Commission on the
Future of Health Care
in Canada

Commission sur
l'avenir des soins de santé
au Canada

DISCUSSION PAPER NO.17

Delivering Health Care Services: Public, Not-For-Profit, or Private?

by

Raisa B. Deber, Ph.D.

University of Toronto

August 2002

The views expressed herein are solely those of the author and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

Contents

Highlights **v**

Executive Summary **vii**

Acknowledgments **x**

Purpose of This Paper **xi**

Defining Our Terms **1**
Elements of Health Care Systems: Financing, Delivery, and Allocation 2
Levels and Characteristics of Public and Private 3
Characteristics of Public Delivery 4
Characteristics of Private Not-For-Profit (NFP) Delivery 5
Characteristics of Private for Profit Small Business (FP/s) Delivery 6
Characteristics of Private for Profit Corporate (FP/c) Delivery 7
Characteristics of Private Delivery by Individuals and Their Families 8
Health Sectors, and Direct vs. Indirect Funding Flows 8

How Should We Evaluate Success? **9**

Interpreting Our Results **11**
Competition, Contestability, Complexity, and Measurability 11
Why (or Why Not) Public Delivery? 13
Where Can FP Firms Make Their Profits? 14
Strong Economies of Scale 14
Better Management 14
Freedom from Labour Agreements 14
Evasion of Cost Controls 15
Sacrifice of Difficult-to-Measure Intangibles 15
Risk Selection / Cream Skimming 15
Dubious Practices 16
Low Bids to Drive Out Competitors, Then Higher Charges? 16
Revenue Generation Outside the Publicly Funded System 17

Lessons Learned **18**
1. Comparisons Across Organizational Forms Are Difficult 18
Heterogeneity of Organizations 18
Differences in the Services Offered 18
Differences in the Clientele Served 18
Differences in the Cost Structure 18
Differences in the Regulatory and Market Environments 19
2. Comparisons Are Not Impossible 19
3. Competition and Cooperation Must Be Balanced 20
4. Measuring and Monitoring of Performance Is Essential 20

5. Measuring and Monitoring of Performance Can Be Costly and Difficult 20
6. Changing Delivery Structures Also Changes Power Relationships 22
7. Experiments Should Not Be Irreversible 22
8. Health Human Resources Issues Must Be Dealt With 22
9. For-Profit Delivery Requires Predictable Revenue Streams 23
10. Barriers to Meeting Patient Demands Can, and Must, Be Addressed 23

Appendix A: What the Literature Shows: Case Studies in Delivery 24
A Note on Statistical Analysis 24
Privatization of Local Government Activities 24
Public-Private Partnerships (the Private Finance Initiative) 26
Acute General Hospitals 29
Nursing Homes 34
Managed Care Companies 35
Social Services/Residential Care 36
Ambulatory Clinics 36
Laboratory Services 39
Home Care 40

References 42

Highlights

- How care is financed is not the same as how it is delivered.

- "Private delivery" is not a homogeneous category. Private providers can be not-for-profit (NFP) or for-profit (FP); in turn, for-profit includes a range from small businesses (FP/s), such as physicians' offices, to corporate organizations which are expected to provide returns on investment to their shareholders (FP/c). The characteristics, and implications, of these different types of organizations vary considerably.

- In Canada, most health care delivery is already private. Although about 70% of Canadian health care is financed publicly, almost all of this care is already delivered by private (usually NFP) providers.

- Comparing public, NFP, and FP delivery is complicated because they usually do not offer the same services. Because they need to make a profit, FP organizations will tend to serve potentially profitable services and client groups. Many attempts to compare costs or outcomes are, in effect, comparing "apples to oranges."

- The desirability of encouraging FP delivery depends upon how such firms make their profits. Potential 'win-win' situations exist if savings result from strong economies of scale (especially for services which can span jurisdictional boundaries) or better management. However, savings frequently arise from more contentious measures, including freedom from labour agreements (and different wage levels and skill mixes), evasion of cost controls placed on other providers, sacrifice of difficult-to-measure intangibles, risk selection/cream skimming, or even dubious practices.

- When services are delivered privately, it is necessary to monitor performance. Such monitoring is often costly and difficult; these costs must be included in any fair comparison of alternative delivery approaches.

- Performance monitoring is more likely to work for services whose outcomes are easy to measure; however, many health care services are too complex to be treated in this way.

- If performance cannot easily be monitored, NFP delivery is more likely to provide high quality outcomes than is FP delivery, with FP/c being the most vulnerable to poor outcomes.

- To the extent that economic advantages arise from private delivery, the literature suggests these derive more from the imposition of competition than from ownership type.

- Competition implies low barriers to market entry and exit, and may clash with expertise, trust, and cooperation.

- The assumption that we can have a competitive model with a single public payer is naive; firms require either predictable revenue streams or the possibility of revenue generation outside the publicly funded system.

- Experiments should not be irreversible, particularly given international trade agreements.

- Regardless of what decisions are made about delivery, it is essential that the client focus of the existing system be addressed with some urgency to discover why existing NFP organizations appear to be less nimble, innovative and flexible than their FP counterparts.

Executive Summary

What is the appropriate role for private delivery within Canada's health care system? The current debate has been characterized by more heat than light, with advocates talking past one another and using similar terms to mean very different things.

Defining Our Terms

Elements of health care systems: financing, delivery, and allocation: Health care systems are commonly divided into several components, including how services are paid for – which we will term "financing" – and how they are organized, managed, and provided – which we will call "delivery." The focus of this paper is on delivery – that is, we are concentrating upon the best way to deliver health care services, regardless of how they are paid for. Certain forms of delivery, however, may prove to be more compatible with certain approaches to financing; the questions are separate, but linked.

Levels and characteristics of public and private: Although we tend to speak loosely of "public" and "private," each of these terms contains multiple meanings and multiple levels. This paper summarizes characteristics of *public*, *private not-for-profit* (NFP), *private for-profit/small business* (FP/s) and *private for-profit corporate* (FP/c) delivery. It also notes that funding flows from government to providers can be direct (e.g., contracts with private laboratories) or indirect (e.g., contracting out by organizations receiving public money).

Where can FP firms make their profits? FP firms may make their profits in a number of ways, including strong economies of scale (especially for services which can span jurisdictional boundaries), and better management. However, savings frequently arise from more contentious measures, including freedom from labour agreements (and different wage levels and skill mixes), evasion of cost controls placed on other providers, sacrifice of difficult-to-measure intangibles, risk selection/cream skimming, and even dubious practices.

Competition, contestability, complexity, and measurability: The literature stresses that most of the efficiencies which arise from changes in delivery structures seem to result from introducing competition, rather than resulting from the incentives associated with private ownership. It also stresses that avoiding poor outcomes requires the ability to measure and monitor performance. Yet, this is not without cost. The ability to measure also depends upon the sorts of services being purchased. Many, but not all, health care services are complex and difficult to measure. The literature suggests that NFP delivery tends to be superior under such circumstances, precisely because NFP providers are less sensitive to bottom line incentives and hence are more likely to deliver the desired level of quality in such complex environments.

Competition is not always desirable either. It presupposes the existence of excess capacity (or low barriers to market entry and exit) and may accordingly increase costs through waste and duplication. Such factors as expertise and a good reputation are deemed barriers to contestability (since they impede market exit). Competition may also interfere with greater cooperation among providers. Careful balancing is essential.

What the literature shows: The literature reviewed includes case studies of: privatization of local government activities; public-private partnerships for capital development (e.g., the Private Finance Initiative); and comparisons among public, NFP, and FP delivery for such sectors as acute general hospitals, nursing homes, managed care companies, social services/residential care, ambulatory clinics, laboratory services, and home care. This paper concentrates on the lessons learned and includes brief descriptions of the case studies in Appendix A.

On balance, the literature suggests that FP/s delivery is less problematic than FP/c. Although FP/c can deliver excellent services when outcomes are measurable and economies of scale span jurisdictional boundaries, in practice, few clinical services meet these criteria.

Lessons Learned

1. Comparisons are difficult. Public, NFP, and FP organizations differ considerably among themselves; each contains a wide range of performance, ranging from excellent to poor. Any generalizations are likely to have exceptions. Attempts to compare performance across organizational types are further complicated because they tend to serve different market niches. FP firms are not identical to NFP organizations – they are likely to offer a different mix of services, to a different clientele, and with different cost structures. For example, the widely reported differences in costs and outcomes between FP and NFP hospitals in the US are difficult to interpret because none of the teaching hospitals in these studies were FP.

2. Comparisons are not impossible. The literature does find systematic differences, particularly with respect to responses to financial incentives.

3. Competition and cooperation must be balanced. Health reform has stressed the need to improve integration and coordination across health providers; competition can introduce additional barriers to such cooperation.

4. Measuring and monitoring of performance is essential, particularly in contracting arrangements.

5. Measuring and monitoring of performance can be costly and difficult. When desired outcomes are difficult to specify precisely, contracts may become elaborate and costly, with particularly adverse impacts on smaller providers.

6. Changing delivery structures also changes power relationships, and with them, how resources are allocated.

7. Experiments should not be irreversible, particularly given international trade agreements.

8. Health human resources issues must be dealt with. Although flexibility can be highly desirable, the literature suggests that much of the savings which arise come from curbing the power of trade unions and transferring public resources from workers to investors. This can be problematic in the long term, particularly if labour shortages result.

9. For-profit delivery requires predictable revenue streams. The assumption that we can have a competitive model with a single public payer is naive; firms require either predictable revenue streams or the possibility of revenue generation outside the publicly funded system.

10. Barriers to meeting patient demands can, and must, be addressed. Regardless of the delivery forms used, barriers which impede existing NFP organizations from innovating and meeting patient demands must be addressed with some urgency.

Acknowledgments

The literature is voluminous, and this paper has merely scratched the surface. Enormous thanks are due to the many colleagues who assisted me by suggesting material, including: Owen Adams, Wendy L Armstrong, Lillian Bayne, Andrea Baumann, Glenn Brimacombe, Adalsteinn D. Brown, Marcy Cohen, Brian Lee Crowley, P.J. Devereaux, Colleen Flood, Colleen Fuller, Carole Kushner, Jonathan Lomas, Tom McGowan, Ted Marmor, Michael Mendelson, Larry Nestman, Michael Rachlis, Thomas Rathwell, Paddy Rodney, Leslie Roos, Noralou Roos, Evelyn Shapiro, William Tholl, and A. Paul Williams, plus several who asked not to be formally recognized. They are not responsible for the interpretations made.

Purpose of this Paper

The Commission requested that this paper be focused on the following question:
"How should the Canadian system determine whether government, non-profit organizations or for-profit organizations deliver which programs and services?"

Defining Our Terms

The question of the appropriate mix between public and private has become a topic of considerable heat; the intention of this paper is to clarify the discussion.

On the one hand, many of the recent provincial reports examining Canadian health care have suggested that more "privatization" is needed. Perhaps the strongest recent statement to that effect has come from the Premier's Advisory Council on Health for Alberta which argued that the current system "operates as an unregulated monopoly where the province acts as insurer, provider and evaluator of health services." Nonetheless, this report echoes similar language from other organizations (Preker and Harding 2000; Preker, Harding, Travis 2000; Crowley, Zitner, Faraday-Smith 2002; Zitner and Crowley 2002). The Alberta report goes on to recommend that "[w]e can't regulate to perfection. It's time to open up the system, take the shackles off, allow health authorities to try new ideas, encourage competition and choice, and see what works and what doesn't" (Premier's Advisory Council on Health for Alberta 2001).

This debate is not confined to Canada. Internationally, however, the public-private debate has been marked by considerably more heat than light. Countries use a wide variety of delivery mechanisms and models; because particular features are embedded within wider systems, one cannot directly extrapolate performance across systems (Organisation for Economic Co-operation and Development 1987; 1994; Marmor 2001). Nonetheless, the advocates of more private sector involvement argue that this is essential to preserve a universal and sustainable health care system, and that private delivery within the context of "public-private partnerships" is likely to be more efficient and can lead to considerable improvements in obtaining value for money (Kelly and Robinson 2000; Arnold 2001; Commission on Public Private Partnerships 2001). On the other hand, opponents of for-profit delivery point to a host of difficulties they fear will arise from greater use of the "private sector" for delivery, including worries about the compatibility of the values inherent in health care with those underlying markets (Relman 1992; Woolhandler and Himmelstein 1997; Fuller 1998a; b; Himmelstein et al. 1999; Kushner 1999; Arvay Finlay 2000; Evans, Barer, Lewis et al. 2000; Taft and Steward 2000; Heyman 2001; Rachlis, Michael, Evans, Lewis et al. 2001). Policy initiatives, such as Alberta's Bill 11, have become emblematic of the disputes as to the appropriate role of for-profit delivery within a publicly funded system (Fuller 1998a; Alberta Health 2000; Arvay Finlay 2000; CCPA – Canadian Council for Policy Alternatives, Armstrong, Armstrong et al. 2000; Choudhry 2000; Plain 2000; Rachlis, Michael 2000).

If we assume that both sides are acting from excellent motives, it is important to recognize the extent to which the two sides have been talking past one another, using similar terms to mean very different things. Because individuals are rarely assigned randomly to public, NFP, FP/s, or FP/c providers, the evidence is often contentious, with advocates of the various positions often resorting to claims that various organizations are or are not comparable. There is remarkably little disinterested information, and a plethora of papers stating positions without benefit of supporting evidence. Before evaluating the evidence about public and private delivery, then, let us stop to define our terms, in full recognition that this paper on occasion superimposes a conceptual framework other than that used by the authors being cited.

Elements of Health Care Systems: Financing, Delivery, and Allocation

Health care systems are commonly divided into several components. Although different writers may use slightly different nomenclatures and break down these functions in slightly different ways, they all note the importance of distinguishing between how services are paid for – which we will term *"financing"* – and how they are organized, managed, and provided – which we will call *"delivery"* (Organisation for Economic Co-operation and Development 1987; Donahue 1989; Deber, Narine, Baranek et al. 1998). Health care systems may also explicitly incorporate other elements – such as planning, monitoring and evaluating – or leave these to the workings of market forces. "Privatizing" a health care system may accordingly involve changes in financing (e.g., budget reductions, user fees, etc., activities which Bendick terms "load shedding") and/or in delivery (e.g., vouchers, contracting out, grants and subsidies, or public-private partnerships) (Bendick 1989; Kamerman and Kahn 1989).

The "missing link" connecting financing and delivery which has sometimes been termed "*allocation*," refers to the incentive structures set up to manage how funds will flow from those who pay for care to those who deliver it. Saltman et al. have suggested allocation approaches can be placed on a continuum (Saltman and von Otter 1992; 1995; Deber, Narine, Baranek et al. 1998; Saltman, Figueras, Sakellarides 1998). At one end, "patients follow money" as funders allocate global budgets to providers. At the other, "money follows patients" as providers are dependent upon attracting clients. Unfortunately for those wishing clear reform prescriptions, there is no one best allocation model which can ensure cost control, client responsiveness, and delivery of high quality appropriate care; instead, one is often faced with policy tradeoffs (McFetridge 1997). Nonetheless, there is clearly room for improvement.

The focus of this paper is on delivery rather than on financing or allocation – that is, we are concentrating only upon the best way to *deliver* health care services, regardless of how they are paid for. However, it must be recognized that whereas approximately 70% of Canadian health expenditures comes from public sources, this has been heavily concentrated in particular sectors. Those services falling under the comprehensiveness provisions of the *Canada Health Act* receive almost all of their expenditures from public sector sources, with the Canadian Institute for Health Information (CIHI) estimating the public share at 99% of expenditures for physician services, 90% of expenditures for hospital care, and variable but considerable portions of such other services as pharmaceuticals, home care, or rehabilitation (Canadian Institute for Health Information 2000a; Deber 2000). Public policy clearly has more interest in how best to deliver those services which are being paid for from public money, if for no other reason than to ensure accountability for the use of public funds. We will therefore concentrate on assisting in answering the question of what difference it makes how we chose to deliver publicly-financed services. However, as we will see, certain forms of delivery may prove to be more compatible with certain approaches to financing; the questions of financing and delivery prove to be separate, but linked. Neither will this paper deal with issues of the underlying values involved, although these are clearly critical to making policy decisions. This paper takes on a more limited role which we believe provides the essential underpinning; assuming that one accepts the observation of Deng Xiaoping that it does not matter whether a cat is black or white as long as it will catch mice, it examines the evidence basis for predicting the relative performance of various delivery options.

Levels and Characteristics of Public and Private

Although we tend to speak loosely of "public" and "private," each of these terms contains multiple meanings and multiple levels (Starr 1989; Ovretveit 1996; Canadian Healthcare Association 2001). As Starr has noted, the terms "public" and "private" are usually paired to denote such oppositions as "open" versus "closed," "government" versus "markets," or "the whole" versus "the part" (Starr 1989). Starr cautions that because the terms "public" and "private" do not have consistent meanings in different institutional settings, it is risky to generalize about the merits of privatization as public policy beyond a particular institutional or national context. Neither are the boundaries between public and private always clear; there exist a number of organizations, often highly regulated and/or dependent upon public funds which profess public service objectives, and which can be classified as either public or private, depending upon the precise definitions being used. Examples include Workers Compensation, the sickness funds used to finance health insurance in certain European countries, or even the regional health authorities in place in many Canadian provinces. One not only has to look at the ownership structure but also the broad framework of incentives that determine how these institutions behave.

