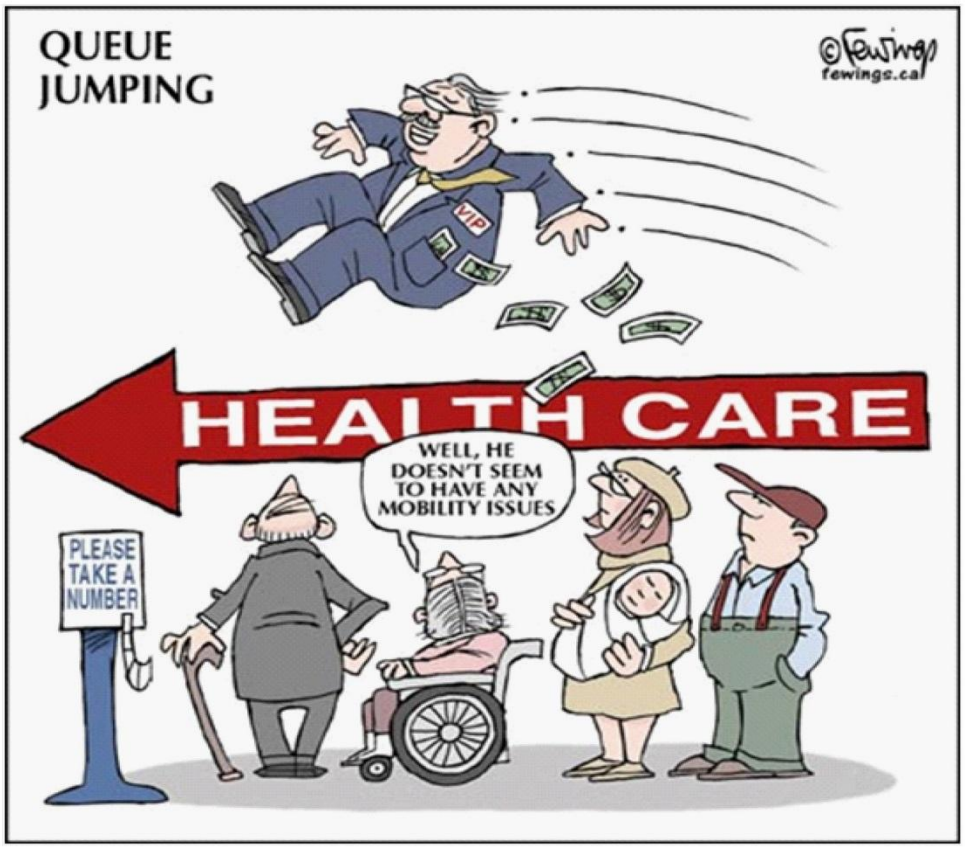

JUMPING THE QUEUE:

How Private User-Pay MRIs will Create Two-Tier Health Care

Submission by: The Canadian Union of Public Employees

In response to Bill 179-MRI Facilities Licensing Act
and draft Regulations – October 28, 2015

CUPE Saskatchewan
Your Community Union

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EXECUTIVE SUMMARY

The Canadian Union of Public Employees (CUPE) strongly opposes the Saskatchewan government's proposal to allow private MRI clinics to charge patients directly for MRI services. We have prepared this submission to present our concerns with Bill 179 – *MRI Facilities Licensing Act,* and to urge the provincial government to withdraw the *Act* that would permit private user-pay MRI clinics to operate in this province.

CUPE submits that this is the time to hold firm to the values and principles of publicly-funded and publicly-delivered health care. It is the time to resist the slippery slope into a system in which Saskatchewan residents will receive only the health care they can afford rather than what they need.

CUPE opposes Bill 179 because private user-pay MRI's will create a two-tiered health care system. Rather than address wait times, the legislation will:

1. Permit queue-jumping
2. Increase existing inequities in the current system
3. Poach workers from the public sector
4. Increase public wait times
5. Increase public health costs

Publicly financed health care redistributes income among different socio-economic groups. Creating a second system through user pay private clinics that allows queue jumping only serves to weaken a system that is already struggling to manage existing inequities.

