the concerns of Medicare advocates, why do politicians from B.C. to Alberta to Québec seek to surreptitiously expand the scope for private insurers without engaging the public in an open conversation about the dangers of such a course?

These, of course, are all pointed queries, infrequently answered by politicians. What is interesting, however, is the way in which the CMA itself responds to the shortcomings in Canadian health care and policy raised by these and other questions. While not discounting the utility of increased public investment to train new physicians and other healthcare professionals, the doctors embrace measures like arrangements with private insurers to boost drug coverage for those who lack it, registered savings

- Health administration costs total $1,059 per capita in the United States, but only $307 per capita in Canada.
- Canada's national health insurance program has an overhead of 1.3%.
- US private insurers averaged an overhead of 11.7%.
- Canada's private insurers had an even higher overhead at 13.2%.

(Data are from 1999)

Source: Steffie Woolhandler, M.D., M.P.H., Terry Campbell, M.H.A., and David U. Himmelstein, M.D. Costs of Health Care Administration in the United States and Canada. *New England Journal of Medicine* 2003; 349(8), 768-775, August, 2003.

plans to help fund long-term care, and, as noted before, an increased role for profit-making providers. They seem to have little sympathy for the Canadian Health Coalition's reasoned assertion that a national Pharmacare program would, while improving many citizens' access to drugs, also redistribute the costs of medicines more fairly by making all employers (and not just those who presently offer plans to their workers) shoulder the payment burden through across-the-board contributions. "Market principles" and shareholders deserve an expanded role within the system, Dr. Day simply affirms.

Following the public-private trend… and drawing selective conclusions

Why is this course chosen? Primarily, the CMA leadership argues, because public-private is the way of the world. Full coverage for additional health services just isn't happening. Private insurance, co-payments and out-of-pocket spending "is the experience of most European and other industrialized countries," notes *Medicare Plus*.

Which is not an outright lie. In France's complex, fairly expensive but historically effective system, charges ranging from zero to a hundred percent for different medical and paramedical services have been levied in recent decades (although citizens generally rely on "complementary social protection organizations" to get costs reimbursed, while the poorest residents are spared co-payments).[10] Yet many French citizens are increasingly unhappy with, and protesting against, a rising tide of insurer-friendly charges levied by for-profit, shareholder-owned clinics – while public hospitals, most of which are running deficits, feel the financial squeeze. Sweden too charges user fees, and has since the Social Democratic Party brought in universal care at the beginning of the 1970s. The present right-of-centre government in Stockholm is encouraging the privatization of pharmacies, hospitals, and, to some extent, primary care. Public dental care has also been significantly eroded in the Scandinavian Mecca of social democracy, and many Swedes are expressing displeasure with these measures. Britain, under the Conservatives and then New Labour, has injected "market principles" and practices into the National Health Service with a vengeance – and largely abandoned free dentistry, to the dismay of numerous working-class Britons. Spain, governed in its post-dictatorship epoch a majority of the time by the Spanish Socialist Workers Party (PSOE), has parallel health systems, public and private – and one for the military. There may not be a single

Spaniard alive who doesn't grumble over time spent in the waiting rooms of public clinics. Australia and New Zealand also have parallel systems, where private care and insurance are prominent. We'll explore the imperfections of their systems later. We all know about the United States.

In short, the CMA isn't wrong about the public-private mix in global medicine. But are they right to imply it is a positive thing? Are they unaware that citizens of other industrialized countries are increasingly restive about recent trends? The fight for profit is a globalized one, and Canada is not the only country in the thick of it.

Global discontent aside, if the ways of the industrialized world were genuinely their model for Canada, the doctors would still, in all good conscience, advocate an increased role for public care and less reliance on private insurance and family budgets to fund services! That is because Canada's roughly 70:30 split between public and private health expenditure is relatively low, at the public end. France's ratio is more like 78:22. Sweden's public proportion is about 85% and pharmaceuticals there, as in France, are heavily subsidized with a cap on patients' annual prescription drug expenses of around $300.[11] Spain, with its parallel systems, nonetheless offers significantly cheaper pharmaceuticals while providing free dental care to young children. Both Italy and Germany spend more public money per capita on their citizens' health than does Canada.

When asked in January 2008 if he didn't think Canada should be improving citizens' access to care through broader public coverage, Dr. Day offered an interesting response. He cited CMA polling data to the effect that Canadians with higher incomes are happy with the current arrangement, while poorer people (those, he said, earning less than $30,000) would prefer a 70:30 ratio across all areas of medical care. Which is to say that if this sort of system were implemented, a patient might pay 30 cents on the dollar of the cost of a visit to the doctor but also enjoy 70% coverage of all drug and dental bills. Dr. Day implied some sympathy for such a reform. He didn't mention whether those poorer citizens polled liked the idea of continuing with free hospital and physician care *as well as* improved coverage of other things, though he doubtlessly sensed what their attitude might have been. After all, is it likely that, given their druthers, people of modest means would gamble on having to be responsible for 30% of the cost of a complex procedure? No doubt, these Canadians could have imagined a set of reforms more honestly bearing the title Medicare Plus. But "governments can't cover everything," the surgeon opined.[12]

You have rights under medicare.

Defend them!

For more information concerning your medicare rights, visit:

www.yourmedicarerights.ca

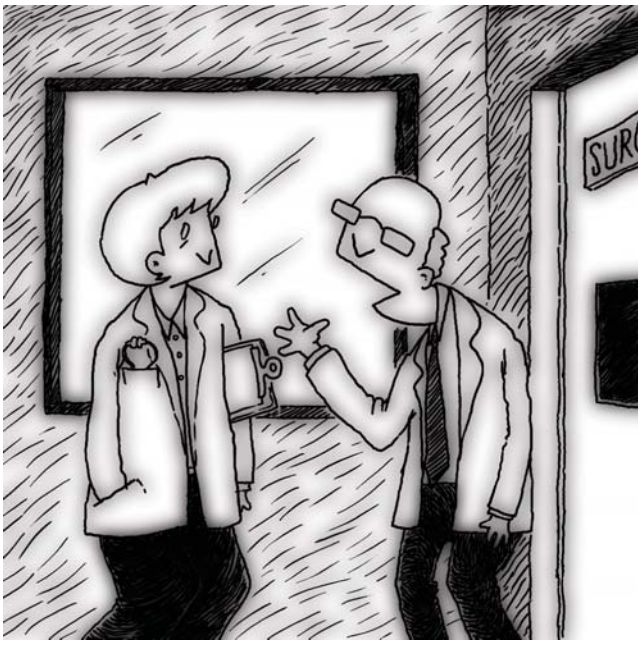
III. Assessing the evidence: Is for-profit activity a help or a hindrance?

Naturally, it's not enough to argue that since 1) an increased role for profit-making health providers is a trend in the world, and 2) in the somewhat troubled Canadian system, hospital and primary sub-sectors largely exclude for-profit activities, remedies therefore reside in market principles and more business for shareholder-driven entities. One has to show that for-profit activities cut or eliminate wait times. So, now, is this the case?

The wait-time record in parallel systems: the privatizers refuted

Industrialized countries other than Canada, having experimented more extensively with private, for-profit care, offer plenty of hints about the effects more private care would have on public wait lists in our country. Public wait lists are of course the key, for it is more than plausible that parallel care shortens wait times for those able to pay. But for-profit boosters often don't make this case, at least in their public relations exercises; they suggest a dual system will help everyone by boosting competition and unclogging bottlenecks.

Back in the mid-1980s, New Zealand arrived at a situation in which private institutions accounted for



How long does the public waiting list need to be before they will come to have it done in my private clinic?

more than one quarter of its hospital beds, while a marginally larger portion of its population had some form of private insurance. Deficiencies in an under-funded public system drove patients with means into the parallel sphere. Did competition help? Data on wait times for all surgery in the public sphere are unambiguous in the 1984-86 period, though different between local health boards. The number of patients cooling their heels for more than one year climbed four percent in one regional example, 27.5% in another. Elsewhere in the country figures approached 10%. The increase in waits for orthopaedic surgery was most dramatic. Public wait lists were longest precisely in areas where the private sector was strongest.[13] What happened? It seems, quite simply, that expanding for-profit care in New Zealand drew resources, human and material, out of the public sphere. Competition meant that a healthcare pie came to be served up in more unequal slices. Those with money to spend benefited, others suffered.

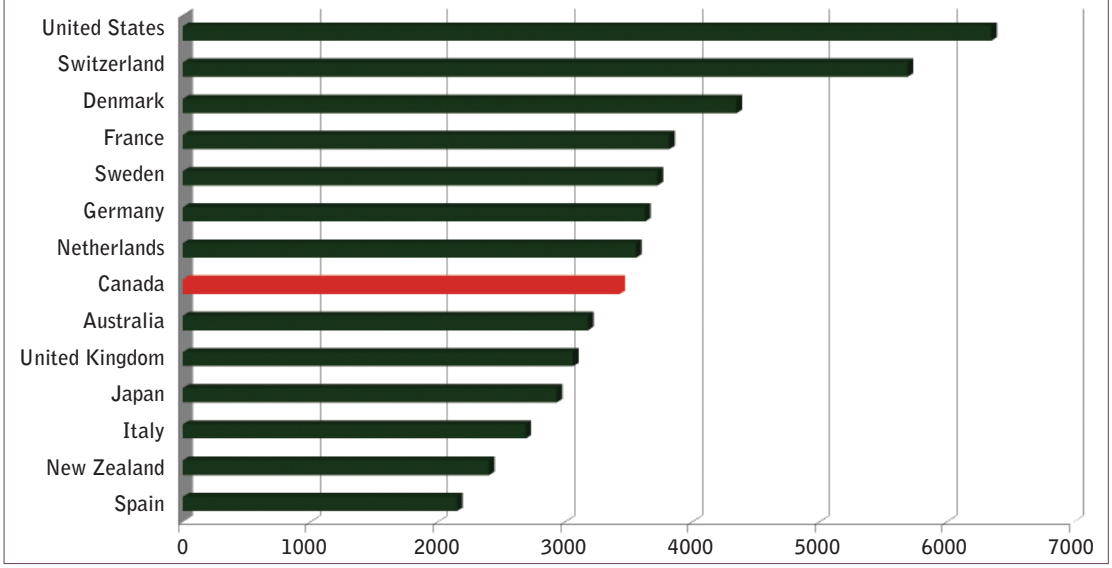
...expanding for-profit care in New Zealand drew resources, human and material, out of the public sphere. Competition meant that a healthcare pie came to be served up in more unequal slices.

Sticking with examples from Oceania, but turning to more recent evidence, let's consider the wait-time tale from Australia where a system of parallel care is well-developed. According to Australian professor of health policy Stephen Duckett, by 2004 fully 40% of hospital admissions in his country were occurring in private institutions. (Between the early 1980s and late 1990s, by way of contrast, the public system had taken over much of the ground previously occupied by private care. The opening years of our millennium then saw a state-backed revival of corporate-driven insurance and care.) Duckett pointed out that "in any specialty, the greater the proportion of surgeries performed in the private sector, the longer the public sector waiting times and the shorter the waiting times for procedures in private hospitals."[14]

According to figures gathered in 2007 by the Australian Labour Party, just prior to its successful bid to take back political power from the long-governing centre-right, the percentage of elective surgery patients in the public sector not seen within recommended wait times climbed from 10% to 19% between 1998 and 2006. The first half decade of the new millennium also saw the share of federal funding of public hospitals in Australia tumble from 47% to 41%.[15] A private system was being

encouraged, apparently at the expense of the public, but people were told heightened competition between the two would bear good fruit for all. Evaluated with an eye on surgical wait times alone, the results were arguably good for those with private insurance, but indisputably bad for those opting to stick with the public sphere.

