Strangulation or Rationalization? Costs and Access in Canadian Hospitals

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Abstract

Beginning a little over a decade ago, Canadian hospitals began experiencing the most severe fiscal restraint of the past half-century. Between 1992 and 1996, hospital expenditure per capita fell sharply, from $939 to $858. These cuts fuelled professional declarations and a swarm of anecdotes about the dire consequences for the health of Canadians, whose confidence in the healthcare system dropped precipitously. Yet, a series of provincial royal commissions or similar inquiries during the previous decade had concluded that there was substantial scope for rationalization and cost containment within the provincial hospital systems. This paper examines the statistical record, looking at hospital capacity, access and utilization, prior to, during and after the 1990s reductions, and the impact of provincial finances on hospital funding decisions. While hospital bed capacity and inpatient utilization declined significantly, day surgery and other hospital-based ambulatory services have increased dramatically. There seems to be little or no evidence of "dire consequences" from the cuts themselves. But having succeeded once in implementing major program cuts in response to looming or actual deficits, right wing governments may, in the future, be tempted to create deficits deliberately through tax cuts. A "privatization" agenda for healthcare, designed to benefit the wealthy and private provider groups, could then be supported by claims that the public system is fiscally "unsustainable."

Beginning about a decade ago, Canadian hospitals entered a period of the most severe fiscal restraint in the past half-century. They were more tightly financially controlled than any other sector of healthcare. Between 1992 and 1996, hospital expenditure per capita fell sharply, from $939 to $858 (Canadian Institute for Health Information 2002a). Accounting for inflation over this period, this represents a real reduction of 14%, and resulted in hospital costs as a proportion of GDP falling by 20%, from 3.8% to 3.0%.

Compression tends to generate heat, in hospitals as elsewhere. The Canadian media became filled with claims of dire consequences, patients going untreated, long waiting lists, anecdotes of catastrophe – a general story of resources insufficient to meet the needs of a stable population, let alone a growing and aging one. Correspondingly, Canadians' confidence in their healthcare system dropped precipitously, from the highest among 11 surveyed nations in 1989–90, to barely above that of the United States in the same survey a decade later (Blendon et al. 2002).

On the other hand, by 1990 a series of provincial royal commissions and other forms of major inquiry had concluded that there was still substantial scope for rationalization and cost containment within the provincial hospital systems (Angus and Douglas 1991). Hospitals' reactions to their more fiscally constrained environment were, in fact, along lines long recommended by those who felt the sector could benefit from considerable rationalization (Ontario Health Services Restructuring Commission 2000). The claim from those concerned about the dramatic declines in hospital funding was that ministries of finance across the country were strangling the hospital sector, killing innocent people along the way and making lives miserable for many more left languishing on increasingly unreasonable wait lists. These two diametrically opposing views cannot possibly both be right. In this paper, we examine the statistical record, looking at the effects of the dramatic hospital downsizing on capacity, utilization, provincial finances and public perceptions.

Hospitals in Canada

There are about 750 "acute care" hospitals in Canada (Canadian Institute for Health Information,

2002b). In reality, many offer a combination of acute, rehabilitation and extended care. The largest single-facility hospital in the country is Centre Hospitalier de l'Université de Montréal, with more than 1,700 beds. There are 61 hospitals with more than 500 beds, and 334 with less than 50 beds. Current bed supply is approximately 4.0 per 1,000 population, with 3.2 per 1,000 designated as "acute care." As of April 2002, there were about 116,850 "approved beds" in acute care hospitals in Canada encompassing acute, rehabilitation and extended care beds. All provinces (except Ontario) have, however, moved to some form of regional governance under which the old notion of an "approved bed" undoubtedly takes on a variety of meanings. A more accurate measure of actual service capability would be "beds staffed and in operation," but consistent longitudinal data by this measure were not available from all provinces.

Hospitals remain the largest single component of publicly funded healthcare, and the importance/size of healthcare as a proportion of all provincial program expenditures has increased significantly over the past few years (Canadian Institute for Health Information 2002c). But as a proportion of all provincial revenues, public healthcare costs have remained stable, and hospitals have become a considerably less important component (on this, more below). Figure 1 shows real (general-inflation-adjusted) per capita hospital costs (Canadian Institute for Health Information 2001a) in Canada over the period 1975–2002. Over a quarter of a century, real per capita costs have risen by about 35%. They peaked in 1992 and fell sharply through to 1997 (with particularly dramatic hospital downsizing in Quebec and Alberta, and a restructuring process in Ontario). They have been rising steadily since.