The proposed Regulations to Bill 179 may have the unintended consequence of exacerbating unequal access to medical treatment. The Regulations require private MRI facilities that have performed a MRI service to a person who has paid privately to "provide a second scan service of similar complexity to a patient identified by the regional health authority…at no charge to that patient."

This arrangement could result in lower priority patients on the public wait list getting access to an MRI test before patients with more critical needs. For example, if a person who is priority level four (lowest urgency) decides to pay privately for a MRI scan at a private clinic, then the private clinic would have to offer a free scan to someone on the public wait list "of similar complexity," or priority level four. In this scenario, individuals with higher medical needs at level two or three could end up waiting longer than those with less urgent needs.

Not only will this requirement for a second free scan create administrative complexities for the regional health authorities and the referring physician, it will make an unfair system even more unfair.

The government has advanced the view that the private option will relieve pressure on wait times in the public system; however, there is a convincing lack of evidence to support this view. In fact, evidence shows a parallel private system lengthens waits for health care in public systems.

For example, in 2012 Alberta had 10.2 MRI scanners per million population compared to 5.6 MRI scanners per million population in Saskatchewan. Of the 39 MRI scanners in Alberta in 2012, 12 were private, while Saskatchewan had 6 public hospital-based scanners and no private MRI clinics. Wait times for MRIs were significantly longer in Alberta, despite the higher rate of scanners and the numerous private clinics. The median wait-time for patients on public lists was 80 days in Alberta compared to 28 days in Saskatchewan.

There is no need to allow private user-pay MRI clinics in this province.

We have improved public capacity and reduced wait times in the last ten years in Saskatchewan.

In 2004, there were only three MRI machines in the province. At the time, the Canadian Association of Radiologists said that we needed five MRIs for our population. Today we have 6 MRI machines in public hospitals: four in Saskatoon and two in Regina. Soon there will be one in Moose Jaw and perhaps one in Prince Albert in the future. When the new hospital in Moose Jaw opens its MRI suite, the hospital expects to scan about 3,000 people a year.[1] Considering that the wait list for MRI services is about 5,000, the new MRI scanner in Moose Jaw will contribute greatly to expanded public capacity.

The government's decision to permit private user-pay MRIs is a dangerous one that will negatively affect our public system, create greater inequalities in access to services, and lead us down the slippery slope to two-tiered health care.

CUPE recommends that the government withdraw Bill 179 and instead develop strategies and policies to address wait lists based on evidence and not ideology.

[1] "MRI Privatization may be coming to Saskatchewan" May 7, 2015.

1 INTRODUCTION

CUPE represents the largest number of employees in the health care sector in Canada – over 190,000 people. In Saskatchewan, CUPE represents over 13,500 health care workers such as continuing care assistants, Licensed Practical Nurses, housekeeping, dietary and environmental services workers, maintenance staff and various technologists, including MRI technologists.

CUPE opposes Bill 179 which, if implemented, will lead to the erosion of our public health care system that Saskatchewan people hold dear. In our view, Bill 179 is a misguided response to a complex situation that, instead, requires courageous leadership on the part of government to ensure the sustainability of a fair and equitable health care system for all Saskatchewan residents.

Our healthcare system is an important reflection of our collective values and principles. Quality public health services that work for everyone are a priority concern for all of our members and for all residents of Saskatchewan.

Throughout our submission we will argue that we must preserve and protect the principles and values of a public health care system and that Bill 179 will endanger the principles of fairness and equity.

2 CUPE'S CONCERNS WITH BILL 179

CUPE strongly opposes Bill 179 because private user-pay MRI's will create a two-tiered health care system. Rather than address wait times, the legislation will:

1. Permit queue-jumping
2. Increase existing inequities in the current system
3. Poach workers from the public sector
4. Increase public wait times
5. Increase public health costs

In the following sections, we briefly discuss CUPE's areas of concern and why user pay private MRI clinics are a poor choice for Saskatchewan people.

We address the highlights in each section and encourage you to follow up on the research-based evidence provided in the [linked] footnotes.

