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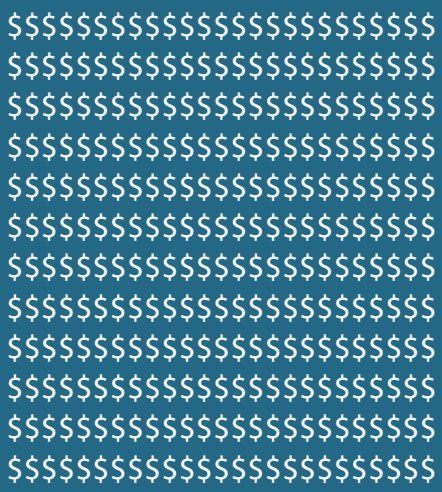
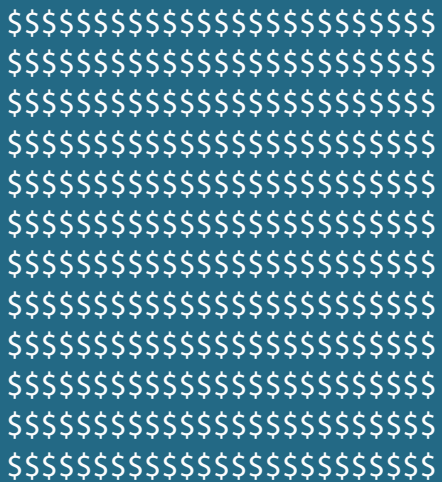


DELIVERY MATTERS

The High Costs of For-Profit Health Services in Alberta



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DELIVERY MATTERS:

THE HIGH COSTS OF FOR-PROFIT HEALTH SERVICES IN ALBERTA

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Delivery Matters:

The High Costs of For-Profit Health Services in Alberta

INTRODUCTION

In Alberta and across Canada, the private for-profit healthcare sector is being positioned as a solution to wait times and the financial challenges facing the health care system. Consequently, for-profit delivery of healthcare is increasing. The provincial and federal governments are also increasingly referring to public healthcare as a publicly funded health system, under the premise that it does not matter who delivers the services. This report explores the implications of this trend with regards to costs, wait-times and other issues associated with healthcare delivery.

The Alberta government promised to provide a cost-benefit analysis to demonstrate to Albertans the value of utilizing for-profit service providers in the delivery of publicly funded health care.[1] To date this has not been completed or published. This report provides some of the information necessary to do that cost-benefit analysis on the basis of information and data garnered through the Freedom of Information and Privacy (FOIP) request process.

This report is the second in a new series by the Parkland Institute: Delivery Matters. The first report examined delivery of long-term and continuing care services and provided a solid body of evidence that quality is significantly poorer in investor-owned facilities. Similarly, this report explores the delivery of clinical services, specifically arthroplasty or total hip and knee replacements, through private, for-profit clinics. It includes a case study of Calgary's Health Resources Centre (HRC) that specifically examines the cost, quality, access and other implications of expanding this form of provision and places it in the context of national and international research. It also examines a wait-list reduction pilot project, the Alberta Hip and Knee Replacement Project, which includes for-profit and not-for-profit providers, allowing for a comparison of the two models.

1 Legislative Assembly of Alberta. 2011. *Alberta Hansard*. March 3, 2011. P. 178.

CONTEXT

In 2000, Alberta passed Bill 11, also known as the Health Care Protection Act.[2] This bill enabled public payment for surgical services at private surgeries in Alberta. The bill was introduced after heated debate over the difference between private surgeries and hospitals and the risks of allowing investor-owned surgeries to operate, a debate that has continued both provincially and nationally.

Understanding what 'private' and 'public' mean in the Canadian health care context is essential. There are two distinct elements that require clarity and appropriate languaging – the financing of health care (how it is paid for) and the delivery of health care (how it is provided). Both financing and delivery can be public, quasi-public and private. This report will focus on the delivery side of the issue.

