

The Eye-Opening Truth About Private Surgical Facilities in Canada

La vérité sur les établissements chirurgicaux privés au Canada



R. TRAFFORD CRUMP, PHD

Associate Professor

Department of Surgery

Faculty of Medicine and Health Sciences

McGill University

Montreal, QC

ALEX RAGAN, MD, LLB

Surgeon

Department of Surgery

Cumming School of Medicine

University of Calgary

Calgary, AB

GUNNAR SILJEDAL, MSc

Research Associate

Department of Surgery

Cumming School of Medicine

University of Calgary

Calgary, AB

JASON M. SUTHERLAND, PHD

Interim Director

Centre for Health Services and Policy Research

Professor

School of Population and Public Health

Faculty of Medicine

University of British Columbia

Vancouver, BC

EZEKIEL WEIS, MD, MPH

Surgeon

Department of Surgery

Cumming School of Medicine

University of Calgary

Calgary, AB

Professor

Department of Ophthalmology and Visual Sciences

Faculty of Medicine and Dentistry

University of Alberta

Edmonton, AB

Abstract

This paper examines the contentious issue of using contracted surgical facilities (CSFs) for scheduled eye surgeries within Canada's publicly funded healthcare system. Despite the debate over the use of CSFs, there is a stark lack of Canadian-focused empirical evidence to guide policy decisions. This paper uses the Organisation for Economic Co-operation and

Development's healthcare system performance conceptual model – access, quality and cost/ expenditures – as a framework to explore the debates surrounding CSFs. It highlights the mixed evidence from international studies and proposes recommendations for policy makers to ensure equitable access, maintain high-quality care and achieve cost-effectiveness. The paper underscores the necessity for informed policy making supported by robust empirical research, stakeholder engagement and continuous policy evaluation to address the challenges posed by the integration of CSFs into Canada's healthcare landscape.

Résumé

Ce document examine la question litigieuse de l'utilisation des établissements chirurgicaux sous contrat (ECC) pour des chirurgies oculaires planifiées au sein du système de santé public du Canada. Malgré le débat sur l'utilisation des ECC, il y a un manque flagrant de données sur le contexte canadien pour guider les décisions politiques. Ce document emploie le modèle conceptuel de performance de l'Organisation de coopération et de développement économiques – accès, qualité et coût/dépenses dans le système de santé – comme cadre pour explorer le débat entourant les ECC. Il met en évidence les preuves mitigées tirées d'études internationales et propose des recommandations aux décideurs pour assurer un accès équitable, maintenir des soins de haute qualité et atteindre la rentabilité. Le document souligne la nécessité d'élaborer des politiques éclairées appuyées par de solides recherches, par la mobilisation des intervenants et par une évaluation continue pour relever les défis posés par l'intégration des ECC dans le paysage des soins de santé au Canada.

Introduction

The demand for “elective” (i.e., scheduled) eye surgery in Canada outstretches the available supply of surgical resources, including operating rooms, ophthalmologists, anesthesiologists and nursing care. The insufficient supply of scheduled eye surgeries is evident by the length of time it takes patients to receive their surgery. For example, in Alberta patients wait, on average, 17.7 weeks for non-urgent cataract surgery and 13.0 weeks for “[o]ther interventions on the eye” from decision to surgery to the delivery of the actual service (Government of Alberta n.d.). In Ontario, the average wait time is 20.2 and 10.1 weeks,¹ respectively (Ontario Health 2023). Whether these wait times are appropriate is beyond the scope of this article; they are merely provided as evidence that the demand for these surgeries outstrips the availability of supply.

The demand for eye surgery is not expected to abate. The demand for cataract surgery in Ontario is estimated to more than double in the next 25 years (Hatch et al. 2012). This growing demand can be explained by an aging population, reduced thresholds of visual impairment warranting surgery, increased frequency of repeated eye surgery and higher expectations of patients for better vision (Erie 2014).

The insufficient supply of resources for scheduled eye surgeries is an issue for health ministries and regional health authorities because the length of time spent waiting for these

surgeries is widely reported in the media and used as an indicator for the performance of provincial health systems. Some provincial policy makers have turned to contracting with private, for-profit surgical facilities (i.e., contracted surgical facilities [CSFs]) (Government of Alberta 2022; Monga 2023). The use of CSFs is a contentious issue in Canada, and it is often difficult to parse fact from fiction. In this article, we aim to frame the issues underlying the contention, highlight relevant empirical evidence and recommend solutions to make more informed decisions regarding the use of CSFs in the Canadian context.