2.1 PRIVATE USER-PAY MRIS PERMIT QUEUE-JUMPING

Bill 179 permits private MRI clinics to charge patients out-of-pocket user fees for MRI services, which will allow patients to jump the queue for diagnosis and treatment. In 2008, Premier Brad Wall told reporters that offering MRI services for a fee "seems to be outside the Canada Health Act" and was an area where the government did not want to tread.[2]

Unfortunately, Bill 179 is going exactly where the Premier did not want to go.

Not many people can afford to pay for a private MRI scan that costs between $895 and $2,395 (prices vary by the nature of the scan).[3] Allowing user-pay private MRIs means the well-off can pay for a test thereby buying their way to the front of the queue regardless of need. Similarily, those who cannot afford a private scan may borrow money or dip into savings to pay for one, resulting in financial hardship.

Queue jumping represents a dramatic departure from the values on which Canadian health care was founded. Health care in Canada is regulated through the *Canada Health Act*. Private user-pay MRI clinics raise two issues that may impede compliance with the *Act*: private payment and queue-jumping.

Passed into law in 1984, the *Canada Health Act* is the foundation of the Canadian health care system. The *Act* specifies that provinces must meet five key principles in order to receive their full share of the federal funds through the Canada Health Transfer. Health care services must be comprehensive, universally available, portable, accessible and publicly administered.

[2] "MRI proposal renews debate", Star Phoenix, February 15, 2008.
[3] Prices of scans on Alberta company website: http://www.canmagnetic.com/scans-rates/

Governments must ensure publicly insured services are available on uniform terms and conditions. In addition, Saskatchewan residents must have reasonable and uniform access to insured health services free of financial barriers including user fees.[4]

Private user pay clinics will create a two-tier system because they allow people to get faster access to health service in two ways: first, they gain faster access to the test itself; and second, once they have a diagnosis they are able to get into the public queue faster for surgery or treatment.

For example, let us examine a situation where Jane and Malia have the same condition and both are put on a 6 week wait list for a MRI scan. Jane does not want to wait at all and she can afford to pay for a private scan within a week. In this situation, not only does Jane get her diagnosis earlier, she also gets into the line for surgery or treatment ahead of Malia. Jane jumps the queue twice: for diagnosis and treatment. Malia, on the other hand, is disadvantaged in access to medical treatment simply because she cannot afford or is unwilling to buy her way to the front of the line.

Allowing queue jumping through private-pay MRIs violates the "accessibility" principle of the Act.[5] When some residents can jump the queue by paying for services privately, it means that not all residents are receiving publicly-insured services on uniform terms and conditions.

Our health care is based on the principle that you should receive health care based on medical need not the size of your wallet. The principles of Medicare are designed to ensure that those who are sickest or most in need receive care the soonest. Queue jumping will create a two tier system for MRI services and will lead to a two tier system in treatment.[6]

The Romanow Commission found it problematic that diagnostic testing performed in a hospital is considered medically necessary in terms of the *Canada Health Act* but the same test in a private clinic is not. His report recommended that this gap be addressed through changes to the *Canada Health Act.* He recommended that the *Act* be amended to explicitly include all medically necessary diagnostic services in the definition of insured health services. This amendment, unfortunately, did not take place but a new federal government may decide to implement this recommendation.

[4] See Madore, O. (2005).
[5] *Ibid.,* (2005).
[6] Donaldson and Currie (2000).

2.2 USER PAY MRIS INCREASE EXISTING INEQUITIES IN OUR HEALTH SYSTEM

It is imperative that we improve the capacity of our health care system by utilizing principled approaches that ensure a just, fair and equitable health care system.[7] We must guard against making choices that may heighten inequalities already present.

We have known for a long time that inequalities in health status exist among Canadians.[8] [9] [10] For example, we know that poverty matters for health: "Groups who have traditionally experienced high rates of poverty or low levels of socio-economic status are the same groups who have worse health outcomes."[11]

In all countries including Canada, health and illness follow a social gradient: the lower the socio-economic position, the worse the health.[12] There is a very clear relationship between individual income and individual health.