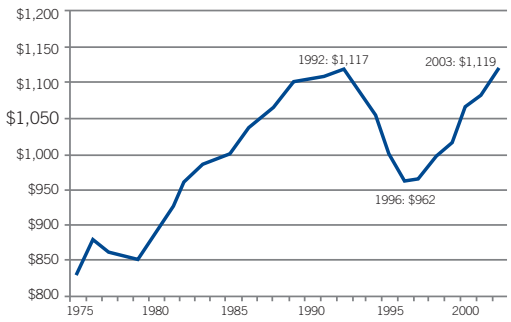
As a proportion of gross domestic product (Figure 2), hospital costs were, in 2002, back where they had been in the mid-1970s – just over 3%. This share has declined dramatically since reaching a peak of 3.8% in 1992.

Despite this fall of about one-fifth in the share of GDP taken up by hospital costs, the proportion of GDP accounted for by all healthcare was about the same in 2002 as in 1992, just under 10%. Figure 3 shows the almost monotonic decline in the relative importance of hospitals within both the total healthcare envelope and the proportion financed from public sources. Hospitals fell from about 45% of total healthcare costs in 1975 to 31% of costs in 2001, and from 55% to 40% of public expenditures.

OUT OF HOSPITALS, BUT ONTO DRUGS?

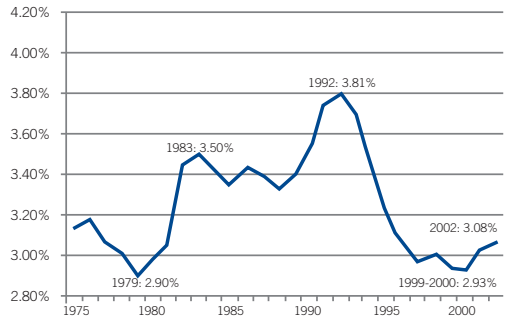
Figure 4 shows the distribution of Canadian healthcare expenditures over time, by expenditure component. Drug expenditures are clearly the main source of cost pressure; their share of the total has risen from just under 9% in 1975 to just over 16% in 2002. The provincial drug benefits plans have borne most (62%) of the burden of this increase; public reimbursement of pharmaceutical costs (incurred outside hospitals) has risen from 1.3% of total healthcare costs, to 5.8%. In the early part of this

Figure 1: Spending on Inpatient Care, Constant (2002) Dollars Per Capita



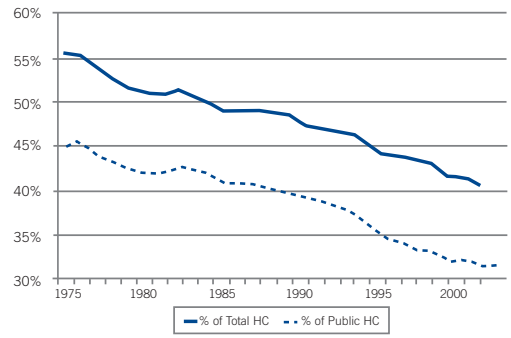
Data Source: CIHI National Health Expenditures Database, 2002.

Figure 2: Spending on Inpatient Care, Percentage of Gross Domestic Product



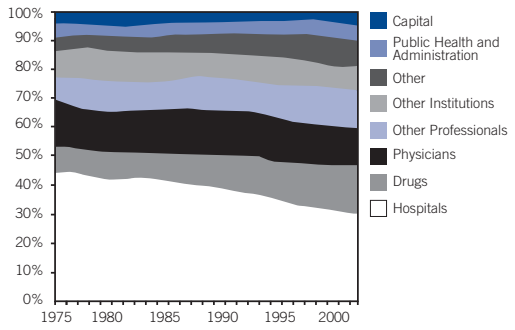
Data Source: CIHI National Health Expenditures Database, 2002.

