

# Public Private Debate

---

Whether the health care delivery system should be public or private or a mix in terms of funding and delivery was a hotly debated topic throughout the Conversation on Health. There was no consensus on this matter, but participants strongly urged the Government to provide an avenue to continue the discussion and provide more information on the *status quo*. The following is an illustration of the Conversation on Health's *Public Private Debate*.

## International Models of Public and Private Delivery

Participants looked at models of health care funding and service delivery around the world. In the end, there was no consensus on which models could be copied and which to avoid. Many participants looked to European models of service delivery for replication in British Columbia. Mixed systems of public and private delivery (not funding) were often described as more efficient in terms of their ability to treat patients quickly. Others warned that it is impossible to review these systems effectively without looking at the other aspects of that social infrastructure which support people's health. The system in the United Kingdom received opposing reviews in terms of its efficiency and ability to serve all of its citizens.

While, for the most part, the American system came up short in terms of its ability to provide adequate health care services to all of its citizens, a number of participants wrote in to describe their positive experiences within that system. Those participants challenged us to consider which aspects of the American system may be worth studying.

The Conversation on Health also looked to Australia, New Zealand and Asia for examples of health care delivery models. Most of those systems include some aspect of private funding or delivery, to varying degrees of success, according to the participants.

Participants concluded that it helps to look at other models of delivery, but we need to be careful about trying to replicate those systems without due consideration for the other factors that may contribute to its success.

## Public Models of Delivery and Funding

Participants, for the most part, believe that the public model of funding health care represents a fundamental Canadian value. Participants were divided on whether or not this must also be a public model of delivery, a mixed model, or a private model. Some argued that the focus on public health care is one of political ideology which has resulted in deterioration in the quality of care for all British Columbians. Others argued that this deterioration, if it exists, is a result of political decisions to reduce funding and support for the public system, allowing the private system to make inroads. These same participants suggested that an increase in funding, services, and facilities would resolve these problems within the public system without the need to resort to a private sector system of funding or delivery.

Many British Columbians supported the principle of a purely public system, but argued that there is not enough public money to support it, and that the only choice is to allow some private funding and delivery to take the load off of the public system. Others contended that it is premature to look to private options when positive public examples of improved services and efficiencies exist.

## Private Models of Delivery and Funding

Among those who supported private models of funding and delivery are those who argued that there is an inherent motivation to attract patients through improved patient care in a private model. Their view is that competition is what drives improvements and efficiencies.

Those who argued against private delivery and funding suggested that it is the profit motive, not patient care, which is the key business driver in this model, and is therefore sure to undermine patient interests over time.

Few participants argued in favour of a purely private system of both delivery and funding.

## Mixed Public and Private Models of Delivery and Funding

The vast majority of those advocating for some involvement of the private sector in health care delivery or funding wished to pursue a mixed model. Most preferred a mixed model of delivery, while maintaining a single public payor. Many participants were concerned that there has been no good debate or informed discussion about this issue. A number of participants believe that the issue is universal health care, not whether the health care is delivered by public or private entities. Others argued that universal health care requires public delivery in order to keep profit out of the system and manage costs more effectively.

Once the idea of new payors was introduced (that is, the ability to pay for medical services if you have the means), then the debate became significantly more impassioned. Those who argued against a mix of payors said this will lead to two health care systems, one for the rich and one for the poor. They believe the best health care professionals will then move to the for-profit system to gain better wages, the for-profit system will have better equipment and better hours, and wealthy British Columbians will inevitably receive better care. Many participants also argued that the private sector interests would take the simplest patients and leave the complex patients to the public system, thus increasing their profit margin and increasing the costs of treating patients in the public system.

Those who supported some mix of payment systems do not believe that these are consequences of a two-payor system, and suggested ways of mitigating these possibilities, for example, requiring that health professionals practice in both systems, and that equipment be similarly shared. Those who advocated for the ability to pay for services argued that this will relieve the burden on the public system, reduce wait-lists and focus the public funding and system on those who cannot pay. These same participants also argued that this is a question of freedom of choice, that is, the ability to choose to spend their money on medical services they need. Those medical services, they argue, could be made available through a mixed public-private system.

What this debate brings into focus is a conflict of values as well as a debate on the merits of the system. For those advocating for a public system (both funding and delivery), the essential value is universality and equality of access: all British Columbians receive the same care regardless of their financial means. For those advocating for some mix of private care in the system, the essential value is freedom of choice: the ability to choose providers and services and pay for those services if they so choose. It is for this reason, that there are fundamental values at issue, that the debate has been so fractious throughout the Conversation on Health.

While participants could not come to a consensus, many did demand more information: more information about the current system, how it operates, how it is funded, and who practices in it. They also demanded more information about other systems, such as the European examples. Finally, most participants wanted to continue the debate, although for some the debate is over and they believe system should include no more private funding or delivery mechanisms than it already does.

*Access to quality care is more important than who is delivering it.*

- Health Professionals Focus Group, Cranbrook

*To me, the key is to permit private facilities to compete with public facilities within a defined framework and within the provincial medical system. This will force the private facilities to prove they can compete effectively with the public facilities and it will force the public facilities to become more cost-effective.*

- Email

*In fact, the more that healthcare is a mix of public and private and profit and non-profit, costs tend to be higher when you have a higher proportion that is not government funded, and costs tend to be higher when they're delivered through for-profit care. The other thing that happens when you do this, of course, is that you increase inequity and you tend to fragment the system because you no longer have a single payer and all the administrative efficiencies there. You're purchasing power is diffused and all the other consequences which you know about. We do know pretty definitively that administrative costs are lower in single payer systems.*

- International Symposium, Vancouver

*[There is] insufficient education of the pros and cons of private versus public systems. [It is an] emotional issue between supporters of the public or the private stance.*

- Health Professional Forum, North Vancouver

## Public-Private Partnerships

Another focus of debate was around public-private partnerships and their utility in the system. Detractors pointed out that there is no evidence these partnerships save money in the long-term, and suggested that there is ample evidence that the projects fail to deliver public benefit or savings. A concern raised frequently by participants was that public-private partnerships have no clear accountability to the people of British Columbia and without this accountability they cannot properly serve the health care system. Some participants argued that there should be more investigation into partnerships with other public or non-profit entities before turning to the private for-profit sector for partnerships.

Those participants who spoke in favour of public-private partnerships argued that the private sector maximizes profit by finding efficiencies, which would by necessity force innovation and improved business processes into the health care system.

## Conclusion

While the vast majority of those in attendance at the forums were in support of the continuation of public health care in British Columbia, this same level of support was not as clear through the other avenues of input in the Conversation on Health. The debate between those in support of some element of private sector involvement in health care delivery and those who suggested a fully public delivery model and funding system continues to be fractious. While the Conversation on Health has managed to elevate this debate to some extent, it is fair to say that the debate among British Columbians around both the existing model of health care delivery, and new models (whether fully public or some combination of public and private) is still in its infancy.

# Public Private Debate

---

This chapter includes the following topics:

**International Models of Public and Private Delivery**

**Public Models of Delivery and Funding**

**Private Models of Delivery and Funding**

**Mixed Public and Private Models of Delivery and Funding**

**Public-Private Partnerships**

## Related Electronic Written Submissions

[Four Initiatives for Healthcare Change in BC](#)

Submitted by Cogentis Health Group

[Is BC's Health Care System sustainable?](#)

Submitted by the Canadian Centre for Policy Alternatives

[Physicians Speak Up](#)

Submitted by the British Columbia Medical Association

[Why Wait? Public Solutions to Cure Surgical Waitlists](#)

Submitted by Canadian Centre for Policy Alternatives

[Saving Medicare Policy Brief](#)

Submitted by the Canadian Independent Medical Clinics Association

[Sunshine Coast Conversations on Health](#)

Submitted by the Women's Health Advisory Network, the Sunshine Coast Hospital and Health Care Auxiliary and the Seniors Network Advisory Group

[HEU Submission to BC's Conversation on Health](#)

Submitted by the Hospital Employees' Union

[A Written Submission to the BC Conversation on Health](#)

Submitted by the UBC Centre for Health Services and Policy Research

[Conversation on Health: My Views](#)

Submitted by Nancy Kenyon

[Submission to the Conversation on Health](#)

Submitted by the BC Cancer Agency

[Submission to the British Columbia Conversation on Health](#)

Submitted by Life Sciences British Columbia

[Submission to the Conversation on Health](#)

Submitted by the British Columbia Government and Service Employees' Union

[Submission to the Conversation on Health](#)

Submitted by the BC Nurses' Union

A Vision for Better Health

Submitted by the British Columbia Dental Association

Recommendations for Improvements to Healthcare Services for Seniors

Submitted by Mary McDougall

## Related Chapters

Many of the topics discussed by participants in the Conversation on Health overlap; additional feedback related to this theme may be found in other chapters including: [Health Care Models](#); [Training](#); [Rural Health Care](#); [Health Human Resources](#); [Innovation and Efficiency](#); [Health Spending and Morale](#).

## International Models of Public and Private Delivery

### Comments and Concerns

[European Systems](#)

[American System](#)

[Asia-Pacific Systems](#)

[United Kingdom System](#)

[General Comments on International Experiences](#)

- [Comments on European systems:](#)

- We need to look at European systems, which have universal access and a mix of public-private delivery to varying degrees.
- I like the health care system in Switzerland where basic health care is purchased by citizens and where health insurance is not controlled by the government but by consumers.
- The European tour report describes the Swedish system as a successful mix of public and private systems, and that this is an accepted reality. In fact, in January 2006, the Swedish Government legislated an end to the creation of any further privatization of health care and rejected the notion of grafting for-profit onto the public system. A statement from the relevant Ministry says that Swedish health and medical services should continue to be democratically controlled, provided on equal terms and according to need. This sounds like an endorsement of Medicare, not of privatization.