The delivery of hospital and other medically necessary services has traditionally been done by either public hospitals or not-for-profit ones. Including for-profit facilities in the delivery mix is relatively new. Private for-profit companies are a rapidly growing entity on the health care landscape. They tend to be referred to as 'focused' because they deliver a specific clinical services such as MRIs, long-term residential care for seniors, laser eye treatments, cosmetic surgery and similar procedures that are either privately purchased or publicly funded.[3] Increasingly, private surgeries have figured into the mix. It is this change and the question of for-profit verses not-for-profit/public delivery that is the focus of this study.

1. HRC CASE STUDY – A DEEPER LOOK

The Health Resource Centre, based in Calgary and owned by Networc Health Inc., was Alberta's flagship private surgical facility until it went bankrupt in 2010. Networc Health Inc. (Networc) was an Alberta based and run company that provided surgical services to a variety of third-party payers such as out-of-province or federal insurers. Networc was founded in 1997 by President and CEO Tom Saunders, an accountant who positioned the firm as a leading private rehabilitation and treatment company. Alongside the President were Chief Medical Officer for Networc Dr. Stephen Miller and COO, Bernie Simpson. Dr. Miller is a long-time vocal advocate in Canada and abroad of private, for-profit delivery of health care. He is also the former orthopedic site chief at

2 Government of Alberta. 2010. *Health Care Protection Act.* Edmonton: Legislative Assembly of Alberta. H-1 RSA 2000.

3 Bulloz, Julia, 2011. "Why the markets can't run hospitals." *Maclean's Magazine.* Science-ish Blog, December 5, 2011 http://www2.macleans.ca/2011/12/05/why-the-markets-cant-run-hospitals/

Foothills Medical Centre in Calgary, while Mr. Simpson is a former investment and securities specialist.

Networc continued to deepen its private for-profit delivery of clinical services to Albertans by merging with the Health Resource Group, a private surgical inpatient facility in Calgary that later gave birth to the Health Resource Centre (HRC). HRC initially focused the majority of its business on contracts with third-party payers such as Workers' Compensation Boards and private insurance, as well as out-of-country patients.[4] Over time this shifted and the bulk of its income was derived from Alberta Health Services (and formerly the Calgary Health Region).

A SPECIAL RELATIONSHIP: HRC AND ALBERTA HEALTH SERVICES (AHS)

In 2003, the College of Physicians and Surgeons of Alberta accredited HRC as an extended-stay non-hospital surgical facility to provide uncomplicated primary total hip and knee arthroplasty (replacement) surgical services.[5] It was the first facility to receive such status and, therefore, the only one at the time able to bid on government contracts. The college now lists 60 independent clinics across the province performing surgeries outside of hospital, with 12 of these performing multiple types of surgery – a huge increase since the introduction of Bill 11 in 2000.[6]

Less than a year after accreditation, the former Calgary Health Region began negotiations with HRC to 'eliminate the backlog of patients waiting for hip and knee replacements.'

Prior to accreditation it had provided podiatry surgical services to the Calgary Health Region from October 2000 to September 2002. Even with this limited track record in total hip and knee procedures derived mainly from private third-party payers, the health authority moved ahead with a two-year contract for the provision of orthopedic surgical services valued at $5.1 million for 625 procedures per annum. The contract maximum was for $10 million per annum based on available funding and need. Additionally, this was a sole-sourced con-

4 Workers Compensation Boards are exempt from the Canada Health Act and can therefore legally purchase medically necessary services from private for-profit providers. Chodos, H., and MacLeod, J.J. (2003). Examining the Public/Private Divide in Health Care: Demystifying the Debate," Canadian Political Science Association. http://www.cpsa-acsp.ca/papers-2005/MacLeod.pdf

5 " Government of Alberta. 2002. "Rationale of Minister's Approval of Proposal Under the Health Care Protection Act: Calgary Health Region/Health Resource Centre," November 9, 2004, p. 2.

6 Glauser, Wendy. 2011. "Private Clinics Continue Explosive Growth." *Canadian Medical Association Journal,* May 17, 2011. 183 (8).

tract as HRC was the only operator within the region that had been accredited to provide overnight stays.[7]

It was not long before HRC had secured multiple profitable contracts from the government. As Table 1 below demonstrates, the Calgary Health Region – and later the superboard of Alberta Health Services – expanded and deepened their relationship with HRC year upon year with an increased number of surgeries and more responsibilities. By 2010, HRC had five contracts in play with the government and were negotiating additional surgical services such as spinal procedures.

