Regulation Of Free-Standing Health Facilities: An Entrée For Privatization and For-Profit Delivery In Health Care

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Though it often appears beleaguered and bedraggled in newspaper and television reports on the state of its health, the Canadian medicare system continues to enjoy strong public support.[1] Despite some serious areas of unmet need and undercapacity, as well as decreasing public confidence that the health care system will be able to meet their needs in the future, people expect deficiencies to be addressed in a way that maintains both the publicly funded system and access to it. Politicians perceived as attacking it, then, do so at their peril. Nonetheless, that *is* what is occurring. Acting not only out of a concern to control costs, but also from ideological commitments to a sharply limited role for the state, several provinces have adopted policy agendas that will increase privatization in health care. Because of the political risks in doing so, however, shifts in that direction are being accomplished obliquely, either without acknowledging the end result or by focussing attention on other, more palatable consequences.[2] A number of these shifts are supported and indeed, made possible by changes in legislation and regulations. While much of this activity may not directly privatize the funding, organization and delivery of health care (indeed, it may be promoted as improving the publicly funded system), its effect is to do so, or to set the stage for further privatization.

While "privatization" has many meanings, I am using the term to refer to a process whereby goods formerly provided or paid for by the state are provided in the private realm through privatized funding and/or delivery of services.[3] The legislative changes that support and structure this reduction in the role and responsibilities of the state often go unremarked. This article focuses on one such development, the rise of free-standing (also referred to as independent or non-hospital) health facilities. It describes how these entities are regulated in a number of provinces, and reviews the ways in which the regulatory systems have been altered

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[1] Canada, Commission on the Future of Health Care in Canada, *Building Values: The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002), online: The Commission on the Future of Health Care in Canada <www.hc-sc.gc.ca/english/care/romanow/index1.html> (Commissioner: Roy J. Romanow Q.C.) [Romanow Report].

[2] For a more complete discussion of these developments, see Joan Gilmour, "Creeping Privatization in Health Care: Implications for Women as the State Redraws Its Role" in Brenda Cossman & Judith Fudge, eds., *Privatization, Law and the Challenge to Feminism* (Toronto: University of Toronto Press, 2002) 267.

[3] Paul Starr, "The Meaning of Privatization" in Alfred Kahn & Sheila B. Kamerman eds., *Privatization and the Welfare State* (Princeton N.J.: Princeton University Press, 1989).

over time. It assesses the policy choices evident in the legal frameworks, and highlights ways in which the regulatory regimes not only facilitate increasing privatization in health care, but often, favour delivery of that care by for-profit businesses. Finally, it analyzes the effects that private for-profit clinics are likely to have on publicly funded health care, concluding that the publicly funded system will be diminished as a result.

I want to begin by making it clear that I am not an opponent of free-standing health facilities *per se*. Hospitals are an expensive setting in which to provide care, and medical advances have meant that many types of treatment and diagnostic tests and services can now be provided safely, more conveniently and less expensively, outside that setting, though they may require a greater intensity of care or monitoring than is generally available in a physician's office. Consequently, in many cases, mid-level care delivered in free-standing health facilities makes sense. Nor do I object to development of separate, tailored regimes to regulate these undertakings. Health care services delivered outside hospitals are increasingly complex, extensive, invasive and potentially risky for patients.[4] It is important that they be provided in a regulated environment to ensure safety and quality of care, as well as control over the way such care is organized.

However, I am concerned that the regulatory frameworks being put in place encourage outcomes that will detract from the publicly funded system. That is so even if efforts are made to ensure that when those clinics provide services that are covered under the public health insurance plan, the cost of that service is paid entirely by the public plan with no additional charge to or facility fee paid by the patient. In my view, it matters whether or not services are publicly or privately delivered, and whether delivery is on a for-profit or non-profit basis, as well as whether they are paid for publicly or privately. Public or private funding is not the only key variable. What one often hears in response to that concern is that many of our health care services are already privately delivered and have been for a long time - physician services are a prime example. That is true. Since the inception of medicare in this country and long before that, doctors have worked on a fee for service basis. They are in business for themselves; they are not state employees. Further, while they are expected to make decisions about treatment in their patients' best interests, they are not always entirely altruistic in the decisions they make about the care they provide. As health economist Robert Evans explains, physicians are "not-only-for-profit" firms, and that can affect their decisions:

> Rarely will the professional seek to influence utilization in ways which she knows to be harmful to the patient, solely in her own interests. But practical health care situations are sufficiently complex and uncertain

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[4] For example, in *Anderson v. Wilson*, (1999) 175 D.L.R. (4th) 409 (Ont. C.A.), a number of patients contracted Hepatitis B at a physician-owned clinic from improperly sterilized needles used in EEG testing by a technician who was a carrier of the virus. The resulting lawsuit was resolved by what was reported to be the largest settlement of a class action in Canada, $27 million; see Gay Abbate "Neurologist loses licence over outbreak" *The Globe and Mail* (13 November 2002) A9.

> that the provider's perceptions of patient interests can readily adjust themselves to accommodate provider interests as well.[5]

The tendency to factor provider interests into decision making about treatment is likely to become even stronger when that "provider" consists not only of a treating professional, but also a superstructure of investors expecting professional staff to generate a return on their investment. The nature of private delivery changes in significant ways when treatment is chosen and provided by an entity that has as its end goal the imperative of making a profit for shareholders, who themselves may have nothing to do with health care at all.[6] Then we move from health care practitioners who are "not only for profit" to a business that is being carried on to make money for others who do not have, nor are they required by their training or any code of professional ethics to have, primary regard for patients as their goal.[7]

Others disagree with this assessment. They suggest that private *delivery* may not be undesirable and may even have advantages, as long as public *financing* of insured health care services remains inviolate.[8] They would encourage experimen-

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[5] Robert G. Evans, *Strained Mercy*: *The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 78. See generally Canada, Commission on the Future of Health Care in Canada, *Delivering Health Care Services: Public, Not-for-Profit, or Private? Discussion Paper No. 17* by Raisa Deber (Ottawa: Commission on the Future of Health Care, 2002) at 5-8.

[6] As an indication of the interest of for-profit businesses in this area, soon after Ontario announced it planned to issue a Request for Proposals to allow up to 20 MRIs and 5 CT scanners at independent health facilities in the province, a newspaper advertisement placed by Millennium Technology Inc. titled "Open MRI" appeared, soliciting interest in a "successful *turn-key business*" providing MRI services [emphasis in original]; "Open MRI" *The Globe and Mail* (29 October 2002) R7. See also Michel Compte "Private Clinics Planned: MRI clinics, surgery services expect expansion" (23-27 April 2002) Business in Vancouver 652, cited in Ross Sutherland, *Scanning for Profit: A Critical Review of the Evidence Regarding For-Profit MRI and CT Clinics* (Toronto: Ontario Health Coalition, 2002) at 6, 19-21 where Millennium's plan to "blanket [British Columbia] with franchised MRI clinics, charging investors $1.45 million for turnkey clinics that include desks, chairs, computers, decor, coat hangers and its own MRI machine" was referenced.

[7] Professional ethics and self-regulation are far from being a panacea, but with careful development and pro-active enforcement, they are instruments that could usefully be employed to curb or halt problematic practices. Some provinces, such as Alberta, have attempted to control for this danger by stipulating that a medical professional must be responsible for activities at a facility that constitute the "practice of medicine", and indeed, is the owner of the practice of medicine conducted at the facility (College of Physicians and Surgeons Alberta, By-law, *Bylaws of the College of Physicians and Surgeons Alberta*, (3 January 2003), s. 45(7)-(10) [CPSA Bylaws]). However, it is not clear that the practice of medicine would or could be divorced from business considerations without more, and sketchy regulatory requirements do not ensure effective monitoring of compliance, applicable standards or controls for conflict of interest.

