

Prescription for Excellence

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PRESCRIPTION
FOR EXCELLENCE

How Innovation is Saving Canada's Health Care System
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PREFACE &
CHAPTER 12

Prescription for Excellence
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This book is dedicated to my parents, Harry and Ruth Rachlis, my partner, Debby, and our children, Linus and Leila. Thanks to Debby for taking on an even more disproportionate share of household management during the past eighteen months. Thanks to Linus and Leila for understanding that their dad has an unusual job.

Preface

It was late on November 28, 2002, as I settled into the back seat of a taxi at Pearson Airport. After I gave my address, the driver asked me what I had been doing that day. I replied that I had been in Ottawa for the release of the final report of Roy Romanow's Royal Commission on the Future of Health Care. The driver immediately responded, "Romanow, Romanow. He says we have to spend more money! We don't have to spend more money."

I reassured him that Romanow had made a lot of recommendations other than spending money, but he was adamant. "We don't have to spend more money, just stop wasting money!" I didn't have to encourage him to tell me more.

"I took my wife to the doctor four days ago. She had a cold. The doctor ordered an X-ray and prescribed her antibiotics. The medicine cost us over fifty dollars. Then he asked her to come back today. She's feeling fine, so I phone the office to find out about the X-ray, but the secretary says she has to come in to get the result. So I have to get off work and drive her. It costs us more money. Then he tells her the X-ray is fine and she should finish the medication. I don't think she needed the X-ray. I don't think she needed medicine. And I don't think she needed to come back to see him."

I tried to suggest that there might have been good reasons for the doctor's course of action, but by this time he was in full flight. "You have to go one place to get your blood taken and somewhere else to see a specialist. The doctors should have their offices together in the hospital so all of your visits and tests could be in one place. And we don't need so many prescriptions."

This driver's views aren't dissimilar from those of others that I have heard in my travels across the country. Taxi drivers often ask what I do and why I'm in town. When I explain that I am a public health physician who subspecializes in health system problems, the floodgates are opened.

First, they mention their adoration of medicare. Canada's taxi drivers are disproportionately not Canadian-born and several have claimed to me that medicare was part of their decision to emigrate to Canada instead of the United States. Medicare symbolizes to them that Canada is a more caring country than the United States. Canadians, new and old, tend to be passionate about medicare.

Then the drivers often express their debt to people who work in the health care system—a wise doctor, a skilled nurse, a compassionate paramedic. A person, a team, a place that made a difference.

The finale is a litany of complaints about the health care system. There are the complaints you read on the front page of the paper—access, funding, coverage. Then there are the ones you don't usually read. Concerns about mismanagement, lots of stories about waste, and, too often, tales of miscommunication. I hear a lot of common-sense recommendations for reform, as well as some not so sensible recommendations.

Canadians want to keep medicare and they want to fix the health care system. But what does that better-quality and more efficient system look like? How do we get there? This book attempts to answer these - questions.

There are solutions to medicare's problems. They have been developed somewhere across this great country by some of the hundreds of thousands of Canadians who work in health care. This book was inspired by the innovators I have been fortunate to meet as I have travelled across Canada. It tells their stories. These are the people who are truly saving medicare.

Canadians are opposed to market medicine, but, like my taxi driver, they don't believe that the cure is a lot of new money. When Romanow's commission wound down, so did much of the informed public debate. One day we hear high-powered misinformation generated by Canadian free-marketers, sometimes paid for by their American friends. The next day, it's media-savvy pressure tactics from health care's powerful interest groups. We seldom hear from average Canadian patients or providers. This book is an attempt to refocus the dialogue on them. Let's design the system around quality care for patients and high-quality work environments for providers. This approach is also our best strategy to control costs and ensure medicare's sustainability.

A quick point about style. When a name is used with an initial for the last name, it means that a patient has requested anonymity or that the profile is really a composite case. When full names are used, it is with the patient's permission or when the case was already a matter of public discussion.

The book uses stories to lead the reader through the analysis. However, I have provided references for important statements of fact. The book's general approach is, in tribute to Neil Postman, evidence-based storytelling.

I would like to sincerely thank everyone who has taken time to contribute to my broader education in the last ten years. I would especially like to thank the many Canadian communities that have invited me to talk about health care. I have felt the passion that burns for medicare throughout our country. Thanks as well to the staff in government departments and health organizations who so willingly helped me with my research.

