Privatizing Health Care:

Laboratory Services – An Early Warning Sign

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In the current round of Ontario's health care restructuring the consolidation of community medical laboratory services in private, for-profit hands is going relatively unnoticed. The final act in this transfer of public health care money to the private sector, specifically three multinational companies, Lifelabs,[1] Dynacare and CML, is the demise of the community operations of two non-profit providers: the Hospital In-Common Laboratories (HICL), and the Hamilton Health Service Laboratory Program (HHSLP). Their forced closure ends 40 years of quality, cost-effective, accessible health care delivery that demonstrated that community and acute care services can be integrated to mutual benefit. Ironically, the end of these services comes at a time when the provincial government is restructuring health care ostensibly to increase integration and control costs.

Understanding this specific paradox adds to our knowledge of the delivery of social services in advanced capitalists states. It takes seriously Colin Leys' assertion that "the impacts of economic forces need to be studied not only at the level of politics in general but also in specific markets"[2] – in this case the market for laboratory services.

FOR-PROFIT HEALTH CARE DELIVERY

One of the main policy debates in Canada is over the future of public health care. While this program continues to enjoy enormous popular support, it is under attack. This is not surprising. Canada's total public sector health expenditures in 2008 were approximately $120-billion. In 2009-2010 the Ontario government will spend $42.6-billion, or 43% of its program spending, on health care, including $1.2-billion on medical laboratories. Robert Evans, writing in 1993, commented tongue-in-cheek, "there has always been a crisis in Canadian health care."[3] And the reasons are always the same: cutbacks, shortages, and spiralling costs. There will always be a crisis in public health care because the main perpetrators of this crisis rhetoric are those who wish to lower the cost to the "wealthy and healthy" and increase benefits to the for-profit health care industry.

The main issue in the health care debate has been universal access to essential services. In many ways this debate has ended. Even Prime Minister Harper has, at least publicly, acknowledged that a public insurance system is best for ensuring universal access.[4] This political victory is due to a century of struggle by progressive forces which won a public hospitals system in 1958, Medicare in 1968 and rules for universal access in the Canada Health Act in 1984.

As the benefits of a single-payer system have become more widely accepted, the new battleground is for-profit access to public funds to build health care infrastructure and to provide acute care services though a variety of private clinics and diagnostic services. Economist Armine Yalnizyan identifies the growing use of public funds to pay for private, for-profit delivery of services as one of the four main threats to the sustainability of Canada's public health care system.[5]

The provision of Ontario's community medical laboratory services is a case study, an historical experiment of sorts, relevant to this debate. For the last forty years non-profit options and private corporations have operated side-by-side in the delivery of the same publicly funded and universally accessible service. The comparison of these providers challenges the assertion that increasing private sector involvement in health care is the solution to the system's problems. Rather it argues that for-profit delivery of health services increases cost, decreases system efficiency and undermines universal public health insurance. It questions whether there is any role for the private sector in the delivery of health care. Further it provides evidence that the public sector is able to meet new needs and improve access, quality and democracy, and decrease cost.

THE GENESIS OF MEDICAL LABORATORIES

At the turn of the last century the precursors of modern medical laboratories emerged in response to concerns about communicable diseases. By 1960 scientific advances in what could be measured in a laboratory, increased systematization of medical diagnosis, mechanization of laboratory procedures and increased funding for doctors' medical services saw a rapid increase in the use of medical laboratories. Virtually all the laboratory work for inpatients, outpatients, community patients and public health was processed in public, non-profit hospitals and public health laboratories.

The emergence of private medical insurance plans to counter pressure for universal government insurance allowed some physicians, primarily pathologists, in areas of greater population such as southern Ontario, to establish commercial laboratories serving other doctors. With the nationalization of medical insurance, many physician-run laboratories used this publicly funded gold mine for diagnostic services to morph into corporate laboratory chains.

Medicare did not directly affect the delivery of health services, including laboratory services, except that by guaranteeing payment for a larger population it increased demand for services. Maintaining a fee-for service structure for most medical services, including community laboratory work, created a significant in-

centive for even greater use. Universal public medical insurance also created a direct government interest in medical expenses as hospital insurance had done for hospital expenses, and it reinforced a central role for the medical profession in Ontario's health care system.