7 Calgary Health Region. 2004. "Net Public Benefit: Proposal for entering into an agreement for surgical services." October 2004. Accessed by Parkland Institute under FOIP, p. 62.

TABLE 1 | Summary of Government of Alberta Contracts with Health Resource Centre Inc. (by year)

YEAR	CONTRACT	FEES PAID	ANNUAL TOTAL
2004/5	Orthopedic Surgical Services	$2,089,658	
		2004/5 TOTAL	**$2,089,658**
2005/6	Orthopedic Surgical Services	$4,917,843	
		2005/6 TOTAL	**$4,917,843**
2006/7	Orthopedic Surgical Services	$7,221,405	
	Acute Post Op and Sub-Acute Agreement	$29,194	
	Internal Medicine Consultation Services	$58,950	
		2006/7 TOTAL	**$7,309,549**
2007/8	Orthopedic Surgical Services	$7,473,854	
	Acute Post Op and Sub-Acute Agreement	$146,692	
	Internal Medicine Consultation Services	$157,418	
	Outpatient Services Agreement	$142,600	
		2007/8 TOTAL	**$7,920,564**
2008/9	Orthopedic Surgical Services	$7,584,883	
	Acute Post Op and Sub-Acute Agreement	$268,948	
	Internal Medicine Consultation Services	$170,468	
	Outpatient Services Agreement	$306,650	
		2008/9 TOTAL	**$8,330,949**
2009/10	Orthopedic Surgical Services		
	Acute Post Op and Sub-Acute Agreement		
	Internal Medicine Consultation Services		
	Outpatient Services Agreement		
		2009/10 Forecasted TOTAL	**$8,317,221**

Source: Alberta Health Services Briefing Note, June 24, 2009, Appendix B, Accessed by Parkland Institute under FOIP, p. 706,

HRC EXPANDS AND GOES BANKRUPT

The HRC was located in the former Grace Hospital, which was retrofitted to accommodate approximately 1,750 surgical inpatient procedures annually. HRC management identified an opportunity to further maximize profits through the expansion of space. HRC entered into construction and long-term lease agreements with Clark Builders and the Cambrian Group to develop and relocate to a new surgical facility with the capacity to do the 3,500 annual procedures anticipated for the Calgary Health Region.[8]

In 2008, the Calgary Health Region was subsumed by the superboard of Alberta Health Services. It wasn't until 2009 that negotiations were revisited on the expansion of HRC's surgical capacity and the construction of a new site. By this time significant progress had been made on the construction of the new private surgical facility by HRC. However, by early 2010, HRC was experiencing serious financial stress. On April 1, 2010, the Cambrian Group – HRC's landlords and creditors – applied for a bankruptcy order against Networc Inc. alleging that they were indebted to them for approximately $636,000 emanating from two unpaid lease agreements.

THE GOVERNMENT INTERVENES

Due to its heavy reliance on AHS for a high portion of the province's orthopedic surgeries, AHS was forced to intervene. AHS responded to the Cambrian Group's bankruptcy claim by requesting the appointment of and paying for an interim receiver (PriceWaterhouseCoopers Inc.) and purchasing HRC's debt and security.[9] This unusual step gave Alberta Health status as creditor and the presence of an interim receiver enabled them to delay bankruptcy proceedings.[10]

At the time, Alberta Health was expanding its own surgical capacity at the new McCaig Tower in the Foothills Medical Centre. This facility would not be ready until January 2011. It would seem that Alberta Health needed to take extraordinary measures to preserve Networc Inc. temporarily, so that it could maintain the volume of surgeries while completing the expansion of its own facilities.

8 Simpson, Bernie. 2010. "Affidavit of Bernie Simpson." Court of Queen's Bench of Alberta, Sworn August 31,2010. Bankruptcy No. BKO1-094004. point 12.

