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For-profit healthcare: a lesson from Canada[1]

The extent to which health systems rely on for-profit mechanisms to deliver public health services varies and can be a source of tension for managers as well as politicians. Canada is generally understood to have a not-for-profit public health system that is frequently contrasted with that of the US, heavily reliant on market principles and price mechanisms.

This article examines Canada's public health system from the perspective of a single province—Alberta. In particular, this article examines Alberta's various attempts to introduce private for-profit services into a seemingly public not-for-profit health system. It focuses on a case study of the demise of a private for-profit surgical facility and examines factors associated with its failure.

Physicians are key actors in health systems. This article challenges assumptions held about physicians as policy actors and suggests that policy analysts and policy makers need to do a better job understanding the centrality of physicians for health policy outcomes.

The organisation and management of healthcare systems—whether in developed, developing, or broken economies—are a major preoccupation for politicians, public health managers, physicians, nurses, private corporations, citizens, and academicians. One important management and policy question for consideration is the role of for-profit, business incentives in the delivery of public healthcare. Public policy discussions frequently have to resolve conflicting viewpoints about how to achieve an optimal provision of public health service—whether clinical or non-clinical—in order to deliver value for money using price and for-profit mechanisms (Hawkesworth 2010: 10). This need for resolution usually relates to the depth of feeling accompanying debates about the role of markets and price mechanisms in the delivery of healthcare.

Viewpoints that favour for-profit healthcare usually consider two major perspectives: management and policy. The management perspective in favour of the for-profit approach in public health is that working through competitive markets builds more efficient service delivery pathways. It is claimed that having these pathways contributes to the optimum alignment between the demand for service and available resources (Mahar 2006: 83–6). The policy perspective

[1] Throughout, I have benefited from the expert advice of my wife, Janice Trylinski, a Canadian health lawyer who has worked in government as both a legislative draft person and a health policy analyst.

usually reflects the moral hazard aspect of public healthcare. Politicians on the right advocate the introduction of market and price mechanisms as a way to make people think twice before a health service is accessed. This perspective assumes that under a publicly funded not-for-profit model, people will over-consume healthcare services, perceived by the public to be freely available. This is the classic moral hazard perspective (Mahar 2006: 167–9). In Alberta, the moral hazard perspective was probably best epitomised in May 1993 by a Progressive Conservative government member during a healthcare debate (Legislative Assembly of Alberta 1993: 2593):

> The issue of overuse was also recently investigated by Dr. Howard Platt who published his findings in the *Alberta Doctor's Digest*, an Alberta Medical Association publication which goes out to 4,000 doctors in this province. Dr. Platt's findings showed that, in one particular area of southern Alberta, 44 percent of children under the age of 10 were taken to their doctors for common colds. [. . .] I find some of these facts alarming, but where do you put the blame, Mr. Speaker? It's not the fault of the doctors who are simply treating those people who walk through the door. Rather, the onus should be placed on the individuals who use the service; make them responsible.

Politicians on the left view the moral hazard problem differently. During the same debate, a member of the Alberta New Democratic Party rebutted the government member's comments (Legislative Assembly of Alberta 1993: 2593):

> So let's deal with the problem that the motion attempts to address: patient abuse. We know that it's not common; it's estimated to be under 3 percent. Just like the abuse of the social services system, it's hard to pin down. I want to ask you: who abuses the system? Not to put too fine a point on it: people who think that they're sick when they aren't abuse the system, but they themselves have a disease called hypochondria which needs to be treated. The other people who abuse the system are healthcare professionals—physicians, chiropractors, what have you—who call you back unnecessarily.

However, a child's 'cold' can be more than just a cold—and, surely, no not-for-profit public health system could depend on hypochondriacal patients for its survival.

There are also compelling arguments against for-profit healthcare from the US. Assessing the US health system, Relman (2007) presented the case against for-profit healthcare comprehensively and provided a superb assessment of the manner in which commercialisation and for-profit business incentives have saturated the provision of healthcare in America (Relman 2007: 15–39)—'[w]hen insurers and providers focus on maximizing their income, health care expenditures inevitably rise, equity is neglected, and quality of care suffers' (Relman 2007: 3). Physicians have been central to the process of commercialisation, through their own

investment in creating and owning for-profit health businesses, and such commercial involvement has undermined physicians' fiduciary duties to their patients (Relman 2007: 33). The US approach to health is probably the most commercialised in the world, he concluded, and other countries may not embrace commercialisation to the same extent (Relman 2007: 15).

In Canada, the publicly funded health system allows some room for private sector involvement in the delivery of a limited and specific range of healthcare services. The current breakdown between private and public financing of healthcare in Canada is as follows (Rachlis 2007: 3):

> In Canada about 70% of health care is financed publicly and about 30% privately. Twenty-five years ago about 76% of funding was public. Canada's rate of public finance is just marginally less than the average for the Organization for Economic Cooperation and Development (OECD) countries for 2005 of 72.1%. But almost all of the countries with comparable standards of living to Canada have a higher proportion of public spending because the average is brought down dramatically by the U.S., Mexico and Greece, where the public proportion of spending is less than 50%. Germany has 77% public proportion of spending, France 80%, Denmark and Norway 84%, Sweden 85% and the UK 87%.

This article reflects on the 'public–private split' in publicly funded healthcare from the author's perspective as both a medical sociologist and a practitioner of many years in a variety of public health policy roles in the Canadian health system. This article focuses on the ways in which the policy space in the Province of Alberta accommodated for-profit healthcare delivery as a specific management option during the period 1993–2012. In the context of this article, the term 'public health policy' means more than just policy designed to achieve health through improved sanitation, more comprehensive immunisation practices, and the provision of clean water and adequate shelter. Public health policy means the entire range of work and practices by which a variety of actors (governments, professionals, employers, and citizens) aim to create health as a state of being that reflects biological, physical, and emotional wellbeing and freedom from disease at individual and collective levels.