What Is the Debate Over CSFs?

The use of CSFs to provide publicly funded surgeries is not new in Canada. Several provinces have contracted scheduled eye surgeries with CSFs for years. Health regions in Alberta and British Columbia, for example, have been contracting out cataract surgery since the 1990s (Adams 2003; Armstrong 2009; Kent 2020). Since that time, provincial governments have passed legislation that specifies how CSFs can comply with the *Canada Health Act* (1985) (Allin et al. 2020).

More recently, several health authorities (i.e., provincial health ministries or health regions) have announced additional agreements with CSFs to perform scheduled eye surgeries paid for by the respective provincial health insurance plans, and remain free to patients. These agreements have been motivated by the growing backlog of patients waiting for their scheduled eye surgeries.

Heated debates over the use of CSFs – for all types of surgery, not just eye surgeries – in Canada’s publicly funded healthcare system have been going on for decades. The issue was given consideration during the Commission on the Future of Health Care in Canada (i.e., The Romanow Commission) (Deber 2002). To characterize these debates, we have adopted the framework for healthcare system performance measurement developed by the Organisation for Economic Co-operation and Development. While originally designed to facilitate comparisons of healthcare quality across systems (Arah et al. 2006), it has been updated to more broadly compare health system performance (Carinci et al. 2015). It is one of the few frameworks that includes the importance of core services (e.g., elective surgery) in defining health system performance and, therefore, provides an appropriate foundation upon which we can frame the debate (Busse et al. 2019). The framework defines performance through the following three dimensions:

1. *Access*. Do patients have equitable access to scheduled surgeries, irrespective of their medical complexity, ability to pay or geographic location? Some argue that CSFs *cream skim* or *cherry-pick* patients, taking those that are less complicated and leaving the more difficult patients for the public system (Armstrong et al. 2000; Friends of Medicare 2019; Mehra 2017). Proponents of their use, however, argue that CSFs open surgical capacity in publicly administered hospitals to deal with more urgent or complicated procedures (Scholl and Bhandari 2022).

2. *Quality.* Are the desirable outcomes from scheduled surgeries achieved? Are they provided in an appropriate and safe manner? Are the providers of these surgeries *patient-centred*? Critics of CSFs argue that there is a profit motive that leads these providers to cut corners, which results in poorer quality of care (Armstrong et al. 2000; Friends of Medicare 2022).
3. *Cost/expenditures.* Establishing whether health authorities receive good value for their spending on CSFs is complex as the concept of value incorporates measures of access, quality and price over short-term and long-term horizons. Relevant to elective surgery, this includes the cost of labour or, more specifically, the cost of nursing services. Proponents claim that CSFs are more cost-efficient at delivering surgeries (Miller and Shingler 2022). Critics argue that CSFs “poach” nurses from public hospitals, ultimately weakening publicly funded healthcare models (ONA 2023; Payne 2023a). Feeding this debate is the perception that CSFs offer better pay and daytime shifts to nurses compared with public hospitals (Payne 2023b). Others counter this argument claiming that this could put pressure on provincial governments to seek nursing staff from agencies or pay up at the negotiating table with unions (“Health Coalition Vows to Fight” 2022; The Canadian Press 2023), which possibly eliminates any cost savings offered by CSFs.

What Does the Empirical Evidence Tell Us?

Despite the history with and debate over CSFs for scheduled eye surgeries, there is no Canadian-focused empirical evidence regarding whether CSFs offer the same access, quality or value to the taxpayer that public hospitals do. As a result, policies are being made in a vacuum – void of any evidence – leaving only opinion and rhetoric to fill.

There are some empirical studies regarding the use of CSFs for scheduled eye surgeries from other countries with universal healthcare systems. There have been no systematic reviews conducted on this topic, and there have been no studies conducted in a Canadian setting. With the weak base of evidence, one must be cautious when generalizing the results of these studies to the Canadian context. Differences in insurance systems, performance measurements and restrictions on healthcare providers make direct generalizations difficult (Holom et al. 2018).

Below, we have attempted to summarize the studies we could find comparing public versus private delivery of scheduled eye surgeries in universal healthcare systems. This is not intended to be a comprehensive review, rather it is intended to demonstrate the mixed evidence that has been published on the topic.