A recent study showed that in several OECD countries, "individuals with higher socio-economic status…tend to wait less for publicly funded care than those with lower socio-economic status."[13]

These inequalities go against the basic principles and values of a health care system in which care is to be distributed on the basis of need.

Depending on how wait lists and times are managed, lists may enhance or detract from the equitable access to health care on the basis of relative need.[14] Publicly financed health care redistributes income among different socio economic groups. Creating a second system through user pay private clinics that allows queue jumping only serves to weaken a system that is already struggling to manage existing inequities.

In Canada, out-of-pocket costs charged by private clinics are beyond the financial reach of most of the population.[15] Introducing user pay private MRI clinics means that the well-off members of society are able to purchase health care services. Or alternately, it could result in patients using limited financial resources or borrowing money to purchase private MRI scans.

The issue of unfairness in access to medical services became such a major concern in Alberta that the government established the Health Services Preferential Access Inquiry in 2012. The report from Commissioner John Z. Vertes in August 2013 examined several

[7] Lewis & Sanmartin, n.d.
[8] Phipps (2003).
[9] Mikkonen & Raphael (2010).
[10] Borowitz, Moran, & Siciliani (2010)
[11] Phipps, (2003), p. iii
[12] Mikkonen & Raphael (2010)
[13] Borowitz et al (2013)
[14] Shortt (2000)
[15] Mehra, 2008.

problems including preferential access to private diagnostic imaging. The report acknowledges that those who decide to pay for a private diagnostic test are receiving preferential access to medical services. Instead of waiting for a public test, individuals can pay for a private diagnosis and then step ahead of others in the line for treatment.[16]

The proposed Regulations to Bill 179 may have the unintended consequence of exacerbating unequal access to medical treatment. The Regulations require private MRI facilities that have performed a MRI service to a person who has paid privately to "provide a second scan service of similar complexity to a patient identified by the regional health authority…at no charge to that patient."

This arrangement could result in lower priority patients on the public wait list getting access to a MRI test before patients with more critical needs. For example, if a person who is priority level four decides to pay privately for a MRI scan at a private clinic, then the private clinic would have to offer a free scan to someone on the public wait list "of similar complexity," or priority level four. In this scenario, individuals with higher medical needs could end up waiting longer than those with less urgent needs.

Not only will this requirement for a second free scan create administrative complexities for the regional health authorities and the referring physician, it will make an unfair system even more inequitable.

This damages both the fairness and the perception of fairness of our system.

Research shows that "Private purchases may affect people's satisfaction with the public system and, indirectly, the cost of that system…Private purchases will diminish the level of equality in health care delivery. If equality of health care delivery is a widely-shared value, private purchasers will reduce this aspect of satisfaction among both purchasers and non-purchasers."[17]

Saskatchewan residents value fairness. They expect their government to maintain and create systems that uphold fairness. Private user pay MRIs threatens both the fairness and the perception of fairness of the public health care system.

2.3 USER PAY MRIS POACH WORKERS FROM THE PUBLIC SECTOR

The government asserts that it is acceptable for the wealthy to jump the queue to access MRI services because it will reduce the number of people on wait lists in the public sector.

The evidence, however, does not support this position. Research shows that private sector health services, including private MRI clinics, have the "perverse effect [that is, the *reverse* effect] of increasing the apparent inefficiency of the public sector."[18] One way this

[16] Vertes, J. 2013.
[17] Glied (2006).
[18] Tuohy, Flood and Stabile, 2004, p. 376.

happens is by drawing health professionals from the public system into the private system.[19] [20] [21] [22]

It is difficult to see how removing health care workers from the public system will shorten wait times. Conversely, introducing private user-pay MRI clinics will increase competition for scarce human resources[23] and lead to poaching from the public system.