This hybrid of public policy and medical sociological analysis is meant to be illustrative rather than prescriptive. The Province of Alberta was chosen deliberately, as the jurisdiction where the author has lived, worked, and studied for about twenty years. Following this introduction, this article outlines a general analytical framework and provides a background description on the opportunity for private for-profit healthcare delivery options in Canada. It then focuses on a specific example of the way in which Alberta allowed private sector involvement in the delivery of surgical services and the problems encountered. The Alberta example is a specific instance of introducing market competition for the delivery of

hip, knee, and other orthopaedic procedures between the established public sector and a private sector surgical group based in Calgary, Alberta. It is an example of private for-profit delivery that ultimately fails. This business failure provides instructive value for policy makers and public health managers. This article concludes with an analysis and discussion of the lessons that can be learned from this Alberta experience.

Analytical perspectives

Based on the authors' shared and separate empirical work, the health policy framework developed by Klein and Marmor (2012) possesses an abstract quality useful to this present discussion—it deals with the worlds of politics and policy in a commonsense fashion that does not mystify the policy making process. Building on their health policy perspective, this article introduces some basic—but often ignored—theoretical and empirical content from medical sociology. Medical sociology considers physicians and physician organisations as policy actors crucial for public health policy design and implementation (Stevens 1998: xiv–xviii). The sociological content of this article will foreground a discussion about how policy interactions in the public health policy and management arenas can often go awry because the interests of a major interest group—physicians—are often misunderstood.

Klein and Marmor (2012: 1) defined public policy as a form of social action that is 'what governments do and neglect to do. It is about politics, resolving (or at least attenuating) conflicts about resources, rights and values.' Their framework rests on three key conceptual building blocks (Klein and Marmor 2012: 2–3):

1. ideas—the mental models (assumptive worlds) used by policy actors to provide both an interpretation of the environment and a prescription about how that environment should be structured;
2. institutions—the constitutional arrangements within which governments operate, the rules of the game, and the administrative machinery at their disposal; and
3. interests—specifically those operating in the political arena: material (primarily financial) and non-material (notions of right and wrong, for example); concentrated versus diffuse; and scale and intensity. The configuration of interests can change over time, as issues are redefined and new actors enter the policy arena.

For Klein and Marmor (2012: 4–5), the principal policy actors are political parties striving to gain office and form the government. Once elected in government, parties advance policies that maintain them in office, even if the policies of governing are not exactly the same as those on which they campaigned for office—such is the way of power. The ability of governments to craft policy is limited not just by the availability of resources required for policy implementation,

but also by the absence of perfect knowledge that ensures policies will work as intended and achieve the goals desired (Klein and Marmor 2012: 3).

Regardless of the prominence assigned to political parties, the public health policy field is also populated with other significant actors. Public health systems are a complex of professions, multinational corporate actors (such as GE or Siemens, which provide expensive imaging equipment, and international pharmaceutical companies), patient interest groups (such as the various regional Heart and Stroke Foundations in Canada), health philanthropies, and many others. These actors are frequently at odds with one another—their interests clash in ways that lead to differing stances on policy issues. The types of interest at stake when any particular policy issue arises can be as diverse as the autonomy to practice (in the case of professional associations), health priorities (whether limited funding should address prevention or cure), and governance (who gets to make the decisions about how services are organised and delivered).

However, physicians and their representative bodies remain the most important organised interest group from a public health policy perspective—despite the existence of other powerful public health policy actors, such as private for-profit hospital corporations, pharmaceutical companies, and insurance companies. If public policy is what governments do or neglect to do, then the strong corollary that this article wishes to draw for discussion is that the interests of physicians are the critical determinants for what governments eventually do or neglect to do when introducing public health policies.

This does not mean that physicians' interests are paramount, but that—as a practical issue—public health policies and public health policy analyses that do not factor them in are incomplete, even if these interests are judged to be minor. Understanding physicians' interests is complicated by the differentiated structure of the medical profession as it interacts within the political economy of public health policy making. Bucher and Strauss (1961) and Freidson (1986 and 1994) analysed this aspect of differentiation within the US health system and Marsden (1977) examined it from the Canadian perspective.

Bucher and Strauss (1961: 326) suggested that medicine as a profession can be viewed as a 'loose amalgamation of segments pursuing different objectives in different manners and more or less delicately held together under a common name at a particular point in history'—the unity of purpose that appears to mark medicine may be more manufactured than real (Bucher and Strauss 1961: 331–2). This model of the medical profession accommodates a 'divergence of enterprise and endeavour' which marks most professions (Bucher and Strauss 1961: 326). The appearance of professional unity—exemplified by codes of ethics, licensure rules, and disciplinary procedures—may hide from the public very real, very internal power struggles. This work of professional unification is often accomplished by key representatives within the profession who take on the roles of

negotiating and presenting its public face—an endeavour successful when people and policy makers approach the profession of medicine as a monolithic bloc.

However, in public health policy debates, interactions between physicians and governments can be difficult to interpret and manage—in the US, Canada, and elsewhere, the medical profession is not a monolithic bloc (Freidson 1994: 142–3). Freidson (1994: 196) differentiated three groupings that do the work of claiming and defending the professional status of an occupational group: the rank and file, the administrative elite, and the knowledge elite. The rank and file members of medicine are physicians involved primarily in clinical practice—they spend most of their time seeing patients. The administrative elite covers the executive, managerial, and supervisory roles in organisations and typically exercises some power and authority over rank and file members—vice-presidents of medical service in hospitals or health systems, for example. The knowledge elite—often referred to as academic physicians—advances and sustains the power and privilege of the profession through education of the next generation of medical practitioners and research into the cognitive / skill base that underlies the group's claims to professional status and sustains its claims for autonomy (Freidson 1994: 142–3). Most often, the work of the knowledge elite is translated into standards of practice—although these standards may or may not be adopted universally by the rank and file (Wennberg 2010).