- *Access.* Browne et al. (2008) reported that patients undergoing cataract surgeries at private facilities in the UK’s National Health Service (NHS) tended to be healthier with less severe cataracts compared to those undergoing the same surgery in public hospitals. Similarly, Solborg Bjerrum et al. (2015) observed that patients receiving surgery in Denmark’s private facilities were younger and healthier. These results, however, cannot be assumed to demonstrate

cherry-picking by private facilities; as Browne et al. (2008) noted in their paper, having the less complicated patients treated at private facilities was the underlying intent of contracts.

- *Quality.* Two studies reported that patients who underwent cataract surgery at private facilities in western Australia and Denmark were at greater risk for post-operative endophthalmitis compared to those undergoing the same surgery at a public hospital (Li et al. 2004; Solborg Bjerrum et al. 2013). Browne et al. (2008) observed that patients treated for cataracts at private facilities in the NHS experienced greater post-operative improvements and lower incidence of complications. Pager and McCluskey (2004) reported that cataract patients in Australia were more satisfied with the pre-operative information and post-operative experience surveys if they underwent surgery in a private facility.
- *Cost/expenditures.* Kruse et al. (2019) reported that private facilities in the NHS provided more “value” (p. 1357) – defined as patient-related outcomes relative to costs – for cataract care as compared with public hospitals. However, these findings were disputed a year later by Tulp et al. (2020), who reported no evidence that private facilities in the NHS outperform public hospitals on quality or price for eye surgery.

In terms of nurses leaving the public system for CSFs, there is very little empirical evidence investigating such occurrences. Chan et al. (2013) conducted a qualitative study on nurses in Hong Kong who had made such a move, revealing multifactorial motivations. However, this study only involved 12 nurses, and the prevalence of nurses leaving the public system for CSFs was not discussed.

What Are the Recommendations?

The limited empirical evidence on the use of CSFs to perform scheduled eye surgeries in Canada has exposed the vacuity to the recent request for proposals made by health authorities. This leads to the pertinent question: How are contracts with CSFs to be evaluated? If CSFs are to be used, we offer a number of recommendations for addressing the concepts of access, quality and value.

- *Access.* Health regions should designate who receives eye surgeries from CSFs. This should safeguard against potential *cream skimming* by providers and ensure equitable access for all patients. To facilitate this, health regions could administer a centralized referral system from primary care to ophthalmology. Patients would be seen by the ophthalmologist with the shortest wait times, irrespective of where they performed their surgery. Alberta Health Services has begun testing such a system for referrals to urology and orthopedics (Alberta Surgical Initiative n.d.).

- *Quality.* CSFs should be required to provide timely and reliable data on the quality of eye surgeries they perform. This means that CSFs would have to collect and report the same safety and quality measures collected by public hospitals, including reporting to the National Ambulatory Care Reporting System or Discharge Abstract Database. Reports should be publicly available analogous with public healthcare facilities. The responsibility and costs for implementing this data collection should be borne by the CSFs and be part of their qualification to bid on contracts with health authorities.

Provinces should create an infrastructure to collect surgical outcomes that are important to patients, such as patient-reported outcomes and experience measures. To ensure that these outcomes can be compared across settings and time, the federal government should offer provinces a targeted transfer of funds for developing this infrastructure, just as it has for previous priorities (CMA 2023). The federal government should also mandate the standards by which this data collection needs to be done, again, as it has been done for previous priorities (e.g., wait times) (Government of Canada 2012). The responsibility for collecting and reporting these data should fall to health regions, hospitals and CSFs though possibly funded federally. Such a system would be analogous to how hospital and emergency utilization data are currently collected and reported (Lucyk et al. 2015).

- *Cost/expenditures.* Health authorities should measure how much scheduled eye surgeries in public hospitals cost. Very few public hospitals in Canada measure their costs for specific activities, such as eye surgery, although the feasibility of the practice has been established at the Kensington Eye Institute (Sadri et al. 2021). The price paid to CSFs by health authorities for scheduled eye surgeries should be made publicly available. This cost information would allow for an apples-to-apples comparison between the two facility types. When coupled with our recommendation for collecting patient-reported outcomes, health authorities would be able to start understanding whether expanding the supply of eye surgeries using CSFs is a good return on investment.