After all this research, I was left with a major problem. The book includes a lot of material—50 per cent more than HarperCollins originally expected. But even at this length, I couldn't include every worthy program and innovator. I apologize to those who gave me their time but don't see their stories in print. I also apologize that there may be more examples from some places than others. I have seen a lot of Canada, but I certainly haven't been everywhere. I also haven't seen everything of possible interest in the places I have visited.

I would like to thank Rick Hudson, Joel Lexchin, Steven Lewis, and Debby Copes, who read portions of the text and made helpful suggestions. Thanks to my editor at HarperCollins, Chris Bucci. Thanks also to Iris Tupholme, Kevin Hanson, Neil Erickson, Noelle Zitzer, Shona Cook, and Rob Firing at HarperCollins, freelance editors Stephanie Fysh and Ian MacKenzie, and indexer Gillian Watts. I owe a special debt to my agent, Dean Cooke. I hope that this product continues to justify the trust that all of you have placed in me.

It is a particular delight for me, and I hope for readers as well, that my son, Linus Rachlis, took the author photo and made a significant contribution to the cover design.

Finally, I would like to thank the readers of **Second Opinion** and **Strong Medicine**, which I co-authored with my friend Carol Kushner.

You have been an endless source of support and strength during the past year and a half. I sincerely hope that this volume vindicates your loyalty and provides you with the tools you need to modernize medicare for the twenty-first century.

Beware of Snake Oil: The Private Sector Has No Panaceas

The previous nine chapters have shown that we already have the solutions to most of the apparently intractable problems facing our health care system. However, we don't usually hear about them. The most commonly offered remedies are a lot more money and privatization. The last three chapters outline how we can develop a Canadian agenda for quality. The first step is to avoid the siren calls for market solutions.

Our twenty-year blind love affair with the private sector seems to be on the wane; but a number of Canadians still believe that you only have to replace the word "public" or "non-profit" with "for-profit" and you have automatically made something 15 per cent more efficient. Adam Smith knew this was a myth over two hundred years ago, but that doesn't stop some modern-day economist wannabes from claiming that if we lift the regulatory shackles, the market's invisible hand will erase all human woes.

Markets are the most efficient mechanism to provide most goods and services, but all markets require a court system to enforce contracts. And most businesses require some form of public-policy framework. Governments regulate capital acquisition through stock markets because otherwise charlatans will beat out honest financiers. Honourable manufacturers can't compete with those that are willing to pollute the environment or reduce labour standards. Business needs government environmental and labour regulations to maintain a level playing field.

Furthermore, markets just don't deal effectively with some goods and services. For example, we publicly fund and administer fire services. We don't rely upon people to purchase firefighting insurance. What if everyone but one on the block had such insurance and his house caught on fire? Would we wait until the fire moved to someone else's house before we called the firefighters? And would different fire services compete with each other? It sounds like a nightmare.*

This chapter examines the public-private mix for health care. It doesn't look as though the private sector is any panacea for medicare's problems.

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

In the US, where most people rely upon private health insurance, each of the roughly one thousand companies selling policies has its own actuaries, sales and marketing people, computer systems, and so on. The administrative costs also add up in hospitals and even in doctors' offices. The average US doctor needs a full-time person just to do billing and reconciliations. An average Canadian doctor's secretary, on the other hand, spends just a couple of hours a month on these tasks. Huge resources are devoted in the US to screening out sick people to prevent them from acquiring insurance, denying claims, and fighting appeals. As a result, the US system has three and a half times Canada's per capita cost for administration despite tens of millions of people being without insurance.¹

User fees are often suggested as a solution to Canadian medicare's woes, although it is unclear what problem they might solve. Some claim that user fees would save money by reducing frivolous use of the system. Others claim that they would bring in much-needed revenue. Clearly, they cannot accomplish both missions! In fact, user fees tend to discourage the poor and the elderly from entering the system. But there are no overall savings. Nature abhors a vacuum, and the health care system detests unused capacity. As a result, any beds or doctors freed up because the sick poor can't get desperately needed care end up being used by the well-to-do for more trivial matters.²

