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Profits and health care delivery

Clarifying the debate

by Raisa Deber

THE QUESTION OF THE APPROPRIATE MIX BETWEEN PUBLIC AND private in health care has become a topic of considerable heat, both within Canada and internationally. Advocates of more "privatization" claim that it is needed to encourage innovation, efficiency, competition and choice. Opponents point to a host of difficulties they fear will arise from greater use of the "private sector" for delivery, including worries about quality of care and the compatibility of the values inherent in health care with those underlying markets. Policy initiatives such as Alberta's desire to approve for-profit surgical clinics or Ontario's to open more private MRI clinics have become emblematic of the disputes over the appropriate role of for-profit delivery within a publicly funded system.

Understanding the debate has been complicated, in part because both sides have been talking past one another, using similar terms to mean very different things. There is remarkably little disinterested information, and a plethora of papers stating positions without benefit of supporting evidence. Such evidence as exists is often contentious, since it depends on assumptions about what client populations different providers are serving. Before evaluating the evidence about public and private delivery, then, let us stop to define our terms.

Who pays, who delivers?

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*. 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. transferring costs between public and private payers by such mechanisms as user fees or deinsurance) or in delivery (e.g. moving the delivery of a service from within government to outside providers through contracting out, public-private partnerships and the like).

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. These allocation approaches can be placed on a continuum. At one end, “patients follow money” as funders allocate global budgets to providers. For example, government may fund a limited number of open heart surgery programs, where anyone needing such care must go. At the other end, “money follows patients” as providers depend on attracting clients for their revenues. For example, physicians will receive payment only to the extent that they attract patients; nursing homes will be paid only for filled beds. Unfortunately for those wishing clear reform prescriptions, there is no one best allocation model that can simultaneously ensure cost control, client responsiveness and delivery of high-quality appropriate care; instead, one is often faced with policy tradeoffs.

I focus here on delivery rather than on financing or allocation – that is, on the best way to *deliver* health care services, regardless of how they are paid for. However, researchers have found that 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.

In addition, whereas approximately 70 per cent of Canadian health expenditures come from public sources, these have 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; the Canadian Institute for Health Information estimates

the public share at 99 per cent of expenditures for physician services and 90 per cent of expenditures for hospital care. Such services as pharmaceuticals, home care and rehabilitation receive both public and private funds, while others (e.g. dental services) are financed almost exclusively from private sources. Public policy clearly has more interest in how best to deliver those services that are paid for from public money, if for no other reason than to ensure accountability for the use of public funds. Therefore, my main interest here is in what difference it makes how we choose to deliver publicly financed services.

I also bypass issues of the underlying values involved, although these are clearly critical in making policy decisions. I explore a more limited question, which I 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, I examine the evidence basis for pre-

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dicting the relative performance of various delivery options.

Beyond public and private

Although we tend to speak loosely of "public" and "private," each of these terms contains multiple meanings and multiple levels. The boundaries between public and private are not always clear; there are a number of organizations, often highly regulated or dependent on public funds, that profess public service objectives and can be classified as either public or private depending on the precise definitions being used. Examples include Workers Compensation, the sickness funds used to finance health insurance in certain European countries, and even the regional health authorities in place in many Canadian provinces. It is not only the ownership structure but also the broad framework of incentives that determine how these institutions behave that needs to be looked at.

In the study I carried out for the Romanow Commission, I categorized organizations that might deliver health care into *public*, *private not-for-profit* (NFP), *private for-profit/small business* (FP/s) and *private for-profit/corporate* (FP/c). Each form has its own characteristics. Further complicating the analysis, 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). In my research, I reviewed a series of 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.

Although the actual evidence is mixed, there is a widespread belief that public sector delivery in general is less able to cooperate across organizational barriers ("silo thinking"), more rigid/less flexible/less nimble, less effective and more complacent (because of the absence of competition) than the private sector. Certainly, public employers 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 their ability to take risks and hence to innovate. Technology may be more antiquated. In recent years, the search for "efficiency" has accordingly 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). This line of argument has encouraged private delivery of services, although these may still be financed by public money.