Figure 3: Canadian Hospital Expenditures, Percent of Total Health Expenditures and Public Health Expenditures



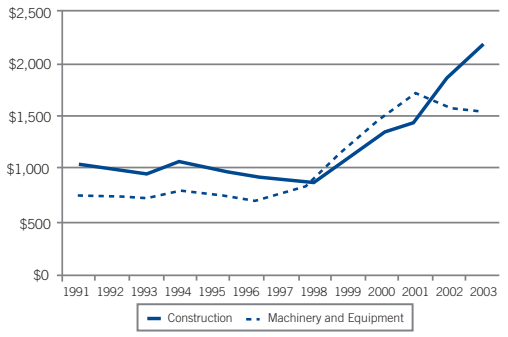
Data Source: CIHI National Health Expenditure Database 2001

Figure 4: Composition of Canadian Health Expenditures



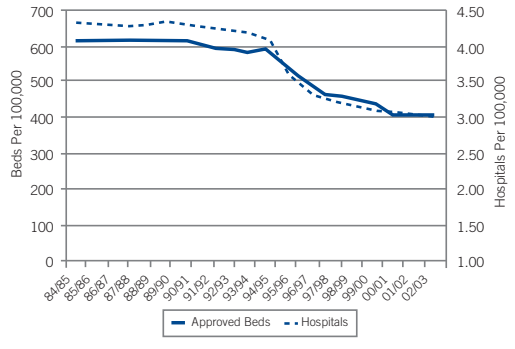
Data Source: CIHI National Health Expenditure Database 2001

Figure 5: Real Capital Investment for Canadian Hospitals



Data Source: Statistics Canada CANSIM II Series V755652 and V755653

Figure 6: Operating Hospitals and Approved Beds per 100,000 Canadians (at Fiscal Year End)



Source: CIHI Custom Data Request

period, the increase was driven by expansion of public coverage of drugs. More recently, provincial governments have been trying to reduce public outlays by cutting back on drug benefits. The escalation of costs in the mixed funding environment of the pharmaceutical sector – much more rapid than in the components of the Canadian system that fall within the universal public programs (Morgan et al. 2003) – has, however, so far thwarted this aim.

THE RE-CAPITALIZATION OF CANADIAN HOSPITALS

Not included in the hospital cost picture above, are the costs associated with the "capital" side of hospital operations – physical structures and equipment and machinery. Figure 5 provides a picture of hospital capital investments in Canada over the past decade. Investments were flat through to 1998 but have since escalated rapidly, probably in response to pressure from a number of influential medical groups and healthier provincial budgets. Prominent in this lobbying were the Canadian Medical Association and the Canadian Association of Radiologists (Canadian Association of Radiologists 2000). In September 2000, the federal government agreed to provide the provinces with $1 billion in new funding for "medical equipment" (Canadian Intergovernmental Conference Secretariat 2000). At time of writing, there is little "hard" evidence on how these funds are being used, but the evidence from national accounts (Figure 5) indicates that, unlike investment in hospital construction, investment in hospital-based machinery and equipment has tailed off, not taken off, in recent years (see, for example, Canadian Medical Association 2002; Health Canada 2002). The national forecasts for 2003 will not, however, include the latest federal injection of funding for capital purchases in the hospital sector. In February 2003, the First Ministers' Accord on Health Care Renewal established a "Diagnostic/Medical Equipment Fund" intended to "improve access to publicly funded diagnostic services" (Canada 2003).

ACCESS TO HOSPITALS I: WHERE HAVE ALL THE PATIENTS GONE?

This "recapitalization" of hospitals was explicitly not intended to finance an expansion of bed capacity and inpatient care. After a decade of stability, Canadian hospital bed capacity fell (per capita) by about one-third between 1993/94 and 1999/2000 (Figure 6); it now appears to be stabilizing again. Declines occurred in all provinces, with the largest (40%) in Quebec and ranging down to relatively small decreases in Manitoba, New Brunswick and Alberta (despite the significant slashing of healthcare budgets in that province in the mid-1990s). Between 1992 and 1995, nominal aggregate public sector expenditures on healthcare fell more than 10%, unprecedented in Canadian post-Medicare history. During the period of 1992 to 1995, more than 275 Canadian hospitals closed, merged or were converted to other uses, a process that was particularly rapid in Quebec (Canadian Institute for Health Information 2001b; Turner 2002).