9 Affadavit Bernie Simpson. op. cit.

10 Court of Queen's Bench of Alberta. 2010. "Alberta Health Services v. Networc Health Inc." p. 5.

2. THE ALBERTA HIP AND KNEE REPLACEMENT PROJECT

In 2004 the provincial government initiated a pilot project to address a myriad of challenges within the arthroplasty field. One of the key elements of this pilot project was to address wait times as directed by the Premier's Advisory Council on Health and its Framework for Reform.[11] A partnership was carved out between Alberta Health – which contributed $20 million in funding – three regional health authorities (and their clinical partners including HRC), the Alberta Orthopedic Society, the Alberta Bone and Joint Institute and physicians from across the province.

In less than two years, the pilot was able to develop, test and successfully evaluate a new and innovative care path for hip and knee replacement patients. The 12-month randomized, controlled trial included 3,434 patients, of whom 1,570 received surgery. It was evaluated across a variety of dimensions such as accessibility, efficiency, effectiveness, appropriateness and acceptability, and was hailed as a major success.[12] As a result, the new continuum of care that was tested and developed has now been rolled out in the major urban centres that accommodate upwards of 80per cent of all hip and knee replacements in the province.[13] The trial illustrated that with improved management practices (such as centralized intake and assessment), realignment of resources, and collaboration and cooperation across the delivery path, costs can be reduced, wait times can be decreased and benefits to patients enhanced within the public, not-for-profit system. Specifically, the trial reduced overall wait times from family doctor through to surgery by 90per cent (from 19 months to approximately 11 weeks).[14]

HRC was involved in the hip and knee pilot from the start as part of its first agreement – and growing 'special relationship' – with the region.[15] The initial contract with HRC was seen by the government as a 'stop gap' to deal with wait-list congestion and ensure Calgary's participation in the Hip and Knee Pilot Project.[16] At this stage HRC had only completed 75 hip and knee procedures.

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11 "A Framework for Reform," Report of the Premier's Advisory Council on Health, December 2001, p.6

12 Alberta Bone and Joint Health Institute. 2006. "Alberta Hip and Knee Joint Replacement Project Evaluation Report."

13 Marshall, Deborah, Paul Rogers, Thomas Rohleder, and Sonia Vanderby. 2010. "System Dynamics Modeling: A Decision Support Tool to Improve Care for Hip & Knee Osteoarthritis." Institute for Health Economics. March 2010.

14 Gooch KL, Smith D, Wasylak T, et al. 2009. "The Alberta Hip and Knee Replacement Project: a model for health technology assessment based on comparative effectiveness of clinical pathways." *Int J Technol Assess Health Care* 2009; 25:113–23

15 Affadavit of Bernie Simpson. Op. cit. p7.

16 Calgary Heath Region. 2004. Op. cit. FOIP docs, p. 61

3. RISKS AND OPPORTUNITIES OF HRC

The next section will examine the costs and risks associated with the HRC. The surgeries were more expensive, but came with significant risk in other areas as well: the dependency between the parties became detrimental to both; the relationship created expensive duplication of capital and lack of control over infrastructure planning; and the private contract meant a serious lack of accountability and transparency. Additional risks identified in international studies include lower quality of services and poorer articulation with the broader health community. The following section examines these risks in more detail.

HRC SURGERIES COSTS MORE

From the outset the government was willing to accommodate corporate 'profit' as an acceptable cost for addressing wait lists. The government stated that, "...this benefit outweighs any additional cost of contracting the procedures."[17] The government's long-promised cost-benefit analysis on the value of utilizing for-profit service providers in the delivery of publicly financed health care has never materialized. An 'apples to apples' comparison by the government would require a level of transparency and access to data not provided by the now-bankrupt HRC or, more importantly, Alberta Health Services. Documents accessed through the FOIP process illustrate not only that costs were higher but that there is a significant under-estimate of costs. Table 2 clearly shows that HRC was charging more for surgeries it conducted.

Table 2 Alberta Health Services: Comparison of Case Costs provides solid evidence to counter the claim that HRC was cheaper than the public solutions available.