5. Total Expenditure on Health Per Capita
World Health Organization (WHO), Core Health Indicators, 2008
www.who.int/en



Canada too offers some examples in comparative wait times. Maude Barlow of the Council of Canadians, in reference to trends in cataract surgery in Alberta and citing that province's Consumers' Association, writes that wait times in Calgary, where clinics were for a time all private entities, were typically more than double those in Edmonton and Lethbridge – cities where the great majority of procedures were carried out in public facilities.[16] Such data potentially point to useful lessons for those involved in the public-private debate.

"There is no evidence from anywhere in the world that profit-making companies make health services more efficient. There is plenty of evidence that they do the opposite, including the experience from England over the last five years. Making profits from health means cutting services and reducing quality. It is the patients who pay the price."

Professor Wendy Savage, Chair of Keep Our NHS Public

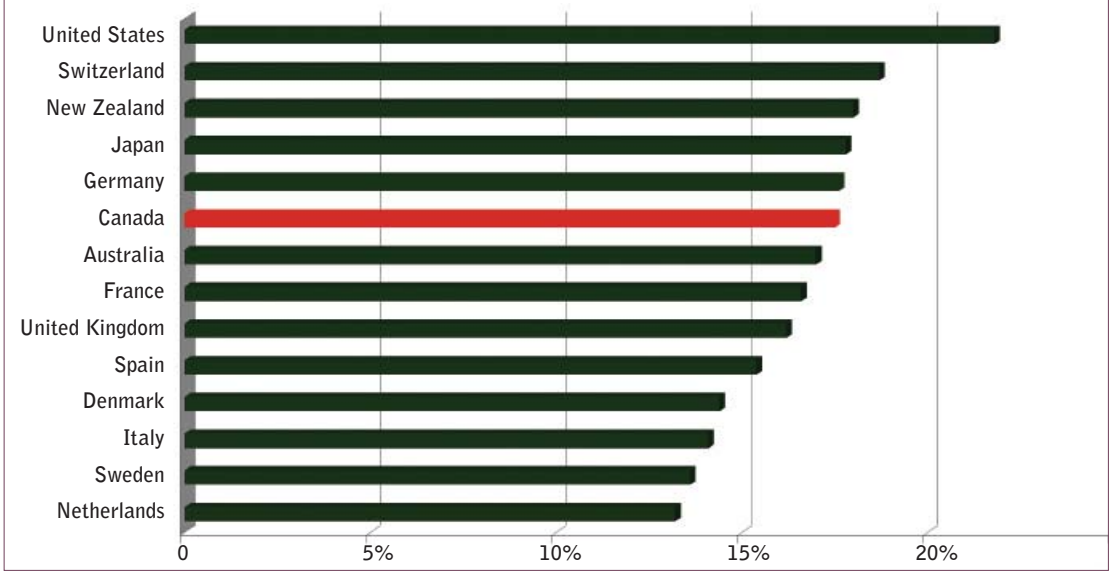
Meanwhile, when it comes to hip and knee replacements in this country, health policy analyst Professor Colleen Flood has estimated that if 10% of specialist capacity in the public sector were diverted to the private sphere, average wait times for both procedures would increase by at least 20 days.

Improving wait times… publicly

Rather than providing much in the way of private-public contrast, Canada is generally more useful, however, as a source of examples showing how wait times for elective surgery can be reduced by public improvements.

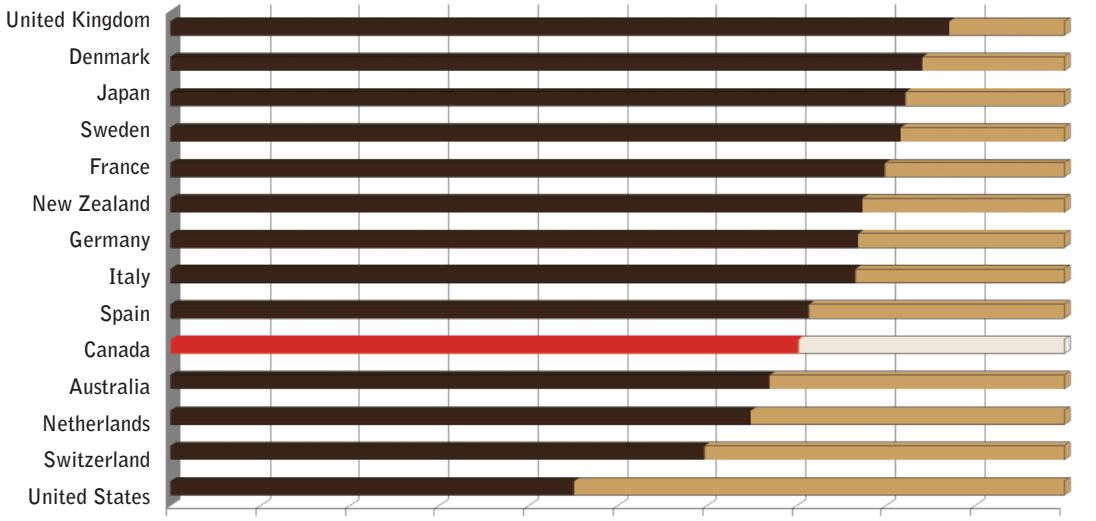
In this vein, let's stick with Alberta for now, where the 2001 report of the Premier's Advisory Council on Health Care called for a greater role for private insurers. There it was thought fine,

6. Government Expenditure on Health as a Percent of Total Government Spending
World Health Organization (WHO), Core Health Indicators, 2008
www.who.int/en



at least by some, to have Don Mazankowski chair such a council even as he sat on the boards of several insurance firms. In that province a piece of legislation called Bill 11 (the *Health Care Protection Act*) similarly affirmed the need for more for-profit medical services. But, it turns out, notable work to make Medicare better is also taking place in Alberta.

7. Public vs. Private Spending on Health
World Health Organization (WHO), Core Health Indicators, 2008
www.who.int/en



At a Western Canada health policy summit held in December 2007 in Calgary, Dr. Cy Frank, executive director of the Alberta Bone and Joint Health Institute, offered a presentation about a pilot project aimed at cutting wait times and improving outcomes for residents needing (or not needing, as the case might be) hip and knee replacements.[17] Dr. Frank touched on the growing importance of these treatments. He noted, for example, that in a single year one out of every four Albertans sees a healthcare professional due to some joint or bone issue, dwarfing, by comparison,

the number of those who seek help for cardiovascular or cancer-related problems. As readers are aware, demand for joint replacement is today sustained by technological advances that render that old option, years in a wheelchair or hobbled by pain, obsolete; meanwhile, an ageing population drives that demand and promises more of the same.

Dr. Frank discussed an initiative that includes central intake for patients, eliminating the inefficiencies inherent in a system of multiple wait lists. Patient assessment in a one-stop clinic by a multidisciplinary team was emphasized as ideal by the executive director, as was a process that lets patients know quickly if they are candidates for surgery and, if they are not, quickly funnels them into alternative treatments and therapy. He highlighted the importance of coordinated information systems to record progress and share feedback so as to speed systemic improvements. Patient accountability was stressed on the theory that men and women, who sign agreements to take measures necessary to maximize their own fitness for surgery and safe, speedy recovery, are key to an improved system.

I don't see what's so wrong with privatized health care – wouldn't you just LOVE to buy a pair of designer kidneys?

Before touching on the wait-time results reported by Dr. Frank, however, let us mention certain tidbits of information he offered that possibly serve to temper concerns in this area – at least when it comes to knee and hip procedures in Alberta.

Referring to official queues in the province from the 2005-2006

"The federal Department of Finance estimates foregone revenues at the provincial level, compared to 1996 personal and corporate income tax rates, totaled almost $119 billion between 1997-1998 and 2004-2005. The federal Budget Plan 2003 shows that, over the same period, the federal government gave up $130 billion in tax revenues. That means tax cuts cost public coffers a cumulated total of almost $250 billion in foregone revenues since the late 1990s. At the same time, cumulative increases in public spending on health care, about $108 billion, have been increasingly portrayed as a fiscal threat. Yet tax cuts are, by far, the most costly single initiative undertaken by provincial and federal governments in recent years."

Can we afford to sustain Medicare? A Strong Role for Federal Government
Armine Yalnizyan

period, Dr. Frank implied that, while all was not splendid, the speed with which the sky was falling had been overemphasized. Lists of patients apparently waiting for joint surgery, with signed consent forms, "were not accurate for the highest volume surgeons." Specifically, the executive director reported, 11% of these patients could not be contacted while another 14% weren't really waiting to be operated on (with 9% already having had surgical intervention). That is to say, about one quarter of the cases weren't waits after all. He argued that "wait lists of patients referred but not yet seen [by a specialist] were even less accurate." Indeed, it turned out that 11% of the individuals on these lists had in fact already been under the knife! In the case of this second list, said the doctor, it had been determined that almost 40% of the "patients" were padding inaccurate statistics. Wait lists weren't as bad as they had been described.

Defenders of public care in Alberta remain determined to keep the government in check, if and when it again lurches in a privatization direction. And they are now armed with additional home-grown data to back up their preference.

He then proceeded to describe a "new way" that was cutting the average delay between referral and the first specialist consultation by 21 working days. Wait time was "down 87%" between the first orthopaedic consultation and surgery. These improvements together contributed to a 23-week total wait, much reduced from the "old way's" 87 weeks. And in a snapshot of the province overall (including communities still subject to the "old way"), Frank affirmed that between October 2006 and the same month of the following year, the number of people waiting for hip replacements fell by almost 30%. A similar figure was offered with regard to knee procedures.

Prior to passing from this Albertan success story to examples of wait-time progress elsewhere, we should include a word about that province's aforementioned private-care initiative. Years before the Bone and Joint Health Institute showed how public care could be better, Albertans had been disturbed by legislation proposed, amended and passed to facilitate an increased role for for-profit providers – ostensibly in order to address public wait lists. The *Health Care Protection Act* of 2000 had also expanded the space for private insurance. At that point, more than two thirds of the

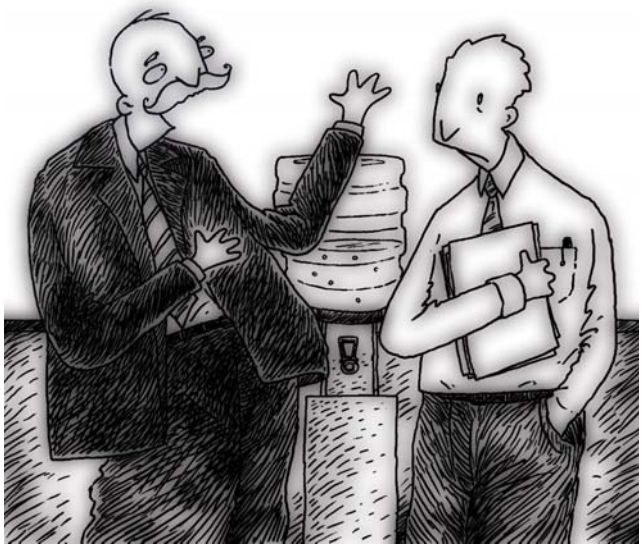
province's population declared health care to be their top priority. Town Hall meetings erupted. Seniors, faith groups and healthcare workers active in the community-based coalition Friends of Medicare managed to slow the government's plans.

The governing team in Edmonton has since been fairly quiet about for-profit care, although the matter is far from decided. In the spring of 2005, it sponsored a conference on the future of Alberta's system. Friends of Medicare, along with several other organizations, responded with their own entitled *Weighing the Evidence* where the supposed benefits of for-profit participation in healthcare were contested by numerous experts, international and Canadian, several of whom are cited in this paper. As late as fall 2005, Health Minister Iris Evans suggested that the province favoured a fully developed private insurance system to eventually compete with the public plan,[18] but then-Premier Ralph Klein subsequently denied that this was the case. Defenders of public care in Alberta remain determined to keep the government in check, if and when it again lurches in a privatization direction. And they are now armed with additional home-grown data to back up their preference.

The evidence appears to affirm that better planning in the public sector can cut wait times for all.

