fects. For example, it may prompt people to think about how they could make a difference. We understand that it is difficult to expect researchers living in developed countries to study what they do not know. As Louis Jacques points out, research on problems of the developing world should be done by those living and working in those countries. Researchers from the developed world could, however, use their research expertise to train investigators working in low-income countries so that they can conduct and publish the studies they think are needed. We also hope our study will serve as a reminder that the human race lives in a global village. Those of us in privileged circumstances must find ways to gain a more global perspective so as to improve health for all.

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Care at for-profit hospitals

I was surprised to learn that Gordon Guyatt, coauthor of an influential paper on health care delivery,[1] was also a candidate for the New Democratic Party during this year's federal election. The statement in the article claiming that there were no competing interests for any of the authors is as shocking as it is false. At the very least, medical studies published by politicians should be transparent about that fact.

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Peter Devereaux and associates[1] estimate the cost of care provided in private hospitals. Unfortunately, they ignore 3 important points.

The first is corporate income taxes. The authors estimate that for-profit hospital care (if half of Canadian hospitals were converted to private for-profit institutions) would cost an additional $3.6 billion. This additional money would be spent on improving care (greater capacity, shorter waiting times, newer technology) or other hospital expenses, or it would become "profit" before taxes. The average combined federal and provincial corporate income tax rate was estimated at 38.1% in Canada for 2002.[2] If none of the additional $3.6 billion were spent on additional hospital expenses, then the for-profit hospitals would have to pay $1.37 billion (38.1% × $3.6 billion) in corporate income taxes. This would reduce the impact on taxpayers.

Second, the authors ignore the role of competition. The study with the most recent data (for 1986–1994) and the most patients found that lack of competition leads to higher prices, even for nonprofit hospitals.[3] Devereaux and associates ignore the effect of competition in moderating prices.

Third, Devereaux and associates have ignored case mix. Instead, they extrapolate one pooled estimate of a congeries of hospital payment ratios to the entire Canadian hospital system.

I am sure that consideration of the above points would substantially alter the policy recommendations that were derived from the meta-analysis.

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DOI:10.1503/cmaj.1041047

[Three of the authors respond:]

William Nuttley raises the issue of competing interests for our article on costs of care in for-profit hospitals,[1] with reference to coauthor Gordon Guyatt's candidacy for the New Democratic Party in the 2004 federal election. The choice of our research question was undoubtedly one of people's interests and values, but that is true of all investigators and all projects.[2] Our work was conducted before Guyatt was nominated as a political candidate. The researchers on our study team hold widely varying political views, but they shared a common conviction that it was crucial to answer the study question (regardless of the results), given

the active debate about the future of Canadian health care. Knowing a priori that some people would not like whatever our systematic review would uncover, we used several measures to minimize any possible bias. For example, we established explicit eligibility criteria and blacked out all study results before determining study eligibility, so that we were unable to select or reject an article on the basis of the study results. Therefore, we did not, and indeed could not, select studies to reach a preconceived conclusion.

Using our estimate of the additional costs of care in for-profit institutions and a corporate tax rate of 38.1%, Vincent Richman estimates that for-profit hospitals would have to pay $1.37 billion in corporate income taxes. Even if corporations were to actually pay all of this income tax and the money was reinvested into health care, Canadians would still be paying an extra $2.2 billion annually for health care.

Richman also states that we ignored the effect of competition in moderating prices. The 3 studies in our meta-analysis that controlled for market competition all demonstrated significantly higher payments for care at private for-profit hospitals.[3-5] Furthermore, a health care system can have competition without private for-profit hospitals, as is the case in many cities with several private not-for-profit hospitals.

Finally, Richman claims that we ignore case mix because we extrapolated our pooled estimate of a mix of hospital payment ratios to the entire Canadian hospital system. We acknowledge that our $3.6 billion annual excess expenditure is an estimate that assumes a relatively similar case mix to US hospitals. Even if we assume a lower-acuity case mix among Canadian patients, any realistic assumption would result in the Canadian public having to pay billions of dollars in excess expenditures if we introduce private for-profit hospitals.

Considering this reality and given our previous finding of higher death rates in private for-profit hospitals,[6] our policy recommendation remains robust (i.e., the evidence strongly supports a policy of not-for-profit health care delivery at the hospital level).

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The gender gap in Canadian health care

Kirsteen Burton and Ian Wong, in their article on the physician workforce in Canada,[1] state that "Compared with men, women work fewer hours per week, see fewer patients (and provide fewer services), [and] are likely to leave the medical profession sooner." Additional detail on these points would be helpful in determining the extent of the problem. Specifically, how many fewer hours are worked by female physicians each week, and how many fewer patients do they see? Also, how many years earlier do female physicians retire? Given that the number of doctors in the country is declining, these differences represent a serious issue.

Is it wise for taxpayers to fund training for a large group of future part-time doctors, when there is already a shortage of doctors in the country? In their selection process, do medical schools screen on the basis of applicants' plans to work part-time or full-time? If not, perhaps they should.

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[The authors respond:]

Differences in practice between male and female doctors, as described in our article,[1] are important to uncover, not only in terms of human resource patterns, but also perhaps in terms of the quality of care provided. The cost–benefit analysis that would be involved in deciding whether governments should fund training for a group of part-time doctors is a complex one, involving many factors in addition to number of hours worked, number of patients seen and number of years in medical service. We have not conducted studies or analyses of these factors, although they are certainly worthy of scientific exploration.

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