[8] See e.g. Canada, Commission on the Future of Health Care in Canada, *Strengthening the Foundations: Modernizing the Canada Health Act, Discussion Paper No. 13* by Colleen Flood & Sujit Choudhry (Ottawa: Commission on the Future of Health Care, 2002) at 12-13:

> The CHA [*Canada Health Act*] appropriately prevents experimentation with private financing through the prohibitions on user charges and extra-billing but it *neither impedes nor encourages* reform or innovation in the *delivery* of health care. We think the CHA should be reformed to actively encourage innovation and evidence-based reform in the delivery of care.

The Standing Senate Committee on Social Affairs, Science and Technology (the Kirby Commission) was agnostic on the subject of public or private delivery of care; Canada, Senate, The Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians – The Federal Role,*

tation with different types of delivery. I am not so sanguine. I become even more concerned in light of the potential for unanticipated consequences under international trade agreements if a province authorizes private delivery of health care services. The impact of international trade agreements on health service delivery is beyond the scope of this article, but it is essential that this factor be taken into account in policy development. It has been suggested that the trend towards increasing commercialization in health care, including for-profit delivery of services:

> … threatens to set in motion a self-reinforcing dynamic… The greater the presence of foreign investors and service providers, the greater the possibility of trade disputes if governments take actions that limit or reverse foreign penetration. Thus, once foreign investors and service providers become involved in Canada's health care system – and the more involved they become – the more difficult and costly it will be to limit or reverse the trend towards commercialization in general.[9]

Even if there were no other grounds for objection, in light of this risk, there must be a clear determination that any initiatives undertaken would not bind governments to continue to support private delivery of care should policy change in the future.

What Are Free-Standing Health Facilities?

Since the 1980s, there has been a significant increase in the number of free-standing or independent health facilities being established to provide diagnostic and surgical services that previously had only been available in hospitals. The types of procedures that can be performed in these settings have broadened as well. Most provide access to technology or high volume, short-stay surgical procedures.[10]

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vol. 6 (Ottawa: The Standing Senate Committee on Social Affairs, Science and Technology, 2002) at ch.17, online: Parliament of Canada <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep- e/repoct02vol6part7-e.htm>. In Alberta, the Premier's Advisory Council on Health recommended the province should "reconfigure the health system and encourage more choice, more competition and more accountability" and "seriously look at expanding the role of the private sector in delivering insured health services"; Alberta, Premier's Advisory Council on Health, *A Framework for Reform – Report of the Premier's Advisory Council on Health* (Edmonton: Queen's Printer, 2001) at 7, 25, online: Premier's Advisory Council on Health <http://www.premiersadvisory.com>.

[9] Canada, Commission on the Future of Health Care in Canada, *Putting Health First: Canadian Health Care Reform, Trade Treaties and Foreign Policy*, *Summary Report on Globalization and Health* by Canadian Centre for Policy Alternatives (Ottawa: Commission on the Future of Health Care in Canada, 2002) at ix. See also Barry Appleton, "International Agreements and National Health Plans: NAFTA" in Daniel Drache & Terry Sullivan, eds., *Market Limits in Health Reform: Public Success, Private Failure* (London: Routledge, 1999) 87; Bryan Schwartz, "NAFTA Reservations in the Area of Health Care" (1997) 5 Health L.J. 99; Canada, Commission on the Future of Health Care in Canada, *How Will International Trade Agreements Affect Canadian Health Care? Discussion Paper No. 22* by Jon R. Johnson (Ottawa: Commission on the Future of Health Care, 2002).

[10] National Forum on Health, *The Public and Private Financing of Canada's Health System*, (Ottawa: National Forum on Health, 1995) at 11-12.

The list of procedures performed in free-standing health facilities continues to expand – in Ontario, it includes anaesthesia, induced abortion, dermatological laser procedures, gynaecologic procedures, haemodialysis, nuclear medicine, ophthalmologic procedures, peripheral vascular surgery, plastic surgery procedures, pulmonary function studies, radiology, sleep medicine, and ultrasound.[11] In 2002, the Ontario government added magnetic resonance imaging (MRI) and computerized axial tomography (CT) scans to the list of authorized procedures, and solicited proposals for 5 MRI machines and 5 CT scanners to be operated in independent health facilities (IHF).[12] Of the approximately 1000 IHFs in Ontario, the majority provide diagnostic services; only a small number provide surgical procedures such as induced abortion or cataract surgery.[13]

Regulation was introduced to enable governments to control these undertakings, but also so that they could facilitate and even promote a new form of delivery of health services. Generally, the legislation and regulations are structured such that governments exercise power through a licensing system to control the establishment and operation of facilities as well as to ensure services performed in these settings meet standards and are of acceptable quality.[14] Governments have typically delegated many of the functions entailed in accreditation, quality assurance and monitoring compliance to the self-regulating body governing physicians in each province.[15] Comparing and contrasting the legal frameworks various provinces

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[11] College of Physicians and Surgeons of Ontario, “Independent Health Facilities Status for 1997/98” (July/August 1998) Members Dialogue at 31; College of Physicians and Surgeons of Ontario, “Independent Health Facilities Program Status Report” (July/August 2000) Members Dialogue. To date, as a matter of policy, procedures requiring overnight stays have not been approved (other than sleep studies, which are diagnostic) – personal communications with Jeff Morgenstern, Director, Independent Health Facilities, Ontario Ministry of Health and Long-Term Care (10 June 2002; 5 May 2003). The governing legislation authorizes the Director to specify a list of services or types of services permitted in a facility as a limitation on its licence; see *Independent Health Facilities Act*, R.S.O. 1990, c. I.3, s. 6(4) [*IHFA*].

[12] Ontario, “Government announces plan to reduce MRI/CT wait times” (8 July 2002), online: Government of Ontario Press Releases <http://www.newswire.ca/government/ontario/english/releases/July2002/08/c3175.html> [*PR July*]; “Ontario one step closer to increased access to MRI’s and CT scans” (15 November 2002), online: Government of Ontario Press Releases <http://www.newswire.ca/government/ontario/english/releases/November2002/15/c2406.html> [*PR November*].

[13] The College of Physicians and Surgeons of Ontario reports that 25 of the independent health facilities in the province provide surgical procedures; the remainder provide diagnostic services; see College of Physicians and Surgeons of Ontario, “Independent Health Facilities Program Annual Status Report” (July/August 2002) Members Dialogue, online: College of Physicians and Surgeons of Ontario <http://cpso.on.ca/Publications/Dialogue/0702/ihf.htm>.

[14] Gilbert Sharpe & David N. Weisstub, “Bill 26: Towards the Restructuring of Ontario’s Health Care System” (1996) 17(2) Health L. Can. 31.

[15] Processes to determine what services and procedures should be licensed in facilities are not uniform among provinces. For instance, in Alberta, the College of Physicians and Surgeons of Alberta is authorized to define what constitutes “major surgical services” by CPSA Bylaws, *supra* note 7 and accompanying text. In Ontario, the Director of the Independent Health Facilities program can specify permissible procedures as a limitation on a facility’s licence; see *IHFA, supra* note 11, s. 6. The Ontario Ministry of Health and Long-Term Care reports developing criteria in consultation with the College of Physicians and Surgeons of Ontario [CPSO] to analyze which additional services should be included

have adopted to regulate these entities reveals underlying ideological tensions, and also illustrates how changes in the law have opened the door to privatizing initiatives.