- It is difficult for me to understand the hostility towards a private health care system side by side a universal one. I come from Germany where those two systems have been practiced very successfully for many years. There are no waiting lists and people in the public system have quick access to all kinds of operations and treatments. I have to admit that the citizens of Germany pay a lot more into their health care insurance and they are willing to do so. One cannot expect a Rolls Royce if you only want to pay for a Datsun.
- The mixed German system tried to get patients in and out as soon as possible. There was little or no follow up for the patients and the burden of follow-up was on the public system.
- Perhaps there is something in the Italian San Patrignano model of social co-operatives that can bridge the divide between the private and public health-care dichotomy, to contribute to the sustainability of the health care system.
- When looking at the complete picture of the European model one can observe that their entire social system affects health care outcomes. For instance, poverty is addressed as well as old age and prevention. Social issues have a huge effect on the cost of health care delivery so to pick and choose parts out of the model is a mistake.
- In Scandinavian countries, you have to factor in the small wage gap between lowest and highest income earners. If a high and equitable standard of living and quality of life was valued in Canada in the same way as it is in Scandinavia, then privatizing services would not prevent people from accessing them.
- A large body of evidence has emerged over the last 15 years from a long and still growing series of European studies regarding the distribution of financial burdens and care use in different member states of the European Community. These studies indicate that equity in care use (defined as equal access for equal need) is better achieved in systems that have greater equity in financing. Less reliance on out-of-pocket payment, which is the principal determinant of regressivity of financial burdens, is associated with greater equity of access. Inequitable financing systems generate inequity of access, which is certainly intuitively plausible. In principle these two dimensions of equity could be separated, but in practice they are not.
- If a privately owned clinic in Sweden can offer services 24/7, supplying physicians, nurses, family medicine and specialists as well as a wide range of diagnostic, treatment and prevention services, then why can not publicly funded clinics in British Columbia do the same?



- Those German citizens that can afford to pay for medical services pay for them. This has allowed the long queues for medical help to lessen. The Canadian Government seems to think that if you speak about private health care then we have to follow the American model. Yet Americans admit their system does not work as there are 50 million people in the United States with no medical insurance. I think we could easily adapt to one of the European systems.
- [Comments on the American system:](#)
  - There is no evidence that private health care is more efficient than a public system. The very expensive American private system seems to indicate that private is far more expensive and that it discriminates on the basis of income. I do not see these as desirable characteristics in a health care system.
  - There are some important advantages to the American system for the insured population. These include more timely effective care than in Canada and much more attention paid to innovation and client interests. The American system is much more responsive to demand than the Canadian system, as the United States ranked first in responsiveness in a World Health Organization study. So we can learn something from the American system, but it is a costly hodge-podge of public and private care and is not an attractive model.
  - The United States has a very quick patient care and delivery system that is 100 per cent run privately and spends twice as much as Canada per capita, yet the life expectancy is shorter than that of Canada and people go bankrupt if they don't carry critical illness insurance.
  - Health in Canada, on average, is superior to the care people receive in places such as the United States, where private services are the norm. While we do not have the whizz-bang service that the wealthy Americans receive, the average Canadian receives far better care than the average American at a lower cost per capita.
  - The scare tactics used by some people when they reference the American system in a discussion about health care is simply a mechanism of fear and a resistance to change. While it is true that many Americans have no health care, those who are covered have excellent, state-of-the-art care. Canada has a unique opportunity to combine the best of the American system with the established national care system to develop a system that could lead the world.
  - The Mayo Clinic in America ends up being less expensive to patients' than St. Michael's in Canada.
  - United States has more uninsured citizens than the entire population of Canada. People are forced to declare bankruptcy therefore losing their possessions and homes in order to pay for procedures.

- **Comments on Asia-Pacific systems:**
  - Australasia has a private health care system that is very tightly regulated so that it does not eat away at the public system.
  - In the Australian choice-based system, doctors are required to spend time in both the public and private systems. This ensures access to the best of physicians in both systems.
  - Australia's system incorporates some sort of two-tier system for which some higher-income people willingly pay a surcharge for. This takes stress off the free component for the majority.
  - We need a two-tiered system. Most of us have extended health through companies we work for or have worked for. For not much more money something could be worked out that those who can afford to pay an extra premium per month can use a private system. Or set up private medical insurance so if someone needs hospitalisation or surgery it would be covered. This would allow Joe Average to have private health care without having to pay thousands of dollars for it. I was hospitalized in New Zealand where there were no waits, I had my own private room and bathroom, and a menu was offered for my food choices as well as a glass of wine. How civilized.
  - Australia has a universal system of health insurance with a mixed public and private system. Primary health care services are fragmented, as they are delivered through a number of different services. The two mainstream or non-Indigenous funding schemes responsible for the support of the primary health care system are the Medical Benefits scheme, which provides subsidy to general practice, and the Pharmaceutical Benefits scheme, which provides a subsidy for our pharmaceuticals.
  - The benefits provided by social insurance in Japan, Korea and Taiwan differ. For instance, both Japan and Taiwan cover dental care, but only Taiwan covers Chinese medicine. In Taiwan, benefits are much more restrictive and providers will often provide services that are not on the public schedule. As a result, prices are unregulated and providers can charge exorbitant costs that patients bear directly. There is very little private insurance that would cover co-payments or full payment of uncovered services.
  - In Japan, Korea and Taiwan, service provision is dominated by the private sector and patients are free to choose among providers so there is very little gate-keeping within any of these systems. Patients will simply self-refer as they see fit to any provider. So you can go to a specialist or a general practitioner or straight to a hospital without any need for a referral. This, of course, has implications for

the provider landscape. In Japan, for example, hospitals have very large out-patient departments that often provide quite simple primary care, while a third of doctors' clinics in Japan have in-patient beds and provide specialist services that other countries like Canada or New Zealand or England might only be provided in hospitals.

- Health care provision in Singapore is mixed. Around 75 per cent of admissions are in public hospitals and about 20 per cent of primary care doctor visits are publicly funded. In Singapore, public hospitals were corporatized in the 1980's and the lesson here, for those interested in corporate structures, is that it was not necessarily a fruitful innovation.
- **Comments on the United Kingdom system:**
  - The National Health Service (United Kingdom) has been turned into a chaotic, inefficient system, facing a \$1.6 billion deficit since moves towards privatization were made. Administrative costs have risen from eight per cent of the budget to 22 per cent.
  - In Great Britain, activity-based funding was initiated and private clinics were introduced to compete with the public facilities. The private clinics even received subsidies; of course, they took the simplest patients and left those with high risk and multiple problems to the public facilities. According to a report, administrative costs have increased and the number of National Health Service managers has risen three times as fast as the number of clinical staff, doctors and nurses. Between 2000 and 2007, National Health Service spending increased by 20 billion pounds, a 40 per cent rise. Some hospitals have been unable to compete and face the possibility of bankruptcy and closure.
  - The recently established for-profit surgery clinics in the United Kingdom that are called Independent Sector Treatment Centres (ISTCs) have had problems with less safe care. In a House of Commons Health Committee report, both the Royal College of Surgeons and the British Medical Association voiced concerns about the quality of care received in these centres. In addition, a survey by the British Medical Association of clinical directors in the National Health Service (NHS) who work in orthopaedics, ophthalmology and anaesthetics, reported that two thirds of the patients had returned to the National Health Service for after-care with higher readmission rates from the for-profit Independent Sector Treatment Centres than from National Health Service-run clinics.
  - I was a believer in a two-tier health system until I had a chance to experience it first hand at a hospital in England. I had a multiple fracture and through a mix-up with my travel insurance, ended up being treated not as a private patient, but

courtesy of Britain's national health system. While I lay with my leg in several pieces, I waited for three days for a surgery space to open up. In that time, anyone with private insurance that came in was provided with immediate service, regardless of the severity of their injuries.

- **General comments on international experiences:**

- A parallel public private system would not only expand supply (the quantity of care), but it would also offer competition to public sector hospitals in terms of the efficiency of production and quality of care. Competition also applies to physicians and if they were free to compete, then they would enjoy improved incentives to attract patients with effective care and to provide that care as efficiently as possible. The *Chaoulli* case in Quebec is a welcome step in the direction of sanity, quality and sustainability. Should the public and private sectors be solitudes with a fence between them? Obviously, rules for physicians working in both sectors would be necessary, but there is no reason why Canada cannot emulate the example of Sweden, Australia, Austria, Belgium, France, Germany, Japan, Luxembourg and Switzerland by permitting private health care providers to compete directly with public sector hospitals for services paid to government under a universal system.
- In South Africa, there is a government system and a private system. The private insurance provides better doctors and health care. Most seniors cannot afford the private insurance option and end up waiting in line-ups for hours on end.
- It makes no rational sense that Canada along with Cuba and North Korea are the only countries in the world that don't allow private health care to co-exist with publicly funded health care. In countries that are more socialist than we, this is the norm and efficient delivery of services is a reality.
- Australia, New Zealand and the United Kingdom have similar systems and allow for some degree of private delivery.
- The international experience with private surgical facilities is that they tend to charge higher prices for the same surgery in a publicly-funded hospital.
- In the Israeli system, doctors work 80 per cent of their time in the public system and 20 per cent in the private system.

## Ideas and Suggestions

[European Systems](#)

[American System](#)

[Asia-Pacific Systems](#)

[General Comments on International Experiences](#)

- [Ideas about European systems:](#)
  - Implement a public-private system as they do in Europe. These provide an opportunity to reduce waitlists. Take pieces of different international systems to make something workable for British Columbia.
  - Open more centres and outsource these to private companies using the Swedish model.
  - Even the nurses' unions in Sweden were asking for reforms that allowed a private system to be more vibrant because it allowed their workers to have more jobs.
  - Check out Norway's system: multi-tiered publicly funded with private delivery. People are happier, there is more quality, and it does not need to be a for-profit private system.
- [Ideas about the American system:](#)
  - Implement a regulatory regime to prevent the American model.
- [Ideas about Asia-Pacific systems:](#)
  - Private sector delivery has been shown to work in the East Asian context, but it requires careful government involvement and development to ensure that there is affordability, equitability and equity. Perhaps the most promising insight from East Asia is in primary care with the advanced services delivered in community settings.
- [General ideas on international experiences](#)
  - Do hospitals need to be owned privately or publicly? Look to other jurisdictions and use what is working. Emulate those pieces that are working.

