

Examining the Public/Private Divide in Healthcare: Demystifying the Debate

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Abstract

In this paper, we review recent developments in the debate over the role of the private sector in healthcare in Canada, with a particular focus on the two major federal reports that were released in the autumn of 2002, the final report of the Senate Committee on Social Affairs (the Kirby report) and the Romanow Commission report.

It is possible to see these reports as representing two polarized positions in the public versus private debate. Kirby has often been portrayed as an advocate of privatization whereas Romanow has been given the role of champion of the public system. However, both conceptualizations are simplistic and inaccurate. We argue that rather than cast these two reports as proxies in an ideological dispute, it is more helpful to try to glean from them workable and flexible solutions to this immensely complex and divisive debate. More specifically, using the similarities and the differences manifest in these reports as a key reference point, we clarify the extent to which the terms used in the public policy debate have accurately represented the reality of the funding and delivery mechanisms that actually characterize the Canadian healthcare system. This allows us to draw some provisional conclusions on the degree of consensus that prevails in the healthcare debate, and on the sources of pressure for change.

Given the universal emphasis currently placed on the need to base policy conclusions on "evidence," we also look at some recent academic contributions to the debate, notably Jim Grieshaber-Otto and Scott Sinclair's *Bad Medicine: Trade treaties, privatization and health care reform in Canada* (2004) in order to better understand what the best available evidence indicates about the merit of the various forms of healthcare delivery. We maintain the current literature tends to fall into a tautological prism that undermines the ability of leaders in the healthcare system to forge a consensus to address current challenges.

Introduction

This paper examines the current debate over the role of the private sector in the delivery of healthcare services in Canada, with a particular focus on the two major federal reports that were released in the autumn of 2002 and a recent report from the Canadian Centre for Policy Alternatives: the final report of the Senate Committee on Social Affairs, Science and Technology (the Kirby report), the Romanow Commission report on the future of healthcare in Canada – *Building on Values: The*

Future of Healthcare in Canada and Grieshaber-Otto and Sinclair's Bad Medicine: Trade treaties, privatization and health care reform in Canada.

There is certainly not yet a consensus in Canada on what should be the appropriate mix between public and private involvement in the healthcare system. The debate surrounding this issue is often heated, and policy activists are often quickly labelled as ardent proponents of one perspective over the other. In fact, there is such commitment to entrenched positions that there seems to be little room for compromise, or even a shared understanding of what the terms of the debate are. As Raisa Deber (2002: vii) aptly points out: "The current debate has been characterized by more heat than light, with advocates talking past one another and using similar terms to mean very different things."

Given this, it is not surprising to note that the Romanow and Kirby reports have been cast as representing two polarized positions in the public versus private debate. Kirby has often been portrayed as an advocate of privatization, whereas Romanow has been given the role of champion of the public system. However, to a great degree this is a simplistic and inaccurate conceptualization. We argue that rather than cast these two reports as proxies in an ideological dispute, it is more helpful to try to glean from them workable and flexible solutions to this immensely complex issue. More specifically, using the similarities and the differences manifest in these reports as a key reference point, we clarify the extent to which the terms used in the public policy debate have accurately represented the reality of the funding and delivery mechanisms that characterize the healthcare system. Ultimately, we propose that it is more useful to develop policy initiatives that improve services for Canadians, rather than remain mired in a divisive debate over abstract principles that do not do justice to the realities of the Canadian healthcare system.

Romanow and Kirby: Public/Private Funding of Healthcare

A first question one might ask is whether all the time, effort and money expended on these two major studies of Canada's healthcare system has actually helped to resolve any of the contentious issues that touch on the public/private split. And, if not, have we nonetheless been given a clearer idea of what the issues are and what we might need to do in order to make further progress in resolving them? The first point, of course, concerns the need to differentiate between the funding of health services and their delivery. The bulk of our discussion will deal with the delivery of healthcare services, but it is worth highlighting a few salient features of the Canadian funding model.

In the wake of the two reports, it is clear that the uniqueness of the Canadian model does not reside in the relative importance of public funding compared to private funding. With around 70% of healthcare services publicly funded, Canada ranks in the bottom third of OECD countries with regard to the proportion of healthcare that is funded through public coffers. It is thus not the extent of public funding, but rather the manner in which the split between public and private funding is organized that makes the Canadian system distinctive. Canada is alone in designating two sectors (medically necessary services provided by doctors or in hospital) as subject to essentially 100% public funding, while leaving funding arrangements in all other sectors (prescription drugs, long-term care, dental care, etc.) up to individual provincial jurisdictions. Only in Canada is there a legal barrier to people spending private money, either out of their own pockets or through the purchase of private insurance, on medically necessary hospital and doctor services.

Both reports acknowledge that while this arrangement may have made sense when medicare was introduced, and the vast majority of services were in fact delivered through the channels of physicians and hospitals, there has been a marked transformation over the years. The growing importance of prescription drug treatments, along with other technological advances that enable many surgical procedures to be undertaken with much shorter hospital stays, has led to what has sometimes been called “passive privatization.” Payment for services gets shifted to individuals or private insurers either because services are increasingly performed outside of the hospital/doctor setting, or because convalescence is possible at home rather than in hospital.

The response of both reports to this evolution was similar. Neither recommended tampering with the basic funding structure that has evolved to pay for medically necessary hospital and doctor services. Both “user fees” (or any form of patient co-payment, whether at the point of service delivery or through some form of tax surcharge) and a parallel private insurance system for medically necessary hospital-based doctor services were ruled out. Patient co-payments were deemed to be a form of tax on the sick and to fall particularly heavily on the less well off as well. Parallel private insurance was seen to introduce unnecessary inefficiencies into the system, and potentially to compromise the clinical autonomy of physicians.

