For-Profit Health Care

Dispelling the Myths

Myth #1
Medicare is not Workable

In recent years, Canadians have been subjected to an organized campaign designed to weaken confidence in the nation's health care system. The motto of this campaign is heard daily: medicare is not working and cannot work.

Promoters of this position have steadily escalated their use of scare tactics in the health care debate. The public is told that waiting lists have grown out of control, the system is becoming unaffordable, and that in the future, care for the elderly will bankrupt the health system.

Convincing Us It Does Not Work

"Imagine that some private interests, political ideologues and civil servants wished to replace the comprehensive, universal, accessible Canadian medicare system with a two-tier structure.... Well, how would they go about it?

First, they would have to convince Canadians that their public system did not work. How? Blunt injudicious cutting would be a start. Better still, combine those cuts with the transfer of medical services to areas not properly integrated into medicare – to home care, for example. As services declined, waiting lists grew, patients suffered from isolation and poor service at home and medication bills piled up, well, the belief in universal medicare would be damaged. Suddenly the time would be ripe for a new "vision." And it would not be universal."

John Ralston Saul
Do We Care? Renewing Canada's Commitment to Health

Staggering cuts in federal transfers to the provinces for health care between 1986 and 1995, combined with subsequent provincial reductions in health care spending, further fueled this rhetoric of crisis. The result has been a serious undermining of public confidence in the health care system.

The "solution" to this crisis, Canadians are being told, is to turn allegedly wasteful and inefficient health care services over to the "more efficient" private sector — to increase the role of for-profit providers and to experiment with the creation of for-profit hospitals.

While the perception that Canada's health care system is under threat is quite correct, the nature of the threat, and the appropriate responses are not well understood. Examining the myths behind the rhetoric of crisis is an important starting point.

Waiting lists

In a May 2000 address titled "The Myths and Agendas Behind the Unsustainability Chorus"[1], health policy analyst Steven Lewis stated that available data contradicts the prevailing opinion that waiting lists are out of control. That data reveals that more procedures are being performed than ever before. Manitoba and Nova Scotia data show, on average, stable or declining waiting times.

That is not to say that waiting lists are not a problem for people in pain or in deteriorating health. But, says health economist Robert Evans, when efforts are made to find out more about the problem, to determine who is waiting, how long, and why, and to determine what might be the best solution to the problem, "... it turns out there is little or no hard data behind the clamorous rhetoric."[2] The data tends to be anecdotal, and efforts to systemize it, and to target a response, are as likely to be attacked as welcomed.

Evans also notes that waiting lists have become an argument for those who promote two-tier health care — letting those with the means buy services privately. He warns against such an approach. "One of the clearest lessons from the U.K. National Health Service is that once you open up private market opportunities for specialists, no amount of public money will ever clear the public waiting lists. If there were no waiting in the public sector, who would ever pay extra for private care?"

Simply spending money — or worse, opening a private option — can never work because it ***rewards*** *the creation and preservation of waiting lists.*

Robert Evans

Private, for-profit clinics will make waiting lists longer.[3]

Channeling public money to the less-efficient private system is a wasteful way to address waiting lists. Eye surgery [in Alberta], much of which is done in private clinics, provides a good example:

- Waiting lists are longest and costs are highest for cataract surgery in Alberta in centres where the proportion of private clinics is highest.
- In Manitoba, waiting lists for cataract surgery were twice as long with surgeons who operated in both the private and public systems, in comparison to surgeons who did all their operations in the public system. Surgeons typically billed $1,000 extra per patient if the surgery was done in a private facility (Manitoba Centre for Health Policy and Evaluation).

Kevin Taft and Gillian Steward
Clear Answers: The Economics and Politics of For-Profit Medicine

In Fact...

The impact of Canada's aging population on the health system

Proponents of two-tier health care often point to the large number of aging baby boomers in Canada and warn that the health needs of this aging population will bankrupt medicare.

While health costs do rise as people age, particularly when people reach their seventies and beyond, the impact of aging baby boomers on the health care system is predictable and there is time to prepare. The peak of the baby boom will hit their early seventies in about 2030. "As some health economists say, the baby boom is a glacier, not an avalanche" (Taft and Steward).

