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Going Public on What is Private

Clarifying the public-private health care debate

The hottest debate in Canadian health policy is the public/private debate. It's also the most confused, for the simple reason that very few of the participants actually define "public" and "private." There are, for example, three broad areas in which the terms public and private can be used: payment for care (or insurance), financing the system's capital needs, and providing care. The three are necessarily intertwined – decisions about how much private finance capital will be permitted affect private supply of care, but they have distinctly different aspects as well. Lumping them all under the heading of public/private health care means that different people will be using the same terms to refer to different things.

In other papers in this series we will look at public/private insurance and funding issues. In this one, we take a look at some of the debate about public vs. private supply of care.

The first thing to note is that most of us get most of our health care from private sector suppliers. The vast majority of doctors, dentists, opticians and optometrists,

Members of the Canadian Health Care Consensus Group (CHCCG) have come together to provide a platform for bold, reasoned and practical plans for genuine reform of the health system and to demonstrate that there is an emerging consensus among reform-minded observers about the direction that real reform must take. The CHCCG, coordinated by the Atlantic Institute for Market Studies (www.aims.ca), includes medical practitioners, former health ministers, past presidents of the Canadian Medical Association and provincial medical and hospital associations, academics, and health care policy experts, all of whom are signatories to the Statement of Principles.

This paper is the first of a series of discussion papers prepared for the CHCCG, which are intended to contribute to that new debate. These papers do not represent official positions of the Consensus Group, and are not themselves consensus documents, but rather are intended to act as starting points for debate, some of which will occur on the Consensus Group's website (www.consensusgroup.ca). The first few papers will deal with aspects of the "public" versus "private" debate, while later ones will consider other issues which were raised in the Consensus Group's Statement of Principles.

pharmacists, chiropractors, and purveyors of natural remedies work in the private sector, in the sense that they're not salaried public sector employees.

Most doctors are small businesspeople

Doctors, for example, and especially family physicians, are, in economic terms, small, for-profit businesspeople. They happen to earn most of their income by supplying services to the publicly funded health care system, but, for all we hear about doctors' salaries, they're not actually employed by it. They earn revenue by supplying individual services to individual consumers, out of their revenue they pay their costs of practice - labour, equipment, rent, electricity and all the rest - and what's left they take home as income. If they were in any other field we'd call the difference between revenue and cost their profit; because they're earning a living by supplying professional services, we call it professional income, but if you described to someone the mechanism by which doctors earned their income without specifying that you were talking about doctors, that person would probably characterize the take-home income as profit.

In fact, not only do most of us get our physician care from private, for-profit suppliers, there's a pretty good chance, since Ontario brought its laws into line with some of the other provinces at the beginning of 2006, that we get those physician services from private, for-profit medical corporations.

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That's not as dramatic as it sounds. What Ontario did, as a result of an agreement signed with the province's doctors in mid-2005, was change its regulations to permit doctors (who were already permitted to incorporate, but generally hadn't found it advantageous in the past) to list members of their families as non-voting shareholders in the physician service corporation. That change lets doctors distribute some of their practice income, called profits, as payments to these shareholders, so that it can be taxed at the shareholder's tax rate. Clearly that's only advantageous so long as the family members are taxed at a lower rate than the physician, but in the case of a spouse or children who have no other income, it could result in a pretty respectable tax saving. It also means that the Ontario government is recognizing doctors as profit-making entities. You can argue that that's just tax jargon, and that it doesn't change anything about physician practice (except the amount of tax Ontario doctors pay) but it does force those who are always telling us about the evils of for-profit corporate medicine to throw in an embarrassing set of qualifiers.

So in terms of how they earn their incomes, doctors are small businesspeople, who necessarily have to keep the same kind of eye on income and expenses as do other small businesspeople. The economic evidence is that that's just what they do, despite the assertions of some that economics doesn't apply to health care. They're small businesspeople in another sense, as well: they have a clientele which, contrary to a widely held view, is as rational in its decision making about doctors' services as it is about any of the other major decisions it makes in the marketplace.