One can combine the public/private and the financing/delivery dimensions to create the following 2x2 table (Donahue 1989; Deber, Narine, Baranek et al. 1998). In Canada, the public financing-public delivery cell (National Health Service type model) includes most public health departments (whose employees usually work for some level of government), as well as provincial psychiatric hospitals, and home care in some provinces. Private financing-public delivery captures both publicly-delivered services which rely heavily upon user fees (e.g., public transit, non-privatized post offices, etc.), as well as such health care examples as "pay beds" in the UK's National Health Service hospitals (Higgins 1988; Ovretveit 1996). Most physician and hospital care in Canada are in the public financing-private delivery cell, while the 30% of privately financed care (e.g., much of pharmaceuticals, rehabilitation, dental care, complementary and alternative medicines, etc.) is largely in the private financing-private delivery quadrant.

	Public (collective payment)	Private (individual payment)
Public Sector Delivery	National Health Service	User fees for public services
Private Sector Delivery	Public Insurance	Private Insurance

The distinction between public and private, however, blurs important distinctions *within* each of these categories. The next section will accordingly categorize various forms of public and private delivery, and summarize some of the contentions from the literature about their characteristics, in full recognition that such organizations tend to be heterogeneous.

Characteristics of Public Delivery

It is well recognized that *public* encompasses at least four distinct levels:

- federal (national government)
- sub-national (state/provincial governments)
- regional governments/authorities
- local governments

Indeed, many of the fiercest battles are being waged *within* the public sector, as various levels of government dispute roles, responsibilities, and who should pay for what.

In terms of service delivery, public organizations are seen to have the following characteristics:

- Their employees are members of the civil service of that jurisdiction.
- They are more likely to have unionized workforces.
- They may have a monopoly on certain types of service provision.
- If the government unit is small, they may find it more difficult to justify (or attract) the critical mass of expertise needed for certain activities.
- They are bound by civil service rules and procedures about a host of issues, including the need for formal procurement and bidding procedures.
- Their operations are subject to transparency and disclosure provisions.
- They cannot raise capital through issuing equity (although they may be able to float bonds). Instead, they must satisfy voters that their claim to tax revenues is warranted.
- They have a number of goals which must be balanced, of which only one is the financial bottom line/efficiency. (Among these goals may be the provision of "good jobs" in areas of high unemployment. Other authors suggest that public delivery tends to emphasize universal coverage, uniform services and quality, and uniform prices which may in turn lessen bottom line efficiency while serving other goals.)
- Depending upon the accounting procedures in place, they may have difficulties in spreading capital expenditures over many years or otherwise depreciating capital assets (e.g., some jurisdictions require the full cost of capital programs to be brought into a single year's budget).
- They are not likely to attract charitable donations or volunteer labour.

Accordingly, although the evidence is mixed, they are often viewed as being bound into "silo thinking," (that is, being unable to co-operate across organizational barriers), more rigid/ less flexible/less nimble, less effective, and more complacent (because of the absence of competition). Certainly, they will have more difficulty in using part-time or temporary help to manage peak service periods, or spreading equipment/capital costs over many jobs. The requirements for accountability may inhibit the ability to take risks, and hence to innovate. Technology may be more antiquated. In recent years, the search for efficiency has led to urging that government separate policy from delivery, concentrate only on core functions, and put its efforts into "steering" (managing policy development and providing leadership) rather than "rowing" (directly delivering services) (Osborne and Gaebler 1992; Skelly 1996; Ford and Zussman 1997; Preker and Harding 2000). Indeed, internationally, many formerly public

organizations in developed and developing nations have been privatized (Hatry 1983; DeHoog 1984; Carroll, Conant, Easton 1987; Donahue 1989; Kamerman and Kahn 1989; Clutterbuck, Kernaghan, Snow 1991; Kemp 1991; McFetridge 1997; Yergin and Stanislaw 1998)

In some countries, including the UK or Sweden, health care has traditionally been delivered by the public sector. The National Health Service (NHS) in Britain owns and operates hospitals, and its workers work for the national government. Swedish hospitals are run by their county councils. In contrast, in Canada, very little delivery of health care occurs within the public sector. As noted above, there are exceptions, including services to the military and northern or aboriginal communities (federal employees), provincial psychiatric hospitals, and public health. Nonetheless, any analysis of delivery in Canada must begin with the recognition that most of it is *already* private.

It is less commonly recognized that *private* also encompasses many levels. In this paper, we will concentrate upon four major levels of the private sector.

Characteristics of Private Not-For-Profit (NFP) Delivery

This heterogeneous category of organizations is referred to by a variety of terms, including non-profit, not-for-profit, voluntary, community, or the "third sector." These organizations may receive their revenues from a combination of charitable contributions, government contracts, or revenues from services provided. They may employ skilled workers or rely upon volunteers. They may work closely with government or at arms length. Indeed, they may carry out publicly-determined purposes. At one extreme, these nominally private bodies can become quasi-public. For example, in British Columbia, home support workers may be employed by Community Health Councils which some observers classify as "public" (Pollak 2000). These councils are a component of B.C.'s regional health authorities; in turn, they are classified by the B.C. government as being among the nearly 700 "public agencies" to whose boards the provincial government makes at least one appointment (Government of British Columbia Board Resourcing and Development Office 2002). Nonetheless, many of these "public agencies" are not subject to the financial or administrative requirements of the provincial government, and in our terms would be termed private NFP. NFP organizations have the following characteristics.

- They are not part of government, and as such are not bound by most of their 'red tape' (although the recent trend towards 'accountability' may in turn increase such formal requirements and move them closer to the 'public' end of the continuum).
- Although they can run a 'surplus' of revenue over expenditures, they cannot distribute this surplus to individuals in the form of profits. They can spend it in other ways, including higher wages or 'perks' to their employees and managers, training/education, research, community service, or subsidizing less profitable services. Some, but not all, of these activities might be judged as 'public goods' which benefit the community.
- They receive special tax exemptions from government.
- They can draw upon volunteers, and receive charitable contributions, as well as grants and contributions from governments.
- They are motivated by multiple objectives, rather than just the financial bottom line.
- They can go bankrupt.

NFP firms have played a critical role in education, health, and social services in most countries; in Canada, they are the dominant form of organization within these sectors. Indeed, most proposals for "privatization" instead represent a shift within private delivery from NFP to FP organizations. The importance of distinguishing between financing and delivery is made evident by considering this category. Canada's "public" hospitals are often, erroneously, classified as being part of the public sector, instead of being recognized as NFP organizations, with independent community-based boards of directors and a long tradition of service to their communities. In addition to the understandable confusion engendered by the title "public hospitals," some authors confound financing and delivery and argue that hospitals are public because they receive about 90% of their budgets from public sector sources. In response, it should be recognized that CIHI reports that 99% of expenditures for physicians' services come from public sources, but the distinction between physicians who work for government (e.g., in provincial psychiatric hospitals) and those in private practice is still clear. Further confusion may arise in provinces such as Ontario which classifies "public hospitals" within the MUSH (Municipalities, Universities, Schools, and Hospitals) sector, because these receive provincial transfers, thus blurring municipalities and public schools which are indeed public, with universities and hospitals which are not. It is important to recognize that hospital (and university) management has considerable autonomy to determine their mix of staff and services, whereas public school principals do not.

The distinction between public and NFP is a critically important one, in large part because many of the arguments made against public delivery do not fully apply to NFP organizations. Nonetheless, the distinction is becoming less clear in some provinces than in others, particularly as provinces move to demand increased accountability for public funds. The move towards regionalization in all provinces other than Ontario which replaced many formerly independent hospital boards with regional health authorities, has further blurred this distinction. Although in theory the regional authorities remain private organizations, whose employees do not work for government, in practice some provincial governments have sought to exert more and more control over their day-to-day operations. Recognizing that the line can be blurry, however, does not eradicate it, although it may suggest the need for more careful balancing of new accountability requirements against allowing flexibility and responsiveness from NFP agencies.

Characteristics of Private for Profit Small Business (FP/s) Delivery

This category of organizations includes small business/entrepreneurs which are privately owned (often by the health professionals delivering the service), but need not answer to shareholders. In Canada, this category includes virtually all physician services other than those delivered by salaried hospital employees, as well as many other providers (e.g., physiotherapy clinics). This category also encompasses many clinics and small hospitals, such as Ontario's Shouldice Hospital (Shouldice Hospital 2002) and CROS private cancer clinic (Office of the Provincial Auditor General of Ontario 2001). The US also has a sizeable number of FP/s hospitals (Cutler 2000). Until recently, most private hospitals in the UK also fell into this category (Higgins 1988). So do most of the private hospitals found in the other European countries, such as France (Poullier and Sandier 2000). Characteristics of these FP/s businesses include the following:

- They pay taxes.
- They can go bankrupt.
- They are not bound by the 'red tape' of government and can be more flexible and nimble.
- They are often not bound by the 'red tape' and accountability requirements of NFP status.
- They usually cannot access charitable donations or the services of volunteers.
- They are not required to provide a return on investment to shareholders.

The evidence reviewed suggests that many of the often-expressed concerns about the implications of FP delivery may not fully apply to the FP/s category. Indeed, in some cases, these differ from NFP organizations only in whether a surplus is deemed a 'profit.'

Characteristics of Private for Profit Corporate (FP/c) Delivery

The FP/c category of investor-owned delivery is what is often referred to by critics of "privatization." The prime duty of management is to maximize the return on investment and ensure that there are profits to be distributed to the individuals holding shares. Thus, providing high quality care can be seen as a means to an end (running a successful business), rather than as an end in itself. Characteristics of FP/c organizations include the following:

- They are expected to provide a return on investment to their shareholders.
- They have access to capital through issuing equity.
- They cannot attract charitable donations or volunteer labour.
- They pay taxes.

Basic economics tells us that the incentives for such organizations are thus to maximize revenues and minimize costs; this is what is *meant* by efficiency. As Evans reminds us, "From the outset, however, it is important to emphasize that profit per se is associated with neither moral turpitude nor additional costs." (Evans 1984) The dilemma is that responding to their incentives implies that FP/c organizations should skimp on care, albeit only to the extent that this would not harm their business (Cutler 2000). A major policy dilemma is that it is not always easy to distinguish between efficiency and skimping. The literature discusses mechanisms to ensure that profit maximization does not harm quality, including transparency (provision of information to consumers), and regulatory controls, in the expectations that such mechanisms would raise the cost of poor practice, either indirectly (a poor reputation may harm 'sales') or directly (through lawsuits or regulatory penalties). These in turn imply considerable administrative costs and assume that quality is easily measured.

Traditionally, FP/c corporations have not played a major role in any developed country in such health care sectors as hospitals or physician services, although they dominate such sectors as pharmaceuticals and are heavily involved in laboratory testing. More recently, in the US, such organizations have also assumed dominant positions in certain markets for hospitals, health maintenance organizations, and insurance (although most U.S. hospitals are still NFP). In Canada, the potential entry of FP/c corporations has evoked considerable concern, particularly given the fears that various international trade agreements may make such experiments irreversible (Manga 1988; Martin 1993; CCPA – Canadian Council for Policy Alternatives, Armstrong, Armstrong et al. 2000; Sanger 2000; Marmor 2001).

Characteristics of Private Delivery by Individuals and Their Families

Finally, although this paper will deal only with formal organizations, as any parent or caregiver can testify, a considerable amount of care is provided by individuals and their families. When individuals are very ill, this desire to help can place considerable burdens on caregivers (Armstrong, Armstrong, Choiniere et al. 1994; Armstrong and Armstrong 1996; Hayes, Hollander, Tan et al. 1997; Hollander 1997; CCPA – Canadian Council for Policy Alternatives, Armstrong, Armstrong et al. 2000; Coyte 2000; Pollak 2000; Armstrong, Armstrong, Coburn 2001). In general, most discussions about private delivery are not referring to individuals, families and friends. Neither are they referring, for the most part, to the NFP sector. Indeed, one might argue that the debate about "public versus private" is, in many cases, mislabeled –the most passionate arguments are really about "not for profit" versus "for profit."

Health Sectors, and Direct vs. Indirect Funding Flows

Health care is not homogeneous. In one analysis, Deber et al. divided Canadian health care into 16 different sectors, only some of which are covered under provincial health insurance plans: acute hospital care; chronic hospital care; ambulatory/outpatient care (including physician's services); laboratories and radiology; capital costs; ancillary benefits (dental, vision, physiotherapy, chiropractic and podiatry); ambulance and transportation; nursing homes/homes for the aged; home care; rehabilitation care; drugs; assistive devices; mental health; public health/health promotion; education/training of health professionals; and planning, research and management (Deber, Adams, Curry 1994). The Canadian Institute for Health Information database has information on up to 38 "uses of funds," although it reports its data only for: hospitals, other institutions, drugs (divided into prescription and non-prescription), physicians, other professionals (divided into dental, vision, and other), other institutions, capital, public health and administration, and other health spending (divided into pre-payment health administration, research, and other) (Canadian Institute for Health Information 2000b).

However defined, these sectors vary in the way care is delivered, the roles of various types of delivery organizations, and the potential implications of different models. Like all organizations, service providers constantly face "make or buy" decisions, that is, they must decide which goods and services will be "made" by the employees of their organization and which will be "bought" from other organizations (Shelanski and Klein 1995; Preker, Harding, Travis 2000). Thus, even public organizations will still obtain many of their goods and services from private sector companies; for example, even the largest local government will still purchase telephone services or paperclips from outside providers. Public funds can accordingly flow to different organizations either *directly* (e.g., provision of funds to provide a particular service) or *indirectly* (e.g., purchase by them of goods and services). Accordingly, one cannot provide simple "yes/no" answers about the "best" form of delivery model. The answer, inevitably, will be "it depends." Appendix A reviews the literature for a number of sectors to provide some guidance as to what "it depends" upon and the circumstances under which one might prefer different modes of delivery. The framework presented above, however, clarifies that it is important to distinguish two separate questions about delivery:

1) Why (or why not) use public delivery as opposed to private delivery?
2) If one is using private delivery, why (or why not) FP delivery as opposed to NFP delivery?

How Should We Evaluate Success?

Evaluation of success depends heavily upon the criteria being used and whose viewpoint matters. For example, from the viewpoint of the recipients of services, the key questions are:

1. What services are being delivered? (including considerations of quality, timeliness, etc.)
2. To whom are they being delivered?
3. What is the effect (impact) of those services?

Although payers and providers of services are also interested in such outcomes questions, they also face a different set of questions:

4. Which resources are being used to provide those services, in terms of:
   a. mix of resources
   b. volume of each resource
   c. cost of each resource
5. What is the fiscal bottom line (profit/loss)?

Accordingly, there are inbuilt conflicts between payers and providers. Payers wish to minimize their costs, while individual providers wish to ensure "good jobs at good pay."

Of course, things are not that simple. One obvious example is that short run cost minimization may not be sustainable over the long term. If those employing providers squeeze down wage and benefit levels, they may create a labour shortage; basic labour economics would predict that they would then have to increase wages (and/or improve working conditions) in order to attract the necessary workforce. Evaluating "efficiency," then, requires some attention to how savings are being obtained. There are a series of 'win win' possibilities. These include increasing appropriateness, improving inflexible bureaucratic rules, and improving quality. Most parties agree that providing services to people who do not need them (or are unlikely to benefit from them) is pure waste. Similarly, poor quality is rarely cost-effective – having to repeat an x-ray because the first one has been lost benefits no one except the seller of x-ray films. However, other purported efficiencies may instead result from incomplete accounting (particularly if organizations being compared do not provide the same services or serve the same client groups) or from changes to the costs of resources being used.

One study evaluating whether services should be provided publicly or privately suggested the following evaluation criteria: (Hatry 1983)

1. What is the cost of the government service? (Full costing would need to include the administrative costs associated with monitoring contracts.)
2. What is the financial cost to citizens, particularly if the delivery mechanism is a private monopoly?
3. What range of choices is available to service clients?
4. What is the quality/effectiveness of service, including considerations of possible fraud or corruption issues?
5. What are the potential distributional effects? Who gains? Who loses?

6. What is the staying power of the provider and the potential for service disruption? (Strikes? Bankruptcies?)
7. Is the approach reversible if it doesn't work well?
8. What is the feasibility/ease of implementation – including legal constraints – and interest group reactions?

In the case of health care services, one might also want to incorporate considerations of defining what is included within the services being purchased (e.g., does laboratory testing extend only to the test or does it also include interpreting and communicating the results, assisting in ensuring that test ordering is appropriate, etc.)? In addition, consideration must be paid to the homogeneity/heterogeneity of both the services to be provided and the population to be served.

Interpreting Our Results

Competition, Contestability, Complexity, and Measurability

Most scholars who have attempted to compare public and private delivery of services have concluded that any efficiency differences which arise can be attributed less to differences between public and private ownership than to the extent of competition (Osborne and Gaebler 1992). The debate thus shifts somewhat from the merits of privatization to the merits of competition (Saltman 1995). Competition is the lifeblood of economics – it refers to the interactions between two or more sellers or buyers in a single market, each attempting to get or pay the most favorable price. Under circumstances of perfect competition, no single buyer or seller can dominate the prices to be paid. Given perfect information, economists assume that the famous invisible hand will then ensure an optimal distribution of resources and an efficient price, as purchasers shop around for the best price, while sellers can seek out those buyers who place the highest value on their services. Under such circumstances, government regulation would not be necessary. Competition is not equivalent to private ownership; monopolies can exist with private ownership, while competition can exist within a system of public ownership and administration.