Careful analysis of health spending shows that our aging population will add more costs to health care, but it need not create a threat to medicare. The challenge is to ensure that our health care responses to aging are appropriate and effective. For example, we have tended to emphasize institutional care over home care for the elderly, though home care is less expensive and often more appropriate.

- Older people are getting healthier.
- The population ages gradually — there will not be a sudden spike.
- Age-specific institutionalization rates are dropping.
- Chronic diseases may be controllable by drugs.
- Medical breakthroughs may reduce the prevalence and severity of dementias.

Steven Lewis
Access Consulting Ltd., Saskatoon

Canada's tendency to institutionalize elderly persons

Almost ten percent of Canada's over-65 population are in chronic-care hospitals or nursing homes. In the United States and Australia only about six percent of seniors are housed in institutions, and in Britain, only five percent.

The 1984 Canadian Medical Association Task Force looked at the allocation of health care resources and was adamant about the need to *reduce*, not increase, the number of elderly in institutions.[4]

Alternatives to institutionalization

- Establish social policies like those in Sweden and Japan, where grown children are given financial incentives to care for their parents.
- Reduce the number of elderly people in acute care hospitals and nursing homes by making adequate home care supports available.
- Develop planning processes for long-term care for the elderly or chronically ill (long-range thinking is absent in our health system.)

In Fact...

Medicare has accomplished what it set out to do

Health policy analysts, like Michael Rachlis, have studied the question as to whether medicare – Canada's single payer health system – has worked in terms of providing access, economic efficiency, a compassionate system, and high quality care.

Their conclusion is that medicare has done what it was created to do – provide equitable care and controlled costs. He points to a variety of studies which show that Canadians are getting health care according to their need, regardless of income.

Furthermore, while costs that need to be paid for privately (for example, prescription drugs and home care) have risen dramatically, the publicly funded and administered system has controlled costs. This is a point emphasized by Robert Evans. "Spending on hospitals and physicians' services, covered by medicare, shows very clearly the pattern of steady escalation of share of GDP prior to 1970, followed by stability in the first decade of universal coverage."[5]

In January 2001, a group of Canada's leading health care academics released a report that refutes as myth the many media reports that suggest Canada's medicare system is in crisis and is facing imminent collapse. The report concludes that while medicare faces many problems they can be fixed while still preserving the public health insurance system.[6]

> *For all the criticism of Canada's medicare program, I for one would be delighted to have its manageable problems in place of those in the United States.*
>
> Theodore Marmor
> Yale School of Management

Comparing U.S. Health Care *with* Canada's Public System

- It consumes more resources (14 per cent of the economy, compared to 9 per cent in Canada);
- It allocates resources less efficiently (44 million Americans lack coverage);
- It is vastly more inefficient in terms of its administrative costs (per capita billing costs in 1995 were $361 in the U.S. and $119 in Canada);
- It provides a lower quality of care in order to maximize profits;
- It produces poorer results in terms of a nation's health indicators: life expectancy, infant mortality and social inequalities. (The U.S. has the highest infant mortality rate among OEC countries.)

Canadian Health Coalition
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References

1. Steven Lewis, in a presentation titled "The Myths and Agendas Behind the 'Unsustainability Chorus'," BCMA Forum, Vancouver, BC, May 11-12, 2000.
2. Robert Evans, in a keynote address titled "The Role of Private and Public Health Care Delivery in Alberta," Health Forum sponsored by The Alberta Congress Board, Edmonton, Alberta, Feb. 5, 2000.
3. K. Taft and G. Steward, *Clear Answers: The Economics and Politics of For-Profit Medicine*, Edmonton: Duval House Publishing, 2000, pg. 96-97.
4. M. Rachlis and C. Kushner, *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It*, Toronto: Collins, 1989, pp. 154-156.
5. Robert Evans, "The Role of Private and Public Care Delivery in Alberta."
6. *Revitalizing Medicare: Shared Problems, Public Solutions*, Tommy Douglas Research Institute, 2001.