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Examining private and public provision in Canada's provincial health care systems: comparing Ontario and Quebec

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Abstract

Globally, the mix of private- and public-sector involvement in health care delivery is a focus of political concern. This concern in Canada takes place within the parameters of the federal Canada Health Act. Private for-profit activities in the health care sector in Canadian provinces have moderately shrunk the definition of 'necessary medical and hospital services' that must be provided by the public administration system under the federal Canada Health Act. In this article, we argue that the development of new technologies, pharmaceutical innovations, competing (non-health) demands on the federal dollar, and an aging population together create an environment where pressures for economic and political sustainability have led to some erosion of necessary health services in the provinces. Such pressures have, in turn, led to the growth of private commercial-sector health services. Within Canada's federal system, provincial negotiation of the role of commercial health care organizations has developed in different ways in Ontario and Quebec. Such sub-national developments are a significant focus for comparative health policy analysis.

Key words

Canada, federal government, health care systems, long-term care, medical services, provinces

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Introduction

This study focuses on the development of the mix of public–private activities in the provincial health care systems of Quebec and Ontario. Public–private sector relationships in provincial health delivery systems operate to some extent within the constraints of the federal Canada Health Act of 1984, which provides for federal transfer payments to provinces that comply with the mandates of the Act. We will particularly focus on recent developments in the private for-profit sector – paying special attention to such initiatives in Ontario and Quebec. Our study postulates that politically perceived needs and resource limitations are important factors affecting the economic and political sustainability of public health care systems, leading to an increase in for-profit providers at the provincial level. The underlying causes for this pattern of health service delivery, and the administrative responses they elicit in the Canadian provinces, are likely to find some parallels in other developed societies, although they will be refracted in different ways according to national historical and political experience.

In our examination of the role of commercial players in these provincial health care delivery systems, we utilize a comparative policy methodology. Thus, we examine the factors underlying provincial dispositions to act with regard to public–private sector initiatives (Blank and Burau, 2004; Heisler and Peters, 1977; Nathanson, 2007). Our analysis touches upon three areas that are particularly featured by Heisler and Peters (1977): first, the levels of government and the nature of their involvement in public policy concerning the provincial health care delivery systems; second, the nature and characteristics of public- and private-sector activities developed within provincial health care delivery systems; and, third, factors influencing provincial governments' political dispositions to act. Heisler and Peters (1977) also note that existential factors, such as perceived needs, availability of resources, and the presence of a political window of opportunity, may be factors that affect policy development in the areas of health and social welfare. A multifactor approach similar to that of Heisler and Peters, but specifically focusing on health care delivery, is presented in the work of Blank and Burau (2004).

In Canada, the health care delivery system is primarily the responsibility of provinces. We consider this sub-national Canadian health care system study to be important internationally, as an aggregate of national studies that use a comparative framework contributes to the international comparative health policy literature through an accumulation of case by case studies (Dutton, 2007; Heisler and Peters, 1977; Jansen and Rodgers, 2001). Indeed, the use of a comparative approach in sub-national studies in this area is widespread (e.g. Altenstetter, 1978; Forest and Bergeron, 2005; Tuohy, 2009).

We contend that the desire to maintain access within the health care system is leading to an increase in the activities of commercial organizations within the framework of Canada's Medicare systems. This is a consequence of increasing financial pressures in health care and other areas seeking federal financial assistance. A similar pattern is emerging internationally. Globally, many national health insurance plans incorporate a mixed public and private health delivery system – albeit that 'mixes' of for-profit and not-for-profit organizations, as well as degrees of public regulatory authority, will vary with respect to the ideological, political, cultural, and historical characteristics of various nations (Blank and Burau, 2004; Forest and Bergeron, 2005; Nathanson, 2007).

In pursuing our analysis, we will, first, review the dynamics of Canadian federalism as it relates to the health care system as well as its relationship to the Canada Health Act of 1984. Next we deal with organizational trends in Canada regarding the involvement of commercial for-profit as well as public and private not-for-profit organizations in the delivery of health care services in Canada. We then proceed to develop case studies of such developments in Ontario and Quebec. Finally, we

reach some conclusions based on our observations of provincial developments in health care service delivery in Ontario and Quebec.

Federalism, the Canada Health Act, and Canadian health care

The functioning of Canadian federalism in the area of health care delivery is characterized by a dynamic relationship between national fiscal power and the constitutional responsibility of the provinces to provide health care services to their residents. This relationship is a stipulation of the initial Canadian Constitution, the British North American Act of 1867, and the more recent Constitution of 1982 (Heuglin, 1986).

