The Case Against Private, For-Profit Hospitals

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Preamble

Alberta Friends of Medicare is a coalition of individuals and organizations committed to the principles of Medicare. Its aim is the protection and enhancement of Canada's publicly administered universal health care system as laid out in the Canada Health Act. It is a voluntary organization receiving no funding from any government or political party. We seek to raise public awareness and educate Albertans and Canadians about the benefits of our Canadian Health Care system.

There are economically powerful forces that are trying to reform Canada's health system by introducing corporate, for-profit medicine to medicare. These forces are operating on several fronts: private home care; private long term continuing care for the frail elderly; private clinics; private diagnostic facilities; and most importantly corporate, for-profit hospitals. It is the thrust for corporate, for profit hospitals that is the central concern of this paper.

While the Friends of Medicare have, amongst many other groups, called for a nationwide and highly public discussion of the increasing privatization of medicare, we also believe that this discussion must move beyond the political and ideological rhetoric that has characterized the minimal discussion so far. Political platitudes like "We support wholeheartedly the principles of the Canadian Health Act" are no more than political froth if they are not backed up by detailed and explicit statements of the interpretation of these principles. Promises to "restructure" and "reform" medicare are really either empty or misleading, unless they are made explicit in terms of the detailed changes that are intended.

As the representatives of the people of Alberta politicians at provincial and federal levels must play a critical and central part in moving the discussion to a consideration of the factual evidence, which is now substantial. What we have tried to do below is to provide an introduction to this factual literature,

with the hope that it will foster such a discussion. This is presented in two forms: First, in an executive summary; and second in a fully reference paper with a more developed discussion.

The Case Against Private, For-Profit Hospitals

The proponents of private hospitals make several claims as to the benefits that would accrue to society generally (aside from the benefits to the owners and to those wealthy enough to patronize them). However, evidence that has been accumulating for the past 40 years suggests that these claims are not well founded. (This evidence is extensive, and we can only touch on a representative sample here.)

1. *It is claimed that private hospitals are more efficient and more cost effective.* There are two ways to look at this, and similar cost saving claims:

    a. *At the micro level, according to proponents, private hospitals should be cheaper to run.* (This argument follows from the general claim that private enterprise is always more efficient than public enterprise). The evidence regarding this claim has been accumulating for the past three decades. Stoddart and Labelle (1985) have provided an excellent review of the early work in this area.[1] As is usual in any new area of research there were growing pains in terms of methodological problems. Once these were overcome, the weight of the evidence clearly showed that this claim is not substantiated by the evidence.

    "Thus, perceptions of the 'superior economic performance' of the private for-profit hospitals over public non-profits would appear to be based on the greater profitability of the former, rather than their greater efficiency. The evidence certainly does not substantiate (indeed it refutes) claims that privately owned for-profit hospitals operate more efficiently (i.e., at lower costs of production) than do non-profit hospitals. In fact, the success of the investor-owners in generating above average sales and revenues appears to have relieved the need to minimize production costs" (Stoddart and Labelle, 1985: 15).[2]

    They remark a bit later that these results don't apply directly to Canada because we don't have privately financed hospitals. Of course, they obviously didn't anticipate the current developments in Alberta.

    That this conclusion is not restricted to that earlier time has been attested by more recent evidence. In a recent issue of the *New England Journal of Medicine* Woolhandler and Himmelstein reported a well-designed study which showed that for-profit hospitals in the United States had significantly higher administrative and per patient costs than did not-for-profit hospitals (Woolhandler and Himmelstein,

1997).[3] They also referred to an earlier study showing that the overall average of administrative costs in American hospitals was much higher than those in Canada: "In 1990, administration consumed, on average, 24.8 percent of total hospital spending in the United States — nearly twice the share in Canada" (p. 769).[4]