TABLE 2 | Alberta Health Services: Comparison of Case Costs (by procedure)

SURGERY (Contracted)	AHS CALGARY CASE COST	HRC CASE COST	COST DIFFERENCE (Relative to AHS Calgary Cost)
Total Joint Replacements			
Total Hip Arthroplasty	$7,238	$7,724	More expensive by $486
Total Knee Arthroplasty	$7,238	$7,724	More expensive by $486
Total Shoulder Arthropasty	$7,851	$8,369	More expensive by $515
Other Procedures			
Foot and Ankle Procedure	$5,677	$7,491	More expensive by $1,814

Source: Alberta Health Services Briefing Note, June 24, 2009, Appendix A. Accessed through FOI request. p. 705,

17 Government of Alberta. 2004. "Rationale of Minister's Approval of Proposal Under the Health Care Protection Act: Calgary Health Region/Health Resource Centre," November 9, 2004, p. 3.

The cost difference is partially accounted for in the profit or return on investment (ROI), which is budgeted at 10% (pre-tax ROI).[18] The costing in Table 2 likely underestimates significantly the costs of the investor-owned surgery because it is not a straight comparison of like facilities, does not include public subsidies, and does not include oversight costs.

1. IT IS NOT AN 'APPLES TO APPLES' COMPARISON
    a. The comparison in Table 2 is not based on economies of scale. AHS uses a "regional average" for its calculations that differs greatly from the costs associated with a focused or specialized clinic such as HRC. Specialized clinics that do a narrow range of surgeries will have lower costs associated with changeover in the operating rooms and lower overhead costs than larger, more diverse hospital that also provide emergency care.
    b. The costing model in Table 2 also does not consider that the private surgery does not take on the more complicated cases. The relationship was specified to include non-complicated cases,[19] leaving the more mixed and challenging caseload to the public system – raising overall costs.

2. SUBSIDIES
    Over the years HRC benefited from public subsidies that were not considered in the cost comparison in Table 2.
    a. HRC was physically located in the former Grace Hospital, a publicly built hospital.
    b. HRC was part of a government-initiated publicly funded pilot project – the $20M hip and knee trial.

3. BANKRUPTCY COSTS
    The financial costs to citizens as a result of this for-profit bankruptcy have been in the millions. The expenditures of the interim receiver were covered by Alberta Health and, according to a variety of media outlets at the time, included hefty bank charges and monthly rental fees totaling anywhere from $3-5M in taxpayer dollars. Add to this the costs of ongoing joint replacement surgeries carried out by HRC throughout the legal process. This is also in addition to the costs associated with the absorption of HRC staff back into the public sector and the negotiations with relevant unions to do so in a smooth and minimally disruptive manner.

18 Calgary Health Region. 2009. Economic Analysis." May 28, 2009. Accessed by Parkland Institute under FOIPPA. P. 698.

19 Government of Alberta, Rationale of Minister's Approval of Proposal Under the Health Care Protection Act: Calgary Health Region/Health Resource Centre, November 9, 2004, p. 2.

Taking these issues into account, we can confirm that the total joint replacements conducted by HRC came with a much higher price tag than even Table 2 indicates. Shareholder returns and higher costs for administration, overhead and purchasing translated into higher costs for surgeries.

INTERNATIONAL EVIDENCE ON HIGHER COST

The HRC case is an illustration of the costs and risks of for-profit delivery but it is certainly not the only example. Private firms are driven by incentives that differ greatly from the public sector in the delivery of health care. They have fiscal bottom lines that shareholders want to see maximized and they employ a variety of corporate tools to ensure this goal is met. These include minimizing labour costs, minimizing quality and reduction of costs associated with non-profitable or performing aspects of their portfolio.[20] Other costs have been well documented with solid evidence that more for-profit finance would increase administrative costs and decrease equity.[21]

Devereaux published a study in 2004, which determined that for-profit hospitals in the U.S. are 20 per cent more expensive than not-for-profit organizations.[22] Costs not only refer to the actual service being provided (i.e. total hip replacement) but also to the management, oversight and administration overheads of the corporate entity itself. Devereaux says it best when he states, "(p)rivate for-profit facilities typically have to generate 10 to 15 per cent profits to satisfy shareholders. Not-for-profit facilities can spend that money on patient care."[23]

