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realized, as he argues, but economics.

Private hospitals operating under Bill 11 in Alberta must obtain payment for patient care from the Alberta government; if they are paid by the patients themselves they are in violation of the Canada Health Act. Furthermore, the government is not likely to reimburse these hospitals at higher rates than those in the payment schedule for non-profit hospitals. These payments do not include reimbursement for one of the major expenses of hospitals, depreciation. If by some slim chance a private hospital manages to turn a profit on the payment schedule that applies to non-profit hospitals then no harm is done: the model used by the private hospital would give nonprofit hospitals a guideline for improving their efficiency and thereby lowering health care costs.

I cannot believe that any American with his head screwed on right will enter the Canadian market to provide, for example, open heart surgery when the payment in the United States is US$75,000 and in Canada it is Can$30,000 or less. The real fear should be on the part of Americans: some bright Canadian health care entrepreneur might head south and take their business away by underselling them on health care services.

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References

I am grateful for the opportunity presented by Marc Baltzan’s comments to reiterate the key message of my paper1 on Alberta’s Bill 11: the critical point is the future legal implication, not the current economics of health care provision in Alberta.

It is likely correct to argue that no wise offshore entrepreneur would view investment in Alberta surgical facilities as a windfall situation. One can, of course, envisage ways in which the commercially adroit might generate an attractive return through the use of obligatory amenity upgrades and administrative fees or simply by hiring less-qualified, nonunionized staff. But for the time being, only investors with a very long-term horizon are likely to consider such action.

Of far greater relevance than immediate investment returns is the role Bill 11 may play as the thin edge of the globalization wedge into Canadian health care. In that respect there are 3 key points. First, once a specific sector is opened to for-profit firms, under the General Agreement on Trade in Services (GATS) that decision cannot be reversed without potentially mountable reparations to the private sector. Second, when a sector of service provision is opened to domestic investment, it is automatically opened to all signatories to the GATS. Third, when a sector is so opened, it becomes subject to the decisions of international trade tribunals and less amenable to the policy direction of elected governments. Economists may view all of this as competitive efficiency, but others will rue the constraints imposed on domestic decision-making.

Given the above line of argument in my paper, I am puzzled by Elizabeth Hall-Findlay’s suggestion that the article was “another thinly disguised attempt to discredit private surgical facilities.” In fact, the paper begins with the thesis that the “two-tier debate has reflected attention from the more arcane policies.” In that respect there are 3 globalization wedges into Canadian health care. In that respect there are 3

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