Under the Canada Health Act of 1984, in order for the provinces to receive full federal financial contributions, provincial programs must provide for the delivery of required health services. They must also meet criteria of public (non-profit) administration, comprehensiveness, universality, portability, and accessibility for all necessary health care services. Provincial 'extra-billing' and user charges are not permitted for these services. Such insured services, which must be provided by the provinces as a condition of financial participation according to the Canada Health Act, consist of all necessary hospital services, physician services, and surgical dental services performed in a hospital. In addition, such provincial health insurance plans may provide for a number of *extended health services*, including pharmaceuticals outside of hospitals, magnetic resonance imaging centers, nursing home care, and in-home care, in the provincial health care budgets (Palley and Forest, 2004). These latter services may have user charges or additional fees as the provinces see fit.

Meeting provincial obligations regarding the delivery of health services has been complicated by the fact that, in the decade after the passage of the Canada Health Act, the average level of federal spending for health care in the provinces declined from around 33 percent to 24 percent. Faced with criticism from provincial governments since 1999, the level of federal funding has since increased, reaching 38 percent in 2007/8 (Finance Canada, 2008) and exceeding 40 percent in 2009/10 (CIHI, 2009; Finance Canada, 2009).

Privatization and health care reform: Some general observations

The delivery of health care services in Canada has evolved in a variety of ways in different provinces as the provinces have dealt with the political pressure to increase privatization of health care delivery as a way of augmenting the supply of services. These approaches have resulted in increased provision as well as public regulation of such services. There seems to be some convergence in most provinces with respect to the increase of private for-profit services, although the nature of these increases differs from province to province. The following section provides some general discussion of these developments and the tension between some of these developments and the mandates of the Canada Health Act.

An issue driving this push to privatization is the difficulty in maintaining equal access to an increasingly technologically expensive medical care system. To a great extent, Canada is a publicly funded health care system. Provincial governments fund a variety of health services through the provincial health care insurance plans, but the services insured under the plans are delivered mostly by a mix of private not-for-profit and private for-profit (individual or institutional) providers.

Doctors who are paid by public provincial Medicare programs cannot also provide medically necessary care for private for-profit payment. They can, however, 'opt out' of the public system and 'go private' for profit – except in Ontario, which does not allow doctors to 'opt out' due to the passage

of the Commitment to the Future of Medicare Act (Boychuk, 2006). The funding of health care in Ontario is done either indirectly through a third party or directly by the individual/family through out-of-pocket spending or premiums, co-insurance, co-payment, or deductibles (Sullivan, 2008).

The uniqueness of the Canadian model does not reside in the relative importance of public funding compared with private funding. Rather, it is the manner in which the split between public and private funding is organized that makes the Canadian system distinctive (Chodos and MacLeod, 2005: 15). There is broad agreement by most Canadians that Canada has a single publicly funded system for core medically necessary hospital and physician services. Ultimately, the issue is whether it is appropriate to enlarge in some fashion the scope of commercial private-sector delivery of health services within the framework of a publicly funded system, or whether measures should be taken to inhibit the growth of the private (for-profit) sector's role (Chodos and MacLeod, 2005: 15). Our study examines some movements toward greater acceptance of peripheral private for-profit services in the 1990s and into the 21st century. The kind of services provided includes free-standing diagnostic centers, limited specified medical services, some ambulatory surgery, and 'boutique' hospitals, as well as extended care services provided by private for-profit nursing homes, and long-term home care and community care services.

Often, the political argument for such services is articulated in a rhetoric of 'individual choice' and 'market efficiency.' This argument was often invoked by former Premier Ralph Klein in Alberta. He believed that the presence of private-sector for-profit competition would reshape Medicare, and that permitting a greater mix of public and private for-profit enterprises in health care services would create a 'more sustainable and responsive health system' (CBC News, 2006). Klein had earlier stated '[I]t is time to open up the system, to take the shackles off and … encourage competition and choice' (Klein, 2005). During his administration, over 50 investor-owned day surgery clinics outside the provincial health insurance system had developed in Alberta by 2000.

Despite the utilization of 'free market' rhetoric to advocate certain policy reforms, our view is that the underlying driver at the provincial level was not primarily the ideology of the efficiency of market competition, but a pragmatism driven by a combination of political and economic sustainability factors. Some significant policy analysts maintain that political sustainability is the most salient factor (Boychuk, 2004; Evans, 2004; Flood et al., 2008). In our view, these authors underestimate economic sustainability factors, such as developing technology trends, an aging population, the health-related costs of social care, and the financial pressure of other areas, which make increasing demands on the federal budget (Berenson and Abelson, 2008; Gaumer and Fleury, 2009; Leland, 2008).