In a similar vein, Woolhandler and Himmelstein, who write extensively on the cost of for-profit incursions into health care in Canada and the U.S., assert that "... investor-owned hospitals are profit maximizers, not cost minimizers. Strategies that bolster profitability often worsen efficiency and drive up cost. Investor-owned care embodies a new value system that severs the community roots and Samaritan traditions of hospitals, makes physicians and nurses into instruments of investors, and views patients as commodities."[24]

The public sector benefits from economies of scale in both administration

20 Deber, Raisa. 2002, "Delivering Health Care Services: Public, not-for-profit, or private." Commission on the Future of Healthcare in Canada. Discussion paper. No. 17. p20

21 Rachlis, Michael, 2007. "Privatized Health care won't deliver," Wellesley Institute, October 2007, p. 1.

22 Devereaux PJ, Ansdell-Heels D, Lacchetti C, et al. "Payments for care at private for-profit and private not-for-profit hospitals: a systematic review and meta-analysis." *Canadian Medical Association Journal* 2004;170:1817–1824.

23 Rachlis. 2007. Op. cit. p.20.

24 Woolhandler, S. and Himmelstein, D. 2004. "The High Costs of For-Profit Care," *CMAJ* June 8, 2004 vol. 170 no. 12 void: 10.1503/cmaj.1040779

and bulk purchasing that make it difficult for the private sector to compete on cost. This is the case for private surgeries in Calgary. In its response to the Minister's Advisory Committee on Health, the Chamber clearly was speaking on behalf of healthcare companies seeking greater access to the market through less regulation and increased competition. The Chamber acknowledged that there was a cost advantage in the public system in advocating for the government to "...level the playing field for both for-profit and non-profit facilities to access the cost savings of bulk purchases of equipment and supplies by Alberta Health Services."[25]

INVESTOR-OWNED HAS OTHER RISKS

The additional risk associated with investor-owned facilities delivering critical medically necessary services is that both sides are dependent on the relationship, and the public are at serious risk if either side falters.

HRC is not the only example of an investor-owned health service going bankrupt with significant impact on the public. Recently, two seniors' retirement facilities in Red Deer, Alberta faced bankruptcy. Though the for-profit businesses managing the homes were not in receipt of provincial funding, many of the seniors who resided there were. As a result, Alberta Health has had to allocate scarce resources to monitoring the company – and managing the fallout from the legal process.

In the U.K., the catastrophic demise of Southern Cross, a private equity firm responsible for seniors' care homes across the country, is yet another example. Like HRC, though on a much grander scale, Southern Cross pursued a heady expansion strategy that was derailed by both the financial crisis and a shortage of clientele referred by the local government authority to its homes. These economic "shocks" translated into crashing share prices and an inability to repay loans that resulted in Southern Cross's insolvency and enormous instability for the 31,000 seniors residing in their homes.[26]

HRC's vulnerability is obvious. As Bernie Simpson himself stated, "HRC cannot carry on its business of publicly funded, privately delivered surgical services except as and to the extent that AHS agrees."[27] Accordingly, Raisa Deber asserts in her analysis Delivering Health Care Services, "...it is difficult to envision private provision from public funds within a competitive model; the

25 Calgary Chamber of Commerce. 2010. "Minister's Advisory Committee on Health report could improve private sector's ability to deliver public health care." New Release, January 20, 2010.