In practice, however, not all markets can function in this textbook manner. One key issue relates to the "production characteristics" needed to generate particular goods and services. Two World Bank economists have developed a theory in terms of two such characteristics which they term *contestability* and *measurability* (Preker and Harding 2000); it is similar to the framework suggested by Vining and Globerman (Vining and Globerman 1999).

> "*Contestable* goods are characterized by low barriers to entry and exit from the market, whereas non-contestable goods have high barriers such as sunk cost, monopoly market power, geographic advantages, and "asset specificity" (Preker and Harding 2000)."

Asset specificity is a technical term used to refer to the relative lack of transferability of assets intended for use in a given transaction to other uses. Highly specific assets represent sunk costs that have relatively little value beyond their use in the context of a specific transaction. For example, the equipment and skills needed to perform open heart surgery would have few alternative uses. The concept of contestability builds upon earlier work by Baumol and Willig; economists adopting this view argue that it is not necessary for government to regulate even natural monopolies, as long as barriers to entry are low enough that higher prices can attract new competitors (Preker and Harding 2000). In short, a contestable market is easy to enter and to exit.

It is easier to sustain a competitive market when contestability is high. For example, it would appear relatively simple for firms offering home making services to enter and exit a market. A firm losing a contract would go out of business; those gaining contracts could hire the now available workers. In contrast, one is unlikely to want to encourage excess capacity for open heart surgery in order to allow for such competition, if for no other reason than the need to maintain sufficient volumes to ensure quality outcomes.

Measurability relates to "the precision with which inputs, processes, outputs, and outcomes of a good or service can be measured" (Preker and Harding 2000). Monitoring performance is easiest when measurability is high. For example, it is relatively simple to specify the performance desired for conducting a laboratory test or collecting municipal garbage. In contrast, it would be more difficult to specify the activities to be expected of a general practitioner, and hence more difficult to monitor her performance and ensure quality.

This observation is consistent with the findings of Bendick, who examined the efficacy of the privatization of publicly delivered social services within a framework of public financing (Bendick 1989). He concluded that privatization to FP organizations tended to be efficient for services where goals were measurable, easily monitored and evaluated (e.g., garbage collection). He noted that evidence also indicated that NFP deliverers had a better record in providing services in the interest of clients beyond what was precisely specified in contracts. Accordingly, where problems are complex, such as health and social welfare programs, and where the processes to be employed are not well understood, he recommended the privatizing of programs to the NFP sector rather than to the FP sector, an approach he refers to as the empowerment of mediating institutions.

One can argue about the degree of contestability and measurability of particular health care items. Where the theory becomes less comfortable, however, is when one begins to consider what makes a market more or less contestible. It is well recognized that high capital investment can present a major barrier to entry; one does not casually set up an automated laboratory. Similarly, professionalism can also represent barriers to entry – one cannot practice as a health professional without considerable training and registration/licensure in that jurisdiction. Competition thus presupposes the existence of excess capacity or, at the very least, the ability of new capacity to appear and disappear depending upon the results of the competition. This runs contrary to the emphasis most countries have placed on controlling costs through controlling supply and leads to some suspicion than competition may not be particularly effective in reducing costs under many circumstances. Indeed, some have linked the increased capacity to an increase in waste and duplication (Higgins 1988).

More alarming, however, is the implication of reducing barriers to exit. The theory notes that contestability is hampered by the existence of organizations (or individuals) which consumers wish to retain as care providers, even though they might be able to purchase services elsewhere for less money. Indeed, Preker and Harding explicitly state that a number of factors which we might consider inherently desirable – such as expertise and a good reputation – can also be viewed as impediments to contestability. "Once incumbents have invested in activities that result in expertise or generate trust, they enjoy a significant barrier to entry for other potential suppliers, thereby lowering the degree of contestability" (Preker and Harding 2000). It is unclear whether policy makers wish to encourage disposable providers, rather than retention and encouragement of excellence.

Another important production factor is *complexity*, that is, whether the goods and services stand alone or require coordination with other providers. Even laboratory tests which are highly measurable, gain much of their value by being embedded within a system of care, in which providers order tests appropriately and are aided in interpreting and acting upon their results.

Similarly, even the most routinized tasks within a hospital have requirements not common in normal business environments – e.g., food service within a hospital must take account of dietary restrictions, cleaning staff must take account of hazardous materials, and so on. Union concerns that contracting out support services might endanger patient care may be self-serving, but also contains a strong grain of truth (Hospital Employees' Union 2001).

Why (or Why Not) Public Delivery?

Returning to the question of whether to employ public or private delivery, it is clear that a number of powerful international agencies have suggested that public delivery is inherently less efficient than delivery through the private sector. This is the language of "public sector monopoly" (Preker and Harding 2000; Preker, Harding, Travis 2000). As Preker and Harding write:

> Public monopolies exhibit the usual negative features. First, monopoly suppliers often reduce output and quality, while raising prices. The excess in prices over and above what the market would normally bear–*rents*–leads to allocative inefficiency or a net deadweight welfare loss to consumers who have to forgo the consumption of other goods...Second, monopoly suppliers have strong incentives to lower expenditures through decreased output when staff members benefit from the financial residuals (Preker and Harding 2000).

This issue of 'rents' is a critical one and would seem to be associated with monopoly in general, whether public or private. It is interesting to note that advocates of one style of delivery tend to point to examples under the disfavoured approach which are clearly abusive – often those activities which can be subsumed under the label 'corruption.' Hence, Preker and Harding suggest that "a manifestation of such rents is the informal user charges that are commonly levied on patients and their families in public health facilities," describing these in terms of "accepting bribes or peddling influence" (Preker and Harding 2000). On the other hand, trade unions like to speak of the fraud which has been found in some examples (largely US) of FP delivery (Sutherland 2001). Indeed, advocates on both sides tend to stretch the definition of fraud and corruption by mentioning in the same paragraphs activities which do not seem as inherently objectionable. Thus, Preker et al. mention in the same passage "public sector workers requiring bribes in order to do their job" and "workers negotiating through collective bargaining better wages and working conditions than other employers might pay" (Preker and Harding 2000).

Recognizing that incentive structures have consequences, in the judgement of this writer, these issues would appear to be more strongly related to the nature and effectiveness of monitoring activities than to the delivery mode *per se*. Certainly, there are honest and dishonest individuals in all walks of life. The issue would seem to be what incentive structures have been set up and how compliance with them is measured and monitored. In general, it does not seem advisable to set up incentive structures which penalize best practices and assume that providers will be so altruistic that they will work against their own economic best interests.

Where Can FP Firms Make Their Profits?

Health care is not exactly like other goods and services. Apart from the emotional/moral implications of dealing with potentially life-threatening conditions, and the reluctance of many to assume that their life and well-being is just another commodity (Marmor, Schlesinger, Smithey 1987), economists recognize the importance of what they call "asymmetry of information," technical words conveying the essential fact that, unlike most commercial relationships, the patient usually must rely upon the provider to tell him/her which services they should purchase (Evans 1984; Rice 1998; Deber 2000). Professional ethics thus stress the role providers must play as agents for their patients. In contrast, FP firms are expected to provide a return on investment to their shareholders. Payers for health care wish to purchase needed care at 'best quality, best price.' For these goals to be compatible, FP firms will have to offer care at rates and quality compatible with those which could be offered by public or NFP providers. Reviewing the findings suggests a number of possible ways in which FP could make their profits, some (but not all) of which would also be acceptable for society (Deber 1998). These include:

Strong Economies of Scale

This particularly applies to services subject to 'make or buy' considerations, where individual organizations can benefit from amortizing costs over a larger population base than would typically be found in a single organization. Public organizations, by definition, are confined to a particular jurisdiction; smaller communities thus stand to gain considerable potential efficiencies of scale. These economies can apply to capital expenditures or to specialized expertise. These considerations appear particularly likely to apply to highly measurable services with many potential customers to spread fixed costs across. Although there is no inherent reason why NFP organizations cannot be set up to accomplish similar goals, history suggests that they are more likely to have difficulties obtaining the necessary capital investments and evoking cooperation from other providers.

Better Management

A related set of factors is the ability of FP companies to allow access to expertise which would otherwise not have been affordable. This issue is particularly true for small communities/ organizations dealing with larger corporations, as noted in the local government cases in Appendix A. However, the ability to monitor activities is key to ensure that the benefits do not accrue solely to the FP firm.

Freedom from Labour Agreements

To the extent that public or not-for-profit organizations offer better wages or working conditions than the minimum necessary to attract "good enough" workers, there is an obvious profit potential in driving down labour costs, including de-skilling. This is one reason for strong union opposition to the shift to the private sector (Heyman 2001). It is critical to note that competition can force NFP organizations to "race to the bottom" and impose similar measures.

Overly aggressive control over wages and working conditions can be counterproductive. To the extent that unattractive conditions encourage workers to leave, and discourage new entrants (e.g., to nursing), such measures can lead to labour shortages and ultimately increase the cost structures. Nonetheless, it is clear that breaking union agreements and the assumption that workers could then be hired at lower rates, is a major theme among the proponents of FP delivery. Whether this constitutes efficiency will be left as an exercise for the reader.

Evasion of Cost Controls

Even though government can still borrow money at a lower cost than the private sector, all parties may find it expedient to replace capital costs by operating costs. A major attraction of the public-private partnerships for capital development noted in Appendix A is that the full costs will not appear on a government balance sheet. To the extent that government is short-sighted, starves access to capital, or refuses to fund technological improvements, there will be incentives to get things done by stepping around government and moving to private partners, even if long term costs are increased considerably. The justifications of public-private partnerships often refer to the fact that the new facilities would not otherwise have been built, rather than to actual savings.

Similarly, some procedures, although highly beneficial, have high marginal costs. Implants are a notable example. To the extent that funding cutbacks lead to arbitrary limitations on how many such procedures will be performed, the demand will be felt in a private tier. The case can, (and in this author's view should), be made that allocation formulae should be modified to ensure that the publicly funded system is continuing to meet genuine needs in a timely manner, but this may be easier said than done. Paradoxically, the success of cost containment may have led to pressures to provide wanted services, higher provider remuneration, and more "creature comforts" outside of the formal expenditure control system. Under such circumstances, private delivery is sought out precisely because it will increase expenditure levels over that which government is willing to explicitly allocate.

Sacrifice of Difficult-to-Measure Intangibles

In the absence of clearly defined outcomes, it is likely that for-profits will devote less money to activities which although important, are not required of them. Obvious examples include teaching (and training the next generation of providers), research, quality assurance, and ties to the community. Appendix A notes such examples as laboratory services in Walkerton (in which FP/c firms did less reporting), CROS (which does not do teaching or research), and the different activities of NFP versus FP women's health centres.

Risk Selection / Cream Skimming

Any organization has an incentive to avoid "unprofitable" patients. However, if an organization is also expected to offer a return on investment to its shareholders, that incentive is magnified. It is not surprising that FP organizations tend to be more responsive to such incentives. In general, most US studies tend to equate "unprofitable" with being unable to pay for care – usually, being low-income and/or uninsured/underinsured (Marmor, Schlesinger, Smithey 1987). The evidence cited nonetheless does confirm that FP facilities are less likely to offer services on which they will not make a profit (Marmor, Schlesinger, Smithey 1987). In

Canada, the issue in determining which services are most lucrative is instead what government is willing to pay.

The term 'cream skimming' is accordingly used to describe a number of situations. The private dialysis clinic is happy to perform uncomplicated dialysis, while transferring the brittle diabetic into a NFP hospital. This division of labour may be appropriate, particularly if the uncomplicated cases do not require access to the expensive infrastructure of the hospital. FP companies tend to locate where the prospects of profits appear best; private ambulance companies do not appear anxious to serve remote northern communities. Here, other sectors (either public or NFP) must assume responsibility for the less attractive business niches. Finally, the private FP tier, performing uninsured services, may nonetheless not assume the full costs of its care if it sends all costs of complications back to the publicly funded system. *In vitro* fertilization may be a "private" service offered only to those able to pay, but the resulting babies are delivered at public expense, including the high costs of those requiring neonatal intensive care.

Risk selection/cream skimming is accordingly not inappropriate, as long as several key conditions are met. First, costing should recognize the differences in populations being served, rather than assume that average costs apply across the board. It is misleading, and unfair, to conclude that "private is best" if private only treats the good risks or routine cases. Second, it is essential that there be a sufficient volume of patients and providers to maintain the infrastructure needed to provide the services and serve the clients which the FP sector is reluctant to address. Under some circumstances (e.g., large cities), there would be enough volume to support both. In others, the FP success may be at the expense of the high needs groups in the community. Here again, one size will not fit all.

Dubious Practices

Another issue which has appeared in US studies is conflict of interest by providers (Donaldson and Currie 2000). Although professional codes of ethics are in place, there is a conflict between incentive structures which reward providers for increasing the services they provide, cost controls which attempt to minimize such services, and quality assurance mechanisms which seek to ensure that those services provided are most likely to maximize health outcomes. To the extent that the incentive structures are too powerful, governments have been forced to introduce regulatory frameworks which in turn increase red tape (and costs), and may hamper clinical autonomy. Although its extent is unclear, fraud, particularly among some of the more aggressive FP companies in the US, would also come under this heading.

Low Bids to Drive Out Competitors, Then Higher Charges?

Where quasi-monopolies exist, and barriers to entry are high, there have been reports of FP companies giving low bids to drive out competitors, and then charging higher monopoly prices. Evaluation clearly must consider both short-run and long-run costs and consequences.

Revenue Generation Outside the Publicly Funded System

A critical insight arises from Donaldson and Currie's thorough review of the literature on public purchase of private surgical services from FP and NFP providers (Donaldson and Currie 2000). They noted that private facilities did not depend upon publicly financed business; most of their revenues came through private purchase of care through private insurance. Thus, contrary to the rhetoric implying that the only issue was whether "public" or "private" delivery could offer better and more efficient care, the business plans of most such organizations depended upon the existence of a parallel private system for *payment*. Sometimes, this parallel system offered enhanced services (including shorter waits). Sometimes it offered other services not insured by the public plan. But the examples reviewed by Donaldson and Currie suggest that 75-85% of patients of the private clinics in England, Wales, Australia, New Zealand, and Sweden paid privately. A thorough analysis of private medicine in the UK reached a similar conclusion (Higgins 1988). In turn, this leads to the issues – beyond the scope of this paper – of impact on costs, access, and waiting lists for those individuals remaining within the publicly financed system. Similarly, Wendy Armstrong of the Consumer Association of Canada, Alberta branch, found that:

> The real problem we have found in Alberta with our over 50 private investor owned day surgery clinics is that private delivery and private payment ultimately walk hand in hand – because they really aren't more efficient or cheaper unless they provide less or charge more on top of the public reimbursement. It also has become pretty apparent that privatization walks hand in hand with commercialization. It appears that you can't give the responsibility to deliver medical care to commercial interests and not expect them to adopt all the commercial trappings including aggressive marketing, focus on increased sales, and pursuit of returns (profit). In such an environment, even the community controlled facilities start taking on these values.

Upon reflection, it is clear that it is difficult to envision private provision from public funds within a competitive model; the financial risk to providers would appear excessive. The proposal that FP services be allowed to compete in the market as long as all funds come from public sources is particularly unrealistic. Similarly, proposals that FP firms be allowed to relieve the pressure on inadequate "public" resources carries with it the assumption that NFP delivery will remain inadequate in perpetuity. Should the NFP hospitals improve their productivity and eliminate waiting lists, the market for the private services would vanish, regardless of how well they had performed. Investors would accordingly appear to require greater guarantees of revenues, given good performance, much as the P3 providers described in Appendix A have. In turn, this would appear to remove any incentive (or even any ability) of the public or NFP sectors to improve their services. It would also imply that competitive markets would be unlikely to persist, since such guarantees would leave little room for new competitors to enter the market. In short, FP firms would appear to require either a guaranteed public revenue stream, and/or the ability to generate additional revenues from private sources. Funding and delivery are linked.

Lessons learned

1. Comparisons Across Organizational Forms Are Difficult

Most of the attempts to compare costs and outcomes across organizational styles become bedeviled by the difficulty in making comparisons across organizational forms. The problems include:

Heterogeneity of Organizations

The categories FP, NFP and public are remarkably heterogeneous, and good and poor performance can be found within each (Gray 1999).

Differences in the Services Offered

For the most part, FP firms do not offer the same service as do their public or NFP counterparts. FP firms tend to occupy niche markets, providing only high volume (or profitable) services. Efforts to "control" for those differences often over-adjust; real differences end up looking statistically insignificant. For example, teaching hospitals are unlikely to be FP. FP laboratories specialized in high volume procedures, leaving specialized testing to NFP hospital-based laboratories. As noted above, there is no inherent problem with this specialization, particularly when the population base is large enough to sustain it, but cost comparisons must (and often do not) take these differences into account.