In B.C., the Richmond Hip & Knee Reconstruction Project has reportedly shrunk average delays by 75%, while slashing the numbers in line by over one quarter. In North Vancouver, a single "gate" into joint replacement procedures has reduced the wait for an initial surgical consultation, says the Canadian Centre for Policy Alternatives, from a worrisome 11 months to less than one. The same source highlights a Sault Ste. Marie, Ontario, breast clinic centre where patients saw the wait time from mammogram to breast cancer diagnosis shrink by 75% in 2005-2006.[19] The consolidation of assorted investigations under one roof has reportedly been the key to this improvement. At the Rexdale Community Health Centre (west Toronto), an enhanced role for two registered nurses in 2003 helped clear the queue of people waiting to see a health professional, Dr. Michael Rachlis has reported.[20] In Newfoundland and Labrador, the use of video conferencing has facilitated specialist access for people residing in outlying communities.

The evidence appears to affirm that better planning in the public sector can cut wait times for all. Private investment, of the sort that has generated a proliferation of MRI clinics in Montreal, can also



There's tons of money to be made in health care, you just have to know how to talk fast and make them think they have no choice.

reduce waits – for those able and willing to write a cheque. But then it seems to cause problems for others, as it did some years ago in Winnipeg when the Maples Surgical Clinic bought an MRI and lured two technicians away from the public sector, leading to a 20-hour per week reduction in services at the Health Sciences Centre, as Rachlis also reported.[21]

To be sure, wait times remain problematic. They are experienced by plenty of countries (Spain, Australia, Britain, Italy, Sweden, the list goes on) with a public-private mix. What is also certain is that wait times can be combated by simply excluding large portions of the population from care, as in the United States, where market forces dissipate line-ups with a wave of the invisible hand, encouraging the uninsured sick to stay home. But that, as far as we are concerned, is no ethical option.

Costs: the economics of public versus private

Central to the public-private debate is the matter of whether increased for-profit operations can lead to the more efficient allocation of resources. How could this question not occur to policy makers convinced that government deficits are dragons to be slain (or not allowed to hatch) and aware that health expenditure, as in more than one province's case, exceeds 40% of the budget?

It is probably best to first reassure those who fear that Canadian health spending is out of control. There are several points to make in this regard. To begin with, the notion that health spending is eating up almost half a provincial budget may be scary, but perhaps not in the way a person initially thinks. Such figures could reflect the fact that Canadian governments seriously under-fund other social services – indeed, that they have cut allocations seriously in these areas over the years while only modestly hiking health investment. After all, in France, healthcare takes up less of the overall state budget, but more health money is spent there per capita, than here. And a greater proportion of overall health expenditure is public. Meaning? The collective part of the spending pie is bigger. More services are free or subsidized. Now, few assert that enhanced social spending is an outright impossibility in Canada, but they do emphasize the trade-offs involved. Former Ontario Premier Bob Rae, for instance, a man who likes to be associated with a decent social safety net, has casually written that Canadians seem to want European-style social services with U.S. taxation levels.[22] Perhaps we want to have our cake and eat it too. But is this really so? A 2005 survey by the Canada West Foundation concluded that tax

There is no public spending crisis.

He wants to know if he can pay for treatment with his goat. He says she's a really good milker.

cuts came in a stunning 11th in a list of respondents' priorities. In Ontario, a political party that gave tax cuts and slashed services in the 1990s has been banished to the political wilderness in this decade. Canada's largest city declines to elect MPs or MPPs, vote after vote, from that major political party most associated with less taxes and more "self-reliance." Can we assert that Canadians are unwilling to contribute more to the public purse once they are assured tax policies are equitable?

As noted earlier in this paper, inflationary pressures have largely been at work in those spheres of Canadian care, like pharmaceuticals, with a great deal of private expenditure. A telling set of numbers for those worried about government accounts are thus those that talk about our public expenditure as a percentage of total health spending; these figures, to elaborate on a point already made in our discussion, show Canada well back of such countries as Sweden, Norway, Germany, Finland, Great Britain and Italy, as well as France, and often by a very significant margin.[23] Per capita government expenditure on health care in our country is, meanwhile, neither low nor especially high compared to numerous other advanced industrialized jurisdictions. There is no *public* spending crisis. Governments who say otherwise are not telling the truth.

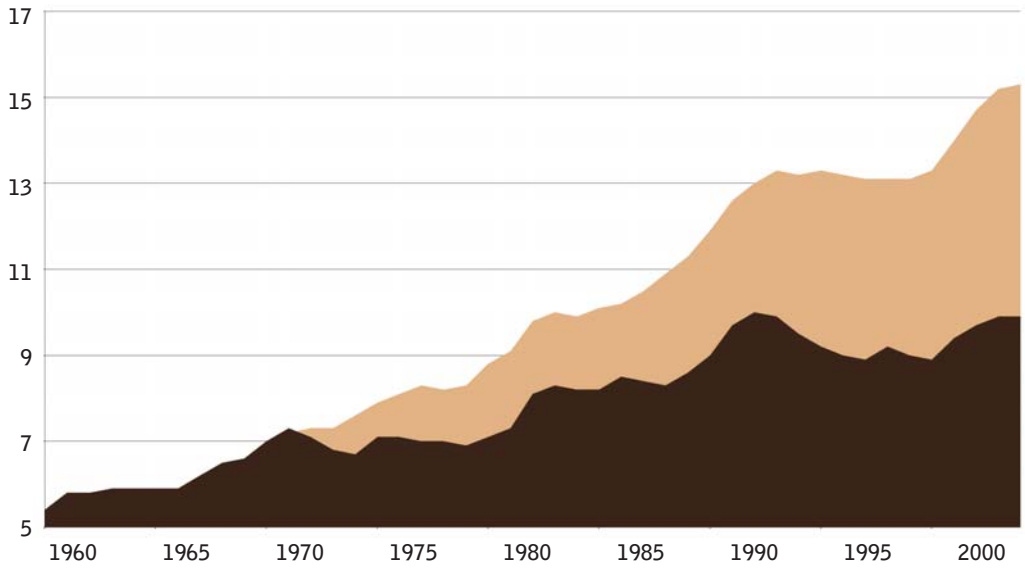
Medicare costs climbed more sharply – and notably so – in American communities with for-profit hospitals than in those with non-profit facilities.

Let's return to Australia for a look at how a sharply expanded role for profit-makers can re-sketch a macroeconomic picture. We have already seen some of the evidence on wait times furnished from "Down Under." But perhaps parallel health systems are good for public accounts?

As we read before, the 1990s and first decade of the new millennium saw limited federal funding for the Australian public system. But that is not to say that the John Howard-led government was unwilling to dispense cash. Even as public care was eroded, tax dollars were thrown at citizens to further encourage them to go private. This, according to Stephen Duckett, spurred some 180,000 patients to shift systems on an annual basis. The government recognized that without fiscal incentives, a viable private system was unlikely to flourish. A market had to be cultivated and nourished. So private packages were backed by the public purse to the tune of 30%. Billions of Australian dollars

were annually injected to support the system. The Lifetime Health Cover Policy (1999) came in to reward people who opt for private care while still young; "penalties" were applied to those who delay taking this route and opt for private coverage later in life. The impact? Professor Duckett reports that before the rebate scheme came into play, the health share of Australia's GDP was 8.5%. Heightened competition and more private care coincided with a rise to 9.5% – not a terrifying percentage, by any means (a bit less than Canada's), but a notable increment nonetheless. According to Duckett's calculation, support to private health insurance became "greater than subsidies to agriculture, manufacturing and mining combined." The economic fruit of the exercise was inefficiency, with

8. Spending on Health as a Percent of GDP: Canada and the United States, 1960-2004
OECD Health Data, 2006 www.oecd.org



the costs for each additional patient treated privately "well over the contemporary price paid for treating additional patients in the public sector."[24] Unless economists and politicians think that

Can you afford this?

Intensive care: $8,000 to $12,000 per day

Angioplasty: $6,000 to $7,000

ECG: $280 to $360

Coronary heart bypass surgery with cardiac catheterization: $40,278 to $63,558

Defibrillator implant: $27,000 to $35,000

Average annual insurance premium for family coverage: $11,480

(Range of prices from US hospital price lists in US dollars)
Source: The Canadian Health Coalition, 2006 brochure

Half of all personal bankruptcies are caused by illness or medical bills. The number of medical bankruptcies has increased by 2,200% since 1981 (Health Affairs, February 2005).

Source: California Nurses Association - www.guarenteedhealthcare.org

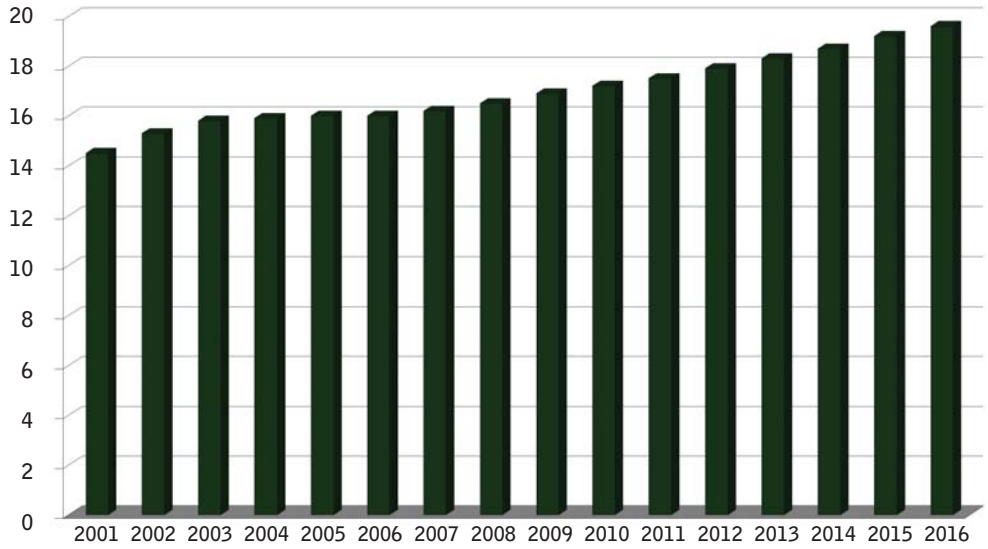
generating a lively business for insurers is in and of itself a worthy goal, they ought to take a dim view of the overall economic impact of Australia's adventure in parallel care.

Apart from profits, many critics of the U.S. system see extensive costs arising from the massive duplication of effort engendered by the parallel private and public bureaucracies that run the system.

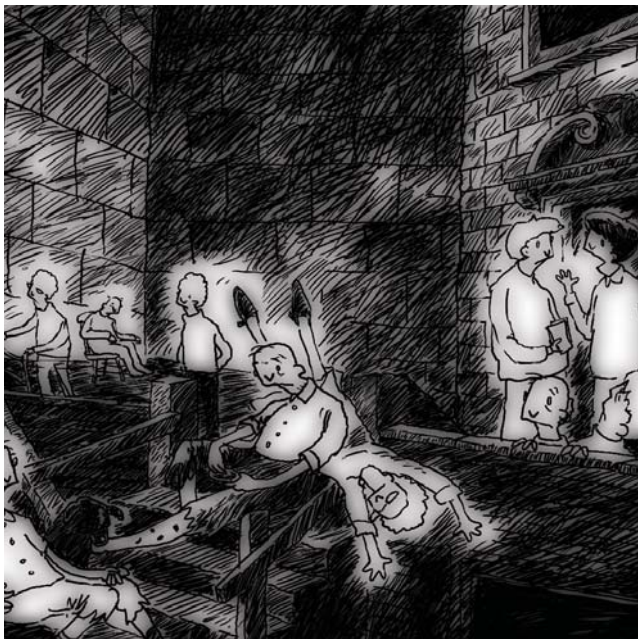
Chaoulli decision effectively invites public money to back private care

When it comes to private insurance to cover physician and hospital services, Canada is of course in a different situation. Yet the

9. U.S. Expenditures on Health as a Percent of GDP, 2001-2016
US Department of Health and Human Services, National Health Expenditure Projections, 2006-2016
www.cms.hhs.gov/



much-discussed Chaoulli decision by the Supreme Court in June 2005 did reveal a path similar to the one tread by Australians. This verdict struck down Quebec's ban on private insurance for necessary medical services as a violation of citizens' rights to security of the person, in instances when publicly funded care isn't provided in a timely manner. The provincial Liberal government responded with legislation creating, on the one hand, specialized private medical clinics (essentially private hospitals) able to seek financial backing on the stock exchange. Thus the Liberal government opened the door to multinational healthcare providers. On the other hand, the government authorized private insurance for hip and knee replacement, cataract removal, intra-ocular lens implantation, plus any other specialized procedure that it might in future authorize. The condition imposed on such plans was that procedures be performed by doctors opted out of the provincial plan, and in non-public facilities, a provision that would hardly help to ease Quebec's physician shortage.[25] The door to care *à l'australien* was thrust ajar by this verdict and then given a shove by the Claude Castonguay-led working group in February 2008.