However, the relevance of this debate to health care is less clear. Although there is a small amount of public delivery (e.g. public health units, public health laboratories, provincial psychiatric hospitals), almost all health care in Canada is *already* delivered by private organizations. Rather than being investor-owned corporations, however, most of these are NFP (e.g. "public" hospitals, which are in fact private organizations with their own boards, or voluntary organizations providing health and social services) or FP/s (e.g. physician offices, provider-owned rehabilitation clinics). Although the debate speaks of "privatization," the dispute actually appears to be about "profitization" and the role of FP/c delivery rather than the public/private mix *per se*.

Evaluation of the success of policies depends heavily on the criteria being used and whose viewpoint matters. For example, from the viewpoint of the recipients of services, the key questions are: What services are being delivered (including considerations of quality, timeliness and the like)? To whom are they being delivered? What is the effect of those services? Although payers and providers of services are also interested in such outcomes questions, they also face a different set of questions, including: Which resources are being used to provide those services, in terms of the mix, volume and cost of resources and the fiscal bottom line (profit/loss)?

Accordingly, there are built-in conflicts between payers and providers. Payers wish to minimize their costs, while providers wish to ensure "good jobs at good pay." Of course, things are not that simple. Short-run cost minimization, for example, may not be sustainable over the long term. If providers squeeze down wage levels, they may create a labour shortage; basic labour economics would predict that they would then have to increase wages (or improve working conditions) to attract the necessary workforce. Evaluating "efficiency," then, requires some attention to how savings are being obtained, and their short-run and long-run consequences.

Health care is not exactly like other goods and services, and not only because of the emotional and 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. Economists also recognize the importance of what they call "asymmetry of information," technical words conveying the essential fact that, in contrast to most commercial relationships, patients usually must rely on providers to tell them which services they should purchase. We thus have several conflicting goals. Professional ethics stress the role providers must play as agents for their patients working in the patients' best interests. FP firms are expected to provide a return on investment to their shareholders. Payers for health care wish to purchase only that care which is needed, and receive "best quality, best price." For all of these goals to be compatible, FP firms have to offer care at rates and quality comparable to those that could be offered by public or NFP providers, while still making enough extra to generate a profit. The case studies suggest that there are a number of possible ways in which FP firms could do so, some – but not all – of which would also be acceptable for society.

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FP companies may be more able to achieve strong economies of scale (especially for services that can span jurisdictional boundaries). They may be able to improve management (especially if they are not subject to inflexible bureaucratic rules). However, although 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 – it is unclear why FP firms would find it easier to make such improvements than NFP firms. Some of the 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. FP firms tend to "cream skim" the most profitable clients and services, leaving the more expensive cases to NFP organizations. More contentiously, savings may result from changes to the costs of resources being used, particularly if FP firms are freed from labour agreements or cost controls placed on other providers. They may also differ in their staffing patterns (numbers, skill mixes), which may have implications for quality of care. They may sacrifice difficult-to-measure intangibles, including training and research. Finally, in some cases, FP firms have employed dubious practices, up to and including fraud.

Competition: Benefits, costs and consequences

Most scholars who have attempted to compare public and private delivery of services have concluded that any efficiency differences that arise can be attributed less to differences between public and private ownership than to the extent of competition. The debate thus shifts somewhat from the merits of privatization to the merits of competition. Competition, the lifeblood of economics, refers to the interactions between two or more sellers or buyers in a single market, each attempting to get or pay the most favourable 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" of Adam Smith will then ensure an optimal distribution of resources and an efficient price, matching up purchasers and providers and making sure that resources to go those buyers who value them the most (or at least are most willing to pay for them).

Competition is not the same as private ownership; monopolies can exist with private ownership, while competition can exist within a system of public ownership and administration. However, scholars have emphasized that avoiding poor outcomes within a competitive market requires the ability to measure and monitor performance. They also note that such monitoring is not cost-free.