Altman and Shactman (1997),[5] in the same issue, question whether administrative costs are the most important issue. They suggest that questions of quality of care and the 'free rider' status of private hospitals are more important. There is evidence, they say, that private hospitals tend to deal only with the more profitable treatments and avoid those that are cost-intensive, e.g., AIDS clinics, 24-hour emergency service, charitable service, etc. (The same problem exists in Britain. Johnson, 1995.)[6]

In any event, it has been claimed that hospital administrative costs are a major problem in Canada. Whether they are or not is moot, but they are certainly much lower here than in the United States, particularly in private hospitals there.

b. *At the macro level, a private hospital system will result in overall cost savings for the economy.*

This claim is a bit more difficult to deal with because of the different meanings and/or assumptions that it might carry. First, does this claim refer only to public expenditures? If so, it is obviously true. The more of the aggregate need for medical care is borne by private financing, the less will be left for the public purse to carry. (This touches on a related claim which we will discuss under #2 below.) The US system is the obvious case in point. While the average share of total health care expenditures borne by the public sector of OECD countries is about 75%, that in the US is only 43% (Auer, et al., 1995).[7] Another case in point is the increase in public expenditures when public health care is introduced (see Iliffe, 1983).[8] Not to belabour this obvious point, it only should be added such a transfer of costs would relieve the provincial government of a sizable burden of responsibility.

The more significant question has to do with whether this claim is intended to mean that the overall costs of health care to the economy will be reduced. Here the evidence is mixed, and unfortunately confounded. First if we look at the United States, we can see that this claim does not seem to hold at the macro level. In the US the share of total health costs carried by the private sector is 67%, while their public sector picks up 43%. And yet the overall cost of their health care absorbs 13.3% of GDP as compared to an average of 7% in

the other OECD countries where, on average the public share is 75% of the total health costs (These are 1991 figures reported by Auer, et al., 1995.[9]) The large private system in the US does not seem overall to have saved them money. In addition this system excludes many.

However, another country Turkey, which, together with the US, has what Auer, et al. (1995) have called the "private insurance model," has the lowest expenditures on health care (4.1%) of the OECD nations.[10] This, of course, raises the issues of quality and accessibility of health care. Life expectancy in Turkey is about 64, while in all other OECD countries it is about 72 (Auer, et al., 1995).[11]

The comparison between the US and Canada is instructive. Just after the Second World War Canada and the US had similar medical systems, largely privately financed. Each country was spending about 5% of GNP on health care. This percentage gradually increased, and the rate of increase was about the same in both countries, until in 1971 when both countries were spending about 7% of GNP on health care. It was at this point that Canada introduced, publicly finance Universal Health Insurance. And it was at this point that the comparative history of health spending increases changed. The increases in health spending in the US continued apace while that rate slowed substantially in Canada. In 1989 after almost 20 years of the supposedly flagrant spending of Government, and the frugality of the competitive private system, the US was spending 11.6% of GNP for health care while Canada was spending only 8.9% (Gorecki, 1992).[12] And the gap keeps widening until today the US is spending a little more than 14% while Canada is spending a little more than 9%. (The Alberta government is spending only about 6%.)

Further evidence within Canada is also instructive. In a study for the National Forum on Health, Deber, et al. (1998) found that as the percentage of public expenditures on health decreased overall spending on health increased.

> Particularly in view of the belief that private spending was a way of relieving the pressure on the public purse, it is of some interest to examine the data. We use OECD data for Canada from 1971 to 1993 to correlate the percentage of the GDP devoted to total health expenditures against the percentage of health spending coming from public sources; the correlation was -0.664, with a slope to the regression line of $-.49$, revealing that the lower shares of health spending coming from public sources are associated with higher shares of GDP being devoted to the health sector . . . Although correlation is not causation, this evidence again suggests that private funding is less economically efficient. At minimum, it

does suggest that increasing private spending is unlikely to achieve cost control.[13]

Britain also provides an excellent case history relevant to this claim which implies more effective health care spending for all the population. They have a National Health Service (NHS) like our medicare, but they also have a parallel system of private care and private hospitals. The overall share of the British GDP for health care is 6.6% (this is the figure for 1991 provided by Auer, et al., 1995: 30).[14] We have not been able at this time to find a statistical breakdown of the per patient costs in each of these two systems. If the relative cost studies in the US are relevant here we would expect that the costs would be higher in the British private system. Several other facts support this inference.