Ontario

The way in which shifts in ideology have been reflected in regulatory changes is most readily apparent in Ontario, as it has not only the longest legislative history *vis a vis* these facilities, but one that spans successive Liberal, New Democratic and Conservative governments. Amendments to the legislation governing IHFs evidence how it has been used to promote privatized and for-profit health care. The *Independent Health Facilities Act, 1989*[16] was introduced by a Liberal provincial government and came into force in 1990. Other than existing facilities that were grandfathered, the *IHFA* combined a mandatory request for proposal process with a policy requirement for the participation of local district health councils. New facilities would have to be licensed by the Ministry of Health and would be subject to ongoing quality assurance review overseen by the College of Physicians and Surgeons of Ontario. It was anticipated that local district health councils would be among the groups that could define a need and recommend establishment of a facility, or that the Ministry of Health would do so and ask district health councils to respond with recommendations.[17]

Physicians providing insured services in an IHF bill the health insurance plan for those services; additionally, facility fees are charged.[18] The latter are meant to reflect overhead and operating costs of providing a service (for example, the costs incurred in: staffing, operating and maintaining an operating room or paying a technician to operate laser equipment; the capital cost of equipment; and the cost of some medical devices used). When that same service is provided in a hospital, generally no separate charge is made. To accommodate this new type of entity, the schedule of benefits covered under the public health insurance plan was rewritten to separate physician fees from facility fees.[19] Where facility fees are incurred in connection with insured services, they are paid by the government, with the amount

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under the *IHFA* (addressing both utilization and quality assurance issues), as well as considering recommendations of the joint Ontario Medical Association / Ministry of Health and Long-Term Care Physicians Services Committee about new areas for inclusion. Factors identified for consideration are: potential risk to patients, rapid utilization or cost expansion, and rapid change in technology or delivery methods. See Ontario, Office of the Provincial Auditor, "Independent Health Facilities: Follow Up (1998)", online: Government of Ontario <http://www.gov.on.ca/opa/english/aud_mint.htm>.

[16] S.O. 1989, c. 59. Relative to the *IHFA*, see generally Gilmour, *supra* note 2, at 282-86, 297-98.

[17] *IHFA, supra* note 11, s. 5. Relative to the role of district health councils, see Ontario, Ministry of Health, *Independent Health Facilities Act* (Fact Sheet) [undated] [Fact Sheet]; Ontario, Ministry of Health, *"Independent Health Facilties Act:* Report of Activities, April, 1990 - December, 1991" [undated].

[18] Indeed, an "independent health facility" is defined as a health facility in which people receive services "for or in respect of which facility fees are paid", or that has been designated as such by the Minister; see *IHFA, ibid.,* s.1(1).

[19] Robert MacMillan & Marsha Barnes, "The *Independent Health Facilities Act*: A First for North America" (1991) 11(3) Health L. Can. 59.

being determined by negotiation with the provider.[20] Patients are not charged separately. That is not the case in all provinces.[21]

The *IHFA* changed significantly with the election of a Conservative government in the province. It quickly introduced sweeping changes to many provincial laws through the omnibus *Savings and Restructuring Act, 1996*.[22] These changes were so extensive and affected so many areas that the shift in orientation in the *IHFA* went largely unnoticed. Initially, the *IHFA* had given a preference to non-profit and Canadian-owned providers.[23] While not a strong commitment, that preference nonetheless represented an ideological choice to continue to favour the non-profit nature of the health care system.[24] The *SRA* removed this preference. District health council involvement in the independent health facilities development process is limited, despite the government's initial commitment to use the IHF process to develop a "more community-based health care system".[25] The *SRA* removed the reference to "insured" in the definition of "health facilities", making it clear they can provide uninsured, for-profit services. An "independent health facility" was defined simply as a health facility in which members of the public receive services for which facility fees are charged or paid, or that has been designated as such by the Minister.[26] The definition of "facility fee" was similarly changed.[27] *Vis a vis* the *IHFA*, the *SRA* was very effective "sleeper" legislation that put in place the conditions to not only allow, but also normalize for-profit clinics. That change was accomplished in Ontario with nothing like the public opposition when legislation enabling private clinics and for-profit care was first introduced in Alberta.[28]

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[20] John N. Lavis *et al.,* "Free-Standing Health Care Facilities: Financial Arrangements, Quality Assurance and a Pilot Study" (1998) 158(3) Can. Med. A. J. 359.

[21] New Brunswick, for instance, has long refused to pay for abortions performed in private clinics; it pays only for abortions performed in a hospital with the approval of two physicians – Campbell Clark "Ottawa girds for battle on abortion" *The Globe and Mail* (5 January 2001) A1, A5; Carol McLeod "Moncton to cease non-emerg abortions" *Medical Post* (19 November 2002) 2. Nova Scotia pays the physician fee for abortion services provided at a private clinic in the province, but not the facility fee. Health Canada considers this a violation of the *Canada Health Act*, and has penalized the province – Canada, Health Canada, *Annual Report for 2001-2002 on the Application of the Canada Health Act* (Ottawa: Health Canada, 2002) at 11, online: <http://www.hc-sc.gc.ca/medicare/AnnualReports.htm>.

[22] S.O. 1996, c.1, amending *Independent Health Facilities Act*, *supra* note 11 [*SRA*].

[23] *Supra* note 11, ss. 6(3), (4).

[24] The "Canadian operator" requirement does not seem to have been difficult to circumvent. For instance, in *Ottawa Carleton Dialysis Services v. Ontario (Minister of Health)*, [1996] O.J. 2721 (Div. Ct.) (QL) [*Ottawa Carleton Dialysis Services*], an American for-profit provider had simply set up a Canadian subsidiary in partnership with a Canadian physician and proposed to contract with the American parent for consulting advice on setting up and managing Ontario dialysis facilities.

[25] Ontario, Ministry of Health, Fact Sheet, *supra* note 17.

[26] *Independent Health Facilities Act*, *supra* note 11, s. 1(1) as am. by *Savings and Restructuring Act, 1996, supra* note 22, Sch. F, s. 19

[27] *Ibid.*

[28] See e.g. Robert G. Evans *et al., Private Highway, One Way Street: The DeKlein and Fall of Canadian Medicare?* (Vancouver: University of British Columbia Centre for Health Services and Policy Research, 2000).

One result of the amendments to the IHF legislation has been that the ability and the temptation to redefine and narrow what services are "medically necessary" (and therefore covered by the provincial health insurance plan and subject to a ban on extra billing) are increased. Independent health facilities, licensed by the Ministry and subject to a statutorily mandated quality assurance program operated by the College of Physicians and Surgeons of Ontario, are explicitly envisaged as providing both uninsured and insured services. The government intends to increase the use of for-profit firms, expand the services they can provide, and continue delisting services from public health insurance.[29]

Governments' willingness to accept a troubling development illustrates one way in which this is occurring. The *Canada Health Act* provides that provincial health insurance plans must meet certain conditions in order for provinces to qualify for full federal cash transfers, including a requirement that they be comprehensive, i.e. that they insure medically necessary physician and hospital services. However, some patients are referred for diagnostic services such as MRIs on the somewhat perverse basis that the service is *not* medically necessary, and therefore can be paid for privately and provided immediately, outside the publicly funded system. The practice is justified on the basis that patients do not need the service (at least, not yet). The non-specificity of many patient complaints can make the need for and timing of this type of diagnostic test a judgment call, supporting the argument that payment for the diagnostic tests by the person concerned or a third party does not breach *Canada Health Act* requirements.[30] Patients clearly in need of diagnostic services too often recount obtaining them outside the publicly funded system and paying for them as medically *un*necessary in order to avoid dangerously long delays.[31] Meanwhile, provided they can afford it, people not in need of diagnostic services (sometimes referred to as the "worried well") can obtain and pay for these

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[29] Relative to de-listing services, see Gilmour, *supra* note 2 at 279, 284; Carolyn Hughes Tuohy, *Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain and Canada* (New York: Oxford University Press, 1999).

[30] Commission on the Future of Health Care in Canada, *supra* note 1 at 64. Commissioner Romanow recommended that the *Canada Health Act* be amended to clarify that it does cover all diagnostic services reasonably required to assess a patient's need for medically necessary hospital and physician services. He pointed out that otherwise, those who can pay privately for testing will effectively be able to queue jump, because earlier diagnosis of need will result in earlier access to insured treatment. A recent study by the Institute for Clinical Evaluative Sciences noted that, because MRIs are used for "…a multitude of non-specific symptoms that could potentially suggest disease…[T]hese numerous presenting complaints and their non-specificity make it very difficult for physicians to determine the appropriateness of a test". Nor is there necessarily consensus among practitioners about the indications for an MRI. Because of gaps in data, the authors of the study could not analyze the appropriateness of MRI use, nor its impact on outcome either in absolute terms or in comparison with less expensive technology, see Karey Iron, Raymond Przybysz & Andreas Laupacis, *Access to MRI in Ontario: Addressing the Information Gap* (Toronto: Institute for Clinical Evaluative Sciences, 2003) at 3, 13.