Differences in the Clientele Served

Similarly, FP firms wish to serve clients who are willing and able to afford their services and who are most profitable. FP dialysis clinics may not take diabetics with major co-morbidities. This market segmentation can be termed "cream skimming," but again, it is only problematic if pricing is unfair or the "buttermilk" cannot be served. This might occur, for example, if the clinic serving the high volume care left the organizations serving the more complex cases without the critical mass or resources to deliver those services (Griffin, Cockerill, Deber 2001).

Differences in the Cost Structure

FP firms pay taxes and NFP firms do not. There may also be differences in access to (and cost of) capital. The calculations about the merits of the PFI initiative described in Appendix A depended heavily upon what 'discount rate' was chosen – that is, how much the future costs (and benefits) of the resources invested were adjusted to reflect the fact that future benefits are worth less than those which can be immediately consumed.

A complex issue is how to report costs. Conventionally, many studies look at average costs. However, a case can be made that this is inappropriate, particularly when there are high fixed costs (e.g., for equipment, staff). In such situations, there are economies (and diseconomies) of scale which are not captured by simply reporting average costs. Indeed, under situations where the facility cannot be closed (e.g., an emergency room serving a remote community, a unit

offering highly specialized expertise), moving cases to "lower cost" alternatives may explode the average costs at the original facility and lead to a *less* efficient system.

Differences in the Regulatory and Market Environments

The regulatory and market environments within which these organizations function vary considerably. Affluent neighbourhoods will attract different clients, with different needs, regardless of organizational form. Since FP organizations are unlikely to locate in areas where clients could not pay for their services, there is likely to be considerable confounding between organization type and other characteristics of these operations. Similarly, organizations will behave very differently in highly competitive markets than they might if they enjoy a quasi-monopoly on service provision.

2. Comparisons Are Not Impossible

There are nonetheless some systematic differences in the incentives and values inherent in the different organizational forms. Marmor (Marmor, Schlesinger, Smithey 1987) argues that the success of organized corporate institutions represents "the incremental decline of a service ethos–more naked in one sector, more camouflaged in the other," and sees the challenge as "to discover rules of the medical game that constrain the vices of both rampant commercialism and complacent professionalism." Thus, public or NFP firms may have little incentive to improve efficiency or client service. In contrast, FP firms are in business to make a profit. They are thus more likely to respond to financial incentives. In theory, firms can maximize profits in a number of ways, depending upon whether they are competing on quality or price. Economic theory would predict that FP firms would be more responsive than NFP or public organizations to incentives to target the most profitable services and client groups, minimize costs, and maximize revenue. The empirical results reported in Appendix A are all in the predicted direction; FP firms are indeed more responsive to these market signals. Similarly, the empirical results support the theoretical prediction that maintenance of quality will be tied to the extent to which this is observable by the potential customers; those factors invisible to potential customers are more likely to be ignored. Thus, firms marketing to providers (e.g., physicians) have different incentives to maintain quality than those marketing directly to patients or third-party payers; in consequence, quality differences are greater in the nursing home sector than among hospitals. Neither is it surprising that FP firms will seek to maximize their revenues by increasing their charges when the reimbursement plan so allows or by decreasing their costs where that is feasible (or that NFP firms will soon follow suit); cost comparisons accordingly depend upon the regulatory and reimbursement environment.

In that connection, it must be recognized that the incentives inherent in a corporate structure, all other things being equal, appear inimical to many desired outcomes. FP firms have an incentive to maximize the amount they bill payers (thus increasing total health care spending), minimize quality of care (unless this will harm their business), minimize labour costs, minimize spending on non-profitable activities (including particular services, client groups, and such activities as teaching, research, and community service). These tendencies can be controlled, but only through fairly elaborate measurement and monitoring of performance which carry their own costs. As Donahue notes:

> The interests of government and of its contractors simply diverge on some fundamental points. The government would like to pay as little as possible...while suppliers would like to earn as much as possible. Each party prefers stability and would rather shift risk to the other. Each wants the other to fulfill commitments precisely, while retaining flexibility for itself. The craft of contracting is to devise covenants that bring divergent purposes into something approaching alignment (Donahue 1989).

3. Competition and Cooperation Must Be Balanced

Competition runs somewhat counter to another highly advocated trend – that of greater cooperation among providers. Considerable emphasis has been placed on the need to integrate and coordinate services. Competition, in contrast, sets up providers as rivals. Best practices can become trade secrets, and information is less likely to be shared. Little consideration has been given as to how these conflicting imperatives (cooperate or compete) can be reconciled.

4. Measuring and Monitoring of Performance Is Essential

An overwhelming theme of the material reviewed is the importance of being able to measure and monitor performance. Many studies end at this point. However, further examination of this point reveals that such measurement and monitoring is neither simple nor inexpensive.

5. Measuring and Monitoring of Performance Can Be Costly and Difficult

Whereas certain services, such as refuse collection, are relatively "straightforward, immediate, measurable, monitorable, and technical," (Bendick 1989), others are not. As the World Bank has noted, it is difficult to measure performance for many – indeed most – health care services (Preker and Harding 2000; Preker, Harding, Travis 2000). The literature reviewed in Appendix A suggests that NFP providers are most likely to provide high quality services under such circumstances, whereas FP/c firms have a strong incentive not to go beyond the levels specified in their contracts. Furthermore, many economists concur that it is difficult for consumers to assess the quality of the care they receive (Evans 1984; Rice 1998; Sloan 2000).

In that connection, it is noteworthy that Donaldson's review of over 2000 references concluded that *no* study they reviewed had a system in place to monitor costs, quality of care, or outcomes in private providers (Donaldson and Currie 2000). Performance monitoring in theory was often called for; performance monitoring in practice rarely occurred.

One reason is that regulatory policy always gives rise to tension between the need to protect and the desire to improve flexibility and reduce the costs and burden of "administrivia." For example, how specific should regulations be concerning the number and skills of staff, their training, their relationships with referring professionals, their handling of pharmaceuticals, their physical plans, the food they serve, and so on? How capable are regulators of observing and enforcing these rules? Where does cost exceed benefit?

Certainly, there are perennial complaints that sufficient data for monitoring is not available, particularly once a service moves outside of direct government control. It is important to note

that this is not a public-private issue *per se*, but one of ensuring accountability within alternative delivery experiments. For example, the Auditor General of Ontario has found that the data being collected was inadequate to evaluate the performance of Ontario's NFP Community Care Access Centres (Office of the Provincial Auditor General of Ontario 1998b).

Donahue's excellent assessment of the privatization debate clarifies how very difficult it is to write good contracts, particularly when the desired outputs are difficult to specify precisely (Donahue 1989). One chapter reviews the history of weapons procurement by the Pentagon, and notes:

> There are several impediments to straight-forward contracting that bedevil the acquisition of all but the most standardized military goods. First, when there is uncertainty over the mission a weapon is to fulfill, or over the technology involved, the government enters into contracts that are incompletely specified and subject to revision. Second, because contracts are incomplete and changeable, competitive bids are, at best, tentative and, at worst, meaningless. Third, once the government has selected a supplier, it has only the feeblest sanctions to deter poor performance, since there are usually formidable barriers against replacing contractors (Donahue 1989).

He goes on to note:

> There are almost no weapons acquisition problems that cannot be overcome by better procedures, closer oversight, and more complete evaluation. But the indignant calls for procedural reform that follow every scandal miss the point that contracting *itself* is costly. The more completely rules, obligations, and procedures are defined in order to enforce accountability, the higher the price in time, money, and flexibility. Herein lies one of hte Pentagon's most important, and most poignant, lessons for advocates of expanding the private sector's role in the public's business (Donahue 1989).

The seemingly endless cycles of reform thus range between the much ridiculed sixteen pages of specifications for a metal whistle, and efforts to relax regulations which end up in new procurement fiascos. The higher the stakes, the more ferocious the competition. Indeed, because "only a few firms have the expertise, equipment, and capital to even contemplate bidding" the competition may be "cataclysmic" whereby "winners will flourish; losers may perish" (Donahue 1989). Indeed, as Donahue notes, uncertainties about the value of what is being purchased increases incentives and opportunities for interested parties "to manipulate perceptions of common need" and politicize spending decisions (Donahue 1989).

In a privatized delivery system, much control over staffing and purchasing escapes from government control. It may no longer clear who controls establishing the mandate, defining the nature of the service, calculating the costs to be borne by the consumer of service, or what experimentation with delivery methods is allowed (Ford and Zussman 1997). As Langford notes, "Whatever contracts may say, in reality, contractors often end up defining the clients to be served and the quality and quantity of the service being provided" (Ford and Zussman 1997). He goes on to add: "How much tolerance will there be among private sector partners in particular, who are putting up their own money, information and equipment for the program design 'add-ons' that are peculiar to government (e.g., external reporting, media management,

freedom of information regulations, labour relations requirements, official language regulations, equity considerations)?" (Ford and Zussman 1997). Firms operating in multiple jurisdictions also resist having to work with different regulatory regimens, and will often seek exemption from government mandates within individual provinces (or regional health authorities) (Kleinke 2001).

An additional worry is that the costs of complying with accountability regulations may be beyond many smaller providers. As Wendy Armstrong observed: "The problem with RFPs is that the inclusion of requirements like incredibly expensive ISO or CSA standards – or providing a full range of products – drive out small competitors and local competitors (including community run agencies) in every industry – not just home care or health care" (personal communication, Nov 12, 2001).

6. Changing Delivery Structures Also Changes Power Relationships

Any system of resource allocation creates winners and losers. Advocates of private delivery often assume that this move will weaken the bargaining position of unionized labour; to the extent that there are labour shortages, this view may be naive. It is less often recognized that private delivery can strengthen the constituency for particular programs, and make it more difficult to reduce their budgets. Indeed, several studies of privatization have concluded that "Suppliers can be mobilized into effective political coalitions to defend and to increase program funding" (Bendick 1989; Donahue 1989). The precise impact will clearly vary from case to case; nonetheless, power relationships are likely to be affected, and with them, the nature and level of resource allocation.

7. Experiments Should Not Be Irreversible

One on-going issue relates to the impact, if any, of international trade agreements upon public private partnerships. For example, lawyer Steven Shrybman has noted the expansive reading which some court decisions have given to "expropriation," which might allow investors to seek damages under NAFTA or WTO procedures for such eventualities as contract cancellation for non-performance, or introduction of public health or regulatory measures (Shrybman 2001a). These disputes would be settled by international tribunals, under their rules; indeed, local or provincial governments would not have standing. Advocates of such partnerships disagree (Fasken Martineau DuMoulin LLP 2001). Nonetheless, considerable uncertainty exists. What is more disquieting is the possibility that experimentation with for-private delivery might be a one-way valve; that is, there would be no way to reverse the experiment even should the results prove disappointing.

8. Health Human Resources Issues Must Be Dealt With

Although the focus of this paper is not on change management, or labour shortages, it was evident that many of the advocates of privatization base their arguments on the belief that existing labour agreements are too inflexible and/or too expensive. The language of 'public sector monopoly' refers less to the form of management (which as noted above, is neither public sector nor a monopoly) than to the existence of centralized bargaining for a unionized workforce.

To many of these writers, the primary advantage of privatization appears to be breaking the power of the trade unions. Plans which seek to mitigate inefficiencies in work rules and allow flexibility and empowerment may be highly worth while. Plans which primarily expect to transfer public resources from workers to investors are unlikely to win long-term support, or to be particularly wise public policy.

9. For-Profit Delivery Requires Predictable Revenue Streams

As was noted above, FP delivery seeks predictable revenue streams. An examination of partnerships for transportation observed that when private sector partners invest money in new facilities, they want government "to commit to a policy framework for the duration of the partnership that will not endanger the financial viability of the new facility" (Ford and Zussman 1997). One possibility is guaranteed funding (e.g., the P3 initiatives); more common is a parallel private revenue stream. At present, the scope for parallel private financing of medically necessary physician and hospital services is small, because of the provisions of the Canada Health Act and the strong views of the Canadian public. However, extra charges to insured persons for insured services are prohibited only for care deemed medically required, and the dividing line between what is necessary and what is not is not always clear. Thus, a clinic may provide a mixture of insured and uninsured services. To the extent that prices paid by the publicly funded system are well controlled, there are clear incentives to expand the uninsured services available, and even to push for private financing to top up public money (Donaldson and Currie 2000).

10. Barriers to Meeting Patient Demands Can, and Must, Be Addressed

Finally, it is essential to recognize that one key justification which is frequently put forward for private FP facilities has been the inability of existing NFP organizations to meet patient needs. The CROS clinic was necessary only because existing CCO facilities were unable to mobilize the human resources needed to operate an additional shift within their clinics. The private market in Britain capitalized on the difficulty which NHS hospitals had in giving patients their choice of hospital dates (Higgins 1988). At present, considerable administrative waste motion exists, frustrating providers, patients, and funders. Hospitals and agencies often do not receive the final information about the money they will receive from the province until well into the fiscal year, a sure prescription for inefficiency. Other barriers may arise from inflexible labour or budgetary arrangements. Constant crisis has burned out workers and managers, while efficiency drives have eroded the flexibility needed for innovation. Morale is low. Regardless of what decisions are made about delivery – and the material reviewed does not leave this author sanguine about the benefits of FP/c delivery except under highly defined circumstances – the client focus of the existing system must be addressed with some urgency. In theory, there is no reason why existing NFP organizations cannot be as nimble, innovative, and flexible as their FP counterparts. Discovering why they are not, and making the necessary changes, would appear to be both necessary and desirable.

A What the Literature Shows: Case Studies in Delivery

This Appendix briefly summarizes some of the voluminous literature on the implications of various delivery modes. A number of authors who have tried to synthesize even tightly defined sectors have found themselves confronted with several thousand references. This review accordingly makes no claim at being comprehensive, although it has sought to locate and analyze the key references and review articles, with an emphasis on Canada, the US, and the UK.

A Note on Statistical Analysis

Many of the studies reviewed rely on statistical analysis of varying degrees of sophistication. In all such studies, the analyst uses statistics to understand variations in a *dependent variable* (sometimes called a criterion variable) as a function of variations in one or more *independent variables* (sometimes called predictor variables). The analysis may or may not *control* for other variables which although unrelated to the hypothesis being tested, are also likely to affect the dependent variable. For example, assume that one is attempting to measure how effective a new drug is at controlling blood pressure. In this case, the dependent variable is blood pressure, and the independent variable is whether the patient is taking the new drug or something else (possibly including a placebo). Clearly, there will be considerable variation in the dependent variable; not all patients have the same blood pressure. The science of statistical analysis will seek to clarify whether the differences *between* groups is greater than the differences *within* them.

The art of statistical analysis, however, lies in the choice of variables. In the blood pressure example, what, if anything, should the analyst control for? Age? Sex? How high the initial blood pressure was? Presence of other co-morbid conditions, such as diabetes or renal failure? The relationship will get larger, or smaller, depending upon which controls are used. This issue is particularly problematic in non-experimental designs, where cases are not assigned randomly. Consider attempting to evaluate the impact of education on future income. Clearly, education is intertwined with other factors, including parental income, residence, work habits, and future occupation. Equally clearly, these factors are not identical – one can find people with very high incomes and very little education (e.g., certain athletes) and others with a great deal of education and very little income (e.g., graduate students). Should one control for occupation in trying to assess the relationship? If one does so, to the extent that education has a strong effect on which occupation an individual will be able to have, this "over controls" and removes much of the relationship one wishes to investigate. As will be noted, selecting which variables to control for has a major impact on many of the studies reported below, particularly those attempting to compare public, NFP, and FP hospitals.

Privatization of Local Government Activities

Local governments are responsible for providing or ensuring the provision of a host of services, ranging from collecting garbage to maintaining police and fire protection. Service delivery costs are a high proportion of local government expenditures. Under fiscal pressure, governments throughout the world have shown increased interest in an array of what are sometimes termed Alternative Service Delivery (ASD) models. Public organizations are

expected to follow democratic principles and adhere to broader policy objectives; at the same time, they are also expected to be efficient and customer-focused. The extensive literature on new approaches to service delivery by local government considers a variety of mechanisms, including changes in financing (e.g., user fees, franchises), management (e.g., improving productivity), and delivery (Hatry 1983; DeHoog 1984; Kemp 1991; Skelly 1996; Ford and Zussman 1997). These mechanisms include, but are not restricted to, examples of shifts from public to private delivery of publicly-funded services which are often termed "contracting out." An overview of such models suggested that these efforts were in large part a response to the perceived rigidities of government: "In essence, has it become easier to solve the internal problems of government by moving innovative organizations/programs outside of the formal system?" (Ford and Zussman 1997).

Evaluation of the relative merits of these programs is relatively sparse. The observations of Hatry continue to describe much of the material reviewed:

> "Unfortunately, little systematic, objective evaluation of most of these alternatives is available. Most available information is descriptive, anecdotal, and advocacy or public-relations oriented. Information on the consequences of the use of these approaches, when mentioned at all, is usually provided by the government that undertook the action, and such information is usually limited to assessments in the first year of the activity – before longer-term consequences have been identified" (Hatry 1983).

The success stories reported often resulted from improving the management of revenues rather than controlling costs – for example, improving the accounting and billing systems to maximize reimbursements from the state and federal governments. These gains tended to be higher in smaller organizations that could not otherwise afford highly specialized expertise. Other advantages of contracting out were avoidance of large initial costs, allowing benchmarking in the cases where multiple competing suppliers were used, and avoidance of bureaucratic problems within government.

