Clinicians' Commentary

Landry et al.¹ report on their study of the restructuring of physical therapy services in hospitals following the delisting of these services in Ontario and the implementation of for-profit clinics in hospitals. The goal of this commentary is to set their findings into a larger context of the privatization of health services in Canada, particularly those related to ambulatory rehabilitation and chronic care services.

As Landry et al.¹ note, health expenditures are increasing in Canada, and hospitals get the biggest piece of the pie (28.7%). However, three additional trends are related to the use of physical therapy services in Canada: the hospitals' share of total health expenditures in Canada has declined from 56% in 1975; the private-sector share of total health expenditures had increased to about 30.0% by 2008; and one-third of the private-sector share goes to dentists, denturists, optometrists and opticians, chiropractors, physical therapists, and private-duty nurses.²

Physical therapists, particularly in Ontario, have been persistent in pursuing independent billing privileges for their services. Physical therapy services funded by the Ontario Health Insurance Plan (OHIP) are delivered in communities by Designated Physiotherapy Clinics. The number of such clinics was frozen in 1964 at 91 billing licences for both clinical and home services and 29 billing licences authorized for home care alone.³ Physiotherapy clinics established after 1964 bill third-party payers or bill patients directly for their services. In 2004, the Ministry of Health and Long-Term Care delisted services previously funded by OHIP for all persons between the ages of 18 and 64, unless receiving benefits under the Ontario Disability Support Program, Family Works, or requiring physiotherapy services following hospitalization. A doctor's referral is required for persons requiring these listed services, whether young, seniors, or otherwise eligible for these services.

In 2008, the Canadian Institutes for Health Information (CIHI) reported that 36.8% of physical therapists in Ontario worked in group professional practices and clinics, while 39.2% worked in hospitals and rehabilitation facilities.⁴ By way of comparison, at the same date about 45% of occupational therapists in Ontario were employed in hospitals, rehabilitation facilities, or mental-health facilities, and about 11% worked in group practices, clinics, or solo practice.⁵

The closure of rehabilitation outpatient services in hospitals has had the secondary effect of reducing the number of positions for other rehabilitation specialists, such as speech-language pathologists, occupational

therapists, and social workers; however, the numbers of positions involved have not been documented. The delisting of services previously covered by OHIP also included the exclusion of chiropractic services and the limiting of services of optometrists and opticians. Substantial segments of rehabilitation services, particularly those provided by physical therapists, have moved into the private sector of health care.

Landry et al.¹ report on the rise of for-profit clinics in hospitals providing physical therapy services. On walking into the atria of GTA hospitals, one can find pharmacies and optic clinics, in addition to fast-food services, coffee shops, bookstores, and gift shops; prescribing and dispensing audiologists offer services for a fee in hospital clinics. Hospitals are finding a number of ways to work private for-profit providers of goods and services into their business plans.

We are also seeing the increase of for-profit clinical services in the community. For example, in exploring websites, we found that the Servpro.ca Business/Classified Directory lists 168 clinics providing physiotherapy services in Ontario.⁶ In addition to physical therapy services, the clinics listed provide sports medicine, massage, kinesiology, chiropractic, acupuncture, music therapy, and/or physicians on site. Senior health professionals work in solo professional practices, but there are businesses offering their services; for example, audiologists are now providing prescribing and dispensing services through national retail outlets.

Ontario's one-tier health care system, funded by public health insurance, works best in the provision of immediate, post-acute care for persons with acute or life-threatening episodes of illness and injury. For the most part, such care is timely, accessible, and universal. Primary health care continues to be subject to criticism, debate, and reform; however, persons who are left with chronic and/or disabling problems require services provided in the private sector. For example, survivors of childhood and adult cancer, childhood disabilities, cardiac problems, and disabling injuries; those with hearing and vision problems; and persons with mental-health problems need services not covered by OHIP. The problems are compounded for such persons who do not have a family doctor.⁷ The private health care system is growing in response to those seeking services.