Instead, an expansion of federally mandated public insurance to begin to deal with the changing patterns of care was recommended by both reports. The areas in which this expansion was proposed were almost identical in both reports (aspects of home care, protection against the risk of incurring catastrophic prescription drug costs, palliative care), although the modalities varied. We will consider some of the implications of these recommendations below.

In sum, though, both reports reaffirmed the value of Canada’s single-payer system for hospital and doctor services on the grounds that it is more equitable and more efficient than the alternatives. This widespread agreement also crosses party political lines, and there are, at present, very few challenges to it being voiced anywhere in the country. It is worth stressing the implications of this broad consensus.

Simply put, retention of a single payer for hospital and doctor services acts as an effective barrier to the introduction of American-style healthcare in Canada. This holds for the funding of medically necessary services by definition, since the American system relies on a multiplicity of competing sources of funding, most of which are private. But although funding and delivery are separate functions, they are also linked. The exclusion of major alternative sources of private funding also guarantees in practice that private delivery of healthcare services will not take the form it does in the United States.

It is possible to see how this kind of de facto restriction operates in the fact that although there is no legislation that prevents physicians from practising outside of medicare, very few do. Physicians who wish to leave medicare must bill entirely outside the system – that is, they cannot accept both public and private patients. Under these conditions, without the presence of a parallel private insurance system to finance these non-medicare practices, they are simply uneconomic. We will examine how the structure of medicare also discourages the emergence of a full-blown for-profit institutional sector, below.

Thus, with greater reliance on private sources to fund medically necessary hospital and doctor services having been taken off the table, and both reports in agreement not only on the need to expand the scope of publicly funded services, but also (broadly speaking) on the initial areas in which that expansion should occur, the remaining areas of dispute between the two reports with regard to funding issues concern how to secure a stable and predictable source of public funding and what mechanisms should be used to go about expanding publicly insured services.

The issue of where the new money that is needed both to “shore up the core” of existing publicly funded services and to pay for their expansion into areas of home care and prescription drug coverage has resurfaced in recent months as the federal government has begun to make ominous noises about an anticipated rapid decline in its budget surpluses. This could have serious implications, since former Prime Minister Jean Crétien made his promise of an additional transfer of \$2 billion to the provinces and territories contingent on the size of the government’s budget surplus.

At some point, then, it seems likely that the need for stable and predictable funding will again come up against governmental unwillingness to consider seeking new sources of public financing. The Kirby report’s proposal that a new, dedicated, federal health insurance premium be used to raise the additional \$5 billion in federal investment in healthcare that it championed represented the first recommendation in recent memory for implementing what is, in fact, a form of tax increase. Although its immediate fate was not therefore surprising, the realities of a slowing economy may yet induce a reconsideration of relying on the putative permanence of federal budget surpluses to fund the reform and renewal of medicare.

In addition, the approach adopted to private funding also has implications with regard to how the expansion of publicly funded services into such areas as home care and prescription drug coverage may be undertaken. Should one insist as Romanow did that these new expanded services come under the umbrella of the Canada Health Act, 1984 (CHA), in order to ensure compliance with its five principles, this will undoubtedly have a significant influence on the design of any new programs. The Romanow Commission envisaged doing this, while the Senate Committee foresaw other legislative and regulatory means to enact its proposed new programs.

The proposed strategies in the two reports to protect Canadians against catastrophic drug expenses illustrate the consequences of bringing new programs under the CHA. If CHA criteria are invoked in the area of catastrophic drug protection, any new program such as the one proposed by Romanow could not contain any element of patient co-pay, unlike all such public programs elsewhere in the world. The restrictions imposed by the CHA would also likely make it problematic to integrate existing employer-sponsored prescription drug plans into a new federal catastrophic drug program. This would effectively rule out the design proposed by Kirby, which envisaged capping individual household expenditures on prescription drugs in a plan that included the continued involvement of private sector insurance programs and an element of co-pay.

The proposal to expand public coverage of home-care services would encounter a different obstacle should it be incorporated into the CHA. The problem here concerns the fact that the CHA applies only to “medically necessary” services. However, drawing the boundary between medically necessary and other home-care services,

such as housekeeping, shopping or cooking, which may be just as essential to the beneficiaries of the program, could prove to be a very difficult task.

Romanow and Kirby: The Public/Private Split in Healthcare Service Delivery

The situation with regard to the public/private split in the delivery of services has also, to some extent, been clarified. In particular, the critical distinction between funding and delivery as it applies to the Canadian system is now better understood, although some misconceptions continue to be influential. Everyone now recognizes that having a single public funder for medically necessary hospital and doctor services does not imply that all delivery of those services is done within the public sector. Both reports acknowledge that to all intents and purposes the core of medicare can be characterized as the public funding of private delivery. Hospitals in Canada are largely not-for-profit private institutions (unlike, for example, Britain, where they are publicly owned and where the issue of devolution of administrative responsibility to certain hospitals that would become “Foundation Trusts” is quite controversial) while doctors’ practices are essentially small businesses.

The key point to emphasize here is that the combination of publicly funded and privately delivered services is nothing new in Canada. On the contrary, it has been among the defining features of Canadian medicare from its inception.

As with funding, then, the idea that the Canadian system is somehow a pristine public program unsullied by private participation is a myth. Both reports do recognize this, but draw different conclusions. Ultimately, the issue is whether it is appropriate to enlarge in some fashion the scope of private sector delivery of healthcare services within the framework of a publicly funded system, or whether measures should be taken to inhibit the growth of the private sector’s role.

