

Commentary: Pricing Cataract (and Other Straightforward) Surgeries – A Policy Perspective to Build Capacity, Value and Innovation

Commentaire : Établissement du prix des chirurgies de la cataracte (et autres chirurgies simples) – point de vue stratégique pour renforcer la capacité, la valeur et l’innovation

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Abstract

Aligning with Crump and colleagues’ (2024) conclusions on cataract surgery, this article champions a level playing field for expanding surgical capacities for straightforward surgeries. It is agnostic toward for-profit or not-for-profit models. It argues for experimenting with new ambulatory facilities to meet urgent needs, emphasizing Ontario’s successful two-decade experience with models such as the Kensington Eye Institute. The discussion advances a three-tiered pricing framework, advocating for transparent, structured pricing to reduce wait times and improve public health outcomes. This approach seeks to balance annual commitments, quarterly adjustments and spot market needs, promoting innovation, cost-efficiency and quality care.

Résumé

Conformément aux conclusions de Crump et de ses collègues (2024) sur la chirurgie de la cataracte, cet article préconise des règles équitables pour une expansion des capacités chirurgicales pour les chirurgies simples. L’article met de côté les modèles à but lucratif ou sans but lucratif. Il préconise l’expérimentation de nouvelles installations ambulatoires pour répondre

aux besoins urgents, en mettant l'accent sur les vingt ans d'expérience de l'Ontario avec des modèles tels que celui du Kensington Eye Institute. La discussion propose un cadre de tarification à trois niveaux, préconisant une tarification transparente et structurée pour réduire les temps d'attente et améliorer les résultats en matière de santé publique. Cette approche vise à équilibrer les engagements annuels, les ajustements trimestriels et les besoins du marché au comptant, en favorisant l'innovation, la rentabilité et la qualité des soins.

Introduction

I agree with most of the conclusions that Crump et al. (2024) reach in their strong article on cataract surgery. We should experiment in a limited and transparent way with new ambulatory facilities applied to other surgical and diagnostic procedures that require urgent added capacity and that have clear appropriateness criteria. Like the authors, I am largely agnostic as to whether such an expansion should occur in for-profit or not-for-profit (NFP) facilities. However, I arrive at a similar endpoint by somewhat different paths.

Discussion

Cataract capacity serves the health needs of our population. These surgeries are valuable to people regardless of who performs them. They are a bargain as they provide direct benefit and also support the health status of the population. Take the example of a 75-year-old woman whose vision has significantly deteriorated due to cataracts. These cataracts have greatly affected her daily activities, making it unsafe for her to drive, and she has been waiting for nine months for the needed corrective surgery. This wait has not only reduced her mobility but also limited her ability to engage in activities such as reading, especially during the winter. Delaying such a surgery makes no sense given the low price at either a for-profit or an NFP facility.

In Ontario, the cost of corrective cataract surgery – which is around \$1,000 – is covered by the Ontario Health Insurance Plan (OHIP). This includes approximately \$400 for the surgeon and a facility fee that ranges between \$400 and \$800.

- Should we invest \$1,000 in such a surgery? Yes.
- Should we accept extended wait times? No.

Allowing my apocryphal 75-year-old to live in partial blindness undermines the health and wellness principles. From a social determinants of health (SDOH) perspective, it undermines health status. We need to eliminate unnecessary wait times for such critical yet straightforward procedures. The same logic can be extended to many joint surgeries and other procedures (without appropriateness concerns). From an SDOH perspective, capacity should be brought on line quickly and ramped up and down as needed. There is little concern about appropriateness, and it is easy to add in year or even in quarter, the volume adjustments for these procedures. Operating rooms are usually available.

Next, I will take a pricing perspective. Crump et al. (2024) argue well for price transparency. I would like to go beyond this and unpack pricing and costs in some detail. My goal here is to suggest a perspective on how to manage pricing well at a system level. I will close by recommending a new pricing system for cataract and other similar surgical procedures.

What price should we pay for a routine cataract (or routine knee or hip) surgery?

I quoted a sum of \$1,000 earlier as a placeholder: \$400 for the surgeon and \$600 for the facility. This number is actually both too high and too low. Some providers will lose money at this price, and some will gain. The argument is often made that providers should be paid a fair compensation and that the definition of “fair” is that they be paid their costs. This argument is now being made by the for-profits as a reason for a higher fee.

THIS ARGUMENT IS NONSENSE

Imagine an airline insisting that you cover their costs with the price of your ticket, an appliance manufacturer listing their costs as the basis for the price, your childrens’ school itemizing the teachers’ and other staff salaries or drivers’ licence renewals based on staffing costs. But healthcare is different, you say. No, it is not – not for straightforward surgeries and other well-defined services.

