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Patient Perceptions of Private Cataract Surgery in Ontario

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ABSTRACT

Prolonged wait times for elective procedures have led to the integration of private healthcare options into the Canadian healthcare system, with current legislation signalling further expansion. This study aimed to assess patient perspectives on being offered private cataract surgery options through a standardized telephone script, as well as patient attitudes towards the role of private healthcare options in cataract surgery and in general. This quality improvement study employed a survey-based approach, conducting both telephone and in-person questionnaires to patients referred for cataract surgery at the Ivey Eye Institute, London, Ontario. Patients with upcoming cataract consultations were contacted using a standardized telephone script on public and private cataract surgery options and later surveyed. Simultaneously, patients attending their consultations were surveyed in person. Chi-square tests and descriptive statistics were used for data analysis. Sixty-nine patients completed the surveys—20 via phone and 49 in person. Most phone respondents (95%) felt no pressure to choose private options, and all agreed it was appropriate to be informed. Overall, 66.7% of respondents supported private cataract surgery options, and 65.2% supported a role for private healthcare in general. No demographic factors were significantly associated with perceptions of private healthcare. Participants responded positively to the telephone script and showed general support for private options, demonstrating the need for additional research to ensure healthcare policy aligns with patient preferences. To our knowledge, this is the first study to examine patient perspectives on private healthcare within Canada.

The principle of universal healthcare has become a core Canadian value, with over 90% of Canadians expressing pride in the universality of the healthcare system [1]. Yet, the system faces significant challenges, including prolonged wait times for many elective procedures [2,3]. One proposed solution to improve healthcare access is the integration of privatized healthcare options into the current system [4–6]. For example, research on public versus private bariatric surgery across Canada found that private clinics are able to offer surgery on average more than a year faster than the public system, although at a direct cost of approximately $16,000 to the patient [7]. Concerns about cost, inequity, and a potential drain of public healthcare resources have been raised as key arguments against private healthcare co-existing alongside the public system in Canadian healthcare [4,8].

As an increasing number of private surgical centres are conducting both insured and non-insured cataract services, cataract surgery has become a central component of the discourse surrounding private healthcare [9–11]. While cataract surgery is publicly insured, innovations aimed at reducing post-operative dependence on spectacles are not. This allows patients the ability to pay out of pocket for surgical options beyond the standard procedure [12]. These innovations can include special feature intraocular lens implants, enhanced pre-operative diagnostic tests such as optical biometry, and femtosecond laser-assisted surgery [13]. According to the Canadian Medical Association's Code of Ethics, patients have the right to be informed of reasonable therapeutic options, including private ones, in order to make informed decisions [14]. Yet, the allure of new technology, often used in private centres, can bias patient perceptions even without evidence of superior outcomes [15]. Despite the importance of discussing private options with patients, there remains a lack of research into patient perspectives on being exposed to private options in a public healthcare system and how this is conducted.

This quality improvement initiative aimed to assess whether patients referred through the public healthcare system are interested in hearing about private cataract surgery options and to evaluate their perceptions of how this information was conveyed. Additionally, we sought to understand their attitudes towards having both public and private healthcare options in general and for cataract surgery in particular.

Method

This study was a secondary analysis of data collected as part of a quality improvement initiative at Western University, London, Ontario. The quality improvement project aimed to ensure that cataract patients were presented with surgical options in an appropriate and sensitive manner, while also assessing their attitudes regarding the coexistence of public and private healthcare services.

Study Design

The study employed a survey-based approach, administering both telephone and in-person questionnaires to gather data on patient perspectives. As per the Tri-Council Policy Statement (TCPS) guidelines, research ethics board approval was not required for the original quality initiative conducted at Western University or for this secondary analysis of anonymous data originally collected for internal quality improvement purposes [16]. The Standards for Quality Improvement Reporting Excellence (SQUIRE 2.0) guidelines were used as a framework to

guide the reporting of this quality initiative during manuscript preparation (eFigure 1, see Online Supplemental Material) [17].