In Quebec, where diagnostic imaging outside of hospitals is all private, radiologists and technologists have been siphoned from the public system. Médecins Québécois pour le Régime Public explains that the growth in private medical imaging clinics has drained the public system "of its technical and medical personnel. Even though there are enough machines and personnel in total, the public supply of medical imaging services has diminished and become more or less inadequate." This has led to a reduction of services and longer wait times in the public system.[24]

A research study commissioned by the Ontario Health Coalition revealed that:

> For-profit clinics are siphoning scarce personnel from local hospitals and the public health care system. In at least two provinces, we found a demonstrable reduction in capacity of public non-profit hospitals as a direct result of staff poaching by nearby for-profit clinics. **Ontario's** for-profit MRI/CT clinics led to cuts in MRI hours in local community hospitals. In **Manitoba,** the for-profit MRI clinic caused a reduction in MRI hours in the Winnipeg Health Sciences Centre. In addition, staff poaching from local hospitals was found in **Nova Scotia** and **British Columbia**.[25]

In Denmark, the growth in private treatment options – both publicly funded and user-pay – has resulted in trained medical staff leaving the public sector. It has "increasingly become difficult to retain trained medical staff…. This means that public hospitals increasingly have to rely on temporary staff."[26]

The movement of health professionals from the public sector to private clinics will weaken our health system. Not only is the public sector drained of human resources, evidence shows there to be "an increased management burden of coordinating services in a fragmented system."[27] [28]

Private user-pay MRI clinics should not be used at the expense of depleting resources from the public system. There are not enough health care professionals in the province for both

[19] Sanmartin et al, 2000.
[20] Quesnel-Vallée, 2013
[21] Mehra, 2008.
[22] Vrangback, 2008.
[23] Quesnel-Vallée, 2013.
[24] Médecins Québécois, 2012.
[25] Sutherland, R. 2002.
[26] Vrangbaek, 2008.
[27] Pfeiffer & Johnson, 2008, p. 3.
[28] See also Retebemberwa, 2014.

the public and private health systems. A study of MRI wait times strategies in Canada points out that 15% of centers tried to hire more MRI Technologists but were limited by lack of funds and qualified personnel.[29]

Data from the Saskatchewan Association of Medical Radiation Technologists (SAMRT) shows that this province has 51 practicing MRI Technologists in 2015. Of those, 18 are employed by the Regina Qu'Appelle Health Region and 21 work in the Saskatoon Health Region. Considering there are 6 MRI scanning machines in the two health regions, there is an average of 6.5 MRI Technologists for each MRI machine.

The remaining MRI Technologists work at SIAST, the Veterinarian College, Saskatchewan Cancer Agency and for private clinics.

Once the MRI scanning machine is operational in the new Moose Jaw Hospital, there will be a need for more MRI Technologists in the province.

Saskatchewan Polyltechnic does not have a Magnetic Resonance Imaging Technologist program but does provide the pre-requisite two-year diploma in Medical Radiologic Technology. After receiving a two-year diploma in the above discipline or similar diplomas, persons interested in becoming a MRI Technologist have to travel out of province for an additional 8 or 8 ½ months of training.

There are six locations in Canada that provide training in Magnetic Resonance Imaging:

- British Columbia Institute of Technology;
- Northern Alberta Institute of Technology (NAIT);
- Red River College in Winnipeg;
- Joint Michener Institute at the University of Toronto;
- Fanshawe College of Applied Arts and Technology in London, ON;
- Cambrian College of Applied Arts and Technology in Sudbury.

The training of MRI Technologists, therefore, is dependent on the willingness of students to study out of province. The province does not have a local source of trained MRI Technology graduates and has to recruit from other provinces.

Although the draft Regulations state that private MRI clinics "may not offer employment or contracts for services to individuals…if those individuals are under contract with or employed by a regional health authority, an affiliate or the Saskatchewan Cancer Agency," there is a real danger that we could lose technologists from the public sector if private MRI clinics are allowed to expand. Hours of work are longer and workload is heavy in the public sector so the private sector could attract technologists to move from the public system.

[29] Emery, Forster, Shojama, Magnan, 2009.

CUPE also believes that it would be difficult for the provincial government to enforce the proposed restriction on employing staff from the public sector. A technologist could leave the employ of a regional health authority before being offered a contract with a private clinic. This proposed provision is difficult, if not impossible to enforce.