[31] See e.g. Brian Laghi "Pay for MRI and jump the queue: Who will object?" *The Globe and Mail* (6 December 2002) A14-A15.

tests privately, even though in the publicly funded system, waiting lists of patients requiring the very same tests grow longer.

The Ontario government has announced that operators of the new MRI and CT scanners in IHFs will only have to commit to provide "40 hours MRI / 35 hours CT insured services per week, 6 days per week, 52 weeks of the year, between the hours of 7 am and 9 pm".[32] Uninsured services must be provided at the same site, with the same equipment.[33] Presumably, outside the hours that must be set aside to provide insured services, the operator can focus on more lucrative uninsured procedures. While increasing the diagnostic equipment available should ease some of the need for these services, it is hard to escape the conclusion that structured in this way, Ontario will normalize the practices of (i) preferring patients not covered under the *Canada Health Act*; (ii) providing unnecessary scans to individuals who do not need them; and/or (iii) intentionally or unintentionally performing some scans that are paid for privately, although they are in fact necessary medical services performed on insured persons.

The value of for-profit IHFs received an additional boost from the Ontario government in 2002. As part of another piece of omnibus legislation, the *Government Efficiency Act*, the *IHFA* was amended to remove all controls on the maximum allowable consideration for the goodwill value of an IHF licence.[34] Government employees writing in the early days of the *IHFA* explained that such controls were important because:

> The experience of the Ministry of Health had been that once a licensing and regulatory system was introduced, the value of these licensed facilities escalated and the license itself became a commodity…the Act is designed to attempt to prohibit the licence from becoming a commodity in itself.[35]

As a result of this about-face in policy, not only commodification, but uncontrolled valuation of licences will now be acceptable in Ontario. As indicated above, the government is aware that the cost of goodwill will increase significantly. Purchasers will look to recover their costs from those who pay for the services. That will include not only private citizens and insurance companies who pay for uninsured services

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[32] *PR November*, *supra* note 12.
[33] *Ibid*.
[34] *Government Efficiency Act*, S.O. 2002, c. 18, Sch. I., s. 12(1). I am grateful to Wendy Sutton for bringing this legislation to my attention. Previously, the maximum allowable consideration in relation to an IHF licence had been controlled by statute and regulation (see *IHFA, supra* note 11, s. 11(3); *Maximum Allowable Consideration,* O. Reg. 381/92, s. 2(1)).
[35] MacMillan & Barnes, *supra* note 19 at 64. Since the consideration paid was not otherwise controlled previously, parties to a transfer were already able to allocate the total consideration paid as they chose, and in that way circumvent controls on the value of goodwill. The amendment may only result in parties re-allocating the consideration paid; it may, however, mean that parties will now regard goodwill as an additional, newly valuable asset that will have to be paid for when transferred.

and fees, but also the government itself, which pays for publicly insured services and associated facility fees. With this change to the legislation, the government is ensuring it will be paying even more for those services.[36]

Alberta

Alberta also passed legislation, the *Health Care Protection Act,*[37] to regulate and expand the role of private health care facilities. Soon afterwards, the Premier's Advisory Council on Health in its 2001 Report, *A Framework for Reform* (the Mazankowski Report), recommended that the health system be reconfigured to encourage increased choice and competition, and that government "seriously look" at expanding the role of the private sector in delivering insured health services.[38] The *HCPA* permits surgical services to be performed in public hospitals or "approved surgical facilities".[39] Although it explicitly prohibits private hospitals, on closer examination, the prohibition seems to be more form than substance.[40] A private hospital is defined as an acute care facility that provides emergency, diagnostic, surgical and medical services *and* admits patients for medically supervised stays greater than twelve hours.[41] The combination of this long list of requirements, taken together with the broad authority granted the College of Physicians and Surgeons of Alberta to approve performance of an extensive list of surgical procedures at surgical facilities, arguably makes the difference between the two a matter of semantics.[42] The distinction is further blurred because the legislation empowers the College of Physicians and Surgeons to permit surgical facilities to perform surgical procedures requiring post-operative care for longer than twelve hours.[43] The College is reported to have approved at least one such facility to perform operations that require overnight stays.[44]

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[36] The *IHFA*, *supra* note 11, s. 24(2) already authorizes the Minister to pay all or part of the operating or capital costs of an IHF.
[37] R.S.A. 2000, c. H-1 [*HCPA*].
[38] Alberta, Premier's Advisory Council on Health, *supra* note 8 at 25.
[39] *HCPA, supra* note 37, s. 2(1). Surgical facilities are facilities "whose primary function is to provide a limited range of surgical services"; see *HCPA* (*ibid.,* s. 29(q)).
[40] *Ibid*., s. 1.
[41] *Ibid.,* s. 29(m).
[42] Timothy Caulfield, Colleen Flood, & Barbara von Tigerstrom, "Comment: Bill 11, Health Care Protection Act" (2000) 9 Health L. Rev. 22 at 22. While the statute limits performance of major surgical services to hospitals, it delegates authority to determine what constitutes a major surgical service to the provincial College of Physicians and Surgeons; see *HCPA*, *ibid.,* s. 2(2). The CPSA bylaws define "major surgical services" generally in terms of risk level and the patient's condition, then specify diagnostic and surgical procedures that may be approved for facilities,see CPSA Bylaws, *supra* note 7, s. 45(1)-(3).
[43] CPSA Bylaws, *ibid.*, s. 45(4.1).
[44] The Health Resource Centre of Calgary, a private, for-profit medical centre, has received College approval to perform procedures requiring overnight stays, including joint replacements, spinal fusions and spinal laminectomies. Its operators expect the majority of patients will be drawn from populations not receiving insured services, such as members of the armed forces, people referred by workers compensation authorities, and foreigners; see Brian Laghi & Dawn Walton "Private clinic to do major surgery" *The Globe and Mail* (14 September 2002) A4.

The College of Physicians and Surgeons of Alberta has been assigned the task of accrediting surgical facilities to provide specified services. It also accredits diagnostic and treatment facilities to provide specific medical services that do not require admission to a hospital, but may not be performed in a general medical office (for example, diagnostic imaging services, dialysis and pulmonary function testing).[45] The services themselves can be insured or uninsured, subject to certain conditions. In order to provide insured surgical services, the facility operator must have a Ministry-approved agreement with a regional health authority.[46] The Minister is not to approve an agreement unless, *inter alia*, it is consistent with the principles of the *Canada Health Act*, would not adversely impact the province's publicly funded and administered health system, is expected to benefit the public (in terms of access, flexibility, cost effectiveness and other listed factors), and addresses monitoring of conflicts of interest and "other ethical issues".[47] A privative clause ensures there is little scope for challenging ministerial judgments about whether these criteria have been satisfied.[48]

Patients are not to be charged extra fees for or in connection with insured services, whether they are treated in a surgical facility or a hospital.[49] However, patients can be charged additional amounts for "enhanced medical goods and services", and these can be sold to the patient in combination with or separately from insured medical services. They are defined as: "…medical goods or services that exceed what would normally be used in a particular case in accordance with generally accepted medical practice"[50]

Rates for such enhanced services are not to exceed "…cost plus a reasonable allowance for administration", and regulations can be made defining both whether something *is* a medical good, and whether it is an *enhanced* medical good or service.[51] Practitioners have enormous discretion in decisions about the advisability of enhanced medical goods and services, as well as enormous influence over patient decisions. Despite legislative requirements respecting informed consent and dis-

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[45] CPSA Bylaws, *supra* note 7, s. 45(2).