Kirby formulates an “indifference” principle with regard to private ownership in healthcare delivery. Essentially this means letting the competitive market decide who is best placed to deliver specific services. Kirby argues that decisions should not be made in advance on grounds of principle, but rather should be based on the relevant evidence in each particular situation (see, for example, *Recommendations for Reform*, pp. 53–54).

A specific area where the Kirby report proposes changes that could make broader experimentation with private delivery possible is in the hospital services sector. Whereas the Romanow report completely avoided addressing the question of hospital financing and restructuring, Kirby recommended moving from the global funding of hospitals to a system he calls service-based funding. Under this scheme, which is similar to the fee-for-service system that most physicians now work under, hospitals would be paid based on the services they perform.

The hope here is that hospitals will become more efficient by concentrating their resources on the procedures they do well and often, since they will be rewarded financially for performing services at a high volume. Kirby argues that service-based funding promotes a more patient-oriented system by compelling hospitals to see patients more as customers than as a drain on resources. Also, he sees accountability being increased because the relationship between public money spent and the services provided will be easier to quantify. Kirby feels that under service-based funding, since the insurer will only have to be concerned that the service being provided is of high quality and is provided in a timely manner, the question of

whether the service provider is a public or private institution would no longer be an issue.

Critics of this type of change argue that service-based funding could be the first step down the “slippery slope” that will eventually lead to the wholesale takeover of the healthcare delivery system by private interests. Others claim that the model is ill suited for Canada. In particular, some question how it could work in rural areas where there is little competition among providers. In rural and remote areas it can be a struggle to find a critical mass of service providers to meet base requirements. Therefore, introducing a payment system based on the number of procedures performed may not be feasible in these communities. In addition, since the provision of hospital services falls within provincial jurisdiction, it is not clear through what mechanism the federal government could influence provincial policy on this issue. In a sense, then, regardless of the possible merits of service-based funding, its implementation is likely to depend on its appeal to individual provinces. (Kirby discusses the special measures needed in order to implement his service-based funding proposal in rural and remote areas in *Recommendations for Reform*, pp. 48–50.)

In contrast to Kirby, Romanow develops an interconnected set of arguments and concludes that there is already enough evidence on the table to warrant drawing a line in the sand with regard to any further expansion of the role of the private sector in delivering what he calls “direct” healthcare services (as opposed to ancillary services such as housekeeping and laundry) (see *Building on Values*, pp. 6–8). For Romanow, any further expansion of private sector delivery would be injurious to the integrity of publicly funded healthcare in Canada.

Given that this disagreement constitutes the core of the differences between the two reports, it is worth attempting to assess whether Romanow’s arguments are convincing. Romanow, and other opponents of increased private sector delivery, deploy three kinds of arguments against expanding private sector delivery. The first set of these revolve around moral and value judgments with regard to the propriety of treating healthcare services as market-type goods. Romanow’s statement in the introduction to his report captures this perfectly: “Canadians view medicare as a moral enterprise not a business venture.”

The second set of arguments could be called the “thin edge of the wedge” or “slippery slope” arguments. Here, the general idea is that any further concession to the private sector will inevitably lead to the full-scale privatization of the entire structure of medicare. Two scenarios are most commonly conjured up: first, that there is a huge and powerful group of “privateers,” supported by right-leaning governments, who are just waiting for their chance to demolish publicly funded healthcare; and, second, that because of the provisions contained in NAFTA, any further loosening of the constraints on the private sector will result in an onslaught of American-based private healthcare organizations who cannot be prevented from imposing a U.S.-style system on Canada.

The third group of arguments can be grouped under the heading “where’s the beef?” as they echo Mr. Romanow’s repeated challenge to proponents of greater private involvement to demonstrate conclusively the gains that the private sector can generate. He, of course, concluded that not only are there no gains, but there are also losses attached to greater private involvement, so this set of arguments also

encompasses the broader debate over how we should evaluate the costs and benefits of the different delivery options that are available.

The Moral Argument

The moral argument relies on two related components, both of which are embedded in the citation from Mr. Romanow's report that "Canadians view medicare as a moral enterprise not a business venture." The first claim (which itself has two parts) is that it is possible to clearly identify Canadian values with regard to medicare, and that we are also able to draw a clear policy direction from them. The second element concerns the comparison between a "moral enterprise" and a "business venture." Taken together, we get the assertion that Canadian values are such as to reject treating the delivery of healthcare services as a business venture.

Two recent articles that appeared in the spring 2003 issue of the journal *Éthique publique* offer strong grounds for questioning both components of the moral argument. The first of these, by Professor Daniel Weinstock of the University of Montreal, examines both aspects of the "values" part of the moral argument, while the second, by Professor Joseph Heath, also of the University of Montreal, tackles the question of just what it is about healthcare that makes it different from other goods and services.

Weinstock makes two points that are relevant to our discussion. First, he argues that there may be serious limits to our ability to read off Canadians' values on healthcare in an easy fashion. He notes that values are different from preferences and opinions and that our values are very much shaped by the institutions that dominate our social landscape. In other words, values and institutions co-exist in a complicated relationship, and it is not simply a matter of locating pre-existing values and then using these to help define the shape of our institutions. In his words (2003: 78):

Some institutions have such a determining impact on our values, on our conceptions of right and wrong, that we must first decide how to judge these institutions before we can evaluate the values that they help to generate. If, instead, we attempt to use the values expressed by individuals in order to judge the institutions that had a hand in shaping those values, we run the risk of getting caught in a vicious circle that will lead us to draw profoundly conservative conclusions.