The introduction of Canada's national Medicare Plan impacted relationships between government and physicians in the late 1960s and early 1970s. In Ontario (Marsden 1977: 8), for example, it enhanced the power and influence of the knowledge elite and created a different balance of power within the medical profession (Marsden 1977: 10):

> The Ontario Council of Health (OHC) has among its members a number of lay people; but of the doctors who have served on the main body [. . .] at least half have been doctors from the medical schools in the province. While doctors having any affiliation with a medical or teaching hospital are only a fifth of the doctors in the province, they are represented on the OHC in grater proportion than in the population of doctors. In 1971, for example, of the 21 Council members, seven were medical doctors. Of the seven, four were medical educators. On the Council's various other working committees and sub-committees, 53% of the doctors were educators.

The practical reason for this representative distribution had to do with the fact that academic physicians do not rely completely on clinical service for remuneration (Marsden 1977: 10), allowing them time and opportunity to interact with government, develop policy, and provide advice on implementation of new programmes.

From a public health policy perspective, success for political parties means crafting policies and programmes that provide a greater range of accessible, high-

quality, and affordable health services—and that lead a majority of electors to vote for them. From a political perspective, success is straightforward—winning health policy delivers electoral victory and avoids defeat. Once elected, the political party that forms government has to implement its policy, while dealing with a collection of groups that have diverse material and non-material interests as stakes in health system policy and implementation. The medical profession typically has a major voice and role in successful health policy development and implementation. However, because the medical profession is not monolithic, a predictable policy response from physicians to any particular policy idea is in no way guaranteed. On the one hand, Freidson's (1994) framework would suggest that the hour-to-hour operational success of broad health programmes—such as Canada's national Medicare Plan—rests with the rank and file physician segment. On the other, Marsden's (1977) research would suggest that this segment is probably the most challenging with which to consult on policy development and implementation. Her research pointed to the administrative and knowledge elites of the medical profession as the most commonly involved with the design and implementation of public health policy. The administrative and knowledge elites share some of the material interests of the rank and file, but they also have other interests—the promotion of education and research as activities within health systems, for example—as well as, perhaps, a stronger attachment to system administrative work. There is no reason to assume that the interests of the rank and file physicians dovetail with the standards work and scholarly interests of the knowledge elite or the administrative / bureaucratic ethos of the administrative elite. The Alberta example will be used to draw out this policy and management complexity as it manifested in one case.

Canada's constitutional framework for public health delivery

Canada is a federal democracy headed by a constitutional monarch and consisting of a federal government, ten provincial governments (including Alberta), and three territorial governments. The federal government retains primary responsibility for healthcare to aboriginals and certain public health services such as quarantine and food safety. However, public healthcare—the provision of hospital and long-term care and most community public health and physician services—is largely a constitutional responsibility of the provinces. The extension of public health as a national public programme in Canada was an initiative of the federal Liberal government through the *Medical Care Act* of 1966 (Government of Canada 1966). In the mid-1980s, after extensive federal–provincial negotiations, this act and its principles were reworked as *The Canada Health Act* (Government of Canada 1985). First in 1966 and then again in 1984,

the federal government and the provinces agreed to cost-share the provision of a set of insured public health services for a provincially delivered and managed health plan that satisfied five conditions—universality, comprehensiveness, portability, public administration, and accessibility.

These funding conditions were defined in the legislation, and provinces had to develop an insurance healthcare model that satisfied them, when the national physician and hospital services plan was started in 1966 under the *Medical Care Act*. The federal government determined compliance, and non-compliance through violation of the conditions resulted in financial penalties. However, the definitions of compliance were not absolute—with regard to access, for example, Section 12(a) of *The Canada Health Act* specified that access to insured services by insured persons need only be 'reasonable', without defining further what 'reasonable' meant.

Once it was determined that they complied with the five conditions, the provinces became eligible for full 50-50 cost-sharing from the federal government. The opportunity to deliver a politically popular programme with what was essentially 50-cent dollars was too attractive at the time to resist—all provinces agreed to cost-sharing with the federal government. Over time, the original 50-50 funding formula was substantially modified. Today, funding flows from the federal government to the provincial governments through the Canada Health Transfer—a combination cash–tax point arrangement between the provinces and the federal government, renegotiated from time to time and currently accounting for about 22 per cent of provincial spending on healthcare.

The federal government uses renegotiations to make provinces more accountable for delivering programmes and services in ways consistent with the original five conditions. However, the provinces argue that calls from the federal government for greater accountability may represent federal intrusion—after all, the constitutional responsibility for public healthcare lies within provincial jurisdiction. Rather than greater accountability, their view is that what is required is greater flexibility from the federal government as to how the money is spent provincially. The federal government's cash and tax point contributions are inadequate to meet the need of their populations, argue the provinces—the decreased federal proportional share of healthcare funding now means that the federal government is seeking constitutional control over health that outweighs its financial commitments. The political dynamic created by the accountability–flexibility tension has resulted in conflict and a degree of diversity. Provinces attempt to push back the limits of federal authority and, in so doing, test the federal government's resolve to enforce the five conditions. Provinces particularly resent federal attempts to use spending powers to adjudicate the administrative propriety of various mechanisms that provinces might choose to manage healthcare locally—

for example, service delivery 'experiments' that include private for-profit models of healthcare delivery.

Today, Canada's national health system consists of ten separate provincial health plans knitted together by the five federal funding criteria and the cost-sharing formula in place at any one time—each province's approach to public health delivery reflects its particular political, social, and economic context. Despite such tensions in the Canadian public health system, innovation is intrinsically possible within the national plan's design because the five founding criteria are actually vague and open to a broad degree of interpretation.