NON-PROFIT SERVICES 1968-1990

HICL was formed in Toronto as part of the public system to provide large volume tests for participating hospitals. The laboratory was funded by special grants from the Ministry of Health. Key principles of the new organization were that it would augment, not compete with, hospital laboratory services, and work to increase efficiency, quality and integration in the system. It is interesting to note that at one open community meeting held to consider establishing the HICL, the laboratory was opposed by some who were later identified as "paid consultants to a private laboratory."[6] The HICL was the most successful of the many non-profit laboratory ventures to emerge during the 1960s and 70s. Hamilton's HHSLP also provided significant non-profit community services in collaboration with hospitals from 1973 to 2007.

In 1976 HICL embarked on a significant new venture. A private laboratory in Brampton, home of the Premier Bill Davis, went bankrupt. The government entered into a contract with HICL to take over its community operations. As part of the deal HICL would pay the local hospital laboratory to process specimens. HICL, like other community laboratories, was to be paid on a fee-for-service basis, but at a rate pegged to about 75% of the rate paid to the private corporations.

The HICL model was a win-win-win for the government, communities and public hospitals. The arrangement provided savings to the government. All hospitals made extra money because HICL paid about 40% of their income to the hospital for processing the specimens. The extra money and volume from the community specimens meant that smaller hospitals would be able to upgrade their laboratory services. Larger hospitals could use their excess capacity and staff at night to process the community specimens that had been collected that day. Local doctors and patients gained from easy access to hospital pathologists and laboratory results. Communities gained from local job creation and stronger hospitals. The Brampton precedent spread slowly around the province over the next 15 years moving into a dozen communities.

FOR-PROFIT COMMUNITY LABORATORIES: 1968-1990

Between 1960 and 1967 commercial laboratories doubled in number to 72 private enterprises: four of these businesses were laboratory chains; the largest, Pathology Services, had 16 laboratories. Ninety per cent were owned by physicians and most of these were pathologists. A condition of receiving insurance payments, which accounted, even before Medicare, for most of their income, was that the medical director of the lab be an MD. Payments included a separate professional fee for each test run. This basic structure continued under OHIP, and with the rapid expansion in the number and kind of tests performed, resulted in significant incomes for the pathologists running the laboratories.

In contrast to hospitals, doctors' offices and private community laboratories were paid on a fee-for-service basis. Since 1969 Ontario's hospitals had been on global budgets which included their laboratory services. They were mandated to provide service to community patients but received no extra funding for this service. In many ways this split in payment regimens (global budgets vs. fee-for-service) between hospitals and community providers proved the most fateful in securing the community laboratory market for private interests. Refining and strengthening this division between hospital and community services became a key goal of the for-profit corporations.

The proliferation of private laboratories led to the licensing of the sector in 1972. This legislation was motivated as much by concerns about increasing costs as by fears about quality. Strategies to control costs included restricting the number of laboratories, decreasing utilization by individual physicians, and limiting the rise in payment per test. These laws sparked a consolidation in the industry and the formation of an industry association, the Ontario Association of Medical Laboratories (OAML), which in turn supported regulations limiting new commercial access to the community market. The Ministry of Health established a branch responsible for community laboratories which became a conduit for the private labs into the centre of the government.

Per capita cost in the community rose faster than hospital costs during the 1970s and 80s. Part of this increase may have been due to aggressive advertising by laboratory companies, including inducements to physicians to order certain tests and use their laboratory. These inducements included subsidized office space, preferential treatment, and payment of staff salaries, copy services, and meals out. By 1993 private laboratories accounted for about 45% of the laboratory work in the province and 90% of community laboratory work.[7]

1990-THE PRESENT: FOR-PROFITS DOMINATE

After decades of exuberant laboratory cost increases and faced with an increasing government deficit and economic recession the NDP government entered into direct negotiations with the OAML to cut costs. In 1993 they signed a Memorandum of Agreement that set hard and decreasing caps on how much money was to be paid for community laboratory services. This capped fund was to be distributed among the laboratories based on market

share. When the cap was reached, no more money was paid for tests done.

The larger labs also gained privileged access to government decision-making and received significant monetary support from an industry-directed publicly financed fund. These initiatives dovetailed with the social democratic government's commitment to creating strong Ontario corporations that would be winners in the world market. One of the winning sectors was health care, and a favoured corporation was the laboratory multinational MDS.