This long-term care facility meets all government standards and makes a profit too!

That body's report called for, amongothermeasures,anenlargement of the category of surgeries to be funded by private insurance in Quebec. More private enterprises in the management of hospitals was recommended as well, as were legal reforms to permit physicians to

practice both inside and outside the public sphere. Castonguay, a man with a background in insurance, also put his signature over a proposal to garner tax revenue for health care through a levy that reflects citizens' use of the system. In other words, the ill should pay more. Backers of public care, such as a union coalition representing public service workers in the province, took the commission strongly to task, noting that it would be "illusory" to sell the population the idea that ordinary Quebeckers would enjoy easy access to parallel insurance. In this regard, the labour leaders were echoing Professor Flood who, in another context, once reminded a gathering of federal MPs that in Germany's mixed system only 9% of the population purchases private insurance, while in Britain, where an under-funded and rundown public system provided a certain incentive to private care, just a single-digit minority of Britons from the poorest 40 per cent of the population held private insurance at the beginning of this decade.[26]

"The well-to-do will have access," continued Quebec's Secrétariat intersyndical des services publics (SISP) in its criticism of the Castonguay initiative[27] – except perhaps for those relatively prosperous citizens able to afford premiums but cursed with a condition liable to alarm insurers. As a matter of fact, a parallel system in Quebec could boom – and draw the interest of at least a sizeable minority of the province's residents – provided that Premier Jean Charest learns from the Australian case and throw enormous

Most people think P3 stands for 'Public Private Partnership,' but WE know it really stands for 'Pilfering the Public Purse.'

Former British Health Minister, Frank Dobson, comments on the British experience with privatization including P3s.

The switch from global hospital budgets to a price-based, fee-for-service system for each procedure has been a costly mess, says Dobson. In the last few years, administrative costs in the NHS have ballooned from four per cent to 15%. The bureaucracy of tracking funding that follows the patient is adding more than $30 billion Canadian to health care costs in Britain.

The lesson here, says Dobson, is that Canada's single-tier, single-payer system is cheaper to administer and fairer for everyone.

"The public system doesn't 'cherry-pick' healthier patients to provide services to. It provides all with healthcare services, regardless of how sick you are, or your ability to pay. Not only does public health care bind your wounds, I would argue, it also binds you as a country."

www.archives.cupe.on.ca/www/frank_dobson_tour

public subsidies at the private sector. More sensibly, the unions called on the government to find additional corporate tax revenue to support public health care in Quebec, noting that reduced fiscal pressure on large enterprises in recent years should make such a move relatively painless.

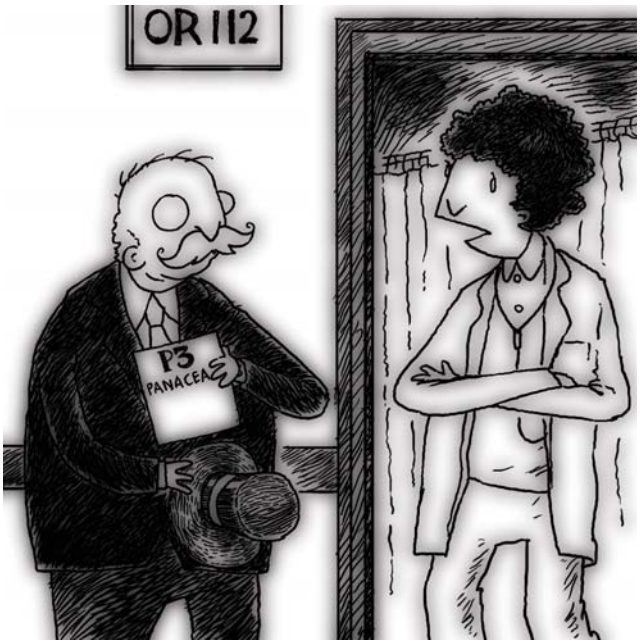
U.S. costs driven sky-high

Let's next proceed to some of the economic evidence emanating from our southern neighbour. Backers of more market in Canadian health care may assert that they don't want to copy the U.S. model. Yet critics have a responsibility to look at the United States for examples and lessons. After all, American health care is not really private care, but a generous mix of private, for-profit and public – not wholly unlike, in its general outline, what groups like the CMA endorse. For anyone who doubts the very sizeable presence of the state sector in the U.S. system, it is only necessary to consider OECD figures from earlier in the decade that show American public health expenditure per capita outstripping (or approximating, under a more conservative interpretation of the data) the total per capita health spending of other countries![28] Public plans cover the very poor (Medicaid) and the old (Medicare). Members of the armed forces get socialized medicine as well.

Politicians... have been convinced by an ideological but factually bereft case: privately managed facilities will be more efficiently run; hospital waste will be squeezed out by managers keen to identify surpluses.

Presently, as the WHO reports, U.S healthcare expenditures exceed 15% of its GDP. As in Canada, pharmaceutical costs are driving overall hikes in spending. The effects are considerable. One sees, for example, a clear trend in employer-offered benefit schemes: between 1960 and 2001, the health component of overall packages climbed from just over 14% to more than 43%.[29] In other words, health contributions are elbowing other non-cash remuneration for American workers out of the way. Meanwhile, health expenses are listed as a contributing factor in almost half of the bankruptcies in the United States.

Some more snapshots, courtesy of the U.S. organization Physicians for a National Health Program, serve to identify where additional culpability for this expense lies. When it comes to managed mental health schemes in the 1990s, overhead costs and profits always consumed at least 45% of premiums paid. In the three decades beginning in 1970, total growth in spending per enrollee in Medicare climbed by 1,614%. That sounds like a lot. But for those covered by private insurance it went up 2,498%! Health Maintenance Organization executives earn millions of dollars in salaries and often tens of millions in stock options. (Canadians may grumble about the six-figure pay slip of a senior health ministry bureaucrat, but this man or woman is hardly in the same league as William McGuire, who a few years ago garnered a $7.2 million salary working for United Healthcare, plus the same figure in stock options – with the decimal moved once to the right.) Settlements, criminal and civil fines for fraud, in the hundreds of millions of dollars, faithfully follow for-profit enterprises like Columbia/HCA (now called HCA Healthcare), Tenet, Fresenius/NMC (dialysis fraud) and Beverly (nursing home fraud). In the 1990s, Medicare costs climbed more sharply – and notably so – in American communities with for-profit hospitals than in those with non-profit facilities.



So you're telling me that we get to pay you to build it and then pay you to use it?

In 2004, glancing over the border from the vantage point of Hamilton, Ontario, a team led by Dr.

P.J. Devereaux published a meta-study synthesizing the results of eight previous cost comparisons of for-profit and not-for-profit hospitals in the U.S. Some 350,000 patients altogether were involved in the eight surveys. Six showed higher payments for care at for-profit institutions, with five of these demonstrating differences that were statistically significant. "The lone study... that showed statistically significant higher payments for care at private, not-for-profit hospitals," wrote Devereaux et al in the *Canadian Medical Association Journal* (CMAJ), "compared hospitals owned by not-for-profit organizations but run by a for-profit firm with hospitals owned and operated by private for-profit organizations."[30]

Apart from profits, many critics of the U.S. system see extensive costs arising from the massive duplication of effort engendered by the parallel private and public bureaucracies that run the system. Hospital staff across the country are dedicated solely to chasing down patient payment from, potentially, an array of different funders. Scores of HMOs maintain complex care and accounting networks. Paradoxically, efforts by autonomous entities like insurers to cut costs sometimes simply pass expenses elsewhere along the chain – as described by one family physician who argues that initially, around 30% of insurance claims are denied. But a doctor's office with an effective (non-medical) staff complement can later slice that rate dramatically.[31] This may be good for the patient in the short term but tacks on staff hours and costs at caregiving facilities that will be passed on in increased costs and insurance premiums.

...when it comes to building a hospital, liability always ultimately rests with government, regardless of what a pact with a private partner might say.

The uninspiring economic results of "partnerships" in Britain

While the United States has a system that has long been a private-public mix, the United Kingdom offers an example of a country in transition from a largely socialized scheme – known as the National Health System and put in place in the post-war period – to one where "partnerships" are championed. WHO data suggest considerable efficiency in this country's health spending,

with the total bill coming in at something over 8% of GDP and over 80% of that accounted for by public expenditure. Backers of the NHS, with one eye on these data and another on the decent health outcomes of the British public, argue that the rationality, simplicity and seamless nature of a centrally planned system have historically allowed pounds sterling to stretch far. European critics might counter that while much more money is spent in the complex French and German systems, citizens of these countries get a better deal in the form of shorter waits, better facilities and considerably more doctors.

In short, P3s on both sides of the Atlantic are stories in excessive expenditure… spun by politicians who depict themselves as thrifty managers.

Without a doubt, there is truth in this criticism. The NHS has been under-funded for decades. Beginning in 1991, the Conservative government led by Margaret Thatcher also introduced an internal market scheme in British health care even as it continued to twist the funding tap tight (while privatizing long-term care at a furious pace).

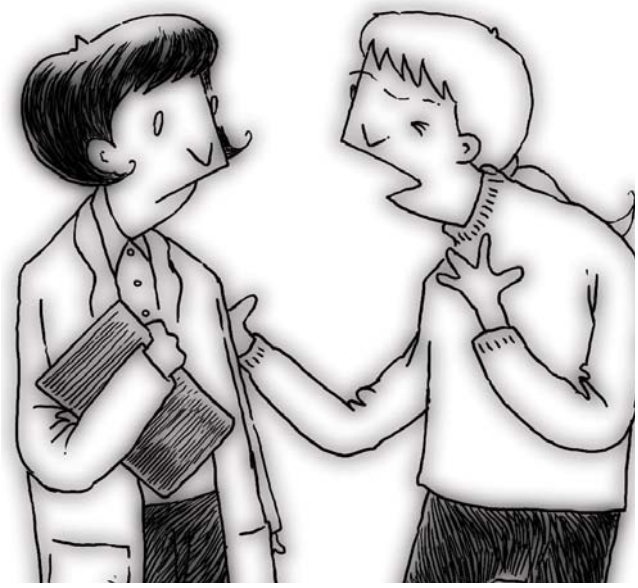
What were the results, economically speaking, of the Tories' reforms? Architects of the initiative made the case that increased competition between health providers would boost efficiency and savings while also improving quality of care. District health authorities and some general practitioners became "purchasers" of care, or fund-holders; hospitals were providers who "sold" services. The marketplace appeared at the point where these two sides met to negotiate contracts. Suddenly, hospitals were earning revenue through itemized transactions with those players who held the cash. The former were responsible for generating a surplus at the end of the day, which of course could be accomplished by doing more "business," cutting the wage bill, possibly outsourcing non-clinical services, finding new sales opportunities (e.g. real estate), carrying out procedures on deep-pocketed foreigners, etc.