The population of Ontario is ageing—both in the sense of demographic trends and in the sense of increased life expectancy—and demands for services and costs of health care will increase accordingly. There is a myth that ageing Baby Boomers will be healthier and

wealthier than their predecessors. In fact, however, they are surviving with health problems and are experiencing increased rates of obesity and the problems associated with it, including diabetes and arthritis. The current financial crisis has affected investments, pension funds, and health insurance coverage; the future wealth of the Baby Boom generation is not guaranteed.

There are four sources of payment for private health care not covered by public health insurance. The Workplace Safety and Insurance Board provides compensation for occupational disease, injury, and disability; health insurance companies offer coverage for employees and pensioners of workplaces; auto insurers cover health care costs of those injured in motor vehicle accidents; and individuals without such coverage pay the rest of their costs out of pocket. Third-party insurers have modified their coverage as the services of health care professionals have been delisted; depending on how one classifies the payers, we have a three- or four-tier health care system.

Hospitals are responding to the changing demand. An estimated 9.3% of hospital costs are now covered by the private sector.² There are no mechanisms for accountability; hospitals are financing and managing these services as free-standing corporations. The for-profit clinics are not included in the reporting of hospital outpatient services in the National Ambulatory Care Reporting System,⁸ and in Ontario, Local Health Integration Networks, the Ontario Hospital Association, health professions, and third-party insurers give minimal consideration to the accessibility, quality, and effectiveness of their services.

So where do we go from here? The 1984 Canada Health Act is the starting/stopping point. The key features are *public administration* (single-payer health insurance), *comprehensiveness* (plans must cover insured services provided by hospitals, medical practitioners, and dentists), *universality*, *portability* across provinces, and *accessibility* (plans must provide reasonable access to insured services by insured persons).⁹

Two major federal reports on Canada's health care system were published in 2002; the final report of the Commission on the Future of Health Care in Canada, chaired by Roy Romanow,¹⁰ and the report of the Senate Committee on Social Affairs, Science and Technology, chaired by Michael J.L. Kirby.¹¹ Courchene has analyzed the perspectives of these reports.¹² The principles of the Romanow Report are stated in the summary of the essay as follows:

- medicare is a moral enterprise, not a business venture;
- private money should not enable one to jump the queue;
- existing private diagnostic providers should be incorporated into the public system, while private treatment provided should be discouraged or prohibited;

- Canada has latched on to the best approach to health care; therefore, there is no need to encourage experimentation with alternative approaches.^{12(p.3)}

In stating the key operating principles of the Kirby Report,¹¹ Courchene noted that Kirby agreed with the single-payer principle but proposed a health care guarantee that would set maximum waiting times for treatment. The government should be agnostic as to whether diagnostic and service providers are government-owned, not-for-profit, or private enterprises; government should fund the services, not control them, and providers, hospitals, and professionals should compete in the provision of these services. Lastly, private payment should be prohibited unless waiting times for diagnostic and treatment services exceed the guaranteed maximum; in such cases, persons paying for the services should be reimbursed from public funds.^{12(p.19)}

After reviewing health care reforms of member countries of the Organisation for Economic Co-operation and Development, Castonguay prepared a discussion paper on changes required in the health care system of Quebec.¹³ Castonguay stated that the health care system is unable to respond to the demands that it is facing; health care is an important issue, and the growth of health care expenditures has to be kept in check. He advocated a change in the governance structure whereby the Régie de l'assurance maladie du Québec would be responsible for purchasing hospital and ambulatory services and for evaluating the performance of institutions. Castonguay also called for the coexistence of public and private services, both in hospital and community services, to optimize the use of resources and services; providers would be expected to improve quality and control costs. This proposal would allow professional freedom and require the professions to re-evaluate their relationships with government and with one another.

The Canada Health Act would have to be changed to permit the public-private mix of services and user fees, including private health insurance for publicly insured procedures, advocated by Castonguay. User fees would be introduced, which would increase the sense of responsibility on the part of persons using services and provide room to manoeuvre in relation to funding. A public assistance program would be required to cover the user fees for low-income individuals and those requiring special services. Castonguay's points were debated in the report of the Task Force on the Funding of the Health System, which he chaired.¹⁴ The government of Quebec rejected many of the bold reforms proposed.