Participants

All patients referred for cataract surgery consultation to one of two cataract surgeons (L.B. and Y.I.) at the Ivey Eye Institute in London, Ontario were considered for inclusion. Patients who were contacted in November 2023 with upcoming appointment information for cataract consultation were given a newly developed standardized statement regarding public and private cataract surgery options. At the end of the phone call, patients were invited to participate in a follow up survey about their understanding of the information provided and their perceptions of private healthcare options. The telephone script and phone survey are provided in Figure 1 and Figure 2, respectively. Simultaneously, patients undergoing cataract consultation in the clinic (L.B. or Y.I.) were invited to complete a similar survey at the end of their appointments focused specifically on their perceptions of private healthcare options (eFigure 2, see Online Supplemental Material). Individuals were assured by the research team that their answers would remain confidential before completing the survey independently in a private room. The goal for the initial quality improvement project was to distribute 50 in person surveys and conduct 50 telephone interviews. However, due to the significant administrative burden and challenges of contacting patients by telephone on two separate occasions, the phone interviews were halted after 20 participants as no new themes were emerging. All data that was available from this project was included in the study.

Figure 1. Standardized telephone script used to inform cataract surgery patients about public and private surgical options

This is _____ calling from the office of Dr._____. We received a referral request from your optometrist to consider you for cataract surgery. Dr. _____ operates at both at the *(hospital)*, where he/she does OHIP covered cataract surgery as well as at *(private centre)*, where he/she offers laser assisted cataract surgery with premium lens options. We have already scheduled you for a consultation with Dr. _____ at the *(hospital)*. However, if you are interested in learning more about laser assisted cataract surgery and premium lens options which are not offered at the *(hospital)*, and could reduce or eliminate your need for
glasses, you can have a free consultation at (private centre) in the next few weeks. The cost of having surgery at *(private centre)* ranges from $1750 to $4000 per eye depending on what options you choose. After the consultation, there would be no obligation to proceed with premium cataract surgery if you do not find an option that suits your needs. We will not cancel the appointment already scheduled for you at the *(hospital)*, unless you decide to proceed with premium cataract surgery. You will not lose your place in the queue by going for the consultation. This phone call is being made to ensure you are aware of all the options available for your cataract surgery and there is no obligation to consider non-OHIP covered cataract surgery.
Would you be interested in a consultation at *(private centre)*?

YES: I will forward your information to *(private centre)* and they will contact you shortly with an appointment date. Your scheduled appointment at the *(hospital)* is _____.

NO: Ok, no problem. Dr. _____ will be happy to take care of you at the *(hospital)*. Your scheduled appointment at the *(hospital)* is _____.

Figure 2. Phone survey assessing patient perceptions of the telephone script regarding cataract surgery options

1. Did you feel like you understood the options available for your cataract surgery?
   A. Yes
   B. No

2. Did you feel like the options were presented in an unbiased way? This means that both the hospital and private options were offered as equally valid ways to have your surgery.
   A. Yes
   B. No

3. Did you feel any pressure to have a consultation at the private centre?
   A. Yes

B. No

4. Are you satisfied to be told about the option for private cataract surgery, or did you feel like the call was inappropriate?
   A. Appropriate
   B. Inappropriate

5. Is there anything that could have been done better?

Data Analysis

Both the in-person and phone cohorts were asked the same questions regarding their perspectives on incorporating private healthcare. However, participants repeatedly provided lengthy responses over the phone, which made it challenging to accurately assign them to the pre-determined options. As a result, the answers to the phone surveys were categorized into either 'yes' or 'no' for questions related to the role of private healthcare options.

Descriptive statistics were used to summarize the demographic characteristics of the study participants and their responses to the survey questions. The chi-square test of independence and Fisher's Exact test were used to examine differences between the telephone and in-person survey groups, as well as to explore relationships between patient perceptions and demographic factors (Microsoft Excel).