Some researchers have claimed that aging is not a major factor with respect to the increase in health care expenses (Lee, 2006; Reinhardt, 2003). Other research has emphasized mixed findings with regard to aging and the high cost of health care services (Payne et al., 2007). Yet a US study of hospitalizations of the elderly by Nagamine et al (2006) noted that from 1997 to 2004, while elderly individuals represented 12 percent of the US population, they accounted for about 35 percent of hospital stays annually in connection with six serious health problems. Another study indicates that 90 percent of elderly adults in the US take prescription medications, averaging five prescription drugs per person (Safran et al., 2005). In our view, maintaining that aging is not a major factor with respect to high health costs tends to underestimate the above factors as well as the long-term care costs associated with those aged over 75 years of age, who are more at risk of suffering from multiple disabling conditions (OECD, 2005). Thus, we consider that both political and economic sustainability related factors are at play, and that both have contributed to the increase in publicly regulated, private for-profit health services in the provinces of Ontario and

Quebec. As former Quebec Premier Lucien Bouchard noted with regard to the growth of private for-profit health clinics in the province, such clinics make 'le gros bon sense' (excellent common sense) where sufficient access to general health services is perceived to be insufficient to meet public need (Courchene, 2007).

In 2010, 45 percent of Quebec's provincial budget was devoted to health expenditure, the comparable figure for Ontario was 40 percent, and the figure for Canadian provinces and territories overall was 38 percent (Adams, 2010). These figures indicate that the financial requirements of health care are at risk of overwhelming other budgetary needs at the provincial level. Arguments focusing on political and economic sustainability have contributed to the increase in publicly regulated private for-profit health services in the two provinces. However, the politics of commercial private health care corporations in the delivery of health services has differed in Quebec and Ontario as our case examples will indicate.

Some approaches to privatization within Canadian health systems

Privatization within a health care delivery system may involve changes in financing, such as the utilization of user fees and public budget reductions. These activities are sometimes accompanied by 'load-shedding' – that is, removing certain health care services from the basket of necessary health services at the provincial and territorial levels (Deber, 2002). Privatization may also involve changes in the delivery of services, such as the use of vouchers, contracting out, purchase of care arrangements, and other public–private arrangements (Deber, 2002). We focus on changes that have taken place in the operation of private for-profit provision. Some of these enterprises are engaged in the purchase of care arrangements under provincial Medicare rules while also providing commercial services outside of this framework; others operate as commercial services entirely outside of Medicare provision of necessary health services. Thus, the Canadian Institute for Health Information (CIHI) data that we will refer to with respect to public–private splits regarding health care expenditures are actually substantial underestimates regarding the activity of commercial, for-profit enterprises in the Canadian provincial (and territorial) health care systems.

A more subtle version of the argument for privatization is that the public sector lacks the ability to finance – on its own – the technological advances and the extent of services demanded by Canadian society, and, thus, publicly regulated participation by the private sector is needed and desirable (Mackie, 2001). A symptom of this has been the problem in public systems of waiting times between a patient's referral by a general practitioner and the start of hospital treatment by a specialist. This problem has led to a major Canadian policy emphasis on reducing waiting times (Health Canada, 2010).

We have chosen to examine in somewhat greater detail trends toward increasing use of the private for-profit sector in the delivery of health care services in two quite diverse provinces: Ontario and Quebec. These two provinces constitute 62 percent of Canada's population of almost 33 million. Ontario with a population of nearly 13 million constitutes 39 percent of this population; and Quebec with a population of 7.7 million constitutes 23 percent (Statistics Canada, 2007b). These provinces are quite diverse with regard to language and religious profile (Statistics Canada, 2001, 2007a). They are also diverse politically. Ontario's political governance has reflected a wide range of viewpoints – including a brief period of neoliberal ascendancy. The politics of Quebec, on the other hand, are more egalitarian, despite shifting between the leadership of the Parti Québécois and the Liberal Party.