We even have a natural experiment from Saskatchewan to back this up. When medicare started under the CCF government in 1962, there were no user charges to see a doctor. However, Ross Thatcher's Liberals came to power in 1964 and implemented user fees for doctors and hospital care in 1968. The NDP eliminated the charges after it won the election of 1971. Afterward, researchers were able to look at changes in use over time by different groups. They found that there had been a small drop in use of doctors' services, but there was no change in overall health care costs because there was no change in hospital use, which was responsible for the vast majority of expenditures. Further analysis revealed that the poor and the elderly reduced their visits to doctors but that there was an increase in the use of doctors by middle- and upper-income groups.³

Some claim that user fees are benign because they discourage only frivolous use. However, a US study involving quite healthy adults showed that user fees led to a 20 per cent increase in risk of death for people with high blood pressure because they were less likely to see a doctor and get their blood pressure under control.⁴ The same study showed that user fees were just as likely to discourage appropriate care as inappropriate care.⁵

Some Canadians, such as Fraser Institute executive director Michael Walker, claim that user fees in Sweden "manage demand without cutting people off."⁶ However, if you cut a Swede, he bleeds. Research shows that if you charge a relatively less well off Swede for health care, he will be less likely to get it.⁷ As Saskatchewan premier Lorne Calvert notes, "The problem with user fees is that if you set the costs too high, you deter people from obtaining necessary health services, but if you keep the fees low and waive the cost for people with low incomes, the administrative costs soon outweigh any financial benefit."⁸

The scientific evidence supporting publicly financed care is long and strong. So why do brain-dead ideas like user fees keep coming back? University of British Columbia professor Bob Evans is one of the world's most respected health economists. He and his colleagues have repeatedly examined this issue and refer to user fees and like ideas as "zombies."⁹ The scientific evidence repeatedly kills them, but, just like zombies, they keep bouncing back to life to wreak havoc. Evans notes that private finance strategies (from user fees through private insurance to medical savings accounts) all tend to benefit the wealthy, the healthy, and those who want to sell services. At the same time, private finance tends to disadvantage the poor and the sick. With the political support of the rich and of aspiring business people, it is not surprising that these zombies are so resilient. They will always be brought back because of whom they serve.

For-Profit Delivery: An Illusion of Innovation

Depending on the exact wording of the survey, approximately two-thirds of Canadians are opposed to so-called two-tier medicine, in which the wealthy pay privately to jump queues in the public system for doctors and hospital care.¹⁰ The current hot public issues concern the extent of public coverage (especially home care and pharmacare) and whether public authorities should contract out their publicly funded clinical services to for-profit corporations.

The terminology can get tricky here because private organizations already deliver most health care in Canada. In Ontario and Quebec, almost all hospitals are private but non-profit. In other parts of the country, hospitals are owned mainly by regional health authorities, which are quasi-governmental bodies, but there are many independent, private non-profit hospitals as well.* Most doctors are in private practice, although more are becoming employees all the time. According to economists, doctors' offices are not the same as other small businesses because they are governed by professional norms as well as by the bottom line. Bob Evans refers to doctors' practices as "not-only-for-profit" enterprises to distinguish them from for-profits and non-profits.¹¹

During the 1980s and 1990s, hospitals contracted out non-clinical services (such as laundry and food) as well as laboratory services. There was very little evaluation of these policies. Former Prince Albert Parkland Health Authority CEO Stan Rice published one of the few assessments of private lab care.¹² Prince Albert saved more than 40 per cent when the health authority took over the private lab services.

It is only in the past five years that there has been a major thrust to contract out surgical and other clinical services. Some claim that as long as the public pays, it doesn't matter who delivers the service, but others claim that profit is incompatible with care.

In May 2002, a group led by Dr. P.J. Devereaux, a McMaster University cardiologist, published a review of all the individual studies that had compared the mortality rates of for-profit and non-profit hospitals.¹³ The group found fifteen studies that met their rigorous requirements. Adults had 2 per cent higher death rates in for-profit hospitals, while the infant mortality rate was 10 per cent higher. The investigators estimated that if all Canadian hospitals were converted to for-profit status, there would be an additional 2,200 deaths per year. This is higher than the number who die every year from suicide, colon cancer, or car accidents. The likely cause of the higher death rates was that the for-profits tended to have fewer staff and less well trained staff. These factors have been found to be associated with higher death rates in other studies of the quality of hospital care.¹⁴

Devereaux's group published a second paper, in the **Journal of the American Medical Association**, in November 2002, comparing for-profit and non-profit dialysis care.¹⁵ In the US, roughly three-quarters of dialysis is conducted in for-profit facilities and one-quarter in non-profits. However, all care for end-stage kidney disease in the US is paid for publicly by the federal government's Medicare program. So the researchers were investigating exactly the situation that Canadian proponents of for-profit care recommend for Canada: public payment but delivery by whoever submits the best bid.