Government funding restrictions in the early 1990s also provided the impetus for a major expansion in HICL's community operations. Hospitals eager to find other income sources looked to HICL to make money from their excess laboratory space. In 1994, Dennis Timbrell, former Conservative cabinet minister, then president of the Ontario Hospital Association, wrote that, "there is massive reserve capacity in the hospital laboratories … a fully staffed evening shift could absorb the private laboratories' workload without difficulty."[8]

HICL doubled the number of its community laboratory sites from 1989 to 1995, establishing new operations in Perth, Kitchener, Fergus, Winchester, New Liskeard, Timmins, Orillia, Napanee, Huntsville, Parry Sound, and Bracebridge. By 1995 it accounted for about 5% of the community laboratory market.

The large private laboratories found it hard to work within the funding caps and started to cut back on services. Both HICL, because of its relationship with hospitals, and some smaller private laboratories, for reasons of flexibility, were able to expand in this environment. The industry cap, HICL and the competitive laboratory market started to threaten the profit of the larger players just when the government had given them more power.

With the stage set by the NDP, the Harris Conservative government elected in 1995 moved quickly to end the HICL's community operations. Using the structure established by Rae, the Ministry of Health in 1998 negotiated with the OAML to continue the hard caps on government spending in exchange for transferring all of HICL's community work to the private sector. In the same agreement the for-profit companies also gained the right to process ten esoteric tests that they previously had to pay the hospitals to process. HICL estimated that these two changes, closing the specimen collection stations and allowing the private laboratories to conduct these ten esoteric tests, took about $11-million a year in revenue away from hospital laboratories.

Communities, labour organizations and pathologists campaigned against the damage that would be done to the smaller hospitals and forced the government to set up pilot projects for 12 small hospitals. These hospitals could, through a Request for Proposal process, come to individual agreements with community providers to use the hospital's laboratory to process specimens. OHIP would pay to those hospital-community laboratory partnerships a set amount based on 86% of the 1996 commercial fee schedule. HICL entered into partnerships with six of these hospitals, MDS with three and CML with three. There was no escalator clause in these agreements so each pilot project has had its total funding frozen at the 1996 level, despite the fact that the funding cap for private community laboratories increased by 36% from 1996 to 2006.

Second, the 1998 agreement with the OAML established a fixed market share for each corporation, effectively ending competition in the medical laboratory sector. This agreement, which greatly favoured the large companies, resulted in some smaller firms paying compensation to the multinationals for taking some of their market share. The agreement established a steady publicly funded income stream to the large multinationals as long as they provided a set amount of service.

Over the last decade a series of regionalization initiatives for Ontario's laboratories have been systematically thwarted by the for-profit sector, except when they allowed access to some of the in-patient laboratory work: for example Gamma-Dynacare has gained a long-term contract to manage the regional in-patient laboratory for the Ottawa region.

The structural division between the hospitals and community health services, including different funding and administrative regimes, has recently been reinforced by the new regional health governance structure, the Local Health Integration Networks (LHINs), and works against integration and public-sector delivery of laboratory services. The LHINs deliver health services within their mandate, which includes hospital laboratory services, but does not include community laboratory services. If hospital laboratory services can be reduced, the money can be shifted to other services or simply saved. At the same time, since the community sector is under a different budget, one that is negotiated directly between the for-profit laboratories and the government, the for-profit laboratory corporations might be able to increase their income as their work increases because of the addition of off-loaded hospital services. Moving community laboratory work outside the hospitals means a savings for the individual LHINs, even though it will likely increase costs for the Ministry of Health.

By 2006 there were only eleven for-profit corporations in Ontario providing 93% of community laboratory services. Five of the remaining non-profit pilot projects will be closed before the end of 2009: most of the for-profit pilots will likely stay open. The Hamilton Regional Laboratory Medicine Programs (the new name for the HHSLP) was forced to close its remaining community collection stations in the fall of 2007.

All of the communities affected by non-profit closures will be served by one of the large corporations, Lifelabs, Gamma-Dynacare or CML. But the work will now be shipped out of the community to a central processing plant, usually in the GTA. Local jobs are lost, local integration is decreased, local hospital services and income are cut and provincial health costs increase. Overall a lose-lose-lose situation. The negative results of the profitization of Ontario community medical laboratories can be seen on cost, accessibility, democracy, quality and integration.

