For-Profit Provision of Medical Services: The Case of Newfoundland and Labrador

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Since the 1980s, a cacophony of voices on the political right have heralded the call for privatizing certain features of Canada's health systems. These politicians, academics, researchers and businesspeople have argued that the publicly funded and administered health systems are inefficient, fail to provide necessary medical services to patients in a timely fashion, deny choices to patients seeking the most modern treatments and drug therapies and entrench the power of key bureaucrats and stakeholders in dictating how and what decisions will be made. Champions of privatization such as former Ontario Premier Mike Harris, Alberta Premier Ralph Klein, former Reform Party leader Preston Manning and the board of directors of the Fraser Institute argue that changes to the health systems will allow Canadians to have faster access to better care at lower cost.[1] Yet, would such a goal be achieved through widespread privatization of health services? Would Canadians be better off with the choice of paying for medically necessary services if such a policy allowed for quicker service and greater efficiencies to the health system?

The clarion call for privatization has been met with harsh criticism from those on the left. For some Canadians, publicly funded and administered health care is viewed as part of the nation's core identity. Our health system guarantees that all persons, regardless of ability to pay, will have access to necessary health services at no cost. However, what many people do not realize is that the Canadian health system does have a substantial component that is private; approximately 31 percent of all health costs are borne by individuals and employers for such items as prescription drugs, physiotherapy and transportation costs[2]. Several items such as prescription drugs and dental care were never parts of the original Medicare bargain.

On June 9, 2005, the Supreme Court of Canada, in a 4-3 decision, ruled that the province of Québec could not prevent individuals from seeking medical services through private, for-profit medical clinics or in other venues. The Supreme Court based its ruling on section 7 of the Canadian Charter of Rights and Freedoms which upholds the right to life. The plaintiff in the case argued that having to wait months for a medical procedure constituted a threat to his life and the Supreme Court agreed; timely access to medical procedures must be preserved and if the marketplace can provide these more efficiently than the public sector, so be it. For those who are horrified at the prospect of a greater private role in the health systems of the country, one interpretation of the Court's ruling is to argue that our largely public system of medical delivery is in difficulty because it is not adequately meeting people's needs. The Court may have reasoned that if governments cannot provide necessary medical services to their own citizens in a reasonable manner, what harm could come from permitting for-profit concerns from filling the gaps? The

would continue to rely on the public health system to meet their needs. The desire by some in the population to allow for a larger private role in health care delivery is premised on the fact that the marketplace is more efficient than the public sector. Yet, would the marketplace respect or even acknowledge the medical needs of those who are

be classified as being informal and outside the bounds of legislatures and other institutions.

Privatization of Medical and Hospital Services in Newfoundland and Labrador

Privatization with respect to health care embodies the following characteristics:

- $ the transfer of service provision from public and non-profit to private and for-profit organizations;
- $ the transfer of responsibility for service payment to individuals;
- $ the transfer of care work from institutions to private households and communities;
- $ the transfer of care work from paid to unpaid workers;
- $ the adoption of for-profit management strategies for health care delivery and
- $ payment for health care services or the provision of health care services.[7]

In the 1990s, the province de-listed several medical services that were previously covered under the Provincial Medical Care Plan (MCP). Under the Medical Insurance Act, the province has the authority to control coverage for medical procedures that do not fall under the Canada Health Act such as prescription drugs, optometry, and some physician services.[8] For example, in 1988 the former Department of Health reduced the amount of eye care coverage under MCP when it went from providing a medical eye exam for patients every 12 months to every 24 months. In 1990, the government, responding to lobbying from optometrists and patients, brought back 12 month coverage for those under 18 years of age and those over the age of 64. However, this was changed again when the province de-listed vision care altogether from MCP. Beginning in 1991, the NLMA announced that it would begin to bill patients for services not covered under MCP but for which patients had not generally been charged in the past. These services included

- $ medical exams for employment or a driver's licence;
- $ medical advice over the phone;
- $ absent from work forms and
- $ the costs of dressings and bandages for casts and splints.[9]

MCP also operates a dental health plan (DHP) for children up to the age of 12 years. Services covered under the DHP include six month dental exams; cleanings every 12 months; fluoride applications every 12 months; x-rays and fillings and extractions. However, the costs of these services are not entirely paid for by the plan. Most dentists charge fees in excess of those paid by the government. Below is a list of services not covered by the Medical Care Insurance Act:

- $ medical advice provided to a patient over the phone;
- $ dispensation of drugs or medical appliances by a physician;

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[7] . Ingrid Botting, *Health Care Restructuring and Privatization from Women's Perspective in Newfoundland and Labrador*. St. John's: Coasts Under Stress Project, July, 2000, 8.
[8] . *Ibid*, 35.
[9] . *Ibid*, 35.