In spite of these diverse demographic backgrounds and some provincial differences in political rhetoric, the expansion of private for-profit interventions in the health care system has increased in

these two settings. The primary driver of this trend appears to be a combination of economic and political sustainability factors given the need for substantial fiscal resources to maintain access to health care services in view of the public's demand. This has led to some pressure for increasing the involvement of the private sector. The following two case studies describe how provinces differing in demography, ideology, rhetoric, and politics arrived at similar solutions with respect to the development of peripheral private for-profit health care delivery. We posit that political and economic sustainability factors have contributed to the modest enlargement of the for-profit sector in these provincial health care systems. We believe that similar trends may result in similar impacts in a variety of international settings.

Quebec

A perception of bottlenecks in access to some health care services in Quebec has resulted in initiatives to increase access at least for some Québécois by expanding the private for-profit sector. An instance of this privatization was the establishment of a private for-profit surgery clinic, the Institut de Polysurgérie de Montréal, that rented rooms to surgeons from Montreal's non-profit hospitals. The doctors then charged their publicly insured patients a 'facility fee' of several hundred dollars per hour in seeming violation of the Canada Health Act (Janigan, 2000; Pinker, 2000). Along with the facility fee, patients paid some additional charges, for example, for medication. In 2000, the Institute was investigated by the Quebec provincial government following allegations of illegal facility fee charges to public patients of $400 per hour. The surgeons at the Institute performed hernia repairs and other day operations covered under Medicare as necessary hospital services. None of the physicians had opted out of Medicare and consequently they billed the public insurance fund, the Régie de l'assurance-maladie, for each operation. At the same time, the clinic billed the patients. Following an investigation by the Régie, a reimbursement averaging $200 per person was deducted from the physicians' earnings. As the Régie had intervened to stop the user charges, Health Canada refrained from fining the province of Quebec.

However, Health Canada has acted more punitively with regard to such activities in other provinces. It imposed a $126,000 penalty on British Columbia in 2004, after concluding that the province had not responded adequately to federal concerns about the growing number of private surgery clinics that charged fees. Waiting lists also constituted a major driver for some privatization practices in Montreal. These events provide some context for a subsequent lawsuit and decision of the Supreme Court of Canada in the Chaoulli case described in the following.

The Chaoulli decision. In June 2005, the Supreme Court of Canada's Chaoulli decision struck down sections of two Quebec laws that prohibited Quebec residents from purchasing private insurance for medical and hospital services covered under the province's public health insurance program (Prémont, 2005; Supreme Court of Canada, 2005). The case was filed by a Quebec doctor, Jacques Chaoulli, and his patient, George Zeliotis, who claimed that overly long waiting times in the public system threatened a patient's right to life, liberty, and security, and argued in favour of allowing individuals to contract insurance for private health care services. It is interesting to note that the question of taking out insurance was not intended to apply to 'participating' doctors, that is, doctors under contract with the public health care system. In fact, the court's ultimate decision noted that doctors following the applicable Quebec statute must choose between being paid exclusively by the public system or by a private-sector employer. It also prohibited participating and non-participating doctors from practicing in the same venue.

The Chaoulli decision and Quebec's response to the Supreme Court decision are congruent with a number of previous provincial private-sector health care system initiatives and may presage things to come. The ruling was made by four of seven Supreme Court judges who based their decision on the law's violation of section 1 of the Quebec Charter of Human Rights and Freedoms. Three of the judges indicated in their opinion that it also violated section 7 of Canada's Charter of Human Rights and Freedoms (Supreme Court of Canada, 2005). While this was a minority opinion, it illustrates the potential for the Canada Charter of Rights and Freedoms to be a benchmark for national standards for health care delivery.

Following the ruling, the government of Quebec elected to follow the recommendations of Canada's Supreme Court and allow private insurance. It chose not to invoke the 'notwithstanding' clause of Section 33 of the Canadian constitution, which allows provincial governments to override legal rulings that might undermine founding provincial principles. To explain its decision, the government published a white paper entitled, *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality* (MSSS, 2006). This paper advocated improving access to medical and hospital services by instituting guaranteed timely access to services and increasing the role of the private sector. Thus, this report provided a mechanism by which the Quebec government took advantage of the Chaoulli decision to spur the debate not only with respect to the introduction of private financing, but also with respect to the role of the private commercial sector in the delivery of health care in Quebec.

On 13 December 2006, Quebec's Liberal government led by Premier Jean Charest passed Bill 33. This bill opened the door to two new kinds of structures (Sansfaçon, 2007). The first related entirely to private centers (the so-called 'private–private' specialized medical centers [SMCs]) staffed by doctors who do not participate in the public system and who perform surgical interventions that are more complex than those traditionally performed in doctors' offices. These centers must hold a permit, appoint a medical director, and offer pre-operative and post-operative care. All services offered by SMCs are payable by the patient or, in the case of elective knee, hip, or cataract surgery, by the patient's commercial insurer.