- Private insurance from multiple insurers imposes higher administrative costs than does a single payer system. (This is certainly true in the US where there are over 1500 different insurers (Churchill, 1994.[15])
- There are extensive waiting lists in the NHS while there are virtually none in the private system. (This speaks also to the accessibility of health care, which we will turn to below.)
- The NHS is reputedly in a state of crisis today because of serious underfunding (*The Economist*, May 3rd, 1997).[16] No such warning has been given for the private system.

It would appear that the involvement of a private health care system is no guarantee of appropriate spending on health care for the population as a whole. In the US system, where only the indigent and elderly are covered by the public purse, and all others by private insurance, costs are excessively high. In the British system of parallel public and private systems, the public system has become increasingly underfunded. These, and other, international comparisons indicate fairly clearly that health care funding is not a simple economic issue, but rather a complex political-economic one. But one point that most objective observers agree on is that public, single payer systems provide the best means of cost control in health delivery systems (Culyer, 1988).[17]

2. *The claim is made that the addition of a private hospitals to our system will reduce the pressure on the public system.*

According to this claim, by allowing those who can afford it to jump queue and pay for their own care in a private hospital we will relieve the pressure on the public system and thus reduce waiting lists. It is therefore relevant to questions of affordability and accessibility (both equity issues)

of health care. On the face of it, this argument is beguiling. But its logic begins to sag when it is combined with the claim that we need to do this because we can't afford medicare any longer. Since it is pretty clear that private care covered by private insurance is more expensive than public care, the question comes to mind: "*How can we save money by spending more?*"

But of equal, if not greater importance, is the claim that siphoning off the affluent will increase the access the rest of us have to similar care. This is potentially true—but only if the level of financial support for the public system is maintained (and consequently *we collectively spend more*). In the real life of political-economics this is not assured.

Take Britain, for example: Although there had been some provisions for health care for the very poor in Britain since late in the nineteenth century, the universal National Health Service was established in 1948 by the then Labour Government. However, this act did not eliminate the private sector health services. The relative sizes of the NHS and the private sector have waxed and waned over the years since, depending on which of the main two British political parties happened to be in power. Since private health care is supported largely by private insurance we can use that as a rough indicator. When the NHS was established there was a precipitous drop in insurance subscriptions from about 10 million before the war to a mere 120,000 in 1950 (Iliffe, 1983).[18] In 1952 the Conservatives were returned to power. While they didn't rescind the NHS, they did make it clear that they favored the private system, and funding for the NHS reflected this bias. By 1960 insurance "subscriptions had reached 995,000, and by 1974, over 2 1/4 million people were covered by private health insurance" (Iliffe, 1983: 111).[19]

In more recent times, the Thatcher/Major Conservative governments had a determined policy to encourage the growth of the private health industry. They did this by, amongst other things, reduced funding to the NHS and by providing tax deductions to companies which paid for private insurance for their employees. Between 1979 and 1990 the number of people in Britain who had private insurance increased from 2.8 million to 5.4 million (Johnson, 1995).[20] Johnson also points out that "private medical insurance is mainly the preserve of the top two socioeconomic groups" (p. 25).[21]

This distinction would not be of other than passing interest if the *access* to treatment in the NHS had been improved, or even maintained. (Of course, if this had happened there wouldn't have been the motivation to get private insurance.) If we take waiting lists as a indicator, the claim that private hospitals will relieve the pressure on the public system is clearly not true. In 1974 the total number in Britain on medical waiting

lists was approximately 752,000. In 1994, after a significant number of people had transferred to the private system with no waiting lists, the number in the public system on waiting lists had increased to 1,070,000 (Mohan, 1995).[22] While it is commonly recognized that there are some error factors in waiting lists which make them less than precise, the gross differences between the public and private figures and the difference between the 1979 and 1990 figures cannot be so attributed. Following the lead of the Institute of Fiscal Studies (an independent economic institute in Britain) *The Economist* predicts that: "If the current target [for spending in the NHS] is observed, it must mean longer waiting lists, more delayed operations and tougher rationing."[23]