# Public Models of Delivery and Funding

## Comments and Concerns

[Values](#)

[Cost and Efficiencies](#)

[Assessment](#)

[Choice and Coverage](#)

[Health Human Resources](#)

- **Comments on values:**

- I am a tremendous admirer of Tommy Douglas and his goal to maintain the public health system.
- Some say the debate regarding public versus private health care is simply an ideological one. And in one sense it is. Really, do we want to look at everything, including the care we need when we are vulnerable or ill as a commodity available to the highest bidder? Or do we want to continue to promote and expand our brand of universal health care that has defined us worldwide as a country that puts common good and fairness above profits for a few?
- Health care is a public service paid for out of public funds.
- Canada has an excellent model of socialized medicine.
- What the Supreme Court of Canada says in the *Chaoulli* case is, if the government, the state or the legislature wishes to prohibit people from using their own resources to protect their health, then the government has to ensure that services are available in a reasonably timely way; in a manner or in a standard determined by medical experts, not by judges, or the system is a violation of right to life and a violation of the right to security of the person.
- The Supreme Court of Canada in *Chaoulli* was quite clear in saying that there is no right for the government to pay for your health care, whether it is in a hospital or any other setting. What *Chaoulli* was concerned with were prohibitions on the individual citizen's right to utilize their own resources. I think the broader principle that is established in *Chaoulli* could be described as one of patient accountability, where patients now have the right to demand accountability and be seen at the center of the health care system, and that their needs must be taken into account. And when I say accountability, there is a legal accountability. There is the opportunity for patients now to say that if you do not provide me that service in a timely way, either you are going to have to provide that through the public system, or you are going to have to allow the development of some other parallel or supplementary form of private health insurance.

- Political ideology is interfering with public health care delivery and has caused a deterioration of quality of health care.
- Public care is a cornerstone of British Columbia and it should be funded on a needs-based system.
- No one should be denied basic health care on an ability to pay, but neither on government's inability to deliver.
- Keep the health system public and accessible to all with no user fees. We do not charge for a visit by the fire truck: fire protection is funded for all and does not depend on ability to pay.
- All of health care, including prevention cure and management, should be publicly funded and managed. Nothing should be delivered privately.
- Medicare is a Canadian value.
- Canadians remain firmly committed to universal health care, but believe that substantive changes are urgently needed to reduce wait times and improve quality. There is also broad support for additional home care services and a national PharmaCare program. Backing up this demand for reform of public health services is the overwhelming agreement among the public that increased spending on health care, from both levels of government, is necessary.
- **Comments on cost and efficiencies:**
  - While it is ideal to have an all public system, it is not realistic because there is not enough money in the public system.
  - Ineffective use of public resources is opening the door to two-tier health care.
  - The public delivery system delivers better long-term health outcomes, and is more respectful to patients and health care workers.
  - Introduce more public facilities as per the Romanow report.
  - The erosion of public services is due to increased demand.
  - The optimum foundation for sustainability for our health care system is good health, and for this we must invest more in a properly functioning public health care system.
  - If you reduce demand in the public system without removing resources, then we will be able to save our public system.

- It is utterly absurd to claim that Canada, one of the wealthiest countries in the world, cannot afford universal public health care for its citizens. It may be true that a percentage of government revenue costs are going up, but that is because government revenues have been in relative decline through tax cuts and the like.
  - It is clear that the government message regarding the lack of sustainability in the public system and need to privatize public health care did not resonate with British Columbians. What did emerge were lots of ideas and suggestions about how to improve public health service delivery and access.
  - Less invasive surgeries can be performed on a day-surgery basis, and do not require all of the overhead associated with a hospital. Private clinics have sprung up, such as the Cambie Surgery Clinic, along with much rhetoric about how much more efficient private clinics are. However, as experience in Alberta suggests, specialized day surgery clinics may make good financial sense, but the same efficiencies and cost savings can also be realized in the public sector, rather than private surgery clinics.
  - If public hospitals are allowed to be innovative and flexible they have proven they can be more cost effective than private.
- [Comments on assessment:](#)
    - Our public health care system is the envy of Americans and Europeans. Keep it public.
    - There is a groundswell of public support for publicly funded health care.
    - The present system is more efficient than a for-profit system.
    - The public system is not working for everyone. Operating room time for doctors is not well provided or organised, which is frustrating for doctors and patients.
    - Why should our laws be allowed to sentence people to never walk again, see again or die because the public health care system cannot provide the health care needed?
    - The reality is that Medicare, Canada's publicly funded and delivered model, costs less and delivers better health outcomes. Many peer-reviewed sources validate this reality.
    - Challenges with public health care include: approximately two million Canadians are on health care wait-lists (92 per cent increase from 1993) and 50 per cent of children wait a medically unacceptable length of time; health care spending is unsustainable; and nearly 45 per cent of provincial budgets are spent on health care and climbing. Under pressure to maintain sustainability, provinces are



rationing health care services by restricting access to facilities, physicians, devices, pharmaceuticals and biologics.

- The health care system can adopt and implement any surgery or procedure cheaper or faster when in public hands.
- Does the private sector do things better, cheaper and more effectively in health care as well as in manufacturing? Well, here is what Harvard Medical Professor Emeritus and Editor in Chief of the New England Journal of Medicine told a Senate committee studying health care: "I have lived my whole career asking: what is the evidence? What are the facts? The facts are that no one has ever shown in fair, accurate comparisons that for-profit makes a greater efficiency or better quality, and certainly no one has ever shown that it serves the public interest better, never."
- Private systems depend on making profit. This motivation does not work for services such as health and education. A well-off nation such as Canada, and a rich province like British Columbia, needs to fund wellness for all. The better off must subsidize health care for those less well off.
- Canada trails the world in health care delivery: Canada's health care system is rated 30th in a World Health Organization survey; Canada is one of the top three countries in health care costs; and Canada is near bottom in access to new technology. Most developed countries, such as France, Germany and Britain, provide universal health care systems complemented by private sector options. The World Health Organization's top six ranked countries have no wait lists and spend less.
- **Comments on choice and coverage:**
  - Let the rich travel abroad for their health care as most of them have dual citizenships anyway.
  - The current system does not allow freedom of choice.
  - The public system can provide a focus on prevention and wellness.
  - The wealthy are paying to get service.
  - Should it not be all public but public coverage should be defined and transparent?
- **Comments on health human resources:**
  - Community health workers want to work in the public system.

- While most physicians would prefer to remain in private practice, at least some would welcome the opportunity to work as medical health officers in a provincially-funded wellness centre where they did not have to shoulder the cost of setting up an office of their own.
- The supply of human resources and the length of waiting lists are very real issues. But they are issues that have been, or should have been, obvious for years. Time, attention and energy that might have been devoted to working out solutions have instead been squandered in public-private arguments. Turf protection by professional associations has been allowed to block efforts to find genuine solutions through streamlining surgical through-puts, re-structuring primary care, or rationalizing nursing education. Nearly 20 years ago, the British Columbia Royal Commission on Health Care and Costs declared bluntly that the health care system needed more management, not more money. But the echo came back, then as now: more money. And calls for more private money links the interests of providers with those of the healthy and wealthy.

## **Ideas and Suggestions**

### Values

### Cost and Efficiencies

### Assessment

### Choice and Coverage

### Health Human Resources

- **Ideas about values:**
  - We are at a key turning point in Medicare's history. Developing strategies for reforming rather than privatizing our public health services is critical to ensuring the long-term sustainability of our public system.
  - We need to define what public health care is and how we utilize our resources (people and money).
  - Everybody is entitled to equal health care, whether they can afford it or not.
  - We need a publicly funded, accountable health care system.
  - Continue to improve and support universal health care that does not discriminate against anyone from receiving the best medical care and services possible.
  - Equal access to health care for all British Columbians.
  - Work harder to put health interests above those of big business.

- The majority of people want a public system so our leadership needs to protect the public good.
- Get more competition in our system. Today you just have to take the doctor you are given.
- **Ideas about cost and efficiencies:**
  - Support a fully-funded, wisely-managed public health care system that encourages preventative measures, focuses on education, has long-term planning and includes better use of other health professionals for more cost-effective use of health care dollars.
  - The public system needs more financial accountability.
  - Invest in and improve public health care so that all are cared for.
  - There should be public partnerships and collaboration in program and service delivery planning within the public system.
  - Health care should be run on sound business principles.
  - Control costs by not going private: invest public money now for future returns and avoid two-tiered, income-based health care.
- **Ideas about assessment:**
  - Ensure open and transparent public ownership and delivery.
  - Make the system more efficient while protecting the universality of our public health system.
  - Universal health care should remain publicly-funded because that is the most effective, efficient and affordable way to deliver health care.
  - We need more accountability in the publicly funded system. To make the system accountable, an independent agency could randomly select patients and follow them throughout their hospitalization. A data collection system could be implemented to not only follow mortality or accidental injury but to subjectively document patient and family satisfaction and impressions. If we truly want a better system, we must have knowledge of where to focus the improvement and not simply a strategy where accreditation signs off on all responsibility and everything else only comes to light with accidental diagnosis or demise of a loved one. We do not want a system that employs lawyers to encourage transparency; we need the public system to be more transparent.

- **Ideas about choice and coverage:**
  - Fully fund and establish public community health care clinics.
  - Support public health care in funding and delivery.
  - Improve the public delivery system through specialized public clinics, expansion of multidisciplinary health care teams and an expanded role for health care providers.
  - Chronic issues and procedures should be done by the public system, which is best suited for this work.
  - Create publicly-funded, publicly-delivered surgery centers and use operating rooms in hospitals to full capacity.
  - Keep health care public and include new improved technology in publicly funded health care (such as renal dialysis).
- **Ideas about health human resources:**
  - Pressures can be alleviated by better management and administration and by implementing recommended efficiencies within the public system.
  - The public system needs to recognize performance and ability and reward those qualities.

## **Private Models of Delivery and Funding**

### **Comments and Concerns**

[Values](#)

[Cost and Efficiencies](#)

[Assessment](#)

[Choice and Coverage](#)

[Health Human Resources](#)

- **Comments on values:**
  - Once health care is privatized there are two groups that receive care: the rich and the poor. The rich because they can afford it, and the poor because the government subsidizes them. It is the middle class who will do without.
  - What private financing mechanisms actually do, as compared with public financing, is redistribute the burden of payment from higher to lower income individuals, and from the healthy to the sick. At the same time, they improve the

relative access of those with higher incomes. This in itself is sufficient explanation for the continuing advocacy of more private financing, which tends to come predominantly from organizations representing upper-income groups. But these conflicting economic interests tend to be paralleled by differences in ideology or values.