In practice, not all markets can function in this textbook manner. Economists accordingly speak of the "production characteristics" needed to generate particular goods and services, and how these affect the ability to have a competitive market. Among the key production characteristics are *contestability*, *measurability* and *complexity*.

A *contestable* market is easy to enter and to exit. For example, it would appear relatively simple for firms offering homemaking services to enter and exit a market. In theory, a firm losing a contract would go out of business; those gaining contracts could hire the now available workers (assuming they have not taken jobs in other sectors in the interim). In contrast, excess capacity to allow for such competition would seem less desirable in the case of open heart surgery, if for no other reason than the need to maintain sufficient volumes to ensure quality outcomes.

Measurability relates to the precision with which the inputs, processes, outputs and outcomes of a good or service can be measured. Clearly, monitoring performance is easiest when measurability is high. For example, it is relatively simple to specify the performance desired for laboratory tests. In contrast, it would be more difficult to specify the activities to be expected of a general practitioner, and hence to monitor her performance and ensure that she was delivering high-quality care.

Complexity relates to 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 on their results. Similarly, even the most routinized tasks within a hospital may have requirements not common in normal business environments – 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 may sometimes contain a strong element of truth.

Many, but not all, health care services are complex and difficult to measure. Researchers have found 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 even when this is not specifically required by contract. In contrast, FP/c providers would have to justify to their stakeholders why they had not maximized profits.

The degree of contestability and measurability of particular health care items clearly leaves room for argument. However, these concepts also shed some light on the costs and consequences of encouraging competition. Consider, for example, what makes a market more or less contestable – that is, what constitute the barriers to entering and exiting particular markets. In the health care sector, barriers to entry are often considerable. It is well recognized that high capital investment can present a major barrier to entry; one does not casually set up an automated laboratory with no assurance of having work. Professionalism can also represent a barrier to entry, since a person cannot decide to practise as a health professional without considerable training

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and registration or licensure in the jurisdiction in question. These barriers to entry are consistent with the emphasis most countries have placed on controlling costs through controlling supply.

However, competition 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. Thus, competition may not be particularly effective in reducing costs under many circumstances; indeed, it may even increase costs through waste and duplication if the excess capacity tries to create enough demand to stay in business.

A further difficulty arises if competition/contestability implies reducing barriers to exit – that is, having those not winning enough business leave that business. Researchers have noted 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. Thus, a number of factors which we might consider inherently desirable – such as expertise and a good reputation generating trust – can also be viewed as impediments to contestability. A large department store going out of business may cause a temporary ripple, but if, for example, we were to lose Toronto's Hospital for Sick Children because a competing provider could do routine services more cheaply, the effects would be far more serious.

Competition is thus not always desirable. In addition to the issues of excess capacity and barriers to market entry and exit, competition may interfere with greater cooperation among providers. Careful balancing is essential.

On balance, research has suggested that NFP delivery is often preferable, but 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. On the other hand, public or NFP firms may have less incentive to improve efficiency or client service if they have a captive market.

In theory, firms can maximize profits in a number of ways, depending on whether they are competing on quality or price. Economic theory would thus 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 all bear out this prediction; FP firms are indeed more responsive to these market signals.

Another theoretical prediction would be 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 will be more likely to be ignored. Thus, firms marketing to providers (e.g. physicians) have different – and stronger – incentives to maintain quality than those marketing directly to patients or third-party payers. Again the prediction is borne out; research suggests that quality differences between FP and NFP providers are greater in the nursing home sector, for example, than they are among hospitals. It is also no surprise that FP firms will seek to maximize their revenues by increasing their charges (rather than increasing their efficiency) when the reimbursement plan so allows. Cost comparisons depend heavily on the regulatory and reimbursement environment. For example, if regulators specify minimum staffing levels, firms cannot make additional profits by reducing staff below that level.