- the preparation of records, reports, certificates or letters;
- time and expenses in travelling to consult with a patient;
- ambulance services and other forms of transportation;
- cosmetic plastic surgery;
- acupuncture;
- testimony in court;
- visits to optometrists for new or replacement glasses;
- dental fees for routine extractions performed in hospital;
- medical exams for drivers;
- reversal of sterilization procedures;
- in vitro fertilization, and
- vaccinations for travel purposes.[10]

There has not been much debate in Newfoundland and Labrador on privatizing medical services or relocating services from hospitals to for profit centres or clinics. As early as 1986 in the Government's Green Paper on health care spending, both the Ministers of Finance and Health were of the view that privatization was not an option to reduce medical expenses. Historically, privatization has not played a major role in the health system in Newfoundland and Labrador and physicians have rarely extra-billed patients for services.[11] Since 1990, private, for profit clinics have been established to provide the following services:

- physiotherapy;
- laser eye surgery;
- chiropractic services;
- therapeutic massage services;
- cosmetic surgeries (hair removal, botox treatments)
- abortion services (Morgentaler clinic).

With the exception of physiotherapy and abortion, the above services are not covered under the Newfoundland Hospital Insurance Plan. Costs for physiotherapy are covered if a patient is referred to a hospital. However, wait lists can be as long as four months in St. John's and longer outside the metropolitan area. With respect to abortion services, a Morgentaler clinic has been in operation in St. John's since 1992. Abortion is covered by Medicare but patients are required to pay a facility fee at the clinic but not at a hospital.[12]

Services such as MRI and CAT scans are provided by the health system through hospital facilities. There are no private for profit clinics that provide these services.

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[10] . *Ibid*, 39.

[11] . Government of Newfoundland and Labrador. *A Green Paper on Our Health Care System Expenditures and Funding*. Jointly released by the Honourable J.F. Collins (Minister of Finance) and the Honourable Hugh Twomey, M.D. (Minister of Health). St. John's: Government of Newfoundland and Labrador, January 1986, 14.

[12] . Health Canada. *Health System Reform: Newfoundland*. Materials sent by John Lavis, n.d.

In sum, there has been little debate about privatization in Newfoundland and Labrador. People who use the private for profit clinics generally have all or a large portion of the costs paid for via supplemental health insurance through their employers. To my knowledge, no specific legislation has been introduced since 1990 explicitly calling for a privatization of hospital services such as MRI and CAT scans. In fact, in the Strategic Health Plan,

"The Government of Newfoundland and Labrador believes that the private purchase of the medically necessary services covered under Medicare will not result in an improved health care system in this province".[13]

With respect to physiotherapy, there has been an increase in the number of private physiotherapy clinics and an increase in the amount of money people are paying out of pocket for these services. Concerns over access to physiotherapy were first raised in the early 1980s when the Newfoundland and Labrador Branch of the Canadian Physiotherapists' Association presented a brief to the Royal Commission on Hospital and Nursing Home Costs. In the early 1980s, the majority of physiotherapists were employed in large urban centres or in hospitals. Only two physiotherapists were employed by Community Services. Government had instituted a hiring freeze at the same time and there was increasing pressure to perform more day surgeries, close hospital beds and integrate disabled children into the school system. All of these practices made access to physio services difficult especially in rural areas. As well, many physiotherapists have migrated to the private sector because wages are far higher than in the public health system ($65 per hour versus $23 per hour in the public system).[14]

