For-profit, user pay clinics won't solve waiting lists
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(**Winnipeg Free Press Headline:** Private Clinics Won't Help)

Picture yourself at age 65 losing your vision in one eye. You need cataract surgery. You are managing, but you would like to have the surgery before too long.

Your options include going to the local hospital, with no direct payment. Of course, you have paid, through your taxes, but that is what public health insurance is about. We all pay regularly, in anticipation that services will be available when we need them.

Alternatively, you can attend a private for-profit clinic and pay $1,000 for the procedure.
As far as you can tell, the quality of care will be the same. Either way you'll have to wait for 4 weeks for the procedure.

No doubt about that choice, right?

What if the wait were longer in the hospital? Say, eight weeks, versus four weeks in the clinic. You are managing fine with one good eye. Many people wouldn't want to spend $1,000 to move surgery up by four weeks. What if the difference were three months, or six months? How long would the difference have to be before you would fork out $1,000?

Two weeks ago in this column, I described how the British Columbia government prepared legislation cracking down on investor-owned for-profit clinics violating the Canada Health Act, and charging patients for quicker care. The Liberals passed the law, but then backed off. We'll never proclaim the law, said BC Premier Gordon Campbell, so it will never be enforced.

Apologists for those for-profit clinics suggest that they might reduce waiting lists in the public-pay system. Let people who can afford it pay, the argument goes, and it will take pressure off the not-for profit hospitals.

But the cataract scenario that started this article shows a gaping flaw in the logic. If there aren't substantial waits in the public system, why would anyone pay more for surgery?

If for-profit clinics substantially reduced waiting lists, they would drive themselves out of business. Investors who own clinics that charge patients depend on unacceptable waits in the public-pay system for the survival of their enterprise.

Wendy Armstrong of the Consumers' Association of Canada conducted a detailed two-year study of waiting lists for cataract surgery. Armstrong looked at three Alberta cities with varying degrees of privatization.

In Calgary, for-profit clinics performed100% of cataract surgeries. In Edmonton, not-for-profit hospitals carried out 80% of publicly insured cataract surgeries and for-profit clinics 20%. In Lethbridge, public hospitals carried out all the publicly insured cataract surgeries.

As it turned out, for-profit delivery appeared to increase the waits. Calgary patients waited an average of 16 to 24 weeks for surgery, Edmonton waits ranged from five to seven weeks, and Lethbridge four to seven weeks.

The more you think about it, the less surprising those results become. In order to shorten waiting lists, for-profit clinics would have to increase the total number of surgeries. That could happen only if there were more doctors, or each doctor performed more surgeries.

You don't need to be a health policy guru to realize that Canada has a doctor shortage. Are for-profit clinics going to create new doctors? Of course not.

What about doctors working harder? When patients are charged extra, doctors take home more per patient. For a given income target, that means surgeons would have to perform fewer operations. Indeed, in defending direct patient charges, doctors often say that it's not about money, it's about lifestyle. More time for them with their families, or just a lower stress level.

So, on average, the private-pay option will lower patient throughput, not increase it. Longer waiting lists, not shorter, will result.

Private-pay also changes the mix of who get operations. Investor-owned facilities make their profit by catering to low risk patients whose surgery is simple and who are unlikely to have costly complications. Such patients will move up the waiting list with for-profit care.

Even worse, perhaps, more patients who don't really need the surgery will get operations. Elective surgery is just that – take it or leave it, sooner or later. In a public-pay system, patients with mild problems – early cataracts for instance – are encouraged to wait. In private-pay, if you have the money, you are in the door, and on the operating table.

That means less opportunity for those who really need it. It also provides yet another reason that for-profit clinics actually increase public-pay waiting times.

The final irony is that our tax dollars subsidize the for-profit clinics' profits. That's because even low-risk patients sometimes get complications. What happens then? The patients go back into the public-pay not-for-profit hospitals that are equipped to deal with the problems.

Scratching the surface shows that the for-profit clinics won't shorten waiting times. They benefit the investors, some of the doctors, and wealthy patients. The rest of us subsidize the investors, and wait longer.