Hundreds of papers and reports have been released since 2000, and the debate and conflicting recommendations on health care in Canada and Ontario continue. Meanwhile, the Ontario government has delisted services and added a health care premium to provincial income taxes, and we are now seeking to understand the

direction of the public–private mix of ambulatory rehabilitation services. As Yogi Berra might have said, when we came to a fork in the road, we took it.

Jack I. Williams

Scientist Emeritus, Institute for Clinical Evaluative Sciences, Scientist Emeritus, Clinical Epidemiology, Sunnybrook Health Sciences Centre, Toronto, ON

Aileen M. Davis

Senior Scientist, Division of Health Care and Outcomes Research, Arthritis and Community Research and Evaluation Unit, Toronto Western Research Institute, Toronto, ON

REFERENCES

1. Landry MD, Verrier MC, Williams AP, Zakus D, Deber RD. Strategic responses to fiscal constraints: a health policy analysis of hospital-based ambulatory physical therapy services in the greater Toronto area. *Physiother Can*. 2009;61:221–30.
2. Canadian Institutes of Health Information. National health expenditure trends 1975–2008 [Internet]. Ottawa: The Institutes; 2008 [cited 2009 Jul 15]. Available from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_31_E&cw_topic=31.
3. Ontario Physiotherapy Association. OHIP & physiotherapy [Internet]. Toronto: The Association; c2005 [cited 2009 Jul 15]. Available from: http://www.opa.on.ca/policy_ohip.shtml.
4. Canadian Institutes of Health Information. Workforce trends of physiotherapists in Canada, 2007 [Internet]. Ottawa: The Institutes; 2008 [cited 2009 Jul 15]. Available from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1594_E&cw_topic=1594&cw_rel=AR_2389_E.
5. Canadian Institutes of Health Information. Workforce trends of occupational therapists in Canada, 2007 [Internet]. Ottawa: The Institutes; 2008 [cited 2009 Jul 15]. Available from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=PG_1592_E&cw_topic=1592&cw_rel=AR_1809_E.
6. Servpro.ca Business/Classified Directory [Internet]. Results for physiotherapists serving Ontario [cited 2009 Jul 15]. Available from: <http://www.ontario.servpro.ca/listcompht/20132/Physiotherapists.html>.
7. Glazier RH. Balancing equity issues in health systems: perspectives of primary healthcare. *Healthcare Papers*. 2007;8(Special Issue):35–45.
8. Canadian Institutes of Health Information. National ambulatory care reporting system [Internet]. Ottawa: The Institutes; c2009 [updated 2009 Jun 30; cited 2009 Jul 15]. Available from: http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=services_nacrs_e.
9. Health Canada. Canada Health Act: overview [Internet]. Ottawa: Health Canada; 2004 [updated 2004; cited 2009 Aug 11]. Available from: <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/cha-lcs/overview-apercu-eng.php>.
10. Commission on the Future of Health Care in Canada, Romanow RJ, commissioner. Building on values: the future of health care in Canada: final report. Ottawa: Queen's Printer; 2002. [Romanow Report].
11. Standing Senate Committee on Social Affairs, Science and Technology, Kirby JL, chair. The health of Canadians—the federal role, vol. 6: Recommendations for reform [Internet]. Ottawa: The Committee; 2002 [cited 2009 Jul 15]. Available from: <http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/rep02vol6highlights-e.htm>. [Kirby Report].
12. Courchene TJ. Medicare as a moral enterprise: the Romanow and Kirby perspectives. *Policy Matters*. 2003;4(1):1–20.
13. Castonguay C. Santé: pour des changements en profondeur [Internet]. Montreal: CIRANO; 2007 [cited 2009 Jul 15]. Available from: <http://www.cirano.qc.ca/pdf/publication/2007DT-02.pdf>.
14. Government of Quebec, Castonguay C, chair. Getting our money's worth: report of the Task Force on the Funding of the Health System [Internet]. Quebec: Gouvernement du Québec; 2008 [cited 2009 Jul 15]. Available from: http://www.financementsante.gouv.qc.ca/en/rapport/pdf/RapportENG_FinancementSante.pdf.

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