Results

A total of 69 respondents participated in the quality initiative study. A total of 27 individuals who provided initial consent were contacted via telephone, with 20 (74%) completing the phone survey. Additionally, 50 individuals consented to the in-person survey, and 49 (98%) ultimately completed it. One in-person paper survey was handed in blank. The demographic characteristics of the respondents are summarized in Table 1. Of the respondents, 46 (66.7%) were female and 28 (40.6%) were between 65-74 years old. A Chi-square test of independence found that patient perceptions of having a private option available in all types of healthcare and cataract surgery were similar in the phone and in person surveys ($\chi^2 = .001$, $^{p} = .98$, $\chi^2 = 1.08$, $p = .30$), allowing for the combination of these two data sets. Regarding patient perspectives on a reasonable out of pocket cost for cataract surgery, 53 (77%) respondents selected it should be between $1-$1000, with only 8 (12%) respondents under the impression it should cost more than $1000. There were no significant differences in patient expectations for reasonable cataract surgery costs between the in-person and phone groups ($\chi^2 = .24$, $p = .88$). Table 2 presents a summary of survey responses.

Table 1. Demographic characteristics of study participants

Variable	Sample (n)	Percentage (%)
Gender		
Female	46	67%
Male	18	26%
Not provided	5	7%
Age Group (Years)		
50-64	9	13%
65-74	28	41%
75-84	24	35%
85+	4	6%
Not provided	4	6%

Education Level		
Elementary school	7	10%
High school	28	41%
University/college degree	23	33%
Professional school	6	9%
Master's degree	1	1%
Not provided	4	6%
Insurance Coverage		
OHIP only	26	38%
Private insurance only	2	3%
OHIP and private insurance	23	33%
No insurance	12	17%
Not provided	6	9%
Annual Income		
<$20,000	6	9%
$20,000-$40,000	8	12%
$40,000-$60,000	11	16%
$60,000-$80,000	9	13%
$80,000-$100,000	3	9%
>$100,000	6	9%
Prefer not to Answer	20	29%
No response	6	9%

Table 2. Patient responses to survey questions regarding private healthcare and cataract surgery options

Questionnaire	In-Person Survey (n=49)	Phone Survey (n=20)	Chi Squared Test
Are you in favour of having both public and private health care options for all types of health care in Ontario?			
Yes, it should always be an option	13 (26%)	13 (65%)	χ^2=0.001 p=0.98
Yes, in most cases	4 (8%)		
Yes, but only in rare cases	15 (31%)		
No, never	15 (31%)	6 (30%)	
Answer not provided	2 (4%)	1 (5%)	
Are you in favour of having both public and private health care options for cataract surgery in Ontario?			
Yes, it should always be an option	14 (29%)	15 (75%)	χ^2=1.08 p=0.30
Yes, in most cases	7 (14%)		
Yes, but only in rare cases	10 (20%)		
No, never	16 (33%)	4 (20%)	
Answer not provided	2 (4%)	1 (5%)	
What do you think is a reasonable out of pocket cost to pay for cataract surgery?			
$0	21 (43%)	10 (50%)	χ^2 = 0.24, p = 0.88
$1-$1,000	16 (33%)	6 (30%)	
$1,000-$2,000	4 (8%)	0 (0%)	
$2,000-$3,000	0 (0%)	2 (10%)	
$3,000-$4,000	1 (2%)	0 (0%)	
$4,000-$5,000	0 (0%)	0 (0%)	
>$5.000	1 (2%)	0 (0%)	
Answer not provided	6 (12%)	2 (10%)	

Patient Perceptions Towards the Initial Phone Call Providing Information About Private Cataract Surgery

Of the 20 respondents to the telephone survey, all 20 (100%) reported that they understood the options presented to them regarding cataract surgery at both the hospital and private centers.

Similarly, all 20 (100%) reported they felt it was appropriate to be informed about the private cataract surgery option. Additionally, 19 (95%) individuals indicated they did not feel pressured to choose a private consultation. Suggestions for improving the phone call included a desire for more detailed information about private cataract surgery by 2 (10%) respondents and concerns about the audio clarity by 1 (5%) individual.