There are several ways in which Canada can be said to have mixed, public–private delivery and for-profit–not-for-profit financing models for public healthcare. First, according to the 'Interpretation Section 2' of *The Canada Health Act*, only physician services that are medically required are insured—non-medically required services (such as cosmetic surgery, for example) are not. Second, the public system pays for private and semi-private hospital room care only if required for medical reasons In other words, *The Canada Health Act* only mandates provincial coverage of medically necessary physician and hospital services, resulting nonetheless in about 91 per cent of hospital bills and 99 per cent of physician bills being paid publicly (Rachlis 2007: 3). Patients must pay out-of-pocket for private and semi-private hospital room care for non-medical reasons (such as privacy, for example). Patients' private health insurance is often with insurers (such as the provincial Blue Cross Plans, for example) that operate as non-profit corporations under provincial insurance regulations—under the public administration criterion, *The Canada Health Act* allows provinces to delegate part of their responsibility for coverage to a third party that is a non-profit entity. Third, the provincial Workers' Compensation Boards were explicitly exempted from *The Canada Health Act*—the 'Interpretation Section 2' excluded workers' compensation health services from the definition of insured medical services. These provincial agencies can thereby purchase medically necessary services for injured workers from any healthcare providers—including for-profit providers, where such providers exist. Fourth, public healthcare provision for certain groups—on-reserve aboriginals, members of the Royal Canadian Mounted Police, and members of the Canadian Armed Forces, for example—is the responsibility of the federal government.

For-profit orthopaedic surgery care: the Alberta case

For the last 20 years, the Canadian Province of Alberta has had a consistent political desire to introduce some degree of private sector involvement into the delivery of clinical services. Alberta has had a unique political history, having

been governed for about eighty years by two centre-right parties—the Social Credit Party of Alberta and the Progressive Conservative Party of Alberta (herewith, the PC Party). Under a succession of leaders, the PC Party has governed Alberta for the last 42 years, during which time political opposition has been minimal. In a Westminster first-past-the-post electoral system, the PC Party has typically won resounding majorities—in many constituencies, its margin of victory could be modestly described as a landslide. These electoral majorities, particularly over the last 20 years, frequently occurred against a background of electorate concern over long wait times in emergency departments, long wait times for elective surgical services, and shortages of physicians and other health professionals. There have been strikes and disagreements between the Government of Alberta (as the employer) and health professions and occupations (as workers, physicians included). Election and pre-election opinion polling of the population often suggested that healthcare delivery and access to healthcare services were major public concerns. Nevertheless, the PC Party has been resoundingly victorious at re-election—the public perception of poor healthcare delivery and inadequate access revealed through opinion polls and public sector worker strife has had no detectable political impact at the ballot box. Today, Alberta receives significant funding from the federal government and operates a publicly funded health system that is substantially consistent with the principles of *The Canada Health Act*.

In 1993, the PC Party government in Alberta initiated a major redesign of public healthcare delivery and financing, as part of a broader plan to reduce overall government spending and accumulated debt which had come about from the collapse of oil and natural gas royalty revenues in the late 1980s (Flanagan 1998: 20). This initiative centred on the creation of regional health authorities—legal entities established under provincial legislation to plan, fund, and deliver comprehensive public health service coverage for the populations of defined geographical areas within Alberta. Alberta's regional health authorities became responsible for the governance of hospitals and other public health services, as well as the budgets for their operation. For the most part, physician billing and remuneration remained outside the regional health authority system.

Under the *Regional Health Authorities Act* (Government of Alberta 2009), health regions were given broad powers to explore different mechanisms for delivering health services, including contracting out with private for-profit and private not-for-profit providers. While this redesign of governance and service delivery was underway, the provincial government made several attempts to introduce a greater degree of private market forces into healthcare and, in the spring of 1998, introduced legislation giving the Minister of Health powers to approve private hospitals. Although public opposition was intense and the bill was withdrawn (Steward 2001: 34), the provincial government did not relent—in 2000, it passed the *Health Care Protection Act* (Government of Alberta 2010) which

remains in force today. Carefully drafted and worded, this created the legal framework within which a private for-profit healthcare market could develop in Alberta around surgical services.

The first part of the for-profit health strategy involved lulling the public—Section 1 of the *Health Care Protection Act* prohibits any person from operating a private hospital in Alberta. The second part of the for-profit health strategy was to create a legal structure within which a market could nevertheless evolve—Section 2(1) of the *Health Care Protection Act* specifies that no physician can provide an insured service in Alberta unless in a public hospital or an 'approved surgical facility', while Section 4 prohibits operators to bill for 'facility services' over and above the amount agreed in the contract of operation with the regional health authority. Moreover, facility services—defined in Sections 29(g)(i) to 29(g)(xii)—are restricted to medically necessary services directly related to the provision of a surgical service at an approved surgical facility. However, section 29(g)(ix) deftly places the following qualifying clause within the definition of a facility service: 'medical goods or services consistent with generally accepted medical practice in the particular case'. The cumulative impact of these sections is that operators of surgical facilities can charge patients directly for enhanced facility service options, as long as such facility service options are not medically required relative to the surgery in question—purchasing gourmet meals and fine wines during a surgical stay, for example, or even better quality hip and knee prostheses than those consistent with the generally accepted medical practice. The College of Physicians and Surgeons of Alberta (CPSA) was empowered to perform the accreditation of private clinics. By 2012, 60 independent clinics across Alberta were performing surgeries outside of hospitals—of these, 12 were performing multiple types of surgery (Gibson and Clements 2012: 7).

The political appetite to grow private for-profit medicine was most intense during the 1990s and early 2000s in Calgary. Politically, the city has been a long-time bastion of conservative politics—two of the longest serving premiers during the PC Party's 42 years in power were elected from Calgary. In Calgary, the regional model of health system governance went through three iterations—from the Calgary Regional Health Authority, through the Calgary Health Region, to the provincial amalgamation into a single region known as Alberta Health Services.