As these reforms unfolded, the nature of hospital management was radically altered. According to Allyson Pollock, a notable student of NHS change, the quantity of such cadre also ballooned. She writes that the number of general and senior managers in the NHS rose from 1,000 in 1986 to 26,000 in 1995.[32] The proportion of NHS spending devoted to administration more

than doubled. Hospitals needed administrators with a sharp eye for revenue-generating opportunities.

To quote Pollack, "The land associated with long-stay hospitals, among them many huge institutions for the care of people with mental illnesses, was sold off for golf courses, luxury homes and supermarkets..."[33]

With some tweaks, and eventually a rise in public investment, trends continued under New Labour. Two main features have marked this most recent period of accelerated reforms: a sharply increased role for for-profit health providers within the public NHS, and a reliance on private investors to build hospitals.



"P3s may SEEM easy to swallow, but they sure taste like bad medicine."

The ballooning costs of P3s under Blair

Labour under Tony Blair gathered fund-holding general practitioners into Primary Care Groups that became PC trusts. By 2003, PC trusts were responsible for dispensing three quarters of NHS budgets in their areas. The government also began signing Private Finance Initiatives (PFI) with consortia to build new hospital facilities. Critics have argued that this approach, in Britain as in Canada, fails to make economic sense. Pollock, for one, raises the obvious objection that it costs private consortia 1-4% more to borrow than it does the public sector. And she has argued that the economic case made for the advantages theoretically accruing to society from PFI deals has been

cooked by overstating the cost overruns that typically occur when British hospitals are publicly financed. Conversely, the total payments projected to be made by the newly built hospital trusts to the consortia, over decades, are understated. Politicians, she argues, have been convinced by an ideological but factually bereft case: privately managed facilities will be more efficiently run; hospital waste will be squeezed out by managers keen to identify surpluses.

Boosters of the PFI approach also argue that costs associated with this strategy are justified by instruments in the contracts that transfer liability to the private builders. If all goes badly, or targets aren't met, the investors are the ones on the hook. Critics are just as unimpressed with this line, noting that when it comes to building a hospital, liability always ultimately rests with government, regardless of what a pact with a private partner might say. In any case, the first wave of PFI ventures in Britain proved more expensive, sometimes spectacularly so, than consultants (who themselves billed millions of pounds) estimated back in the 1990s.[34] One source maintains that final costs typically have exceeded projections by 72%.[35] Profit margins can reach 25%.

Labour rule in this decade has also opened the door to for-profit furnishers of care seeking work within the NHS; the government has encouraged this as a way to tackle wait times. The plan, as worked out in the early 2000s, was to have independent surgical centres implanted by private investors eventually perform hundreds of thousands of hip, knee and cataract procedures per annum. At the same time, the country's network of private, for-profit hospitals already in place was to be increasingly used to offer publicly covered care. What have been the economic implications of this approach? Minimum payments have been guaranteed to private players, even where procedures aren't performed. Sometimes extra compensatory money has been disbursed to public facilities when the state wanted surgical work diverted to a foreign investor and an NHS infirmary stood to lose revenue. And it seems that profit-making providers have sometimes been paid well above the average NHS cost for treatments, after making arrangements to restrict their patient load to rapid turnover cases – thus leaving more costly procedures to public facilities.[36] Savings are nowhere to be seen.

The privatization of long-term care leads to the neglect of our most frail elderly citizens. The profit-seeking behaviour of private facilities diverts funds and focus from providing care and leads to cutting corners in staffing. For-profit facilities pursue profit by cutting staff or spending on services and care.

Source: *Dignity Denied: Long-Term Care and Canada's Elderly*
www.nupge.ca

Public-private hospitals up and running… and costing Ontarians as well

In Ontario, imitations of recent practice in the UK are well underway. Commentary on the economics underpinning those PFI or P3 hospitals that are up and running, notably the Royal Ottawa Mental Health Centre and the William Osler Health Centre in Brampton, has emphasized points similar to those made in the British context. The facility in Ottawa, as reported by Local 479 of the Ontario Public Services Employees Union (OPSEU), built and run by the consortium Carillion, was supposed to cost $95 million and hold 284 beds. It opened with 188 beds at a cost of $146 million.[37] Construction of the Brampton facility, where standards of care have already been criticized (more on that later), was initially forecast to reach $350 million and offer 608 beds. When the hospital opened in 2007, there were some 480 beds and the price tag had reportedly almost doubled. About one-half of the facility, including patient support services, was in the hands of for-profit entities, according to the Ontario Health Coalition. This same source maintains that the final bill for the taxpayer for this facility could climb to $3.5 billion. In something of an understatement, the former director of audit operations with the office of the auditor general stated that the project gave poor value for the money.

…service cutbacks drove a very economical, non-profit provider out of the field, while generating business for commercial players who billed more and paid front-line staff less.

Meanwhile, a P3 in B.C. (Access Health Abbotsford) similarly featured ballooning capital costs plus yearly service payments that climbed from an initial projection of $20 million to reportedly over $40 million. In short, P3s on both sides of the Atlantic are stories in excessive expenditure… spun by politicians who depict themselves as thrifty managers.

The framework for new ways of financing hospitals' operating budgets is also in place in Canada's Pacific province. B.C. Health Minister George Abbott affirmed in February 2008 that "activity-based funding" will, to an extent still to be determined, be the way of the future. Under the new Innovation and Integration Fund, a portion of the public money that B.C. hospitals receive is henceforth tied

to the number of surgeries and other treatments they perform. A mechanism by which acute care facilities compete for dollars in an "internal market" has hence been introduced. Each B.C. patient is now a potential contributor to a better bottom line for facilities that for the moment remain publicly owned. In Ontario, the ground for a similar scenario was prepared starting in 2005 by the introduction of Local Health Integration Networks (LHINs) and their boards' mandate to manage purse strings and seek efficiencies and savings. Canadian hospitals, needing cash, will compete for the "business" of ill individuals while also stepping up their practice of renting out space to providers offering uninsured and pricey services (as is the case at the Royal Ottawa Mental Health Centre, where reportedly "at least one" ROMHC psychiatrist furnishes patients with a referral slip to receive $5,000.00 to $7,500.00 treatments at MindCare, a clinic right in the building).[38]

The costly fruits of profit in home care

Meanwhile, a market increasingly populated by for-profit players is well-entrenched in Ontario homecare.[39] On January 16, 2008, on a chilly night on Hamilton Mountain, over 1,500 citizens, including homecare nurses and their families, jammed a community hall to listen to speeches and music. They were unhappy with a development in their community and determined to respond. A month before, two non-profit agencies, the Victorian Order of Nurses (VON) and St. Joseph's Home care, had been told they were ineligible to participate in the province's competitive bidding process to provide nursing care to residents through

the local Community Care Access Centre (CCAC). It is not as though the two organizations were new to the field. For some eight decades St. Joseph's employees had been providing care. Hamilton VON had chalked up more than a century of service.

...there is international evidence that a well-funded homecare system can benefit a nation's overall health bill.

Before the Tories' Common Sense Revolution swept the province in the mid-1990s, home care in Ontario was furnished by non-profits such as VON and the Red Cross. The victorious Conservatives, converts to Thatcherism, argued that the interests of efficiency could be served – and quality care maintained – by ending grants to non-profits and encouraging commercial players to enter the field. With salaries and benefits for nurses and home-helpers constituting the overwhelming bulk of costs in this sub-sector, what occurred under the new regime was not surprising. Firms interested in profit squeezed compensation packages in order to simultaneously generate a surplus and make an economically attractive bid. In turn, nurses increasingly sought better-paying jobs in hospitals or homes for the aged – or they left the profession altogether.

Governments have denied that price and projected savings are the decisive factors in awarding homecare contracts. Yet the Ontario Health Coalition has noted the following:

> *The minister of Health and the CCACs have asserted that 'quality control' is given priority in the awarding of contracts and that quality accounts for 70-80% of the points used to assess bids. But 'quality' is assessed [via] a bidding document – not actual quality of care. It is simply a paper exercise. Agencies with few or no care staff have been awarded contracts in competitive homecare bidding based on their documents...[This favours] multinational companies that hire expensive consultants to write the bids.*[40]

Actually, one review of previous events – also in Hamilton – perversely suggests that in the quest for short-term savings, sensible objectives of *both* economy and quality end up being

sacrificed. In 2002, VHA Health and Home Support Services closed operations in the steel city after finding it could no longer afford a dramatic loss of revenue occasioned by the local CCAC's decision to rescind services for thousands of clients. The CCAC was in turn responding to government pressure to eliminate a deficit, and refused to revisit the terms of VHA's contract in order to help it cope with this unforeseen loss of business. Non-profit VHA had furnished almost 60% of home-support services in the area, boasting around 2,500 clients. (To be clear, we are not talking in this instance about nursing but services to help elderly or incapacitated patients bathe, clean and realize other household tasks.)

Data offered by Jane Aronson, Margaret Denton and Isik Zeytinoglu, writing in the journal *Canadian Public Policy,* suggest that, compared to its for-profit competitors with contracts in the Hamilton area, VHA actually offered the smallest "gap" between the compensation it paid employees and the fees it charged. It also paid the next-to-best wages, after another non-profit, at almost $12.00 per hour – not a royal wage but comparatively good. Most strikingly, it was cheaper than all the for-profit companies save one (with whom, in terms of cost, it was tied)![41] In short, service cutbacks drove a very economical, non-profit provider out of the field, while generating business for commercial players who billed more and paid front-line staff less. Did the government, when it declined to help VHA out of a difficult situation not of its own making, simply see an opportunity to assist some for-profit friends?

As it turns out, there is international evidence that a well-funded homecare system can benefit a nation's overall health bill. By definition, accessible home care for seniors and others keeps at least some individuals out of more expensive institutional beds. A comparison between developments in Denmark and the United States between 1985 and 1997 goes some way to illustrating this point. In the European jurisdiction, per capita spending on continuing care services for seniors climbed just 8%. In the U.S., the figure was 67%. For the very old (80-plus), the American increase was almost identical to its overall spending hike, while costs for this upper age bracket dropped 12% in Denmark. During the same period, the total number of nursing home beds in the European country declined by 30% but climbed by 12% in our southern neighbour.[42] What occurred was that public money was spent to help older Danes stay in their homes or reside in assisted living facilities. Overall, greater efficiencies were achieved.

Significantly, one researcher found that 80% of the price for long-term home care for people with complex health needs (which fairly describes many Canadians in LTC institutions) is spent on support, with only 20% aimed at more costly professional services – that is medical attention, strictly understood.[43] So the paradox is that people with even reasonably serious medical issues often could remain at home and that most of the cost devoted to maintaining their health, in this friendly and familiar environment, would actually pay moderately remunerated staff to give baths, prepare food, do the washing and vacuum the floors.

...according to B.C. data, admission rates to acute-care hospitals for LTC residents suffering anaemia, pneumonia and dehydration are higher in for-profit institutions.

Of course there is another way to proceed with community care, different from the Danish approach and typified, at least in this country, by the so-called Alberta model. This system has been critically examined by health policy analyst Wendy Armstrong – and contrasted with innovative attempts to improve public, non-institutional forms of long-term care carried out in that same province.[44] The "Alberta model" shares the assumption that assisted living facilities and seniors' autonomy can be preferable to traditional institutional care, but lets markets and the profit motive largely shape the sub-sector. Under this approach, public coverage of services, in home and elsewhere, is cut, while investors are invited to build assisted living facilities where a range of services are available. Government accounts are apparently improved as the public sector ceases to erect LTC facilities, as has basically been the case since the 1990s in oil-rich Alberta. Direct-care staff is sharply reduced in those centres that muddle on. Yet understood globally, the system is far from inexpensive. Residents in such facilities (or their hard-pressed families) pay hundreds or indeed thousands of dollars per month for meals, personal aid, transport and medical services. A brimming public purse isn't used to further goals of equity and aid to the province's most vulnerable.