But in many ways the most telling criticism addressed by Weinstock to the Romanow Commission is that, in the process of conducting the deliberative dialogues that formed an important part of its extensive public consultation, some of the prevailing confusion over the nature of the public/private split in our current system was perpetuated. This is how Weinstock (p. 81) puts it:

The way the choices were presented to focus group participants was not always entirely transparent ... As a case in point, notice the way that our current system was described as a "public" one and that parallel systems were presumed to lead in the direction of a more "private" system.

This causes him to wonder whether the outcomes of the process were as reflective of underlying values as the Commission claimed, and what impact this lack of transparency might have had on the evaluation by participants of various scenarios for reform. Thus, Weinstock

(p. 82) affirms: "The framing of the possible alternatives to our current system in such a way as to exaggerate the distance between them and the system we currently have no doubt encouraged participants to harden their resistance to change."

Heath's concern is with pinpointing what it is about healthcare that differentiates it from the supply of other goods and services. He begins by arguing that the inclination to seek non-market methods for delivering healthcare cannot be based on a supposedly inherent impropriety of buying and selling healthcare services. He notes that there are two main reasons that can be invoked against treating some goods or services as commodities for sale (2003: 84):

The first draws on the observation that some types of goods are so intimately tied to one's personal integrity that their purchase or sale would be an affront to human dignity ... This is why we do not buy and sell human organs ... However, this reasoning is clearly inapplicable in the case of healthcare services. To the best of my knowledge, no one has ever suggested that it is intrinsically evil to purchase or sell medical services, or that it is somehow incompatible with human dignity.

The second reason that can be invoked is more relevant, according to Heath, and it is that in the case of healthcare it just might be that moral incentives will work better than monetary ones to distribute the needed services to those who require them. He insists, however, that this applies only to the insurance function (i.e., the funding function) associated with healthcare and not to the actual buying and selling of the services themselves. Heath tells us that neither the undoubted importance of healthcare to people nor the existence of economic inequality can be used to justify the public provision of healthcare services.

For Heath, there is no "right" to healthcare that would require its delivery by a public body. Rather, it is because of the nature of the need for healthcare services, their unpredictability and their potential cost, that governments can take over the healthcare insurance funding model and render it more efficient by spreading the risk across the broadest possible group (the population as a whole). Heath (p. 87) writes:

The difference does not lie in the fact that access to healthcare is a "right" while access to food and clothing is not. The real difference is that people can easily anticipate their food and clothing needs, and allow for them in their budgets, whereas medical expenses are extremely unpredictable ... It is the uncertainty involved with the consumption of healthcare that is the main feature of markets in medical goods and services.

These two articles thus offer an important challenge to the moral argument that serves as a starting point for

Mr. Romanow's rejection of a greater role for the private delivery of healthcare services. But the moral argument is to some extent independent of the other kinds of arguments that the Commission mobilizes against private delivery, and it is to the second category of these, the "slippery slope" arguments, that we now turn.

Slippery Slope Arguments

In many ways this category of argument would seem to be the weakest, for two connected reasons. First, as many commentators have remarked, healthcare systems in general are "sticky," or in more social scientific language, "path

dependent." In James Wilsford's words: "The institutions of the healthcare system ... evolve and adapt very slowly, not freely. As such, they lay out and enframe policy paths so that they become difficult to depart from substantially (2000: 976).

This difficulty in effecting major change reinforces the second reason that tends to weaken the appeal of the slippery slope argument, one to which we alluded earlier. Until and unless there is a parallel, private insurance or funding system in place, the basic structure of Canadian medicare will not be fundamentally altered. It is worth noting that this conclusion is also supported by international evidence. After surveying the various forms of competition that were introduced into healthcare systems across the industrialized world in the 1990s, James Morone (2000: 964) concluded that "only one – middle class exit – poses a genuine threat to traditional national health insurance."

Allowing the middle class to "exit" means providing middle-income earners with an alternative insurance system that would enable them to withdraw from the public system. The strengthened consensus in Canada that has emerged in the wake of the two reports on the value of our single-payer, publicly funded insurance system thus constitutes a formidable barrier to the erosion of medicare. As long as the single-payer system is intact, it is very difficult to see how permitting a somewhat wider range of private delivery of healthcare services could be the catalyst to a slide down the slippery slope toward American-style healthcare.

A variant on this theme involves concern over the impact of international trade agreements, in particular NAFTA, on our ability to sustain a publicly funded insurance system. However, as the Romanow Commission itself points out in its Chapter 11, "there is strong consensus that the existing single payer monopoly of Canada's healthcare system is not subject to a challenge under NAFTA" (*Building on Values*, p. 237). So, to the extent that the single-payer insurance system is the guarantor of the integrity of the Canadian model, even possible challenges under NAFTA are unlikely to undermine the fundamentals of the system.

"Where's the Beef?"

This third category of argument is different from the previous two in that what is involved is an empirical, evidence-based assessment of the costs and benefits associated with a greater role for the private sector in healthcare delivery. It is significant that people on both sides of the debate over private delivery of healthcare services endorse the underlying rationale behind this type of argument. That is, everyone is in favour of basing public policy decisions on the best available evidence. What seems to be at stake in this regard, rather, is the scope of the conclusions that one is inclined to draw from the available evidence. In particular, those who oppose greater private delivery, like Romanow, believe that there is sufficient evidence to warrant foreclosing on some options, while those, like Kirby, who express a greater indifference toward ownership structure, tend to argue on a case by case basis.