The Calgary Regional Health Authority developed a history of contracting out surgical services to private for-profit clinics beginning at least as early as 1995 (Steward 2001: 13). These contracts covered a broad range of surgical services—including ophthalmology; abortion; ear, nose, and throat; podiatry; dermatology; oral surgery; and publicly insured dentistry procedures—and the contracting process had some interesting local features (Steward 2001: 13–14). First, the largest contract (for eye surgery) was awarded to a private for-profit clinic partly-owned by the Division Chief of Ophthalmology at the Calgary Regional Health

Authority. Second, a contract for podiatry surgical services was awarded to a private for-profit clinic partly-owned by the Chief of Orthopedics at the Foothills Medical Centre, the largest acute care hospital in Calgary with a major academic role. Third, in 2000, two contracts for eye surgery were awarded to Surgical Centres Inc., a company where the Chief Medical Officer and Senior Vice President of the Calgary Regional Health Authority and his spouse were part-owners. The pattern is distinct—physicians who can be best described as prominent members of the administrative elite of the Calgary medical profession took leading roles in the privatisation of clinical health services.

In 2003, the College of Physicians and Surgeons of Alberta accredited Calgary's Health Resource Centre (herewith, Centre) to deliver surgical care with overnight stays. The Centre had previously been incorporated as the Health Resource Group (herewith, Group)—a surgical consortium that focused the majority of its business on providing day surgical services to third-party payers such as Workers' Compensation Boards, private insurers, and out-of-country patients. The Group had received accreditation from the College of Physicians and Surgeons of Alberta to offer only day surgery without overnight stays (CUPE 2000: 8).

How commercial or corporate was the Group as it transformed into the Centre? In its analysis of private healthcare in Alberta, the Canadian Union of Public Employees (CUPE 2000: 10) noted that the Group had multiple private investors in 1998—the Group was a privately held registered company that paid taxes and offered dividends to its closed group of investors. Its Board of Directors included locally prominent Calgary business leaders, such as the former President and Chief Executive Officer of the Alberta Children's Hospital, the President of the Calgary 1988 Olympic Organizing Committee, an architect whose spouse was a Member of the Legislative Assembly of Alberta (MLA) representing a Calgary riding[2], and a prominent Calgary orthopaedic surgeon who already had a private business servicing Workers' Compensation Board patients. Another prominent member was a physician who had been the founding Dean of the Faculty of Medicine at the University of Calgary, and who had since moved into the medical research venture capital business—his career as a physician clearly spanned several professional segments, but at that particular stage and in those particular circumstances he was acting as an investor seeking returns, not as a member of the medical profession's knowledge elite.

The Centre was owned by its parent company, Networc Health Inc. (Gibson and Clements 2012: 6), whose Chief Medical Officer was an orthopaedic surgeon who had been chief of orthopaedic surgery at the Foothills Medical Centre in Calgary as well as Medical Director of the Group. A physician drawn from the mid-echelon

[2] Electoral district.

of the administrative elite of the local medical profession, to use Freidson's terminology, his interests would have been more aligned with those of the rank and file and those of the administrative elite than with the interests of academic physician colleagues in the knowledge elite. The knowledge elite of the medical profession in Calgary controlled the Faculty of Medicine, and had succeeded in achieving administrative control at the Foothills Medical Centre.

As regional health system governance evolved, the reorganisation of services away from the hospital model to the regional model was accompanied by a novel physician management strategy that substantially altered the traditional relationships among different segments of the Calgary physician population. The Calgary Health Region and the Faculty of Medicine at the University of Calgary reached a new accommodation with regard to clinical and academic activities—with a few minor exceptions, one person was to cover both clinical and academic leadership roles, and was to lead both organisations. In so doing, the Calgary Health Region was recognising the city's importance in the academic health sciences and was accepting the need for organisational integration between the service and scholarly missions of the Faculty of Medicine at the University of Calgary, on the one hand, and those of the city, on the other.

This innovation is worth bearing in mind, when considering the policy and service developments that occurred on parallel tracks in 2003–4.

Soon after its accreditation in 2003, the Centre entered into a contract with the Calgary Health Region to provide hip and knee replacement surgery as part of the plan to reduce wait times for this surgery. This was a sole-source contract, initially, as there were no other providers of this service that could deliver overnight stays during recovery (Gibson and Clements 2012: 8). However, the arrangement proved problematic. Originally, in 2004–5, the Centre had a single contract for orthopaedic surgical services, valued at CAD 2.1 million (Gibson and Clements 2012: 9). By 2009–10, the Centre had four contracts—one covering orthopaedic surgical services, one covering acute post-operative and sub-acute services, one covering internal medical consultation services, and one for an outpatient services agreement—worth CAD 8.3 million (Gibson and Clements, 2012: 10–11). Over time, as the contracts increased in size and became more diverse, Networc Health decided to expand the Centre and improve its physical space in order to accommodate requests for increased surgeries from the Calgary Health Region. About this time, the regional model of governance changed again, and all Alberta health regions were amalgamated into a single region known as Alberta Health Services. When absorbing the Calgary Health Region, Alberta Health Services took on the previous regional contracts with the Centre.

In 2004, the Government of Alberta had initiated an evidence-based pilot project to address wait time challenges in the knee and hip replacement field (Gibson and Clements 2012: 11). To this end, a province-wide pilot project

partnership was developed among the provincial Ministry of Health, the Alberta Orthopedic Society, the Alberta Bone and Joint Institute, and family physicians from across the province who initiated referrals. This pilot project included the Centre facility and surgical workloads in the study. A prominent orthopaedic surgeon—who was a Calgary academic physician and clinical and scientific leader of the Alberta Bone and Joint Institute—championed the pilot project and led its research evaluation. He had been a national scientific leader with the Canadian Institutes of Health Research, and he had played a significant role securing philanthropic and government financial support to build a large, new surgical wing for bone and joint surgery at the Foothills Medical Centre—where he practised—that would be publicly funded as a public hospital facility and therefore as a non-profit venture.

The outcome of the pilot project was a new evidence-based continuum of care that was rolled out in major urban centres across Alberta in a major effort to reduce provincial wait times for hip and knee joint surgery. The pilot project demonstrated that—with a realignment of resources and evidence-based clinical pathways—it was possible to deliver enhanced care within the public not-for-profit system that reduced wait times and provided benefits to patients cheaper than private for-profit alternative providers (Gibson and Clements 2012: 11). This outcome was critical in the Centre's ultimate slide into bankruptcy.