The investigators found that patients attending for-profit dialysis clinics had 8 per cent higher death rates than those who got their care at non-profits. For-profit clinics had fewer staff and less well trained staff. They also dialyzed patients for less time and used lower doses of key medications. These results suggest that in the US there are 2,500 premature deaths every year for people on dialysis because their care is being provided in for-profit clinics.

A review of the performance of for-profit and non-profit nursing homes found that for-profit homes tended to have poorer quality than non-profits.¹⁶ For-profits averaged fewer and less well trained staff and had higher staff turnover. The for-profits also had more violations of US federal regulations for care, higher rates of skin ulcers, pneumonias, falls, and fractures, and greater use of restraints. They also spent less on food. The review included one Canadian study, from Manitoba, which came to similar conclusions.¹⁷ Residents in for-profit facilities in Manitoba had higher rates of hospitalization for four conditions (dehydration, pneumonia, falls, and fractures) that are sensitive to poor quality of care in nursing homes.

There is little comparative peer-reviewed literature comparing for-profit with non-profit home care, but the few studies available also found poorer quality in for-profits.¹⁸

Other US studies have also produced damning evidence on for-profit care. For-profit US health maintenance organizations (HMOs) rated lower than not-for-profit HMOs on all fourteen quality indicators measured by the National Committee for Quality Assurance.¹⁹ The Harvard researchers who conducted this study estimated that there would be six thousand more breast cancer deaths annually in the United States if all HMOs were for-profit.

It also appears that for-profit care tends to be more expensive than non-profit care. American public hospitals are 25 per cent less expensive than private for-profit facilities. Private non-profit hospitals are 12 per cent less expensive than for-profits.²⁰ Fifty-three per cent of the difference in cost between public and for-profit hospital care is due to higher administrative charges in commercial facilities.

A study of US Medicare* costs found that health spending was higher and increasing faster in communities where all beds were for-profit than in communities where all beds were non-profit.²¹ Spending grew fastest in those communities that converted all their beds to for-profit care during the study period. Spending fell the most in those communities that converted all their beds to non-profit care.

Recent rhetoric claims that private markets for the finance and delivery of health care should lead to more efficient health care.²² However, with over 75 per cent of health care costs being personnel, the literature indicates that for-profit providers tend to skimp on staffing, leading to poorer outcomes. At the same time, their costs tend to be higher because of extra administrative expenditures, which include 10 to 20 per cent profit margins.

From Justice Emmett Hall's 1964 Royal Commission on Health Services to the 2002 Romanow Royal Commission, Canadian inquiries have consistently concluded that health care is not a normal market good. Asymmetry of information between providers and patients prevents consumers of health care from being fully informed, a key factor for the establishment of any market. The consequent public-policy reactions of legislation and regulation (for doctors, hospitals, drugs, and so on), which are necessary to protect consumers, present further barriers to the establishment of traditional markets. And, as the US system bears witness, fraud is still a major concern despite expensive regulatory controls.²³ That is why all developed countries except the US have opted for mainly public and overwhelmingly non-profit systems.

For-Profit Services Create Problems with International Trade Treaties

Canada has asked that health care be reserved as a public service under the North American Free Trade Agreement. However, the US does not accept that Canadian health care is a public service. Experts differ in their level of concern about this issue. However, they all agree that the more commercial health care activity Canada allows, the more difficult it will be to maintain that health care is, in fact, a public service.²⁴ Roy Romanow concluded that no one really knows with certainty how significant trade issues are for medicare. He advised the federal government to be more mindful of the risks of permitting more commercial involvement in health care delivery.

Economists distinguish between small firms owned by professionals, who are ruled by professional norms as well as by the bottom line, and large publicly traded corporations, which have a fiduciary responsibility to maximize profits for shareholders. Unfortunately, NAFTA and other trade agreements do not.