It is worth noting that anyone who would seek clear-cut guidance from international experience faces considerable obstacles. In her review of reform experience in seven OECD countries (including Canada) with regard to the roles of the public and private sectors, Claudia Scott (2001: 157) concludes: "Reform experience demonstrates that while some configurations of private roles and interfaces are clearly superior to others in terms of supporting particular policy goals, no ideal set of public-private roles and interfaces emerges as international best practice for all countries." Some of

her other conclusions are also highly pertinent. For example, she reaffirms that the “evidence confirms that governments should maintain a role in funding in order to address market failures in areas of health insurance and healthcare” and that “countries with a substantial funding role have been more successful at cost containment than those which place extensive reliance on private insurance markets” (Scott 2001: 158).

Scott also provides some possible guidelines for distinguishing those kinds of services that may benefit from a competitive delivery environment (pp. 156–57):

Public policy choices in the area of provision can be usefully divided into low-cost frequently-used services and high-cost infrequently-used services. Low-cost frequently-used services are likely to generate efficiency gains if provided competitively ...

Efficiency gains arising from contracting out and greater competition and contestability among services and service providers are easiest to achieve when it is possible to define the nature of the service, quality characteristics and the relationship between outputs and outcomes.

Of course, this distinction between low-cost frequently used services and high-cost, infrequently used services can at best serve as a general guideline for differentiating between those services that may warrant private for-profit delivery from those that do not. In addition, recognizing the benefit that might be generated by creating a contested environment in which multiple service providers compete to deliver a particular service within a publicly funded system clearly does not mean that all the providers must be for-profit. If it is the competition as such that renders providers more effective and efficient, there may be ways of inducing not-for-profit and public providers to actively compete alongside their for-profit counterparts.

Much has been made recently of the conclusions reached by P.J. Devereaux and his colleagues in their meta-analyses of studies comparing outcomes in U.S. for-profit (FP) and not-for-profit (NFP) hospitals and kidney dialysis clinics (Devereaux et al. 2002a, 2002b). In both cases they concluded that FP ownership of either hospitals or clinics led to poorer outcomes reflected in higher mortality rates. These articles were both published in peer-reviewed journals and would appear to constitute the strongest evidence to date that FP healthcare delivery is bad for patients’ health.

We are not in a position to contest the scientific validity of these studies, nor are we inclined to do so. The question nonetheless arises as to how their conclusions should be applied in the Canadian context. The conclusions of their first study (2002a), comparing mortality rates in FP and NFP general hospitals, would actually seem to dovetail with Scott’s remarks regarding the lack of potential for efficiency gains from the private delivery of highly complex services. To date, as well, most advocates of expanded private delivery have shied away from recommending that general hospitals be converted to FP status. In this sense, as long as the Devereaux et al. conclusions are taken as applying only to the general hospital sector, there would appear to be grounds for broad agreement.

The conclusions of the second study (2002b), on specialized hemodialysis clinics, would seem to be more troubling for the advocates of expanding private delivery of

services in Canada. Here, however, caution is probably warranted. For example, the authors themselves note that one of the factors that may have contributed to the higher mortality rates in FP dialysis clinics is the shorter duration of treatment they provided, since “shorter durations of dialysis treatment are associated with higher mortality” (Devereaux et al. 2002b: 2456). The authors suggest other possible causes, such as the use of less well trained staff in FP clinics, but they do not indicate the relative weight of each of these factors. The point we wish to make is that issues such as the duration of treatment can surely be resolved through better regulation of clinical practices. If this was a significant contributor to the higher mortality rates, it suggests that under a different regulatory regime, outcomes may be different, independently of the ownership structure of the clinics. In other words, it may not be possible to generalize the American experience in this area to a Canadian context, where a different approach to regulating hemodialysis clinics could very well apply. It is worth noting that a recent examination of the literature on for-profit versus not-for-profit hospital care reached a very similar conclusion. Gillian Currie, Cam Donaldson and Mingshan Lu (2003: 232) write:

In short, the empirical results from comparisons of for-profits and not-for-profits are particular to the regulatory and competitive environment within which the hospitals are operating.

An example of privately funded and privately delivered services that seldom prominently figure in the debates over the quality of private delivery are dental services. The Romanow report cites dental services as an example of the private healthcare services that it defines as those services “that we either pay for directly or are covered through private insurance plans or employee benefit plans” (*Building on Values*, p. 5). While there may be issues relating to access to dental care, since dental services are largely funded through employer-sponsored private insurance that is not available to everyone, one does not often hear generalized complaints that these services are of a lower quality because they are outside publicly funded medicare.

At an even broader level, however, there are a couple of examples, worth looking at briefly, which point to a variety of benefits that may be derived by having a diversity of kinds of healthcare providers. The first of these is the fact that Workers’ Compensation Boards are exempt from the Canada Health Act and can therefore legally purchase medically necessary services from private for-profit providers. In his report, Mr. Romanow indicated that he felt this practice should be halted since it constituted a blatant example of two-tier healthcare.

However, it is possible to make the case that this example illustrates how society can derive a benefit from allowing carefully circumscribed queue jumping using FP healthcare providers. The rationale behind giving WCB cases preferential treatment is that as long as workers are off the job, it costs the compensation system considerable sums of money to support them. By speeding up their treatment, these costs are reduced, even if the system has to pay for their treatment at private clinics. Is this wrong? It all depends whether one places the emphasis in this instance on ensuring identical treatment for all injured people regardless of where their injuries occurred, or whether one looks at the overall economic gain to be had by minimizing compensation payments and returning the injured worker to the workforce in the shortest possible time.