No one can be surprised by this chain of events. It is simply consistent with the standard politics of health care. When the affluent, and consequently politically powerful, are satisfied with their own level of medical care the motivation to support the public system is reduced. The fate of the less fortunate fade into the background. This is not just speculation. Researchers in Britain have found that this is exactly what happens (Besley, et al., 1996).[24] Two of their findings are relevant here:

a. Individuals who express dissatisfaction with the NHS are more likely to purchase private insurance.
b. The privately insured are less likely to favour increased spending on the NHS or to see health spending as a priority.

We can only conclude that in the normal course of political-economics, the introduction of private hospitals, followed by private health insurance, will eventually lead to decreased access to medical services by those lower on the economic ladder.

3. *A third claim that is often made in arguments for private medicine is that there is increased choice both for the doctor and the patient.*

Here again we must deal with ambiguity in the language that politicians use, either in ignorance or deliberately. The "choices" being spoken of can be of two kinds.

In the first instance, the center of this claim is that medical decisions will be made by the doctor and patient without the interference of the bureaucratic state. One has only to look at what is happening to in both the US and Britain to see the weakness in this claim. With the increasing costs of medical claims the private insurers in the US are getting increasingly involved in the treatment decision process. Often the procedure proposed by the doctor must be pre-approved by the insurer, and the patient's choice of doctor and hospital are restricted by her HMO. Increasingly large insurance companies are buying or starting HMOs themselves so that it is essentially the same party involved in

both restrictions. Larry Churchill projects an increasingly restrictive and expensive private system in the US. As he points out, insurance companies, in order to restrain rising costs and protect profits, are restricting treatments, increasing premiums and increasing deductibles (Churchill, 1994).[25] Daniels, et al. (1996) document these changes.

The current unseemly debate in the US congress about the need for a "Patient Bill Of Rights" is the predictable outcome of a system which has become increasingly focused on profits rather than patients (see also, "For Our Patients, Not for Profits" in the *Journal of the American Medical Association*, Dec. 3, 1997).[26] Similar events are taking place in Britain (Johnson, 1995).[27]

The second meaning of "increased choice" is one of values. The claim here is that the individual has the right and should be given the right to choose to spend her money on either a public or private medical service. This is an important claim that is often introduced in such a way as to be confounded with the first claim. This claim, when and if it is clearly made, is accompanied with the factual claims we have covered above. But most importantly it is supported by a certain value orientation — that of the libertarian. Most Canadians would reject the pure libertarian view when it is applied to our social programs, particularly medicare and education. Graves, et al. (1997) have provided an up to date and substantial study of Canadian values with respect to medicare. They sum up their work by saying:

> The public is highly concerned about the health care system and it may well be emerging as the defining issue for governments in the near future. People are proud of the existing system and see it as a source of collective values and national identity. They are worried about the future viability of the system and are resistant to many of the options/alternatives currently on the table. Cynicism about change is high and the public reject many of the premises for "reform". They believe cost problems are rooted in mismanagement and abuse and would prefer to see these dealt with first. Failing this solution, people prefer fueling the system with new public resources in order to preserve its integrity and core values.
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> The public will be resistant to a rational discourse on the costs issues because they are more likely to see these issues in terms of higher-order values. The evidence suggests that further dialogue will tilt the debate more to values than economics. The public will insist on inclusion and influence in this crucial debate and they will reject elite and expert authority.[28]

It is on the basis of the values that we share with the majority of other Canadians and the factual evidence which we have presented above that

The Friends of Medicare are strongly opposed to the establishment of any private hospital in Alberta, or anywhere else in Canada for that matter. The overwhelming factual evidence (and we have been able to provide only a small portion above) provides conclusive reasons for this opposition. Parallel private and public health systems have been tried elsewhere and almost universally have resulted in increased costs generally, and restricted access and diminished quality in the public system. Canadians want a high quality medical service, which is available to all, in equal measure, and not based on ability to pay.