- I want my health care provider to be primarily concerned with my health care and not considering which post-operative medication will make them more money or which procedure will give them the most money for the least effort.
- The accumulated evidence makes it clear. The interminable public-private debate arises from conflicts of ideology and economic interest, conflicts that are real and permanent, and so cannot be resolved by the accumulation of fact or the refinement of argument. Private financing mechanisms do not result in more appropriate patterns of care use, and private delivery systems do not yield more efficient or more effective care. There is evidence on both counts and it is negative.
- Private can work well, but it is ideologically different from public health care. It will have good customer base and will work well and does not need any public funding.
- The private system does not have incentive to reduce illness.
- Canada is the only industrialized country that does not permit private insurance for medical services. The Lowest Common Denominator approach to health care is not necessary.
- There is no private system to fall back on if public system fails you.
- Large systems need renewal.
- Under-funding of the public system has created the crisis.
- The goal of private companies is to make money. This is accomplished by charging more or providing less.
- There are no controls or accountability in a public system. The private system has to make it work, while the public often is not motivated.
- Are we waiting for the public system to deteriorate so the private option looks good?
- The developmentally challenged and special needs community, often with a life-long dependence on health care, do not fit into a business model or a private style health care system. There is not a lot of interest in that aspect of health care because there is not a lot of profit to be made of the poor.

- There is not a lot of money to be made in remote communities so the for-profit and business interests do not look to remote communities as a way to get involved in the health care system.
- I do not see people lining up looking for ways to provide health care to the mentally ill as a for-profit model.
- I see that we are split along lines of those who have means and those who do not. Those who have the means see all kinds of logic in a business model, in a fee-for-service or a two-tiered or private model.
- There is an apparent conspiracy among physicians to move towards a private system.
- We need to get the laws of supply and demand working for us with more competition and less monopoly.
- Keep health care public. Our per capita costs are much lower than in the United States and we all have access.
- Sometimes for profit health care is not provided with the best interests of the patient in mind.
- The profit from health care should be public money. Public health care should not be allowed to suffer under any public-private partnership because the business model is short-term thinking. The public model is long-term thinking.
- The drive to private care is coming from international agreements which are threatening the public system.
- Every dollar given to private for-profit health care means one less dollar for public care. It allows the wealthy to queue jump and means that everyone else waits longer for needed care.
- A profit-based system increases quality, and attracts more investment and human resources because of improved quality of services.
- For-profit owners are in it for the money, not for the good of the patient.
- The public is not fairly educated as they only get sound bites. There are too many mixed messages.
- Preventative dentistry is an example of the private sector promoting healthy choices, which is also a pay system.
- Private health care cannot deliver the quality of service equal to the public system due to profit motive.
- The private system is good if you have the money.

- The big American corporations are pushing very hard for privatization so they can rip us all off and too many politicians are listening.
- **Comments on cost and efficiencies:**
  - If we can prove through economic evidence that the private system can do it better and cheaper than the public system, then we will consider a role for the private system.
  - In a public operating room, all the tools needed for a surgery are prepped and opened, even if they are not necessarily single use tools. This would not occur in a cost-monitoring private surgery facility.
  - If health care is expensive now, why would you privatize it and immediately increase costs by at least 20 to 30 per cent to cover higher administrative costs and profit?
  - Private systems include additional costs such as advertising.
  - Private clinics and hospitals have to use an activity-based model to keep track of costs. They can use private capital to invest in equipment and extra frills that public hospitals lack and then charge a premium for each element of care to make profit. They can pay specialists more.
  - That the private hospital may actually make a profit seems to bother some people. If their operators can do so, then more power to them. There are ways of making a business more efficient other than by cutting corners. Could it be that the public institutions are still going around corners that should have been eliminated long ago?
  - It is interesting to note that British Columbia increased private sector spending by 48 per cent from 2001 to 2006. As a result, British Columbia now ranks fourth in private spending in comparison to the other provinces and territories, up from seventh in 2001. In contrast, British Columbia slipped from sixth to ninth position in per capita health expenditures between 2001 and 2006 compared to other provinces and territories. This is despite the fact that the economy in British Columbia performed better than most other provinces. This suggests that there may be some potential to increase public spending on health.
  - Owners of private, freestanding surgical clinics argue that the profit motive encourages a more efficient and lower cost supply of surgical services. But here the evidence is at best inconclusive. The problem is that private facilities tend to provide a limited range of services to generally healthy patients. A for-profit facility has incentive to select the patients that are most profitable. They avoid the

more complex and expensive cases, elderly patients with multiple co-morbidities, and leave these to public hospitals.

- The public system does not seem to know the costs of doing things.
- It seems illogical that you cannot purchase services.
- Private care depends on the quality of monitoring and oversight as well as managing need and access.
- For people who can afford to pay for private services, it works.
- Privatizing vehicle insurance was supposed to result in the cheapest insurance rates in the country. However, the cheapest rates are in three provinces, which have publicly held vehicle insurance.
- **Comments on assessment:**
  - A general flaw is suggesting that a market economy model will work for health care like it works for buying groceries. The market model works on a large scale to some degree, but as soon as you introduce features that do not respond well to mass approaches such as rare conditions or diseases, health promotion or vulnerable and disadvantaged populations, the market model generally fails miserably.
  - Public services allow for detailed accountability through the legislature, with public officials being held responsible and if necessary replaced. The only form of control for private services is the extreme one of breaking the contract if service delivery becomes clearly unsatisfactory.
  - There is government pressure to move to private care through scare stories and bad press about public health care. The public system is under-funded and poorly administered. Private health care does not work: it is just as costly for government (or more so) than the public system.
  - Privatizing of services will result in lower levels of goods and services and loss of local jobs.
  - A growing body of research evidence suggests that the profit status of health care providers does make a difference in the type and quality of care provided. The case of pharmaceuticals is pretty straightforward: pharmaceutical companies are interested in securing long patents on their products, in marketing those products to physicians and directly to consumers, and in ensuring that branded products (rather than cheaper but therapeutically equivalent alternatives) are prescribed wherever possible. The combined affect of these strategies is to drive costs in this sector of the health care system steadily upward without necessarily achieving an offsetting health benefit.



- Privatisation is not going well in dietary services and cleanliness.
  - Emergency medicine and diagnostic services are excellent in the public system and do not need to be privatized.
  - Kaiser Permanente, a private American firm, has a good prevention system.
  - Maintenance and support services are poor. We do not want to hand over control to private companies.
  - The for-profit facility will appear to be more efficient, but its lower costs may simply reflect the selection of lower-cost cases. The specialized facility also has the advantage that operating room schedules do not have to be disrupted by emergency cases or unexpectedly time-consuming procedures. It may well be entirely appropriate that the more complex and costly procedures are referred to hospitals, where the back-up facilities are available. But it is entirely inappropriate to compare the relative costs of procedures in the two settings as if they corresponded to equivalent workloads. Furthermore, establishing specialized facilities to serve the cheap and cheerful could be, and in some cases has been, done within the public system. This approach has no necessary connection to private, for-profit delivery.
  - Is for-profit health care better and/or cheaper? The answer is no. Romanow's review, which was pretty systematic, said no. McMaster has done systematic reviews of the quality of care with a bit of a cost component, and it is shown to be sometimes equal but usually lower when it is provided in a for-profit sector. Kirby was a dissenter. Kirby said that we do not have the evidence.
- [Comments on choice and coverage:](#)
    - There are many myths and illusions created by private health insurance and one of them is that you will be able to get the care you want when you want it with no line ups. Wrong. Private health insurance companies are far more ruthless when determining who is eligible for what services.
    - Outside the Lower Mainland there are not enough doctors and not nearly enough permanent facilities to provide adequate care. If a for-profit group was willing to improve the quality of service in outlying communities and would only charge the going rate to the medical plan then there is no reasonable case for denying them the opportunity. There is certainly a need for the service that the system clearly is not meeting.

- Insurance companies are notorious for refusing service on a number of bases, including a pre-existing condition, not medically necessary procedures, and deemed experimental procedures. Private insurance companies also come with extremely large deductibles.
  - Private dental and veterinary systems work well. Both dental and veterinary systems have price caps.
  - Private insurance models are too costly. In private insurance there are many exclusions, no control and too many options, and subsidised premiums do not provide universal coverage.
  - People think private means the American system and they will have to pay using a Visa not a CareCard. People think the profit component will increase costs.
- [Comments on health human resources:](#)
    - The reasons Registered Nurses choose to work at private facilities are flexible schedules and less critical patients, while the reasons they quickly leave these facilities are understaffing, low pay and poor patient outcomes.
    - Contracting out of nursing services, housekeeping and dietary results in less money into care because it goes to profit.
    - Under-funding of the private system has created a staffing and quality of care crisis and increased workload, particularly in seniors' care.
    - Privatisation in health care demoralizes workers.

## **Ideas and Suggestions**

[Values](#)

[Cost and Efficiencies](#)

[Assessment](#)

[Choice and Coverage](#)

[Health Human Resources](#)

- [Ideas about values:](#)
  - Do not focus on privatisation to the exclusion of other possibilities for fixing the public system.
  - Obey the *Canada Health Act* and stop the increase in for-profit delivery of health care.

- Government should accept the fact that citizens want a public health care system and they support a truly public health care system through funding and legislation. No privatization.
- Ideas about cost and efficiencies:
  - Independent auditors need to monitor care provided in private facilities.
  - There is a role for private delivery, for example, to address overflow or ensure prompt surgeries.
  - End the use of public facilities by for-profit health care providers such as WorkSafe BC, the Insurance Corporation of British Columbia and the military.
  - Save money by privatizing certain aspects of health care, for example, laboratories.
  - Get government out of health care delivery and let the private sector take over. Efficiency in a system that includes big government, big business and big unions is extremely hard.
- Ideas about assessment:
  - Some private models may work, but we need a more open discussion.
  - Privatized services need to be better, with more consistent enforcement of cleaning and food services standards.
- Ideas about choice and coverage:
  - Set up a public corporation which focuses on health to deliver services.
- Ideas about health human resources:
  - Make doctors practice either in public or private health care, not both (which would result in double dipping).