A subsequent Alberta Health Services internal economic analysis and comparison based on the pilot project results indicated that the Centre could not provide surgical services at a price competitive with the public not-for-profit system (Gibson and Clements 2012: 12)—the Centre's higher costs per case were attributed to factoring into its business model a pre-tax return on investment of 10 per cent. The management irony was that—through successive reorganisations (from Calgary Regional Health Authority, through Calgary Health Region, to the province-wide Alberta Health Services single-region)—the public provider had acquired the scale required to offer much more cost-efficient orthopaedic surgical services. Alberta Health Services decided not to increase the surgical volumes of the Centre any further.

The Centre's ending was neither elegant nor graceful. The space expansion undertaken by Networc Health to accommodate the previously increasing surgical contracts led to financial difficulties. In 2010, the Centre's landlords, the Cambrian Group, initiated an unexpected bankruptcy order against Networc Health, alleging amounts owing from unpaid leases in the order of CAD 630,000[3] (Gibson and Clements 2012: 10).

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[3] For full details from the Centre's perspective, see Osler, Koskin & Harcourt LLP (2010).

Alberta Health Services intervened in the bankruptcy proceeding between the Cambrian Group and Networc Health / the Centre, requesting and paying for an interim receiver and purchasing the Centre's debt and security—this 'gave Alberta Health Services status as creditor and the presence of an interim receiver enabled them to delay bankruptcy proceedings' (Gibson and Clements 2012: 10). Alberta Health Services wound down the Centre—which happened to coincide with the opening of a large, new hospital wing by Alberta Health Services at the Foothills Medical Centre with a major focus on orthopaedic bone and joint surgery. Thus ended this particular experiment with the private provision of orthopaedic surgical services in Calgary.

Discussion and conclusions

That a private sector company such as Networc Health / the Centre should go bankrupt is hardly surprising. Bankruptcy is as common an occurrence in the private sector as corporate mergers and takeovers. Such is the way of markets—price competition creates corporate winners and losers.

Today, private sector, for-profit involvement in the financing and delivery of healthcare services in Canada is probably best characterised as moderate. The principal economic rationale advanced by Canadian advocates of free market principles in healthcare is that market incentives and structures can bring efficiencies to the delivery of healthcare (Flanagan 1998: 25). In terms of a day-to-day management strategy, the private sector, market-driven approach is most commonly advocated as a way for Canada to deal with long wait times for service (Rachlis 2007: 1). Rachlis (2004: 302–5) suggested that—while there may be a role for the private sector in Canada's healthcare system—any such role is probably limited at best for a variety of technical reasons having to do with the requirements of private sector, market-driven healthcare delivery:

1. low contestability. Market conditions make it difficult for many firms to enter healthcare. For instance, not many companies can afford to buy a hospital, attract doctors and other staff, and meet all the regulatory requirements for health service delivery.
2. high complexity. Health services may often have—frequently multiple and at times conflicting—policy goals. For instance, while a major goal of a health programme may be to increase or improve access to primary healthcare, this goal can be at odds with the goal of providing care within reasonable cost parameters.
3. low measurability. Specifically related to quality—and the inability to adequately rate the quality of many health services in a readily quantifiable way that is reliable and reproducible. Quality measurement in healthcare frequently

means an assessment of work practices by professionals and quasi-professionals that can become an enormously contested practice.

4. cream skimming. This is a better-known flaw of private sector approaches, whereby the private providers organise in a way that allows their participation in healthcare delivery to service the most easily diagnosed and treated patients, while the public system serves the harder to diagnose and treat and more complex patients, who are usually the more costly.

Flanagan (1998: 25) went even further and argued that the circumstances for an efficient market solution do not exist at all in the Canadian healthcare system—market success requires competition where numerous autonomous producers survive only by producing efficiently, at the lowest costs of production.

From a healthcare management perspective, the Group / Centre experience as a for-profit option illustrates how the absence of clear costing methodologies that ensure 'apples' are being compared with 'apples' is a major evaluative obstacle for determining which approach works better. William and Eisenberg (1991: 71–90) admirably explained how this problem can occur on multiple levels of method and analysis. First, healthcare costing methodologies can be hampered by a basic confusion between efficacy (whether a specific type of care works) and efficiency (what a service costs relative to its benefits). Second, whether evaluating healthcare issues from efficacy or efficiency perspectives, healthcare costing methodologies have to assess and compare the direct, indirect, and intangible costs of service provision. When evaluating the pilot project, the comparisons the Alberta Health Services made were based on average costs, and should have accounted for the administrative costs of contract administration. With Alberta Health Services being a CAD 12 billion-budget organisation and the Centre being a CAD 8.3 million-revenue organisation, the validity of the cost comparisons is unclear—without access to the contract, an independent verification is impossible. Lastly, third, it is difficult to determine whether the prices charged by private or public providers are fair and reasonable. In the particular case of the Centre's demise, the following particular features need to be noted:

1. The Centre operated as a sub-contractor to the public system and could not 'carry on its business of publicly funded, privately delivered surgical services except as and to the extent' that the public provider—Alberta Health Services—agreed (Gibson and Clements 2012: 15).

2. The most recent history of healthcare privatisation in Alberta—with its diffusion of market-oriented approaches to healthcare delivery—coincides with regionalisation as the dominant governance model. Within this governance model, efforts to increase a market-driven service delivery approach seem replete with physicians who were in leadership positions in these regions. These physicians were essentially carving out deals with and for themselves. This is a poor and ethically questionable practice.

3. Gibson and Clements (2012: 13) noted that private providers usually only 'do' non-complicated cases, leaving the more mixed and challenging caseload to the public system. This is the 'cream skimming' technical issue noted earlier by Rachlis (2004).