[46] *HCPA*, *supra* note 37, ss. 7, 8. Surgical facilities must be designated by the Minister to provide uninsured surgical services. Factors to be considered include impact on the publicly funded system, the public interest, and compliance with the *Canada Health Act* (*ibid.,* s. 15).

[47] *Ibid.,* s. 8.

[48] *Ibid.,* s. 23; ministerial decisions are final and conclusive, and subject to judicial review only for jurisdictional error or patent unreasonableness. *Toronto Birth Centre v. Minister of Health* (1996), 92 O.A.C. 74 (Div. Ct.), illustrates the difficulty in challenging ministerial decisions about free-standing health facilities. The court simply accepted the Minister's assertions that he had considered the statutory factors and ended the licensing process for a free-standing birth centre on the grounds of fiscal responsibility, despite the applicant's evidence that there was no factual basis for that conclusion. But see *Ottawa Carleton Dialysis Services*, *supra* note 24, where the Minister's statement was not accepted as dispositive.

[49] *HCPA, ibid.*, s. 4.

[50] *Ibid.*, s. 29(f).

[51] *Ibid.,* ss. 5, 25(1).

closure,[52] the potential for serious conflicts of interest, breaches of the *Canada Health Act*, undue pressure and intentional or unintentional coercion of patients to purchase enhanced services is clear. Patients may struggle to pay more if they possibly can, perhaps in hopes of obtaining quicker access to insured services, even though queue jumping is prohibited[53] or seeking better health results. The nature of much illness and health care is such that significant information asymmetries often exist between patients and providers, making it difficult for a lay person to assess provider recommendations and leaving patients vulnerable to provider suggestions and influence.

British Columbia

The College of Physicians and Surgeons of British Columbia, in accordance with Rules made under the *Medical Practitioners Act*, is charged with approving independent health facilities and the procedures they may perform.[54] "Facility" is defined as a non-hospital facility in which medical or surgical procedures that require special resources or that constitute a special risk are performed.[55] A committee of the College approves the list of procedures both generally and for the particular facility.[56] Physicians cannot practise at facilities that do not have a certificate of approval.[57] Independent health facilities provide insured health services under contract with regional health boards. They can also provide services that are uninsured. Procedures requiring overnight stays are permitted if the procedure is approved by the College; at present, it limits stays to 23 1/2 hours, pending government consideration of the issue of extended stays, i.e. those of longer duration.[58]

While the Rules made under the *Medical Practitioners Act* allow independent health facilities to charge facility fees,[59] the *Medicare Protection Act*[60] and the *Medical and Health Care Services Regulation*[61] regulate the matters for which health practitioners can bill. Patients cannot be charged for insured benefits, or for materials, consultations, procedures, use of an office or clinic or other matters that

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[52] *Ibid.,* s. 5(3).
[53] *Ibid*., s. 3.
[54] College of Physicians and Surgeons of British Columbia, Rules made under the *Medical Practitioners Act*, R.S.B.C. 1996, c. 285, online: College of Physicians & Surgeons of British Columbia <http://www.cpsbc.ca/policymanual/rules/index.htm> [*Rules*]. See Parts XV and XVI for sections relative to surgical facilities and diagnostic services and facilities.
[55] *Ibid*., ss. 102, 199.
[56] *Ibid.,* ss. 103, 107, 110. Acceptable risk levels are delineated in s. 110.
[57] *Ibid.,* s. 104.
[58] Personal communications with Dr. Harrigan and Dr. Rebbeck, College of Physicians and Surgeons of British Columbia (11 June 2002 and 5 May 2003).
[59] *Supra* note 54, s. 118.
[60] R.S.B.C. 1996, c. 286.
[61] B.C. Reg. 426/97.

relate to the rendering of a benefit.[62] Patients can be charged directly for services that are not "benefits" (i.e. not insured) or ancillary to the provision of a benefit, and also for

> … the cost to a practitioner of therapeutic drugs, appliances, implants, materials or dental laboratory services if
> (a) these are related to a benefit but are not themselves benefits; and
> (b) the commission or special committee determines the individual cost of these items is significant in comparison to the fee payable for the related benefit.[63]

Health Canada is reportedly investigating a number of suspected violations of the *Canada Health Act* in British Columbia involving private clinics, including patient charges for medically necessary MRI scans, privately purchased insured health services under the guise of third-party payment, and a specialist referral service that arranges quick consultations with specialists on payment of a fee that is greater than that paid by the provincial health insurance plan.[64]

Saskatchewan

Free-standing health facilities in Saskatchewan are governed by the *Health Facilities Licensing Act*,[65] regulations and By-laws of the College of Physicians and Surgeons of Saskatchewan. Health facilities are defined as any place where "a diagnostic or therapeutic medical procedure is provided", other than those operated by government or district health boards, or exempted.[66] However, no non-hospital surgical or MRI/CT facilities operate at present.[67] While diagnostic services such as bone density scans are provided in clinics, they are not considered to fall within the purview of the College's By-laws on health facilities.[68] The *HFLA* was passed

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[62] *Medicare Protection Act*, *supra* note 60, s. 17(1). The Medical Services Commission determines whether a service is a "benefit" and whether a matter "relates to the rendering of a benefit" (*ibid.,* s. 5).

[63] *Medical and Health Care Services Regulation*, *supra* note 61, s. 30.

[64] Lisa Priest "List reveals provinces violated health act" *The Globe and Mail* (13 December 2002) A1, A14. In "Code Blue", a Promotional Feature extolling the opportunities for and success of entrepreneurs providing private health care in British Columbia that appeared in BC Business (August 2002), reference is made to a specialist referral clinic that will arrange appointments with specialists at a cost "in the $325 range". The article appears opposite an advertisement for a specialist referral service offering "guaranteed quick access to BC's top specialists" with no referral required.

[65] S.S. 1996, c. H-0.02 [HFLA].

[66] *Ibid.*, s. 2(1)(i).

[67] Personal communications with Brian Salte, Associate Registrar, College of Physicians and Surgeons of Saskatchewan (11 June 2002 and 16 May 2003) [Salte Communication].

[68] Salte Communication, *ibid.* Health Canada is reportedly investigating a Saskatchewan physician's practice of charging patients at a bone density clinic user fees (styled as mandatory donations to a Bone Research Foundation), see Priest, *supra* note 64 at A14. The physician involved was also reported to be subject to investigation by the College of Physicians and Surgeons regarding the same matter; see Deana Driver "$95 'donation' expedites Sask. patients' bone density tests" Medical Post (14 May 2002) 67. However, after investigation, the College concluded there was no basis to proceed further (Salte Communication (16 May 2003) *ibid.*).

in 1996 to prohibit the practice of private surgical clinics billing the government for insured services while charging patients additional facility fees.[69] Under the *HFL*A private health facilities must obtain a licence from the province, and are prohibited from charging patients additional fees for insured services.[70] The Regulations establish a health facility accreditation program operated by the College.[71] It has broad discretion to approve the surgical procedures that are allowed. Procedures requiring overnight stays may be approved.[72] Factors the Minister is to consider in deciding whether to issue a licence are similar to those that Alberta requires the Minister to take into account before approving a health authority's agreement with a facility operator – need, effective and efficient use of public resources, lack of prejudice to the public interest, compliance with the *Canada Health Act* and other statutes.[73] Thus, in common with all the provinces reviewed, the *HFL*A stablishes a framework for private health facilities to enter into agreements with the Minister or district health boards to provide insured services.[74] However, unlike Ontario, Saskatchewan still requires the Minister to consult with the relevant district health board on the question of need for the facility before granting a licence, and prohibits transfers of licences.[75]

As noted above, health facilities are defined as places where diagnostic or therapeutic medical procedures are performed that are not operated by government or a district health board or exempted. The *Act* in turn defines "diagnostic or therapeutic medical procedure" as "an insured health service that was primarily provided in a hospital" prior to 1996, or that became an insured health service after 1996.[76] In an interesting departure, "insured health service" is defined to include services covered under the provincial health insurance plan, as well as MRI's and CT scans.[77]