# Mixed Public and Private Models of Delivery and Funding

## Comments and Concerns

[Values](#)

[Cost and Efficiencies](#)

[Assessment](#)

[Choice and Coverage](#)

[Health Human Resources](#)

- **Comments on values:**

- There has been no meaningful public debate on mixed model health care delivery for one main reason, in my view: governments dare not bring this up because it is viewed as electoral suicide to question the Medicare status quo.
- The issue is not really public versus private but universal health care. If everyone has equal access to the private side and the public side all paid out of the health care budget it should not matter if we have for profit clinics and hospitals.
- Private health care should be allowed and encouraged. The public or private debate is a red herring. Medicare was never envisaged to cover all the things it attempts to cover now. It was basically developed to ensure that if you had to go into hospital and have emergency surgery, then you did not lose the farm. Develop a basic but comprehensive package of medical services of what the system should and could cover and allow people to purchase additional procedures if they want to. One size does not fit all. We do not tell people what make of car or size of house to buy. Why do we stop them from spending money on the most important thing in life, their health?
- It is not fair to all citizens that a person who has the means to afford the high cost of private health service would get priority to that service.
- The public system rests on a fundamental value that health care should be available to Canadians on the basis of need, and should be financed on the basis of ability to pay. Those values are widely, but not universally, shared. The competing ideology that would base access on ability and willingness to pay does tend to be concentrated among those with greater ability to pay. A consequence of these conflicts in values and economic issues is that the real and important issues of health care management tend to be overlaid by the public-private lens. Discussion is further distorted by the fact that all expenditures are by definition equal to someone's income. Public financing systems have proven more effective at containing costs than have mixed public-private systems. Provider representatives accordingly advocate more private payment as a way to increase,

or at least protect, their incomes against the (relatively effective) constraints of single-source funding. For their part, the preferred answer to all health care issues is never better management, but more money, which automatically becomes increased income.

- British Columbians are being asked to choose between two models, but not all the information is there for consideration.
- What is so fundamentally wrong with allowing a parallel private system and giving people a choice to go and purchase private services outside of the system if they choose to, in so doing reducing demand in the public system?
- People are blind to the fact that 40 per cent of the existing system is private.
- I am not interested in using the spectrum of health care as a lever to try to open up the *Canada Health Act* and find ways of flowing more private money into hospitals and doctors. I think that is something that there will be a continual fight over, and quite rightly. I think the population has made its choice. I think that a lot of our leaders have made a different choice and that is one of the reasons why it is so contentious. I think it has to do with the fact that our leaders are drawn from the upper income strata of our society, which is growing very rapidly. One of the underlying things which we have not discussed, but we need to keep in mind, is that since 1980 the proportion of total incomes in Canada going to the upper 10 per cent, the upper one per cent and the upper 10,000th of a per cent has been growing really quite dramatically and continues to grow. So our public policy debates in health care are increasingly driven by the interests of relatively wealthy people and they are not interested in paying taxes to support health care for the rest of us. And they are interested in making sure that they have preferred access to the care that there is.
- Vested interests continue to mislead the public.
- Is there a way to have private care while preserving public system?
- Remove profit from medical care.
- Information is starting to come out that private providers already exist (for example, the British Columbia Bio-Med), and that you use your CareCard to pay.
- Two-tier health care creates a concern that we are moving away from universal, publicly-funded care to a private care system.
- There is a conflict of interest in a mixed system.
- If you increase private health care funding and delivery, then you are now having a small group of shareholders who are determining health care policy.

- It is not whether the system is public or private, or a mix, or from Britain or from Norway, or from Mars, it is what works. When my child is sick and I take them to the doctor, do they get fixed?
- There is an unwillingness to look at different solutions, or even to acknowledge that we already have a two-tier system.
- There is insufficient education of the pros and cons of private versus public systems. It is an emotional issue.
- Health care has changed over the past 50 years with new technologies and treatments available. Government spending on health care has sky-rocketed. This cannot continue unless the public is willing to spend money on the situation through a public-private split.
- Increasingly health employers and authorities are contracting out more of the work to private sector even though it costs the taxpayers of British Columbia between one hundred and three hundred per cent more than performing the same work in-house. The reasons for this are three-fold: lack of qualified staff due to uncompetitive wage rates; a mind-set and an ideology that favours the private sector regardless of the cost or quality of the work; and lack of accountability and ability to recognise the best way to deliver health care maintenance and renovation services.
- The Premier asked what does it matter who is providing service be it private or public. It does matter. A private company is entrusted and legally obliged to earn profit for its shareholders. The environment of today demands the highest return on their investment and this may lead to a sacrifice in quality over quantity. We want a public system.
- **Comments on cost and efficiencies:**
  - Please be aware that government policies have created a two-tier medical system. If I could not afford the naturopathic care and supplements and massage therapy, then I would still be in excruciating pain. I have diligently tackled my problem, but it has cost a great deal of money. It is unfair that if I went the allopathic route (as unsuccessful as that may be) my treatments would be free. But going an alternative route, I have had to bear the full costs myself.
  - Every privately run company in this country is de-centralizing, outsourcing and contracting out. But the company still pays for the work – it is just not done in-house. So why are we struggling along with backlogs and waiting lists, with everything done in house. Why does not the government just pay for the services to be done by private clinics, hospitals and so on? They can bill the government for the work done.

- Public funding of private facilities leads to public subsidising of the facilities provided by the private practitioner to use for their private patients, that is, the public funding is paying for private services.
- Nearly every general practitioner and specialist in British Columbia (the exception being those who are employed or contracted directly by hospitals or health authorities, such as emergency room doctors), operates as a private entity. Government funds, namely through the medical services commission, pay doctors on a fee for service basis. From this, the doctor must pay for rent, supplies, staff, telephone, and other operating expenses. Providing publicly funded surgical care in a private centre is much the same principle. The government is paying the centre for providing this care, and patients do not pay anything directly.
- Virtually all doctors' offices (and after-hours clinics) are already private clinics: their services to patients however are paid for by the public health system. There are very few doctors who actually work for a hospital. They are private contractors who enter into an agreement with the hospital that usually exchanges hospital admission privileges for on-call duty and on other services.
- Any move to a two tiered system would increase the cost burden for people on fixed incomes that worked in the private sector and do not have extended benefits.
- As long as the facility is accredited and qualified personnel is running it and the fees are according to the government contract then it does not matter. Competition is healthy and one may find out that the privately run facilities are much more economical for the taxpayer. For example, the cost of looking after a simple ear infection in an emergency room is probably somewhere near \$200 and in a private walk in clinic it is less than \$30, and yet the clinic makes a profit.
- It is my strong view that we should have a combination of public health care paid for exclusively out of the public purse and private health care. The private sector can bring investment and efficiencies that government and unions will not or cannot. To say this does not exist today is to lie to the public, as, the last time I looked, my eyes and teeth are part of my body and there are no waiting lines for these areas of my body when I need service. The socialistic approach to medical care in the 1940's will not cut it today with advances in medicine and technologies and we need to explore other more progressive ways to handle the looming problem. And if government cannot handle the problem, then it should get out of my way and the private sector way and let us find solution to problems with other resources. Government is historically demonstrating it cannot handle the problem. The old ways just do not cut it anymore.

- Be careful what you wish for: If all deficiencies were costed, then the case for private health care may be strengthened.
- Cream-skimming refers to the fact that for-profit clinics have a material interest in serving patients for whom procedures are less complex, outcomes more predictable and costs lower. It allows for-profit clinics to minimize their risk and maximize their profit. It also results in an increase in the average level of severity among patients who remain in the public system, and in the costs associated with their treatment. Consequently, the average cost of treating patients in public institutions rises. If payments to the public system do not increase to reflect these higher costs, then the public system becomes less sustainable. Evidence suggests that when public authorities are confronted with deteriorating health among patients waiting for care, they will divert patients to private clinics to relieve their suffering even when this may threaten the sustainability of the public system in the long run.
- The two systems (private and public) are not properly coordinated.
- One thing we do know is that if you add private insurance options with the view to reducing waiting lists and waiting times, you are not going to be very successful.
- We spend more private dollars in Canada than any other country in the world except the United States, and all other countries actually have a mixed system for a lot of acute care and they provide a lot more coverage for complementary and community medicine.
- We have more private health care in Canada than people think. Over 30 per cent of health care spending is to the private sector for diagnostics, pharmaceuticals, non-listed surgical interventions and other types of therapies (dentistry, massage and plastic surgery for example).
- Private does not necessarily mean personal payment.
- If parallel private health care is initiated, then it should follow the United Kingdom and European systems. They take care of all of the issues related to the administration of services in terms of clinical care and the system of private insurance. Using a single insurance agency also makes it cheaper to run.
- Australia is an interesting example: they created a movement to encourage the purchase of private insurance, which would get you, in essence, faster access to a number of services. It started off reasonably well, then it ran into trouble, and it was on the brink of failure until the government had to step in with a policy that subsidized people for buying private insurance, which is a bit of an oxymoronic concept when you really think it through. But I think there is a cautionary tale



there that if you leave private insurance purchase to the market and you do not intervene in people's decisions about whether or not it is worth their doing when you have a reasonable public system, intelligent people tend not to want to. This is why Canada does not ban private and parallel health insurance for the publicly financed system (medical and hospital services) and there is no market for it.