COST: PRIVATE IS NOT CHEAPER

While the cost savings provided by the HICL were transparent, since it was paid about 75% of the rate paid to the private labs, studies of the Hamilton project have shown a cost savings in the range of 25-30% compared to the cost of having the for-profit sector deliver the same service. It has been argued that this difference is because HICL used the hospitals' infrastructure to keep costs down . The weakness in this argument is that all the money involved, whether paid to the hospitals, HICL or the for-profit corporations, is public tax dollars. Closing the HICL and HHSLP community operations also means the loss of a source of revenue for hospital laboratories, leading to more pressure on the Ministry of Health to increase hospital funding at the same time as it is paying more for community laboratory services.

ACCESSIBILITY: PRIVATE DOES NOT 'OPEN DOORS'

This history of community laboratory services supports a point that has been made before: for-profit providers are primarily interested in providing service to areas of larger population concentration and wealth, which increases inequality of access to services. Rural and northern communities have had a greater reliance on the public sector for their access to laboratory services. Also, the centralization of laboratory facilities in a few larger communities, usually the Greater Toronto Area, has left most cities, large and small, without laboratories, and communication with the laboratory corporation, even for information about their local specimen collection centres, is only possible by long-distance telephone. In the face of funding cuts for-profit laboratories decreased service to marginalized populations affecting equality of access.

DEMOCRACY: PRIVATE IS NOT TRANSPARENT OR ACCOUNTABLE

The existence of for-profit providers has made it more difficult for the public and ultimately the government to access information needed to engage in democratic debate and make policies for the collective good. Corporations control access to most of their internal information and Section 17(1) of the *Freedom of Information and Privacy Act* formalizes the barrier to commercial information provided to the government.

The existence of for-profit corporations creates an inherent conflict in policy-making between the imperatives of private capital accumulation and the public good. The imperatives of capital are realized through increased lobbying power, the transfer of personnel from corporations to government departments and government departments becoming facilitators of private corporations: all of which has happened in Ontario's laboratory sector. Also the impact of private interest works in a more insidious way on limiting options, which directly affects decision-making. Indeed, as the history of Ontario's laboratory sector shows, to accept for-profit providers into a sector is to start down a slippery slope.

The concept of an independent medical profession figured prominently in profitization of the laboratory sector and its negative impact on democracy. Concerns about doctors self-policing in monitoring conflict of interest, their unilateral control over quality, and their notion of professional autonomy, all played a role in the emergence of the for-profit laboratory corporations. This history makes the argument that greater democratic control of health care institutions provides both greater protection of services from market forces and increase their responsiveness to a community's needs.

QUALITY: PRIVATE IS NOT BETTER

There is very little doubt that the quality of laboratory results in both for-profit and non-profit facilities has significantly improved in Ontario over the last 40 years. But, as the presence of private corporations has increased so has the secrecy around the quality control programs in the laboratory sector. In the 1970s the information collected by these programs was available by ownership type, commercial laboratories compared to hospital laboratories, and it was broken down by size, so infractions in smaller laboratories could be compared to larger ones. Currently only the aggregated figure for all laboratories is provided, making full discussion of quality issues difficult.

But the actual accuracy of the test is only one part of the quality of laboratory services. The interpretation of the results, as dramatically shown by the cancer pathology scandals plaguing Canada, is also an issue. For-profit providers hire less well trained staff; have less integration of specialists, family doctors and patients; and increase centralization of testing facilities and fragmentation of providers, all factors with significant potential to reduce quality.

INTEGRATION: PRIVATE IS NOT EFFICIENT

Some form of regional medical laboratory integration to control costs and improve quality has been identified in major studies and purported to be a policy goal of all governments from 1970 to the present: yet integration has been at best limited. Among non-profit providers some progress has been made. Hospitals have developed a variety of solutions to coordinate and integrate their laboratory services, and the HICL and the Hamilton projects have shown that community and hospital services can be integrated.

The consolidation of for-profit laboratories into three dominant corporations has also brought about a kind of integration.

While the companies compete, often having collection stations right across the road from each other, they negotiate centrally and each corporation has internally integrated services on a province-wide basis. But neither of these integration processes solves the problems of duplication, excess capacity and responding to actual regional needs.

