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 nonprofit 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 nonprofit 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.

Marc Baltzan
Nephrologist
Saskatoon, Sask.

Reference

1. Shortt SED. Alberta's Bill 11: Will trade tribunals set domestic health policy? [editorial]. *CMAJ* 2001;164(6):798-9.

Samuel Shortt's paper on Bill 11 is another thinly disguised attempt to discredit private surgical facilities and instill fear in the public that such facilities are going to doom our Canadian health care system.

We already have "for-profit" surgical facilities in most physicians' offices, because many provinces pay physicians a "tray fee" for removing skin lesions or performing other minor procedures. If Shortt is correct, then the North American Free Trade Agreement has already doomed us.

Couldn't we all be open to the fact that there are many ways to achieve good medical care? Some people work better on salary. Some work better in institutions where they have all the administrative functions looked after for them.

I know that I work better in my own surgical facility where I can hire and promote on the basis of performance and not some arbitrary union rule. Operating my own facility allows me to perform surgery, to organize my time and to provide a level of patient care that I have not been able to achieve in a publicly run institution.

Creating fear about losing our system because of the North American Free Trade Agreement is skirting the issue. I believe in our Canadian health care system, but we need not be so afraid about talking about and discussing all the options.

Elizabeth J. Hall-Findlay
Plastic surgeon
Banff, Alta.

Reference

1. Shortt SED. Alberta's Bill 11: Will trade tribunals set domestic health policy? [editorial]. *CMAJ* 2001;164(6):798-9.

[The author responds:]

I am grateful for the opportunity presented by Marc Baltzan's comments to reiterate the key message of my paper[1] 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 than 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 insurmountable 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.[2]

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 deflected attention from the more arcane and yet immediate concern that Bill 11 will allow international trade tribunals to intrude into our domestic health policy."[1] My paper does not discuss the merits of for-profit facilities.

In the near term, Bill 11 is likely to be relatively innocuous. But it has left open what was previously a closed door. When the timing is correct, I have no doubt that international for-profit firms will be willing to accommodate short-term losses in anticipation of achieving a lucrative foothold in the Canadian health care system through the application of the GATS provisions.

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References

1. Shortt SED. Alberta's Bill 11: Will trade tribunals set domestic health policy? [editorial]. *CMAJ* 2001;164(6):798-9.
2. Adlung R, Carzaniga A. Health services under the General Agreement on Trade in Services. *Bull World Health Organ* 2001;79:352-64.