Patient Perceptions Towards Private and Public Healthcare Options

The survey revealed mixed opinions on the role of private healthcare, as 45 (65.2%) answered there should be a role for a private option in all types of healthcare, while 21 (30.4%) answered there should be no role while 3 (4.3%) individuals did not provide a response. Similar results were observed in the context of cataract surgery, as 46 (66.7%) answered they supported incorporating private options, 20 (29%) answered they were against any role for private options, and 3 (4.3%) individuals did not provide a response. Additional insights from the in-person survey demonstrated that of 32 individuals who thought private healthcare should have a role in the Canadian healthcare system: 13 (40.6%) answered it should always be an option, 4 (12.5%) answered it should be an option most of the time, and 15 (46.9%) answered it should be available only in rare cases. Similarly, of the 31 respondents who thought private healthcare should have a role in cataract surgery, 14 (45.2%) answered private healthcare should always be an option, 7 (22.6%) answered it should be an option most of the time, and 10 (32.3%) answered it should only be an option in rare circumstances (Table 2).

Chi-square tests of independence and Fisher's Exact test were employed to assess whether demographic factors influenced preferences for private healthcare (eTable 1, see Online Supplemental Material). Analysis revealed no significant association between age and preferences for private healthcare options in general (p=0.94) or specifically for cataract surgery (p = .94). Additionally, sex was not significantly associated with preferences for private healthcare in general ($\chi^2 = 2.00, p = .16$) or with regards to cataract surgery ($\chi^2 = 1.59, p = .21$). Likewise, neither annual income nor educational attainment showed a significant relationship with perceptions of private healthcare options in general ($p = .53, p = .79$), or with respect to cataract surgery ($p = .53, p = .79$).

In response to an open-ended question on the perceived benefit of private healthcare, 32 (46.3%) expressed reduced wait times, 5 (7.2%) expressed better perioperative care and customer service, and 1 (1.4%) individual expressed receiving care outside a teaching hospital to be an advantage. The remaining individuals did not provide a response to this question. Conversely, when asked about the drawbacks of private healthcare, 24 (34.8%) of respondents expressed the high financial cost to patients, 13 (18.9%) expressed concerns about inequity, 5 (7.2%) expressed that the introduction of private healthcare could reduce the dedicated resources and quality of public healthcare, and 2 (2.8%) expressed that removing patients from the hospital was less safe in the case of an intraoperative emergency. The remaining individuals did not provide a response to this question.

Discussion

This study provides insights into patient perceptions of private cataract surgery options within Ontario's healthcare system. Most participants demonstrated openness to the integration of privatized healthcare, both for cataract surgery and general healthcare, although many believe

it should only be offered selectively. These findings are particularly pertinent considering Ontario's recent legislative changes, which aim to expand the role of private healthcare services [18]. The telephone script used in this surgical practice was developed with input from the hospital patient relations department to ensure transparency and respect for patient autonomy. Patients expressed high satisfaction with the information provided about private cataract surgery options via this script, suggesting that the goal was achieved. Even among those opposed to broader privatization within healthcare, all respondents felt the phone call informing them of a private option for cataract surgery was appropriate.

A similar telephone script could be implemented by cataract surgeons who offer services in both the public and private sectors to triage patients at the time of referral. This could divert patients interested in a private pay option even prior to their consultation, in theory reducing public wait times. However, substantial evidence suggests that a parallel private option may not shorten public waiting times [19–21]. In the 1990s, Manitoba permitted private cataract surgery, and it was noted that surgeons who worked in both public and private sectors carried longer public wait times than those who only operated in the public system (10 weeks versus 23 weeks) [22]. It is possible that surgeons may choose to operate in the private sector due to limited access within the public system, which may itself be the underlying reason for their long wait list. Additionally, concerns have been raised that private healthcare selectively focuses on easy, quick cases, leaving the public system to handle more complex and time-consuming procedures.[23–25] While these concerns highlight the potential negative impacts of privatization on public healthcare, private surgical centres do increase the overall available operating time and may be more effective in maximizing surgeons as a limited resource through enhanced operational efficiency [20,26,27].