The Saskatchewan Commission on Medicare, which recently undertook a major review of the province's health care system, did not address the subject of independent health facilities separately in its Report, *Caring for Medicare: Sustaining a Quality System*.[78] However, if some of its recommendations to close or

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[69] *Supra* note 65. See generally Kay Willson & Jennifer Howard "Missing Links: The Effects of Health Care Privatization on Women in Manitoba and Saskatchewan" in Pat Armstrong *et al.*, eds., *Exposing Privatization*: *Women and Health Care Reform in Canada* (Aurora: Garamond Press, 2001) 227.
[70] *Ibid.,* ss. 3, 12(3).
[71] Health Facilities Licensing Regulations, S. Reg. 38/1999; College of Physicians and Surgeons of Saskatchewan, By-law, The Bylaws pursuant to the *Medical Profession Act, 1981*, s. 42(5), online: The College of Physicians and Surgeons of Saskatchewan <http://www.quadrant.net/cpss/bylaws.html>.
[72] Salte Communication, *supra* note 67.
[73] *Supra* note 65, s. 7.
[74] *Ibid.,* s. 18.
[75] *Ibid.,* ss. 6(1), (3), 10.
[76] *Ibid.,* s. 2(1).
[77] *Ibid*.
[78] Saskatchewan, Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (Regina: Commission on Medicare, 2001) (Kenneth Fyke, Commissioner) [*Fyke Report*], online: Commission on Medicare <www.health.gov.sk.ca/info_center_pub_commission_on_medicare-bw.pdf>.

convert rural hospitals are adopted, free-standing health facilities may appear in their stead.

Manitoba

During the 1990s, a number of physicians practising in clinics in Manitoba received fees from the province for providing insured services, and charged patients an additional facility fee. Health Canada considered this to be a violation of the *Canada Health Act* and penalized Manitoba for allowing extra-billing.[79] In response, the province amended its *Health Services Insurance Act*[80] in 1999 to prohibit charging patients facility fees for or in connection with insured services. In 2001, a private surgical clinic opened in Winnipeg over the objection of the provincial Minister of Health. While the Minister conceded he could not prevent it from performing day surgery, this development precipitated passage of the *Health Services Insurance Amendment and Consequential Amendments Act*.[81] It amended provincial health insurance legislation to prohibit overnight stays in surgical facilities (i.e. more extensive procedures, with higher risk).[82] Seemingly out of an abundance of caution, the definition of "private hospital" was also broadened to include facilities caring for one or more patients, the licence category for "surgical" private hospitals was eliminated, and surgical services in private hospitals were explicitly prohibited.[83] The legislation also closed off a "third party billing" loophole.[84] Unlike many provinces, then, when faced with initiatives to expand private for-profit care, Manitoba legislated to narrow private clinics' permissible scope of operations.

Nonetheless, this legislation, too, recognizes that private clinics can have a place in the provision of insured services; operators of free-standing health facilities that perform insured out-patient services pursuant to an agreement with the Minister are entitled to government reimbursement.[85] The *Health Services Insurance Act* regulates agreements for the provision of insured services between surgical facilities and the Minister. The Minister is not to enter into an agreement unless the facility has been accredited, provision of insured services would comply with the *Canada Health Act*, and "…the agreement will serve the public interest".[86] The provincial College of Physicians and Surgeons governs the accreditation process for surgical facilities under a By-law, and determines the procedures that may be

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[79] Willson & Howard, *supra* note 69.
[80] C.C.S.M. c. H35.
[81] S.M. 2001, c. 21.
[82] *Ibid.,* s. 64.2(1). See David Square, "Winnipeg clinic opens over minister's objections" (2001) 165(1) Can. Med. A. J. 74. The legislation specifically prohibits provision of a surgical service if it is anticipated the patient would require post-operative care after 11 p.m. that night.
[83] *Health Services Insurance Amendment and Consequential Amendments Act, ibid.,* s. 19.
[84] *Ibid.,* s. 3(2).
[85] *Ibid.,* s. 3(1).
[86] *Health Services Insurance Act, supra* note 80, s. 64.1(2).

performed.[87] Insured services in surgical facilities that have an agreement with the Minister are covered by public health insurance, subject to the patient's liability for "authorized charges".[88] Patients cannot be charged facility fees in connection with insured services.[89] Provided the facility is operated by a regional health authority or the operator has an agreement with the Minister, these will be paid by the government. Where there is no such agreement, patients are not to be charged in connection with insured services, nor can payment be accepted from them or third parties on their behalf.[90]

Legislative Environments and Free-Standing Health Facilities

Each of these provinces – Ontario, Alberta, British Columbia, Saskatchewan and Manitoba – has put in place a legislative framework that anticipates government and/or regional health authorities entering into agreements for the delivery of insured health services – i.e. publicly funded care – with operators of free-standing health care facilities that may be non-profit or for-profit.[91] Many of these facilities will also provide uninsured services. The legislation generally provides that patients (or others) are not to be charged facility fees for or in connection with insured services; rather, these fees are to be negotiated with and paid by the provincial government or regional health authority. However, as discussed above, a prohibition on additional charges may be difficult to enforce, particularly if the legislative regime is structured to be open to the possibility of patients paying additional costs, as with the ability to charge for "enhanced goods and services" in Alberta, or if determining what services are "medically necessary" is contentious.[92] Provincial Colleges of Physicians and Surgeons have been delegated much of the responsibility for setting accreditation requirements and practice standards as well as monitoring and quality assurance. On the whole, the regulatory frameworks tend to be sketchy and provide little detailed assurance as to the rigour with which monitoring and quality assurance activities in particular will be pursued. Neither the extent of governments' commitment in this regard nor the resources they will devote to ensure that proper regulation occurs or that regulatory bodies are adequately funded and supported to provide such oversight are clear.

Decision-making about the services clinics can provide has most commonly been delegated to the self-governing body for physicians (and sometimes that of

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[87] College of Physicians and Surgeons of Manitoba, By-law, *Non-hospital medical/surgical facilities*, made pursuant to the *Medical Act*, R.S.M. 1987, c. M90, No. 3D, s. 40(2).
[88] *Supra* note 80, s. 46(1). "Authorized charges" are those the regulations permit to be made directly for hospital or medical services, personal care and other services under the health plan. See also s.113(1).
[89] *Ibid.,* s. 48.
[90] *Ibid.,* s. 48(4), reinforced by the *Surgical Facilities Regulation*, Man. Reg. 222/98 as am. by Man. Reg. 124/2001.
[91] See also the *Health Authorities Act*, R.S.B.C. 1996, c. 180, ss. 5(1)(d), 7(1)(b)(ii) (powers of boards and councils).
[92] See *supra* notes 42, 64.

other health professionals such as dentists). The lists of approved procedures continue to expand, and in some provinces, include the possibility of procedures requiring overnight stays. Governments retain a gatekeeping role by conditioning entitlement to payment for insured services on a prior agreement between the facility operator and the ministry of health, or between the operator and a regional health authority that has received government approval.[93] Alternatively, the Minister of Health may retain power to determine what services such facilities can provide.[94] Typically, the statutes direct the Minister to consider whether licensing or entering into an agreement with a facility to provide insured services will adversely affect the publicly administered health system. Some statutes require that the minister make decisions about health facilities in the public interest or for the benefit of the public.

In sum, the legal frameworks in these provinces allow and in some instances, promote increasing reliance on free-standing health facilities to deliver certain types of patient care. Charging patients facility fees for insured services is prohibited, as are extra billing and user charges for services covered by public health insurance. Enforcing those prohibitions may be difficult, particularly when "enhanced" services or their equivalent are anticipated. Governments have retained power to assess the impact of free-standing health facilities on the health care system. However, government judgments about the impact on and overall direction of the system are likely to be consistent with its underlying ideological views as to the role of the state and its responsibility for the social welfare of citizens. The alacrity with which some governments are moving to expand the role of private for-profit delivery of health care makes it essential to assess claims that doing so will genuinely relieve pressures on the publicly funded system and result in better care for patients, and to evaluate concerns raised.