It's easy enough to say, as some do, that doctors shouldn't be influenced by economic considerations. Like everybody else doctors have bills to pay, mortgages to manage and children to feed and educate. And while doctors are, these days, in the upper end of the Canadian income distribution (that certainly wasn't always the case - as recently as the 1950s and '60s, many doctors' incomes were considerably more modest), survey evidence suggests that they work pretty hard for the money.[1] It's sometimes suggested that we should switch doctors from fee-for-service to salary or capitation,

in the mistaken belief that doing so would eliminate economic incentives. All it would actually do is change them - evidence from countries that have made the switch suggests that such a switch would lead to a reduction of about 25% in the quantity of services doctors provide. And while there are still some who believe that the whole problem with Medicare is that doctors as a group provide too many services, not many people would be inclined to agree. That is particularly true of people living in areas where you can't get a GP.[2]

Actually, while doctors are still working longer hours than most Canadians,[3] there's evidence that that's changing.[4] Two things seem to be happening. First the proportion of females in the physician workforce is increasing, and female physicians have historically preferred to work fewer hours than have male doctors. Second, there is some evidence that young male doctors are less inclined to work the long hours that earlier generations of male physicians tended to put in. For both reasons, access to physician care is likely to decline in the future even if the physician-population ratio stays unchanged. At the very least it seems safe to say that policy makers should not be overly concerned with the possibility that MDs as a group are sitting around idle, trying to dream up ways to boost their incomes by persuading their patients to have unnecessary care.

Physicians aren't complete free agents, of course. Hospital-based specialists have to get hospital privileges before they can set up practice in an area, and most provinces now limit the total number of Medicare billing numbers they will issue, as well as the number that they will issue in a particular area. Without a Medicare billing number a doctor can't bill Medicare for his services, and would have to work as a completely opted-out physician. Recent evidence from Quebec, in particular, is that the shortage of doctors, which was engineered by governments of various stripes in order to control costs, has created a market in which some primary care physicians can earn a satisfactory living while completely opted out of Medicare, something that had never been the case in the past.[5] Still, doctors have more control over how they manage their activities than hospitals have over theirs.

Hospitals are private non-profit institutions

Some people have argued that Canadian hospitals should be classified as private sector non-profit institutions, on the grounds that virtually all have boards of directors charged with the running of the facility. It has been suggested that because of that, Canadian hospitals are more like private American non-profits than they are like American government hospitals. It's not a convincing argument.

To put it simply, Canadian hospital boards and management have virtually none of the management authority of their presumed counterparts at American non-profit hospitals. Canadian hospitals are creatures of the provincial governments, and have been for many years. If a provincial department of health decides to convert a community hospital into a bedless community health centre, or to close one community's hospital and open a new facility in a neighbouring town, both of which have happened in New Brunswick recently, the boards of the hospitals involved have no recourse except possibly to public opinion. The Canadian experience is full of episodes of provincial departments of health closing or merging hospitals, and telling hospitals what services they may or may not supply. Hospital boards and hospital management have decision making authority only so long as the decisions they make are the decisions the provincial departments of health want them to make. Should a hospital board take a decision that the provincial department of health regards as politically troublesome, the department will intervene,

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and not uncommonly leave the board to take any flack that might follow. Observers have often wondered exactly why anyone would actually want to sit on the board of a Canadian hospital or health region.

Private, for-profit hospitals are a world-wide phenomenon. They specialize in medical niches and, with the exception of the US, don't compete with general hospitals

Canadian hospitals get over 90% of their funds from public sources. American hospitals are also dependent on the public sector - on average about 60% of their funding comes from various government programs - but with a fundamental difference. Canadian hospitals (with a few minor variants) get their funding in the form of global budgets while American hospitals get theirs by selling their services to government programs - Medicare, Medicaid and the like. The global budget approach means that Canadian provincial departments of health have virtual monopoly control over hospital funding, and Canadian hospitals have very little scope for finding funds from other sources. In Canada, while hospitals might have the trappings of private, non-profit institutions, provincial departments of health call the tune in all its detail. As one commentator[6] put it:

> "The first and perhaps most important piece of the story is that the same provincial health ministry from which hospitals derive most of their operating funds is also the major source of funding and the control point for capital equipment purchases and building construction. Although in many provinces hospitals or their communities are responsible for some component (usually less than 50 percent) of the funding for new construction or major new equipment, the final decision as to whether to build (or, in the case of equipment, to buy) almost always rests with the ministry of health. (Exceptions to this rule tend to be purchases of major diagnostic equipment funded from private philanthropic sources, often without the approval of the provincial ministry and without any guarantee that associated operating costs will be covered in future years' budgets.)"

Note the paucity of mentions of the decision-making authority of hospital boards in the process.