The late Harvard professor, Clayton Christensen, and co-authors discuss pricing in their excellent book *The Innovator’s Prescription* (Christensen et al. 2008), which was the healthcare follow-up to the professor’s earlier book, *The Innovator’s Dilemma* (Christensen 1997). Christensen et al. (2008) argue that “value-added processes or VAPs” (p. 76) (such as cataracts) are best paid for on a fixed-fee basis, “... to fix problems after definitive diagnoses have been made” (p. 77). Christensen et al. (2008) compare VAPs with facilitated networks and solution shops. Facilitated networks are paid on a membership basis (think Netflix or your gym membership or healthcare-capitated primary care services). “The solution shop activities within a hospital are generally those involved in diagnosing patients’ problems” (Christensen et al. 2008: 76). The three streams differ in several ways, one of which is how they are best paid. Building on Christensen and colleagues’ (2008) work, I believe that fixed pricing for VAPs is aided by certain clinical criteria, the two most important being the following:

1. The risk of inappropriate treatment is low. This can be due to clear inclusion criteria and/or low negative consequences if inappropriate treatment is given.
2. The complexity and comorbidity criteria can be established to create a relatively homogeneous diagnostic population.

Christensen and colleagues’ (2008) make a compelling case that paying for VAPs with a fixed price encourages innovation and quality improvement.

During my career over the past two decades, I have repeatedly seen the same thing in the Ontario system with respect to cataracts. Prices and costs for cataracts have declined as facilities and surgeons innovated. They created special chairs that convert to operating room (OR) tables, they introduced nursing anesthesia that allows multiple room coverage, they consolidated surgical packs from many sutures and instruments to fewer in number and they got faster and faster. Post the World War II period, cataract surgery costs have declined consistently (Shapiro et al. 2001). When first invented, the procedure required six hours of OR time and weeks immobilized in a hospital bed. Today, it is done in under 90 minutes door to door and often in under 10 minutes in the actual OR. Crump et al. (2024) are correct in that a transparent price is important. I am saying that this should come with an understanding of what is driving prices and an expectation that we can and should manage to bring prices down over time. We have done so in the past when we have been diligent.

The Kensington Eye Institute (KEI) was created in 2006 under Premier McGuinty using wait time monies allocated using the ‘retired brain surgeon model’ of funding (Kensington Health n.d.). Alan Hudson, former Toronto Hospital president and neurosurgery chief, was addressing long wait times by allocating funds to existing facilities around the province for several surgical procedures (almost all were what Christensen et al. [2008] would later call VAPs). He found that the pace of change for ophthalmological surgery was too slow and that he needed a more aggressive provider to push the hospitals, expand capacity and reduce prices. He worked with the Kensington Community Foundation and created the NFP KEI. The KEI, today, does 10,000 to 15,000 cataracts every year and has been doing so for more than a decade. They have stopped telling me what they charge because I kept talking about it, but my guess is that they are somewhere in the low \$400s.

I used to take my business school class to KEI once a year (Christensen et al.’s [2008] was my textbook) to look at how a VAP works. It is not a hospital, but it is the site of the chief of academic ophthalmology for the University of Toronto. We saw the innovations I mentioned earlier being demonstrated. And those innovations quickly spread to other competing hospital-based providers.

Could volumes have stayed at the Toronto Western Hospital, where most of these surgeries were done before KEI, and been done as effectively? I do not believe so. There were those who argued that case at the time. I know almost no one who would argue that today. My perspective is that by creating the new service and ratcheting down the reimbursement, Hudson and McGuinty created reference pricing and a model of clinical excellence, which they used to manage other providers. KEI, today, shows all of the attributes that Crump et al. (2024) talk about. They transparently report their quality, access and prices. When they upsell consumers, they do so transparently.

My third perspective is health system policy. We need to encourage consistent improvement and innovation in our system, and new models may help with this. Hudson and McGuinty brought on the new capacity at a lower price point. Ontario Premier Doug Ford and Ontario Health Minister Sylvia Jones appear to be bringing it on at a higher price point.

The Canadian Broadcasting Corporation (CBC) reports (Crawley 2023) that a freedom of information request produced figures stating that the facility fee for cataracts was \$1,264 at a new private facility as opposed to \$508 for public hospitals. I have no reason to doubt the CBC's numbers. And Minister Jones did not dispute them directly (Crawley 2023).

I note that it is not unreasonable to pay higher fees to a new service supplier to encourage market entry. Windmills and solar power producers get guaranteed tariffs that are much higher than those of the existing electricity producers, and policy makers believe that there are good reasons for this. In healthcare, we do pay special fees to new facilities that can be quite significant.