The reduction in bed supply makes a corresponding decline in inpatient utilization no great surprise. This decline has come about largely through reductions in admission/separation rates, with much smaller declines in average lengths of stay. (It is important to note, however, that the overall pattern here likely masks quite different trends within acute- and extended-care beds. (The national data combine these, whereas the B.C. analysis reported below is able to separate them.) Over the period 1994/95 – 2000/01, crude separation rates from acute care hospitals in Canada fell from about 115 to 94 per 1,000, or about 3.4% per year. Age-adjusting makes almost no difference to this picture, in part because of the short time period, and in part because these patterns are dominated by use of acute care hospitals by seniors. The decline in total days of care over the period was very similar, 3.7% annually, from 850 to 680 days per 1,000 population. In contrast, between 1984/85 and 1999/2000, the number of clinic/outpatient (including emergency department) visits to Canadian hospitals doubled.

Recent research in British Columbia provides a more detailed look inside the Canadian hospital. (While this work is admittedly based only on one province, trends in bed reductions and the movement of an increasing number of procedures to a day basis across the country suggest that the results would fairly represent the national picture. (See Anderson [1997]) for a similar analysis of hospital downsizing in Ontario during the early 1990s.) Over the period since the late 1960s, hospitals in British Columbia have gradually transformed into two "systems" sharing the same facilities – one caring for short-stay patients, often on a day basis, the other housing long-stay, typically very old patients. Between 1969 and 1985, there was a steady and significant decline in acute care utilization, almost exactly offset by an increase in use of extended care beds. This was not, however, simply a transfer or re-labelling of patients. Acute care use fell most among the non-elderly, while extended care use rose among the very elderly. Over the decade between 1985 and 1995, the decline in acute and rehabilitation day use accelerated dramatically, a product of reductions in use by younger (<65) patients. This reduction in acute/rehabilitation days was the result of both reductions in the number of stays lasting fewer than 60 days, and reductions in lengths of stay among both short- and long-stay patients in acute care beds (McGrail et al. 2001).

In contrast, over the same decade, extended care utilization rates were relatively stable, as increases in lengths of stay were being offset by a declining separation rate. Extended care beds are largely occupied by very senior seniors. These increasing lengths of stay suggest, in part, increasing difficulty over the period in placing long-stay, non-acute, elderly patients in alternative levels of institutional or community care – an increasing proportion of those days of care were accounted for by patients (mostly seniors) with very long stays ending in death in hospital.

Increasing rates of surgical day care almost exactly offset the sharp reduction in acute care short-stay separations over the period. At first blush, this looks like a simple substitution of day surgery for inpatient surgery, but this explanation is incomplete. The decline in patient days was much larger than could be explained by such substitutions – sharply lower lengths of stay were the key driver. And different types of patients were involved in the two trends. For seniors, for example, the total "cases" (inpatient and day surgery) actually increased. Similarly, there was a very large increase in rates of cataract surgery (Meddings et al. 1997), implying reductions in separation rates for other conditions or procedures. Rates for eye procedures (largely cataracts) continue to increase rapidly across the country, though there are wide inter-regional variations, while the appropriateness of increasing numbers of these and other day procedures is coming under increasing scrutiny (Health Services Utilization and Research Commission 1995; Wright and Robens-Paradise 2001).

ACCESS TO HOSPITALS II: CONSEQUENCES FOR PATIENTS

Of course, data on bed supply or utilization can tell us nothing about whether access to appropriate and necessary care is getting better or worse. So, is there substance to claims that provinces overshot in cutting capacity in their zeal to reduce public expenditure on hospitals? Much was made, for example, of the decision by Saskatchewan in the early 1990s to shut down more than 50 hospitals in small communities (Calgary Herald 1993; Winnipeg Free Press 1993). Despite protests and anguish before and during the process, residents' fears about the impact of the closures turned out to be groundless. Death rates in communities where hospitals closed actually declined faster than those in communities that retained their hospitals (Liu et al. 2001). Urban downsizing in Winnipeg had similar (non)-effects – the closure of 700 beds in the mid-1990s had no detectable effect on death rates, frequency of visits to physician offices/emergency rooms or re-admission rates (Brownell et al. 1999). And a recent analysis of the rationalization of coronary revascular-

ization procedures in Calgary found no evidence of adverse effects on health outcomes (Hemmelgarn et al. 2001).