Homecare's inclusion in the *Canada Health Act* has been demanded in the past, for example by the National Forum on Health in 1997. But in 2002 Romanow, presumably interested in questions of economy as well as care, declined to recommend this course. Health Ministries have instead opted to emphasize uneven public support for short-term home care delivered to patients

just out of acute hospital facilities. Alberta, for example, has chosen to let for-profit, assisted living investors get a return on their dollar. For its part, Québec has subcontracted its InfoHealth service which provides over-the-phone medical advice to, among others, patients who require homecare, to a private company in Ontario. A more far-sighted and egalitarian approach would feature a national, public plan to help Canadians with medical needs, and of varying incomes, continue to live independently.

Ensuring quality care and optimum outcomes

Let's continue reviewing home care for the moment, but shift our emphasis from economy to quality of care and patient outcomes. At the January 2008 public meeting in Hamilton held to protest the ouster of VON and St. Joseph's, most of the concern expressed centred around the ways in which the disruptions inherent in competitive bidding potentially traumatize patients. Community activist Aznive Mallet, herself a homecare patient since suffering a severe head injury some three decades before, reported that with the changeover from one provider to another, patients "suffer enormous amounts of stress." New staff, if they genuinely are new and not the same caregivers hired by the new contract-holder, often arrive with inadequate knowledge. The "beautiful perfection" of VON's treatment – Mallet's phrase and derived from her experience of years of uninterrupted patient-caregiver rapport – can be shattered by a transition motivated by the belief that a market mechanism can correct defects that are not, to those cared for, apparent.

In the course of the event, senior Barbara Lustig appeared on video to tell the assembled that "it's frightening to me" to have to get to know a new nurse and familiarize her or him with the ins and outs of the care required by Martin, her bedridden husband who is unable to speak. "We're being penalized for having him at home," Mrs Lustig added, her fear palpable. Of course, governments would reply, seniors in long-term facilities might see different caregivers too. Discontinuity of care may also occur when non-profits retain a homecare contract. Nurses and other professionals quit or change jobs. Absolute stability isn't a realistic goal in any life situation. Backers of not-for-profit homecare reply, fine, we grant you that, but this is *planned* instability aimed at those sections of the population least able to handle change. Competitive

"The dominance of for-profit insurance and pharmaceutical companies, a new wave of investor-owned specialty hospitals, and profit-maximizing behavior even by nonprofit players raise costs and distort resource allocation."

"Profits, billing, marketing, and the gratuitous costs of private bureaucracies siphon off $400 billion to $500 billion of the $2.1 trillion spent, but the more serious and less appreciated syndrome is the set of perverse incentives produced by commercial dominance of the system."

New England Journal of Medicine 358 (6), February 7, 2008, www.nejm.org.

bidding inevitably causes under-paid nurses to flee home care in significant numbers. And "marketization" is instituted through a process shrouded in secrecy, one that fails to disclose any (intended) benefits in a transparent fashion.

Some days after the gathering, Ontario Health Minister George Smitherman announced the cancellation of the Hamilton process that had so annoyed local residents. A general freeze of the competitive bidding system across the province was declared. At this writing, it was unclear what this decision might mean in the longer term.

...investors want a 10-15% return, and corporate officers desire substantial salaries plus bonuses. Other costs being equal, such revenue has to be wrung from somewhere. Patients are the ones short-changed.

Investigations show that people cut off from publicly covered homecare – a form of privatization or rationing – suffer more in comparison to those who continue to receive treatment and help in their own bedrooms. With a ready-made laboratory inadvertently designed by a government looking to save money, Marcus Hollander looked at British Columbia in the wake of that province's decision, some years ago, to cut services to patients requiring lower levels of attention. Across B.C., regional health authorities adopted different responses to this policy measure, with some implementing the service reductions and others declining to do so. By the second year after the cuts, those individuals still getting home care had, on the whole, seriously limited their hospital use. But a clear majority of those who had lost services testified to a decline in their health. More than a quarter reported "hardship" as a result of the change.[45] Of course, these individuals, assuming they had the means, might have purchased replacement services. Or, they may have spent more time in emergency rooms.

On the subject of care, access and outcomes, data from B.C. also suggest that frequent visits from a public health nurse in the initial months of home care lead to a dramatic drop in patient death and rates of admission to LTC facilities over a three-year period. In short, home care seems to present an opportunity for public investment that is likely to pay social dividends. Not all politicians grasp that message.

When returns trump care in long-term facilities

Nevertheless, even in the context of a well-funded, accessible homecare system, many elderly and otherwise incapacitated individuals would have to reside in long-term care institutions. Because this is an area where Canada has well-developed systems of for-profit care alongside not-for-profit services, we are able to relate some contrasts from familiar territory.

A study published in 2005, examining 109 not-for-profit LTC facilities and 58 profit-seeking centres in B.C. (just over three quarters of all long-term care centres in the province), concluded unambiguously that the former provided residents with more daily attention, both in terms of direct care and support services (0.34 hours per resident/day and 0.23 hours respectively).[46] As the authors noted, higher registered nurse hours per resident are "associated with fewer violations of care standards and improved functional ability of residents."[47] Again according to B.C. data, admission rates to acute-care hospitals for LTC residents suffering anaemia, pneumonia and dehydration are higher in for-profit institutions. Similar results have been revealed in Manitoba.[48]

We got a great new hi-tech siren - the best money can buy!

With almost 60% of its publicly funded LTC beds in for-profit environments, Ontario also provides an ongoing experiment in public-private partnership. Here, the official attitude is essentially the

following: given the developed network of for-profit homes, and the readiness of chains such as Extendicare to invest in the sub-sector, the most feasible policy is to boost accessibility by lending the support of public dollars to corporate initiative.

Elaine Gilbert is an RN who has worked both in municipally run, not-for-profit homes for the aged and shareholder-driven nursing homes.[49] Indeed, she presently works full-time for one of the latter while adding casual hours in a public facility. Her experience and impressions, though anecdotal, merit consideration.

"It isn't," she says, "that nursing homes don't provide good care." But corporate managers aren't the ones responsible for what Gilbert thinks are usually decent results. "Front-line staff, through their own innovation, give quality care." What she means by innovation includes an ability to scramble and even fight for supplies that are often not abundant (or squirreled away) in for-profit homes. In contrast, not-for-profits "seem to have endless supplies," Gilbert remarked in an interview.

As of early 2008, the Ontario Federation of Labour was trying to interest the province's Human Rights Commission in a complaint against nursing homes unwilling to change residents' incontinence materials (informally called diapers or briefs) until they are 75% full. "One of the jobs of [my] director of care is to count out briefs to staff... and she takes pride in limiting handouts more than her predecessor was able to," asserted Gilbert. As for RN staffing, this nurse observes that five years ago she was responsible for 153 patients at a for-profit facility and now has 80 residents in another shareholder-owned centre. This compares to 32 at a municipal not-for-profit home for the aged that once employed her.

The chain for which she currently works, says Gilbert, announces annual profits in the millions. Where does this surplus come from? In her opinion, it is derived from scrimping on supplies and squeezing workers. Management regularly denies claims for overtime when staff misses lunch, or the rest period is interrupted due to the requirements of patient care – even though provision for extra pay in these cases is clearly stipulated in the collective agreement. The result: an expensive grievance process and a poisoned work environment. Could the latter be good for care and resident happiness, Gilbert wonders rhetorically?

Data from the United States about the effects of ownership by private investment groups reinforce the thesis that the quest to derive profit from nursing homes generally entails staff cuts

and declining quality. In a September 23, 2007, article by Charles Duhigg, the *New York Times* unveiled the results of a lengthy investigation of more than 1,200 homes, from around the U.S., acquired by large private equity groups between 2000 and 2006. Analyzing records from the Centres for Medicare and Medicaid Services, the prominent American daily concluded that 60% of facilities bought within the time period examined experienced radical cuts in registered nurse numbers, "sometimes far below levels required by law." Interestingly, among the remaining 40% considered in the study, staffing was also "typically" below national averages. The author added that "the typical nursing home acquired by a large investment company... scored worse than national rates in 12 of 14 indicators that regulators use to track ailments of long-term residents." But for shareholders of firms like Formation and Warburg Pincus, active in this acquisition wave, the news was good: returns were hefty.

For-profit hospitals drive up mortality rates

Returning to acute-care hospitals, this time in the context of outcomes, we again find data that tell troubling stories about the bottom line. As before, a research group led by P.J. Devereaux unearthed key information. In a summary of studies not dissimilar to the one that found shareholder-driven hospitals to be more expensive, the medical scientist's team determined, through a 2002 review of enquiries into a total of 26,399 hospitals and over 36 million patients in the United States, that for-profit facilities tend to generate higher death rates. "The private for-profit hospitals employed fewer highly skilled personnel per risk-adjusted hospital bed."[50] And it is the presence of such staff, again, that mitigates these rates. So why should for-profits employ fewer skilled staff? Most likely, the authors opined, investors want a 10-15% return, and corporate officers desire substantial salaries plus bonuses. Other costs being equal, such revenue has to be wrung from somewhere. Patients are the ones short-changed.

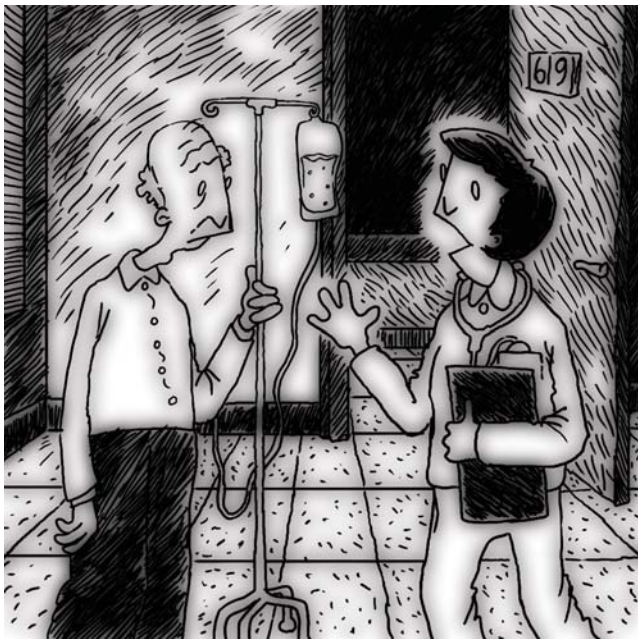
Other glimpses of U.S. practice add to the picture. Not-for-profit Health Maintenance Organizations give more care when it comes to toddler immunization, mammography service, pap smears, and diabetic eye exams. Death rates for dialysis patients, in a market where for-profit Fresenius has been a dominant player, have been recorded at almost 50% higher after controls

account for age, race, sex and other factors, than in America's northern neighbour. Meanwhile, a significant portion of U.S. patients are treated with reprocessed dialysers.[51] This cost-saving measure, studies suggest, increases patient risk.

Back in Canada, care concerns at the William Osler P3 have also been raised – and were indeed sparked by two patient deaths at the hospital in 2007 that in turn produced community protests in December of that year. It would of course be premature to draw direct links, at this writing, between the for-profit nature of the facility and those tragedies. And certainly, complaints about bed shortages and care can be heard in traditionally built and managed Canadian centres as well. But brand new William Osler, it would be an understatement to say, was not bathing in a wave of public confidence and appreciation during its first few months of life. Officials scrambled to assure a worried community that patient outcomes came first at the P3 institution.

Finally, Sweden – a country sometimes embraced by both critics and boosters of an increased role for privatized care – offers an example of how clinical concerns can even arise from the privatization of non-clinical services. On May 9, 2006, Swedish television aired an investigative report into the results of University Hospital Lund's experiment with a private cleaning firm.[52] Cleaners have a heavy workload, learned the journalist covering the story, and, with a smaller staff than before the reform, have to work even harder when a colleague phones in ill. Dust and dirt abound in various wards over which the camera was permitted to sweep. It seems that infections patients acquire in hospital and take back to the community were proliferating when this report was made. Is the link between cleaning for profit and more ill, local Swedes established with iron-clad, scientific certainty? Perhaps not. But the story is troubling... and ongoing.