Conclusion

The increasing demand for scheduled eye surgeries, a trend likely to be seen across many surgical specialties where elective surgery is an effective treatment option, necessitates that health authorities considering contracting out some elective treatments to CSFs develop and implement policies to manage this increased supply. Contracting out surgical services to CSFs is not a new concept, yet provinces should be proactive in determining how to mandate new reporting and data collection methods and how to measure the value of this policy option. We offer several recommendations that could equip health authorities to negotiate

smarter contracts with CSFs, rewarding better performance or value. Health authorities will also need to monitor the number of nurses attracted to CSFs and assess the impact it has on the public system. If this proves to be problematic, policy makers and nursing unions may need to focus on creating more competitive working conditions for nurses in the public system. The potential impact of these changes on healthcare costs will need to be empirically studied.

Correspondence may be directed to R. Trafford Crump by e-mail at trafford.crump@mcgill.ca.

Note

1. Ontario Health reports specific eye surgeries, rather than Alberta's global "[o]ther intervention on the eye" (Government of Alberta n.d.). We are referencing the average wait time for non-urgent glaucoma (eye pressure-lowering surgery).

References

- Adams, C. 2003. Contracting for Surgery: ... The Vancouver Coastal Approach. *Healthcare Quarterly* 6(4): 78–79. doi:10.12927/hcq.2003.20456.
- Alberta Surgical Initiative. n.d. Facilitated Access to Specialized Treatment (FAST) Program: Centralized Referrals. Alberta Health Services. Retrieved April 14, 2023. <<https://albertahealthservices.ca/aop/Page14114.aspx>>.
- Allin, S., M. Sherar, M. Church Carson, M. Jamieson, R. McKay, A. Quesnel-Vallée et al. 2020, February. *Public Management and Regulation of Contracted Health Services: Rapid Review*. North American Observatory on Health Systems and Policies. Retrieved March 20, 2024. <https://naohealthobservatory.ca/wp-content/uploads/2020/02/NAO-Rapid-Review-23_EN.pdf>.
- Arah, O.A., G.P. Westert, J. Hurst and N.S. Klazinga. 2006. A Conceptual Framework for the OECD Health Care Quality Indicators Project. *International Journal for Quality in Health Care* 18(Suppl_1): 5–13. doi:10.1093/intqhc/mzl024.
- Armstrong, P., H. Armstrong and C. Fuller. 2000, November. *Health Care, Limited: The Privatization of Medicare: A Synthesis Report*. Canadian Centre for Policy Alternatives. Retrieved March 20, 2024. <https://policyalternatives.ca/sites/default/files/uploads/publications/National_Office_Pubs/health_care_ltd.pdf>.
- Armstrong, W. 2009. *The Consumer Experience with Cataract Surgery and Private Clinics in Alberta: Canada's Canary in the Mine Shaft*. Consumers' Association of Canada. Retrieved March 20, 2024. <<https://citeseerx.ist.psu.edu/document?repid=rep1&type=pdf&doi=0278832fd4f6f7b843f194e0e239b951aab523ec>>.
- Browne, J., L. Jamieson, J. Lewsey, J. van der Meulen, L. Copley and N. Black. 2008. Case-Mix & Patients' Reports of Outcome in Independent Sector Treatment Centres: Comparison with NHS Providers. *BMC Health Services Research* 8(1): 78. doi:10.1186/1472-6963-8-78.
- Busse, R., D. Panteli and W. Quentin. 2019. An Introduction to Healthcare Quality: Defining and Explaining Its Role in Health Systems. In R. Busse, D. Panteli and W. Quentin, eds., *Improving Healthcare Quality in Europe: Characteristics, Effectiveness and Implementation of Different Strategies*. *Health Policy Series*, No. 53 (pp. 3–18). European Observatory on Health Systems and Policies.
- Canada Health Act* (R.S.C., 1985, c. C-6). Government of Ontario. Retrieved March 20, 2024. <<https://laws-lois.justice.gc.ca/eng/acts/c-6/>>.

