

Private not-for-profit or private for-profit

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Understanding the problems with private for-profit health care delivery requires separating issues that politicians, media commentators, and even doctors get muddled.

To understand the issues we need to distinguish between who pays for health care, and who delivers health care. The delivery side is confusing because people often refer to "public" when they mean "private, not-for-profit."

For example, in Canada, public funds pay all hospital costs. Except for items such as a private room, hospital patients do not pay any out-of-pocket costs for their care. In most Canadian provinces, hospitals get their support from general tax revenue. In Alberta and British Columbia, health care premiums, basically another form of taxation, also contribute to hospital funding.

However, just because hospital care is funded by the government doesn't mean it is delivered by a government agency. In fact most of Canada's hospitals are not publicly administered; they are private not-for-profit institutions, owned and administered by a board of directors, or a religious institution. This means that although they get their money from the government, their primary responsibility is to the communities they serve.

The question is not whether we should allow hospitals, and other institutions such as cancer clinics, to go private. Most are already private. The issue is whether we should move from not-for-profit to for-profit health care delivery.

The United States has a large private for-profit sector, and an equally large proportion of health care delivered by private not-for-profit institutions. That mix allows direct comparisons of costs and quality of care.

Health researchers have found consistent results. American for-profit hospitals are 3 to 11% more expensive than not-for-profit hospitals.

Studies show that the private for-profit based US system eats up over 13% of the American Gross Domestic Product, in comparison to around 9% in Canada, which relies much more on not-for-profit providers.

If for-profit institutions are more expensive, how can they ensure the profits their shareholders demand? They use three strategies:

1. They generate additional income, either by extracting more money from third-party (government and insurance company) payers or from direct payments from patients.
2. They take advantage of the fact that not all sick people are equally sick. Private for-profit companies are good at attracting low-risk patients that their strategies have earned a vivid term: "cream-skimming".

For instance, patients requiring joint replacement may be otherwise well. On the other hand, they may have diabetes, or heart disease. Patients who have these other conditions in addition to their joint problems require extra attention from specialists, more careful monitoring, and develop complications more often. Thus, their surgery generates higher costs.

3. They save money by cutting back on their quality of care, and patients suffer. For instance, comparisons of private for-profit with private not-for-profit American dialysis centres have found a higher death rate in the for-profit facilities. The Canadian experience with for-profit care is similar to the US story. The for-profit cancer delivery clinic at Sunnybrook costs taxpayers \$3,250 instead of the \$3,000 paid to private not-for-profit facilities. Converting a for-profit cataract clinic in Manitoba to not-for-profit has reduced costs from \$1,000 per patient to \$700.

The results of comparisons between for-profit and not-for-profit health care delivery should come as no surprise. Health-care investors expect returns of 15% or more on their investment. To just break even in comparison to not-for-profit delivery, that means that for-profit companies must cut costs by 15%. Canadian for-profit providers will have to reduce costs in a health care environment that has already been severely squeezed with budget cuts.

Canadian not-for-profit hospitals, for instance, have gone through years of cutting beds, firing administrators and nurses, and relying on lower paid nursing assistants instead of nurses. Furthermore, because CEO's in for-profit companies are ultimately responsible to their shareholders, we should not expect them to have the same commitment to quality of care as administrators in charge of not-for-profit institutions who are responsible to the community.

For Canadian taxpayers, the question is whether to entrust their health care dollars to for-profit company CEOs who will ensure that some of those dollars go to shareholder profits, or to not-for-profit administrators who will spend all the tax dollars provided to their institutions on health care delivery.

If advocates can show that, against all expectations, Canadian private-for-profit facilities can reduce costs while maintaining quality, we should reconsider. But for now, all the evidence tells us that a switch from private not-for-profit to private for-profit will be a disaster for Canadian health care.