PFI to P3s: Perfidious Financial Idiocy to Public-Private Pickle

Advocates for more private-sector involvement in health care suggest that governments contract with commercial firms to build and manage hospitals and other health facilities. In 1992, the British Conservative government introduced the Private Finance Initiative, or PFI, to facilitate the building of public works. The concept has since spread like malaria and is widely being touted in Canada under the name of “public-private partnerships,” or P3s. The Ontario government used a P3 to build Highway 407 north of Toronto and planned to use P3s to build hospitals in Ottawa and Brampton.* British Columbia and Alberta are also actively investigating using P3s to build new health facilities.

The concept behind P3s, as stated by their proponents, is that the private sector provides the capital and takes on the risks while the public sector reaps the benefits. The schemes’ proponents purr reassuringly about the symbiotic relationship between the private and public sectors that will generate extra value for taxpayers and shareholders alike.

However, these reassurances sound eerily like late ’90s Wall Street’s attempts to calm investors with words like “synergy” and “convergence” while stocks climbed to perilous heights. In the cold reality of morning, we know that high-tech stocks are subject to the law of gravity. We also know that many of the leaders of high-flying companies never believed their own pap. We were being taken for a ride.

It appears that P3s cannot defy gravity either. The risks are not transferred to the private sector. The public is still on the hook. The Ontario provincial auditor concluded, regarding Highway 407, “We observed that, although cited as a public-private partnership, the government’s financial, ownership and operational risks are so significant compared to the contracted risks assumed by the private sector that, in our opinion, a public-private partnership was not established.”²⁵

In Australia, government has had to bail out two P3 hospitals.²⁶ The Victoria state government had to buy the La Trobe Hospital from a private firm because it was losing so much money, it could “no longer guarantee the hospital’s standard of care.” Private companies might go bankrupt or one of their officers might abscond with their assets, but patients will still need care. There is no way of transferring that risk to the private sector.

Another problem with P3s is that the private sector pays higher costs for capital than the public sector. Allyson Pollock and her colleagues at University College in London have dissected the experience of the PFI in Britain and conclude that the PFI capital costs are twice what they would have been if the hospitals had been publicly constructed.²⁷ To quote Richard Smith, the editor of the **British Medical Journal**, “The schemes produce more problems than solutions, partly for the simple reason that private capital is always more expensive than public capital.”²⁸ As a senior doctor in one of the Ontario hospitals due for a P3 partnership puts it, “Of course it will cost more, but it was the only way the government would let us build our new hospital.”

When the Nova Scotia government announced its decision to end its P3 program used to build schools, Finance Minister Neil LeBlanc noted that the previous government had used the P3 concept to push the expenses off the province's books, not because it was a good idea.²⁹ Far from transferring risk, the P3 schools program in Nova Scotia cost taxpayers an additional \$32 million, which, LeBlanc noted, could have built three additional schools. It looks as though P3s are yet another private-sector chimera. They are certainly no saviour.

What Should Be the Role of the Private Sector in Health Care?

Clearly there is some role for the private sector in health care. Even the most ardent supporters of medicare don't advocate a government monolith that extends from insurance through hospital ownership to drug manufacturing. Let's consider the issue methodically for a few moments.

If a Service Is Needed, Then It Should Be Publicly Financed

At present, roughly 70 per cent of the system is publicly funded. The public purse picks up 90 per cent or more of hospital and medical services. The coverage for other services varies widely across the country. In general, coverage improves as one moves west within Canada for home care, long-term care, and pharmacare. Someone in Nova Scotia could pay tens of thousands of dollars a year for drugs and nursing home care while a person in Manitoba wouldn't have to spend more than her old age pension to get the same services.³⁰ In fact, in many provinces sick people have to pay down their savings and go on welfare before getting publicly funded care. Sounds eerily like the United States, doesn't it?