There are, of course, many important issues associated with the possible expansion of for-profit delivery of publicly funded healthcare services. Concerns have frequently been expressed about the ability of public purchasers to effectively monitor quality and hold their for-profit contractors accountable. As well, questions have been raised as to whether private contractors will be able to secure sufficient profits from uncontroversial sources such as economies of scale, or whether they would engage in practices, such as underpaying their workforce, that many would find objectionable.

There is an additional difficulty that is posed by the pervasive human resource shortage in the healthcare sector. Under conditions of scarcity of personnel, an expansion of private FP delivery of services might easily occur at the expense of other kinds of providers. As there are a limited number of trained and educated professionals on the market, those who move to FP firms will no doubt come from existing providers, and potentially undermine their ability to survive, or compromise the quality of the services they can provide. There does not seem to be an easy answer to this problem, other than to increase the supply of healthcare professionals, so that there is greater flexibility in the marketplace.

It is worth looking at the structure of the argument deployed by the authors of *Bad Medicine*, Grieshaber-Otto and Sinclair, because it illustrates the pitfalls of taking a false understanding of the nature of the Canadian health care system as a starting point for policy recommendations. We will argue that, in fact, the whole structure of their argument rests on a false premise.

Grieshaber-Otto and Sinclair are concerned about the incursion of the private sector into the public healthcare system. In particular, they argue that any further expansion of the private sector would likely be irreversible because of existing (and feared future) trade agreements. Their use of a trade lens through which to think about healthcare policy picks up on one of the recurring themes in left leaning discourse. Roy Romanow devoted an entire chapter of his final report to the issue, and *Bad Medicine* represents a book length development of the key arguments.

The authors marshal many familiar arguments against private health care funding and delivery, concluding that neither private funding nor private delivery (even of the ancillary services that Roy Romanow accepted). For them, any expansion of the private sector in healthcare would erode the quality and availability of the care that Canadians receive. This negative assessment of all private involvement, whether on the funding or delivery side, is the background against which they make their main argument.

The central thrust of their case against allowing additional private sector activity is that it would alter the current status quo, and therefore make the Canadian health care system vulnerable to foreign (mainly American) takeover, with an American style system as the implied result. In their view, it is dangerous to experiment in any way with greater private sector involvement because this would lead to the removal of the protections that have been grandfathered under current free trade agreements.

For the time being everyone (including Roy Romanow) agrees that we are safe. The simple, inescapable, fact is that publicly funded health care in Canada is not under immediate threat from existing trade agreements. This should be a rather obvious conclusion, given that there are no current NAFTA challenges to the structure of Canadian health care as it is now constituted, nor are there any serious potential ones anywhere on the horizon. To date, then, Canada has successfully held back the presumed legions of private players who continue to eagerly await their opportunity to devour our public system.

However, our authors fear that should the dam be breached there will be no holding these powerful forces back. And once the floodgates have been opened – even under the guise of modest experiments with either

private funding or private delivery – we would be unable to avoid being overwhelmed by a tsunami of foreign and private investment that could never be reversed. In their view, because trade agreements insist on equal treatment for all investors, should the current state of affairs be even slightly altered it will become impossible to defend publicly funded healthcare in Canada. Change Canada's public system by allowing even small increases in private involvement and the game, to all intents and purposes, is over.

The way that they understand and describe the nature and structure of Canadian healthcare as a public system is therefore central to their case. One can only invoke the fear that trade agreements will intervene to make privatization easier, and irreversible, if a change has been made to the status quo. If there is no change to the configuration of the healthcare playing field, there is no reason to think that foreign healthcare corporations would have cause to modify their behaviour towards Canada. And, since there is nothing in the current configuration that encourages them to expand their operations in Canada, there would be no fear of them increasing their presence as long as the status quo is maintained.

So, what if the expansion of at least some kinds of private sector involvement in healthcare in Canada did not entail a fundamental shift in the structure of the Canadian healthcare system? If the description of the Canadian healthcare system they propose does not hold up to scrutiny, their argument about the danger of trade agreements being invoked in the wake of any changes to it is no longer plausible.

[Explain here our understanding of the nature of Canadian healthcare as the public funding of private delivery, or refer to it if it has already been outlined in another part of the paper. Reiterate the point that none of the commentators on our earlier article challenged this assessment, nor, to our knowledge, has anyone done so to date.]

It is true that allowing multiple sources of funding would alter the structure of the *funding* side of the Canadian healthcare equation, and could hypothetically entail the kind of scenario the authors envisage. But until and unless the single payer structure of Medicare is transformed, one cannot argue that the danger from trade agreements is any greater than it is currently. And since everyone agrees that the current danger is minimal, we can conclude that the maintenance of the single payer system will continue to act as a secure bulwark against challenges to Medicare under free trade agreements.

Of course, there is still a discussion to be had concerning private delivery. But the framework for this discussion is a different one than is required to evaluate the impact of trade agreements. Reasonable people can reasonably disagree over which elements of the healthcare system should be delivered using what structure of corporate ownership. Some may indeed be better than others either in terms of efficiency or in terms of quality. But these are matters that are generally best settled in practice. Experimentation on the *delivery* side of the equation is thus essential to discovering the best means of giving people access to the wide array of care that they need or want. Precluding such experimentation with delivery mechanisms, on the grounds that it will open the door to the destruction of the publicly funded system, is bad policy. Yet this is the conclusion our authors are constrained to reach because of their faulty starting point.

But it is not just authors on the left who begin from false premises. On the right, however, the distortion happens at the other end, so to speak. For many authors on the right (and in this they echo the dominant – although not unchallenged – view in the U.S.) the private sector is always more efficient and more conducive to fostering both quality and innovation. This, the argument goes, is because private enterprise is driven by a consumer satisfaction ethos. While this may be true in some areas (although it also always comes with its own set of costs) it is not true of all sectors.