- Canadian Medical Association (CMA). 2023. *Assessing Canada's Health Accords 2000–2023: Buying Time or Buying Change?* Retrieved March 20, 2024. <<https://policybase.cma.ca/link/policy14495>>.
- Carinci, F., K. Van Gool, J. Mainz, J. Veillard, E.C. Pichora, J.M. Januel et al. 2015. Towards Actionable International Comparisons of Health System Performance: Expert Revision of the OECD Framework and Quality Indicators. *International Journal for Quality in Health Care* 27(2): 137–46. doi:10.1093/intqhc/mzv004.
- Chan, Z.C., W. Tam, M.K. Lung, W. Wong and C. Chau. 2013. On Nurses Moving From Public to Private Hospitals in Hong Kong. *Journal of Clinical Nursing* 22(9–10): 1382–90. doi:10.1111/jocn.12253.
- Deber, R.B. 2002. *Delivering Health Care Services: Public, Not-for-Profit, or Private?* Commission on the Future of Health Care in Canada. Discussion Paper No. 17. Retrieved March 20, 2024. <<https://publications.gc.ca/collections/Collection/CP32-79-17-2002E.pdf>>.
- Erie, J.C. 2014. Rising Cataract Surgery Rates: Demand and Supply. *Ophthalmology* 121(1): 2–4. doi:10.1016/j.optha.2013.10.002.
- Friends of Medicare. 2019, March 28. UCP Health Policy Announcement Insupportable: Leadership Is Needed to Introduce Proven Public Solutions to Strengthen Our Public Health Care. Retrieved March 20, 2024. <https://www.friendsofmedicare.org/ucp_health_policy>.
- Friends of Medicare. 2022, September 07. Expansion of Private Surgeries Puts Profits Before Patients yet Again. Retrieved March 20, 2024. <https://www.friendsofmedicare.org/expansion_of_private_surgeries_puts_profits_before_patients_yet_again>.
- Government of Alberta. n.d. Alberta Wait Times Reporting. Retrieved March 20, 2024. <<http://www.waittimes.alberta.ca/>>.
- Government of Alberta. 2022, April 22. Moving Surgical Recovery Into High Gear. Retrieved March 20, 2024. <<https://www.alberta.ca/release.cfm?xID=8240731BCB85A-ED2C-41E5-D54730000A077AE8>>.
- Government of Canada. 2012, February 24. First Minister's 2004 Meeting on the Future of Health Care. Retrieved March 20, 2024. <<https://www.canada.ca/en/health-canada/services/quality-care/wait-times/first-minister-meeting-future-health-care-2004.html>>.
- Hatch, W.V., E. de L. Campbell, C.M. Bell, S.R. El-Defrawy and R.J. Campbell. 2012. Projecting the Growth of Cataract Surgery During the Next 25 Years. *Archives of Ophthalmology* 130(11): 1479–81. doi:10.1001/archophthalmol.2012.838.
- Health Coalition Vows to Fight any Privatization Efforts by Ford Government. 2022, August 16. *CBC News*. Retrieved March 20, 2024. <<https://www.cbc.ca/news/canada/toronto/fight-privatization-public-health-1.6552468>>.
- Holom, G.H., N. Alexandersen, J.D. Goldhaber-Fiebert and T.P. Hagen. 2018. Which Patients Receive Surgery in For-Profit and Non-Profit Hospitals in a Universal Health System? An Explorative Register-Based Study in Norway. *BMJ Open* 8(6): e019780. doi:10.1136/bmjopen-2017-019780.
- Kent, H. 2020. Cataract Surgery Contracted Out in Vancouver. *CMAJ* 162(8): 1187.
- Kruse, F.M., S. Groenewoud, F. Atsma, O.P. van der Galiën, E.M.M. Adang and P.P.T. Jeurissen. 2019. Do Independent Treatment Centers Offer More Value Than General Hospitals? The Case of Cataract Care. *Health Services Research* 54(6): 1357–65. doi:10.1111/1475-6773.13201.
- Li, J., N. Morlet, J.Q. Ng, J.B. Semmens and M.W. Knuiman; Team EPSWA. 2004. Significant Nonsurgical Risk Factors for Endophthalmitis After Cataract Surgery: EPSWA Fourth Report. *Investigative Ophthalmology and Visual Science* 45(5): 1321–28. doi:10.1167/iovs.03-1000.
- Lucyk, K., M. Lu, T. Sajobi and H. Quan. 2015. Administrative Health Data in Canada: Lessons From History. *BMC Medical Informatics and Decision Making* 15(1): 69. doi:10.1186/s12911-015-0196-9.
- Mehra, N. 2017. *Private Clinics and the Threat to Public Medicare in Canada*. Retrieved March 20, 2024. <<https://www.ontariohealthcoalition.ca/wp-content/uploads/OHC-report-executive-summary.pdf>>.
- Miller, A. and B. Shingler. 2022, August 20. Would More Privatization in Canadian Health Care Solve the Current Crisis? *CBC News*. Retrieved March 20, 2024. <<https://www.cbc.ca/news/health/canada-healthcare-privatization-debate-second-opinion-1.6554073>>.