The second kind of structure permitted under the new law was again SMCs, but ones that are staffed by doctors who participate in the public system. Specialists for the most part, these doctors again practice interventions that are more complex than those traditionally performed in doctors' offices. In contrast to private SMCs, SMCs staffed by publicly paid physicians can be associated with hospitals by virtue of contractual purchase of care agreements that guarantee them a minimum number of interventions in predetermined priority areas where timely access to service is an issue (e.g. cataract operations and knee and hip replacements). These 'non-hospital' SMCs are not required to associate with hospitals, but if they do not do so, patients are liable for the costs of medication and anesthesia. However, these costs may be covered by private insurance, as may the costs of such services provided in the offices of physicians who participate in the public system.

Although Bill 33 maintained the divide between participating and non-participating physicians in the public system, since its passage Quebec has seen the emergence of private medical complexes with operating rooms where specialists paid by the public system provide services, with operating costs (such as the use of equipment and the salaries of support staff) paid by patients (Lévesque, 2007). These payment arrangements have violated the Canada Health Act as well as the spirit of Bill 33, which did not intend to allow private 'mini-hospitals' to provide services covered by the public system apart from cataract, knee, and hip surgery. After public pressure mounted, the province's public insurance agency, which had previously ignored this situation, investigated and proscribed

the activity. In the meantime, similar commercial initiatives have emerged. One example is that of the private Montreal company that secured appointments with specialized doctors within 72 hours in exchange for a fee of Cdn$290 or more. While this activity was also eventually prohibited, the variety of enterprises in this vein shows that the current atmosphere is increasingly supportive of commercial endeavors occurring outside the public health care system. Indeed, the Minister of Health and Social Services has raised the possibility of allowing residents to contract private insurance for operations other than cataract, hip, and knee surgery (*Official Gazette Du Québec Projet de règlement Loi sur les services de santé et les services sociaux*, 2007).

In June 2007, the government of Quebec went a step further and commissioned Claude Castonguay, a former Liberal Minister of Health and Social Services, to make recommendations for health care financing and the future role of Quebec's private sector in the provision of services. Released on February 19, Castonguay's report (Castonguay et al., 2008; Québec government, 2008) suggests that the solution to Quebec's health care difficulties lies in allowing certain services presently covered by the public sector, in accordance with the Canada Health Act, to be provided privately by commercial enterprises and reimbursed by private commercial insurance. It also recommends that in certain circumstances, the Quebec legislation barring a doctor from being remunerated from both public and private sectors be lifted. Touching on essential questions of both the role of private financing in health care and the means of dispensing health care services, Castonguay's recommendations have generated controversy in the health services community and the public at large. The initial response from the Quebec government to these proposals was unenthusiastic (Dutrisac, 2008). The Minister of Health and Social Services did not follow any of these recommendations and decided only to ask Castonguay to work on one suggestion related to the creation of a National Institute of Health Excellence that would develop clinical guidelines for Quebec's health care system (Québec government, 2008). Thus, Quebec's government has accepted the idea of supplementary private insurance to cover specified 'niche' medical services and has even embraced the possibility of expanding the types of services that can be covered by such insurance while rejecting the more fundamental changes in Quebec's Medicare recommended by Castonguay's report.

As we have noted, in the wake of the Chaoulli case, Quebec statutes have sought to reaffirm the principle that physicians receiving public insurance payments in their practices do not deal with privately paying patients or patients covered by private insurance and that physicians operating privately do not receive payments from the Régie. However, a gray zone has developed. It is possible for specialized medical centers with participating and non-participating specialists to operate under the same roof, but under different corporate structures (Noël, 2009). Thus, the ideal of separation has been breached in what are, in effect, small hospitals with complex corporate organizations. In sum, a series of governmental, political, and judicial decisions driven in an atmosphere of need for political and economic sustainability have led to an increase in the role of private insurance and investor-operated enterprises in Quebec's health care system.