Health care insurance is one sector where market competition is neither the most efficient nor the most equitable mechanism for allocating resources. On this the evidence from the U.S. is practically irrefutable. Competitive insurance does not hold down societal costs. Competitive insurance cannot, on its own, guarantee universal coverage. Competitive insurance does not improve service to patients. Competitive insurance does not make doctors more efficient.

When it is the predominant form of insurance provision, what it does do is drive up costs and reduce accessibility to needed care. As the distinguished economist Paul Krugman noted in a recent *New York*

Times column, competition in the insurance sector only yields bloated bureaucracies that are paid for by diminishing people's access to, or the quality of, the care they receive. In his words:

...we've created a vast and hugely expensive insurance bureaucracy that accomplishes nothing. The resources spent by private insurers don't reduce overall costs; they simply shift those costs to other people and institutions. It's perverse but true that this system, which insures only 85 percent of the population, costs much more than we would pay for a system that covered everyone.¹

The key lesson to be drawn from the clearly inferior overall structure of American healthcare is not that everything private (or even that everything that is private-for-profit) is to be rejected. It is that a system in which competitive insurance is the principal or predominant form of healthcare insurance is to be avoided like the plague.

All healthcare systems (with the possible exceptions of Cuba and North Korea) contain a mix of public and private, both with respect to funding and to delivery. Even in the U.S. public funding accounts for around 45% [check figure] of healthcare spending, and most hospitals are either public or private not for profit. In Europe, the so-called Bismarckian systems (e.g. Germany and the Netherlands) rely on a variety of non-governmental insurance providers, including some that are for-profit, yet their systems provide universal coverage and often rate higher than the Canadian system with regard to the quality of care delivered. It is not the presence or absence of private players as such that is the problem, but whether or not the model of competitive private insurance is allowed to shape the entire system according in its own image.

So it is with great caution that one should approach the recent suggestion by former Ontario Premier Mike Harris and former Reform Party leader Preston Manning to do away with the Canada Health Act. Despite any limitations it may have², the CHA does ensure that there is single public insurer for medically necessary services.

In fact, in order to sustain their argument Harris and Manning distort the nature of Canada's healthcare system in a way that is the flip side of the misrepresentations contained in *Bad Medicine*. For Harris and Manning, the Canadian system is one of "government monopoly and associated restrictions" that leads "to a very inefficient and wasteful system that denies timely health care to all but those with connections or personal wealth." The idea that the system can be given the blanket designation 'government monopoly' is as misleading as claiming that it is a pristine 'public' system.

The hyperbole in which they indulge is perhaps the first sign that their position on the structure of Canadian Medicare is misguided. It is quite simply not true that most Canadians are denied timely access to the care they need. The waiting time problem is certainly a serious one, but the system has not degenerated to the point that excessive waiting has become the norm. There are no doubt many unacceptable case of people waiting too long, but they are not yet the majority.

Once we get past this factual distortion, it is instructive to look at how they create the impression that the nature of government monopoly is much broader than the one that everyone acknowledges, the monopoly over funding for medically necessary services. They write:

The Canada Health Act (CHA) as interpreted by the current federal administration establishes a public-sector monopoly with respect to health-care insurance, requiring government financing and

¹ *NYT*, Apr. 22, 2005

² Space permitting we could note the limits, but point out that they are not of the kind that Harris and Manning suggest. The example of psychologists or nurse practitioners show the limits of the CHA model. Practices that could be systemically beneficial are discouraged because they are legislatively placed outside the public funding envelope. The solution is to find ways of broadening the public funding envelope to include them.

administration of all core health-care services and denying Canadians the opportunity to acquire such services from private providers.

First, it is not just the current administration that interprets the CHA as establishing a public sector monopoly with respect to health care insurance. As we have seen, the core of the Canadian system is precisely this monopoly, and if there is anyone who has suggested that the CHA should not be interpreted in this way they have yet to make their voice heard in health policy circles. The fact that the CHA establishes this monopoly does not automatically make it right, but there is little doubt that this is what the CHA does.

Second, intentionally or not, they introduce a slippage in the use of the term monopoly. Thus they write:

[Health care services] should not be limited by a government monopoly over service provision. This holds even in areas where insured services are covered by government. Government and its agencies need not run hospitals any more than doctors need to be civil servants.

Without ever explicitly stating that there is a government monopoly on the delivery of services, they nonetheless imply the existence of such a monopoly. The confusion they perpetuate on the nature of monopoly also allows them to recommend that the monopoly over funding medically necessary services be eliminated. They tell people to be prepared for “more ‘cost sharing’ between yourself and the province for some of your health care through a combination of user fees, insurance premiums, deductibles, and co-payments.”

They thus make two claims that are false. First, they attribute a monopoly on service delivery to the state that does not exist, and second they falsely suggest that the monopoly on funding that does exist is bad for the system in the same way that a monopoly over service delivery would be.

The fact that they are misleading their readers as to the nature of the Canadian system is most clearly revealed, however, when they come to extol the virtues of the reforms they wish to introduce. What is striking is that the reformed system they purport to be championing sounds an awful lot like what we already have.

If the services provided by the private facility are core services covered by your provincial health-care insurance plan, upon presentation of your Health Care Card the cost of your treatment will be covered by the province in accordance with the same fee schedule used at publicly run facilities. If the services you require or desire are not covered by your provincial health-care insurance plan, they may be paid for directly or through any private supplementary health-care insurance plan (which is the case now).