26 Wearden, Graeme. 2011. "The Rise and Fall of Southern Cross." Guardian. *The Guardian,* June 1, 2011. http://www.guardian.co.uk/business/2011/jun/01/rise-and-fall-of-southern-cross?intcmp=239

27 Simpson. 2010, Op. cit. point 8,9.

financial risk to providers would appear excessive. The proposal that for-profit services be allowed to compete in the market as long as funds come from public sources is particularly unrealistic."[28]

POORER QUALITY - Parkland Institute's Fact Sheet "Delivery Matters," on the impacts of for-profit involvement in long-term care facilities illustrates that the type of ownership of residential long-term care facilities is a determinant of the quality of care provided. According to national-level research findings, "[w]hile the link between for-profit facility ownership and inferior care does not imply that all for-profit facilities provide poor care, the evidence suggests that, as a group, such facilities are less likely to provide good care than non-profit or public facilities." The for-profit motive of generating income, through reducing staffing levels and other means, appears to often result in inferior quality of care.[29]

Research by McGregor and Comondore and Devereaux shows that for-profit companies are more likely to deliver poorer quality care, or cost more, or simply be a much riskier choice for governments and, ultimately, patients.[30] [31] In Devereaux's study of for-profit and not-for-profit clinics delivering kidney dialysis services in the U.S., it was determined that patients attending for-profit dialysis clinics had eight per cent higher death rates and that the staff were fewer and less well trained.[32]

DUPLICATION AND LACK OF CONTROL – Having private deliverers reduces the ability of the government to effectively allocate resources to infrastructure and plan capacity, and makes for costly duplication. Both HRC and AHS were constructing surgical facilities – the McCaig Towers and the HRC facility – at the same time with no coherence in strategic plans. With the profit motive as a driver, the investors are apt to aim for growth and expand capacity. In this case, HRC made expensive expansion commitments without any formal agreement from the government and no written contract for services. This expansion meant high capital costs, duplicating capacity and ultimately jeopardized the whole delivery system.

28 Deber, R., 2002. Op. cit. p.36.

29 Parkland Institute. 2012. "Delivery Matters: The Impacts of For-Profit Ownership in Long Term Care," Parkland Institute, University of Alberta. Feb 2012.

30 McGregor, Margaret and Ronald, Lisa. 2011. "Residential Long Term Care for Canada's Seniors: Non-profit, For-Profit or Does it Matter?" Institute for Research in Pubic Policy (IRPP), No. 14, January 2011

31 Comondore, V.R., P.J. Devereaux, et al. 2009. "Quality of Care in For-Profit and Not-for-Profit Nursing Homes: Systematic Review and Meta-Analysis." *British Medical Journal.* 339:b2732.

32 Devereaux, PJ, HJ Schunemann, N Ravindran et al., "Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: a systematic review and meta analysis," *Journal of the American Medical Association*, 2002; 288:2449–2457.

LACK OF COMMUNITY ENGAGEMENT – Non-profit health services are much more likely than for-profits to expend resources on linking different organizations together to plan community networks, engage their communities and enlist volunteers, and to provide continuing education and training programs.[33]

LACK OF ACCOUNTABILITY AND TRANSPARENCY – The HRC example demonstrates how little information the public is privy to regarding the machinations of public-private partnerships, yet how drastically these strategic decisions impact taxpayers and patients. The government signed numerous contracts with HRC agreeing to higher costs but has not provided a publicly available cost-benefit analysis as promised. Confidentiality clauses within contractual arrangements have made it exceedingly difficult for the public to access information and data on cost, quality and access issues specific to HRC and its relationship with AHS.

This section has outlined a series of risks associated with the for-profit nature of the HRC including increased costs, lower quality, poor planning for infrastructure and duplication, poor communication with other service providers and the broader community, and the lack of transparency and accountability. This is consistent with the findings in the broader national and international studies.

The justification for taking on the cost and risk of investors delivering health care services was wait-list reductions. However, the public pilot project reveals that wait-time improvements can be achieved more reliably and at lower cost in the public and non-profit sectors.

4. COMPARING FOR-PROFIT TO NON-PROFIT

The Alberta government acknowledged that the for-profit surgeries would cost more but justified this with the wait-time reductions were worth the cost. The examination of the performance of HRC in contrast with the public non-profit elements of the pilot project helps to illuminate the wait-list issue. The analysis above reveals that the public partners in the Alberta Hip and Knee pilot are still working well, with wait-time advances at lower cost than the HRC and without the risks. Those risks are significant and costly. The public sector partners demonstrated that they were able to evolve and adapt by reducing the average length of stay in hospital, reducing wait lists and finding cost efficiencies through improved coordination.