Conclusion

There are problems with our health care system. But we firmly believe that allowing, or more to the point encouraging, privately financed treatment is not a viable solution to any of them. As Stoddart and Labelle have said:

> . . . it seems highly relevant to remind ourselves that greater public involvement has occurred over time in all health care systems precisely because of the failure of private mechanisms to achieve equity or efficiency (or both) in the delivery of health care, even though such mechanisms may produce and allocate other commodities in ways society finds acceptable. Therefore, commonly heard assertions to the effect that "there are problems in the health care sector because government is involved" demonstrate a dangerous ignorance of history as well as economics. The reverse statement would be more factual. (Stoddart and Labelle, 1985: 64)[29]

NOTES

1. G.L. Stoddart and R.J. Labelle, *Privatization in the Canadian Health Care System: Assertions, Evidence, Ideology and Options* (Ottawa: Health and Welfare Canada, 1985).
2. Ibid., p. 15.
3. S. Woolhandler and D.U. Himmelstein, "Costs of Care and Administration at the For-Profit and Other Hospitals in the United States," *New England Journal of Medicine* (March 13, 1997), pp. 769–774.
4. Ibid., p. 769.
5. S.H. Altman and D. Shactman, "Should We Worry About Hospitals' High Administrative Costs?" *New England Journal of Medicine* (March, 13, 1997), pp. 798–799.
6. Norman Johnson, " The United Kingdom." In N. Johnson, ed., *Private Markets in Health and Welfare* (Oxford: Berg Publishers, 1995).
7. L. Auer, et al., *Cost-Effectiveness of Canadian Health Care*, Research report (University of Ottawa, 1995).
8. S. Iliffe, *The NHS: A Picture of Health?* (Southampton: Camelot Press, 1983).

9. Auer, et al., 1995.
10. Ibid.
11. Ibid.
12. Paul K. Gorecki, *Controlling Drug Expenditures in Canada* (Economic Council of Canada and the Ontario Ministry of Health, 1992).
13. Raisa Deber, et al., "The Public-Private Mix in Health Care." In *Health Care Systems in Canada and Elsewhere*, in papers commissioned by the National Health Forum, Vol. 4, 1998, pp. 422–545.
14. Auer, et al., 1995, p. 30.
15. Larry R. Churchill, *Self-Interest and Universal Health Care: Why Well Insured Americans Should Support Coverage for Everyone* (Cambridge, Mass., Harvard University Press, 1994).
16. *The Economist* (May 3, 1997).
17. A.J. Culyer, *Health Care Expenditures in Canada: Myth and Reality; Past and Future* (Canadian Tax Foundation, 1988).
18. Iliffe, 1983.
19. Ibid., p. 111.
20. Johnson, 1995.
21. Ibid., p. 25.
22. John Mohan, *A National Health Service? The Restructuring of Health Care in Britain since 1979* (London: MacMillan, 1995).
23. *The Economist* (May 3, 1997).
24. Timothy Besley, John Hall and Ian Preston, *Private Health Insurance and the State of the NHS* (London: Institute for Fiscal Studies, 1996).
25. Churchhill, 1994; Norman Daniels, D.W. Light and R.L. Caplan, *Benchmarks of Fairness for Health Care Reform* (New York: Oxford University Press, 1996).
26. "For Our Patients, Not for Profits," *Journal of the American Medical Association* (Dec. 3, 1997).
27. Johnson, 1995.
28. Frank L. Graves, Patrick Beauchamp and David Herle, "Research on Canadian Values in Relation to Health and the Health Care System." In *Evidence and Information*, Vol. 5 of papers commissioned by the National Health Forum, 1997).
29. Stoddart and Labelle, 1985, p. 64.

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