Detailed patient chart reviews continue to suggest that, even with the significant downsizing of the past decade, some beds continue to be occupied by patients who either did not need to be in a bed in the first place, or whose occupancy of a hospital bed reflects an inappropriate placement or level of care (Wright et al. 1997; Wright and Cardiff 1998). Recent studies based at individual hospitals are reporting fewer inappropriate admissions to hospital, but continued issues related to patients with unnecessarily long stays, due to inadequate alternative community-based resources and the absence of effective mechanisms for connecting patients with appropriate resources in a timely fashion, even when the resources exist (Cardiff 2002).

Yet, such evidence of continuing inappropriate hospital use coexists with continuing concerns about excessive waits for hospital care. Unfortunately, Canada continues to lack any reliable method of reporting, in a consistent and systematic way, changes in lengths of wait lists, or median or mean wait times (McDonald et al. 1998; Sanmartin et al. 2000; McGurran 2002). As a result of a recent Federal/Provincial/Territorial Performance Indicator Reporting Committee process, there is now an agreement in place on how to measure waiting times for a few procedures, but many jurisdictions are not yet in a position to report these data.

Recent research reports from Manitoba and Nova Scotia, using administrative data, have provided a mixed picture, with waits for some procedures increasing and for others showing declines (Nova Scotia Department of Health 1997; De Coster et al. 2000). Data from the British Columbia wait list registry (covering most of the province's largest hospitals) similarly show increased waits for a number of procedures, but decreases for others, over the period since 1996 (Canadian Institute for Health Information 2001b). And data reported recently by the provinces (Foss 2002) include long wait times for many procedures. Available data on urgent/emergent hospital care continue to show very short waits (see, for example, Cardiac Care Network of Ontario 2002; De Coster et al. 2000). In short, the little reliable data that do exist provide a mixed picture, with waits for some elective procedures getting longer, for others shorter, but for more urgent procedures, continued timely care.

But the overall information deficit leaves the field wide open for powerful anecdotes that happily fill the evidentiary vacuum, and convey the impression that waits for hospital-based procedures and beds, and in emergency departments, are getting longer, with increasingly serious effects on the health of patients (Globe & Mail 2000; Priest 2000; Wente 2002). These are aided and abetted by annual surveys from the Fraser Institute that have questionable validity: low response rates (about 30%) and unvalidated self-reporting by respondents who could stand to benefit from particular responses (Esmail and Walker 2002a).

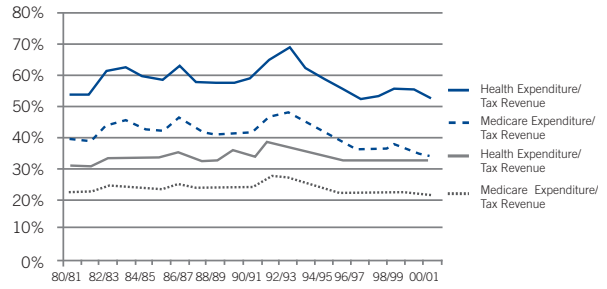
Wherever the truth about wait lists and times lies, there is no disputing that the population continues to be concerned about difficulties in accessing care on a timely basis. Recent surveys (Sanmartin et al. 2002a; Sanmartin et al. 2002b; Hay Health Care Consulting Group 2001) suggest that significant numbers of Canadians are experiencing waits that they feel are unacceptable and affect their quality of life. Personal experience appears to depend critically on where one lives, what procedure one is awaiting and which physician's list one is on. But the fact that the public is expressing anxiety about access to surgical and diagnostic procedures appears to be getting the attention of at least some policy-makers across the country (Senate Standing Committee on Social Affairs, Science and Technology 2002; Canada 2003).

Yet, without a sound information base from which to determine relative priorities, policy will be driven, at least in the short run, on the basis of perception and anecdote (Lewis et al. 2000). This leaves open the strong possibility that money will be thrown at highly politicized crises, despite compelling evidence that throwing money at waiting time problems rarely, if ever, brings the relief that is hoped (McDonald et al. 1998). Recent research on cataract surgery in Manitoba, for example, found that an increase in procedures performed did not result in shorter wait times or lists, and that waits for public sector patients whose surgeons worked in both public and private sectors were much longer than the waits for patients whose physicians did cataract surgery only in the public sector (De Coster et al. 2000).