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 of a health care system. FP firms have an incentive to maximize the amount they bill payers (thus increasing total health care spending and the burden on payroll), minimize quality of care (unless this will harm their business), minimize labour costs and minimize spending on non-profitable activities (including particular services and 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.

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 different organizations 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, with different cost structures. For example, the widely reported differences in costs and outcomes between FP and NFP hospitals in the United States are difficult to interpret because none of the teaching hospitals in these studies were FP.

2. Comparisons are not impossible. Research has found systematic differences, particularly with respect to responses to the incentives and values inherent in the different organizational forms.

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. Particularly when desired outcomes are difficult to specify precisely, contracts may become elaborate and costly, with particularly adverse impacts on smaller providers. One reason is that regulatory policy always gives rise to a 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? At what point does the cost of imposing "accountability" measures exceed their benefit?

Given international trade agreements, experimentation with for-profit delivery might be a one-way valve; that is, there would be no way to reverse the experiment, even if the results should prove disappointing.

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. Collecting data is difficult, and does not always happen. In addition, as the history of weapons procurement by the U.S. Defense Department illustrates, it is hard to write good contracts, particularly when

the desired outputs are difficult to specify precisely. The seemingly endless cycles of reform thus oscillate between the much-ridiculed 16 pages of specifications for a metal whistle and efforts to relax regulations which end up in new procurement fiascos. Can government define a "physician visit" sufficiently clearly that it can monitor the performance of private clinics, or must it in the final analysis rely on professional ethics? If the latter, how risky is it to allow such judgements to be made by for-profit corporations that are under pressure to maximize the return to their shareholders?

An additional worry is that the costs of complying with accountability regulations may be beyond the means of many smaller providers

6. Changing delivery structures also changes power relationships, and with them, how resources are allocated. In a private delivery system, much control over staffing and purchasing escapes from government control. It may no longer be clear who controls defining the mandate and the nature of the service, calculating the costs to be borne by the consumer of the service or establishing the acceptable limits of experimentation with delivery methods. 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).

7. Experiments should not be irreversible, particularly given international trade agreements. The impact, if any, of international trade agreements on public-private partnerships is an ongoing source of concern. In the context of these agreements, resulting disputes would be settled by international tribunals, under their rules; indeed, local or provincial governments would not have standing. There is considerable uncertainty about how valid such concerns are. What is more disquieting is the possibility that experimentation with for-profit delivery might be a one-way valve; that is, there would be no way to reverse the experiment, even if the results should prove disappointing.

8. Health human resources issues must be dealt with. Although flexibility can be highly desirable, the case studies suggest that much of the savings that 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. An important finding is that 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. Indeed, the literature on public purchase of private surgical services in various countries has found that most of the revenues of the FP providers 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 on 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 at least three quarters of patients of the private clinics in England, Wales, Australia, New Zealand and Sweden paid privately. In turn, this leads to the issues – beyond the scope of my discussion here – of the impact on costs, access and waiting lists for those individuals remaining within the publicly financed system.

It is thus difficult to envision a workable system incorporating both FP private provision paid entirely from public funds and a competitive model; the financial risk would appear excessive. A particularly unrealistic model is that expressed in the widespread argument that allowing FP services to compete in the market will relieve the pressure on inadequate "public" resources. Is such relief temporary or permanent? Should the NFP hospitals improve their productivity and eliminate waiting lists, the market for the private services would vanish. Investors would accordingly appear to require greater guarantees of service volume. 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.

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

It is essential to recognize that one key justification for private FP facilities has been the real or perceived inability of existing NFP organizations to meet patient needs. 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 I have reviewed does not leave me sanguine about the benefits of FP/c delivery except under highly defined circumstances – the client focus of the existing system must be urgently addressed.

It is difficult to envision a workable system incorporating both for-profit private provision paid entirely from public funds and a competitive model; the financial risk would appear excessive.

In theory, there is no reason why existing not-for-profit organizations cannot be as nimble, innovative and flexible as their for-profit counterparts. Discovering why they are not, and making the changes indicated, is both necessary and desirable. ■

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