However, Donahue's review of evaluations of local service contracting in the U.S., including a 1984 study done for the U.S. Department of Housing and Urban Development's Office of Policy Development and Research, found that much of the savings came from lowering wage costs. In only one example, the capital-intensive task of laying asphalt, did the private sector pay more; for the other services, between 18 and 75% of the additional costs in the public sector came from wage differentials. In addition, monthly benefit costs for municipal employees averaged $553 a month, as compared to $368 for contractors. He concluded that: "Delegating certain functions to private firms usually saves tax dollars, and much of these savings comes at the expense of public employees. What remains to be done is to weigh the joint implications of these two facts." (Donahue 1989).

> Hatry concluded that there were indeed success stories, but that the results were ambiguous: "a shift in either direction, either from municipal to private or from private to municipal, would likely lead to reduced costs. The rationale is that when a local government is willing to make such a substantial shift, its previous condition is likely to be so inefficient that any change would lead to an improvement" (Hatry 1983).

Provincial Auditors General have examined a number of such experiments. Although a lesson consistently drawn in the literature was the importance of carefully monitoring contractors' performance (Hatry 1983), paradoxically, when governments are too weak to manage programs internally, they are often too weak to manage external contracts. In a number of cases, governments have failed to clearly specify expectations, and have ended up paying considerably more than expected and/or getting far less. In New Brunswick, a leasing arrangement for the Evergreen School was estimated to have cost the province $774,576 more than if would have had it done the work itself, with no savings in operating costs realized (Office of the Auditor General of New Brunswick 1998). In Ontario, a contract between the Ontario Ministry of Community and Social Services and Anderson Consulting to support transformation of the former Family Benefit and General Welfare Assistance programs also led to huge cost overruns and estimated expenses far higher than would have been the case had government workers delivered the services (Whorley 2001). The Standing Committee on Public Accounts and the Ontario Auditor General have issued scathing reports (Office of the Provincial Auditor General of Ontario 1998a; 2000).

In contrast, when outcomes could be clearly defined, efficiencies have been realized through contracting out. However, a review of solid waste contracting among 327 Canadian municipalities revealed that substantial public-private differences occurred only in communities with a population of under 10,000, who were able to take advantage of economies of scale and management efficiencies by contracting out services. The author concluded that the main gains came from competition, rather than public or private delivery per se (McDavid 2001).

A number of these experiments resemble the military procurement examples cited by Donahue (Donahue 1989), in that the sunk costs become sufficiently high that government becomes reluctant to abandon the existing vendor, even as expectations are not met. Other lessons learned from the military were noted in the conclusions.

The studies also stressed the importance of the ability to monitor the activities and performance of the private sector companies, yet at the same time they expressed some concern about government's capacity to do so. Whorley concluded that "the success of collaborative arrangements is threatened when public actors enter as the subordinate player" and expressed "concern about power imbalance, divergent interests, [and] the appropriate allocation of benefits and accountability" (Whorley 2001).

Public-Private Partnerships (the Private Finance Initiative)

Governments in many countries have been experimenting with public-private partnerships (P3) arrangements. The primary justification of these efforts has been as a way of enhancing access to capital in an era when government has been unwilling to provide such resources directly. Students of P3 arrangements have distinguished among an array of arrangements, depending upon the nature of risk transferred between public and private sectors. At one extreme, the arrangements can be described as outsourcing or contracting out. At the other, public assets are sold outright to the private organization ("privatization"). Between are an alphabetical array of such options as BOO (Build Own Operate), BOT (Built Operate Transfer),

BOOT (Built Own Operate Transfer), DBFO (Design Build Finance Operate) and the like (Bennett Jones 2001) .

One of the more enthusiastic experiments with, in effect, contracting out the construction of hospitals has been occurring in the UK. Unlike the situation in Canada, the National Health Service (NHS) was built on public delivery; the NHS absorbed most existing hospitals into the public sector, subject to management directives from the government, and its employees became part of the national civil service (Higgins 1988). UK experiments thus begin with asking the "why/why not public delivery" questions, before progressing to considering the role of FP versus NFP organizations. The Private Finance Initiative (PFI) was introduced by the Conservatives in 1992 with a dual set of rationales – both as a way of securing more capital resources than would otherwise be available, and as a way of bringing private sector efficiencies to the procurement process. As noted by many observers (Gaffney, Pollock, Price et al. 1999a; b; c; Pollock, Dunnigan, Gaffney et al. 1999; Boyle and Harrison 2000b; Harrison 2001), the first rationale appears largely spurious. Although third world governments indeed have problems in obtaining access to capital, the UK (and, indeed, Canadian provincial governments) do not appear to fall into that unenviable category. Indeed, for the most part, these governments can borrow at lower rates of interest than can be obtained by private partners.

Several UK observers have scrutinized the extent to which these arrangements succeed in giving better "value for money (VFM), affordability, efficient allocation of risks, and the ability to retain a strategic overview of health service provision within a framework accountable to the public at large" (Boyle and Harrison 2000b). Since the PFI, although introduced in 1992, had not yet delivered a new hospital as of 2000, it was difficult to evaluate its success. Some authors are highly negative (Gaffney, Pollock, Price et al. 1999a; b; c; Pollock, Dunnigan, Gaffney et al. 1999); others term the benefits of the approach "unproven" (Boyle and Harrison 2000a; b), adding:

> Evaluation of some aspects of its impact is therefore inevitably a speculative matter. Judgments can turn on fine points of disagreement around issues where there is a high level of uncertainty. This created scope for political reasoning rather than economic evaluation to be the effective determinant of the balance of public and private finance (Boyle and Harrison 2000b).

Boyle et al. note that in the one case examined by the National Audit Office, it was unable to determine whether there were any savings at all, and conclude:

> Moreover, even if the basic VFM (value for money) conclusions were accepted, cost savings between the PFI option and the PSC (Public Sector Comparator) almost entirely depend on the kind of things that are included in the transfer of risk to the private sector, and how these have been costed. Finally, claims that the PFI would introduce substantial innovation in the design and running of health care buildings seem largely illusory (Boyle and Harrison 2000b).

Their analysis brings us back to the difference between encouraging a private role, and encouraging competition. In four of the first 15 PFI contracts, there proved to be only one final

bidder. Not surprisingly, the costs of successful bids under such circumstances increased substantially from initial estimates (Boyle and Harrison 2000b). They also point to the high transaction costs inherent in managing the competitive bid process, including payments to consultants which would eventually have to be absorbed into the final price, and clarify that there are two types of risks in such arrangements, only one of which has been emphasized by advocates of PFIs:

> On the supply side there are the risks of building procurement which are common to most large development projects: that the structure is not available on time and within costs, and that what is delivered diverges from the intended design specification. There is also the maintenance of the building and associated services – to a specified quality – over the lifetime of its use by the NHS client. The risk transfer element of the PFI process has focused on these supply-side risks: on construction delay and cost overrun, unavailability of parts of the hospital, and the failure of facilities management to meet contract standards. Meanwhile the public sector retains the uncertainty of the demand side risk. Moreover, by taking on a 30-year contract for services, there is an additional risk for the public sector. If the demand for hospital services were to decline dramatically, then the NHS trust is tied into an agreement for maintenance and facilities management services over and above any cost of producing the building itself. If this were a public sector procurement, then in the worst case scenario, the facility could be allowed to run down at no expense to the trust other than – in PFI terms – the availability fee. This is a potential risk that has not been factored into the equation when comparing the two options. There are examples – Dartford & Gravesham is one – where the contract allows for the charge to be reduced in the event of lower utilisation, but only if the consortium is able to avoid costs (Boyle and Harrison 2000b).

In Canada, cost containment by governments have meant a large pent-up demand for capital, and increasingly desperate hospitals and other public agencies. In addition, accounting rules in provinces such as Ontario have required hospitals to expense all capital contributions in the year of funding; neither has the province funded depreciation. In consequence, capital costs have not been amortized or reflected in operating costs (Canadian Institute for Health Information 2001). Not surprisingly, hospitals have sought out other possibilities of gaining the needed capital investment, even if the long-term cost might be higher.

Accordingly, some hospitals have been looking with interest at P3 arrangements. B.C. has proposed building a private hospital in Abbotsford, to the dismay of hospital unions (Hospital Employees' Union 2001). A recent report for the Ontario Hospital Association's Committee on Hospital Capital Development incorporates enthusiastic reports on UK, Australian (state of Victoria), and US (veterans administration hospital) examples (Bennett Jones 2001), but concentrates only upon the risks of construction cost overruns, ignoring the demand-side risks identified in the UK evaluations. (The PFI would lock participating hospitals into specified costs over the lifetime of the contract; even in a downturn, the partners would have first call upon hospital resources, regardless of other priorities.) In BC, the provincial government has decided to finance long-term care institutions through what are called P3 initiatives which have evoked concern from some analysts (Vogel, Rachlis, Pollak 2000).

It is interesting to note that, strictly speaking, the descriptions being used by Canadian advocates of P3 arrangements do not apply to the Canadian health care system. The Bennett Jones report begins with the debatable assumption that the health care systems in the UK and Australia are "highly analogous to the Ontario system," thus equating NFP and public entities, and bypassing whatever complexities would be introduced by the three-way relationships among government and the NFP and FP/c partners.

Assessment of such partnerships is complicated by issues related to "risk adjustment." For example, private companies, in general, cannot borrow money as cheaply as government can, although this factor is less important in the current low interest environment. On the other hand, they may be able to build more efficiently. The extent to which private efficiency can offset higher interest rates will clearly vary across situations. The University Health Network, in Toronto, financed its recent renovation through a bond issue; this was "priced at only 34 bp over comparable Ontario bonds" (Bennett Jones 2001). Other examples cited under the PFI cost more than they would have under traditional procurement approaches; however, the existence of the PFI allowed the hospitals to be built now, rather than waiting for government money to become available (Bennett Jones 2001). In effect, the PFI arrangements shift building costs from capital to operating budgets, and take them "off the books" for government. There is reason to believe that total costs will be higher, but the total is easier to shield from public accountability. Thus, judgments about the merits of such arrangements are based on policy rather than accounting considerations.

Some authors note that private sector operators were somewhat risk averse and reluctant to take on the expenses of building a hospital without a guarantee that their lease payments would continue, regardless of changes of government or service utilization patterns (Bennett Jones 2001). It is also noteworthy that the areas which "need" care, may not be those in a position to pay market prices. Australia's first large P3 project, the La Trobe hospital, was a failed experiment; the private sector company operating the facility lost money and eventually returned it to the government (Bennett Jones 2001). The report describing this example indicated a major lesson learned: "Ensure that a good location is picked. La Trobe which was in an isolated area suffering from a crash in the town's industry, was a poor choice for sustaining a vibrant hospital" (Bennett Jones 2001). Its residents may not have agreed.

Recently, the Auditors General in a number of Canadian provinces have expressed some concern about P3 arrangements (Office of the Auditor General of Nova Scotia 1997; 1998; 1999; Office of the Auditor General of New Brunswick 1998; Office of the Provincial Auditor General of Ontario 1998a; 2000; Office of the Provincial Auditor General of Ontario 2001). Considerable concern has also arisen as to whether P3 arrangements will have implications under international trade obligations, such that experiments are not reversible (Fasken Martineau DuMoulin LLP 2001; Shrybman 2001a; b).

Acute General Hospitals

In Canada, almost all (98%) hospitals are NFP, with a residual sector of small FP hospitals which pre-dated Medicare and were allowed to continue. One prominent experiment with FP management of a NFP hospital occurred in 1984 in Hawkesbury, Ontario, (population about

10,000), in response to a need for renovations following the merger of three local hospitals into two. Ontario requires that hospitals and their communities provide a portion of capital expenditures, and the hospital was unable to raise its share. The provincial government accordingly sponsored a competition, using a Request for Proposals (RFP) to find an operator who would pay for the community share of capital, in exchange for a ten-year management contract for all non-clinical services. The only qualified bidder was a US company, American Medical International (AMI), then a chain of 130 hospitals operating in 13 countries. Although it was able to achieve some economies of scale in operating costs (e.g., IT systems), the management contract was not renewed, and Hawkesbury General Hospital returned to NFP management (Bennett Jones 2001).

In contrast, hospitals in the US exist under many ownership types, usually categorized into: public (primarily the veteran's administration hospitals, and municipal hospitals in poor inner city neighbourhoods); NFP (often, but not always, run by religious or charitable organizations), and FP (often, but not always, run by large publicly-traded chains which are expected to give a return on investment to their shareholders). As of 1994, 60% of "nonfederal short-term general hospitals" in the US were NFP, 28% public, and 12% FP, mostly owned by large publicly traded corporations (Sloan 2000). A number of articles have reviewed the literature, attempting to compare performance by organizational type. These comparisons are extremely complex, since the three types of hospitals prove not to be interchangeable. They often serve different patient populations and provide different services. Analyses hence differ in the sorts of factors they control for, while critiques of the analyses generally suggest yet other controls which might have been conducted.

Accordingly, it is not surprising to see that some syntheses conclude that FP hospitals perform better, while others take similar data to conclude that they are worse, and still others decide that there are no significant differences. Woolhandler and Himmelstein found that FP hospitals had the highest charges, with NFP in the middle, and public the lowest (Woolhandler and Himmelstein 1997; 1999; Himmelstein, Woolhandler, Hellander 2001). They suggested that the higher administrative charges from the FP facilities accounted for much of the cost difference (Rachlis, Michael M 2000). Silverman found that spending on the US Medicare program was highest in communities where all hospital beds were in FP institutions (Silverman, Skinner, Fisher 1999). In contrast, Zelder concluded that "of the 15 studies reviewed, 8 showed that private hospitals performed better, 3 found that public hospitals performed better, and 4 revealed no difference in performance." Some of his analyses combined FP and NFP institutions, while others separated these out. Zelder attributed the superior showing of private hospitals to their ability to avoid paying high wages to unionized employees, particularly those doing such non-professional tasks as cleaning or meal preparation (Zelder 2001).

As noted in the section on statistics, the question of which factors should be controlled for can critically affect the conclusions of these studies. For example, teaching hospitals are known to have higher costs and better outcomes. Yet because there were no FP teaching hospitals in the U.S. data base used by these studies, controlling for teaching status thus selectively removed the most complex cases from the analysis. Similarly, one of the ways in which FP hospitals maximize profits is by adjusting their case mix and labour costs; they also tend to be smaller. Yet one important study by Robinson and Luft first "controlled for a wide range of differences

among hospitals, including number of competitors, case-mix, size, occupancy, and labour costs" (i.e., most dimensions on which FP hospitals would differ from NFPs) before concluding that "for-profits had significantly lower cost per admission and per day than non-profits" (Zelder 2001). Another of the studies cited by Zelder (by Ferrier and Valdmanis) as showing the greater efficiency of FP organization controlled for such factors as "quality (defined as a hospital's excess mortality), hospital size and occupancy rate, and the proportion of services provided to outpatients and in intensive care." A national study of 981 U.S. hospitals in the early 1980s by Shortell and Hughes found "no difference in quality measured in terms of mortality by ownership;" however, "using fewer covariates," Hartz et al. found higher mortality in FP than in NFP hospitals (Sloan 2000). Sloan's work was clearly affected by the fact that all teaching hospitals in his sample were either public or NFP; controlling for this factor thus excluded many of the most complex cases from the FP sample (Sloan, Picone, Taylor et al. 1998).

Clearly, analysts can differ as to which of these factors should be controlled for and which might be seen as sufficiently associated with ownership type that their effects should not be removed from the comparison. The point here is not that one analysis is "right" and the other "wrong," but that such comparisons are rarely value neutral.

Donaldson and Curie conclude that "faced with the same financial pressures, for-profit facilities respond differently compared with not-for-profits, to the detriment of patient care" (Donaldson and Currie 2000). For example, Los Angeles private hospitals were found to perform more Cesarean deliveries for Medicaid patients (Gregory, Ramicone, Chan et al. 1999). One paper widely cited in support of this conclusion is an examination of US patients with end-stage renal disease. Early praise for FP clinics (Lowrie and Hampers 1981) had led to a proliferation of such organizations; subsequent evaluation found that those being treated in FP facilities had a higher crude mortality rate and a lower likelihood of being placed on the waiting list for a renal transplant (which if successful, would remove them from the need for dialysis) as compared with NFP facilities (Garg, Frick, Diener-West et al. 1999). However, a set of letters to the editor variously argued that they had studied too small a sample, did not properly adjust for case mix, didn't consider distance to a transplantation centre, used old data which didn't account for changes in how dialysis is delivered, didn't control for affiliation with academic programs, or didn't properly control for co-morbidity. The criticism was somewhat muted by the letter which reported that another independent analysis had come to similar conclusions, although with smaller differences (a 5-7% higher mortality rate, rather than the 20% reported by Garg et al.). Clearly, there is always one more control that might be performed.

Both supporters and opponents of FP delivery note that these organizations tend to reduce labour costs, and are much less likely to employ unionized workers (Zelder 2001). Whether this is a good or bad thing, of course, is highly dependent upon the views of the commentator.

