been estimated that the annual cost to society per problem gambler ranges from $18,600 to $56,000.

The problem with VLTs in particular is their ubiquity. They are easily accessible, located in bars and restaurants throughout the province, and their accessibility contributes significantly to increasing the incidence of problem and pathological gambling. Black quotes L.L. Desjardins, Chairperson of the 1996 Manitoba Lottery Policy Review Working Group, as follows:

> I believe that VLTs are responsible for the majority of gambling problems in this province. They are referred to as the "crack cocaine of gambling." (p. 10)

This crack cocaine of gambling, Black argues, is no economic boon for Manitoba, despite the claims of the provincial Conservative government. On the contrary, it is a costly public health menace, adversely affecting the lives of tens of thousands of Manitobans — and disproportionately lower-income Manitobans — while producing no net economic benefit for the province as a whole. The CCPA-Mb. study concludes by calling for the elimination of VLT gambling in Manitoba.

NOTE

1. The study by Errol Black, *The VLT Controversy: Economic Boon or Public Health Menace? A Primer on Video Lottery Terminals*, is available from the CCPA-Mb. office. Phone: (204) 943-9962; fax (204) 943-9978; e-mail ccpamb@policyalternatives.ca.

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Alberta

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The most pressing social policy issue in Alberta today is a bill to give the Alberta Minister of Health the power to approve private, for-profit hospitals. Bill 37 was introduced in the Spring session but died on the Order Paper. However, the Klein Government appears set to reintroduce and pass this bill, thereby paving the way for private, for-profit hospitals. This is a *national* issue because, under NAFTA, approving one private, for-profit hospital in Alberta means that private, for-profit hospitals must be approved everywhere in Canada.

Three arguments are made to support private, for-profit hospitals. These arguments appear reasonable and are believed by some on purely ideological grounds, but systematic data do not support them.

1. *It is falsely claimed that private, for-profit hospitals are more efficient and more cost effective.* Two sets of data are relevant to this false claim:

a. *At the microlevel*: Private, for-profit hospitals are *not* more efficient and cost effective than public hospitals. Two of numerous studies demonstrating this fact are: Canadians Stoddart and Labelle (1985) demonstrated publicly financed and administered hospitals were more cost effective; and Woolhandler and Himmelstein (1997) found that US private, for-profit hospitals spent more on administration than US non-profits, and spent twice as much (25%) as Canadian hospitals (12%) on administration.

b. *At a macro level*: Private, for-profit hospitals increase the overall amount of money spent on hospital services if current service levels are maintained. The National Forum on Heath shows that increasing reliance on the private medical sector leads to increased overall costs. Comparing the US and Canada before and after Medicare was introduced (1971), shows our system, which provides universal coverage and a very high quality of service, is much less expensive than theirs, which provides only partial coverage. Evidence from all OECD countries shows that publicly funded and administered medical care is more cost effective than mixed public-private systems.

2. *It is falsely claimed that the addition of private hospitals to our system will reduce the pressure on our public system.* It is argued that as a nation we cannot afford to spend more on hospitals, but if those who can afford it pay for their own care in private for-profit hospitals, the pressure on the public system and waiting lists will be reduced. This argument has two major flaws:

   a. If the wealthy paid for their own care from private, for-profit hospitals and current funding to the public system was maintained to reduce waiting lists and improve services, then a larger, not smaller, proportion of the total economy would go to hospital care. If funding for the public system is not maintained, it deteriorates, as the NHS has in Britain.

   b. When the well-to-do get their care from private hospitals, either paid by themselves or by employer-supplied insurance, they are loath to pay taxes to support a public system they no longer use. The US and Britain illustrate this political/economic truism.

3. *It is falsely claimed that private, for-profit hospitals will increase choice for both physicians and patients.* Two kinds of choices are spoken of:

   a. *Medical choices*: In both Britain and the US insurance companies and HMOs are severely limiting the choices of physicians and patients. The US Congress is debating a "Patients' Bill of Rights" to protect against a system increasingly focussed on profits rather than patients. Not only have individual middle-class Americans lost "choice", but they have lost any chance to control the quality of care they receive.

b. *Values choices*: The claim is that the individuals have the right to choose either public or self-funded private hospitals. The liberty of the individual should not be constrained by the collective good. However, affluent Canadians already have the *liberty* to buy private hospital care in the US or Britain. Therefore, we don't need a two-tiered system in Canada to satisfy the *libertarian* ideal.

The Values study of the National Forum on Health found most Canadians favour social justice choices that enhance the good of the community as a whole. Recent data indicate only one in ten Canadians favour a two-tiered system. Unfortunately, many of that one-tenth of Canadians favouring a two-tiered appear to be in the Klein Government cabinet and caucus. Therefore it is very important that everyone who cares about our current system become active in stopping this potential destruction of our medical/hospital care system.

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