- Once British Columbia, or any jurisdiction in Canada, formally sanctions a mix of public and private health delivery, the North American Free Trade Agreement will kick in, allowing American health corporations the ability to move into Canadian health care with the same rights to public funding as Canadian companies. In no time, the public system would be bankrupt and we would have an Americanized corporate health care system. In non-free trade Europe, these are not issues.
- There is too much fragmentation of health services and too much bureaucracy within a mixed private and public system.
- WorkSafe BC dances to its own tune. It should contribute more to our health care system.
- Support the 2003 First Ministers' Accord on Health Care Renewal.
- There would be an inequity between those who are financially secure and pay for services, while those without resources have everything free.
- A mixed system results in private enterprise competing with scarce resources from the public system (such as doctors).
- When you offload you shift costs, but you do not contain them. In fact, costs tend to be higher when you have a higher proportion that is not government-funded, and costs tend to be higher when they are delivered through for-profit care. The other thing that happens when you do this, of course, is that you increase inequity and you tend to fragment the system because you no longer have a single payer and all the administrative efficiencies there. Your purchasing power is diffused and all the other consequences which you know about. We do know pretty definitively that administrative costs are lower in single payer systems.
- [Comments on assessment:](#)
  - We contract out day care surgery in Kelowna to a private center and the patients rave about the facility. They do not ever want to go back to the hospital after having their surgery at the private surgical center. As long as they are not paying out of pocket, no one cares.
  - There is no doubt the system is under strain, most acutely in waitlist times for elective surgery. However, it is not clear this crisis actually exists, and research shows that private, for-profit investment in health care is not the right approach

to deal with the challenges that do exist. There are many innovations within the public system working to address waitlists and other health care challenges. The policy priority must be to expand and build upon these successes.

- Procedures in the public system do not face the same level of scrutiny or competition as the private sector. Consequently their level of complexity and inefficiency tend to be greater.
- I am sure that upper middle class and wealthy persons believe that it would be to their advantage to have both private and public care. It would not be an advantage to the middle and lower classes.
- Claims about the superiority of mixed public and private European health care systems are made without reference to the rest of the European social program package (including income equality, generous social benefits, low post-secondary tuition and labour rights). These other benefits have no appeal to those advocating that mixed health care systems be imposed in British Columbia.
- Canada and British Columbia have always had a large component of private delivery of health care services. Physicians operate as private businesses. Hospitals are public, but are not owned or operated by provincial governments, as they might be in other health care systems (for example the United Kingdom). Another critical distinction in health care delivery, however, is for-profit versus non-profit. Hospitals are not-for-profit providers, and physicians, while private, have significant motivations other than profit. In contrast to this, there is a mix of non-profit and for-profit nursing homes in British Columbia, home care services are provided by both for-profit and non-profit providers, and the pharmaceutical industry is entirely for-profit.
- The majority of what is done in our public system tends to be the high cost, high complexity and high risk. In the private system, it tends to be high volume, low complexity and low risk. So making comparisons across systems is really difficult in that environment.
- It is no longer easy to determine how to keep the profit motive out of influencing an individual's health care. Each layer of intermediary private contractors between the payer, that is, the government, and the client receiving health care introduces the potential for profit considerations to influence the health care given. To preserve the non-profit principle of public administration, therefore, the number of private-sector layers must be minimized. Moreover, the government must set and administer strict guidelines for the contractor or contractors and must fully accept responsibility for the actions of the contractor or contractors.

- Canadian independent medical clinics are meeting patient needs and the expectations of provincial health authorities with timely and quality care. We have, however, only tapped a fraction of the potential for quality patient care available in the independent health care sector. A change in the regulatory framework could widen opportunities for greater public and private health care partnerships that could enhance the sustainability of the public health care system.
- Over seven out of ten Canadians support the Supreme Court decision allowing supplementary private health insurance and care (COMPAS poll, January 2006). Over five out of ten Canadians agree with the option to pay privately for faster treatment (Pollara poll, June 2005).
- International studies show that countries with parallel public and private health care systems have longer, not shorter, public-sector waiting times than other nations. Canadian studies point to similar results. A 1998 study from the University of Manitoba found that cataract patients whose surgeons worked in both the public and private sectors waited 23 weeks for surgery, more than twice as long as patients whose doctors only worked in the public hospital system. The problem stems from the fact that there is a finite pool of health professionals, both doctors and nurses. Private hospitals and clinics draw scarce human resources out of the public system, lengthening wait times for patients who want to access public services. As the Manitoba cataract example suggests, waitlists are longest for patients of doctors who work in both the public and private systems. One reason is that doctors who work in both systems have an incentive to keep public waits long so that way they have a steady pool of patients willing to pay for private service.
- We already have a multi-tier system: public care, insured services through employers and individual patients.
- A key reason for poorer quality of care and health outcomes in for-profit facilities is the lower number of skilled personnel employed. In 2002, a study in the Journal of the American Medical Association reported that patients at for-profit dialysis clinics had an eight per cent higher death rate than those attending non-profit clinics, and a lower chance of being referred for a kidney transplant. But it was not the only study to find such sobering outcomes. The same group also published an overview of all individual studies comparing mortality rates for 26,000 for-profit and non-profit hospitals serving 38 million patients. They found that adults had a two per cent higher death rate in for-profit hospitals, while newborns had a ten per cent higher rate. They concluded that concerns that the profit motive may adversely affect patient outcomes in for-profit hospitals were justified. The

investigators estimated that if all Canadian hospitals were converted to for-profits, there would be an additional 2,200 deaths a year.

- The private sector has traditionally played a pivotal role in the delivery of health care services in Canada. Medical clinics, staffed by doctors, nurses and health care providers operate as private businesses treating patients and billing government.
- Provincial health authorities have taken advantage of private-sector services by sub-contracting patient care to independent health care facilities.
- Contract services can have lower standards.
- Private clinics do the most profitable and least complicated procedures, leaving the public system with more costly procedures.
- Private health care may not result in improved wait times. For example, the recent significant improvement in hip replacement wait times came as a result of more efficient organisation as well as more money.
- Mixed private clinics for certain diagnostic services are controversial but seem to be useful.
- Private clinics are necessary to mitigate wait lists, to provide timely access and to address the concerns raised by the *Chaoulli* decision.
- Private Clinics can be better integrated into the medical system, providing more medically necessary services that are publicly funded. The issue is who controls the system, not who delivers the service.
- Private clinics have been operating for decades, and even though they are for profit, they are still able to provide care much faster and often for less money.
- Private and public delivery can co-exist within a common government funding model: look at the French model.
- The privatisation of housekeeping, laundry and food services has resulted in deteriorating services.
- There is a political attitude that we can operate both a public and private health care system without compromising equity, availability and quality of care.
- People are giving up on public health care because of horror stories and the current government is pushing the message that the system is broken. The government is failing to implement positive public solutions in favour of promoting private sector incursion into health care.
- Public-private models end up dividing people into two groups and it is the wealthy that drive the changes.

- There are various tiers of health services right now that are avoiding the *Canada Health Act* (such as WorksafeBC and the Royal Canadian Mounted Police).
  - 95 per cent of the clinicians in this country are private practitioners. It is a privatized system in many parts. So let us just do it in the most successful way we can.
  - Private clinics could speed up surgeries.
  - There is an underlying assumption that private care is substandard.
  - How does the North American Free Trade Agreement (NAFTA) impact on our maintenance of our Medicare (public) system if private involvement increases? Do not allow North American Free Trade Agreement (Chapter 11) to have any jurisdiction over public services like Medicare. Provide a guarantee that North American Free Trade Agreement will not apply to Medicare and clearly inform everyone about its implications, as well as what government will do to protect the Medicare system.
  - I disagree that if we open our public services up to competition North American Free Trade Agreement will destroy it.
  - Essentially there are two delivery models: private and public. All alternative health care is private. The conclusion is that the health care in British Columbia is fragmented.
  - The private sector will play an increasingly important role as the public infrastructure adjusts to a new standard of care. Canadian health care delivery currently employs the use of many private facilities to deliver publicly funded services. Examples include physician offices, diagnostic centres, long-term care facilities, home care agencies and pharmacies. Private facilities are effective, efficient providers of publicly funded health services and our health care system would simply not function without them. The question is not whether private delivery should exist, but how society can make the most efficient and effective use of the private sector while retaining accountability to a public authority.
  - Researchers have analyzed data from studies that compared outcomes at non-profit and for-profit hospitals. Their conclusion? Non-profit facilities produce better outcomes, and this is after controlling for differences in the type and complexity of patients cared for in these different hospitals.
- [Comments on choice and coverage:](#)
    - I once read that Canada has a much higher percentage of self-employed people than does the United States because of our public health care system. As a self-

employed person, am I going to be at a serious disadvantage in a mixed model system?

- Why is Canada the only nation in the developed world which does not allow private health care?
- We need private health facilities as well as public.
- The wealthy will continue to go outside country for their health care needs. Why not allow them to obtain and pay for the service here?
- It is not fair or reasonable that a person, out of frustration, or pain or impending death, is now prevented from paying for their care over-and-above what they pay through taxes.
- Many services are already provided and funded (at least in part) privately. These include dental, vision and hearing care, physiotherapy, chiropractic, acupuncture, most prescriptions, alternative medicines and so on. Sophisticated diagnostics and even simple tests are already being judged as to medical necessity (and therefore whether or not they are covered by the Medical Services Plan), and they are being offered by both public and private providers. This medical necessity determination must be used to retain any possibility of sustainability. However, those who desire (and can afford) a more aggressive medical approach should not be denied the right to do so, provided that the services used are funded privately.
- We have two options: reduce current levels of care and maintain the current budget, or maintain and potentially expand existing levels of care and seek alternate payer sources.
- All health care systems present problems of cost-containment and value for money. But this real issue has been converted into a fallacious claim of lack of sustainability to which the answer offered is not better mechanisms for cost control but a shift of costs from public to private budgets. No one's income is threatened, indeed new income opportunities may be opened, but the re-distribution of access and of cost burdens will favour the healthy and wealthy.
- A common frustration among physicians and patients has been the lack of any recourse where the publicly funded health system fails to provide timely access. This gap in Canadian health policy must be addressed in a way that compels the system to provide timely care while preserving the right of Canadians to seek alternate care if the public system fails to deliver.
- Demand management, or different ways of delivering, is quite different than looking at funding mix options.