These conflicting interpretations reinforce the difficulty of defining "better" performance. For example, one study analyzed by Zelder focused only on profits from treating elderly (Medicaid) patients, and assumed that since all hospitals were dealing with the same reimbursement formula, the higher profits among FPs must have represented lower costs. In the absence of outcome data, lower costs were then equated to better performance (Zelder 2001). Marmor's 1987 review of FP versus NFP hospitals noted that the study results were inconsistent,

and the differences small; the FP facilities tended to have a higher cost per day, but shorter lengths of stay, meaning that the cost per admission fluctuated around zero (sometimes higher, sometimes lower) (Marmor, Schlesinger, Smithey 1987). Furthermore, when physicians control the delivery of care, there was no measurable difference in quality of care between FP and NFP settings (Marmor, Schlesinger, Smithey 1987). The analyses performed under the auspices of the National Bureau of Economic Research (NBER) (Cutler 2000) found that FP hospitals were more financially successful than were NFP hospitals, but that much of the difference resulted from skill at increasing public sector reimbursement. They also found that NFP hospitals in the same market followed closely behind and adopted similar approaches.

Some studies have examined the performance of hospitals which have "converted" their form by moving from being a NFP to a FP organization. Once so converted, a hospital can pay out future surpluses in the form of profits to shareholders (although past surpluses must be transferred to other charitable uses). FP hospitals can then raise working capital through equity instruments not available to NFP or public institutions. Government may also benefit in terms of increased revenues because the FP hospitals lose the tax exemptions they had formerly held, although there are potentially offsetting losses from changes in the 'public goods' (such as care to the indigent) formerly provided by these institutions.

Sloan's case study of hospital conversions in North Carolina, South Carolina, and Tennessee was affected by small sample sizes (which made it difficult to reach statistical significance), but also found that changes occurred in the predicted direction. Moving from NFP to FP status decreased the probability that a hospital would run certain potentially unprofitable programs – specifically, AIDS, community health, rehabilitation programs, open heart surgery, or having a skilled nursing unit. It increased the probability of having home health (which at the time was quite lucrative), sports medicine, or MRI, and increased the emergency room visits (Cutler 2000). However, the conversion also brought in capital resources and allowed service improvements. Interpretation of the results is complicated because those hospitals which chose to convert were by no means a random sample. In general, the research shows that those hospitals deciding to convert from NFP to FP were the ones with poorer financial performance, a high debt load, and an organizational culture more oriented to business (Cutler and Horwitz 1998; Cutler 2000). Indeed, 6 of the 10 cases studied by Sloan were relatively small hospitals in small communities which were otherwise in risk of closing; merely changing ownership did not make these hospitals particularly profitable (Cutler 2000).

An extensive analysis of private health care in the UK finds similar differences between FP and public facilities. Higgins traces the evolution from a "cottage industry" of small, non-corporate FP facilities providing relatively simple care (what we have termed FP/s organizations) to a profit-seeking business enterprise (Higgins 1988). The difficulties of comparing across jurisdictions were also evident; for example, in the U.K., the key advantage to patients in "going private" was not earlier admission (queue jumping), but the ability to plan their admission dates (an advantage which many Canadian patients already have). There was no evidence that the private alternative reduced waiting lists, and some anecdotal evidence to the contrary. Higgins concludes that:

On balance, the evidence suggests that public systems of care (such as the NHS) may be relatively cost-effective and moderately successful in controlling costs but at the price of under-investment in important facilities and services. Private systems, on the other hand, are often characterised by waste, for which patients (or their insurers) have to pay in the form of higher prices, over-provision of services and under-occupancy of beds (Higgins 1988).

Similarly equivocal results emerge from a major comparison of the U.S. literature comparing public, NFP, and FP hospitals, psychiatric hospitals, nursing homes, and managed care companies conducted by the Institute of Medicine in 1986, and updated in 1999 (Gray 1999). The initial review had concluded that "studies generally showed that expenses were similar at nonprofit and for-profit hospitals. However, depending upon method of payment (cost-based or charge-based reimbursement), the costs to purchasers were from 8-24 percent higher in for-profit hospitals than in nonprofit hospitals" (Gray 1999). This is consistent with the finding that the FP firms were better at maximizing their reimbursement, although NFP firms soon discovered and exploited the same loopholes (Cutler and Horwitz 1998; Cutler 2000; Sloan 2000). Recognizing that comparisons were complicated because no teaching hospitals were FP (although several have since converted their status), Gray reached the following conclusions:

- "Nonprofits care for more uninsured patients than for-profits, though not as much as public hospitals." However, the extent of such care varied considerably.
- "Nonprofit hospitals provide a wider array of services than do for-profit hospitals, including services focused on vulnerable populations (e.g., HIV/AIDS) or services that lose money."
- Quality differences were small, but tended to favour NFPs. Cost differences were smaller once the incentive system was changed (i.e., the US Medicare system phased out their cost-based reimbursement formula), but markups and costs to purchasers remained higher in FP hospitals.
- NFP psychiatric hospitals "had fewer quality violations and complaints and higher staff/patient ratios" than did FPs, while expenses of FPs "were either similar to or higher than those of nonprofits." "Performance differences between for-profit and nonprofit psychiatric hospitals regarding community benefit activities (e.g., uncompensated care) depended upon the extent of pressure and influence by communities, regulators, and professionals" (Gray 1999).

The summary results suggest that FP hospitals are slightly more expensive than public or NFP hospitals, and more likely to serve a niche market which investors believe can be profitable. However, to the extent that health professionals (particularly physicians) control care, there are unlikely to be major differences in quality. Competition tends to lower the differences, largely by forcing private NFP hospitals "to be increasingly similar to their for-profit counterparts" (Sloan 2000).

Although this review did not systematically review other OECD systems, it should be noted that many of their hospitals are public or NFP, and that most of the FP hospitals which exist fall into the FP/s category. For example, more than 2/3 of hospital care in France is provided by public hospitals (which are part of the civil service), most of the "private" hospitals are NFP, the

existing FP hospitals tend to be small and occupy niche markets, and both public and NFP hospitals have been operating under budget caps for the past 15 years (Poullier and Sandier 2000). Although several FP/c hospitals have been established in recent years, they do not appear to constitute a major portion of the hospital market. For example, the fourth largest private hospital company in France owned only eight hospitals, with net revenues of $75 million US (Universal Health Services 2001).

Nursing Homes

A number of studies of nursing homes express concerns about the quality implications of FP delivery (Tarman 1990; Spector, Selden, Cohen 1998). Marmor summarized over a dozen such studies of US nursing homes in his 1987 study; these used different data bases and different measures of costs. He argues that they nonetheless reach the same conclusion: "controlling for characteristics of patients, range of services provided, and other attributes of the facility, for-profit homes have average costs 5 to 15 percent lower than their nonprofit counterparts" (Marmor, Schlesinger, Smithey 1987). These lower costs appeared to translate directly into lower quality – "for-profit facilities are disproportionately represented among institutions offering the very lowest quality care" (Marmor, Schlesinger, Smithey 1987).

Gray's review similarly concluded that "Expenses per patient day were higher in nonprofit than in for-profit nursing homes, but charges were similar and for profits were more profitable. The distribution of costs differed by type, with nonprofits spending more on patient care and for-profits having higher "ownership costs" (interest, depreciation, rent). Most studies of nursing home quality favored nonprofits, using such measures as care planning, quarterly review of patients, room conditions, and quality of living environment" (Gray 1999). These findings appear to persist in current work; a recent study concluded that "investor-owned nursing homes provide worse care and less nursing care than do not-for-profit or public homes" (Harrigan, Woolhandler, Mullan et al. 2001).

Why are the differences in quality between FP and NFP so much more pronounced in the nursing home sector than among hospitals? A number of economists have hypothesized that one cause is "asymmetric information" – that is, the difficulty which most consumers of such services have in distinguishing between high and low quality care. Some writers have hypothesized that NFP can accordingly be seen as a proxy for better quality. Others hypothesize that transparency and scrutiny are essential. In the hospital sector, clinicians may thus enforce adequate standards of care. In contrast, nursing homes may be under less scrutiny. Chou accordingly compared the care for nursing home residents who were visited by a spouse or child within one month of admission with those who were not. Two of the four quality indicators he used indeed showed larger differences between for-profit and NFP homes for those residents without familial eyes on the staff. He concludes that "The NFP nondistribution constraint will soften the incentive to exploit those aspects of quality of service which are hard to monitor. On the contrary, for-profit homes are more likely to take advantage of their patients to make a profit" (Chou 2002).

Consistent with this view, other authors have observed that the availability of cost-cutting mechanisms often depends upon regulatory factors – that is, upon the extent to which "outside

bodies" are willing to set constraints upon the workings of market forces. For example, in B.C., "the unionization of B.C. staff in both for-profit and NFP facilities has limited the ability of private employers to pay substandard wages" (Vogel, Rachlis, Pollak 2000). However, B.C. did not control staffing levels, and "[s]everal [for-profit] facilities were ordered to close in B.C. in the late 1990s due to poor staffing levels and inadequate care, including lack of nutritional supports and incontinence supplies (Vogel, Rachlis, Pollak 2000).

Managed Care Companies

Managed care organizations combine the insurance and delivery function; although the details vary, the intention is that the customers of that managed care organization agree to seek care only from the associated providers. In return, the managed care organization can use the buying power associated with their client base to negotiate better rates from providers. The most well known form of managed care organization is the Health Maintenance Organization (HMO). Initially, HMOs were NFP organizations, that employed salaried physicians and emphasized (at least in theory) preventive medicine. As health care costs increased, the United States placed increasing emphasis on managed care; it has largely replaced the older style of insurance (which merely paid bills) in much of the country.

Although attacking HMOs is a popular sport in the US, it is worth noting that the HMO industry includes both NFP and FP companies. Kleinke, who helped build one of the managed care companies and describes himself as a former "true believer in the managed care revolution," summarized some of his objections to the industry. He notes that customer satisfaction can be measured by disenrollment rates which are much lower in "fiercely not-for-profit MCOs like Kaiser and Group Health" (Kleinke 2001). The reason appears to be the result of corporate response to incentives to maximize return to their shareholders. The industry refers to the proportion of revenues they spend for medical services as their "medical loss ratio" – clarifying that all resources spent for care can be seen as coming directly out of shareholder pockets. In his view, the for-profits use "aggressive adverse-risk avoidance, highly differential premium rating, and constant enrollment turnover" (Kleinke 2001). Quoting Kuttner (Kuttner 1998a; b), he notes that the average medical loss ratio for NFP HMOS was 90%. This fell to 80% for most FP plans, and as low as 60% for "some of the most ferociously managed MCOs." Kleinke argues that those managed care organizations "that spend as little as 80, 70, or only 60 percent of the premium dollar on medicine are not managing care. Instead, they are managing money, and doing it quite well" (Kleinke 2001).

Gray's review of the literature showed that "nonprofits in 1996 spent more of the premium dollar on medical expenses, had higher member satisfaction, provided more appropriate services to patients with six conditions, and performed better on measures of prevention." (Gray 1999) Himmelstein et al. found lower performance by FP HMOs than by NFPs on all 14 of the quality indicators being used by the National Committee for Quality Assurance (Himmelstein et al. 1999).

The managed care example suggests another lesson which emerges from the literature reviewed. Competition can lead to a "race to the bottom" and cause NFP organizations to behave in similar ways as their FP rivals (Gray 1997). Kleinke argues that Kaiser and Group

Health were dragged "into a bidding war that resulted in significant losses for everybody, the for-profits included, in the late 1990s" (Kleinke 2001). One consequence was that "socially oriented HMOs [were compelled to] embrace practices they once abhorred just to stay in business." (Kuttner 1998a)

Social Services/Residential Care

Although some authors have suggested that business discipline could improve the delivery of such services (Carroll, Conant, Easton 1987), social services also tend to have low measurability which the literature suggests could make them vulnerable to stinting on the less difficult to measure outcomes. In the 1980s, Knapp compared the relative efficiency of public, private NFP, and private FP providers of publicly-funded residential child care in the UK (Knapp 1986). After controlling for technologies of care and characteristics of clients, the tentative conclusion drawn was that private (both FP and NFP) provision appeared more cost effective than the public sector, in large part because they paid lower wages than did the public sector, and could tap charitable donations. However, the study did not look at outcomes, particularly the long-term effects of care on children and their families. Judge, who compared private sector provision of residential care for the frail elderly to public provision in England and Wales, initially concluded that private provision was good value for money (Judge 1986). In subsequent work, he found that private FP provision was less expensive than the public (National Health Service) or NFP (consortia between the NHS and voluntary providers) for providing mental health services (Knapp, Chisholm, Astin et al. 1998; Knapp, Hallam, Beecham et al. 1999), but also performed least well on quality of care indicators (Knapp, Hallam, Beecham et al. 1999). He also noted that the different sectors supported different clienteles, complicating the ability to make comparisons (Knapp, Chisholm, Astin et al. 1998). In Canada, an increasing proportion of residential care falls outside the public sector (Chambers, Labelle, Gafni et al. 1992), including a growing market share for unregulated retirement homes.

Ambulatory Clinics

Alberta's Bill 11, like Ontario's Independent Health Facilities Act (Lavis, Lomas, Anderson et al. 1998), allows public financers to purchase clinical services from FP providers. Accordingly, the issue of private clinics (by which most observers mean private FP clinics) has been hotly contested. Two Canadian studies found that allowing private surgery increased waiting lists within the "public" (NFP) sector (DeCoster, Carriere, Peterson et al. 1999; Armstrong 2000); although one can question whether other explanations might apply, studies in other systems have reached similar conclusions (Donaldson and Currie 2000). Indeed, Alberta's Auditor-General and its medical regulator both recently called for more stringent controls on the contracting out of certain clinical services (Weber 2001).

The Shouldice Hospital is often pointed to as emblematic of the value which FP clinics could offer. Established by Dr. Shouldice in 1945, at present, this 89-bed private hospital employs 12 surgeons, and performs 7,000 abdominal wall hernia repairs per year. It has an excellent reputation, attracting clients from around the world. The clinic does not appear to be shareholder owned; we would classify it in the FP/s category. It is licensed and inspected by the Ontario Ministry of Health and Long Term Care, and provides its services without charge to Ontario

residents (with the exception of the premium for semi-private room accommodation which is also charged by NFP hospitals). The hospital is proud of its activities in training and research (Shouldice Hospital 2002). This clinic is thus noteworthy for not appearing to respond to the fiscal incentives of maximizing profits; it instead exemplifies the "focused factory" offering high quality care within a niche market. There are clearly limits to how many such facilities can be established which will depend upon the catchment area and need for the procedure. However, it does not appear to exemplify FP corporate medicine; the clinic appears proud of activities (such as rehabilitation, follow-up, training, and research) which are not often conducted by companies attempting to maximize their bottom line.

Similarly, in 2001, the NFP Cancer Care Ontario (CCO) contracted with Canadian Radiation Oncology Services (CROS), a FP/s business under the direction of Dr. Tom McGowan (formerly a top clinician/manager with CCO), initially to treat breast cancer patients who would otherwise have been referred, at far higher cost, to the United States (Canadian Radiation Oncology Services (CROS) 2001). The reasons this clinic was needed related to complex failures (at the provincial, Cancer Care Ontario, and clinic levels) to be able to deal with the numbers of patients requiring treatment. At the time, there was spare capacity of the necessary equipment for radiation treatment and diagnosis, but a shortage of personnel willing to work for the wages offered by Cancer Care Ontario. The private clinic accordingly uses the facilities of a large NFP teaching hospital (the Toronto Sunnybrook Regional Cancer Centre), operating a second shift weekdays between 6:30 p.m. and 10:30 p.m. Most of their 80 staff work in the NFP cancer clinics during the day. The FP clinic was able to pay $50 per hour for overtime work; evidently, the NFP clinic was unable to find the flexibility in its wage structure to do the same.

Cost comparisons between CROS and Cancer Care Ontario are complex. CROS treats only breast cancer and prostate cancer patients within a narrow range of treatment protocols, leaving the more complex cases to the NFP clinics. It does not do teaching or research which are a major part of CCO's mandate. It relies upon the services of the teaching hospital for all unexpected events, such as managing cardiac arrests, and purchases other key resources (e.g., machine maintenance and treatment planning) on an incremental cost (per patient) basis. There has been a battle of the auditors, arguing over the appropriate cost comparisons. The FP clinic is far cheaper than sending overflow patients to the US ($3,500, versus $18,000). It is not clear whether it is cheaper than care in the existing NFP clinics. The conflicting reports raise such issues as the appropriateness of making comparisons based on average costs, given that a large portion of the cost structure is based on the fixed costs of having the facility, equipment, and trained staff. (Changes in volume treated thus affect average costs far more than they do the marginal costs of treating one more, or one less, patient.) The reports also raise such issues as the appropriate balance of clinical versus academic responsibilities, differences in case mix, and differences in costs to patients. (Office of the Provincial Auditor General of Ontario 2001; Bryant and Pepler 2002; Elitzur 2002)

The overall merits of such FP models are thus highly debatable. Analysis must separate out the short-run implications of this clinic (which appears to be run by sincere individuals meeting a genuine need) and the longer-run implications for the cancer care system. Organizationally, it falls within the FP/s category run by health professionals; the evidence reviewed suggests that such models, unlike the FP/c models, do not appear particularly susceptible to incentives to

skimp on care or quality. On the basis of the material reviewed, the clinic appears to deliver high quality care to patients who need it, and has introduced more innovative uses of non-physician health professionals than the NFP clinics had been able to accomplish. One key policy question is why the NFP clinics were unable to find the necessary flexibility to handle these patients without the need to contract with CROS, and how (and whether?) to remove similar barriers to innovation within the NFP sector. The implications of the FP model for the rest of the system are also unclear; will staff at the CCO clinics agree to work overtime when they could receive higher remuneration at CROS? Finally, once the principle of FP operation is accepted, are there any mechanisms which can ensure that corporate FP clinics whose activities appear less benign cannot move into the newly created markets?