There would not be great excitement for more volumes at the lower public fee level of \$508 (about \$900 with the surgeon fee), but there would be some takers. My friends at KEI will, I hope, forgive me for saying that they would probably take 2,000 to 5,000 more cataracts at that price. (Please note that a couple of thousand at that price is \$1.8 million, which is not even a rounding error on the rounding error of the hospital budget in Ontario and is a truly inexpensive price to take thousands of Ontarians out of partial blindness.)

How did Minister Jones and her team arrive at \$1,264 for the facility fee? This is not at all clear. What is clear is that many legacy providers would be very interested in more cataracts at this price. Jones is playing a business class fare, and there is no reason to believe that there is improved service or quality. In fact, there is good reason to believe that the lack of reporting suggests an immaturity of systems and the poor processes call into question clinical quality. This is not to suggest that these organizations may not be of good quality, rather to underscore Crump et al.'s (2024) point that this needs to be transparently reported.

So how should governments price cataracts and other VAPs?

The answer to this question is not academic. Even though Hudson was a renowned academic (Trypuc et al. 2006a, 2006b), his buying of cataracts was practical and pragmatic. We need such an approach now. The new volumes are targeted for Windsor, London, and other areas, and the price for cataracts may be higher there for practical reasons. Running a low-cost, high-quality facility such as KEI requires at least two ORs and preferably four to spread fixed costs and the anesthetist's time. In my experience, a single-room facility will have trouble getting below \$800. So a number of the hospitals in southwestern Ontario may struggle with lower prices and certainly would not be able to make a \$508 number in a new and growing facility. Judgement needs to be exercised to set prices and then reduce them over time.

Southwestern Ontario may be somewhat more expensive than KEI, but it is absolutely fair that if customers are willing to travel as far for their cataracts as they would for a Mirvish production (<https://www.mirvish.com/>), they should be able to get a cataract done at an NFP facility for under \$1,000 in the public system (plus the \$400 surgeon fee that is flat across the province).

As Crump et al. (2024) argue, these prices should be radically transparent. VAP services and prices should be posted and discussed. Quality should be assured, and Accreditation Canada (<https://accreditation.ca/>) is a respected and excellent group to do this. Contracts with all providers should be in place to limit upselling (corrective lenses, tests not covered by OHIP and changed eye colour). No one should be allowed to sell access through the back door; access for VAP should be guaranteed for all.

Competition among these providers will result in a win by providers already in the public system, in my opinion, as they have a lower cost to serve. When you have a pricing discussion with them, they will argue that their costs are higher, but watch how they behave, not how they negotiate for higher prices. Very few providers (if any) should ever be compensated based on historic costs; doing so causes price inflation in healthcare services as it does in other industries.

The ministry should be an active buyer of all VAP surgical services. Within the Crump framework (Crump et al. 2024) of pricing, access and quality transparency allow me to suggest a specific model.

Proposed pricing framework for VAP surgeries

Create three tranches of buying:

1. A total of 75% annual volumes committed at the start of each fiscal year based on negotiations and existing accountability agreements (such as the Hospital Service Accountability Agreement) (Middlesex Hospital Alliance n.d.)
 - a. In my opinion, this will end up at about \$1,200: divided \$800 and \$400.
2. Then, 20% to be priced quarterly using a bond auction methodology where the clearing price is given to all bidders.
 - a. In my opinion, this will end up at about \$900: divided \$550 and \$350.
3. And, 5% spot market (or “buy it now”), which the ministry offers and raises when needed.
 - a. This will likely clear at a surprisingly low number: perhaps \$600; divided \$400 and \$200.

Note that I bundled surgeon and facility fees. For more complex VAPs, such as knees and hips, I would bundle rehabilitation services and home care as well. There is a lot of international literature on bundling and some good experience in Ontario from the quality-based procedures program (<https://www.hqontario.ca/Quality-Improvement/Quality-Improvement-in-Action/QBP-Connect>).

There has to be some attention paid to travel time. I might offer patients willing to travel a free hotel (and a Mirvish show?) so that the bigger city price advantage can influence

local monopolies. Such a care guarantee also helps solve regional shortages and addresses the access issues raised by Crump et al. (2024).

Conclusion

Please note that none of my perspectives was anything other than agnostic about for-profit and NFP providers. I have huge respect for our public hospitals, but I do think they need to be challenged. Many of the same arguments against privates were advanced when KEI came on as an NFP. Those arguments were not true then. In particular, the argument that staff will be hired away by new competitors is one that I am skeptical about as a reason for wholesale rejection of all non-hospital options (Miller and Shingler 2022). Yes, there are huge human resource issues in healthcare, and we need to fix them. But allowing people to deteriorate in semi-blindness because we cannot organize ourselves to provide a \$1,000 procedure in a timely way is not okay.

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