- At a private surgical centre, you would be shipped out to a hospital if you went in to anaphylactic shock or cardiac arrest which is scary.
- Many people have argued, incorrectly, that *Chaoulli* somehow establishes a right to private health insurance or somehow mandates a two-tiered healthcare system, which I do not think is the case. But it certainly does augur for change in the health care system. Basically what the judges indicated was that they were not willing to somehow re-write the basic terms of the health care delivery system that we have in Canada, and somehow to mandate that there was a Constitutional right to a separate parallel private system. But, what Senator Kirby and his colleagues advanced to the judges was that it is perfectly acceptable to establish a monopoly publicly-funded system as long as patients can access services in a reasonably timely way. There does not seem to be an answer to it, at least I have never heard an answer to it, because it would be really contrary to the entire purposes of the system to require people to suffer or die and prohibit them from protecting their own health in the guise of preserving access to a quality healthcare system. The Supreme Court of Canada, by the narrowest of margins, by four to three margin, did accept this argument.
- [Comments on health human resources:](#)
  - Skilled professionals will not leave in droves to the private sector, just as municipal employees and teachers have no shortage even with private institutions such as private school operating alongside them. If there is a two tiered system, then public salaries and benefits will be kept attractive when compared to the private system.
  - Many people fear the best doctors and nurses would go to the private side in a two-tier system, the inherent assumption being that people and medical professionals are so greedy that the good ones would chase the big dollars and only the duds would be left for the rest of us. I would like to think that some of those medical people would want to actually help regular people. I am not sure I would want a doctor who was totally focused on money anyway.
  - Proposals by some health authorities to remove simple day surgical procedures to off-site private, for-profit clinics will drain nurses and other professionals away from hospitals, increase operating room staff shortages and leave remaining staff confronting a never-ending burden of complex cases.
  - The creation of a two-tier system will create more pressure on available health care professionals.

- The government was free to alter the health care system as it chose and as the electorate would get away with it. But they could not do so without consulting with the workers involved, which is the workers' right under the Collective Agreement.
- There is a false sense of shortage of staff in a two-tier system.
- A mixed model reduces number of doctors available within the public system.
- The system will remain inefficient as long as the private sector competes with the public system and poaches support services and professionals.
- The private sector can provide new and innovative ideas to the health care industry. However, the danger that many doctors would leave the public system for an unregulated private system is very real. Right now, a doctor in the public system is paid a flat fee for services which is far less than that doctor could charge for the same service in a private clinic. The incentive to go private is obvious. Incidentally, these private clinics have existed for many years: just ask any professional sports athlete how many weeks he waited for his knee surgery.

## **Ideas and Suggestions**

[Values](#)

[Cost and Efficiencies](#)

[Assessment](#)

[Choice and Coverage](#)

[Health Human Resources](#)

- **Ideas about values:**
  - Access to quality care is more important than who is delivering it.
  - At the core of this discussion is the need to reaffirm provincial commitment to the principles of universal health care, including public funding and public delivery of our health care services. Canadians cherish universal, public health care.
  - Have public funding, but include public and private delivery.
  - Canada has the required science, technologies, and talent needed to create a sustainable industry, which can translate our public and private investment into improving patient outcomes, both in British Columbia and for export around the world.
  - The public could contract services to the private system: they would be paid for by the public at public rates.



- Health care delivery should all be not-for-profit, even when there is a private component.
- When opting for private treatment, you should also bear the costs of diagnostic services delivered through the public system.
- Have private clinics help with services, but charge the public rate if services are funded by the taxpayer. People who want to be fast-tracked for elective surgery should pay out of their own pocket.
- Remove partisan politics and ideology from health care and make the best decisions for the common good.
- We need to examine opportunities for the private sector in the health care system.
- The Provincial Government should purchase the buildings rather than shutting down seniors' homes and moving the seniors to public-private owned buildings.
- Work on reducing the fear the public has about mixed private and public delivery systems.
- Implement a two-tiered or multi-tiered system, but require a compulsory contribution to British Columbia Medicare. Low income earners would have the same treatment.
- People, who can afford private health care, should not take away from, or have priority over, those who depend entirely on the public system.
- Keep private and public separate as they are ideologically different and are crashing in on one another. Private care has its merits and Vancouver has a larger population able and willing to keep up the private system along with the private insurance catering to it.
- Government should be insurer, payer and setter of standards, but allow delivery by both public and private facilities.
- The family should be able to pay for their care if the system does not work.
- No public money to private initiatives.
- Health care services should be publicly funded with co-existing public and private delivery.
- Some health services should be allowed to be conducted by the private sector.
- We have to dispel the horror stories being spread about for-profit alternatives.
- Health care needs to be funded publicly and adequately, and managed publicly.
- We need improved communication of the nature of and potential benefits associated with private delivery.

- Support a publicly-funded single payer system of health care, but if government is unable to provide a timely, adequate level of care a second tier will be demanded and developed and should not have artificial barriers placed around it. If the government wishes to fully fund health care in British Columbia, then it has the obligation to ensure that the level of care available is timely and appropriate such that there is no need for a second tier.
- Support a single-pay, fully government-regulated system that permits the use of privately built and owned facilities.
- Encourage funding models and innovative programs that reward positive health outcomes and respect the past, while not being afraid to explore the benefits of other models.
- The private company should not have a say in quality control or accountability measures.
- Private care must follow strict regulations and control.
- Look at private options, not funded by the public system.
- The discussion of public and private is very difficult so we need to create a way to have the discussion.
- Governments should retain the principle of public administration and implement it more whole-heartedly. Therefore, whenever government contemplates contracting out a function in the health care system, it should first: 1. ensure its own health administration is of top quality, with particular emphasis on first-rate information management systems including financial and statistical information; 2. examine the relative costs and benefits of improving its own systems in comparison with the costs and benefits of policing those of a potential private contractor; 3. set strict, detailed and enforceable guidelines for the actions of contractors; and, 4. accept government responsibility for a contractor's actions.
- Our health system is an educator and an insurer rather than a provider of services. Private industry should provide the services, with our system underwriting the cost.
- There should be a three-tier health system in Canada. Tier one of universal coverage and access to health care services and facilities as it is now. Tier two of regulated private care where doctors have access to public facilities such as unfunded or empty hospital beds, operating theatres and equipment and their fees and standards of care are set in provincial legislation or regulation. Tier three of regulated private care where standards of care are set in legislation or regulation but fees are not.

- Ideas about cost and efficiencies:
  - A dynamic health system will find an optimal blend of private and Government-subsidized services that compliment each other and jointly deliver quality services while creating a robust sector which benefits all.
  - Determine the total cost of each major service in the public system. This figure should include overhead, including the cost of operating the hospital, insurance and so on. Next, allow private clinics to perform these services at a five or ten per cent discount and have the public health care system pay the bill. The result is a win, win situation for all parties.
  - There are proven models where industry has been a major partner that have been executed within Canada and other jurisdictions that can be adapted to create pilot programs within British Columbia that can provide insight into measurable improvements for patients and provide insight as to how to optimize resource allocation. This will ensure that the costs borne by publicly funded health care within the province provide the highest possible return on investment in improved patient outcomes and within the health care system.
  - Private facilities can frequently deliver services in a more efficient manner than publicly run hospitals and are capable of producing similar outcomes. If publicly-funded insured services can be delivered more efficiently through the private sector, then those efficiencies should be captured provided it can be done within a properly regulated framework.
  - Government should rationalize the integration of the public and private surgical and diagnostic delivery sectors. This integration must include: a) the regulatory framework within which both public and private care facilities function; b) the establishment of transparent performance and delivery standards for each facility; c) contracting out scheduled procedures to reduce waitlists and achieve wait time benchmarks; and, d) where necessary, utilization of private facilities as the safety valve if wait time benchmarks are not achieved.
  - The private system should kick in after the maximum wait time is exceeded. Care should still be paid by public funds.
  - Private clinics may enable specialists to bring special equipment and services to rural areas.
  - We need to eliminate the notion that the word profit is synonymous with escalating costs, irrespective of where you sit on the private versus public debate. This has been repeatedly proven through history to be flawed logic, both economically and with respect to basic human behaviour.
  - Allow private care facilities, but make them pay higher taxes.

- Have a blended system where service providers handle both private and public. Improve funding through co-payment by patients (a nominal amount) for doctor visits and other services.
- In order to sustain the economy and at the same time, find additional payer sources for the health care system, employers and disability insurers must become legitimate payer sources for a wide range of health care services for their employees. This will reduce the cost of attraction and training of temporary replacement workers, increase the number of payer sources for health care and ensure that employees are well cared for.
- Direct the attention of Canada's health care decision makers toward the untapped potential of the independent health care sector. The sector should not be viewed as a competition to Medicare, but as an arch of support that can release some of the pressures on the public health system and contribute towards Medicare's fiscal sustainability.
- Improve patient care with a renewed universal publicly funded health care system complemented by independent health care facilities.
- Structure health care financing through a publicly-insured system complemented by private sector financing and insurance options (strengthen government funded universal health care coverage); amend provincial legislation to accommodate private health care insurance; lift the ban on private insurance by amending the *Canada Health Act*; and give patients the option to pay for medical procedures through private health care insurance or out-of-pocket).
- There should be public health care for children up to age 18 and it should be Cadillac care. From ages 18 to 25, the government could assist with payments for an individual's choice of health plan. After age 25, you are on your own. Pay for what you want.
- Authorize regional Health Authorities to call for tenders from private clinics for specific diagnostic and repetitive type treatments. For example, a private Medical Resonance Imaging (MRI) machine might operate 24 hours a day and seven days a week: a patient could be given the option of having the scan done within 24 hours, knowing it might be at 3:00 in the morning, or waiting two weeks to have it done at the hospital between 8 a.m. and 6 p.m.
- Why should British Columbians go elsewhere to pay for medical procedures? Here it would fuel the economy and create highly paid jobs with taxes paid in this country.