The literature reviewed suggests that ambulatory clinics are subject to the same pressures to avoid unprofitable services and clients as were observed for hospitals. Khoury et al. (Khoury, Weisman, Jarjoura 2001) examined 296 NFP and 108 FP women's health centres in the US. Using data from the 1994 National Survey of Women's Health, they found that the NFPs outperformed the FPs on several outcome measures: serving underserved women, delivering comprehensive primary care services, providing training for health professionals and education services for clients and the community, and involving the community in center governance. Similarly, FP dialysis clinics are said to treat only routine cases, leaving the complex ones to hospitals. This specialization is not in itself objectionable, but can complicate cost comparisons, particularly if average costs are used to compute reimbursement.

Finally, under some circumstances, FP delivery can operate by the same 'buyer beware' rules as the free market, sacrificing such professional niceties as ensuring that care is given on the basis of need, rather than just willingness to pay. Laser eye surgery has been a classic example. Although the laser equipment is costly, the same equipment and staff can serve individuals with cataracts (a medically necessary, if elective procedure insured by the health care system) and the large market of near-sighted individuals who would like to eliminate the need to wear glasses or contact lenses (a procedure not deemed medically necessary). In a critical examination, Guyatt noted that the dominant form of laser surgery, Laser-assisted in situ keratomileusis (LASIK), took about 10 minutes per eye. Most clinics were performing about 20 procedures per day, and charging $2,000 per eye for the procedure (Guyatt 2001). The high profit potential attracted not only physician-run clinics, but also several large corporations which then employed opthalmologists to do the surgery. The increased capacity then led to price wars, and behaviour more commonly found in the marketplace than in traditional health care organizations. Some of these firms ran hard-sell advertisements, including "buy one, get one free" offers. Guyatt argues that they underplayed the risks of surgery, overstated benefits, and aggressively recruited customers from optometrists (including offering financial incentives for each referral). Ultimately, the leading firms overexpanded, merged, and declared bankruptcy. The final nail came when their major surgeon, unpaid, resigned.

The negative impact was not restricted to the customers of these firms. Although data was only anecdotal, Guyatt suggests that the laser eye-surgery boom increased waiting times for patients with higher medical needs (Guyatt 2001). This is not unexpected; if there is not a surplus of health human resources, the staff (and time) devoted to privately-funded care can often be at the expense of the 'medically necessary' care being delivered by the publicly-funded

system. Thus, if not well managed, private clinics can also drain off resources. In addition, there are suggestions that many patients were harmed by the procedure rather than benefitting from it. In addition to the adverse consequences to patients and their quality of life, many of the 'repair' costs would be absorbed by the publicly funded system.

Laboratory Services

Laboratory services are relatively well suited to private provision. The tests are well-defined. Quality assurance procedures can be established and performance measured and monitored. Many tests can be performed in large, automated facilities, requiring large capital investment but promising considerable economies of scale for common, routinized tests. In Canada, they can be offered in public (e.g., public health laboratory), NFP (e.g., hospital labs), FP small business (e.g., physician offices) or corporate FP (e.g., commercial laboratories) organizations. Barriers to entry are considerable; at present, three private companies have nearly 90% of the business (Browne 2000). Since hospital laboratories are part of hospital global budgets, there are strong incentives to out-source testing and gain the resulting budgetary flexibility.

Obtaining cost data is difficult because corporate balance sheets are not subject to the same disclosure requirements as would apply to public or NFP organizations. Conversations with individuals involved in laboratory services suggested that FP companies are able to extract a premium for their services. For example, in July 1, 1995, Alberta was able to combine their funding for hospital laboratory services (about $150 million/year) with the private fee-for-service billing for laboratory services (about $90 million), and negotiate a 30% reduction in the costs they paid. This was held out as a success story; however, even at this reduced level (which is below that being paid in such provinces as Ontario) per capita costs are still considerably higher than in Atlantic Canada, where there were no private FP labs at all.

The laboratory services example clarifies the importance of properly defining what services are being purchased. Clearly, costs are less for routine tests than for the more complex procedures often carried out within hospitals. Providing that costing is accurately done, and the results reported quickly and accurately, there would not seem to be any reason not to capture the economies of scale available (although one might question why these might not also be available within a NFP organization). However, an ongoing issue is the failure to recognize that a "test" is only one component of a larger service – such tests must also be interpreted, and their results communicated. Ontario's Walkerton Inquiry noted that one major cause of the public health catastrophe, in which contaminated drinking water killed seven people and sickened more than 2,300, was a failure of regulation. The local officials responsible for testing and maintaining the water system were both incompetent and dishonest. Provincial government reductions eliminated public testing of drinking water. The FP firm which had assumed responsibility for testing Walkerton's water was staffed by individuals who could perform the tests, but were not trained microbiologists. Neither did they forward test results to regulatory bodies. In consequence, the severity of the outbreak was underestimated, with very adverse consequences to the health of the community (O'Connor 2002). The report goes on to stress the importance of having proper regulatory mechanisms in place:

> When government laboratories conducted all of the routine drinking water tests for municipal water systems throughout the province, it was acceptable to keep the notification protocol in the form of a guideline under the ODWO [Ontario Drinking Water Objectives] rather than in a legally enforceable form – that is, a law or regulation. However, the entry of private laboratories into this sensitive public health area in 1993, and the wholesale exit of all government laboratories from routine testing of municipal water samples in 1996, made it unacceptable to let the notification protocol remain in the form of a legally unenforceable guideline. This was particularly so since, at the time, private environmental laboratories were not regulated by the government. No criteria had been established to govern the quality of testing, no requirements existed regarding the qualifications or experience of laboratory personnel, and no provisions were made for licensing, inspection, or auditing by the government (O'Connor 2002).

One of many lessons of Walkerton is that the FP provider gained "efficiencies" by focusing narrowly upon the actual testing; it was not required to provide such (in retrospect essential) intangibles as interpreting results or notifying affected parties.

Home Care

Home care is another sector in which all three modes of delivery can coexist (Ontario Home Health Care Providers' Association 2001). For example, publicly-financed home care services in British Columbia can be delivered by regional health authorities (which some of the analyses term "public"), charitable organizations, or FP businesses (Pollak 2000). It is also characterized by relatively low barriers to entry or exit. Workers delivering homemaking services tend to be low paid and to leave for better paying jobs. Even professionals, such as nurses, PTs, or OTs, can in theory move relatively easily between companies. Accordingly, home care is a sector that has seemed relatively well suited for experiments with competition.

Ontario has sought to test the managed competition model for the purchase of home care services (Baranek, Deber, Williams 1999; Williams, Barnsley, Leggat et al. 1999). In the former non-system, care was provided by a mixture of NFP (e.g., the Victorian Order of Nurses, Saint Elizabeth) and FP providers. In 1996, the province began to set up 43 Community Care Access Centres (CCACs), and gave them fixed budgets, with a mandate to ensure that care was purchased on a "best quality, best price" basis. In turn, the CCACs issued Requests for Proposals (RFPs). The consequences on the sector have been severe (Browne 2000; Sutherland 2001; Williams, Deber, Baranek et al. 2001). Some of the complaints that have arisen could apply to any sort of delivery model, regardless of ownership; labour objects to what they see as duplication and unproductive procedures, and to the disparity in compensation levels (found in Ontario, although not in some other provinces) between the hospital and home care sectors. Other complaints refer to any competitive model, again regardless of ownership: time spent monitoring the system, communication/coordination difficulties, impaired teamwork, lack of critical mass, chilling effect on ability to criticize care, downward pressure on wages and working conditions, leading to increased turnover and diminished continuity of care, and the undermining of trust between agencies (Browne 2000). However, a number do relate specifically to private delivery, including difficulty in obtaining accurate data when FP firms are allowed to keep much of their information secret, and the possibility of fraud, heightened

because one of the FP agencies (Olsten) had recently paid $61 million to the US Department of Justice for criminal violations in their US home care billings (Sutherland 2001).

The balance between competition and cooperation is also highlighted in the home care sector. Shapiro recently synthesized all the "innovative" home care studies funded by the Health Transition Fund. She observed that one of the recurring themes noted was the problems associated with trying to provide services via external organizations, whether for-profit or non-profit organizations (personal communication, 2001). In effect, the formalization of relationships was seen to impinge on flexibility in a number of ways. It was difficult to provide continuity of care, to arrange more flexible time arrangements (e.g., using full-time workers to serve a number of clients in a senior citizens' apartment building), or to have closer, more informal, contact with providers in other organizations to exchange information on clients.

Thus, even in this market with low barriers to entry and exit, competition was proving to have adverse effects on the sector. These experiments with competition (regardless of ownership type) have made clear the importance of properly defining expected outcomes. For example, a destabilized work force may lead to high turnover (with ominous implications for both training costs and continuity of care) and difficulty in attracting enough competent workers. Shapiro (Shapiro 1997) examined the implications of the shift of home care services in Manitoba after the province contracted out a portion of home care services that had been provided through public sector workers to a US FP corporation (Olsten). This move drew widespread opposition from health care workers and the public. Indeed, after a one-year trial period, the project was abandoned on the grounds that the FP delivery was more expensive than publicly delivered care (Shapiro 1997; Vogel, Rachlis, Pollak 2000). Quality was also endangered; Shapiro found that the turnover rate increased from 15-25% for workers in the public sector to 50% in the FP company.

In summary, the literature reviewed stresses the complexity of comparing public, NFP and FP delivery, and the importance of being clear which elements of the delivery system are being referred to.

References

Alberta Health. 2000. *Bill 11, Alberta's Health Care Protection Act: A Stronger Health System for the Future*. Tabled in the Alberta Legislature, March 2.

Armstrong, Patricia and Hugh Armstrong. 1996. *Wasting Away: The Undermining of Canadian Health Care*. Toronto: Oxford University Press.

Armstrong, Patricia et al. 1994. *Take Care: Warning Signals for Canada's Health System*. Toronto: Garamond Press.

Armstrong, Pat, Hugh Armstrong, and David Coburn. 2001. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Don Mills, ON: Oxford University Press.

Armstrong, Wendy. 2000. *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft*. Report published by the Consumers' Association of Canada (Alberta), January.

Arnold, Tom. 2001. *Majority Open to Mix of Public/Private Health: Poll Reveals 'Dichotomy'*. National Post, July 13, http://www.nationalpost.com.

Arvay Finlay. 2000. *Canada Health Act and Alberta Bill 11*. Prepared for the Canadian Union of Public Employees, March 8.

Baranek, Pat, Raisa B Deber, and A Paul Williams. 1999. Policy trade-offs in "home care": the Ontario example. *Canadian Public Administration*. 42(1), 69-92.

Bendick, Marc, Jr. 1989. Privatizing the delivery of social welfare services: an ideal to be taken seriously, in *Privatization and the Welfare State*, edited by Sheila B Kamerman and Alfred J Kahn. Princeton, NJ, Princeton University Press. pp. 97-120.

Bennett Jones. 2001. *Public-Private Partnerships for Ontario Hospital Capital Projects*. A background report prepared by Bennett Jones LLP for the Ontario Hospital Association's Committee on Hospital Capital Development, August.

Boyle, Sean and Anthony Harrison. 2000a. *Investing in Health Buildings: Public-Private Partnerships*. King's Fund, The Private Finance Initiative in the NHS, http://www.kingsfund.org.uk, May.

Boyle, Sean and Anthony Harrison. 2000b. *PFI in Health: The Story So Far*. King's Fund, The Private Finance Initiative in the NHS, http://www.kingsfund.org.uk.

Browne, Paul L. 2000. *Unsafe Practices: Restructuring and Privatization in Ontario Health Care*. Ottawa: Canadian Centre for Policy Alternatives.

Bryant, Murray J and Eileen Pepler. 2002. *Report to the Members of the Public Accounts Committee, Ontario Legislative Assembly*. January.

Canadian Healthcare Association. 2001. *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*. Ottawa: CHA Press.

Canadian Institute for Health Information. 2000a. *National Health Expenditure Trends, 1975-2000*. National Health Expenditure Database.

Canadian Institute for Health Information. 2000b. *NHEX Definition*. Composition of Total Health Expenditures by Source of Finance, http://www.cihi.ca/facts/nhex/defin.htm.

Canadian Institute for Health Information. 2001. *Canada's Health Care Providers*.

Canadian Radiation Oncology Services (CROS). 2001. *Bringing Radiation Oncology Closer to Home: Report of Canadian Radiation Oncology Services First Six Months of Operation, February – August 2001*. November.

Carroll, Barry J, Ralph W Conant, and Thomas A Easton. 1987. *Private Means, Public Ends: Private Business in Social Service Delivery*. New York: Praeger.

CCPA – Canadian Council for Policy Alternatives et al. 2000. *Health Care, Limited: The Privatization of Medicare*. A synthesis report prepared by the CCPA for the Council of Canadians, in collaboration with the Canadian Health Coalition.

Chambers, Larry W et al. 1992. *The Organization and Financing of Public and Private Sector Long Term Care Facilities for the Elderly in Canada: Report on Part 1: Survey of the Provinces*. Centre for Health Economics and Policy Analysis Working Paper Series 92-13, Hamilton: McMaster University, April.

Chou, Shin-Yi. 2002. Asymmetric information, ownership and quality of care: an empirical analysis of nursing homes. *Journal of Health Economics*. 21, 293-311.

Choudhry, Sujit. 2000. *Bill 11, The Canada Health Act and The Social Union: The Need for Institutions*. 38 Osgoode Hall Law Journal, July 31, 39-99.

Clutterbuck, David, Susan Kernaghan, and Deborah Snow. 1991. *Going Private: Privatisations Around the World*. London: Mercury Books.

Commission on Public Private Partnerships. 2001. *Building Better Partnerships: The Final Report of the Commission on Public Private Partnerships*. London: Institute for Public Policy Research.

Coyte, Peter. 2000. *Home Care in Canada: Passing the Buck*. Dialogue on Health Reform, http://www.hcerc.utoronto.ca.

Crowley, Brian L, David Zitner, and Nancy Faraday-Smith. 2002. *Operating in the Dark: The Gathering Crisis in Canada's Health Care System*. Atlantic Institute for Market Studies (AIMS).

Cutler, David M. 2000. *The Changing Hospital Industry: Comparing Not-for-Profit and For-Profit Institutions*. Chicago: The University of Chicago Press.

Cutler, David M and Jill R Horwitz. 1998. *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?* Working Paper 6672, National Bureau of Economic Research, http://www.nber.org.

Deber, Raisa B. 1998. Public and private places in Canadian healthcare. *Hospital Quarterly*. 1(2), 28-29, 31.

Deber, Raisa B. 2000. Getting what we pay for: myths and realities about financing Canada's health care system. *Health Law in Canada*. 21(2), 9-56.

Deber, Raisa B, Orvill Adams, and Lynn Curry. 1994. International healthcare systems: models of financing and reimbursement, in *Proceedings of the Fifth Canadian Conference on Health Economics*, edited by Jack A Boan. Regina, Canadian Plains Research Center. pp. 76-91.

Deber, Raisa B et al. 1998. The public-private mix in health care, in *Striking a Balance: Health Care Systems in Canada and Elsewhere*, edited by National Forum on Health. Sainte-Foy, Québec, Éditions MultiMondes. pp. 423-545.

DeCoster, Carolyn et al. 1999. Waiting times for surgical procedures. *Medical Care*. 37(6 (suppl)), JS187-JS205.

DeHoog, Ruth H. 1984. *Contracting Out for Human Services: Economic, Political, and Organizational Perspectives*. Albany: State University of New York Press.

Donahue, John D. 1989. *The Privatization Decision: Public Ends, Private Means*. New York: Basic Books.

Donaldson, Cam and Gillian Currie. 2000. *The Public Purchase of Private Surgical Services: A Systematic Review of the Evidence on Efficiency and Equity.* Institute of Health Economics Working Paper 00-9.

Elitzur, Ramy. 2002. *Review of the Report by the Provincial Auditor on the Canadian Radiation Oncology Services*. January 22.

Evans, Robert G. 1984. *Strained Mercy: The Economics of Canadian Health Care*. Toronto: Butterworths & Co.

Evans, Robert G et al. 2000. *Private Highway, One-Way Street: The DeKlein and Fall of Canadian Medicare?* Centre for Health Services & Policy Research, UBC, HPRU 2000:3D (March).

Fasken Martineau DuMoulin LLP. 2001. *Comments of Fasken Martineau DuMoulin LLP on the Shrybman Opinion: Submission to the Walkerton Inquiry, Part 2*. Prepared for the Canadian Council for Public-Private Partnerships.

Ford, Robin and David Zussman. 1997. *Alternative Service Delivery: Sharing Governance in Canada*. Toronto: KPMG and IPAC.

Fuller, C. 1998a. *Canada's Health Care Crisis: More and More Health Care Services Being Privatized*. Canadian Centre for Policy Alternatives Monitor, March.

Fuller, Colleen. 1998b. *Caring for Profit: How Corporations are Taking Over Canada's Health Care System*. Vancouver: New Star Books.