If anything, the major obstacle to continued improvement in the quality of hospital care in Canada is the fact that hospital managers are not allowed to manage. We will discuss the running of hospitals in more detail in another paper in this series, and here note only that you can't expect managers to produce the best possible results when they're given virtually no actual managerial authority. Things aren't going to improve until provincial departments of health adopt the strategy of deciding what outcomes should be produced, hiring good people to produce them, then stepping back and letting those people do their jobs.

Hospital myths and facts

This is probably as good a point as any to try and counter some myths about the American hospital system. Take the role of for-profit institutions in the US hospital sector. For all we hear about the profit-driven American system, only 15% of American hospitals are actually for-profit institutions and they account for about 12% of hospital beds. The other 85% of hospitals are non-profits, either government or private. If the problems of the US hospital system are to be laid at the door of the for-profits, it must be assumed that those for-profits have an influence out of all proportion to their size and number. Other countries[7] also have for-profit hospital sectors: in Germany, over 20%

of hospitals are private, for-profit institutions. They're small - they account for about 9% of beds, but they're there. In France, private, for-profit hospitals account for about 40% of all hospitals and about 20% of beds. Norway has a (very) small private hospital sector that grew as a result of frustration with long waiting times for treatment in public hospitals. Belgium has no for-profit hospitals, but the government encourages Belgian hospitals to treat patients from other EU countries who seek treatment in Belgium as commercial patients.[8] Belgian hospitals may be non-profit when they're treating Belgians, but as exporters of hospital services they're for profit.

In the UK the private for-profit sector has gone from pariah to saviour in under a decade

In Japan, 80% of hospitals are private, physician-owned institutions. Most are small, really just clinics with beds. In fact, for these institutions the distinction between a clinic and a hospital is based on bed size - fewer than 20 beds, it's a clinic, more than 20 beds it's a hospital. In most cases these clinics grew out of the desire of doctors to expand what they could do in their practices, and as a result of competition among doctors and with the few, much larger, public hospitals. You can split hairs over whether a physician owned clinic is a for-profit institution. Investor ownership of hospitals is prohibited, but the take-home income of the doctors who own those clinics still looks a lot like profits, and Japanese doctors' willingness to respond to economic incentives is well established.

In the UK the private, for-profit sector is well established and its role in reducing waiting times for care is well known. As one commentator put it, the private sector has gone from pariah to saviour in under a decade.[9] And in Australia, the only country in the world that actually modeled its health care system on Canada's (it's undergone many changes over the years - the Australians have proven very willing to tinker with the system in order to try and improve it) just under half of its hospitals are private, and of those, about half are for-profit.[10]

Private, for-profit hospitals are a world-wide phenomenon. They specialize in medical niches and, with the exception of the US, where the historical development was different, don't try to compete with general hospitals. They can be found in countries like Japan that spend a smaller proportion of GDP on health than Canada does, and whose general measures of population health are better than Canada's. They don't cause the sky to fall.[11]

We mentioned above that Canadian public hospitals, for all they have the trappings of independence, are really government institutions, unlike American non-profit hospitals. There are also some misconceptions about the nature of non-profit hospitals in the US that tend to cloud the debate. The most significant of those is the claim that non-profit hospitals don't have investors.

In fact, what they don't have is shareholders, but as a quick glance at an introductory corporate finance text will reveal, shareholders and investors are not synonymous. American non-profits are prohibited from having shareholders, but they can have bondholders. Indeed, as Carpenter, McCue and Moon note,[12] "For more than three decades, tax-exempt debt has been the primary source of long-term capital for non-profit hospitals and health systems."

The Illinois Hospital Association (IHA), in a news release,[13] puts it this way:

> "To ensure high quality patient care, hospitals must upgrade equipment, expand and improve facilities such as emergency departments and operating rooms, replace aging buildings, and invest in new medical

> technology. Because such projects cost millions of dollars, most hospitals must borrow the necessary funds (known as "raising capital" or "obtaining capital").
>
> "Unlike for-profit businesses which can raise "equity capital" by issuing stock, not-for-profit hospitals (nearly all hospitals in Illinois) have a limited number of options when it comes to raising capital. Most hospitals obtain capital by issuing bonds, which function like a loan or mortgage. Investors purchase the hospital bonds, which receive interest payments from the hospital, and are guaranteed repayment of the principal amount of the bond at a specified time. Most hospital bonds are purchased by large "institutional investors," such as mutual funds."