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[93] See e.g., *HCPA*, *supra* note 37, s. 8(3); In Alberta, the Minister must conclude *inter alia* that the provision of insured surgical services by a clinic would not have "an adverse impact on the publicly funded and publicly administered health system", and that there is an "expected public benefit" in terms of access, quality, flexibility, efficient use of existing capacity, and "cost effectiveness and other economic considerations". In Manitoba, the minister is not to enter into an agreement with a facility to provide insured services unless "the agreement will serve the public interest"; see *Health Services Insurance Amendment and Consequential Amendments Act, supra* note 81. In Saskatchewan, the minister may issue or renew a licence if there is a need for the services to be provided at the facility or in the health district, if licensing the facility would be "an effective and efficient use of public resources", and issuing the licence "would not be prejudicial to the pubic interest"; see *Health Facilities Licensing Act*, *supra* note 65, s. 7(2). British Columbia's *Health Authorities Act*, *supra* note 91, s. 3(3), does provide that when setting provincial standards for health services and specifying services that must be provided in a region or community, the minister must ensure that "…health services in British Columbia continue to be provided on a predominantly not for profit basis".

[94] As in Ontario, see *IHFA*, *supra* note 11, ss. 4, 5. Ontario shed its legislative directive favouring non-profit independent health facilities with the coming of the Conservative government in 1996; see *supra* notes 23-24, and accompanying text. In deciding whether to authorize a Request for Proposals, the Minister is to consider the need and availability of the service, its nature, and the cost and availability of public money to pay for the facility. It may consult with stakeholder groups (often, the governing body of the profession and professional associations) (*IHFA*, *ibid.,* s. 9).

Why Is For-Profit Delivery of Publicly Funded Health Care A Concern?

Advances in technological capabilities in the health sciences as well as increasing fiscal constraints and the rise of neo-conservatism have contributed to the growth of both independent health facilities and a political climate favourable to that development. The legal frameworks not only regularize the place of private clinics in the health care system, but in significant ways, normalize the presence of for-profit businesses in providing publicly funded health care as well as uninsured health services. What is this new model for health care delivery supposed to achieve? Why is for profit health care a concern?

In promoting private for-profit delivery of publicly funded health care, governments typically rely on two main justifications. First, they assert that the private sector is more efficient, and so can provide care more cheaply, thus benefiting the public. Second, they argue that with competition and choice, care will improve in all sectors, again to the benefit of the public as a whole. Private for-profit care is presented as better for the health and wealth of the public. There is little Canadian experience with such initiatives, and consequently, limited evidence on which to evaluate these claims in the context of the Canadian health care system.

Relative to the first claim – that for-profit health care will be less costly – the Provincial Auditor of Ontario recently examined one experience with for-profit publicly funded care in that province. Cancer Care Ontario (CCO), a non-profit agency established in 1997 to integrate cancer services throughout the province, in an effort to stop the practice of sending patients faced with dangerously long waiting lists for radiation treatment to distant centres or out of the country, proposed to the provincial government that it contract with providers of radiation services to treat patients at regional cancer centres after hours. It proposed payment to these service providers based on cost plus a bonus for the number of cases treated. The government agreed, and the private clinic, headed by a former CCO Executive Vice-President, began operating in early 2001. As a result of questions in the legislature, the Standing Committee on Public Accounts passed a motion requesting the Provincial Auditor to conduct a "… value- for- money audit of the policy decision by Cancer Care Ontario to provide after-hours radiation therapy through a private clinic rather than in-house".[95]

The Auditor's Report was submitted at the end of 2001. Not surprisingly, it concluded that it was certainly less expensive to treat patients at the after-hours

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[95] Ontario, Office of the Provincial Auditor of Ontario, *Special Audit for the Standing Committee on Public Accounts: Cancer Care Ontario* (Toronto, Office of the Provincial Auditor of Ontario, 2001) at 1 [*Cancer Care Ontario*]. See also Deber, *supra* note 5 at 37-38. Although the contract to operate the private clinic was renewed once, CCO recently decided to close the clinic – Theresa Boyle "$70 million boost for Ontario cancer care" *Toronto Star* (11 February 2003) A8; Theresa Boyle "In Ontario, they call it private health by stealth" *Toronto Star* (12 April 2003) E1, E4.

clinic than in the United States. However, it also concluded that treatment in the private after-hours facility was more expensive than care in the publicly funded regional cancer centres, and that there was little evidence the public body, CCO, had "… considered all reasonable options for providing these services itself" before proposing the private clinic.[96] Further, while patients were no longer being sent out of country, there had been no significant change in overall waiting times for treatment, and waiting times at the regional centres and the private clinic were approximately the same.[97] The Auditor concluded that, "… by not following an open competitive process in selecting the private operator of the after-hours clinic, CCO did not ensure that it was receiving the best value for the funds expended".[98] CCO was also criticized for its failure to avoid the appearance of conflict of interest inherent in allowing its Vice-President to remain in its employ until after it awarded the contract to the organization he headed.[99] Additionally, CCO's decision to grant the operator of the private clinic a right of first refusal for any future private radiation clinics at other regional cancer centres on the same terms and conditions meant it could not pursue more cost-effective options for delivering radiation treatment.[100] Finally, the Auditor observed that the agreement's provision for quality review by CCO had not been implemented, although CCO indicated it planned to do so. Thus, in one of the few Canadian ventures into for-profit publicly funded health care that has been subject to public scrutiny, government's argument that for-profit health care can deliver services more cheaply was not borne out.

Some general points about cost control must be kept in mind as well. First, shifting costs from government to other payers does not control health care costs overall. Private clinics that can provide uninsured services and government moves to delist services from the public health insurance plan will reduce state responsibility to fund or provide some types of services and equipment.[101] Allowing private clinics will also reduce the political cost of not providing these services through the publicly funded system. However, to the extent people still obtain and pay for those services themselves or through private health insurance, total costs are not reduced, but simply passed on to others.[102] Directly or indirectly, the public still pays. To take the example discussed previously, when private payment is permitted for a "medically unnecessary" MRI, and timeliness of access is accepted as the factor making the service "unnecessary", many patients (or third party payors) will still pay to receive the service, and will likely pay more than the public health insurance

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[96] *Cancer Care Ontario, ibid.* at 2, 8-9.
[97] *Ibid.* at 9.
[98] *Ibid.* at 4.
[99] *Ibid.* at 7.
[100] *Ibid*.
[101] Although, as Carolyn Tuohy points out, delisting has saved provincial governments very little money – target savings through delisting were only "2% or less of the…provincial governments' expenditures on physician services"; see *supra* note 33 at 220.
[102] Robert G. Evans, "Tension, Compression and Shear: Direction, Stresses and Outcomes of Health Care Cost Control" (1990) 15(1) J. Health Pol. Pol'y & L. 101.

plan would have reimbursed the provider.[103] Total costs for health care are not reduced, and may in fact increase. Secondly, investors in such facilities expect a return on their investment, resulting in an additional cost. Third, as health economist Robert Evans points out, the only demonstrably successful approach to cost control in health care has been "monopsonistic control of the payment process" – i.e. a single payer system.[104] Encouraging increased provision of uninsured services as well as parallel provision of insured services in private clinics will increase the number of "health administrations" to support financially, while at the same time, the (now multiple) payers' ability to control costs through bargaining will decrease. Some of the costs of supporting those additional administrations, paying profits, and the higher prices likely to be negotiated for health services in the private system, will work their way back into the fees and other monies private clinics receive from governments for providing insured services.