In fairness to the Centre, it is not at all clear whether the decision to cancel its surgical contracts was made for strictly economic reasons. With a significant new surgical wing—that could accommodate the surgical volumes being done at the Centre—opening at the Foothills Medical Centre, perhaps the political need to ensure that this new surgical capacity was effectively utilised weighed into the Alberta Health Services decision making. A very real political lesson from this experience would seem to be that—in making deals with governments and their agents—constancy of purpose may be elusive. Governments and their agents can be fickle, and those who expect constancy from them are often disappointed.

The Centre's demise also illustrates that non-obvious tensions and conflicts in the medical profession need to be better understood, when studying public healthcare policy issues. The Centre's focus was the provision of surgical services and not education or research—the Centre was a facility dedicated to the type and style of work that would be of most interest to the rank and file segment of the medical profession. Orthopaedic surgeons' and anaesthetists' participation likely provided them with an additional opportunity to maintain their skills, as limited operating theatre time in the public system can be a liability for a specialty group that relies on volume to maintain craft. Presumably, the physicians who worked at the Centre did so because it was financially lucrative, it allowed them to address patients' needs, and probably it allowed them to practice in a facility other than the Foothills Medical Centre, which was the major Calgary teaching and research hospital controlled by academic physicians. A medical politics challenge for the Centre was that it provided rank and file orthopaedic surgeons and anaesthetists an opportunity to practice away from the academic physicians who were in control at the Foothills Medical Centre. Academic physicians who educate future physicians need to ensure that students and postgraduate resident physicians have access to a sufficient range and volume of morbidity[4] and pathology[5] to ensure adequate education experiences. The Centre's success growing its surgical business over time was a potential challenge to the continued viability of the surgeon-in-training education that could be offered by the knowledge elite segment in the not-for-profit public system. These 'town versus gown' tensions are rarely mentioned in the public health policy literature, even though they are real and tangible factors dictating how different physician segments approach policy issues.

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[4] The rate of incidence of a disease.

[5] The manifestations of a disease.

Similarly, tensions regarding the way different segments are remunerated are rarely factored into public health policy discussions of for-profit care. How physicians are paid in Canada and what constitutes their fees have an impact on the general context within which for-profit healthcare becomes an option, as well as on how the different segments relate to one another. Canadian physicians are normally remunerated for their clinical services on a fee-for-service basis. In each province, these fees are set following negotiations between a physicians' association and the provincial government. Because physicians are viewed as small businesses, the fees negotiated include a component to cover office overhead expenses such as the employment of a secretary, rental of a clinic space, and other such expenses usually incurred by small business. This portion of the fee may represent on average 40 per cent of the charge. Technically, the extent to which physicians can manage their practice with less than 40 per cent overhead constitutes a profit for the practice. In Alberta, it is not unusual for all physicians—rank and file, administrative elite, and knowledge elite segments—to be incorporated as businesses for their clinical time. The reasons are simple—tax advantage and the ability to be more creative with a retirement savings strategy. In the case of the knowledge elite, academic physicians generally incorporate for their clinical time, while being employees for their university appointment time. It can be reasonably concluded that—on a formal basis—much of Canada's public health system is delivered by private sector businesses owned and operated by physicians. It may be a reasonable assertion that a business ethos is pervasive throughout Canada's public healthcare system—although, in the author's experience, critics of for-profit healthcare delivery rarely, if ever, concede this point. It may even be worth considering whether this business ethos is a major component of most public healthcare systems sanctioned by governments anywhere in the world.

The Alberta case study discussed in this article suggests that the interests of physicians are not monolithic when it comes to the political economy of health system policy making and management. It may be imprudent for policy makers to assume that physician participation in policy making and management processes is guided solely by the needs of—and demand for—high-quality, reasonably priced, and accessible clinical services. Health systems also support significant scholarly enterprises of intense interest to the knowledge elite segment. The integration of the scholarly and clinical service missions that happened in Calgary is not common across Canada and may not be common in other national health systems. It may be a feature too unique to this case study to be specifically useful elsewhere. However, it does highlight the need for policy makers and public sector managers to give some degree of thought to how very different outputs and outcomes can be at stake in public health policy and management for different individuals in the same professional group.

Going forward, it may be timely to re-examine the role and possibility for private for-profit providers as players in publicly funded health systems. Engaging for-profit providers may be possible, if governments and other public funders give care and attention to the outputs around quality, safety, and access in such a way that both not-for-profit and for-profit providers play within a shared and transparent set of rules. Whether as for-profit players who generate revenues for shareholders or not-for-profit players who generate budget surpluses, as long as they are tied to requirements for safe, high-quality, and timely care provision, the public will be the major beneficiary. This is a task for the regulator that in most instances is a government—ultimately, clear expectations and rules around safety and quality may be even more important for providers, whether they are for-profit or not-for-profit operators.

Approaching the question of the public–private split with these considerations in mind raises a fundamental theoretical question—is not-for-profit public healthcare in Canada or elsewhere at all possible? For example, major equipment—such as magnetic resonance imaging (MRI) machines—is purchased with public dollars from large multinational manufacturers such as GE or Siemens. Even though the public tendering and bidding processes can be rigorous, the health businesses of GE and Siemens continue to be profitable, and some of their profit gets reinvested into research and development to improve technologies. Should the profit amassed by a large international corporation such as GE or Siemens be considered as different from profit amassed by businesses owned and operated by incorporated physicians? This is an important question to consider, but not here.

References

Bucher, R. and Strauss, A. (1961). 'Professions in Process', in *The American Journal of Sociology*, 66/4: 325–34.

CUPE (Canadian Union of Public Employees) (2000). *Private Hospitals in Alberta* (CUPE Research Background Paper), at http://cupe.ca/updir/Private_Hospitals-Alberta_-1.doc (accessed 31 May 2013). Edmonton: CUPE (Canadian Union of Public Employees).