The Illinois Hospital Association clearly regards bondholders as investors. Bondholders don't get votes at shareholder annual meetings, but anyone who thinks that they don't have clout as investors, and that they won't use that clout to endeavour to ensure that they get a competitive return on their investment, needs to look at that introductory corporate finance text again. Or, if they still doubt that a financial institution regards a loan as taking an investment position in a company, ask any small businessperson what his bank would do if he decided not to make a loan payment.

There are really too many myths about non-profits for us to clear them all up here. For example, American non-profit hospitals do not, despite the common view, provide more charity or uncompensated care than do for-profits operating in the same community. In fact, in the US, non-profit status does not require that a hospital provide any such care. It did before 1969, but since then the IRS has been much more flexible in what it requires of institutions that seek non-profit status. Nowadays[14] there's a whole range of activities that will buy non-profit tax status: running health fairs and providing cholesterol screening among them. Increasingly, states are asking what community benefits they're getting in exchange for the tax breaks a non-profit hospital derives, and in many cases the answer is that the benefits the hospitals are providing are worth considerably less than the value of the tax exemptions. The press release from the Illinois Hospital Association quoted above was part of the IHA's campaign against a bill that would require Illinois non-profit hospitals to provide charity care equal in value to 8% of the hospital's operating costs. Apparently that's too heavy a load for Illinois hospitals to bear.[15] Illinois isn't the only state cracking down on non-profits that it suspects of being for-profits in disguise - Kansas is beginning an investigation of its own, as are Minnesota, New York and Wisconsin.[16]

Some of Canada's health care system is private

Doctors and hospitals aren't the only health care providers in Canada, of course, and most other providers are quite clearly private in funding and delivery. Optometrists, for example, who supply many of the same services as do ophthalmologists, are, in most provinces, private, for-profit providers who receive payment from both public and private sources. The actual mix depends on provincial decisions about what services to cover under Medicare. Ontario recently removed from Medicare coverage ordinary optometrist eye exams for certain age groups of the population, while leaving it in place for others. The age groups no longer covered by Medicare must pay either through private insurance or out of pocket, but there seems to this point to be no evidence that their eye care has suffered materially as a result.

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And dentists are quintessentially everything that self-styled defenders of Medicare hate - private, for-profit practitioners who are paid from private sources and who have a degree of freedom that GPs must envy, over what services to provide in their offices and what staff to employ. GPs are still restricted in their use of Nurse Practitioners: if dentists had been brought under Medicare back in 1968 it's a good bet that they still wouldn't be able to employ hygienists.

It's certainly true that spending on dental care has risen over the past decades. We'll look at those numbers in another paper, when we look at the composition of private and public spending. It's also true that the value of the services we receive from dentists has increased dramatically over the same period. Yet there's no sign that dentists are abusing the system the way opponents of private supply claim would happen, if we gave doctors more freedom in deciding what services they could provide in their offices, or the freedom to open Japanese-style small, non-profit, private clinics. There are no signs that for-profit practice has resulted in poorer quality care nor that dentists are inducing demand to pump up their incomes. They certainly maximize profit, and they are certainly aware of just how sensitive their patients are to the price of care. And since there's really no convincing evidence that dentists are intrinsically more honest and virtuous than are doctors, we can probably draw on the market for dental services to give us some idea of what would happen if we eased our current, outdated restrictions on private supply of care.

Medical technology has changed dramatically since 1968. Much of the technological change has been in the direction of allowing procedures that formerly had to be performed in hospitals now be performed in much less expensive settings, like stand alone specialty clinics, or even doctors' offices. Opponents of greater private initiative on the supply side of care generally have no objection when the government decides to establish such clinics; it's when a group of doctors see a need and, without waiting for government action, take steps to fill it that the red flags go up. Ultimately, much of the opposition is ideological. A great many opponents of private supply initiatives firmly believe that doctors simply can't be trusted. It's about time that we decided whether that's really a good basis for Canadian health care policy.

Our aim in this series of papers is to dispel some of the myths surrounding the public/private debate, by clarifying the terms "public," "private," "for-profit" and "non-profit" as they relate to the funding, supply and quality of physician and hospital services. One thing that we hope to make clear is that setting doctors free to make the decision to turn their practices into clinics that provide, on a Medicare-funded fee-for-service basis, care that under our current funding rules is available only in government-owned hospitals, will not mean the end of civilization as we know it. ■

Setting doctors free to turn their practices into clinics that provide care currently available only in government-owned hospitals will not mean the end of civilization as we know it

Endnotes

1. The Canadian Medical Association conducts a regular survey of physicians in Canada looking at things like hours of work, although it does not, unfortunately, ask about practice conditions, expenses or earnings. http://www.cma.ca/index.cfm/ci_id/16959/la_id/1.htm#3. According to the Canadian Institute for Health Information (2006) report, *Average Payment per Physician (APP) Report, Canada, 2002-2003 and 2003-2004*, at http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_82_E, Canadian specialists in family medicine had gross Medicare earnings of about $190,000 in 2002-2003. That would tend to suggest a net income of $115,000. While that's a good income there are other groups that take home as much as a GP does without having to work as hard for it.