Governments' second argument to justify increasing the role for private for-profit clinics in providing publicly funded care is that the care itself will be better. Again, apart from individual professionals or small groups of practitioners (the "not only for profit firms"), there is little Canadian experience on which to evaluate such a claim. However, in two recent studies, researchers conducted systematic reviews of earlier studies of private for-profit and private not-for-profit American hospitals and dialysis clinics.[105] Dialysis is paid for by the government in the United States, so the service itself is publicly funded regardless of whether service delivery is in a for-profit or non-profit facility. Because the team of researchers was largely Canadian, the studies were conducted with a view to informing the current debate among Canadian health policy-makers about whether private for-profit health care delivery should be expanded in this country. For-profit and non-profit providers were compared to determine the respective risks of patient mortality. In each study, private for-profit ownership of the hospitals and dialysis centres was associated with a statistically significant higher risk of mortality for patients. The authors suggest that for-profit facilities employed fewer highly skilled personnel, and in the dialysis clinics, patients received shorter durations of dialysis treatment. Since wages are such a high portion of a facility's costs, the tendency to control that expense by employing less costly, less skilled personnel is exacerbated by the business imperative that the enterprise return a profit.[106] Other studies on quality and outcome of care in American for-profit facilities reach similar conclu-

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[103] Romanow Report, *supra* note 1 at 64, points out a secondary effect if privately paid testing reveals a condition requiring treatment, which will in turn be accessed sooner because the need was diagnosed earlier. If diagnostic services can be purchased privately, "then initial access is being determined by ability to pay rather than need".

[104] *Supra* note 102.

[105] P.J. Devereaux *et al.*, "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals" (2002) 166 Can. Med. A. J. 1399; P.J. Devereaux *et al.*, "Comparison of mortality between private for-profit and private not-for-profit hemodialysis centers: A systematic review and meta-analysis" (2002) 288(19) J. Am. Med. A. 2449.

[106] Devereaux, "A systematic review", *ibid.* at 1405 ; Devereaux, "Comparison of mortality", *ibid.* at 2456.

sions. For instance, researchers concluded after an extensive review that patients treated with dialysis at for-profit facilities in the United States had both higher mortality rates and lower rates of placement on waiting lists for transplant, suggestive of a "more aggressive" response to incentives to economize in the former instance, and to maintain the income stream associated with dialysis in the latter.[107] There have been similar unfavourable comparisons between American investor-owned health maintenance organizations and non-profit HMOs.[108] Since the regulatory and insurance environments differ between the two countries, it cannot simply be assumed that American results will be replicated in this country. However, incentives to economize and maximize profits will characterize for-profit facilities here as well, even when services and facility fees are being paid with public dollars.

Many of the undesirable effects on patient care associated with for-profit private clinics offering parallel care to that in public hospitals and/or uninsured services have been catalogued and analyzed elsewhere.[109] Briefly, private clinics can "cream skim" both more lucrative procedures and lower cost, less complicated patients. Physicians may devote more time to higher paid for-profit work, reducing their availability to work in non-profit settings such as public hospitals providing insured services. Private care can drain resources from the public system in less obvious ways as well, for instance when skilled personnel, often already in short supply in the non-profit sector, are lured to more lucrative jobs in for-profit clinics.[110] Nor do private clinics improve waiting times in the public system. The Romanow Report concluded that private facilities "may improve waiting times for the select few who can afford to jump the queue, but actually make the system worse for other patients because much-needed resources are diverted from the public system to private facilities".[111] Opportunities for extra charges and sales of "enhanced" or inappropriate services and products can taint the fiduciary nature of the physician/patient relationship and subject patients to improper pressure.

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[107] Pushkal P. Garg *et al.,* "Effect of the Ownership of Dialysis Facilities on Patients' Survival and Referral for Transplantation" (1999) 341(22) New Engl. J. Med. 1653.
[108] See e.g. David U. Himmelstein *et al.,* "Quality of Care in Investor-Owned vs. Not-for-Profit HMOs" (1999) 282(2) J. Am. Med. A. 159.
[109] See e.g. Evans *et al., supra* note 28; Gordon Guyatt, "Laser Eye Surgery: A Disturbing Model for Private Health Care Delivery" (2001) 34(3) Ann. R.l Coll. Phys. & Surg. Can. 157; Wendy Armstrong, *Canada's Canary in the Mine Shaft: The Consumer's Experience with Cataract Surgery and Private Clinics in Alberta* (Edmonton: Alberta Chapter, Consumers Association of Canada, 2000), online: Edmonton Community Network <http://www.ecn.ab.ca/consumer/CanaryS.htm>; Carolyn De Coster *et al., Waiting Times for Surgery in Manitoba* (Winnipeg: Manitoba Centre for Health Policy and Evaluation, 1998).
[110] Ann Graham Walker "Disputed private MRI clinic opens in Halifax" *The Medical Post* (27 August 2002) 47. When a private MRI clinic opened in Halifax, it was widely reported that it had lured skilled technologists away from employment at a public hospital in the city. In Ontario, the Ontario Hospital Association has expressed its concern about the impact of new MRIs and CT scanners in IHFs on hospital human resources; see Ontario Hospital Association, "Media Release/Bulletin" (15 November 2002), online: Ontario Hospital Association <http://www.oha.com/oha/MEDIA>.
[111] *Supra* note 1 at 139.

Independent health facilities have a place in health care – that is apparent from changing technological capabilities and financial constraints. However, entrepreneurial health care, with neither effective oversight nor effective and proactive enforcement of professional obligations, is likely to promote business interests over patient interests.[112] The two will not always conflict, but what is good for one – the business – is not necessarily good for the other – patients and the health care system. Health Canada is investigating a number of suspected violations of the *Canada Health Act* based on user fees and extra billing in private for-profit clinics.[113] The Romanow Commission concluded that allowing patients or third parties to pay privately for quick access to advanced diagnostic services results in initial access to publicly insured care "being determined by ability to pay rather than need".[114] The federal Office of the Auditor General recently concluded that Health Canada still does not have adequate information to assess whether provinces and territories are complying with the *Canada Health Act.*[115] The investigations Health Canada does conduct focus on user charges and extra billing, not on whether provinces are complying with the statutory criteria – i.e. that a province's health insurance plan be universal, accessible, comprehensive, portable and publicly administered.[116] Nor does Health Canada pursue suspected non-compliance vigorously, in part because it is concerned provinces will simply choose to absorb the cost of penalties imposed.[117] This is not an environment in which policies and laws encouraging for-profit private clinics to assume a greater role in the delivery of health care bode well for the future of the publicly funded system.

Health care is not a business like any other. Nor should the regulatory environment encourage its organization on that model. Some provinces have resisted moves to facilitate for-profit care. Unfortunately, a number of provinces seem determined to opt for a for-profit approach before there is evidence to support it, and even in the face of evidence that for-profit care may be harmful to patients' health and publicly funded health care.

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[112] The process Ontario settled on to evaluate proposals to operate MRIs and CT scanners in IHFs may be a case in point. The Ontario Hospital Association wrote to the provincial Minister of Health expressing its concern that the assessment scale noted in the request for proposals allows for a maximum of 5 points for relevant experience, but a maximum of 80 points based on price, in its view "send[ing] a clear message…that lowest cost is significantly more important than quality"; see Letter from the Ontario Hospital Association to Minister Clement (4 December 2002), online: Ontario Hospital Association <http://caohat03.oha.com/oha/MEDIA.NSF/e52fde738168d3cd0525668000169ac4/91367a96fe799 33a85256c870074b586/$FILE/LettertoMinisterClementReMRIandCTIndependentHealthFacilityRF Ps.pdf>.

[113] Canada, Office of the Auditor General of Canada, "Health Canada: Federal Support of Health Care Delivery" in *2002 Status Report* at ch. 3, online: Office of the Auditor General of Canada <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20020903ce.html>; Priest, *supra* note 64.

[114] *Supra* note 1 at 64.

[115] Office of the Auditor General of Canada, *supra* note 113.

[116] *Ibid.* at 7, 10.

[117] *Ibid.* at 9, 10-12.