AFTER THE FALL: W(H)ITHER THE PUBLIC REVENUE BASE?

Whatever its effects on patient care, for good or for ill, the great contraction in hospital funding in Canada seems to have been motivated primarily, if not entirely, by concerns over escalating public deficits. The early 1990s recession in Canada reduced the revenue base from which all provinces supported the provincially

Figure 7: Provincial Spending on Medicare and on All Health as a Share of Tax Revenue and of Total Revenue



funded components of healthcare (the largest component being hospitals). Figure 7 shows all healthcare expenditures, and public-only healthcare expenditures, as shares, respectively, of tax revenues, and all revenues. The decline in tax revenue between 1990/91 and 1992/93 led to a dramatic increase in the share spent on Medicare. The combination of being a "big target" and being less politically bruising to take on than physicians (though that was being done as well) (Barer et al. 1996), meant that hospital budgets were going to take a hit. And they did.

Over the subsequent four years, the combination of significant reductions in hospital expenditures and a gradually recovering economy resulted in a ratio of Medicare expenditures to tax revenues in 1996/97 that was the lowest since the beginning of the 1980s. Since then, this ratio has continued to trend down, so that Medicare spending in 2000/01 absorbed 34% of provincial tax revenue, well below the 39% in 1980/81. Total provincial government revenues recovered less rapidly than the tax component, however, because the federal government restructured its cash transfers to the provinces, effective in 1996/97, lowering the total by about $5 billion. Despite subsequent increases, these transfers were in 2000/01 still somewhat below their 1995/96 levels.

In the recovering fiscal climate after the mid-1990s, the federal government and several provinces have introduced substantial cuts to income tax rates over the past few years. In most provinces, however, total tax revenues have been relatively stable, due primarily to rising incomes, but also due to increases in other taxes. The net effect and presumably the intent of these changes has been to reduce the progressivity of the overall tax mix, redistributing after-tax income in favour of the wealthy (Kesselman 2002). Whether motivated by deficit reduction or by income redistribution, however, none of these recent tax changes has been necessitated by runaway hospital (or other healthcare) costs.

DISCUSSION

An increasingly common claim in Canada is that the healthcare system is "unsustainable." Interestingly, this view co-exists with arguments (often from the same voices) that the solution lies in policies that will almost certainly increase overall costs (see, for example, Mazankowski 2001; Esmail and Walker 2002b). The "unsustainability" claim is but the latest in a large and growing collection of "zombies" – claims about public healthcare that are intellectually dead but will not stay buried (Barer et al. 1998). The claims themselves dissolve in the light of serious empirical scrutiny, but they are constantly "revitalized" by those whose economic and ideological interests they serve. Alleging that public costs are out of control has been a relatively effective strategy for deflecting attention from the real Canadian issues, from where costs truly are out-of-control and coverage and access are inequitable, and for advancing a long-term privatization agenda.

There is no cost crisis in the Canadian hospital sector; real per capita costs have increased about 30% in the last 25 years. Hospitals absorbed in 2002 the same share of national income (about 3%) as they did a quarter century earlier. But behind these numbers, seemingly conclusive in themselves, there may be other causes for concern. First, and most obviously, recent trends in hospital capacity and inpatient utilization might appear to confirm the common view that the public hospital system has been systematically strangled. However, as noted above, commissions of inquiry in virtually every province during the late 1980s or early 1990s had concluded that a good deal of inpatient use was inappropriate, and that the system was "overbedded." It is conceivable that some provinces "overshot" in the mad scramble to empty hospitals of all patients who did not need to be there. For example, when asked about the severe downsizing undertaken in Alberta in the early- to mid-1990s, the Premier of the province, Ralph Klein, admitted that they really had no idea what they were doing (Steinhart 1996).

Yet, the data surveyed in this paper, with the possible exception of some evidence of, and growing public concern about, excessively long waits for some types of (non-emergent) care in some locations, provide little support for that view. While lengths of inpatient stay have, indeed, fallen dramatically, a much higher proportion of patients are now cared for through various forms of ambulatory

care. There is no evidence of systematic under-treatment and resulting threats to patient health.