This doesn't make any sense. The whole idea of medicare was to prevent people from having to resort to charity care. For that matter, why is there no coverage for dental care and vision care? These are also essential health care services, and Hall recommended children's dental and vision programs forty years ago.* The same economics that concludes that a Canadian-style single-payer system is more efficient and more equitable for hospital and physicians' care also applies to these other services. In all cases, there are major administrative savings (in the order of 20 per cent or higher) when one moves from a multi-payer to a single-payer system. Canadian public drug plans cost less to administer than do private plans, just like Canadian public hospital insurance costs a lot less than American private hospital insurance.³¹

Emmett Hall also recommended coverage for home care and pharmacare forty years ago. At that time, many European countries covered most bills for home care, pharmacare, long-term care, and other goods and services, including hearing aids, eyeglasses, and dental care. Now even more do. But the Liberal government of the 1960s was split, and so we ended up with only doctors' services being covered. We have been waiting forty years for the federal government to implement Justice Hall's eminently reasonable recommendations. Oh, by the way, in case anyone is keeping count—the Liberals have been in power for thirty of the past forty years.

The Closer You Are to Patient Care, the More You Need Non-Profit Services

Economists note that it is hard to contract privately for health care services if they are characterized by low contestability, high complexity, low measurability, or susceptibility to cream skimming.³²

Low contestability means that conditions make it difficult for firms to enter the market. For example, not that many companies could afford to buy a hospital, attract doctors, and meet all the regulatory requirements. As a result, there is little competition for hospital care. This can lead to "lowballing," whereby after a government or health authority gives up its own hospitals, it is at the mercy of the provider when the initial contract expires.

o **High complexity** means that the service has multiple (and perhaps conflicting) goals, which are best attained when the service is embedded within an overall system of care. For example, long-term institutional care is a very complex service with multiple goals. Even a blood test requires professional interpretation, including the implications for future care, but it is far less complex than most kinds of health care services.

o **Low measurability** means that it is difficult to quantify the quality of service. For example, how would one measure the quality of palliative care, that is, the quality of a death? And if you can't measure quality, how do you know what you're buying?

o **Cream skimming** means that a provider can choose the easiest patients but be paid at the same average rate. If a for-profit hospital does all its knee replacements on middle-aged athletes but is paid at the same rate as would apply to a complicated patient (such as a seventy-eight-year-old with heart disease and a bleeding disorder), then it is being overpaid for its services.

There are some health care goods and services for which markets do work. There is no need for crown corporations to build hospital beds. Many companies can manufacture beds. It's not difficult to get into this market. It's not hard to determine whether a hospital bed has met specifications. Cream skimming doesn't apply. Some claim that the for-profit sector is more innovative than the public and non-profit sectors. Camille Orridge, executive director of Toronto's home care agency (Community Care Access Centre), says that for-profits are more flexible. She claims that in particular, smaller, owner-operated agencies are more likely to adjust care to the patient's needs. For example, she maintains that originally she couldn't get non-profit nursing agencies to see AIDS patients, so she went to a for-profit firm.

There is no doubt that some for-profit providers are very innovative. But, overall, the non-profit sector adds more value. Non-profits are much more likely than for-profits to:

- expend resources on linking different organizations together to plan community networks,³³
- engage their communities and enlist volunteers,³⁴ and
- provide continuing education and training to their staff.³⁵

Private markets are still the best way to ensure the efficient manufacture of medical equipment and pharmaceuticals. But the for-profit sector appears to offer little but headaches for patient care. The private sector is no panacea for the problems medicare faces. Up close it looks a lot more like snake oil.

On the other hand, non-profit delivery is only one part of the solution. Recent reports from the Canadian Institute for Health Information indicate that patients in the Canadian hospitals with the best outcomes have 50 per cent lower death rates from stroke or heart attack than patients in hospitals with the worst records.³⁶ This difference is much larger than differences reported in studies of for-profit vs. non-profit care. Retaining non-profit care is a very important step in preserving quality and access and reducing costs, but we have to do a lot more to ensure Canadians the high-quality health care they deserve.

Conclusions

Overall, this review of the evidence on public vs. private health care concludes the following:

- o Public finance increases equity of care and efficiency of financing.
- o Non-profit care is, in general, less costly and of better quality.
- o Public-private partnerships (P3s) cost more money. The private partner borrows the money to front the project but has to pay higher interest rates than if government put up the cash. The public sector still retains most of the risk.
- o Permitting for-profit providers to enter a new sector or allowing the growth of for-profit providers in sectors in which they already operate means that it will be more difficult for Canada to maintain that health care is a public service in negotiations with our international trade partners. It is understandable that some Canadians believe that private profit can save medicare—private markets are generally the best way to distribute goods and services. But they're not the best way for everything. In the next two chapters we'll look at the real solutions to medicare's woes—re-engineering for quality.

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