Flanagan, G. (1998). 'Cutting Health Care: The Hidden Cost', in *Alberta Views*, 1 (Spring): 20–6, at http://albertaviews.ab.ca/issues/1998/spring98/spring98social.pdf (accessed 31 May 2013).

Freidson, E. (1986). *Professional Powers: A Study of the Institutionalization of Formal Knowledge*. Chicago, IL: The University of Chicago Press.

Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy and Policy*. Chicago, IL: University of Chicago Press.

Gibson, D. and Clements, J. (2012). *Delivery Matters: The High Costs of For-Profit Health Services in Alberta*. Edmonton: The Parkland Institute, University of Alberta.

Government of Alberta (2009). *Regional Health Authorities Act: Revised Statutes of Alberta 2000: Chapter R-10* (current as of 1 April), at http://www.qp.alberta.ca/documents/Acts/R10.pdf (accessed 31 May 2013). Edmonton: Alberta Queen's Printer.

Government of Alberta (2010). *Regional Health Authorities Act: Revised Statutes of Alberta 2000: Chapter H-1* (current as of 1 November), at http://www.qp.alberta.ca/documents/Acts/H01.pdf (accessed 31 May 2013). Edmonton: Alberta Queen's Printer.

Government of Canada (1966). *Medical Care Act: Statutes of Canada: Chapter 64: Section 1*. Ottawa: Queen's Printer Canada.

Government of Canada (1985). *The Canada Health Act: Revised Statutes of Canada: Chapter C-6*. Ottawa: Queen's Printer Canada.

Hawkesworth, I. (2010). 'Public–Private Partnerships: Making the Right Choice for the Right Reason', in *The OECD Observer*, 278 (March): 10–11, at http://www.oecdobserver.org/news/fullstory.php/aid/3228/Public-private_partnerships.html (accessed 30 May 2013).

Klein, R. and Marmor, T. (2012). *Politics, Health, and Health Care*. New Haven, CT: Yale University Press.

Legislative Assembly of Alberta (1993). *Alberta Hansard* (1992–3, 22nd Session, 6 May). Edmonton: Legislative Assembly Office.

Mahar, M. (2006). *Money-Driven Medicine: The Real Reason Healthcare Costs So Much*. New York: HarperCollins.

Marsden, L. (1977). 'Power within a Profession' in *Sociology of Work and Occupations*, 4/1: 3–26.

Osler, Koskin & Harcourt LLP (2010). *Notice of Motion*, at http://www.pwc.com/en_CA/CA/car/networchealth/assets/networc-014_09072010.pdf (accessed 31 May 2013). Calgary: Osler, Koskin & Harcourt LLP.

Rachlis, M. (2004). *Prescription for Excellence: How Innovation Is Saving Canada's Health Care System*. Toronto: HarperCollins Publishers.

Rachlis, M. (2007). *Privatized Health Care Won't Deliver (Commissioned Policy Research: Privatization of Health Care)*, at http://wellesleyinstitute.com/files/privatizedhealthcarewontdeliver.pdf (accessed 30 May 2013). Toronto: Commissioned Policy Research, Wellesley Institute.

Relman, A. (2007). *A Second Opinion*. New York: Public Affairs Publishers.

Stevens, R. (1998). *American Medicine and the Public Interest: A History of Specialization*. Berkeley, CA: University of California Press.

Steward, G. (2001). *Public Bodies, Private Parts: Surgical Contracts and Conflicts of Interest at the Calgary Regional Health Authority*. Edmonton: The Parkland Institute, University of Alberta.

Wennberg, J. (2010). *Tracking Medicine: A Researcher's Quest to Understand Health Care*. New York: Oxford University Press.

William, M. and Eisenberg, J. (1991). 'Understanding the Economics of Health Care Decision Making', in Rovin, S. and Ginsberg, L. (eds), *Managing Hospitals: Lessons from the Johnson and Johnson Wharton Fellows Program in Management for Nurses*. San Francisco, CA: Jossey-Bass Publishers.

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Tom's areas of expertise are the sociology of healthcare and the sociology of the professions. He received his PhD in 2007 from the University of Calgary, having studied and researched his dissertation topic under the supervision of Dr. Arthur Frank. As a sociologist, Tom would classify himself as a mixed-methods critical sociologist who strongly favours the theoretical perspective developed by the late Pierre Bourdieu. His dissertation was a study of academic medicine in Canada using Bourdieu's analytical framework and a qualitative approach interviewing deans of medicine and academic and university leaders across Canada.

One of the more interesting aspects of Tom's PhD training is that, throughout, he maintained a full-time job as Director of Strategic Planning for the Faculty of Medicine at the University of Calgary. At the time, he had the great good fortune to work for an astute and enabling Dean, the late Dr. Grant Gall, who encouraged academic development and was supportive of his doctorate. This was one of a series of jobs in academic medicine that Tom held across a 25-year span. Early in his career, he had more of a hands-on, quantitative focus and conducted several population health surveys and health programme evaluation studies in various provinces. Progress through the health management field involved working in a variety of policy roles across multiple sectors, from provincial ministries of health to the non-governmental health advocacy sectors. Working most often directly in support of chief executive officers allowed Tom a view into the makings of public health policy at the very highest levels. He also had the opportunity to engage in

high-level political advocacy. These experiences shaped Tom's view of both the art of strategy planning and the craft of policy making and implementation.

Following his PhD, Tom had the opportunity to engage with the Center for Policy Studies (CPS) at the Central European University (CEU) as a Post-doctoral Research Fellow. He spent the period September 2010–August 2012 in Budapest, Hungary, and became aware of the challenges facing public health systems in post-communist states. Tom learned a great deal at CEU with a group of bright, hard-working, and kind colleagues and associates—all of whom he considers friends.

Currently, he is interested in further research into how the commercialisation of public policy research occurs through the use of consulting firms and think-tanks and the roles of physicians in these organisations. With more time, Tom would like to explore the ways in which personalised medicine and genomics are disseminated into medical practice and how professions—such as engineering, medicine, and the law—approach major policy game-changing events such as climate change.

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