Ontario

Pressures for the development of more private for-profit health care facilities have also been a political issue in the province of Ontario. In the late 1990s, 35 percent of the Ontario budget was devoted to health care services. In the 1990s, the Progressive Conservative Party was concerned with cutting the health care budget and instituting a number of economies. Under Ontario Premier Mike Harris, the Conservative government had changed in the mid-1990s from a party espousing

middle-of-the-road traditional conservatism to an anti-tax, anti-public welfare movement, which also sought mechanisms for substantial cutbacks in provincial health responsibilities (Sheppard, 1999). By taking $800 million out of the hospital budget during the first two years of the Harris administration, bottlenecks in emergency services were created, and longer waiting lists occurred for cancer treatment, day surgery, and hospital beds (Ontario Ministry of Finance, 1999). To reduce some of these backlogs, Ontario approved a temporary plan to send cancer patients to the United States for speedier treatment.

Subsequently, with the 1999 infusion of federal money, the provincial government partially reversed course. It agreed to hire 1200 new nurses only one year after dismissing 3000 nurses (saving $400 million) as part of a 'severance and restructuring' package (Monsebraaten and Orwen, 1999). Nevertheless, cutbacks in revenue resulted in hospitals being closed without the creation of a fully functioning community-based primary and preventive care infrastructure. Thus, hospital cutbacks, and cutbacks in health care spending in general, had a particularly acute effect. Overcrowded emergency rooms, understaffed and underequipped cancer and cardiac treatment centers, and shortages of new high-technology diagnostic equipment resulted (Winsor, 1999). Some of the Harris economies involved reorganization. For example, the province's 33 District Health Councils with responsibility for public health issues were cut back to 16. The Community Care Access Centers (CCACs) providing community-based care also underwent reorganization – in the sense that hospitals and hospital-based care no longer was as dominant a factor in health care delivery.

Between 1990 and 1999, total governmental spending for home care (not a 'necessary service' under the Canada Health Act) had doubled to $2.1 billion, with over half of this spending occurring in Ontario. Home care patients were a mixture of post-surgery patients, frail older people, and the disabled needing long-term care, as well as palliative care patients (Picard, 1999). Before 1996, there were 1200 organizations in Ontario offering home nursing and homemaking services, with government purchasing their services via 74 placement coordination services and regional homecare programs. The Conservative Harris government argued that such agencies were not accountable and that services varied in terms of regional equity (Picard, 1999). This system was replaced by government-financed access centers that purchased services from various agencies through a process of competitive bidding (which varied from center to center). It created 43 CCACs in Ontario. Ontario also became the first province in Canada that allowed for-profit companies to bid for all home care contracts; a process that critics believed undermined quality standards in favor of cost considerations (Picard, 1999). In 2006, Ontario established 14 Local Health Integration Networks in an attempt to facilitate the integration of long-term care services (Ontario Ministry of Health and Long-Term Care, 2007). To coordinate with this change, the number of CCACs was decreased to 14.

The initial introduction of the Ontario CCACs model by the Harris administration established a regional structure. It sought to impose 'managed competition,' which allowed intermediary organizations set up by the Ontario government to purchase services from providers who were in competition with each other on the basis of a combination of price and/or quality (Williams et al., 1999). As Williams et al. (1999: 131–2) note:

> where problems are … complex, processes are not well understood, and/or quality isn't easily or immediately identifiable even by consumers themselves, as is the case for community-based long-term care, the risk arises that for profit providers will seek to gain a competitive advantage by refusing to care for higher risk consumers or providing poorer quality of care.

This situation is still germane to the continuing discussion concerning how decisions are made with respect to selection of private service deliverers within CCACs.

The Harris period with its underfunding of various aspects of the Ontario health system set the stage for the development of private commercial ventures as a mechanism for repairing the problems of access, equity, and quality of care that arose in the wake of the Harris reforms. With the increasing unpopularity of the neoliberal Harris administration, the more moderate Liberal Party replaced the Progressive Conservative Party in the governance of Ontario. Moreover, the neoliberals in the Conservative Party had been replaced by a more traditional style of leadership under Conservative Premier Ernie Eves in 2002. Since the 2003 election, the Progressive Conservative Party of Ontario has been the official opposition to the Liberal government in Ontario.

Preceding the Harris government, within Ontario's hospital system, there had been elements of public–private partnerships involving for-profit health care facilities (Beltrame, 2000). Ontario's Shouldice Hospital is an illustration of a small 'niche' or 'boutique' for-profit hospital that has successfully operated within the constraints of Ontario's not-for-profit system. Shouldice is an exceptional case in Ontario as it is the sole for-profit hospital allowed to continue and to participate in Ontario's Medicare at the time of the passage of Medicare's hospital provisions (Deber, 2002).