One final issue focuses on user fees. Prior to the passage of the Canada Health Act in 1984, the province charged patients $5 per night for hospital stays. The fee was eliminated in 1984 but the Department of Health was opposed to this policy. Nonetheless, patients are required to pay user fees for a variety of services provided in hospital including ambulance costs, some crutches, extra x-rays from the lab department and photocopies of health records.[15] As well, some patients with employer or third-party medical coverage are sometimes required to pay a user fee for a semi-private or private room. The amount of money generated through user fees is staggering. As Botting notes, in 1997-98, the Health Care Corporation of St. John's was owed $4.6 million in unpaid user fees.[16]

Privatization of medical services has affected Workers' Compensation programs in Newfoundland and Labrador. These programs are exempt from the Canada Health Act

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[13] . Government of Newfoundland and Labrador, Department of Health and Community Services. *Healthier Together: A Strategic Health Plan for Newfoundland and Labrador*. St. John's: Office of the Queen's Printer, 2002, 26.

[14] . Botting, *op.cit*, 45.
[15] . *Ibid*, 50.
[16] . *Ibid*, 51.

meaning that provinces can require that workers' compensation insurance be administered on a non-profit basis or it can allow private for profit insurers to be responsible. Some provinces have passed legislation reducing benefit levels in order to force workers back to work more quickly.[17] Since 1984, the Newfoundland and Labr5890m4 Af-5(br)34e10

from the contracting out of hospital services would allow for the costs of restructuring to

- a focus on health outcomes;
- better emphasis on health promotion and disease prevention with individuals taking more responsibility for their own health;
- promoting a health system where evidence-based decision-making is the norm and specific clinical data is supported by a coordinated and integrated information technology system;
- a revised human resource plan to plan for the appropriate use of health providers, and
- increased emphasis on appropriate use of health services and drug therapies.[26]

The bottom line is that health care reform in Newfoundland and Labrador has been driven by two factors: financial concerns and the desire to create efficiencies in service delivery. However, it can be argued that the specific reforms produced by the above factors were not cast within a long term policy framework. Rather, many of the reforms were adopted at a time when the health care system was in crisis and specific groups of persons were demanding change. As well, the reaction of government was sometimes myopic in that substantive policy change was not initiated. In fact, in both the Tobin and Grimes governments, the province embarked on a process of extensive consultation with policy stakeholders, interest groups and community groups to devise ways of improving the health system. Little in the way of change has yet to be enacted based on these consultations. Was this merely an exercise in public relations or a legitimate attempt to address real concerns with respect to health care? Nonetheless, the province has been hurt by the deep cuts in federal transfer payments for health and social services spending and this has further made the reform process difficult. One factor that has not been present is ideology. There has not been an overt desire expressed by governments or citizens to wholeheartedly adopt neo-conservative and market driven solutions to health care delivery such as the case in Alberta and Ontario. There has not been a large scale attempt to privatize medical services such as MRI and CT Scans in Newfoundland and Labrador because of the small population and economies of scale.

Privatization of Medical and Hospital Services: the Government Agenda

The issue of privatizing and introducing for-profit medical and hospital services in Newfoundland and Labrador has dimly pierced the policy radar. Since the 1990s, no government has passed legislation, held public hearings or commissioned research to study this issue in a formal manner. Why, then, has the province not embraced the option of delivering health care through for-profit clinics and businesses? The main reasons include:

widespread poverty and regional economic disparity within the province;
no groups acting as policy champions;
province's political culture;
limited policy capacity of the provincial Department of Health and Community Services;
the lack of support among physicians for privatization of medical and hospital

[26] . Health Canada. *Health System Reform: Newfoundland*.

services, and
changes to fiscal federalism.

A significant driver for the lack of for-profit delivery of medical and hospital services in the province is the level of poverty in the province. Historically, Newfoundland and Labrador has the highest rates of unemployment, child poverty, illiteracy, obesity, diabetes and heart disease in the country. Levels of taxation are high, public services are typically minimal and the population is geographically dispersed. Even before Medicare arrived in Newfoundland and Labrador in 1968, few, if any, residents could afford to pay physicians for medical care: "the physician billings were always a challenge, so that - and, you know, we're talking early 1950's and prior to that - the poverty in this province really meant that any kind of private billing or private set-ups were anathema."[27] Only a tiny fraction of the population, located mainly in St. John's, could afford to pay for medical and hospital procedures out of pocket. This has severely limited the appeal of for-profit delivery in the province. As one informant noted,