2.4 USER PAY MRIS INCREASE PUBLIC WAIT TIMES

The government has advanced the view that the private option will relieve pressure on wait times in the public system, however, there is a convincing lack of evidence to support this view.[30]

Empirical evidence shows that "supplementing publicly-funded care with a private payment system will not necessarily reduce waiting times in the public system".[31] [32] In fact, evidence shows a parallel private system lengthens waits for health care in public systems.[33]

Many OECD countries with two-tier systems struggle with waiting times.[34] A study conducted in Australia provided clear evidence that the greater private sector interests, the longer the wait time in the public system.[35] New Zealand's two-tier system, where health care specialists are able to work in both systems, has struggled with public sector wait times.[36] And the United Kingdom has struggled with long wait times despite providing private options in health care.[37]

In Canada, an investigation of the impact of for-profit activity in the Canadian health care sector found evidence of wait times that are highest in areas with the most privatization as resources – financial and human – are taken out of the public health system.[38]

Further,

> Statistics Canada reports that Montreal is the hardest place in Canada to get a family doctor. Yet Montreal has a very high density of private "boutique" physician clinics – perhaps the most in the country – selling two-tier health care for wealthy executives and companies. These services are inaccessible for the vast majority who cannot afford the clinic's extraordinary prices. Longer wait lists in areas with high levels of privatization have also occurred with Alberta's private cataract surgery clinics.[39]

[30] This is the conclusion of The Honorable Justice John Z. Vertes, Commissioner, HSPAI – Alberta, Volume 1: Inquiry Report, August 2013.
[31] Short, 2000, p. 1.
[32] See also DeCoster, MacWillians & Walld, 2000; Borowitz et al, 2013; Flood, 2006; Flood, Stubile, Tuohy, 2008; OECD, 2013.
[33] Quesnel-Vallée, 2013; Hughes, Tuohy et al, 2004.
[34] Flood, 2006.
[35] Duckett, 2005.
[36] Flood, 2006.
[37] Sanmartin et al, 2000; Short, 2000. [deeper reference]
[38] Mehra, 2008, p. 7.
[39] Mehra, 2008, p. 10.

In Quebec, where diagnostic imaging outside of hospitals is all private, radiologists and technologists have been siphoned from the public system. This has led to a reduction of services and longer wait times in the public system.[40] The long wait lists in Quebec exist even though Quebec has the highest number of MRI machines per million residents (11.2) in Canada, a large number of them in private clinics (see Table 1).

Ironically, the high per capita number of MRI machines has not translated into a high volume of scans: the number of tests per million residents is lower in Quebec than in Ontario and Alberta, according to the physician group Médecins Québécois.[41] A review of CIHI data shows that Quebec conducted 44 MRI scans per 1,000 population in 2012, compared to 66 MRI scans per 1,000 population in Ontario.[42]

In Manitoba, the presence of a parallel private system did not shorten wait lists in the public sector. In fact, waiting times in the public sector were found to be longest for specialists who also worked in a private clinic.[43] There is no longer a private MRI clinic in Manitoba.

The Ontario Health Coalition examined the existing evidence of the effects of for-profit MRI-CT clinics on waiting times, cost and quality of care.[44] The research included searches of major medical, economic and political data bases and interviews with health authorities, provincial and federal governments, government agencies, professional associations and private clinic operators. Researchers concluded:

> **Our study was unable to find any evidence supporting the contention that for-profit MRI-CT clinics reduce waiting lists faster than the public system, improve quality or decrease costs.** However, evidence was found which indicates that:
>
> Opening for-profit clinics would, at best, have a minimal impact on waiting times, and probably increase waits in the public sector.[45]

Our immediate neighbor to the west ignored the evidence and, in 1993, Alberta became the first province to allow private for-profit MRIs. However, by 2001, the province had reversed their move to private MRI clinics: "Instead, Alberta increased the capacity of the public system, and patients who had paid out-of-pocket for medically necessary scans were reimbursed by the province."[46] [47]

Private MRI clinics still operate in Alberta but outside of the public system. In 2007, Alberta had 7.9 MRI scanners per million population, which was the second highest rate