An increase in the operation of commercial for-profit operations in health care delivery has been a trend in the area of long-term care in Ontario. Nursing homes in Ontario are of three types: municipal homes (public nursing homes); non-profit charitable homes run by both sectarian and non-sectarian groups; and for-profit nursing homes. As of 1993, all follow the same Ministry of Health and Long-Term Care regulatory standards for operation and have the same provincial funding formula. As of January 2008, there were more for-profit nursing home facilities than non-profit facilities, but about 52 percent of beds were in non-profit facilities and 48 percent in for-profit facilities (Ontario Long Term Care Association, 2008; see also Tory, 2007).

Also, as alluded to previously, in Ontario a system of 'contract-bidding' under global budgets for home- and community-based health services has been established. Under the locally based auspices of regional CCACs run by volunteer boards, decisions are reached in which cost factors play an increasingly significant role (Williams et al., 1999). This has led to non-profit, non-governmental organizations such as the Victorian Order of Nurses (VON) and St. Elizabeth's Health Services being replaced in some areas by private for-profit companies such as Comcare (Canada) Incorporated. By 2009, only 23 percent of personal support services of a low-skill level were supported by the two major non-profits, VON and St. Elizabeth's; whereas non-profits were the main providers of in-home visiting nursing services that require a higher level of training prior to competitive bidding. By 2009, VON and St. Elizabeth's provided only 39 percent of such services (Ontario Association of Community Care Access Centers, 2009). Thus, while still major players, the non-profit care providers had lost considerable ground to for-profit agencies. In some cases the competitive bidding decisions became encumbered by controversy as criteria regarding quality lacked clarity, as did criteria regarding membership on voluntary boards making contract decisions. In the case of the city of Hamilton the award of a contract to a for-profit home care provider was suspended by the Health Minister in the face of protests from the local community questioning the criteria that led to a commercial enterprise obtaining the contract (*The Toronto Star*, 2008). Commitment to the competitive bidding process has been maintained by the Liberal government, although it was placed under a moratorium for an extended period of time during the administrations of Premier Dalton McGuinty in the face of complaints that for-profits were supplanting the not-for-profits by essentially underbidding them.

More recent developments in privatization in Ontario have concerned health technology. Following permissive legislation in 1996 and 2002, Ontario's Health Minister announced plans to provide as many as 20 new MRI scanners and five new CAT scanners to independent, non-hospital health facilities that would allow for-profit delivery of medically necessary services. In early 2003, Ontario's Progressive Conservative Health Minister, Tony Clement, released the names of three for-profit company bidders who were selected to provide MRI and CAT scans (Gilmour, 2003).

This movement toward the inclusion of more private for-profit 'contracted-out' services within Ontario's Medicare was set back by the purchase of seven for-profit providers of diagnostic services by the subsequent Liberal government, which reversed the movement for the establishment of commercial diagnostic centers. In addition, new or expanded publicly funded MRI sites were under way in a number of locations throughout Ontario. The Liberal Party considered the rise of for-profit diagnostic centers that provided services under purchase of care agreements with the province as a threat to the maintenance of a classless Medicare system. Commenting on the expansion of non-profit diagnostic centers financed by the province of Ontario, Health Minister George Smitherman noted that: 'The important thing here is that the publicly funded diagnostic center will be driven by patient needs and health priorities, not by profits' (Mackie, 2004: A11).

In spite of these developments, it is interesting to note that in 2005 a Vancouver-based company had initiated a large for-profit family medical clinic specializing in screening and preventive medicine. It also had plans to set up three similar clinics in Ontario cities – in Toronto, Ottawa, and London (Krauss, 2006). Such for-profit private clinics may alleviate the waiting list problem, but they risk draining the public system of health care personnel that it can ill-afford to lose. For example, about 1.4 million people in Ontario are without a regular family physician (Krauss, 2006).

In a variety of ways, particularly for extended health services, increased investor-owned health care service provision has developed in Ontario in the 1990s and since 2000. The return to a Liberal Party government reversed this trend substantially in the area of MRI diagnostic clinics, but not in the area of the provision of in-home and community-based services.