Gaffney, Declan et al. 1999a. NHS capital expenditure and the private finance initiative: expansion or contraction? *British Medical Journal*. 319, 48-51.

Gaffney, Declan et al. 1999b. PFI in the NHS: is there an economic case? *British Medical Journal*. 319, 116-119.

Gaffney, Declan et al. 1999c. The politics of the private finance initiative and the new NHS. *British Medical Journal.* 319(7204), 249-253.

Garg, Pushkal P et al. 1999. Effect of the ownership of dialysis facilities on patients' survival and referral for transplantation. *New England Journal of Medicine*. 341(22), 1653-1660.

Government of British Columbia Board Resourcing and Development Office. 2002. *Board Resourcing and Development Office – Home Page*. Downloaded from: http://www.fin.gov.bc.can/abc/index.htm March 1, 2002.

Gray, Bradford H. 1997. Conversion of HMOs and hospitals: What's at stake? *Health Affairs*. 16(2), 29-47.

Gray, Bradford H. 1999. *The empirical literature comparing for-profit and nonprofit hospitals, managed care organisations and nursing homes: Updating the Institute of Medicine Study*. Washington, D.C.: Coalition for Nonprofit Healthcare. Downloaded from http://www.cnhc.org/Report3.pdf.

Gregory, Kimberly D et al. 1999. Cesarean deliveries for Medicaid patients: A comparison in public and private hospitals in Los Angeles County. *American Journal of Obstetrics and Gynecology*. 180(5), 1177-1184.

Griffin, Pat, Rhonda Cockerill, and Raisa B Deber. 2001. Potential impact of population-based funding on delivery of pediatric services. *Annals RCPSC*. 34(5), 272-279.

Guyatt, Gordon H. 2001. *Laser Eye Surgery: A Disturbing Model for Private Health-Care Delivery*. Annals of The Royal College of Physicians and Surgeons of Canada, December, http://rcpsc.medical.org.

Harrigan, Charlene et al. 2001. Does investor ownership of nursing homes compromise the quality of care? *American Journal of Public Health.* 91(9), 1-5.

Harrison, Anthony. 2001. Public-private partnerships within health care since the NHS plan, in *Health Care UK 2001 – Autumn – The King's Fund Review of Health Policy*, edited by John Appleby and Anthony Harrison. London, King's Fund Publishing. pp. 63-81.

Hatry, Harry P. 1983. *A Review of Private Approaches for Delivery of Public Services*. Washington, DC: The Urban Institute Press.

Hayes, Virginia E et al. 1997. *Services for Children with Special Needs in Canada*. A report prepared for the Canadian Association for Community Care and Health Canada, October: Victoria, BC: Health Network, Canadian Policy Research Networks.

Heyman, George. 2001. *A Presentation to the Select Standing Committee on Health.* President, B.C. Government and Service Employees' Union, November 7.

Higgins, Joan. 1988. *The Business of Medicine: Private Health Care in Britain*. London: Macmillan Education Ltd.

Himmelstein, David, Steffie Woolhandler, and Ida Hellander. 2001. *Bleeding the Patient: The Consequences of Corporate Health Care*. Monroe, ME: Common Courage Press.

Himmelstein, David U et al. 1999. Quality of care in investor-owned vs. not-for-profit HMOs. *Journal of the American Medical Association*. 282, 159-163.

Hollander, Marcus J. 1997. *Assessing the Impacts of Health Reforms on Seniors: Part 1. A Synthesis Report of Health Reforms and Seniors' Perceptions of the Health System*. A report prepared for the National Advisory Council on Aging, December.

Hospital Employees' Union. 2001. *Build Hospitals for People, Not for Profits.* Presentation to the B.C. Select Standing Committee on Health, November 8.

Judge, K. 1986. Value for money in the British residential care industry, in *Public and Private Health Services: Complementarities and Conflict*, edited by Anthony J Culyer and B Jonsson. Oxford, Basil Blackwell. pp. 200-218.

Kamerman, Sheila B and Alfred J Kahn. 1989. *Privatization and the Welfare State.* Princeton, NJ: Princeton University Press.

Kelly, Gavin and Peter Robinson. 2000. *A Healthy Partnership: The Future of Public Private Partnerships in the Health Service*. London: Institute for Public Policy Research.

Kemp, Roger L. 1991. *Privatization: The Provision of Public Services by the Private Sector*. Jefferson, NC: McFarland & Company, Inc.

Khoury, Amal J, Carol S Weisman, and Chad M Jarjoura. 2001. Ownership type and community benefits of women's health centres. *Medical Care Research and Review*. 58(1), 76-100.

Kleinke, JD. 2001. *Oxymorons: The Myth of a U.S. Health Care System*. San Francisco: Jossey-Bass.

Knapp, M. 1986. The relative cost-effectiveness of public, voluntary and private providers of residential child care, in *Public and Private Health Services: Complementarities and Conflict*, edited by Anthony J Culyer and B Jonsson. Oxford, Basil Blackwell. pp. 171-199.

Knapp, Martin et al. 1998. Public and private residential care: Is there a cost difference? *Journal of Health Services Research and Policy*. 3(3), 141-148.

Knapp, Martin et al. 1999. Private, voluntary or public? Comparative cost-effectiveness in community mental health care. *Policy and Politics*. 27(1), 25-41.

Kushner, Carol. 1999. *In Search of the Greenest Grass: A Comparative Analysis of Recent Funding Announcements and Recommendations for Home Care Services in the New City of Toronto.* Report prepared by the Toronto-area CCACs.

Kuttner, Robert. 1998a. Must good HMOs go bad. First of Two Parts: The commercialization of prepaid group health care. *New England Journal of Medicine*. 338(21), 1558-1563.

Kuttner, Robert. 1998b. Must good HMOs go bad. Second of Two Parts: The search for checks and balances. *New England Journal of Medicine*. 338(22), 1635-1639.

Langlois, Kathy. 1997. A Saskatchewan Vision for Health: Who Really Makes the Decisions?, in *Alternative Service Delivery: Sharing Governance in Canada*, edited by Robin Ford and David Zussman. Toronto, KPMG and IPAC. pp. 173-184.

Lavis, JN et al. 1998. Free-standing health care facilities: financial arrangements, quality assurance, and a pilot study. *Canadian Medical Association Journal.* 158(3), 359-363.

Lowrie, Edmund G and CL Hampers. 1981. The success of medicare's end-stage renal-disease program: the case for profits and the private marketplace. *New England Journal of Medicine*. 305(8), 434-438.

Manga, Pran. 1988. *The Canada-U.S. Free Trade Agreement: Possible Implications on Canada's Health Care Systems.* Discussion Paper No. 348 prepared for The Economic Council of Canada, May, 1988.

Marmor, Theodore R. 2001. Comparing global health systems: lessons and caveats, in *Global Health Care Markets: A Comprehensive Guide to Regions, Trends, and Opportunities Shaping the International Health Arena*, edited by Walter W Wieners. San Francisco, Jossey-Bass. pp. 7-23.

Marmor, Theodore R, Mark Schlesinger, and Richard W Smithey. 1987. Nonprofit organizations and health care, in *The Nonprofit Sector: A Research Handbook*, edited by Walter W Powell. New Haven, CT, Yale University Press. pp. 1-35.

Martin, Brendan. 1993. *In the Public Interest? Privatization and Public Sector Reform*. Atlantic Highlands, NJ: Zed Books.

McDavid, James C. 2001. Solid-waste contracting-out, competition, and bidding practices among Canadian local governments. *Canadian Public Administration*. 44(1), 1-25.

McFetridge, DG. 1997. *The Economics of Privatization*. C.D. Howe Institute Benefactors Lecture, Toronto, October 22.

O'Connor, Dennis R. 2002. *Report of the Walkerton Inquiry: The events of May 2000 and related issues. Part One: A summary*. Toronto: Ontario Ministry of the Attorney General.

Office of the Auditor General of New Brunswick. 1998. *1998 Auditor General's Report, Chapter 14 (Special Report for the Public Accounts Committee, Evergreen and Wackenhut Leases).* http://www.gnb.ca.

Office of the Auditor General of Nova Scotia. 1997. *1997 Auditor General's Report, Chapter 8 (Education and Culture: Public-Private Partnerships for School Construction).* http://www.gov.ns.ca/audg/1997ag.htm.

Office of the Auditor General of Nova Scotia. 1998. *1998 Auditor General's Report, Chapter 7 (Education and Culture: Public-Private Partnerships for School Construction Follow-up Review).* http://www.gov.ns.ca/audg/1998ag.htm.

Office of the Auditor General of Nova Scotia. 1999. *1999 Auditor General's Report, Chapter 5 (Education: Public-Private Partnerships (P3s) for School Construction – Follow-up Review).* http://www.gov.ns.ca.

Office of the Provincial Auditor General of Ontario. 1998a. *1998 Annual Report, Chapter 3.01 (Ministry of Community and Social Services, Business Transformation Project/Common Purpose Procurement).* located: http://www.gov.on.ca/opa/english/r98t.htm.

Office of the Provincial Auditor General of Ontario. 1998b. *Long Term Care Community-Based Services Activity.* 1998 Annual Report, Chapter 3.05.

Office of the Provincial Auditor General of Ontario. 2000. *Special Report on Accountability and Value for Money, Chapter 4 (Follow-up of Recommendations in the 1998 Annual Report).* http://www.gov.on.ca.

Office of the Provincial Auditor General of Ontario. 2001. *Special Audit for the Standing Committee on Public Accounts: Cancer Care Ontario*. December 13.

Ontario Home Health Care Providers' Association. 2001. *Private Sector Delivery of Home Health Care in Ontario*. June, http://www.ohhcap.on.ca/docs.

Organisation for Economic Co-operation and Development. 1987. *Financing and Delivering Health Care: A Comparative Analysis of OECD Countries*. Paris: OECD.

Organisation for Economic Co-operation and Development. 1994. *The Reform of Health Care Systems: A Review of Seventeen OECD Countries*. Paris: OECD.

Osborne, David E and Ted Gaebler. 1992. *Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector*. Reading, Mass.: Addison-Wesley Publications.

Ovretveit, John. 1996. Beyond the public-private debate: the mixed economy of health. *Health Policy*. 35, 75-93.

Plain, Richard. 2000. *The Privatization and Commercialization of Public Hospital Based Medical Services within the Province of Alberta: An Economic Overview from a Public Interest Perspective.* Department of Economics, University of Alberta, Medicare Economics Group, March.

Pollak, Nancy. 2000. *Cutting Home Support: From "Closer to Home" to "All Alone"*. Without Foundation, Part 111.

Pollock, Allyson M et al. 1999. Planning the "new" NHS: downsizing for the 21st century. *British Medical Journal.* 319, 179-184.

Poullier, Jean-Pierre and Simone Sandier. 2000. France. *Journal of Health Politics, Policy and Law*. 25(5), 899-905.

Preker, Alexander S and April Harding. 2000. *The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organizational Theory.* The World Bank Group Documents and Reports, Working paper #21875.

Preker, Alexander S, April Harding, and Phyllida Travis. 2000. "Make or buy" decisions in the production of health care goods and services: new insights from institutional economics and organizational theory. *Bulletin of the World Health Organization*. 78(6), 779-789.

Premier's Advisory Council on Health for Alberta. 2001. *A Framework for Reform*. Report of the Premier's Advisory Council on Health, December.

Rachlis, Michael 2000. *A Review of the Alberta Private Hospital Proposal*. Caledon Institute of Social Policy, March.

Rachlis, Michael et al. 2001. *Revitalizing Medicare: Shared Problems, Public Solutions*. A study prepared for the Tommy Douglas Research Institute, January.

Rachlis, Michael M. 2000. *The hidden costs of privatization: An international comparison of community care*. September 25.

Relman, Arnold S. 1992. *What Market Values Are Doing to Medicine*. The Atlantic Monthly, 99-106, March.

Rice, Thomas. 1998. *The Economics of Health Reconsidered*. Chicago: Health Administration Press.

Saltman, Richard B. 1995. *The Public-Private Mix in Financing and Producing Health Services*. Mimeo report prepared for the World Bank, February.

Saltman, Richard B, Josep Figueras, and Constantino Sakellarides. 1998. *Critical Challenges for Health Care Reform in Europe*. Philadelphia, PA: Open University Press.

Saltman, Richard B and Casten von Otter. 1992. *Planned Markets and Public Competition: Strategic Reform in Northern European Health Systems.* Philadelphia: Open University Press.

Saltman, Richard B and Casten von Otter. 1995. *Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility.* Buckingham: Open University Press.

Sanger, Matt. 2000. *Reckless Abandon: Canada, the GATS and the Future of Health Care: Executive Summary*. Canadian Centre for Policy Alternatives.

Shapiro, E. 1997. *The Cost of Privatization: A Case Study of Home Care in Manitoba*. Ottawa: Canadian Centre for Policy Alternatives.

Shelanski, HA and PG Klein. 1995. Empirical research in transaction cost economics – A review and assessment. *Journal of Law, Economics & Organization*. 11(2), 335-361.

Shouldice Hospital. 2002. *Shouldice Hernia Centre Home Page*. Downloaded from: http://www.shouldice.com on March 1, 2002.

Shrybman, Steven. 2001a. *Canada's International Trade Obligations and Municipal Government Authority: Response to the Canadian Council for Public-Private Partnerships*. Prepared for the Canadian Union of Public Employees.

Shrybman, Steven. 2001b. *A Legal Opinion Concerning the Potential Impact of International Trade Disciplines on the Proposed Public-Private Partnership Concerning the Halifax Harbour Solutions Project*. Prepared for the Canadian Union of Public Employees, September 17.

Silverman, EM, JS Skinner, and ES Fisher. 1999. The association between for-profit hospital ownership and increased Medicare spending. *New England Journal of Medicine*. 341(6), 444-446.

Skelly, Michael J. 1996. *Alternative Service Delivery in Canadian Municipalities*. Toronto: ICURR Publications.

Sloan, Frank A. 2000. Not-for-profit ownership and hospital behavior, in *Handbook of Health Economics*, edited by Anthony J Culyer and Joseph P Newhouse. Amsterdam, Netherlands, Elsevier Science. pp. 1141-1174.

Sloan, Frank A et al. 1998. *Hospital Ownership and Cost and Quality of Care: Is There a Dime's Worth of Difference*. Working Paper 6706, National Bureau of Economic Research, http://www.nber.org.

Spector, William D, Thomas M Selden, and Joel W Cohen. 1998. The impact of ownership type on nursing home outcomes. *Health Economics*. 7, 639-653.

Starr, Paul. 1989. The meaning of privatization, in *Privatization and the Welfare State*, edited by Sheila B Kamerman and Alfred J Kahn. Princeton, NJ, Princeton University Press. pp. 15-48.

Sutherland, Ross. 2001. *The Costs of Contracting Out Home Care: A Behind the Scenes Look at Home Care in Ontario*. CUPE Research, February.

Taft, Kevin and Gillian Steward. 2000. *Clear Answers: The economics and politics of For-Proft Medicine.* Alberta, Canada: Duval House Publishing.

Tarman, Vera Ingrid. 1990. *Privatization and Health Care: The Case of Ontario Nursing Homes*. Toronto: Garamond Press.

Universal Health Services. 2001. *Universal Health Services, Inc., acquires fourth largest private hospital company in France*. Press release. Downloaded from http://www.uhsinc.com/releases/release63.htm.

Vining, Aidan R and Steven Globerman. 1999. Contracting-out health care services: a conceptual framework. *Health Policy*. 46, 77-96.

Vogel, Donna, Michael Rachlis, and Nancy Pollak. 2000. *Without Foundation: How Medicare is Undermined by Gaps and Privatization in Community and Continuing Care*. Canadian Centre for Policy Alternatives, http://www.policyalternatives.ca.

Weber, Bob. 2001. *Privatization Worries Alberta Auditor-General*. The Globe and Mail, Wednesday, October 10, A16.

Whorley, David. 2001. The Andersen-Comsoc affair: partnerships and the public interest. *Canadian Public Administration*. 44(3), 320-345.

Williams, A Paul et al. 1999. Long term care goes to market: managed competition and Ontario's reform of community-based services. *Canadian Journal on Aging*. 18(2), 125-151.

Williams, A Paul et al. 2001. From medicare to home care: globalization, state retrenchment and the profitization of Canada's health care system, in *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*, edited by Pat Armstrong, Hugh Armstrong, and David Coburn. Don Mills, ON, Oxford University Press. pp. 7-30.

Woolhandler, Steffie and David U Himmelstein. 1997. Costs of care and administration at for-profit and other hospitals in the United States. *New England Journal of Medicine*. 336, 769-774.

Woolhandler, Steffie and David U Himmelstein. 1999. When money is the mission: the high costs of investor-owned care (editorial). *New England Journal of Medicine*. 341(6), 444-446.

Yergin, Daniel and Joseph Stanislaw. 1998. *The Commanding Heights: The Battle Between Government and the Marketplace that is Remaking the Modern World*. New York: Simon & Schuster.

Zelder, Martin. 2001. *How Private Hospital Competition Can Improve Canadian Health Care*. Public Policy Sources #35, The Fraser Institute, http://www.fraserinstitute.ca.

Zitner, David and Brian L Crowley. 2002. *Public Health, State Secret*. Atlantic Institute for Market Studies (AIMS), Research Report, January.