Numerous difficulties with coordinating, let alone integrating, the public and commercial laboratory systems have been identified: the different purposes, for one the generation of profit and the other provision of a public service; the method of funding; the method of workload measurement; and the secrecy of the commercial sector. The evolution of these two systems indicates that many of these differences enabled the commercial laboratories to freely expand and dominate the community market. Further there is an inherent bias in the private sector against integration. Integration is a winner-takes-all situation. In the end there will only be one provider, so all of the others lose whatever separate business identities they have developed. What the Ontario experience indicates is that a commercial laboratory sector not only increases cost but its existence has created a fundamental block to the rationalization of laboratory services and whatever cost-savings, quality and service integration that might bring about.

STRATEGIC CONCLUSIONS

The story of the demise of the non-profit laboratories points to a few conclusions that are relevant to today's struggles over the delivery of essential services. First, the focus of progressive strategies on access to quality health care has made it possible for key components of the delivery system, medical technologies, drugs, private diagnostic and medical clinics and laboratories, to go relatively unchallenged; yet they are some the biggest cost-drivers in the system and significantly influence the kind of care people receive. It is understandable that this focus on individual consumption is a common rallying point as it converges with key aspects of capitalist ideology and the biomedical model of health care. But the lack of concern with ownership and control has worked against quality health care as a communal project for the public good.

Second, the history of these laboratories shows that there are good non-profit alternatives for the delivery of public services. Actually better than good, preferable. They can deliver a superior service at a fraction of the cost.

Third, this history shows dramatically how viable non-profit alternatives have been systematically undercut by changes in the parameters of public policy as the balance of class power has shifted. In the 60s and 70s a Conservative government dynasty in Ontario could legitimately support a public laboratory option, while successive provincial governments of different political stripes have, over the last twenty years, aided in the demise of this alternative and structured a health care market to transfer public funds to private corporations.

Another important point is that to pay for-profit corporations to deliver a public service is indeed to start down a slippery slope. The inherent uneven playing field that results from the rights afforded to private, for-profit corporations benefits them in competition with public, non-profit options. They benefit from legal rights to greater secrecy, lower standards of accountability and privileged government access. For most of the last forty years there have been no direct polices forcing community laboratory work out of hospitals and non-profit laboratories into the for-profit sector. Rather, incremental policies have structured a new area of service provision to benefit the private sector over public facilities. The lesson to be learned from this is that the creation of strong boundaries around public services and strong progressive programs to improve the delivery of these services is necessary for their preservation. **R**

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1. Formerly MDS. Now owned by a consortium including the Ontario Municipal Employees Pension Fund.

2. Colin Leys, *Market Driven Politics*, 2001, p.81.

3. Robert Evans, "Health Care Reform: 'The Issue From Hell'," *Policy Options*, July/August 1993, p. 35.

4. There is agreement in the academic and policy community, though obviously this assumption continues to be challenged by the right wing. Recently they won the Chaoulli decision and are currently challenging legal restrictions of setting up private clinics. Also there are continuing battles over a two tier system, for example, what services are covered. For these reasons increasing access requires continued progressive political attention but this does not negate the majority opinion in favour of universal government health insurance.

5. Armine Yalnizyan, "Can We Afford to Sustain Medicare? A Strong Role for Federal Government," Ottawa: Canadian Federation of Nurses Unions, 2004.

6. Theodore Freedman, A review of the Experience of the In-Common laboratory in the Development of Joint Laboratory Services, thesis for the Diploma in Hospital Administration, university of Toronto, 1970, p. 131.

7. This is a best guess based on data from the Laboratory services review. Laboratory statistics and who uses hospitals laboratories has long been a source of contention.

8. "Response to Laboratory Services Review External Advisory Sub-Committee Social Contract Study Summary Report," Ontario Hospital Association: Toronto, March 1994, p. 9. There have been no completed system-wide studies on excess capacity in hospital laboratories. Some of the recent regionalization efforts, for instance the Ottawa Hospital's new regional laboratory, developed under the management of Dynacare, are rumoured to be working at full capacity and yet are not able to meet current inpatient needs. It would be interesting question to explore whether for-profit sector influenced restructuring to remove excess capacity from the hospital system, possibly jeopardizing inpatient care, to undercut the argument that hospitals can provide community laboratory services.