Conclusion

If there is one safe conclusion to be drawn from the myriad of studies and analyses that have emanated in the past few years from governments, stakeholders and the academy, it is that there are no easy, cost-free, magical solutions that will resolve overnight the complex problems facing the healthcare system in Canada. There is some solace to be had in the knowledge that the difficulties we confront, and the absence of simple remedies to them, are not unique to this country. Rather, there is a striking similarity to the issues on the healthcare agenda across the industrialized world.

But, as we have seen, the common nature of these problems does not mean that the same solutions will work in countries that have very different institutional profiles, political sensibilities and socio-cultural proclivities. While every system is struggling

with the best way to draw the boundary between public and private in their healthcare systems, no single recipe has emerged that could provide firm guidance to our ongoing debate over these matters in Canada.

For there to be any possibility of forging a broad consensus and a workable recipe for addressing health care reform it strikes us as exceedingly important that we attempt to establish a common starting point that is firmly anchored in the reality of Canadian medicare as it now exists.

Let us put the matter as plainly as we can. Those who declare that the expansion of private delivery of healthcare services in Canada should be blocked on the grounds that it would infringe on deeply held Canadian values are making what could be called (for want of a better term) a doughnut argument, that is, an argument with a gaping hole at its centre. This is because the reality of the Canadian healthcare system, which they insist is a reflection of Canadian values, is not what they portray it as being.

It seems to us that the fact that Canadian medicare involves the private delivery of publicly funded services means that the values-based opposition to the private delivery of publicly funded services is confronted with what would appear to be an insurmountable dilemma. For the sake of argument, let us grant the point that medicare reflects Canadian values. If one also accepts that medicare is what we have said it is, then it is hard to see how one can avoid the conclusion that the values that are reflected in medicare already allow for the private delivery of publicly funded, medically necessary, services. And it then follows logically that since the acceptance of the private delivery of publicly funded services is already part of Canadians' values, reference to these same values cannot be used to justify, in and of itself, a principled and blanket prohibition of the private delivery of healthcare services.

There may very well be other values that would support a prohibition of expanded private sector delivery, but one cannot simply assume that such values are widely shared by Canadians on the grounds that there is a general popular acceptance of the structure of medicare as it now exists. To repeat, this is because the endorsement of Canadian-style medicare implies an acceptance of the private delivery of publicly funded services.

We do agree that a fundamental shared Canadian value that is reflected in the structure of medicare is the principle of equality of access to medically necessary services. There is a broad consensus in Canada that scarce healthcare resources should be allocated on the basis of need, not according to the ability to pay. There is also general agreement that the current single-payer, publicly funded system by and large accomplishes this goal. But as we have just seen, it does so using a variety of delivery mechanisms, many of which are private in one form or another (which does not necessarily imply that all forms of private delivery would achieve the objective of providing healthcare services in an equitable fashion). In this sense, invoking fundamental Canadian values that are embodied in medicare establishes parameters for what outcomes are acceptable but does not (and cannot) specify on its own the exact mechanisms that should be deployed to attain these objectives.

Peeling away misconceptions will help to set out the nature of the various disputes more clearly, and can be the first step in creating more favourable conditions for addressing the many serious outstanding issues. It is not lost on us that there is a

multi-layered political dimension to the ongoing healthcare debate. If there is an emergent common understanding among healthcare system policy analysts of the basic composition and operation of the system as it relates to public and private roles, debate in the public arena remains significantly more polarized and confused. Unfortunately, many myths continue to influence public perception, and the quality of the public discourse suffers as a result. We nonetheless continue to hope that it will be possible to dispel these myths and to work toward the broadening of the consensus on the best way to work out the public and private mix in the funding and delivery of healthcare services in Canada.

Postscript

Given the centrality of the single-payer approach to medically necessary hospital and doctor services to the integrity of our healthcare system, it is worth noting that there is a significant threat looming on the horizon. However, it does not come from the introduction of FP clinics in some provinces or from the use of public-private partnerships to fund the construction of new hospitals. Rather, the source of this potential challenge to the basic structure of medicare comes from a court case originating in Quebec that has been winding its way through the judicial system and will be heard in the coming months by the Supreme Court of Canada. What is at stake in this case (*Jacques Chaoulli et al. v. Attorney General of Quebec*) is nothing less than the single-payer system itself.

The case was discussed at some length in the Kirby report, but had not at that time proceeded beyond the original lower court trial judgment. The issue raised by the *Chaoulli* case is whether there is an infringement of Charter rights that occurs when the public system is unable to provide timely access to needed services while simultaneously prohibiting individuals from purchasing these services using their own resources (either directly or through privately held insurance). It is beyond the scope of this paper to review the details of the case or to speculate on the options that may be available to the Supreme Court. However, it is clear that should the Court rule in favour of the plaintiff, and declare that it is not reasonable in a democratic society to outlaw the private purchase of healthcare services, the entire structure of Canada's single-payer publicly funded insurance system could be in jeopardy.

At the very least, such a decision would radically alter the healthcare landscape in Canada and create a new context in which the debate over the roles of public and private would have to be pursued. Regardless of the outcome of the *Chaoulli* case, in coming years Canadians will not be able to avoid confronting the issue of how best to handle the relationship between public and private in healthcare (any more, we suspect, than the country will ever be free of federal-provincial wrangling on the subject). We can hope, though, that in the wake of the two recent federal reports it may be possible for this debate to proceed with a greater degree of clarity with regard to the current realities of medicare, and with a better understanding of the potential impact of the diverse options for reform on the future prospects of our healthcare system.

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