[40] Médecins Québécois, 2012.
[41] *Ibid.,* p.14.
[42] *CIHI, National Inventory of Selected Medical Imaging Equipment,* 2012.
[43] DeCoster, MacWilliams & Walld, 2000.
[44] Sutherland, 2002.
[45] Sutherland, 2002, p. 2.
[46] Silversides, 2008, p. 1112-1113.
[47] See also "Province to reimburse for some private MRIs".

for all Canadian provinces and above the OECD average.[48] By 2012 the rate of MRI scanners per million population in Alberta had increased to 10.2, second highest in the country after Quebec, which had a rate of 11.2 scanners per million population.[49] The OECD average in 2011 was 5.2 MRI scanners per million population. By comparison, Saskatchewan had 5.6 MRI scanners (all in public hospitals) per million population in 2012.

TABLE 1- NUMBER OF MRI SCANNERS BY POPULATION AND PROVINCE, 2012

Jurisdiction	# MRI scanners hospital	# MRI scanners Free standing	Total # MRIs	MRI scanners/ million population
NFL	5	0	5	9.7
PEI	1	0	1	6.9
NS	8	1	9	9.5
NB	6	0	6	7.9
QUE	62	28	90	11.2
ON	96	8	104	7.7
MB	8	0	8	6.4
SK	6	0	6	5.6
AB	26	13	39	10.2
BC	24	16	40	8.7
Canada			308	8.9
OECD average				5.2

Source: CIHI, National Inventory of Selected Medical Imaging Equipment, 2012

TABLE 2- NUMBER OF MRI EXAMS PER 1,000 POPULATION, 2012

Province	# MRI Exams	Population	Exams/1000 pop
NFL	19,820	513,503	38.60
PEI	4,641	145,855	31.85
NS	35,755	948,459	37.70
NB	38,051	755,835	50.34
QUE	352,489	8,011,996	44.00
ON	827,787	13,438,807	61.60
MB	69,142	1,259,375	54.90
SK	42,069	1,068,117	39.39
AB	177,986	3,815,498	46.65
BC	150,893	4,600,919	32.80
Canada	1,718,633	34,671,306	49.57

Source: CIHI, National Inventory of Selected Medical Imaging Equipment, 2012. Calculations by author.

[48] Hailey (2008), p.2.
[49] Canadian Institute of Health Information MRI data base, 2013.

Despite the high number of MRIs in Alberta (39 MRI scanners or 10.2 scanners per million population), the province has average wait times for MRI services that are significantly higher than in Saskatchewan (see table 3 below).

TABLE 3 PROVINCIAL WAIT TIMES (IN DAYS) FOR MRI SCANS, APRIL TO SEPTEMBER 2013, BY PROVINCE

	50th Percentile	90th Percentile
PEI	58	135
Nova Scotia	47	136
Ontario	23	60
Manitoba	70	127
Saskatchewan	28	88
Alberta	80	247

Source: Canadian Institute for Health Information (2012).Data from other provinces not available.

The government should heed the evidence from Alberta, Ontario, Manitoba, Quebec, the United Kingdom, Australia, New Zealand and a host of other jurisdictions and recognize that introducing private user-pay MRIs lengthens wait lists in the public sector.

2.5 PRIVATE MRI CLINICS WILL INCREASE PUBLIC HEALTH COSTS

Although charging patients out-of-pocket for MRIs may seem a simple proposition, the consequences are much more complex and risky.[50] Wait times are not exclusively an issue of supply.[51] Good public policy on the part of government means resisting empirically unsubstantiated notions that running a private parallel or second tiered system will relieve pressure on the public system.

Although Bill 179 purports to reduce public wait lists, it creates more administrative responsibilities for a fragmented system. The draft Regulations for Bill 179 place high demands on regional health authorities (RHAs) to manage lists and coordinate services with private MRI clinics. Matching patients on the public list with privately paid patients, sharing patient records and reporting MRI facilities to RHAs adds work to an already burdened public health system. Will RHAs, which currently are being asked to drastically reduce costs, need to add administrative staff instead of front-line staff who deliver services?