Discussion and conclusion

In 1990, 82 percent of all estimated health care expenses in Canada were charged by the public sector; by 2009, such expenditures were estimated to amount to only 70 percent of total health care spending (CIHI, 2009). Thus, the private-sector share of such health spending had increased from 20 percent to almost one-third of national health expenditures in this period. For Ontario in 2009, estimated private expenditures constituted 33 percent of health care spending, and for Quebec, 29 percent; the overall figure for Canada was 30 percent (CIHI, 2009). In 1990, Ontario's private expenditure constituted 27 percent of health care expenditure; Quebec's level of such private expenditure was 24 percent (CIHI, 2009). Of course, many commercial, investor-owned health care corporations are providing services that adhere to Medicare provincial rules and receive public funds while often at the same time receiving funds from private sources that are not governed by Medicare rules. Thus, the role of commercial, for-profit enterprises in provincial health care systems is greater than the 70 percent public, 30 percent private health care expenditure 'split' often noted in the recent Canadian heath care literature. The ideational rationale for expanding public–private partnerships that is most congruent with the principles of equity and fairness engendered in the Canada Health Act is that such partnerships, if successful, allow for the sustainability of health services in Canada in a way that can expand access without undermining equity.

Statements by Premiers from Quebec to British Columbia have taken this position. Health policy analysts have argued that such sustainability is in fact driven by political considerations, as it presents a way of expanding access that is sustainable without additional government expense (Boychuk, 2004; Evans, 2004). Yet, while minimizing the economic sustainability argument, proponents of this view concede that, over the long run, new technologies such as medical devices and biogenetic pharmacology, as well as the demands of an aging population, may increase the salience of the argument for public–private partnerships on the grounds of economic sustainability. Perhaps, therefore, the most accurate statement would be that a combination of political and economic sustainability factors are involved in the development of the growing trend toward greater inclusion of commercial, investor-owned enterprises in the provincial Medicare systems. While we have presented a Canadian sub-national comparative health policy focus, we believe that a combination of economic and political sustainability factors, which act as a driver for greater inclusion of commercial private-sector participants in the mix of health care services, is also relevant in settings beyond the Canadian context.

Increasingly, the cost of high-tech health care services in Canada has led to some delays in diagnostic services and treatment and waiting list problems, which are currently being addressed. Private for-profit health care services have provided an option – either with public authorization or outside the framework of provincial public health insurance plans. However, the downside of these efforts is the creation of an increasingly inequitable class- and income-based asymmetrical health care delivery system. Nevertheless, the enactment of proposals to expand publicly regulated private commercial health care services in some instances, both as necessary health services and as extended health services, within the framework of the Canada Health Act could result in increased health care services in an equitable framework. In so doing, it is of utmost importance to maintain public accountability for private initiatives through a visible and active public regulatory framework (Minow, 2003). Examples of such public regulation of private commercial initiatives have occurred in Switzerland and The Netherlands (Reinhardt, 2004; Rosenau and Lako, 2008).

In examining the private sector more closely, we find that some of the increase has involved expansion of private 'boutique' services, such as removal of cataracts or hernia repair, or limited surgeries. The commercial private sector has also grown in extended health service areas, such as MRI diagnostic centers and long-term care services, including both in-home and nursing home care services. Other services have been 'delisted' as necessary health services. There have also been trends in diverse provincial contexts with respect to the expansion of non-core, private for-profit health-related services. These trends have involved some increases in the presence of for-profit organizations in health care delivery. We further note that, given different patterns of path dependency, these same dynamics are played out internationally.

While fiscal federalism sets important constraints on provincial health budgets, the Canadian constitutional prerogatives of the provinces have allowed these governments to approach 'privatization' in a variety of ways. Examples of privatization of health care services have increased in Canada's provinces in an increasingly budget-challenged health care delivery system. Such privatization provides an alternative and an additional source of locally based community health care services for some of the Canadian middle class frustrated by delays in receiving services from the public system. However, for-profit privatization also presents a challenge to the goal of providing universal, quality health care services on an equitable basis. The exact public–private sector mix in the delivery of health care services, and the regulatory frameworks adopted in regard to for-profit deliverers of health services, will reflect differences in the politics and political culture of the various provinces.

Thus, utilizing the Heisler and Peters framework as a general guide to the multidimensional aspects of political decision-making with regard to public policy, we note that the Canadian health care delivery system remains a dynamic one in terms of the levels of government involved in the delivery of health care services within a framework of fiscal federalism, and in terms of the uniqueness of the provincial health care delivery systems within the federal system. It is also characterized by the complex and developing relationship between the private and public sectors in the delivery of health care services in the provinces we have discussed. In addition, our study illustrates that both political and economic considerations at the federal level and within the various provinces (at a sub-national level) are factors affecting the development of the policies and programs characterizing Canada's provincial health care delivery systems. Thus, the growth of commercial, private-sector developments does not proceed at the same pace, take the same shape, or occur exactly in the same areas in Quebec and Ontario, as they are affected by different political ideologies and different resource aggregations.

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