And international evidence offers strong support for the view that there was, pre-1990s, significant excess capacity in the acute care sector in Canada. For example, even after the downsizing during the last decade, Canada's rate of acute care use was closer to that of the NHS in the UK than to California's Kaiser Permanente health maintenance organization. Yet, a recent comparison of those two systems found "more comprehensive and convenient primary care services and much more rapid access to specialist services and hospital admissions" in the Kaiser system (Feachem et al. 2002: 135). Such international experience reinforces the view that the Canadian inquiries had it right – there was plenty of excess capacity in the acute care sector prior to the 1990s downsizing.

A second cause for concern may be that the stability of costs in the hospital sector reflects, in part at least, the transfer of costs from hospitals to other agencies or persons. Some of these "cost shifts" may be a consequence of entirely appropriate changes in service patterns – from inpatient to home healthcare, for example – and represent net cost savings. Others, however, are accidental by-products of the funding system, and actually raise total costs.

Drugs provided in hospital, for example, are paid for out of the hospital's global budget. After discharge those same drugs, prescribed by the same physician, must be purchased by the patient, with or without the assistance of private or public insurance. Since hospital purchasing departments typically acquire and dispense drugs at costs well below the "community pharmacy" price, total costs go up. In either case, however, the transfer of activities and costs takes them outside the ambit of the Canada Health Act, leaving provinces free to finance healthcare services any way they choose – or not at all (Armstrong 2002).

But if there is, in fact, no cost crisis within the hospital sector per se, what is the source of the rhetoric about "unsustainable" escalation of healthcare costs? Much of the public concern may be a product of continuously hearing about the seemingly uncontrollable increases in costs of public drug benefit programs, and believing, correctly it seems, that provinces will react by offloading more of this rapidly growing financial burden onto patients. With limited information and facing endless "crisis" rhetoric, the public may extrapolate this experience to other components of healthcare (including hospitals), assuming they must all be out of control and that, here too, costs will increasingly be offloaded to patients.

Amid the repeated, and too seldom contested, claim that universal public payment has become unsustainable and there is not much that governments can do, some provincial governments seem increasingly prepared to condone and even promote the development of private hospitals, on the dubious grounds that these will somehow reduce wait lists and times in the public sector. Already there are increasing numbers of private "clinics" – hospitals in all but name – providing user-pay care allegedly only for foreign patients or for patients covered through provincial Workers' Compensation systems. It is generally suspected, but not documented, that these facilities are also increasingly providing privileged access for other Canadians willing to pay. The federal government does not appear overly energetic in carrying out its legal responsibilities under the Canada Health Act to monitor such activities and withhold federal funds from provincial governments that permit them. They may perhaps be reluctant to deal with what they might find.

This could be the thin edge of a very destructive wedge for Canadian hospitals. If private hospitals accessed by private payment become increasingly commonplace, the public sector may lose two very important things. Better-off (and politically influential) Canadians may become increasingly resistant to being taxed to support a public system when they themselves prefer to "go private." And a reliable supply of healthcare professionals, already difficult to find, may increasingly be drawn away by better wages and working conditions in better-financed private facilities with a "better class" of patients. Both foreign experience and fundamental economic logic point to the virtual certainty that, far from improving access in the public sector, increased private funding of hospitals would mean lengthened public sector wait times (recall the cataract story from Manitoba) and other difficulties of access. Clinicians who earn higher fees, and/or have an equity interest, in private facilities face an obvious incentive to ensure that the public option is less attractive.

Will a full-blown "two-tier" hospital system develop in Canada? There are a number of groups who stand to benefit from a successful campaign to convince the general public that Canada's publicly financed healthcare system is not sustainable. First, a move by provincial governments to vacate, or cede, increasing components of hospital financing to private sources – lower taxes and higher patient charges or private health insurance – will benefit the "healthy and wealthy," at the expense of the unhealthy and unwealthy (Evans et al. 1994; Evans 2002).

Second, recent large personal and corporate tax cuts in a number of provinces have left those provinces facing the stark choice between reducing expenditures, or returning to deficit financing. Deflecting attention by claiming that cost pressures simply make public programs as currently configured "unsustainable," may be intended to soften up the public to the notion of increased private financing (couched as patients taking more "personal responsibility").