[50] Shortt, 2000.
[51] Borowitz et al, 2013.

In addition, there is a danger that the profit motive will encourage an over use of diagnostic testing, which increases costs to both the individuals who pay privately for services and to the public system which must increase its treatment or follow up care. As Flood points out, with the expansion of private delivery of health services in Canada, "the worry is that introducing a profit incentive for physicians will undermine the delivery of care."[52]

The doctor's group Médecins Québécois point out that private radiology clinics in Quebec offer preventive tests for patients worried about their health. The tests are not medically necessary but "with any medical imaging test, there is the risk of identifying an anomaly that is not clinically significant – that is, a false positive. This can lead to needless anxiety and further tests that will overload the system and involve additional costs."[53]

Canadians value the fundamental social principles underpinning a publicly funded and publicly delivered health care system. However, long wait time contribute to public concern about the sustainability of the single-tier publicly funded health care delivery system. The public also is concerned about the effects the needs of an aging population and expensive new technologies will have on a publicly funded system.

While an aging population and expensive new technologies may be inevitable, how we choose to respond is within our control – social, economic and political choices are within our control.[54]

Public health care costs less and delivers more.[55] [56] Private user-pay clinics are bound to profits – they primarily exist to create profit for their investors. Profit places "misaligned incentives"[57] in the health care sector. Private for profit clinics have the purpose of increasing the wealth of shareholders by limiting expenses and maximizing profits – a model that does not serve the health care sector well.[58]

Medicare is as sustainable as the public and governments want it to be.[59] Introducing a second tier of private health services will have adverse consequences and only serve to undermine our public health care system.[60] It also takes the government off the hook for finding lasting solutions in the public system.

[52] Flood, 2006
[53] Médecins Québécois, 2012.
[54] Stoddart et al, 1993.
[55] Glied, 2006.
[56] Epple & Romano, 1996.
[57] Herrera et al, 2015, p. 15.
[58] Glied, 2006
[59] Rachlis, 2013.
[60] Flood et al, 2008

3 WHERE DO WE GO FROM HERE?

According to the Canadian Institute for Health Information, half the provinces including Saskatchewan report diagnostic imaging wait times information on public websites. Overall volumes for MRI scans increased over the past five years with ranges in wait times remaining fairly stable.[61] In Saskatchewan, wait times are going down and this trend will continue.

As we build capacity in Saskatchewan with one new MRI machine, let us ensure the public system remains vital. We have improved public capacity and reduced wait times in the last ten years in Saskatchewan.

In 2004, there were only three MRI machines in the province. At the time, the Canadian Association of Radiologists said that we needed five MRIs for our population.[62] Today we have 6 MRI machines in public hospitals: four in Saskatoon and two in Regina. Soon there will be one in Moose Jaw and perhaps in Prince Albert. When the new hospital in Moose Jaw opens with a MRI suite, the hospital expects to scan about 3,000 people a year.[63]

The greatest threat to the sustainability of public funded publicly delivered health care is the myth that it is not sustainable.[64] [65] We have the opportunity to listen to the research and act on what we know will be best for all Saskatchewan people.

The evidence is clear: private user-pay MRIs cannot coexist with a public system without harming the public system. In provinces where private MRI clinics exist, public wait lists are longer and resources scarce.

CUPE urges government to abandon Bill 179 and the option of private user-pay MRI clinics.

CUPE urges government to make the right choice and align medical access with need not ability to pay.[66]

It is a choice that requires sustained commitment, political will and political courage to manage our health care system so that it lives up to the collective values, and serves to ensure the accessibility, of all Saskatchewan people.

We urge you to improve public capacity and access in publicly-funded and publicly-delivered healthcare and to resist the illusion of gains from private user-pay option.

[61] Canadian Institute for Health Information, 2013, p. 10.
[62] Ehman, A.J. (2004)
[63] "MRI Privatization may be coming to Saskatchewan" May 7, 2015.
[64] Birch et al, 2015.
[65] Rachlis, 2013
[66] Lewis & Sanmartin, n.d.

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