"this is still a very poor province and we have probably a larger group of people with money than we used to in the 1950's; as you know, I was a member of the Royal Commission last year [the Royal Commission on Renewing and Strengthening our Place in Canada, 2003], and that Commission showed us in spades we're still the poorest province in the country. St. John's is wealthier, obviously, and has more people going to it; but outside St. John's - and I'm talking not far outside St. John's either - from there out, you have people struggling to survive, and you have people who are unemployed, under

Deputy [Minister] about (bringing in)? some private MRI, and he didn't rule it out but he never really pursued it because (he can't)?. They're [the government of the day] so preoccupied with ...(other stuff)?."[31] The Deputy Minister of the day confirmed that he had been approached about the possibility of allowing diagnostic services to be delivered via for-profit facilities:

"We had several approaches from private sector operators of MRI services and diagnostic imaging services generally. Some had local physicians involved. Others didn't. Some were local entrepreneurs without physician involvement. Some were entrepreneurs or well-established businesses from elsewhere in the world. They were basically pitching a

indicative of the lack of formal education for many Newfoundlanders until the province entered Confederation in 1949. Particular institutions have been privileged within Newfoundland's political culture. These include churches, families and communities as well as ethnic self-help and benevolence groups.

change with respect to health was the introduction of the Canada Health and Social Transfer by the federal government in 1994. The CHST reduced federal funding for health forcing provincial governments to scramble to make up the shortfall. An informant noted that “My sense of it [for-profit medicine] would be that it would have

The decision to undertake private-public partnerships allowed the Liberal government to construct long-term care facilities more quickly to accommodate need than waiting until

Labradorians have not been challenged on the issue of private, for-

1980s until 2000, noted “there are some very pragmatic issues here. You can't even get a private industry 20 miles outside of St. John's, let alone talk about private health care outside of St. John's. Just the economics from the privatizer side, apart from St. John's, would make it impossible here.”[50] Another informant noted “from a business perspective a company coming in to do business in Newfoundland in health care would be very difficult because we are, you know, a half a million people spread all over a huge land mass, so it's not like you can come to St. John's and get the bang for your buck right in this one core area and I would think that perhaps the business process unless they see a benefit to coming in and doing business, I can't imagine they would be able to cover their expenses.”[51]

A second explanation concerns public opinion and political acceptance of the status quo. The discussions about private, for-profit medicine in the province attract the ire of several key groups of opinion makers including physicians, health care unions, nurses, academics, and some politicians. Political leaders have had difficulty persuading the general public that it might be beneficial to the health system to allow market solutions to determine delivery of select servic

choice may still be to go with some form of private delivery as long as it can meet the other parameters of equity and efficiency."

'nursing home'
'board',
'budget
Canada'
control'
'culture'.

APPENDIX 2 CODING TABLES FOR CASE STUDY

NOTES ON TABLES AND METHODOLOGY

The terms employed for the tables are drawn from the coding report found in Appendix 1.

TABLE 1.4 IDEAS ABOUT EQUITY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4			

TABLE 1.8 IDEAS ABOUT POLICY

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	3	60
5	Civil Servant	1	20
7	Interest Group	0	0
8	Civil Servant	0	0
9			

TABLE 2.9 INTERESTS OF NURSES IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	1	20
4	Politician	4	80
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	5 (0.4%)	100

TABLE 2.10 PRIVATE, FOR-PROFIT NURSING HOMES

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	3	100
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	3 (0.24%)	100

TABLE 2.11 INTERESTS OF PATIENTS IN REFORM

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	0	0
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	1	100
	TOTAL	1 (0.08%)	100

TABLE 4.2 BUDGETS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	50
5	Civil Servant	1	50
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.3 FISCAL

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.4 FUNDING

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	1	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	1 (0.08%)	100

TABLE 4.5 MINISTER OF HEALTH

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3	RHA	0	0
4	Politician	2	100
5	Civil Servant	0	0
7	Interest Group	0	0
8	Civil Servant	0	0
9	Interest Group	0	0
10	Health Professional	0	0
	TOTAL	2 (0.16%)	100

TABLE 4.6 HOSPITALS

RESPONDENT	CLASSIFICATION	# OF MENTIONS	% OF MENTIONS
3			