For a sense of what physicians can bill per service, the Ontario Health Insurance Plan fee schedule can be found online at http://www.health.gov.on.ca/english/providers/program/ohip/sob/physserv/physserv_mn.html

2. See Brian Ferguson: Doctors Have To Make A Living Too: The Microeconomics of Physician Practice, at http://www.aims.ca/healthcare.asp?typeID=1&id=163&fd=0&p=1

3. Abdul Rashid (1999): "Earnings of Physicians," Statistics Canada, *Perspectives on Labour and Income,* 11(4) Winter. http://www.statcan.ca/english/studies/75-001/archive/1999/pear1999011004s4a04.pdf

4. See the Canadian Institute for Health Information's 2001 report, *The Practicing Physician Community in Canada: 1989/90 to 1998/99*, http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_29_E

5. Opted-out physicians in Quebec must opt out of Medicare for all their patients, not just selectively. There are two types of opted-out physicians: (1) "withdrawn," in which the patient pays the doctor according to the Medicare tariff and is reimbursed by medicare; (2) "non-participating," in which the physician is not bound by the Medicare tariff, bills the patient directly and neither of them receives a reimbursement from Medicare

6. Morris Barer: "Hospital Financing in Canada" in U.S. Congress, Office of Technology Assessment, *Hospital Financing in Seven Countries*, OTA-BP-H-148 (Washington, DC: U.S. Government Printing Office, May 1995)

7. The numbers cited here are drawn from various publications of the European Observatory on Health Care Systems and Practices, http://www.euro.who.int/eprise/main/WHO/Progs/OBS/Hits/20020525_1

8. Irene A. Glinos, Nicole Boffin, & Rita Baeten: *Contracting Cross-border Care in Belgian Hospitals: An Analysis of Belgian, Dutch and English Stakeholder Perspectives*, Europe for Patients Project, August 2005, http://www.ose.be/files/health/BelgianCaseStudy_ForPrint.pdf

9. Richard Smith: "The private sector in the English NHS: from pariah to saviour in under a decade," *Canadian Medical Association Journal*, August 2, 2005; 173(3). http://www.cmaj.ca/cgi/content/full/173/3/273

10. Figures from the Australian Institute of Health and Welfare, at http://www.aihw.gov.au/publications/hse/ahs03-04/ahs03-04.pdf

11. The quality of care in for-profit hospitals is a much debated topic with which we will deal in a later paper. For the moment we simply note two recent additions to the literature that find no advantage for non-profits over for-profits: on American data, see Frank A. Sloan, Justin G. Trogdon, Lesley H. Curtis, and Kevin A. Schulman (2003), "Does the Ownership of the Admitting Hospital Make a Difference? Outcomes and Process of Care of Medicare Beneficiaries Admitted with Acute Myocardial Infarction," *Medical Care,* 41(10) October, 1193-1205, and on evidence from France, concluding that patients have on average a lower probability of dying in a for-profit than a non-profit hospital, see Carine Milcent (2005): Hospital ownership, reimbursement systems and mortality rates," *Health Economics*, 14, 1151-1168

12. Caryl E. Carpenter, Michael J. McCue and Sun Moon (2003): "The Hospital Bond Market and the AHERF Bankruptcy," *Journal of Health Care Finance,* 29(4) Summer, 17-28

13. Illinois Hospital Association press release (undated), *HB 5000 Will Harm Health Care and Health Care Jobs.* http://www.ihatoday.org/issues/payment/charity/hb5000jobs.pdf

14. Robert Pear (2006): "Nonprofit Hospitals Face Scrutiny Over Practices," *New York Times*, March 19, 2006

15. The Illinois measure was defeated – John Dorschner: "Measuring Medical Charity," *Miami Herald*, July 23, 2006. http://www.miami.com/mld/miamiherald/15097424.htm

16. Mark Taylor (2006): "More charity-care scrutiny," *Modern Healthcare*, March 20, 2006, 36(12), p. 17