IV. The primary health care challenge



We've cut our long-term and acute care beds, Mr. Smith -- I'm afraid you'll have to sleep standing up.

According to Dr. Martin, Canada "does very well in terms of access to acute care services." She acknowledges that the adjective "bad" describes our performance on elective procedures, though on this front she is quick to list some of those improvements already described. But "we do a terrible job of prevention," she recently observed. "We could reduce hospital visits dramatically with better prevention."[53]

On this front, the Canadian Nurses Association (CNA) has been a determined advocate. Noting that the cause of illness prevention could be substantially furthered by more interdisciplinary as well as inter-sectoral collaboration (which is to say, more systemic cooperation and information-sharing between members of the various health professions as well as between caregivers and experts in such fields as housing, anti-poverty and immigration), the Association has identified some primary health care success stories in Canada. At the Northeast Community Health Centre in Edmonton, for example, health teams aided by an integrated information system deliver care ranging from prevention to emergency services. The centre itself is located on public transportation routes that facilitate community access; it maintains links to local workplaces, schools and social housing facilities.

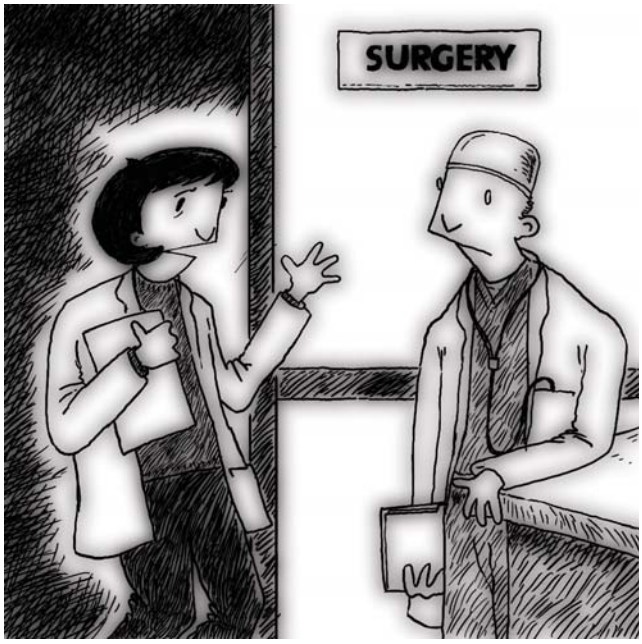
Quick to offer praise where praise is due, the CNA has also, however, identified key barriers to improvements in prevention in Canada. One of these is the pay-for-service system of remuneration to which most physicians are subject – an arrangement that encourages lucrative curative care, diagnoses and high-tech repair. Nurses have noted that a system emphasizing prevention would place greater emphasis on the role of salaried Nurse Practitioners – RNs with an enhanced skill set able to perform numerous functions previously restricted to physicians.

Charging to see the doctor…and undermining access

Certain doctors and investors have something else in mind: fee-charging ambulatory clinics where expensive services that boost the bottom line abound. Witness Don Copeman, CEO of Copeman Healthcare Centre, an enterprise that sprang to life on the west coast, is reportedly heading to Calgary and may one day turn into numerous clone operations across the country. At this facility, adult patients are invited to pay $3,900 for an "all-inclusive health care program" during a first year of treatment. The fee apparently declines somewhat in subsequent years. How does the company get around the legal matter of billing patients directly for an insured service as defined by the *Canada Health Act*? The answer, the CEO says, is that in acquiring access to a team of healthcare professionals, patients are only paying for extra services not covered by B.C.'s public plan. When a physician provides insured services in the course of a patient (or is that "client"?) visit, then he or she bills the provincial plan for those particular services. It is all quite legal, argues Copeman. In the fall of 2007, the B.C. Medical Services Commission agreed with him. "If some elements of private care can enhance the public service delivery in the province, I'm not prepared to rule it out," said British Columbia's Minister of Health George Abbott.[54]

Not-for-profit, primary health care seeks to partially correct the unfortunate outcomes that inevitably arise in an unequal society.

Medpoint Health Centre in London, Ontario, is a similar initiative. One pays a $500.00 "introductory fee" for a "Comprehensive Health Assessment" of a sort usually reserved, suggests



He wants to know if deluxe hip will make him a better dancer before he agrees to the higher cost.

the centre's website, for CEOs and other high-profile decision-makers. A 2.5-hour "total body analysis" is undertaken. There are refreshments and a grooming centre; presumably these services figure among the set of extras that a patient is theoretically paying for. Less frivolously, Medpoint also offers nutrition services, access to a foot clinic, a pap clinic (OHIP-covered, to be sure) plus referrals to "partners" that can help patients avoid the public queue and purchase private surgery, CT scans, MRIs, and other procedures.

Clearly, such pricey schemes won't help Canadians most in need of primary attention, like those individuals living on the streets of Vancouver's poorest neighbourhoods who make use of *Insite*, an innovative partnership involving Vancouver Coastal Health (VCH) and the PHS Community Services Society. Here residents suffering from addiction can inject drugs in a safe environment and be referred to healthcare professionals able to attend to the special needs of people ground down by destitution.

Then there is VCH's focus on aboriginal health. Doctors, nurses and other professionals are working with First Nations communities in British Columbia to help repair some of the damage done to status and non-status people alike. Statistics Canada tells us, for example, that the death rate for First Nations babies in B.C. is 7.5 out of 1,000 births, compared to 2 out of 1,000 for other British Columbian infants. Diabetes and heart disease strike aboriginals with greater frequency

than other citizens. Better outcomes, lower infant mortality and greater longevity among aboriginal Canadians will probably not occur chiefly as a result of innovations by clinics. These problems are primarily questions of poverty and inequality. But public care initiatives that respect native values and belief systems and encourage the education of health professionals from within these very communities – thus realizing a fundamental tenet of a well-rounded primary health care approach – are having some impact.

So there resides the contrast in a nutshell. Not-for-profit, primary health care seeks to partially correct the unfortunate outcomes that inevitably arise in an unequal society. Clinics that charge deepen the social gulf that political economy, drugs and mental illness have already dug.

Curiously, in 2006, the Ontario government intimated to Don Copeman that his clinics were not welcome east of the Manitoba border. But as of early 2008, Medpoint seemed to be in full operation. Observers suggested there was little question that this facility was in violation of the *Canada Health Act* if its patients could reasonably be understood to be purchasing listed physician services. Was Medpoint, by promoting its package in a large advertisement in the *Toronto Star,* inviting a legal confrontation with Queen's Park? Was it seeking to fling open the doors to corporate clinics in the country's largest market? Will the government have the principles and gumption to take this centre on?

V. Conclusion

In terms of health outcomes, Canada does not do badly. Our life expectancy is high, our infant mortality rates low – although First Nations peoples continue to die young and suffer disproportionately, to the country's shame.

We favour a nationally coordinated plan for fully-funded home care, short and long-term, as well as a Pharmacare initiative. Both would help the elderly, disabled and less-prosperous lead better lives; both could save resources over time.

A study supported by the Commonwealth Fund released in early 2008 ranked Canada sixth out of 19 developed countries in mortality amenable to health care, in the 2002-2003 period.[55] This means we have relatively few deaths among residents below age 75 due to a series of causes that health professionals have deemed preventable. In the 1997-98 period we ranked seventh. Still earlier data looking at results for people aged 5-64 showed Canada leading OECD countries in the preventable deaths category during the mid-1990s (that is, getting the best results), so it is possible that our country has slipped marginally in this measure.[56] Nonetheless, Canada's standing remains highly respectable. In the most recent Commonwealth Fund-supported review, the U.S., for its part, ranked last. (Australia placed third, showing that all is not bad in that country from a health care point of view.)

But if things in Canadian health care aren't catastrophic, there is plenty of room for improvement. Wait times for elective surgery, for example, don't end up in elevated death statistics; they do however contribute heavily to our national bank of agony and frustration. We need to continue to improve public services to speed these procedures up, to boost the role of facilities like the one headed by Dr. Cy Frank in Calgary. Yet when considering the role of "one-stop" surgical centres, even not-for-profit ones, we have to be mindful of the fact that speed isn't all, that complications can arise in even the simplest procedures, and that safety is often best guaranteed by an acute-care facility and all the equipment and expertise it contains. Quality and safety must come first.

Quite clearly, Canada lacks healthcare personnel. While not a subject of this paper, our serious nursing shortage needs to be emphasized here; working nurses are aging. We need a dramatic infusion of new professionals into the field. It is also evident that we need more doctors in certain areas of the country and in particular specialties.

Parliament shouldn't, under the guise of cooperative federalism, ignore its responsibility to challenge provinces that undermine the principles of accessibility and universality in service delivery.

In this discussion, medical and medical support services that in our view should be brought into the public system have been identified. We favour a nationally coordinated plan for fully-funded home care, short and long-term, as well as a Pharmacare initiative. Both would help the elderly, disabled and less-prosperous lead better lives; both could save resources over time. All evidence suggests that the runaway costs of pharmaceuticals, coupled with the proliferation of new products, demand radical measures. Enhanced patent protection in Canada and elsewhere for pharmaceutical firms has boosted profits and served inflationary ends. A national Pharmacare program would help contain prices through the advantageous buying position that large public sector players enjoy. Such a program would obviously improve accessibility to drugs for those Canadians who now pay for their prescriptions out of pocket. It would spare the additional expense of providing ER attention and other procedures to poorer residents whose conditions are aggravated by an inability to afford medication. It could also ease costs for employers saddled with private drug plans, by, among other measures, reducing charges currently paid to private insurers to cover administrative and other costs. Moreover, to repeat a point made earlier, the costs of coverage would be more equitably distributed as all employers would assume the responsibility of contributing to a national public fund. The competitive position of numerous companies that presently offer private insurance to their employees would be improved.

This is not to say that the public purse ought to pay for everything that emerges from the laboratories. In this connection, we repeat the Canadian Health Coalition's demand for a transparent, objective regime of drug approval that prioritizes safety and cost. Approval processes for new

medicines that depend on funding from pharmaceutical firms, like the current Canadian method, are bound to be at least significantly market-driven. Physicians and members of the public do not currently find, in Health Canada, a partner ready to share data.[57] Secrecy is largely the order of the day when it comes to putting the stamp of approval on new drugs. This has to change.

In April of 2008, the federal government introduced bill C-51 to amend the Federal *Food and Drugs Act* for the first time since its inception. While the bill may yet be amended, it appears to take a new direction for drug approval. Rather than ensuring that new pharmaceutical products are absolutely safe, the government will allow them on the market faster while managing risks to the population through a process that would weigh those risks against possible benefits. This "progressive licensing" would leave the government open to more lobbying efforts by the industry to further remove obstacles to profitable and possibly unsafe pharmaceutical products. The idea that Canada could become a national laboratory for new drugs is hardly comforting. Moreover, the bill seems to eliminate obstacles to direct-to-consumer advertising while legitimizing commercial secrecy and confidentiality for drug producers. Unfortunately, attention to these aspects of the bill has been deflected by controversy over its regulation of natural health products.

We wouldn't want to endanger the health of the nation by insisting on equal access to health care!

We are, no doubt, more of an over-prescribed than an under-

prescribed society. Cost control, when it comes to pharmaceuticals, is inextricably linked to an effort to only recommend and fund medications that are proven to be helpful and to enhance the quality of patients' lives – and to achieve ends that can't be attained through alternative methods.

New programs like Pharmacare and home care could be integrated in the *Canada Health Act* or not. The point is that they be accessible, universal and of quality. Nor does it seem that inclusion of a service in the *Act* is a guarantee that the federal government will sanction provinces that allow charges for listed services. Clearly, as the federal share of health funding has declined over the decades, Ottawa's stick has become less fearsome. But the carrot of federal dollars could be employed, by a government interested in public services, to negotiate both a comprehensive homecare system and Pharmacare.