Third, various private interests, including surgeons interested in investing in private clinics, companies interested in public-private capital partnerships, private insurance companies salivating over opportunities to expand operations in Canada, and drug and device manufacturers, all have interests in seeing the total size of the healthcare pie increase. Healthcare costs are their revenues. But if tax revenues going into healthcare fall, the only way for this to happen is through new (private) sources of funding. These private interests all understand that the key to increased aggregate healthcare costs lies with multiple funding sources – mixed public and private insurance and user pay. Convince the public that the only way to sustain the system is through the injection of new sources of funding, and the battle is half won.

The escalation of pharmaceutical costs in Canada is a case in point. Since pharmaceuticals are outside the federal-provincial Medicare program, provinces are free to shift escalating drug costs onto patients or private insurers. Yet, such approaches have had only a short-term impact on the public sector share of pharmaceutical costs that have trended steadily upwards for over 20 years. "What goes around, comes around" – attempts to shift costs achieve only uncontrollable cost escalation for all payers. Only universal public coverage permits cost containment – which is why the pharmaceutical industry opposes it with such vigour (Pear 2003). And the very success of cost containment in the hospital sector may turn out to have made it vulnerable to the same agenda, of private interests seeking cost escalation on the one hand, and promoting controlled public costs on the other.

Pharmaceutical manufacturers are particularly adept at this sleight-of-hand, attempting to ward off criticism of their rapidly escalating revenues by claiming that increasing expenditures on new and more effective pharmaceuticals keep people out of hospitals (or permit earlier discharge), and are thus the reason for the stability of hospital costs (Lichtenberg 1996). Unfortunately, the argument is false. The evidence that significant proportions of surgical patients could be treated effectively and safely on a day surgery basis has been around for over 30 years, long predating the recent explosion in drug costs (Evans and Robinson 1980). And references to excessive lengths of stay in Canadian hospitals date back to the original Hall Commission of 1964.

But such evidence was not enough to empty inpatient beds. It took financial pressure, not new drugs, to make Canadian hospitals get serious about translating that evidence into programmatic change. This is not unlike the effects of the shift to prospective payment in the United States; the emptying of beds at that time also had nothing at all to do with new drugs (Hsiao and Dunn 1987). More recently, the Veterans' Health Administration in the United States undertook a major system restructuring in the latter half of the 1990s, building "integrated service networks" and slashing acute care use by over two-thirds. At the end of that process, key quality indicators showed dramatic improvements (Kizer et al. 2000; Jha et al. 2003). But the initiative had nothing to do with more effective drug therapy. While technological advances, such as non-invasive surgical techniques and new anaesthetic agents, have undoubtedly increased the potential for reduced inpatient use, it is difficult to know how much bed-emptying, if any, would have taken place without application of budgetary pressures in each of these situations.

Recent events in a number of provinces, such as the intention in British Columbia to finance construction of the new Abbotsford Hospital and Cancer Centre through a public-private partnership (Partnerships British Columbia 2003), or the publicly-condoned proliferation of for-profit MRI facilities in Ontario – and the attendant siphoning off of scarce medical radiation technologists from public facilities (Harper 2002; Landsberg 2002) – appear to be prima facie evidence of a growing private-sector-friendly policy shift that is playing out in some provinces without much in the way of public debate, and despite clear evidence of the likely consequences. Canadians should not be surprised to see right-wing provincial governments and entrepreneurially-inclined private providers continuing to conspire to push the claim of public sector unsustainability in the teeth of the evidence, as a means of justifying the introduction of more private facilities and financing. This may occur despite whatever efforts to stem the tide may be mounted by the federal government (whose enforcement of its Canada Health Act has been rather sporadic) (Auditor General of Canada 2002).

Provinces that condone the development of private facilities, and eventually private payment for access

to those facilities, and that continue, through their policy choices, to try to push more of the prescription pharmaceutical bill onto the backs of sick Canadians, seem to be following a consistent privatization agenda. That agenda is clearly out of sync with a Canadian public that, by and large, still remains heavily in favour of a publicly funded system, and expresses a willingness to pay more taxes for healthcare if they can be sure the funds will be used to improve efficiency, effectiveness and equity (Janigan 2002; Maxwell 2002). But the shift away is already happening by stealth.

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