- The key is to permit private facilities to compete with public facilities within a defined framework and within the provincial medical system. This will force the private facilities to prove they can compete effectively with the public facilities and it will force the public facilities to become more cost-effective.
- **Ideas about assessment:**
  - A comprehensive list as to the cost of procedures should be maintained by the health authority. When a patient is diagnosed with a condition that requires surgery, then they receive a voucher that is worth the amount listed for the specific surgery. It is then the job of the patient to redeem that voucher at any health services facility, be it public or private. This will force the public system into a more efficient and cost effective mode.
  - Private clinics need to have all services available in case of complications.
  - Show the public that new innovations and technologies provided in the private sector can offset costs associated with the profit motive. High costs of administration in large bureaucratic systems often cost more than the profit component in private systems. The private system can benefit the public system.
  - Acknowledge that the public-private system exists.
  - Educate people that change is not bad. Truly study and compare other systems in the world. Allow private delivery of publicly-funded health services. Promote Canada as a destination for innovative quality modern health.
  - Allowing private participation brings innovation and new technologies to the system. The public system is so large and bureaucratic that this does not happen there.
  - Look for blended systems rather than completely separate delivery systems. That is how we start to overcome some of the critical mass of density-driven decision-making models: not by further segregating our delivery of health care, but by working together and blending our systems so we can assure the population that our people actually get the best care.
  - Explore options for other insurers to administer the non-insured health benefits plan.
  - Do a cost analysis to determine if an alternate provider is more efficient and effective.
  - We need an open mind on the subject and the ability to test private supplementary programs.
  - We need more criteria for deciding whether to pursue public or private systems.

- Private and public health care should be analyzed to determine if there should be a mix of both or if one is superior.
- A model for a mixture of public-private funding needs to be developed for the population of British Columbia to vote on.
- **Ideas about choice and coverage:**
  - If there are private clinics, maybe the system could be set up as a fee for service based on a person's income. Therefore those who can afford to pay would and those who could not afford to pay would not. This way everyone would have access to services and would pay according to ability.
  - Choice of public or private is critical.
  - Government should continue to explore models to contract with private general anesthetic facilities for low-risk surgeries.
  - British Columbians should still have health insurance, but there should be a choice about where to spend our health care funding. Every person should get health insurance and take it to whatever institution that gives the best care.
  - Services intended for birth control, fertility and premature birth should be housed in a private, non-profit facility.
  - Put all the options on the table: other countries, the results of the Premier's visits to Europe and the dental system of care.
  - Use private clinics where the government pays for the treatment. Allow private insurance to pay for a higher level of service or faster access. Give patients a choice.
  - Basic health care must be covered by either public or private delivery systems. Allow patients to pay for private services through private insurance or direct payment.
  - Private clinics could be utilised if all of the services were universally available and were covered by the Medical Services Plan. No one should be able to pay for treatment as that will mean queue jumping and preferential treatment for the rich.
  - Create a parallel system, rather than two-tier and therefore introduce choices.
  - Educate British Columbians that the private sector is already working in the public system.
  - We need more options without causing a negative impact on the public system.
  - Persons able to pay should go to a private facility.

- Out-source to private services as long as they use the same fee schedule.
  - Running private clinics under provincial guidelines can take care of non-essential procedures thus freeing up spaces in our public system.
  - Allow patients to choose between the public system and a private clinic for medically necessary work. The government would pay in either case.
  - Keep regulation but offer patients greater choice in medical care.
  - We should consider allowing patients to pay for diagnostic tests.
  - Cost effective health care with equivalent outcomes, regardless of the delivery system, should be encouraged.
  - The public will have to expand their acceptance of private providers to include services such as advanced diagnostic imaging, cancer screening and surgical services.
  - Not-for-profit specialized clinics should be used.
  - Commit Canada to having the best health care system in the world by offering universal health care to those who need it as well as having options (delivery, payment and health insurance) in a private form to those who can utilize it.
  - Provide real choice via parallel private system, while maintaining mandatory Medical Services Plan contributions and a universal access public system. The choice to pay for extras or alternatives should be a personal matter for patients, but staff in private practice should be required to work at least part-time in the public system, to avoid a dramatic drain of talent.
- **Ideas about health human resources:**
    - Regulate physicians and other staff around working in the mixed system.
    - Government could legislate that doctors work in both systems: two days private to three days public.
    - Allow practitioners to access all available tools and facilities irrespective of whether they are private or public and have the government pay.
    - Limit the number of hours that doctors can work in the private system.
    - There is no need to seek more operating room capacity from private, for-profit entrepreneurs. These ventures will cost the system more and drain our hospitals of scarce staff and resources.

# Public-Private Partnerships

## Comments and Concerns

### Values

### Assessment and Cost

### Governance and Accountability

- **Comments on values:**

- There is not enough of a track record of public-private partnerships in the health system to say how it works. However, public-private partnerships are companies out to make a profit. Do we want to have companies controlling our health care?
- The government is looking to the private sector for partnerships before community and non-profit options are explored.
- Partnerships British Columbia is not critically analysing private-public partnerships. The idea seems to be motivated from a desire to provide investment opportunities for large pools of capital. Infrastructure will degrade near the end of the contract. The risk is carried by the government and profit goes to the private sector. Private-public partnerships waste money because of higher interest rates and the need for profits. Workers are not treated well. The Abbotsford private-public partnership has been a disaster as a result of construction delays and consultation costs.
- The companies who build the hospitals and hold the lease are only doing it to make huge profits. The last year of the lease they do no maintenance and you eventually inherit a dilapidated structure.
- Public administration does not require or imply public ownership of physical facilities. That had been clear since the introduction of the national hospital insurance plan well before Medicare. However, once health care became a full-blown industry, the established pattern of hospitals owned by public trusts and religious orders was augmented by the appearance of for-profit hospital companies. These provoke some controversy in the same way that non-hospital institutions for personal care do (extended care homes, seniors' residences, nursing homes): do the facilities generate profits through low standards of care and exploitation of their employees rather than through higher standards of administrative ability?
- Quite clearly, the continued use of public-private partnership procurement strategies to build and maintain hospitals and other health care facilities will exacerbate rather than alleviate the sustainability crisis in our public health



system. Yet the government persists. This is an area where a simple reversal in provincial policy is needed to ensure that health care infrastructure developments are cost effective and sustainable.

- **Comments on assessment and cost:**

- Capital projects and some operations are constructed by private for-profit organizations and then run by public organizations (public-private partnerships). Nothing is good about this. It is a more expensive way of doing things.
- While public-private partnerships can be a good first step if designed properly, they do not go far enough. The benefits of outright privatizations are well established and result from the key differences between how the private and public sectors behave and the incentives each faces.
- There are no cost benefit analyses for public-private partnerships.
- Doctors' offices and hospitals work well when funded by the public sector.
- With no evidence to show that privately financed, constructed, or maintained hospitals were any more efficient than public hospitals, the province began to implement its public-private partnerships and P3 hospitals. The fact is that all the evidence from other jurisdictions had already shown that these sorts of P3s were more expensive than the traditional public hospital projects. Experience to date in British Columbia bears that out: the new P3 hospital in Abbotsford is way over budget.
- In the long run, costs to tax payers are greater for public-private partnerships than for publicly-funded projects.
- Private facilities pay taxes, contributing to government.
- Privatized assisted living and long-term care beds are much more expensive.
- Public-private partnerships are more expensive and drain the public system.
- Public not-for-profit long-term care centres can work well and do not have to involve public-private partnerships or privatisation and the costs that go with it.
- Are private-public partnerships cheaper? I think the evidence we have here is conclusively no. The biggest review of this has been done by Allyson Pollock in the United Kingdom. She calculated that the private-public partnerships generated an approximate average rate of return of about 18 per cent guaranteed for the private partner. I think the central issues here are why would you think it would be cheaper when you need a private partner who:
  - a. will not put him or herself at risk in a long-term expensive project;
  - b. will want a relatively high rate of return for engaging in it; and

- c. can you borrow money at a higher rate than government, or must borrow money at a higher rate than governments can?

So it is both logically unlikely that they would be cheaper, and it is empirically, I think, fairly well established that they are not. The attraction of private-public partnerships, of course, is that you keep the capital costs off your short-term books as the government. So it is other people's capital project, not yours, but you end up paying a pretty high price for it.

- The annual lease payments for the Abbotsford hospital have already escalated ninety-four per cent from \$20 million to \$39.7 million per year.
- Shareholders in private-public partnerships expect a profit and this cost is factored into the lease payments. Private-public partnerships come with additional layers of legal, financial and administrative bureaucracy, all of which costs more and diverts funds away from patient care.
- When the accounting is done, all the projected savings from public-private partnerships turn out to be hypothetical assumptions based on risk transfer. In the United Kingdom, after a 15-year experiment with public-private partnership schemes, tax-payers are outraged over cost overruns, poor design and construction and inadequate service levels.
- Having a privately owned and operated hospital in Abbotsford will be very beneficial.
- [Comments on governance and accountability:](#)
  - Public-private partnerships have no accountability to the public.
  - Privately owned entities are not accountable and it is hard for the public to access the information.
  - Public-private partnerships allow for reduced accountability for the government.
  - In private-public partnerships, building design is not directed by a user group. If there are cost over-runs, then they are borne by government.

## Ideas and Suggestions

### Values

### Assessment and Cost

### Governance and Accountability

- **Ideas about values:**
  - Implement a sustainable primary care facility through a private-public approach or through a public cooperative (that is, a non-profit service).
  - We need to create more dynamic, public-private partnerships. The public system cannot do it all. There are times when the private sector could make a huge difference with not a lot of funds. They have most of it there. They just need a little bit to push them over the edge, instead of re-creating it all.
  - Eliminate private for-profit options for public buildings.
  - Encourage public-private partnerships or private enterprise if it will improve accessibility (wait times) or sustainability.
  - Develop dynamic private-public partnerships, as in the Ontario community centres partnerships with private fitness clubs.
  - Explore innovative ideas for service provision through public-private partnerships.
- **Ideas about assessment and cost:**
  - The Government of British Columbia should look at some recently publicized public-private partnership disasters in the United Kingdom.
  - Look at public-public partnerships, as was done on the Queen Charlotte Islands, with active community involvement.
  - Government can borrow at better rates than the private sector. Use government directly to build and run our public facilities.
  - Public-private partnerships should be explored. This would be helped with more communication and education.
- **Ideas about governance and accountability:**
  - The advent of public-private partnerships is a secretive, non-publicly accountable system for spending taxpayer dollars. It must end.
  - All capital expenditure must be owned and operated by the Province of British Columbia, not private corporations where profit is expected.

- We need to establish safeguards to ensure the long-term viability of the asset and if that cannot be done then the government should not permit public-private partnerships. The profit motive must be eliminated from the public-private partnerships model.
- The focus of sustainability of health care should not be on public-private partnerships, but on good quality health care run by the public system, not businesses.