The Eye-Opening Truth About Private Surgical Facilities in Canada

- Monga, V. 2023, January 21. Canada Pursues Private Options to Ease Healthcare Backlogs. *The Wall Street Journal*. Retrieved March 20, 2024. <<https://www.wsj.com/articles/canada-pursues-private-options-to-ease-healthcare-backlogs-11674316841>>.
- Ontario Health. 2023, September 6. Wait Times. Retrieved March 20, 2024. <<https://www.ontariohealth.ca/public-reporting/wait-times>>.
- Ontario Nurses' Association (ONA). 2023, February 25. Ontario Nurses' Association Demanding Answers as The Ottawa Hospital Allows Private Surgeries to Be Performed Under a Veil of Secrecy. *Cision*. Retrieved March 20, 2024. <<https://www.ona.org/news-posts/20230225-statement-toh-private-surgeries/>>.
- Pager, C.K. and P.J. McCluskey. 2004. Public Versus Private Patient Priorities and Satisfaction in Cataract Surgery. *Clinical and Experimental Ophthalmology* 32(5): 482–87. doi:10.1111/j.1442-9071.2004.00868.x.
- Payne, E. 2023a, February 27. Critics “Alarmed” by Private Surgery Plan They Say Will Poach Staff From the Public Health System. *Ottawa Citizen*. Retrieved March 20, 2024. <<https://ottawacitizen.com/news/local-news/critics-alarmed-by-private-surgery-plan-they-say-will-poach-staff-from-the-public-health-system>>.
- Payne, E. 2023b, March 21. Surgeries at For-Profit Orthopedic Clinic Already Impacting Hospital Staffing, Some Insiders Say. *Ottawa Citizen*. Retrieved March 20, 2024. <<https://ottawacitizen.com/news/surgeries-at-for-profit-orthopedic-clinic-already-impacting-hospital-staffing-some-insiders-say>>.
- Sadri, H., S. Sinigallia, M. Shah, J. Vanderheyden and B. Souche. 2021. Time-Driven Activity-Based Costing for Cataract Surgery in Canada: The Case of the Kensington Eye Institute. *Healthcare Policy* 16(4): 97–108. doi:10.12927/hcpol.2021.26496.
- Scholl, E. and M. Bhandari. 2022, November 4. More Surgeries, Lower Cost, Timelier Access to Care: The Future of Ambulatory Centres. *OE Insights*. Article No. 113. Retrieved March 20, 2024. <<https://myorthoevidence.com/Insight/Show/149>>.
- Solborg Bjerrum, S., J.F. Kiilgaard, K.L. Mikkelsen and M. la Cour. 2013. Outsourced Cataract Surgery and Postoperative Endophthalmitis. *Acta Ophthalmologica* 91(8): 701–08. doi:10.1111/aos.12279.
- Solborg Bjerrum, S., K.L. Mikkelsen and M. la Cour. 2015. Epidemiology of 411 140 Cataract Operations Performed in Public Hospitals and Private Hospitals/Clinics in Denmark Between 2004 and 2012. *Acta Ophthalmologica* 93(1): 16–23. doi:10.1111/aos.12576.
- The Canadian Press. 2023, January 17. Ontario's Expansion of Private Clinic Procedures Could Give Nurses More Bargaining Power: Union. *CBC News*. Retrieved March 20, 2024. <<https://www.cbc.ca/news/canada/toronto/ontario-private-clinic-impact-nurse-bargaining-1.6716735>>.
- Tulp, A.D.M., F.M. Kruse, N.W. Stadhouders and P.P.T. Jeurissen. 2020. Independent Treatment Centres Are Not a Guarantee for High Quality and Low Healthcare Prices in The Netherlands – A Study of 5 Elective Surgeries. *International Journal of Health Policy and Management* 9(9): 380–89. doi:10.15171/ijhpm.2019.144.