You can't sleep now, there is no one coming in to replace you!

A further point must be made in this regard. Merely because provincial governments don't like to be told what to do by Ottawa, and although the federal authorities have lost some of the financial clout they once enjoyed, it does not follow that Ottawa need no longer try and enforce the terms of the *Canada Health Act*. In February 2008, the presidents of the Canadian Union of Public Employees (CUPE) and the Canadian Federation of Nurses Unions (CFNU), Paul Moist and Linda Silas respectively, wrote to the auditor general of Canada requesting an investigation into Health Canada's performance

in meeting its obligations under the *Act*. "Despite the rapid growth of for-profit delivery of medically necessary services, financial barriers to ensured services and queue jumping, we see virtually no monitoring, reporting or challenging of these practices by the federal government," the presidents observed. It is not as though the feds have ceased to matter when it comes to healthcare financing. In 2004 Ottawa agreed to boost health transfers to the provinces by some $41 billion over a decade. Parliament shouldn't, under the guise of cooperative federalism, ignore its responsibility to challenge provinces that undermine the principles of accessibility and universality in service delivery.

Other public initiatives should also be on the table, like free or, as a first step, heavily subsidized dental care, at least for children under a certain age. There is no reason to think Canada cannot afford such initiatives.

Disdaining equality

More for-profit care shows no sign of being able to improve Canadian health services. Where are the peer-reviewed studies showing that investor-owned providers lower costs and improve outcomes for the general population? They don't exist.

Where are the peer-reviewed studies showing that investor-owned providers lower costs and improve outcomes for the general population?
Answer: They don't exist.

Certainly, private clinics can cut wait times and add "choice" for those with financial resources. Politicians and other elite voices who favour such measures are really speaking to this constituency, the more prosperous, even if they couch their argument in the language of the common good. Like some of our elected governors, the Supreme Court justices constituting the majority in the Chaoulli case also revealed a certain disdain for egalitarian principles. As Colleen Flood, Mark Stabile and Sasha Kontic have written, "...equality cannot trump all other factors, for equality in misery is not worthwhile. But if Chief Justice McLachlin and Justices Major and Bastarache had put some value on aspiring to achieve equality in allocating health care..." then their "bullish approach" might have been "tempered" – and there might have been no 2005 legal decision inviting private insurers to extend their scope in Canada.[58]

A second to last thought: When Canadians participate in the healthcare debate, they have to remember that what's best for patients and taxpayers is far from the only consideration in play. Politicians and others may promote private care for reasons that are no more than ideological; they just want medicine to conform to their pro-market preferences and prejudices. Governments may favour markets because they have an eye on trends in international investment. They will open doors to healthcare corporations because they want Canadian businesses to enjoy access to other nations' markets. One can't make sense of the public-private debate without being aware of a deal called the General Agreement on Trade in Services (GATS). According to GATS, which includes medical care, a country's services can be protected from liberalization measures. But as soon as these services are provided on a commercial basis, protection gets dicey. Dispute panels are less likely to allow healthcare sectors to be sheltered from market forces in cases where those sectors already have commercial players. (In this connection, the introduction of private insurance to cover already listed services in Québec, for example, will almost certainly pose problems for the whole country – even if the federal government ignores what its leading lights prefer to deem a provincial matter.) Corporations, for their part, regard governments as responsible for opening and securing new investment frontiers. Questions of care and savings are secondary, in this perspective.

Finally, how should citizens react when care and quality are undermined in the name of profit? Of all their public services, Canadians seem to most cherish quality treatment delivered on the principle that illness, rather than bank account size, ought to determine their place in the healthcare line. It is hard to think of another good or service distributed on that basis of pure need. Unfortunately, such a principle does not generally describe the ways of this world, a world in which private wealth is the key that opens doors to good and necessary things. For that very reason, a defence of care that treats the rich and less well-to-do as equals requires determined efforts by Canadians. And not just the efforts of a few "activists." Hamiltonians offered a good lesson in how to react to assaults on not-for-profit care in the winter of 2008, as did Albertans some years before.

Controlled anger, politely but firmly demonstrated, gets attention. Politicians often don't know best. But their hearing remains generally unimpaired. With enough people up in arms (metaphorically speaking), elected representatives may yet pay more attention to citizens than to investors and trade lawyers.

Notes

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5 Ibid., p. 12
6 Article by Helen Branswell of the *Canadian Press* in the *Toronto Star,* "Wait times cost economy $14.8 billion: CMA," January 15, 2008
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8 Canadian Health Coalition, *More for Less, a National Pharmacare Strategy* (Ottawa, 2006), p. 7
9 Dr. Brian Day cited Canada's ratio of physicians to 1,000 residents both in his October 12, 2007, address to the Empire Club in Toronto and in his January 15, 2008, speech to the Economic Club on the cost of wait times. At the latter event, held on the premises of Toronto's National Club, he also asserted that 4.5 million Canadians lack a family physician. The 2007 speech was accessed at www.cma.ca. The author was present at the 2008 function.
10 Anne-Laurence Le Faou, *Les systèmes de santé en questions: Allemagne, France, Royaume-Uni, États Unis, et Canada* (Paris, Ellipses: 2003), pp. 71, 119. For a compelling review of the effects of current public funding policies in the French system and the spread of for-profit players, see André Grimaldi, Thomas Papo, and Jean-Paul Vernant, "Traitement de choc pour tuer l'hôpital public," *Le Monde Diplomatique,* February 2008.
11 See World Health Organization statistics, core health indicators, at www.who.int/whosis/database/core/core_select.cfm
12 An oral communication from Dr. Brian Day to the author on January 15, 2008
13 J. Ross Barnett and Pauline Barnett, "The growth and impact of private hospitals in New Zealand," in *Health Service Privatization in Industrial Societies,* Joseph L. Scarpaci (Ed.), (Rutgers University Press, 1989), p. 98

14 See Stephen J. Duckett, "Living in the parallel universe in Australia: public Medicare and private hospitals," *CMAJ* September, 2005, available at www.cmaj.ca/cgi/content/full/173/7/745

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19 Canadian Doctors for Medicare, *Success Stories in Medicare,* available at www.canadiandoctorsformedicare.ca

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22 Bob Rae, "Health policy in the consumer era," in *Do We Care? Renewing Canada's Commitment to Health,* Margaret Somerville (Ed.), (Montreal, McGill-Queen's University Press: 1999), pp. 89-94

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25 Canadian Union of Public Employees, *Defending Medicare, A Guide to Canadian Law and Regulation* (January, 2008), p. 10

26 Colleen Flood at the CFNU's 2005 *Hot Topic breakfast on health privatization.* At this event Professor Flood also mentioned her estimate of the delays in knee and hip replacement surgery likely to occur in the event of a diversion of resources from the public to private sectors. See this paper's discussion of wait times.

27 *Communiqué de presse,* Rapport Castonguay, le 19 février 2008. Available at www.fiqsante.qc.ca

28 Physicians for a National Health Program (U.S.), 2003 PowerPoint presentation; OECD statistics

29 Ibid. The PNHP draws on data from the Employee Benefit Research Institute and the U.S. Department of Commerce.

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31 Fuller and Gibson, *The Bottom Line,* pp. 29-30

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33 Ibid., pp. 28-29

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38 *Risky Business II,* p. 8, Information about treatment cost was gleaned from www.mindcarecentres.com.

39 The Ontario government has asserted its commitment to a public system, but critics of Ontario's Commitment to the Future of Medicare Act (Bill 8), like economist Armine Yalnizyan, have taken the provincial government to task for making "motherhood" statements against two-tier care but not passing a law with teeth to combat creeping privatization. Yalnizyan has argued that public care can only be sustained through, among other measures, initiatives that closely monitor and evaluate the results of public dollars spent in investor-owned facilities. Are such payments "merited by greater cost savings or quality improvements?" she asks. See her "Presentation to the Standing Committee on Justice and Social Policy on Bill 8," February 2004, available through the Canadian Centre for Policy Alternatives at www.policyalternatives.ca.

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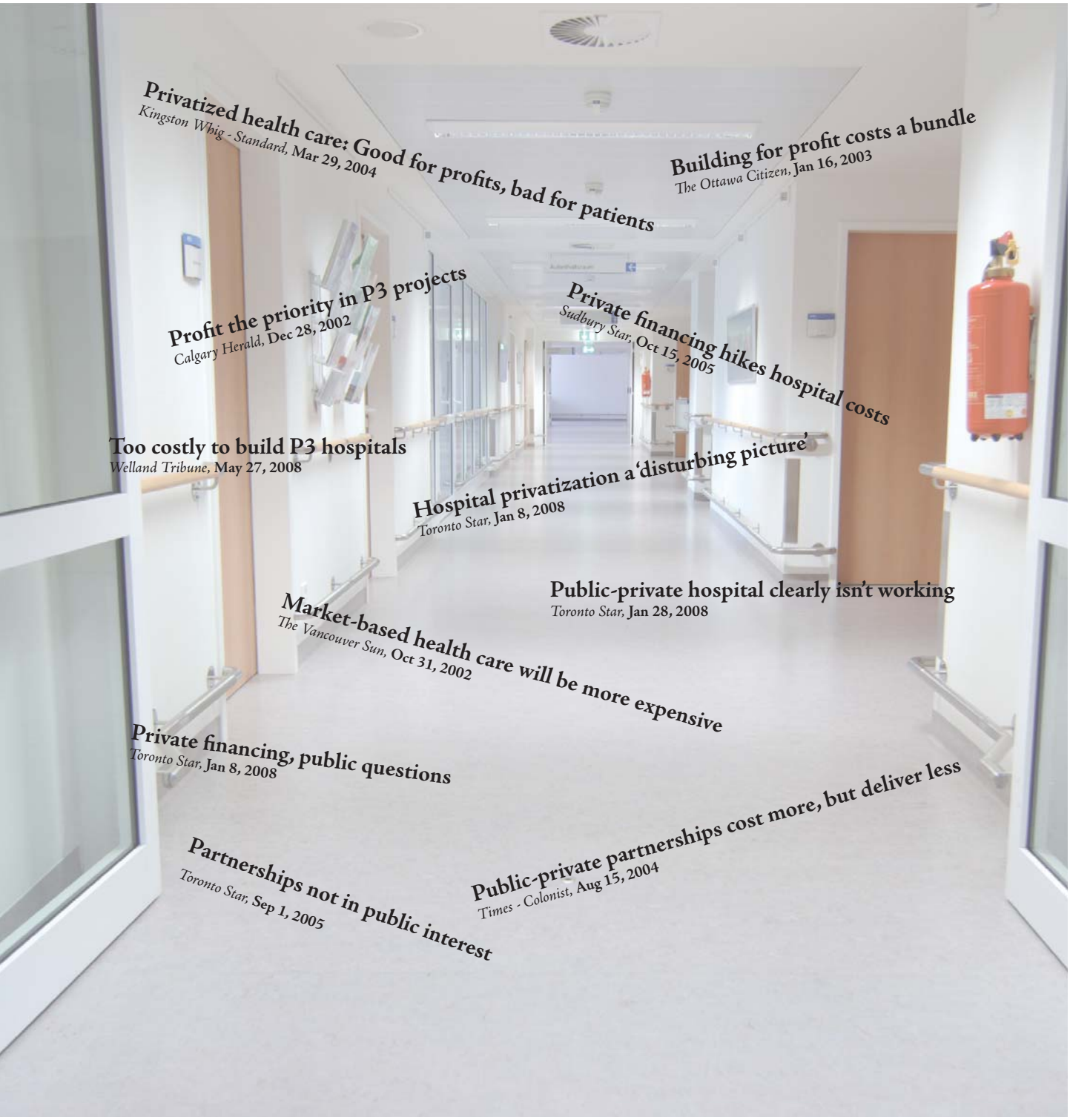
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