

Delivery Matters:

THE HIGH COSTS OF FOR-PROFIT HEALTH SERVICES IN ALBERTA



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. In 2011 the college listed 60 independent clinics, with 12 performing multiple types of surgeries - a huge increase since the introduction of Bill 11 in 2000.

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. To date this has not been made public. 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 in terms of wait list reductions.

HRC SURGERIES COST MORE

From the outset the government admitted that the private surgery would cost more and 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." Table 2 clearly shows that HRC was charging more for surgeries it conducted.

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

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. Other costs have been well documented with solid evidence that more for-profit finance would increase administrative costs and decrease equity (see sources for references)

TABLE 1 | 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 Arthroplasty	\$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,

WAIT LISTS: THE ALBERTA HIP AND KNEE REPLACEMENT PILOT

In 2004 the provincial government initiated a pilot project to address wait times. 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. 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 80 per cent of all hip and knee replacements in the province. 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 90 per cent (from 19 months to approximately 11 weeks).

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 HRC was part of 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.

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. The innovative potential of the public system has been much neglected in health reform initiatives. National physician and research-

er, 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. 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.

CONCLUSIONS

It matters who delivers clinical services. 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.

SOURCES AND FURTHER READING

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.

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

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.

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.

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; vol. 170: 1817-1824.

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.

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 Public Policy (IRPP), No. 14, January 2011

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

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

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

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.104079