The wait-list reduction achievements of this project were attained despite, not because of, for-profit involvement in the trial. It was the specialized or

33 Rachlis. 2007. Op. cit. p.17.

focused nature of the clinic, not the investor-owned nature, which increased patient access and enabled innovation. This is consistent with international evidence from Canada and abroad demonstrating that wait lists are actually lengthened as a result of the existence of for-profit entities delivering clinical health care services.[34]

What advocates of for-profit delivery suggest is that the removal of patients from the public queue will shorten the queue. What they fail to note is that the removal of health professionals from the public delivery system will slow down the system and result in the queue growing even longer. A study by 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.'[35]

The bankruptcy of course illustrates the risks of relying on a third party to address a critical public issue such as wait times. The wait-list improvements offered by the third party were short-lived and at high cost. The dependence of the public on the investor-owned clinic made the public very vulnerable when the clinic failed, worsening, not improving wait times.

The Alberta Hip and Knee pilot project demonstrates the capacity of the public health system to evolve and innovate in such a way that costs are maximized, wait lists are reduced, and patient outcomes are improved. The pilot set the stage for province-wide learning and provided a platform for a revolution in hip and knee surgical practices. Gains from the pilot continue to be made through the Transformational Improvement Program (TIP), which specifically addresses wait lists. Results to date show improvements in length of stay at almost every site, as well as gains in other key indicators of quality such as patient satisfaction and early mobilization after surgery. The rewards are substantial. They include higher volumes of surgeries as more bed days become available, greater satisfaction as patients move more quickly from referral to surgery, and reinvestment of the efficiency savings in ways that can further improve care quality and safety.[36] Our public health system is more than able to meet the needs of our citizens when the political will exists and resources are allocated.

Key to the success of the Alberta Hip and Knee pilot and its new care path was

34 Canadian Health Services Research Foundation, "Myth: A parallel system would reduce waiting times in the public system," Mar 2005.

35 Priest, A., Rachlis, M., Cohen, M., 2007. "Why Wait? Public Solutions to Cure Surgical Waitlists," CCPA and BC Health Coalition, May 2007, p.11.

36 Alberta Health Services. 2011. "Alberta's Transformational Improvement Program: Increasing Surgery Capacity and Improving Quality of Care for Hip and Knee Replacement Patients." Bone and Joint Clinical Network, Alberta Health Services, June 2011.

the strengthening of health care networks and communication and cooperation across different elements of the system. Benefits such as these are critical to patient outcomes but essentially lost on focused for-profits who, by their nature, remain outside the system.

The innovative potential of the public system has been much neglected in health reform initiatives. Dr. Michael Rachlis notes that there are a variety of ways that wait lists and costs can be addressed using public sector solutions. Examples of successful public wait time initiatives abound across Canada. These include 'queue management techniques' that tackle organizational inefficiencies in the system and the introduction of specialized, short-stay surgical centres.[37] Solutions such as this employ the same 'focus' used by the private surgeries yet reduce administrative, management and monitoring costs and eliminate the extraction of resources by shareholders. Indeed, a publicly financed and delivered specialized clinic for orthopedic procedures opened in Edmonton in 2012.

CONCLUSION

It matters who delivers clinical services. The spectacular fall from grace of HRC is a fascinating study in the ills of health care privatization, the risks to patient care, and the need to reiterate the importance of our publicly financed and delivered health care system. The case study of HRC is very consistent with international studies, validating the conclusion that for-profit incursions into the health care system are risky, costly and lack the accountability Canadians expect, demand and deserve.

The findings of this report are that HRC clearly cost more on a per surgery basis than public alternatives. The report also finds that the wait time gains were despite not because of the for-profit nature of HRC.

The success of the public partners in the pilot project on wait-time reductions in Alberta clearly shows that public solutions can achieve the same wait-list targets at less cost and much less risk to the public.

37 Rachlis, Michael, "Public solutions to health care waitlists," Canadian Centre for Policy Alternatives, Dec 2005.

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