While our study investigated patients' beliefs surrounding private healthcare, our study notably did not investigate which option participants would select for themselves. A 2015 study from New Zealand found that participants significantly preferred a public hospital compared to a private one, even if cost was not a factor. Wait times, contact with surgeon, and facilities were cited as other key factors influencing their decision, highlighting the complex interplay of factors that lead individuals to select their desired healthcare [28]. With regards to the cost of private cataract surgery, we observed a substantial discrepancy between patient expectations and reality. Despite our study finding no statistically significant relationship between income and beliefs surrounding healthcare privatization, it is still possible that individuals with higher incomes are more likely to tolerate the higher-than-expected costs of private surgery. This discrepancy underscores the importance of ensuring that patients have an accurate understanding of potential costs when introducing private options, especially if it requires the patient to complete a consultation at a separate location.

The most common reported benefit expressed by survey participants was decreased waiting times, a finding corroborated by previous reports [30]. Likewise, data from Manitoba in the 1990s demonstrated that private cataract surgeries occurred within 3-4 weeks on average compared to 3-4 months in the public system [22]. Another perceived benefit cited in our study was better peri-operative care and customer services associated with private services. This is consistent with international research indicating higher patient satisfaction in private settings due to improved hospitality, customer service, and facilities [31–33]. Yet, public healthcare often performs more favourably in terms of health outcomes compared to private [34,35]. For

instance, studies from Italy and the United Kingdom found that increases in private healthcare were linked to higher rates of avoidable mortality [36,37]. Furthermore, public systems utilizing private outsourcing—such as contracting out cleaning services within England's public NHS system—have been associated with higher rates of infection [38]. One possible explanation is that as private healthcare primarily prioritizes profit, it may lead to a reduction of expenses beyond the standards set in the public system [34]. Accordingly, a study of private bariatric surgeries in Canada found that patients had significantly fewer pre-operative visits than similar surgeries in public systems [7]. It is difficult to make any firm conclusions with limited research into private healthcare within Canada and none with regards to cataract surgery. However, it does raise the question of whether private healthcare may lower the standard of care in the pursuit of efficiency.

Limitations

While this study offers important insights, several limitations must be acknowledged. As a quality improvement study, the total number of individuals who had the opportunity to participate was not recorded. Rather, only the number of individuals who consented to the survey was documented. Consequently, there is a substantial risk of response rate bias, as the response rate could not be measured or reported. The approach to data collection, which included both telephone and in-person surveys, introduced a risk of measurement bias due to differences in the timing and context of data collection. Patients who completed the in-person survey had just completed their initial cataract consultation, while those who participated in the telephone survey had only recently been referred, potentially leading to different experiences and perspectives. However, the consistency of responses across both groups suggests that this was not a significant effect. The majority of respondents answered the closed-ended questions regarding beliefs surrounding private healthcare, other than the question about a reasonable out-of-pocket cost for cataract surgery, which 12% declined to answer. Similarly, 38% of individuals did not report their annual income, limiting the reliability of the analysis examining the relationship between income levels and beliefs about privatization. It is possible that participants refrained from answering these questions due to their sensitive nature despite being reassured that the survey results would remain completely anonymous. The relatively small sample size of 69 patients from in or around London, Ontario, limits the generalizability of the findings. Additionally, the participants were individuals already referred for cataract surgery, many of whom may have been directly experiencing the frustrations of long wait times in the public system. As such, their attitudes towards private healthcare may not fully represent the broader population, particularly compared to those who have not faced lengthy healthcare delays. Nonetheless, this is the first investigation of its kind within Canada, and it provides an important foundation for future research to build on.

Conclusion

The purpose of this study was not to make recommendations on the appropriateness of private cataract surgery options but rather to explore patient perspectives on its use and availability. This study highlights the complex attitudes of patients towards private healthcare options within Canada's publicly funded system. There was support for the integration of private healthcare options, with the majority of participants agreeing that there is a role for private options within

the Canadian healthcare system. Additionally, participants reported high satisfaction with the telephone script used in this study. As cataract surgery techniques and technology have advanced, patient expectations surrounding post-operative refractive outcomes and spectacle independence have correspondingly increased [39]. The findings in this quality initiative underscore the value of presenting private healthcare options to all patients, enabling them to pursue the refractive outcome and healthcare pathway they desire. Larger studies are warranted to ensure that healthcare policy and practice continue to align with patient values and expectations.

Declarations

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